OCR 2016 HIPAA Desk Audits – Audited Entity Questions and Answers

#	WEBINAR QUESTIONS	OCR CLARIFICATION
	TECHNICAL	
1	Are we able to delete files previously uploaded?	No, once an entity selects the "review and submit" button, you can not return to the system to delete and replace files previously uploaded.
2	Can you upload more than 1 file per section or will the last file uploaded over-write the previous files uploaded.	You can upload multiple files in each section.
3	If I uploaded documents in incorrect area - how do I remove.	If the entity has already selected the " review and submit" button, it cannot go back and delete a previously uploaded file; therefore, it will need to provide an explanation in the comment section. If the entity has not yet clicked the submit button, it can over-write the wrong file with a new file.
4	If a practice sends/uploads the wrong information, will you go back to the practice to clarify what you were looking for?	No. We will rely only on the submitted documentation
	ADMINISTRATIVE	
5	Will a copy of the presentation be available to attendees?	Yes, a follow-up email was provided to all persons who registered for the webinar, 24 hours after the presentation that provided a link to a recording.
6	If questions arise over these next several days, can we email for clarification?	Yes, but we may not be able to respond to all requests for clarification. Entities must make their best efforts to provide the requested documentation.
7	I received the email for audit twice, was that a mistake or does that indicate something else?	Yes, you should have received two emails. The notification letter was one email, and a second email both provided the link to the webinar and the directions for submitting documentation of current business associates.
8	We did not receive a separate email requesting the BA listings. Were we suppose to receive them on the same day as other email?	Review the email that contained information on the webinar. It also contains the business associate request. The information is also available at http://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/audit/batemplate/index.html. Be sure to provide your entity name and contact information in the submitted document and in the email transmission you use to submit the document by July 22, 2016
9	Will attendees receive a copy of PowerPoint?	Yes. OCR will send a copy of the presentation to all selected entities. Additionally, we will post the presentation on our website.
10	WHAT IS THE LIMITATION FOR DOWNLOADING DOCUMENTS AGAIN? IS IT LIMITED BY AMOUNT OF PAGES?	10 MB. No page limit is specified.
11	Did everyone get two emails?	Yes
12	If entity received audit request as a covered entity but is not itself a covered entity but rather a BA, what should it do?	If you are a health care clearinghouse, please respond as a covered entity. If you are not a covered entity and only function as a business associate, please contact the Audit Program Manager, Zinethia Clemmons at Zinethia.Clemmons@hhs.gov
13	Can we complete the online submissions throughout the 10 day period, or do we need to do it all at one time before the deadline?	You can make your submissions at any time before the deadline. We encourage you to not wait until the last day to submit all at once.
14	I want to be clear on submit date. Is it 7/22?	Yes 7/22, unless you are the entity that received notification on 7/12 and therefore was provided with a deadline of 7/24
	GENERAL	
15	Can policies that have been in process for 3 plus months be included even though they have not yet cleared the final approval step?	Where entities are asked to provide documentation for a specified time period (e.g., current, previous calendar year, 6 years ago) they should submit documentation that reflects what is in place and in use in the time frame specified.
16	If we do not have the number of incidents requested and have to go back, do we need to provide the ones that are within the time frame requested in addition to the ones in the previous time frame not requested?	Yes. If you do not have documentation of the full number of events in the specified time interval, search back and include additional events in previous time intervals until you are able to compile the specified number. If you have not experienced the total number of requested events, be sure to attest to that in your submission.
17	What type of entities were selected for this audit? We are not a health care provider. We are in the energy industry with a self-insurance medical plan. Is it applicable to us?	Selected entities include health care providers, health care clearinghouses and health plans; health plans include employer sponsored self insured group health plans.

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18	Will we see all the questions that we are responsible for answering on the first (only) page of the web portal? We only see privacy related questions, does this mean we were only selected for the privacy audit and not security? Do we need to submit BAA contract information?	All the questions you are responsible for answering will be on the document request screen. If you see Privacy Rule related questions, you must answer those questions as well as the Breach Notification questions on the screen. Entities selected for a security audit will not see privacy and breach notification questions. However, all entities must separately provide business associate contact information, per the email communication.
