Document Type:[1]	__ Policy & Procedure	__ Process Guideline	Adopted:	1/1/2019
			Last Reviewed:	4/3/2025
	__ Plan	X System Description	Retired:	

Revisions: 2/28/2020, 4/11/2022

Document Scope: (applies to Policy & Procedure only)

X The requirements herein apply only to the GCBH BH-ASO Central Office and its functions.

– The requirements herein apply, verbatim, to GCBH BH-ASO and its network providers[2].

– The requirements herein apply to both GCBH BH-ASO and its network providers[2]. Additionally, network providers must have internal documents outlining their processes for implementing the requirements, insofar as they relate to actions for which network providers are responsible.

PURPOSE: To provide definitions applicable to all HIPAA Administrative Simplification Regulations.

I. General Definitions:

Except as otherwise provided, the following definitions apply to all HIPAA Administrative Simplification Regulations.

A. Act: The Social Security Act.

B. ANSI: Stands for the American National Standards Institute.

C. Business Associate:

(1) Except as provided in paragraph (2) of this definition, business associate means, with respect to a covered entity, a person who:

(i) On behalf of such covered entity or of an organized health care arrangement in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of:

1. A function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or

2. Any other function or activity regulated by the HIPAA Administration Simplification Regulations; or

(ii) Provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health care arrangement in which the covered entity participates,

[1]See definitions of document types in AD100, "Development, Approval & Review of Formal GCBH BH-ASO Documents"

[2]"Network Provider" – An organization with which GCBH BH-ASO is contracted for the provision of direct services.

where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or Arrangement, or from another business associate of such covered entity or arrangement, to the person.

(2) A covered entity participating in an organized health care arrangement that performs a function or activity as described by paragraph (1)(i) of this definition for or on behalf of such organized health care arrangement, or that provides a service as described in paragraph (1)(ii) of this definition to or for such organized health care arrangement, does not, simply through the performance of such function or activity or the provision of such service, become a business associate of other covered entities participating in such organized health care arrangement.

(3) A covered entity may be a business associate of another covered entity.

D. Compliance Date: The date by which a covered entity must comply with a standard, implementation specification, requirement or modification.

E. Covered Entity: Is one of the following:

(1) A health plan.

(2) A health care clearinghouse.

(3) A health care provider who transmits any health information in electronic form in connection with a transaction covered by these regulations.

F. Group Health Plan: (also see definition of health plan in this section) An employee welfare benefit plan (as defined in section 3(1) of the Employee Retirement Income Security Act of 1974 (ERISA) 29 U.S.C. 1002(1)), including insured and self-insured plans, to the extent that the plan provides medical care (as defined in section 2791(a)(2) of the Public Health Service (PHS) Act, 42 U.S.C. 300gg- 91(a)(2)), including items and services paid for as medical care, to employees or their dependents directly or through insurance, reimbursement, or otherwise, that:

(1) Has 50 or more participants (as defined in section 3(7) of ERISA, 29 U.S.C. 1002(7)); or

(2) Is administered by an entity other than the employer that established and maintains the plan

G. HCFA: Stands for Health Care Financing Administration within the Department of Health and Human Services.

H. HHS: Stands for the Department of Health and Human Services.

I. Health Care: Care, services, or supplies furnished to an individual and related to the health of the individual. Health care includes the following:

(1) Preventative, 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.

(2) Sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription.

J. Health Care Clearinghouse: A public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches that does either of the following functions:

(1) Processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction.

(2) Receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for a receiving entity.

K. Health Care Provider: A provider of services (as defined in section 1861(u) of the Act, 42 U.S.C. 1395x (u)), a provider of medical or other health services (as defined in section 1861(s) of the Act, 42 U.S.C. 1395x(s)), and any other person or organization who furnishes, bills, or is paid for health care in the normal course of business.

L. Health Information: Any information, whether oral or recorded in any form or medium, that:

(1) Is created or received by a health care provider, health plan, public health authority, employer, life insurer, school or university, or health care clearinghouse; and

(2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual.

M. Health Insurance Issuer: (as defined in section 2791(b) of the PHS Act, 42 U.S.C. 300gg-91(b) (2), and used in the definition of health plan in this section) 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. Such term does not include a group health plan.

