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New ONC rules on information blocking and promoting patient privacy

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On March 4, 2019, the Office of the National Coordinator for Health Information Technology (ONC) released a Notice of Proposed Rulemaking (NPRM) that, among other things, defines exceptions to the definition of “information blocking” laid out in the 21st Century Cures Act (Cures Act) passed by Congress and signed into law in December 2016.^[1] Several provisions of the Cures Act directed ONC to implement provisions relating to advancing interoperability; prohibiting information blocking; and enhancing the usability, accessibility, and privacy and security of health information technology (health IT).

What is information blocking?

Congress included the information blocking provision in the Cures Act in response to concerns that some healthcare providers and health IT developers engage in practices that unreasonably limit the availability and use of electronic health information (EHI) for otherwise authorized and permitted purposes. These practices undermine the heavy investment made in local, state, and national health IT infrastructure development under the Health Information Technology for Economic and Clinical Health (HITECH) Act.^[2]

The Cures Act defines information blocking as “a practice that...is likely to interfere with, prevent, or materially discourage access exchange, or use of electronic health information.”^[3] The Cures Act goes on to apply this definition to not only health IT developers, exchanges, and networks, but also to healthcare providers themselves. In addition to providing a general definition, the Cures Act describes certain practices that constitute information blocking:

...practices that restrict authorized access, exchange, or use under applicable State or Federal law of such information for treatment and other permitted purposes under such applicable law, including transitions between certified health information technologies; implementing health information technology in nonstandard ways that are likely to substantially increase the complexity or burden of accessing, exchanging, or using electronic health information; and implementing health information technology in ways that are likely to (i) restrict the access, exchange, or use of electronic health information with respect to exporting complete sets or in transitioning between health information technology systems; or (ii) lead to fraud, waste, or abuse, or impede innovations and advancements in health information access, exchange, and use, including care delivery enabled by health information technology.^[4]

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