19	Without identifying entity, our chain has been selected for two separate desk audits for two of our locations....one has requested privacy and the other is security under the same ownership. Is this the intent to treat separate locations as separate covered entities?	Yes
20	If a facility was not selected for this round of audits, is it possible they could be selected later. We are a system of multiple entities and only one was chosen	Yes, it is possible that another affiliated entity could be selected for an onsite audit.
21	When can we expect to receive notices of on-site audits?	Yes, notifications for onsite audits will be in late fall.
22	Assuming there are findings will we then need to submit a Plan of Correction (POC) based on your responses? If yes would it typically be something like a 90 day window to implement the POC?	You will not be required to submit a corrective action plan.
23	We are a multisite organization. How would we know if this is site specific or for our entire organization?	Respond for the entity name and location on your notification. If the notification is sent to a centralized headquarters or administrative office, report on your entire covered entity. The information should be congruent with the information you submitted in response to the questionnaire. Use your best judgment.
24	Our calendar year is July, and so we do the analysis in summer. Want to make sure that spring 2016 dates will be valid with you.	Follow the period requirements of the question. Current means current as of July 11, 2016. If the documentation was created in the spring and in use on July 11, 2016, it would be considered current.
25	Were we chosen because we run a mental health clinic and if so do we respond only in regard to that entity?	This audit is of HIPAA covered entities, and the relevant covered entity should be named in the notification letter and should have been clarified in the questionnaire phase; use your best judgment.
26	Can we get the list of the other entities selected?	No
27	If there are findings associated with the audits, what is the outcome? Plans of Correction? Fines?	The audit program is a compliance tool OCR is using to provide guidance on how entities need to comply with the various HIPAA Rules. With that, a final report will be provided to the CE.
28	Will we receive formal notification that you have received all submitted documents?	Upon submission of the business associate listing, entities will receive a confirmation email. No confirmation email will be sent upon completion of the portal submissions. However, you will be contacted for response to the draft findings.
29	Are any of the company specific uploaded documents potentially viewable by the public via a FOIA request? If so, should we redact other elements other than PHI such as potential Security risks?	We believe that a company specific document submitted by a CE for the audit is covered by the following exemption from FOIA: Exemption 4: Trade secrets or commercial or financial information that is confidential or privileged ed.
30	What factors will go into deciding whether the desk audit is followed up by an onsite audit?	Covered entity lack of cooperation with the desk audit would be the factor that could lead to inclusion in the onsite audit pool.
31	We have 21 locations and the letter was sent to our administrative offices (no clinic at that location). In the Q&A it was stated the location to be audited would have been specified in the letter. Can we find out specifically which location is being audited?	If the letter is sent to the administrative offices, the audit is for the entire covered entity, all locations.
32	If we are selected as a CE now, will we be selected for a BA audit if we are also BA to another CE?	It is possible, but not likely
	BREACH NOTIFICATION	
33	Under BNR13 Content Notification, you ask for an upload of a written notice sent to affected individuals. If we do not have a breach incident affecting over 500 individuals, should we identify this as not applicable or provide you with a letter from a notice of breach under 500?	If the entity has not reported a breach involving 500 or more individuals in the specified time period, the entity should search for and provide the evidence from breaches in previous time periods until the requested number of events is reached. If the entity has reported in total fewer than 5 breaches involving 500 or more individuals, the entity may attest to it using the comment field.
34	In BNR 12 and 13, can you provide an example or elaborate on appropriate "sampling methodologies"?	You may ignore the phrase "using sampling methodologies." This phrase will be deleted from the document submission pages.
35	For BNR #3 are you requesting all breach letters sent in the previous year or just one letter sent as an example?	BNR13.3 asks for a single copy of the notification sent to individuals for each event. So if you have experienced three breaches, provide one letter for each breach.