N. Health Maintenance Organization (HMO): (as defined in section 2791 of the PHS Act, 42 U.S.C. 300gg-91(b)(3), and used in the definition of health plan in this section) A Federally qualified HMO, an organization recognized as an HMO under State law, or a similar organization regulated for solvency under State law in the same manner and to the same extent as such an HMO.

O. Health Plan: An individual or group plan that provides, or pays the cost of, medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)).

(1) Health plan includes the following, singly or in combination:

(i) A group health plan.

(ii) A health insurance issuer.

(iii) An HMO.

(iv) Part A or Part B of the Medicare program under title XVIII of the Act.

(v) The Medicaid program under title XIX of the Act, 42 U.S.C. 1396 et seq.

(vi) An issuer of a Medicare supplemental policy (as defined in section 1882(g) (1) of the Act, 42 U.S.C. 1395ss (g) (1)).

(vii) An issuer of a long-term care policy, excluding a nursing home fixed-indemnity policy.

(viii) 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.

(ix) The health care program for active military personnel under title 10 of the United States Code.

(x) The veterans' health care program under 38 U.S.C. chapter 17.

(xi) The Civilian Health and Medical Program of the Uniformed Services (CHAMPUS), as defined in 10 U.S.C. 1072(4).

(xii) The Indian Health Service program under the Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

(xiii) The Federal Employees Health Benefit Program under 5 U.S.C. 8902 et seq.

(xiv) An approved State child health plan under title XXI of the Act, providing benefits that meet the requirements of section 2103 of the Act, 42 U.S.C. 1397 et seq.

(xv) The Medicare + Choice program under part C of title XVIII of the Act, 42 U.S.C. 1395w-21 through 1395w-28.

(xvi) A high risk pool that is a mechanism established under State law to provide health insurance coverage or comparable coverage to eligible individuals.

(xvii) 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 section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)).

(2) Health plan excludes:

(i) Any policy, plan, or program to the extent that it provides or pays for the cost of, expected benefits that are listed in Section 2791(c)(1) of the PHS Act, 42 U.S.C. 300gg-91(c)(1); and

(ii) A government funded program (other than one listed in paragraph (1)(i) -(xvi) of this definition):

1. Whose principal purpose is other than providing, or paying the cost of, health care; or,

2. 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.

P. Implementation Specification: The specific requirements or instructions for implementing a standard.

Q. Modify or Modification: A change adopted by the Secretary, through regulation, to a standard or an implementation specification.

R. Secretary: The Secretary of Health and Human Services or any other officer or employee of the Department of Health and Human Services to whom the authority involved has been delegated.

S. Small Health Plan: A health plan with annual receipts of $5 million or less.

T. Standard: A rule, condition, or requirement:

(1) Describing the following information for products, systems, services or practices:

(i) Classification of components.

(ii) Specification of materials, performance, or operations; or

(iii) Delineation of procedures; or

(2) With respect to the privacy of individually identifiable health information.

U. Standard Setting Organization (SSO): An organization accredited by the American National Standards Institute that develops and maintains standards for information

transactions or data elements, or any other standard that is necessary for, or will facilitate the implementation of, this part.

V. State: refers to one of the following: (1) For health plans established or regulated by Federal law, State has the meaning set forth in the applicable section of the United States Code for each health plan. (2) For all other purposes, State means the United States, the District of Columbia, the Commonwealth of Puerto Rico, the Virgin Islands, and Guam.

W. Trading Partner Agreement: An agreement related to the exchange of information in electronic transactions, whether the agreement is distinct or part of a larger agreement, between each party to the agreement. (For example, a trading partner agreement may specify, among other things, the duties and responsibilities of each party to the agreement in conducting a standard transaction.)

X. Transaction: The exchange of information between two parties to carry out financial or administrative activities related to health care. It includes the following types of information transmissions:

(1) Health care claims or equivalent encounter information.

(2) Health care payment and remittance advice.

(3) Coordination of benefits.

(4) Health care claim status.

(5) Enrollment and disenrollment in a health plan.

(6) Eligibility for a health plan.

(7) Health plan premium payments.

(8) Referral certification and authorization.

(9) First report of injury.

(10) Health claims attachments.

(11) Other transactions that the Secretary may prescribe by regulation.

