Effective Date: 8/11/2020
Review Date: 8/11/2020
Revised Date:

North Sound Behavioral Health Administrative Services Organization, LLC

Section 2500 – Privacy: Definitions for Policies Governing Protected Health Information (PHI)

Authorizing Source: 45 CFR 164 (HIPAA); 42 CFR Part 2 (Part 2); RCW 70.02
Approved by: Executive Director Date: 08/11/2020 Signature:

POLICY # 2502.00

SUBJECT: DEFINITIONS FOR POLICIES GOVERNING PROTECTED HEALTH INFORMATION (PHI)

PURPOSE

This policy provides definitions for North Sound Behavioral Health Administrative Services Organization (North Sound BH-ASO) policies relating to Protected Health Information (PHI).

DEFINITIONS

1. **Authorized Representative** means a personal representative who is authorized under HIPAA, State Law or other law to act on behalf of an Individual in making decisions related to Health Care. This includes a court-appointed guardian and a person with a Power of Attorney that extends to Health Care decisions but may also include other persons such as the parent, guardian or person acting in loco parentis of an unemancipated minor.

2. **Breach Notification Rule** means the Notification of Breach of Unsecured Protected Health Information standards promulgated to implement HIPAA, as may be amended from time to time.

3. **Breach of Unsecured PHI** means the acquisition, access, Use or Disclosure of PHI in a manner not permitted under the Privacy Rule that compromises the security or privacy of the PHI, subject to certain exceptions listed in 45 C.F.R. § 164.402. An analysis must be performed to determine whether notification of an event affecting PHI is required. To establish whether a Breach of Unsecured PHI has occurred with respect to North Sound BH-ASO, please refer to Policy 1009.00: Critical Incident.

4. **Business Associate** means any person or entity (other than in the capacity of Workforce) who:

    4.1 **Activities on Behalf of a Covered Entity Involving PHI.** On behalf of a Covered Entity (or Organized Health Care Arrangement in which a Covered Entity participates) creates, receives, maintains or transmits PHI for a function or activity regulated by HIPAA, including claims processing or administration, data analysis, processing, or administration, utilization review, quality assurance, patient safety activities, billing, benefit management, practice management and repricing;

    4.2 **Services Involving PHI.** Provides to a Covered Entity (or Organized Health Care Arrangement in which a Covered Entity participates) legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services involving the Disclosure of PHI from the Covered Entity or Organized Health Care Arrangement; and/or

    4.3 **Specified Entity.** Is: (a) health information organization, e-prescribing gateway or other person that provides data transmission services with respect to PHI and requires access on a routine basis to the PHI; (b) a person who offers a personal health record to Individuals on behalf of a

Covered Entity; and/or (c) a Subcontractor that creates, receives, maintains or transmits PHI on behalf of a Business Associate.

4.4 **Exclusions.** Is not: (a) Health Care Provider (for Treatment purposes); (b) a sponsor of a Health Plan (for Health Plan activities in compliance with HIPAA); (c) a government agency (for determining eligibility for or enrollment in a government Health Plan); or (d) a Covered Entity performing services on behalf of the Organized Health Care Arrangement in which it is participating.

4.5 **Examples.** North Sound BH-ASO acts as a Business Associate for its Upstream Covered Entities. Additionally, North Sound BH-ASO contracts with Subcontractor Business Associates.

5. **Business Associate Agreement or BAA** means the satisfactory written assurance from a Business Associate to permit the Business Associate to create, receive, maintain or transmit PHI on behalf of a Covered Entity or Upstream Business Associate. A BAA, in part, establishes the Business Associate's: permitted or required Uses and Disclosures of PHI; obligations to safeguard PHI; and facilitation of the rights of Individuals with respect to PHI. At a minimum, the BAA must contain the language required by HIPAA. A BAA may take many forms including a stand-alone contract, addendum to a service contract or amendment to a contract. North Sound BH-ASO at times, will be contracting both with Upstream Covered Entities (as their Business Associate) and with downstream Business Associates Subcontractors.

6. **Correctional Institution** means any penal or correctional facility, jail, reformatory, detention center, work farm, halfway house or residential community program center operated by, or under contract to, the United States, a state, a territory, a political subdivision of a state or territory or an Indian tribe, for the confinement or rehabilitation of persons charged with or convicted of a criminal offense or other persons held in lawful custody. Other persons held in lawful custody include juvenile offenders adjudicated delinquent, aliens detained awaiting deportation, persons committed to mental institutions through the criminal justice system, witnesses or others awaiting charges or trial.