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36	We had five HIPAA incidents (assumed breaches) in 2015. However, if we determined after an analysis that notification was not required for all breaches in 2015, would you like us to provide a notification from 2014?	We are asking for documentation for breaches for which notification was provided. If you did not have a sufficient number for 2015 to meet the request, please add incidents from previous years until you reach 5 total.
37	BNR13 -3 copy of single written notice-is this for 500< only	Provide a copy for all breaches reported by your entity since compliance date. BNR13.3 asks for a single copy of the notification sent to individuals for each breach event, regardless of size. So if you have experienced one breach under 500 and two over 500, these count as three breach events, and you would provide one letter for each.
38	We are a small pharmacy and only sent out one breach notification to a patient. Should we just upload that one?	Yes. If you only have a total of one breach notification, attest to that in the comment box and provide the required documentation for that one notification.
39	Breach definition: would that include all the unpermitted/unintended releases that were not reported? How about cases that were only reported to States?	The subject of this section is breach notification. Please provide information regarding breaches for which you determined notification was required by the HIPAA Breach Notification Rule. State law reporting is not the subject of this audit.
40	BNR12: Can we enter this information into an Excel spreadsheet? Or do you need the documentation for each data element?	A spreadsheet would be helpful, but all the specific documentation requests must be met--which likely will require additional documentation.
41	We are an entity with one tax ID, and many sites. One of our sites was identified for the audit, and we report the HIPAA breaches as an entity. We have only had one breach for that particular site that was identified. Do I just enter that one breach? Should I use all sites as response for the breach examples?	Use your best judgement. In general, notifications were sent to the location of interest. If the address was to a headquarters, reply based on the entire entity.
42	We had an incident in December, but once the audit was concluded we reported in January 2016. Can we count that for 2015?	You may reach your own determination of what to include in documentation "for the previous calendar year" (i.e., 2015).
	PRIVACY	
43	Do you wish to receive pictures of the Notices hanging on the walls in addition to receiving the uploaded paper copies?	Yes. Please ensure that the text is readable.
44	On P65 do you want access requests from individual only or include access requests from other entities authorized by the individual?	The individual right to access includes the right to inspect or obtain a copy, or both, of the PHI, as well as to direct the covered entity to transmit a copy to a designated person or entity of the individual's choice. Therefore requests by the individual to transmit a copy to a designated person should be included. However, requests for disclosures of PHI that are merely authorized by the individual are not considered an exercise of the access right and should not be included. Please see http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html#newlyreleasedfaqs
45	When submitting proof of access , breach etc. all of the data should have PHI deleted?	Please redact PHI as you are able.
46	Can URL be simply entered into comment section?	Yes, in question P58, regarding Notice of Privacy Practices, you may provide the requested URLs in the comment section or in a downloaded document.
47	Regarding Access Requests, are you expecting copies of the DRS that we provided to the patient? We believe it should not be included.	No, audited entities do not need to submit the DRS provided to the individual in response to an access request.
48	P65 Right to Access- If the access request is from a personal representative on behalf of the patient, are we required to submit documentation proving the personal representative's authority?	P65 requires all documentation related to the specified access requests. That would include documentation of personal representative status when such status is relevant to the handling of the request.
49	Could you please define "access request?"	See http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html#newlyreleasedfaqs and http://www.hhs.gov/hipaa/for-professionals/training/index.html
50	If we are as an employer (as a CE), our employee would not make their request for their health info to the healthcare provider (our BA), do you expect us to provide these request from our BA?	In circumstances where a group health plan has contracted with a business associate for administration of benefits and payment of claims, please provide in the comments section a description of how access requests are addressed by the TPA.
51	Is Request for NPP duplicate? one request under "Right to Access" (subsection 4, and then under "Notice of Privacy Practices" subsection 1	Yes, the entity Notice(s) of Privacy Practices is requested in two places within the Privacy section. The documents will be reviewed for overall compliance with the content requirements for Notice in P55.1. In P65.4, the audit will assess whether the access policies and procedures are congruent with the notice description of the access right.