Y. Workforce: Employees, volunteers, trainees, and other persons whose conduct, in the performance of work for a covered entity, is under the direct control of such entity, whether or not they are paid by the covered entity.

II. Electronic Data Regulation Definitions:

Except as otherwise provided, the following definitions apply only to the Electronic Data Regulations of the HIPAA Administrative Simplification Regulations:

A. Code Set: Any set of codes used to encode data elements, such as tables of terms, medical concepts, medical diagnostic codes, or medical procedure codes. A code set includes the codes and the descriptors of the codes.

B. Code Set Maintaining Organization: An organization that creates and maintains the code sets adopted by the Secretary for use in the transactions for which standards are adopted in this part.

C. Data Condition: The rule that describes the circumstances under which a covered entity must use a particular data element or segment.

D. Data Content: All the data elements and code sets inherent to a transaction, and not related to the format of the transaction. Data elements that are related to the format are not data content.

E. Data Element: The smallest named unit of information in a transaction.

F. Data Set: A semantically meaningful unit of information exchanged between two parties to a transaction.

G. Descriptor: The text defining a code.

H. Designated Standard Maintenance Organization (DSMO): An organization designated by the Secretary under Sec. 162.910(a).

I. Direct Data Entry: The direct entry of data (for example, using dumb terminals or web browsers) that is immediately transmitted into a health plan's computer.

J. Electronic media: The mode of electronic transmission. It includes the Internet (wide-open), Extranet (using Internet technology to link a business with information only accessible to collaborating parties), leased lines, dial-up lines, private networks, and those transmissions that are physically moved from one location to another using magnetic tape, disk, or compact disk media.

K. Format: Refers to those data elements that provide or control the enveloping or hierarchical structure, or assist in identifying data content of, a transaction.

L. HCPCS: Stands for the Health [Care Financing Administration] Common Procedure Coding System.

M. Maintain or Maintenance: Refers to activities necessary to support the use of a standard adopted by the Secretary, including technical corrections to an implementation specification, and enhancements or expansion of a code set. This term excludes the activities related to the adoption of a new standard or implementation specification, or modification to an adopted standard or implementation specification.

N. Maximum Defined Data Set: All of the required data elements for a particular standard based on a specific implementation specification.

O. Segment: A group of related data elements in a transaction.

P. Standard Transaction: A transaction that complies with the applicable standard adopted under HIPAA.

III. Preemption of State Law Definitions:

Except as otherwise provided, the following definitions apply only to the Preemption of State Law as part of HIPAA Administrative Simplification Regulations:

A. Contrary: When used to compare a provision of State law to a standard, requirement, or implementation specification adopted under the HIPAA Administrative Simplification Regulations, means:

(1) A covered entity would find it impossible to comply with both the State and federal requirements; or

(2) The provision of State law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of part C of title XI of the Act or section 264 of Pub. L. 104-191, as applicable.

B. More Stringent: In the context of a comparison of a provision of State law and a standard, requirement, or implementation specification, a State law that meets one or more of the following criteria:

(1) With respect to a use or disclosure, the law prohibits or restricts a use or disclosure in circumstances under which such use or disclosure otherwise would be permitted under these regulations, except if the disclosure is:

i. Required by the Secretary in connection with determining whether a covered entity is in compliance with the regulations; or

ii. To the individual who is the subject of the individually identifiable health information.

(2) With respect to the rights of an individual who is the subject of the individually identifiable health information of access to or amendment of individually identifiable health information, permits greater rights of access or amendment, as applicable; provided that, nothing in these regulations may be construed to preempt any State law to the extent that it authorizes or prohibits disclosure of protected health information (PHI) about a minor to a parent, guardian, or person acting in loco parentis of such minor.

(3) With respect to information to be provided to an individual who is the subject of the individually identifiable health information about a use, a disclosure, rights, and remedies, provides the greater amount of information.

(4) With respect to the form or substance of an authorization or consent for use or disclosure of individually identifiable health information, provides requirements that narrow the scope or duration, increase the privacy protections afforded

(such as by expanding the criteria for), or reduce the coercive effect of the circumstances surrounding the authorization or consent, as applicable.

(5) With respect to recordkeeping or requirements relating to accounting of disclosures, provides for the retention or reporting of more detailed information or for a longer duration.