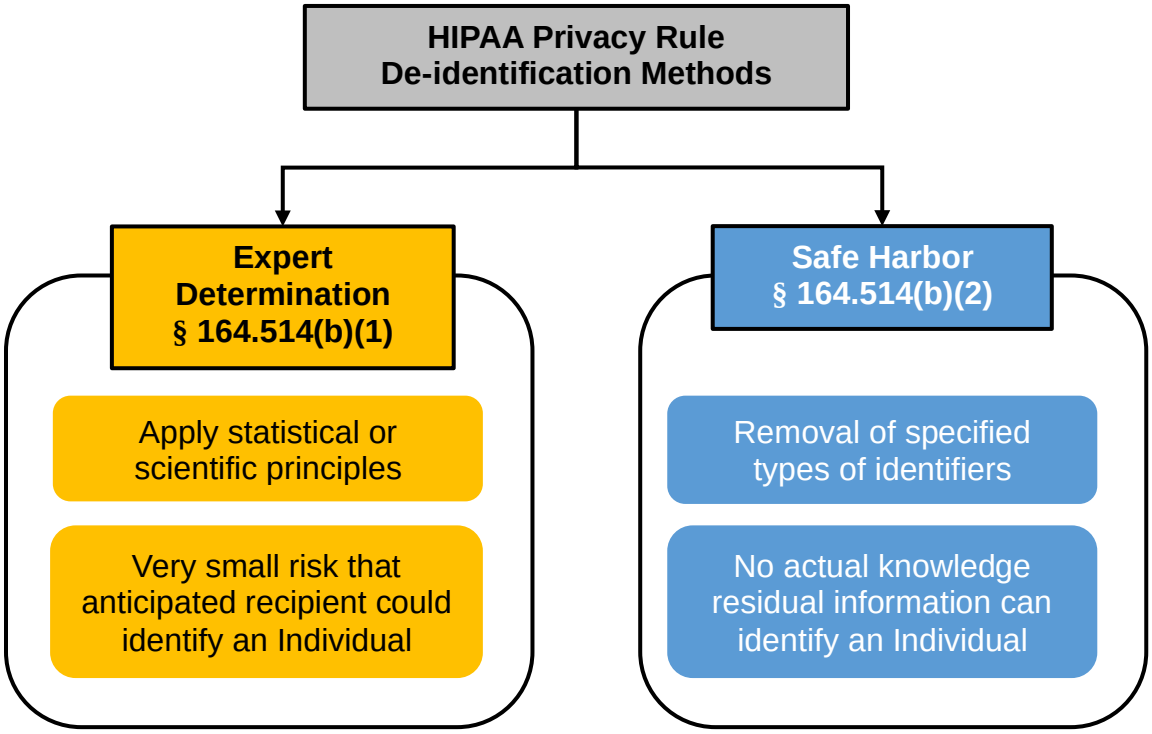
7. **Covered Entity** means one of the following entities, which must comply with HIPAA: (a) Health Care Provider that electronically transmits any HIPAA-covered Transaction (usually related to electronic billing); (b) Health Plan; and/or (c) Health Care Clearinghouse. Most, if not all, of the Health Care Providers that provide critical care services, the Washington Health Care Authority and the MCOs are Covered Entities. Prior to the Transition Date, North Sound BH-ASO was a Covered Entity and continues to have obligations with respect to Pre-Transition PHI.

8. **Covered Functions** means those functions of a Covered Entity, the performance of which makes the entity a Covered Entity (e.g., a Health Plan, Health Care Provider or Health Care Clearinghouse).

9. **Data Aggregation** means, with respect to PHI created or received by a Business Associate in its capacity as the Business Associate of a Covered Entity, the combining of PHI by the Business Associate with the PHI received by the Business Associate in its capacity as a Business Associate of another Covered Entity, to permit data analyses that relate to the Health Care Operations of the respective Covered Entities.

10. **Data Use Agreement** means the written assurances that must be provided by a recipient of a Limited Data Set. A Data Use Agreement, at a minimum, must contain the language required by the Privacy Rule.

11. **De-Identified Data or De-Identification** means health information that does not identify an Individual and with respect to which there is no reasonable basis to believe the information can be used to identify an Individual. To constitute De-Identified Data, the Covered Entity or Business Associate must meet one of the two De-Identification standards, which are depicted below:



See Policy 2503.00: De-Identification and Limited Data Sets.

12. **Designated Record Set** means a group of records maintained by or for a Covered Entity that is used for or constitutes:

    12.1 **Health Care Provider Records.** The medical records and billing records about Individuals maintained by or for a covered Health Care Provider;
    12.2 **Health Plan Records.** The enrollment, payment, claims adjudication and case or medical management systems maintained by or for a covered Health Plan; or
    12.3 **For Decisions.** The PHI used, in whole or in part, by or for the Covered Entity to make decisions about Individuals.
    12.4 **Definition of Record.** For purposes of this definition paragraph, the term "record" means any item, collection or grouping of information that includes PHI and is maintained, collected, used or Disclosed by or for a Covered Entity.

13. **Disclosure** means the release, transfer, provision of access to or divulging in any other manner of information outside the entity holding the information.

14. **Financial Remuneration** means, for Marketing purposes, direct or indirect payment from or on behalf of a third-party whose product or service is being described. Direct or indirect payment does not include any Payment for Treatment of an Individual. See also Section 28 of this policy (definition of Marketing) and Policy 2508.00: Marketing.

15. **Group Health Plan** means an employee welfare benefit plan, including insured and self-insured plans, to the extent the plan provides medical care, including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement or otherwise, that: (a) has 50 or more participants; or (b) is administered by an entity other than the employer that established and maintains the plan.