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52	In regards to access request, this in regards to just those involved in a breech or all release of information for all including insurances and patients?	The requests for information about compliance with the access requirements of the Privacy Rule are distinct and separate from the information requests regarding compliance with the Breach Notification Rule. Please review the relevant provisions of the HIPAA rules (see protocol for citations) to help you understand the distinction.
53	Is the right to access about giving the individual information about who has seen the record?	See http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html for more information about the right to access. The individual right to access their protected health information is not the same as their right to request an accounting of disclosures of their information.
54	Regarding the right to access: what documentation is to be uploaded to respond to "all documentation related to the first five access requests which were granted, and evidence of fulfillment, in the previous calendar year."	There is no one required process for fulfilling access requests under HIPAA and therefore we are not able to specify all the possible documentation. Generally, entities should have a record of the requests they have received and filled in 2015. Do not submit copies of the PHI provided to the individual in response to the individual's request.
55	If we do not have the capability to upload information to a patient electronically, how should we answer that question?	P58.2 and 3, regarding electronic provision of the notice of privacy practices, requests submission of information if the entity does provide the notice electronically. If not, please note that in the comment box.
56	In a physician office, would access request apply to all requests for medical records by a patient?	Generally, an individual has a right of access to inspect and obtain a copy of protected health information about the individual in a designated record set, for as long as the protected health information is maintained in the designated record set, and the covered entity must permit individuals to request access to that information. Access requests include requests for medical records made by patients that fit this description. See the OCR access guidance http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html
57	Can you provide clarity on the electronic request questions in privacy section - is that direct access to the EHR or does providing access to the portal suffice?	If you review the protocol posted online and examine the document request, you will see that this question pertains to provision of the notice of privacy practices electronically. This question does not involve EHRs
58	Is an "access request" the whole record set? What about a request for a single record or just certain payments or just a explanation(s) of benefits (EOB(s))?	An access request may be for the entire designated record set but is not limited to that. An individual may request access to portions of the record, such as a medication list, a lab report or other information. See the OCR access guidance http://www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html
59	How about Notice of Privacy Practices (NPP) translated version. Would you like us to submit that as well?	Yes, provide all versions of the Notice of Privacy Practices
60	Can you provide an example of what would be "evidence of fulfillment" with respect to right to access (P65). For example, if our access request form includes a section where a workforce member signs off that he or she has completed or responded to the access request and it is signed and dated...would that work?	Yes, that is an example of "evidence of fulfillment." Other entities may have other types of documentation.
	SECURITY	
61	Can we submit documentation of an annual risk assessment performed by third party?	Yes, a covered entity may use a business associate to conduct the risk analysis and the results may be submitted in response to S2 (1), Security Rule Risk Analysis
62	If we recent conducted a risk analysis, but the report is in draft form - should we submit the draft, as well as the prior finalized risk analysis?	Where entities are asked to provide documentation for a specified time period (e.g., current, previous calendar year, 6 years ago) they should submit documentation that reflects what is in place and in use as in the time frame specified.
63	Can you please clarify the difference between S2 question 1 and 5?	Question 1 is asking for the results of the risk analysis. Question 5 is asking for documentation that the risk analysis was conducted.
64	For the SR S2 Document request, is the request to upload documentation of CURRENT risk analysis results referring to 2015?	Current means what is in place and in use as of the date of the notification letter you received--July 11, 2016
65	Can you please be more specific about 6 previous years of risk assessments - that's a lot of documentation? I am only seeing request for 6 previous years of policies - can you repeat again where this request is?	Question S2.3 and S3.2 both ask for documentation that the subject policies and procedures were in place and in effect 6 years prior to the date of the notification letter--i.e., July 11, 2010. The questions do not require documentation of what was in effect during the intervening years.

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66	What would be an example of proof that the risk analysis was available to the workforce members?	Supporting documentation should show that the entity makes appropriate documentation available to appropriate individuals or groups in order for those individuals or groups to perform their job duties with respect to implementing procedures of the security rule to which the documentation pertains. For example, to show that individuals or groups requiring electronic access to risk analysis documentation (i.e., IT teams, security teams, management, legal counsel, etc.) screen shots could be used to show the availability of the risk analysis documentation by showing document properties, mapped drive permissions, etc. that indicate that the individuals or groups required to have access to such documents have such access.