(6) With respect to any other matter, provides greater privacy protection for the individual who is the subject of the individually identifiable health information.

C. Relates to the Privacy of Individually Identifiable Health Information: With respect to a State law, that the State law has the specific purpose of protecting the privacy of health information or affects the privacy of health information in a direct, clear, and substantial way.

D. State Law: A constitution, statute, regulation, rule, common law, or other State action having the force and effect of law.

IV. Privacy Regulation Definitions:

Except as otherwise provided, the following definitions apply only to the Privacy Regulations of the HIPAA Administrative Simplification Regulations:

A. Correctional Institution: 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 includes 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.

B. Covered Functions: Those functions of a covered entity the performance of which makes the entity a health plan, health care provider, or health care clearinghouse.

C. Data Aggregation: With respect to Protected Health Information (PHI) created or received by a business associate in its capacity as the business associate of a covered entity, the combining of such 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.

D. Designated Record Set:

(1) A group of records maintained by or for a covered entity that is:

i. The medical records and billing records about individuals maintained by or for a covered health care provider;

ii. The enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for a health plan; or

iii. Used, in whole or in part, by or for the covered entity to make decisions about individuals.

(2) For purposes of this paragraph, the term record means any item, collection, or grouping of information that includes PHI and is maintained, collected, used, or disseminated by or for a covered entity.

E. Direct Treatment Relationship: A treatment relationship between an individual and a health care provider that is not an indirect treatment relationship.

F. Disclosure: The release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information.

G. Health Care Operations: Any of the following activities of the covered entity to the extent that 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:

(1) Conducting quality assessment and improvement activities, including outcomes evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such 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 patients with information about treatment alternatives; and related functions that do not include treatment;

(2) 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;

(3) 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), provided that the requirements of Sec. 164.514(g) are met, if applicable;

(4) Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;

(5) 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

(6) Business management and general administrative activities of the entity, including, but not limited to:

i. Management activities relating to implementation of and compliance with the requirements of these regulations;

ii. Customer service, including the provision of data analyses for policy holders, plan sponsors, or other customers, provided that PHI is not disclosed to such policy holder, plan sponsor, or customer.

iii. Resolution of internal grievances;

iv. 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

v. Consistent with the applicable requirements of Sec. 164.514, creating de-identified health information, fundraising for the benefit of the covered entity, and marketing for which an individual authorization is not required as described in Sec. 164.514(e)(2).

H. Health Oversight Agency: 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 such 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 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.

I. Indirect Treatment Relationship: A relationship between an individual and a health care provider in which:

(1) The health care provider delivers health care to the individual based on the orders of another health care provider; and

(2) The health care provider typically provides services or products, or reports the diagnosis or results associated with the health care, directly to another health care provider, who provides the services or products or reports to the individual.

J. Individual: The person who is the subject of protected health information.

K. Individually Identifiable Health Information: Also known as Protected Health Information (PHI), is a subset of health information, including demographic information collected from an individual, and:

(1) Is created or received by a health care provider, health plan, employer, or health care clearinghouse; and

(2) Relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future payment for the provision of health care to an individual; and

i. That identifies the individual; or

ii. With respect to which there is a reasonable basis to believe the information can be used to identify the individual.

L. Inmate: A person incarcerated in or otherwise confined to a correctional institution.

M. Law Enforcement Official: 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:

(1) Investigate or conduct an official inquiry into a potential violation of law; or

(2) Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

N. Marketing: To make a communication about a product or service a purpose of which is to encourage recipients of the communication to purchase or use the product or service.

(1) Marketing does not include communications that meet the requirements of paragraph (2) of this definition and that are made by a covered entity:

i. For the purpose of describing the entities participating in a health care provider network or health plan network, or for the purpose of describing if and the extent to which a product or service (or payment for such product or service) is provided by a covered entity or included in a plan of benefits; or

ii. That are tailored to the circumstances of a particular individual and the communications are:

1. Made by a health care provider to an individual as part of the treatment of the individual, and for the purpose of furthering the treatment of that individual; or

2. Made by a health care provider or health plan to an individual in the course of managing the treatment of that individual, or for the purpose of directing or recommending to that individual alternative treatments, therapies, health care providers, or settings of care.