    NOTE: A Group Health Plan is an umbrella term, encompassing a number of different kinds of employer-provided benefit plans. Most private-sector group health plans are covered by the Employee Retirement Income Security Act (ERISA), which commonly are referred to as "ERISA plans." Examples of group health plans include, but are not limited to:

    - A group health plan that is covered by health insurance;
    - A self-insured health plan; or
    - A self-insured medical reimbursement plan.

    See also, Section 21 (definition of Health Plan); § 3(1) of ERISA, 29 USC § 1002(1); and § 2791(a)(2) of the Public Health Service (PHS) Act, 42 USC 300gg-91(a)(2).

16. **Health Care** means care, services or supplies furnished to an Individual and related to the health of the Individual. Health Care includes the following:

    16.1 **Care and Services.** Preventive, diagnostic, therapeutic, rehabilitative, maintenance or palliative care and counseling, service, assessment or procedure with respect to the physical or mental condition, or functional status, of an Individual or that affects the structure or function of the body; and

    16.2 **Drug, Device or Equipment.** Sale or dispensing of a drug, device, equipment or other item in accordance with a prescription.

17. **Health Care Operations** means any of the following activities of a Covered Entity to the extent the activities are related to Covered Functions and any of the following activities of an Organized Health Care Arrangement in which the Covered Entity participates:

    17.1 **Quality Assessment and Improvement.** Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, as long as the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from the activities, population-based activities relating to improving health or reducing Health Care costs, protocol development, case management and care coordination, contacting of Health Care Providers and Individuals with information about Treatment alternatives and related functions that do not include Treatment;

    17.2 **Professional Competence or Qualifications.** Reviewing the competence or qualifications of health care professionals, evaluating practitioner and provider performance, Health Plan performance, conducting training programs in which students, trainees or practitioners in areas of Health Care learn under supervision to practice or improve their skills as Health Care Providers, training of non-health care professionals, accreditation, certification, licensing or credentialing activities;

    17.3 **Underwriting.** Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits and ceding, securing or placing a contract for reinsurance of risk relating to claims for Health Care (including

stop-loss insurance and excess of loss insurance). (Note: the requirements of 45 CFR §164.514(g) must be met, if applicable);

17.4 **Medical, Legal and Auditing Review.** Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;

17.5 **Business Planning.** Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and

17.6 **Business Management.** Business management and general administrative activities of the entity, including, but not limited to:

17.6.1 Management activities relating to implementation of and compliance with the requirements of the Privacy Rule;

17.6.2 Customer service, including the provision of data analyses for policyholders, plan sponsors or other customers, as long as PHI is not disclosed to the policyholder, plan sponsor or customer;

17.6.3 Resolution of internal grievances;

17.6.4 Due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is a Covered Entity or, following completion of the sale or transfer, will become a Covered Entity; and

17.6.5 Creating De-Identified Data, fundraising for the benefit of the Covered Entity and Marketing for which an Individual authorization is not required as described in §164.514(e)(2), subject to applicable de-identification requirements of §164.514. See also, Section 10 of this policy (definition of De-Identified Data) and Policy 2503.00: De-Identification and Limited Data Sets.

18. **Health Care Provider** means:

18.1 A "provider of services," which includes a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency or hospice program;

18.2 A provider of "medical or health services," which includes: physician services; "incident to" services, hospital services, outpatient physical and occupational medicine services, diagnostic services, rural health clinic services, home dialysis supplies, equipment and services, antigens, physician assistant and nurse practitioner services, blood clotting factors, immunosuppression therapy, physician assistant services, certified midwife services, qualified psychologist services, clinical social worker services, erythropoietin, prostate cancer screen tests, oral anti-cancer drugs, colorectal screening tests, diabetes outpatient self-management training, anti-emetic to accompany chemotherapy, glaucoma screening, medical nutrition therapy services, initial preventative physical examination, cardiovascular screening blood tests, diabetes screening tests, intravenous immune globin, ultrund screening, other preventive services, cardiac rehabilitation, kidney disease education, personalized prevention plan and home infusion; diagnostic x-rays; x-ray, radium and radioactive isotope therapy; surgical dressings, splints and casts; durable medical equipment; ambulance services; prosthetic devices; braces and artificial limbs and eyes; pneumococcal vaccine; certified registered nurse anesthetist services; certain custom molded shoes; screening mammography; pap smear and screening pelvic exam; and bone mass measurement; or

18.3 Any other person or organization who bills or is paid for Health Care in the normal course of business. See, §1861(u) of the Social Security Act, 42 USC § 1395x(u)].

19. **Health Maintenance Organization or HMO** means a health insurance provider with a network of contracted Health Care Providers and facilities. Subscribers pay a fee for access to services within the HMO's network. Typically, an HMO develops its network by contracting with primary care physicians (e.g., internists and family doctors), specialists (e.g., cardiologists and ophthalmologists) and clinical facilities (e.g., hospitals and specialty clinics). The HMO agrees to pay these parties specific levels of compensation for a range of services they provide to its subscribers. In return for a monthly fee, or premium, subscribers are granted access to Health Care Providers inside the network at no additional cost. Subscribers may access services outside the network with the HMO's approval but may need to pay for part of the services. See, §2791 of the Public Health Service Act (PHS), 42 USC § 300gg-91(b)(3). See also, RCW 48.46.020 (13) (HMO means any organization that provides comprehensive health care services to enrolled participants of the organization on a group practice per capita prepayment basis or on a prepaid individual practice plan, except for an enrolled participant's responsibility for copayments and/or deductibles, either directly or through contractual or other arrangements with other institutions, entities, or persons, and which qualifies as a Health Maintenance Organization pursuant to RCW 48.46.030 and 48.46.040).

