Frequently Asked Questions
About New G.S. 130A-12

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Background

Local health departments in North Carolina are no longer required to obtain consent to disclose patient health information for purposes of treatment, payment, or health care operations (TPO), as those terms are defined by the HIPAA privacy rule. This very significant change in state medical confidentiality law was part of the Public Health Preparedness Act (S 582). The Act amended G.S. 130A-12, the state law that requires local health departments to keep patient information confidential. The new G.S. 130A-12 says:

> **§ 130A-12. Confidentiality of records.**
> All records containing privileged patient medical information or information protected under 45 C.F.R. Parts 160 and 164 that are in the possession of the Department [of Health and Human Services] or local health departments shall be confidential and shall not be public records pursuant to G.S. 132-1. Information contained in the records may be disclosed only when disclosure is authorized or required by State or federal law. *Notwithstanding G.S. 8-53 or G.S. 130A-143, the information contained in the records may be disclosed for purposes of treatment, payment, or health care operations.* For purposes of this section, the terms 'treatment,' 'payment,' and 'health care operations' have the meanings given those terms in 45 C.F.R. § 164.501. (emphasis added)

Questions About the New Law

1. Does the new law mean that local health departments are no longer required to obtain informed consent for treatment?

No. Informed consent to treat a patient is an entirely different legal obligation. The new law addresses only consent to disclose (or release) information, not consent to treat. The new law means simply that local health departments are no longer required to obtain consent *to disclose patients' information* for specific purposes (treatment, payment, and health care operations). Health departments still need informed consent to treat a patient.

2. Is the new law consistent with HIPAA?

Yes. The HIPAA privacy rule already permitted local health departments to disclose information for TPO purposes without patients' consent. However, local health

departments must comply with state law as well as HIPAA. Before this recent legislative change, state law on this issue was unclear, but there were good reasons to believe the local health department should obtain patients' written consent for TPO-related disclosures. The new law makes clear that local health departments do not need written consent to make most TPO disclosures (there are some exceptions for some HIV-related disclosures). As a result, HIPAA and state law are now the same on this issue (except for those HIV-related disclosures).

3. May a local health department continue to ask patients for consent to disclose PHI for TPO purposes, if it would prefer to do so?

Yes. However, the department needs to recognize that if it asks a patient to consent, it must abide by the patient's answer. If the department asks for permission and the patient refuses to give it, the department may not disclose that patient's information for TPO purposes—even though, under the new 130A-12, the department could have made those disclosures if it *hadn't* asked for permission.

Before deciding whether to continue to ask for consent for TPO disclosures, the health department should consider the administrative and financial consequences when patients refuse to consent. Unlike private health care providers, health departments may not refuse some types of treatment to patients who refuse to consent to TPO disclosures. As a result, some serious challenges may arise if a department asks for consent and a patient refuses. For example:

> *Payment*: If a patient is asked to consent to TPO disclosures and refuses, the health department may be required to provide treatment that may not be billed to a third-party payer or referred to debt collection services if the patient does not pay. (In some cases, such as STD and TB diagnosis and treatment, the department is not permitted to ask the patient to pay.) A July 7, 2003 memo from the Division of Public Health said patients seeking the following services should be treated, even if they refused to give consent for TPO disclosures:
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> - communicable disease evaluation and treatment, including STDs;
> - family planning;
> - maternity care; and
> - well child care, including immunizations.
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> The memo went on to state that Medicaid and other third-party payers could not be billed for those services if the patient refused to consent to TPO disclosures; nor could STD/TB patients be classified as self-pay.
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> *Health care operations*: If a patient is asked to consent to TPO disclosures and refuses, the health department may be thwarted in its ability to carry out some of its administrative and business functions, if it needs to disclose the patient's information in order to do so.

The purpose of the amendment to G.S. 130A-12 was to alleviate the problems that were created when patients refused to consent to TPO disclosures. However, the new G.S. 130A-12 does not *require* a local health department to stop obtaining the consent. But, a local health department that continues to ask for patients' consent needs to abide by the patient's decision and, as a result, may continue to have the problems described above.