(2) A communication described in paragraph (1) of this definition is not included in marketing if:

i. The communication is made orally; or

ii. The communication is in writing and the covered entity does not receive direct or indirect remuneration from a third party for making the communication.

O. Organized Health Care Arrangement:

(1) A clinically integrated care setting in which individuals typically receive health care from more than one health care provider;

(2) An organized system of health care in which more than one covered entity participates, and in which the participating covered entities:

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

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

1. 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;

2. 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

3. 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.

(3) A group health plan and a health insurance issuer or HMO with respect to such group health plan, but only with respect to Protected Health Information created or received by such health insurance issuer or HMO that relates to individuals who are or who have been participants or beneficiaries in such group health plan;

(4) A group health plan and one or more other group health plans each of which are maintained by the same plan sponsor; or

(5) The group health plans described in paragraph (4) of this definition and Health Insurance Issuers or HMOs with respect to such group health plans, but only with respect to PHI created or received by such health insurance issuers or HMOs that relates to individuals who are or have been participants or beneficiaries in any of such group health plans.

P. Payment:

(1) The activities undertaken by:

i. A health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or

ii. A covered health care provider or health plan to obtain or provide reimbursement for the provision of health care; and

(2) The activities in paragraph (1) of this definition relate to the individual to whom health care is provided and include, but are not limited to:

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

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

iii. 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;

iv. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;

v. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and

vi. Disclosure to consumer reporting agencies of any of the following Protected Health Information relating to collection of premiums or reimbursement:

1. Name and address;

2. Date of birth;

3. Social security number;

4. Payment history;

5. Account number; and

6. Name and address of the health care provider and/or health plan. Plan sponsor is defined as defined at section 3(16) (B) of ERISA, 29 U.S.C. 1002(16) (B).

Q. Protected Health Information (PHI): Any individually identifiable health information:

(1) Except as provided in paragraph (2) of this definition, that is:

i. Transmitted by electronic media;

ii. Maintained in any medium described in the definition of electronic media at Sec. 162.103 of these regulations; or

iii. Transmitted or maintained in any other form or medium.

(2) PHI excludes individually identifiable health information in:

i. Education records covered by the Family Educational Right and Privacy Act, as amended, 20 U.S.C. 1232g; and

ii. Records described at 20 U.S.C. 1232g(a)(4)(B)(iv).

R. Psychotherapy Notes: 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 and that are separated from the rest of the individual's medical record. Psychotherapy notes excludes 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.

S. Public Health Authority: 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 such 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.

T. Required by Law: A mandate contained in law that compels a covered entity 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 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 such information if payment is sought under a government program providing public benefits.

U. Research: A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge.

V. Treatment: 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 a patient; or the referral of a patient for health care from one health care provider to another.

W. Use: With respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information.

V. Organizational Requirement Definitions:

Except as otherwise provided, the following definitions apply only to the Organizational Requirements of the HIPAA Administrative Simplification Regulations:

A. Common Control: Exists if an entity has the power, directly or indirectly, significantly to influence or direct the actions or policies of another entity.

B. Common Ownership: Exists if an entity or entities possess an ownership or equity interest of 5 percent or more in another entity.

C. Health Care Component:

(1) Components of a covered entity that perform covered functions are part of the health care component.

(2) Another component of the covered entity is part of the entity's health care component to the extent that:

i. It performs, with respect to a component that performs covered functions, activities that would make such other component a business associate of the component that performs covered functions if the two components were separate legal entities; and

ii. The activities involve the use or disclosure of PHI that such other component creates or receives from or on behalf of the component that performs covered functions.

D. Hybrid Entity: A single legal entity that is a covered entity and whose covered functions are not its primary functions.

E. Plan Administration Functions: Administration functions performed by the plan sponsor of a group health plan on behalf of the group health plan and excludes functions performed by the plan sponsor in connection with any other benefit or benefit plan of the plan sponsor.

F. Summary Health Information: Information, that may be individually identifiable health information, and:

(1) That summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and

(2) From which the information described at Sec. 164.514(b)(2)(i) has been deleted, except that the geographic information described in Sec. 164.514(b)(2)(i)(B) need only be aggregated to the level of a five-digit zip code.

APPROVAL

Sindi Saunders 4/3/25

Karen Richardson or Sindi Saunders, Co-Directors Date