20. **Health Insurance Issuer** means an insurance company, insurance service or insurance organization (including an HMO) that is licensed to engage in the business of insurance in a state and is subject to State Law that regulates insurance. A Health Insurance Issuer does not include a Group Health Plan. See § 2791(b)(2) of the Public Health Service Act, 42 USC 300gg-91(b)(2).

21. **Health Oversight Agency** means an agency or authority of the United States, a state, a territory, a political subdivision of a state or territory or an Indian tribe, or a person or entity acting under a grant of authority from or contract with the public agency, including the employees or agents of the public agency or its contractors or persons or entities to whom it has granted authority, that is authorized by law to oversee the Health Care System (whether public or private) or government programs in which health information is necessary to determine eligibility or compliance, or to enforce civil rights laws for which health information is relevant.

22. **Health Plan** means an individual or group plan that provides, or pays the cost of, medical care. A Health Plan is an entity that provides, offers or arranges for coverage of designated health services needed by plan members for a fixed, prepaid premium.

22.1 **Inclusion.** Health Plan includes the following, singly or in combination:

22.1.1 A Group Health Plan, as defined in Section 15 of this policy.
22.1.2 A Health Insurance Issuer, as defined in Section 20 of this policy.
22.1.3 An HMO, as defined in Section 19 of this policy.
22.1.4 Part A or Part B of the Medicare program under Title XVIII of the Social Security Act.
22.1.5 The Medicaid program under Title XIX of the Social Security Act, 42 USC §1396 et seq. In Washington State, Medicaid is called "Apple Health." Apple Health provides preventative care, like cancer screenings, treatment for diabetes and high blood pressure and many other Health Care services.
22.1.6 An issuer of a Medicare supplemental policy [as defined in §1882(g)(1) of the Social Security Act, 42 USC §1395ss(g)(1)].
22.1.7 An issuer of a long-term care policy, excluding a nursing home fixed-indemnity.

22.1.8 An employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more employers.

22.1.9 The Health Care program for active military personnel under Title 10 of the USC.

22.1.10 The Veterans Health Care Program under 38 USC Chapter 17.

22.1.11 The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in 10 USC §1072(4).

22.1.12 The Indian Health Service program under the Indian Health Care Improvement Act (25 USC §1601 et seq.).

22.1.13 The Federal Employees Health Benefit Program under 5 USC §8902 et seq.

22.1.14 An approved state child health plan under Title XXI of the Social Security Act, providing benefits that meet the requirements of §2103 of the Act, 42 USC §1397 et seq.

22.1.15 The Medicare + Choice program under Part C of Title XVIII of the Social Security Act, 42 USC §§1395w-21 through 1395w-28.

22.1.16 A high-risk pool that is a mechanism established under State Law to provide health insurance coverage or comparable coverage to eligible individuals.

22.1.17 Any other individual or group plan, or combination of individual or group plans, that provides or pays for the cost of medical care [as defined in §2791(a)(2) of the PHS Act, 42 USC §300gg-91(a)(2)].

22.2 **Exclusions.** The definition of "Health Plan" excludes:

22.2.1 Benefits that are generally not health coverage (e.g., life insurance, automobile insurance, liability insurance, workers compensation and accidental death and dismemberment coverage). These benefits are excepted in all circumstances. See, §2791(c)(1) of the Public Health Services (PHS) Act, §733(c)(1) of ERISA and §9832(c)(1) of the Internal Revenue Code (IRC).

22.2.2 Any policy, plan or program to the extent it provides or pays for the cost of, excepted benefits, which may include: limited scope vision or dental benefits and benefits for long-term care, nursing home care, home health care or community-based care. To be excepted under the excepted benefits category, the benefits must either: (1) be provided under a separate policy, certificate or contract of insurance; or (2) otherwise not be an integral part of a Group Health Plan, whether insured or self-insured. See, §2791(c)(2)(C) of the PHS Act, §733(c)(2)(C) of ERISA, and §9832(c)(2)(C) of the IRC.

22.2.3 Non-coordinated excepted benefits, which include both coverage for only a specified disease or illness (such as cancer-only policies) and hospital indemnity or other fixed indemnity insurance. These benefits are excepted only if all of the following conditions are met: (a) the benefits are provided under a separate policy, certificate or contract of insurance; (b) there is no coordination between the provision of the benefits and any exclusion of benefits under any Group Health Plan maintained by the same plan sponsor; and (c) the benefits are paid with respect to any event without regard to whether benefits are provided under any Group Health Plan maintained by the same plan sponsor. See, §2722(c)(2) of the PHS Act, §732(c)(2) of ERISA, and §9831(c)(2) of the IRC.