4. What about the administrative burdens on the other side of the issue? If a local health department stops seeking consent for TPO disclosures, does it need to take any other administrative steps in order to comply with HIPAA?

A local health department that stops seeking consent for TPO disclosures has three administrative responsibilities under the HIPAA Privacy Rule. First, it must update its policies and procedures to accurately reflect the practices of the department. (See section 164.530(i).) Second, before implementing a new policy or procedure, the department should review its Notice of Privacy Practices and determine whether it needs to be revised to ensure that it accurately reflects the new policy or procedure. (See section 164.520.) Finally, the department must provide updated training to those members of its workforce expected to be affected by the change. The rule requires the entity to provide updated training "within a reasonable period of time after the material change becomes effective…." (See section 164.530(b)).

5. In the past, local health departments were advised that the communicable disease confidentiality law (G.S. 130A-143) required the local health department to obtain consent before disclosing a patient's information for purposes of payment or health care operations, and that the physician-patient privilege law (G.S. 8-53) could be interpreted to require the local health department to obtain consent before disclosing any information for TPO purposes. Has that changed?

Yes, it has changed. The new law explicitly says, "*Notwithstanding G.S. 8-53 or G.S. 130A-143,* the information contained in the records may be disclosed for purposes of treatment, payment, or health care operations." The term "notwithstanding" means that those laws—G.S. 8-53 and 130A-143—no longer apply in this situation. Therefore, they no longer prohibit the health department from disclosing information for TPO purposes.

6. What if another law—not G.S. 8-53 or 130A-143, but something else—requires the local health department to obtain consent before disclosing information for TPO purposes?

If the health department is subject to another law that requires consent for a TPO-related disclosure, the health department must abide by that law and obtain the consent. For example, there is a N.C. communicable disease rule that requires local health departments to obtain written consent before billing a patient's third-party payer for HIV testing or counseling. The health department therefore must obtain consent before making that particular disclosure. (For more information about implementing this requirement, see question 8.)

7. Suppose the local health department does not ask patients to consent to TPO disclosures, but a patient asks the department not to reveal his health information to his insurer (or another doctor)?

The patient has a right under HIPAA to make this kind of request. (See section 164.522 of the HIPAA Privacy Rule, which establishes the individual right to request restrictions on disclosures.) The department does not have to agree to the request. However, if it does agree to the request, it must honor its agreement and not disclose the information—even though both HIPAA and G.S. 130A-12 would otherwise allow it to. The health department should be careful not to agree to a restriction it cannot or will not honor.

8. Under state communicable disease rules, local health departments still need a patient's consent to bill third-party payers for HIV testing and counseling. Suppose a local health department finds it difficult to determine ahead of time which patients will have HIV testing as part of their care. The department presently obtains consent for TPO disclosures as part of intake. This ensures that permission to bill for the HIV testing/counseling is there, if needed. If the patient stops getting consent on intake, it is likely that some patients will fall through the cracks and their insurance will be billed without permission. Must the department change its procedures?

No, the department does not have to change its procedures, but see question 3. If the department continues to seek general consent for TPO disclosures upon intake, it cannot make any such disclosures for a patient who refuses consent.

As an alternative, perhaps local health departments could obtain permission to bill third-party payers at the same time they obtain informed consent to conduct the HIV test (as required by G.S. 130A-148(h)). *Caution:* The department must not under any circumstances require the patient to consent to disclosure to the third-party payer before conducting the test, or in any way imply that the test will not be done unless the patient consents. If the patient refuses to consent to the disclosure, the department still must conduct the test and provide appropriate follow-up counseling—it just may not bill for it. Nor can it require the patient to self-pay, as HIV testing and counseling are services that local health departments are required to provide at no cost to the patient.

9. Does the new law apply to any entities other than local health departments? For example, does it apply to community-based organizations that have contracts to serve local health department clients?

The law is limited to information contained in records in the possession of the N.C. Department of Health and Human Services or local health departments. It does not extend to records in the possession of other entities, such as CBOs or other health care providers who have contracts with health departments.