22.2.4 Supplemental excepted benefits if they are provided under a separate policy, certificate or contract of insurance and are Medicare supplemental health insurance (Medigap), TRICARE supplemental programs or "similar supplemental coverage"

provided to coverage under a Group Health Plan. Although not specifically defined, "similar supplemental coverage" provided to coverage under a Group Health Plan would include the coverage specifically designed to fill gaps in primary coverage, such as coinsurance or deductibles. See, §2791(c)(4) of the PHS Act, §733(c)(4) of ERISA, and §9832(c)(4) of the IRC.

22.2.5 A government funded program other than above-referenced programs in §21.1 of this Policy:

(a) Whose principal purpose is other than providing or paying the cost of, Health Care; or

(b) Whose principal activity is: (i) the direct provision of Health Care to persons; or (ii) the making of grants to fund the direct provision of Health Care to persons.

23. **HIPAA** means the administrative simplification section of the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations (including the Privacy Rule, Security Rule and Breach Notification Rule), as may be amended from time to time.

24. **Human Subjects Regulations** means regulations in 45 CFR 46 (Protection of Human Subjects) referring to all Research involving human subjects conducted, supported or otherwise subject to regulation by any federal department or agency that takes appropriate administrative action to make the policy applicable to the research. This includes Research conducted by federal civilian employees or military personnel, except each department or agency head may adopt procedural modifications as may be appropriate from an administrative standpoint. It also includes Research conducted, supported or otherwise subject to regulation by the federal government outside the United States. For additional information and illustrations concerning Human Subjects Research regulations, please see: https://www.hhs.gov/ohrp/regulations-and-policy/regulations/45-cfr-46/index.html#46.201.

25. **Individual** means the person who is the subject of PHI.

26. **Institutional Review Board or IRB** means any board, committee or other group formally designated by an institution, or authorized under federal law or State Law, to review, approve the initiation of or conduct periodic review of Research programs to ensure the protection of the rights and welfare of human research subjects.

27. **IS/IT Administrator** means North Sound BH-ASO's Information System/Information Technology Administrator.

28. **Law Enforcement Official** means an officer or employee of any agency or authority of the United States, a state, a territory, a political subdivision of a state or territory or an Indian tribe who is empowered by law to: (a) investigate or conduct an official inquiry into a potential violation of law; or (b) prosecute or otherwise conduct a criminal, civil or administrative proceeding arising from an alleged violation of law.

29. **Limited Data Set** means PHI that excludes 16 categories of direct identifiers related to the Individual or relatives, employers or household members of the Individual and may be Used or Disclosed, only for purposes of Research, public health, or Health Care Operations, without obtaining either an Individual's authorization or a waiver or an alteration of authorization, as long as the recipient of the Limited Data Set enters into a Data Use Agreement. To constitute a Limited Data Set, the following direct identifiers of an Individual and the Individual's relatives, employers or household members must be removed:

29.1 **Names;**
29.2 **Postal addresses** other than town/city, State, and zip code;
29.3 **Telephone numbers;**
29.4 **Fax numbers;**
29.5 **Email addresses;**
29.6 **Social Security numbers;**
29.7 **Medical record numbers;**
29.8 **Health plan beneficiary numbers;**
29.9 **Account numbers;**
29.10 **Certificate/license numbers;**
29.11 **Vehicle identifiers** and serial numbers, including license plate numbers;
29.12 **Device identifiers** and serial numbers;
29.13 **Web Universal Resource Locators (URLs);**
29.14 **Internet Protocol (IP) address numbers;**
29.15 **Biometric identifiers**, including finger and voice prints; and
29.16 **Full-face photographic images** and any comparable images.

Note: Dates, town/cities, states, zip codes may be included in a Limited Data Set and other numbers, characteristics or codes not listed as direct identifiers.

30. **Marketing** means a communication about a product or service that encourages a recipient of the communication to use the product or service.

30.1 **Included as Marketing.** Marketing includes an arrangement between a Covered Entity and any other entity whereby the Covered Entity discloses PHI to the other entity, in exchange for direct or indirect remuneration, for the other entity or its affiliate to make a communication about its own product or service that encourages recipients of the communication to purchase or use that product or service.

30.2 **Exceptions.** Marketing does not include a communication made:

30.2.1 To provide refill reminders or otherwise communicate about a drug or biologic currently being prescribed for the Individual, only if any Financial Remuneration received by the Covered Entity in exchange for making the communication is reasonably related to the Covered Entity's cost of making the communication. See Section 14 of this policy (definition of Financial Remuneration).

30.2.2 For the following Treatment and Health Care Operations purposes, as long as the Covered Entity does not receive Financial Remuneration (see Section 14 of this policy (definition of Financial Remuneration) in exchange for making the communication:

(a) For Treatment of an Individual by a Health Care Provider, including case management or care coordination for the Individual or to direct or recommend alternative treatments, therapies, Health Care Providers or settings of care to the Individual;

(b) For service (or Payment for the product or service) that is provided by, or included in a plan of benefits of, the Covered Entity making the communication, including communications about: (i) the entities participating in a Health Care Provider network or Health Plan network; (ii) replacement of, or enhancements

to, a Health Plan; and (iii) health related products or services available only to a Health Plan enrollee that add value to, but are not part of, a plan of benefits; or

(c) For case management or care coordination, contacting of Individuals with information about Treatment alternatives and related functions to the extent these activities do not fall within the definition of Treatment.

31. **MCO** means an organization having a certificate of authority or certificate of registration from the Washington State Office of Insurance Commissioner that contracts with HCA under a comprehensive risk contract to provide prepaid health care services eligible to HCA enrollees under HCA managed care programs. The North Sound BH-ASO provides administrative services to the North Sound Region Managed Care Organizations.

32. **Mental Health Information** means a type of Health Care information that relates to all information and records compiled, obtained or maintained in the course of providing services by a mental health service agency or mental health professional to Individuals who are receiving or have received services for mental illness. The term includes mental health information contained in a medical bill, registration records and all other records regarding the Individual maintained by Washington State Department of Social and Health Services (DSHS), regional support networks and their staff and treatment facilities. The term further includes certain documents of legal proceedings or somatic Health Care information. For Health Care information maintained by a hospital or a health care facility or Health Care Provider that participates with a hospital in an Organized Health Care Arrangement, "information and records related to mental health services" is limited to information and records of services provided by a mental health professional or information and records of services created by a hospital-operated community mental health program. The term does not include Psychotherapy Notes.

33. **Organized Health Care Arrangement** means:

33.1 **Clinically Integrated.** A clinically integrated care setting in which Individuals typically receive Health Care from more than one Health Care Provider;

33.2 **Held out as Organized System.** An arrangement that holds itself out as an organized system of Health Care in which more than one Covered Entity participates and in which the participating Covered Entities:

33.2.1 Hold themselves out to the public as participating in a joint arrangement; and

33.2.2 Participate in joint activities that include at least one of the following:

(a) Utilization review, in which Health Care decisions by participating Covered Entities are reviewed by other participating Covered Entities or by a third-party on their behalf;

(b) Quality assessment and improvement activities, in which Treatment provided by participating Covered Entities is assessed by other participating Covered Entities or by a third-party on their behalf; or

(c) Payment activities, if the financial risk for delivering Health Care is shared, in part or in whole, by participating Covered Entities through the joint arrangement and if PHI created or received by a Covered Entity is reviewed by other participating Covered Entities or by a third-party on their behalf for the purpose of administering the sharing of financial risk;

33.3 **Group Health Plan and Health Insurance Issuer/HMO.** A Group Health Plan and a Health Insurance Issuer or HMO with respect to the Group Health Plan, but only with respect to PHI created or received by the Health Insurance Issuer or HMO that relates to Individuals who are or who have been participants or beneficiaries in such Group Health Plan;

33.4 **Combined Group Health Plans.** A Group Health Plan and one or more other Group Health Plans each of which are maintained by the same plan sponsor; or

33.5 **Group Health Plans and Health Insurance Issuers/HMOs.** The Group Health Plans described in Section 15 and Health Insurance Issuers or HMOs with respect to the Group Health Plans, but only with respect to PHI created or received by the Health Insurance Issuers or HMOs that relates to Individuals who are or have been participants or beneficiaries in any of these Group Health Plans.

34. **Part 2 Information** means any records containing information, whether recorded or not, received or acquired by a Part 2 Program that identifies an Individual as a recipient of services from a Part 2 Program (e.g., diagnosis, Treatment and referral for Treatment information, billing information, emails, voice mails and texts). Essentially, Part 2 Information will state or suggest the Individual has an Substance Use Disorder ("SUD") or has been treated by a Part 2 Program.

35. **Part 2 Program** means a federally assisted program engaged in the provision of SUD diagnosis, Treatment or referral for Treatment.

36. **Part 2** means the regulations at 42 CFR Part 2 related to the confidentiality of substance use disorder treatment information.

37. **Payment** means:

37.1 **To Make or Receive Reimbursement.** The activities undertaken by:

37.1.1 A Health Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Health Plan; or

37.1.2 A covered Health Care Provider or Health Plan to obtain or provide reimbursement for the provision of Health Care; and

37.2 **Included Activities.** The activities in Section 37.1 relate to the Individual to whom Health Care is provided and include, but are not limited to:

37.2.1 Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts) and adjudication or subrogation of health benefit claims;

37.2.2 Risk adjusting amounts due based on enrollee health status and demographic characteristics;

37.2.3 Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance) and related Health Care data processing;

37.2.4 Review of Health Care services with respect to medical necessity, coverage under a Health Plan, appropriateness of care or justification of charges;

37.2.5 Utilization review activities, including pre-certification and pre-authorization of services, concurrent and retrospective review of services; and

37.2.6 Disclosure to individual reporting agencies of any of the following PHI relating to collection of premiums or reimbursement:

(a) Name and address;
(b) Date of birth;
(c) Social Security number;
(d) Payment history;
(e) Account number; and
(f) Name and address of the Health Care Provider and/or Health Plan.

38. **Power of Attorney** means a written record that grants an agent authority to act in the place of a principal or Individual.

39. **Pre-Transition PHI** means PHI that was used, created, received or maintained by North Sound BH-ASO when it was, and in its capacity as, a Covered Entity prior to the Transition Date. Pre-Transition PHI should be segregated from PHI created, received, maintained or transmitted by North Sound BH-ASO, in its capacity as a Business Associate, beginning on the Transition Date.

40. **Privacy Board** means a board with members of varying backgrounds and appropriate professional competency as necessary to review the effect of the Research protocol on the Individual's privacy rights and related interests. The Privacy Board includes at least one member who is not affiliated with a Covered Entity, not affiliated with any entity conducting or sponsoring the Research and not related to any person who is affiliated with any of these entities; and does not have any member participating in a review of any project in which the member has a conflict of interest.

41. **Privacy Officer** means the Workforce member designated as the Privacy Officer or the Privacy Officer's designee. The Privacy Officer may delegate certain tasks to other Workforce or Business Associates but retains overall responsibility for North Sound BH-ASO's privacy policies, procedures and practices.

42. **Privacy Rule** means the Privacy of Individually Identifiable Health Information Standards promulgated to implement HIPAA, as may be amended from time to time.

43. **PHI** means health information, including demographic information, in any medium, that: (a) is created or received by or on behalf of a Covered Entity, a Business Associate or by or on behalf of Health Care Provider, Health Plan, employer or Health Care Clearinghouse; (b) relates to the past, present or future physical or mental health or condition of an Individual, relates to the provision of Health Care to an Individual or relates to the past, present or future payment for the provision of Health Care to an Individual; and (c) identifies the Individual or for which there is a reasonable basis to believe the information can be used to identify the Individual; and (d) does not constitute (i) education records covered by the Family Educational Rights and Privacy Act ("FERPA"), (ii) "treatment" records covered by FERPA, (iii) employment records or (iv) information about an Individual who has been deceased for more than 50 years. PHI includes information about Individuals living or deceased.

PHI is broadly defined and includes demographic information about an Individual when associated in some form with Health Care or Payment for Health Care. For example, information that identifies an Individual as a patient of a Health Care Provider or a member of a Health Plan is PHI. PHI includes Part 2 Information, Mental Health Information and Sexually Transmitted Disease (STD) information.

North Sound BH-ASO maintains certain PHI in its capacity as a (former) Covered Entity before the Transition Date (see Section 39 for definition of Pre-Transition PHI). North Sound BH-ASO also maintains certain PHI in its capacity as a Business Associate of Upstream Covered Entities (see Section 61 for the definition of Upstream Covered Entities). The term "PHI" includes both Pre-Transition PHI and PHI created, received, maintained or transmitted in North Sound BH-ASO's capacity as a Business Associate of Upstream Covered Entities.

NOTE: The following identifiers for an Individual or family, employers or household members of an Individual are considered personally identifiable information (unless the information is deemed to be De-Identified). This information can be used to identify, contact or locate a single Individual or can be used with other sources to identify a single Individual. When personally identifiable information is used in conjunction with an Individual's physical or mental health or condition, Health Care or Payment for that Health Care, it becomes PHI.

- Name;
- Address (all geographic subdivisions smaller than state, including street address, city county, and zip code);
- All elements (except years) of dates related to an individual (including birthdate, admission date, discharge date, date of death, and exact age if over 89);
- Telephone numbers;
- Fax number;
- Email address;
- Social Security number;
- Medical record number;
- Health Plan beneficiary number;
- Account number;
- Certificate or license number;
- Any vehicle or other device serial number;
- Web URL;
- Internet Protocol (IP) Address;
- Biometric identifiers, including finger or voice prints;
- Photographic facial image or comparable images;
- Deoxyribonucleic acid or DNA; and
- Any other unique identifying number, characteristic, code or combination that allows identification of the Individual.

44. **Psychotherapy Notes** means notes recorded (in any medium) by a Health Care Provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint or family counseling session. Psychotherapy Notes must be separated from the Individual's medical record. Psychotherapy Notes exclude medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of Treatment furnished, results of clinical tests and any summary of the following items: diagnosis; functional status; the Treatment plan; symptoms; prognosis; and progress to date.

45. **Public Health Authority** means an agency or authority of the United States, a state, a territory, a political subdivision of a state or territory or an Indian tribe, or a person or entity acting under a grant of authority from or contract with the public agency, including the employees or agents of such public

agency or its contractors or persons or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate.

46. **Record** (as Part of a Designated Record Set) see Section 12 (definition of a Designated Record Set) of this policy for definition of Record.

47. **Required by Law** means a mandate contained in law that compels North Sound BH-ASO or a Workforce member to make a Use or Disclosure of PHI and that is enforceable in a court of law. "Required by Law" includes, but is not limited to: court orders and court-ordered warrants; subpoenas or a summons issued by a court, grand jury, a governmental or tribal inspector general or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to Health Care Providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require PHI if Payment is sought under a government program providing public benefits.

48. **Research** means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge.

49. **Sale of PHI** means a Disclosure of PHI by a Covered Entity or Business Associate when the Covered Entity or Business Associate directly or indirectly receives remuneration from or on behalf of the recipient of the PHI in exchange for the PHI, subject to the following exceptions:

    49.1 For **public health** purposes;
    49.2 For **Research** purposes, when the only remuneration received by the Covered Entity or Business Associate is a renable cost-based fee to cover the cost to prepare and transmit the PHI for those purposes;
    49.3 For **Treatment** purposes;
    49.4 For **Payment** purposes;
    49.5 For the **sale**, transfer, merger or consolidation of all or part of the Covered Entity and related due diligence;
    49.6 To or by a **Business Associate** for activities the Business Associate undertakes on behalf of a Covered Entity, or on behalf of a Business Associate in the case of a Subcontractor and the only remuneration provided is for the performance of the activities;
    49.7 To an **Individual** for access to records or to receive an accounting of disclosures;
    49.8 As **Required by Law**; and
    49.9 For any other purpose permitted by and in accordance with the applicable **requirements of the Privacy Rule**, when the only remuneration received by the Covered Entity or Business Associate is a renable, cost-based fee to cover the cost to prepare and transmit the PHI for that purpose or a fee otherwise expressly permitted by other law.

    See Policy 2523.00: Sale of PHI for more details,

50. **Security Incident** means the attempted or successful unauthorized access, Use, Disclosure, modification, or destruction of information or interference with system operations in an information system.

51. **Security Officer** means the Workforce member designated as the Security Officer or the Security Officer's designee.

52. **Security Rule** means the Security Standards for the Protection of Electronic Protected Health Information promulgated to implement HIPAA, as may be amended from time to time.

53. **Sexually Transmitted Disease (STD)** means a bacterial, viral, fungal or parasitic disease determined by the State of Washington, based on recommendations of the Centers for Disease Control and other nationally recognized medical authorities to be sexually transmitted, to be a threat to the public health and welfare and to be a disease for which a legitimate public interest will be served by providing for regulation and treatment. Acquired immunodeficiency syndrome (AIDS), human immunodeficiency virus (HIV) infection, chancroid, gonorrhea, granuloma inguinale, lymphogranuloma venereum, genital herpes simplex, chlamydia, nongonococcal urethritis (NGU), trachomitis, genital human papilloma virus infection and syphilis, have been designated as STDs.

54. **State Law** means a constitution, statute, regulation, rule, common law or other state action having the force and effect of law. This generally refers to laws of the State of Washington.

55. **Subcontractor** means a person to whom a Business Associate delegates a function, activity or service, other than in the capacity as a member of the Workforce of the Business Associate. Subcontractors may include outside consultants, contractors, suppliers and vendors. Subcontractors may become Business Associates if they create, receive, maintain or transmit PHI on behalf of the Business Associate. See Section 4 of this policy (definition of Business Associate). Vendors, suppliers and service providers of North Sound BH-ASO may be Subcontractors.

56. **Subcontractor Business Associate** means a Subcontractor, (including a vendor, contractor or other third party) that provides services to North Sound BH-ASO (e.g., a "downstream entity") and that creates, receives, maintains or transmits PHI on behalf of North Sound BH-ASO (e.g., the Subcontractor qualifies as a Business Associate).

57. **Transaction** means the transmission of information between two parties to carry out financial or administrative activities related to Health Care. For example, a Health Care Provider will send a claim to a Health Plan to request Payment for medical services. It includes, but is not limited to, the following types of information transmissions:

    57.1 Health Care Claims submission and equivalent encounter information;
    57.2 Health Care Payment and remittance advice;
    57.3 Health Care Claim status;
    57.4 Eligibility for a health plan;
    57.5 Enrollment and disenrollment in a Health Plan;
    57.6 Referral certification and authorization;
    57.7 Coordination of benefits;
    57.8 Premium payment to Health Plans;
    57.9 Health Care electronic funds transfers ("EFT") and remittance advice;
    57.10 First report of injury;
    57.11 Health claims attachments; and
    57.12 Other transactions the Secretary of the U.S. Department of Health and Human Services may prescribe by regulation.

58. **Transition Date** means July 1, 2019, which is the date on which North Sound BH-ASO transitioned from a behavioral health organization to an administrative services organization. As an administrative services organization, North Sound BH-ASO is a Business Associate of its Upstream Covered Entities.
59. **Treatment** means the provision, coordination or management of Health Care and related services by one or more Health Care Providers, including: the coordination or management of Health Care by a Health Care Provider with a third-party; consultation between Health Care Providers relating to an Individual; or the referral of a patient for Health Care from one Health Care Provider to another.
60. **Unsecured PHI** means PHI that is not rendered unusable, unreadable or indecipherable to unauthorized persons through the use of a technology or methodology specified by HIPAA.
61. **Upstream Covered Entity** means a Covered Entity for which North Sound BH-ASO provides administrative services and acts as a Business Associate of the Covered Entity. For example, North Sound BH-ASO is the administrative service organization (and Business Associate) for the Washington Health Care Authority and various MCOs.
62. **Use** means, with respect to PHI, the sharing, employment, application, utilization, examination or analysis of PHI within an entity that maintains the PHI.
63. **Vulnerable Adult** includes abuse of a person: (a) sixty (60) years of age or older who has the functional, mental or physical inability to care for himself or herself; (b) found incapacitated; (c) who has a developmental disability; (d) admitted to any facility; (e) receiving services from home health, hospice or home care agencies; (f) receiving services from an individual Health Care Provider; or (g) who self-directs his or her own care and receives services from a personal aide.
64. **Workforce** means employees, volunteers, trainees and other persons whose conduct, in the performance of work for North Sound BH-ASO, is under the direct control of North Sound BH-ASO, whether or not they are paid by North Sound BH-ASO.

ATTACHMENTS

None