67	Some of the documentation around risk analysis and management seems to apply to several of the different layers of request. Should we upload to each individual question?	The questions each ask for different documentation; of existing policies and procedures, or evidence that an analysis was conducted or risks addressed, or the results of those actions.
68	For SR audits, do all the Security Policies and documentation need to be submitted or is there a specific list that you can provide.	Refer to the audit protocol for more information about the audit inquiry, which may help you determine what documentation to submit.
69	What constitutes appropriate documentation for questions that relate to security measures/recommendations being given to and reviewed by appropriate personnel?	Management approval of plans and/or projects to implement security measures to remediate or mitigate identified risks. Such approvals could take the form of management signatures on risk management plans or other indicators of approval for implementation and/or documentation showing approval and funding of specific projects to implement security measures.
70	Could you provide an example of documentation that would demonstrate people had access to what they needed? This is in the Security section.	Supporting documentation should show that the entity makes appropriate documentation available to appropriate individuals or groups in order for those individuals or groups to perform their job duties with respect to implementing procedures of the security rule to which the documentation pertains. For example, to show that individuals or groups requiring electronic access to risk analysis documentation (i.e., IT teams, security teams, management, legal counsel, etc.) screen shots could be used to show the availability of the risk analysis documentation by showing document properties, mapped drive permissions, etc. that indicate that the individuals or groups required to have access to such documents have such access.
71	Do you truly want us to upload our current risk analysis to the portal? This would list vulnerabilities in our system (which we are working to resolve) and they would possibly become public knowledge under the FIOA?	We believe that a risk analysis submitted by a CE for the audit to be covered by the following exemption from FOIA: Exemption 4: Trade secrets or commercial or financial information that is confidential or privileged.
72	If the most current risk analysis is not that "current", do you recommend having one performed within the time frame allotted and submit this? If so, do you recommend having it done internally, or third party?	No, do not create a new analysis. Current means as of July 11, 2016, not later.
73	Please explain what you are looking for in S2 Number 2. Are you looking for training records?	Supporting documentation should show that the entity makes appropriate documentation available to appropriate individuals or groups in order for those individuals or groups to perform their job duties with respect to implementing procedures of the security rule to which the documentation pertains. For example, to show that individuals or groups requiring electronic access to risk analysis documentation (i.e., IT teams, security teams, management, legal counsel, etc.) screen shots could be used to show the availability of the risk analysis documentation by showing document properties, mapped drive permissions, etc. that indicate that the individuals or groups required to have access to such documents have such access. Training records are not responsive to the request.
74	Would the absence of a HIPAA security risk analysis be viewed as a "significant threat" to PHI potentially triggering an enforcement action?	Please include in the comment field a rationale for why a risk analysis will not be submitted
75	For clarification on Security audit, you listed 164.308 at beginning of slides and then 164.316 in the sample audit -- are you asking for only one area	164.316 is the provision that requires covered entities and business associates to implement reasonable and appropriate policies and procedures to implement the required safeguards (e.g. for 164.308, risk analysis and risk management); to maintain documentation of them for 6 years; and to review that documentation periodically and update as needed.
76	Risk assessments are a daily ongoing process and the technical controls implemented are vast. How much evidence is enough or not enough? We want to make sure we strike the right balance.	The amount of evidence required to show compliance with the risk analysis implementation specification is whatever amount is necessary to show that an accurate and through assessment of potential risks and vulnerabilities to the confidentiality, integrity and availability of all of the ePHI the entity creates, receives, maintains or transmits has been conducted.

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77	The security request to provide documentation the proper people had access to the information is confusing. Can you please clarify what is being request? Are you looking to see that employees of a CE have access to policies? Or are you asking if the authorized individuals in management are reviewing security risk assessments	Supporting documentation should show that the entity makes appropriate documentation available to appropriate individuals or groups in order for those individuals or groups to perform their job duties with respect to implementing procedures of the security rule to which the documentation pertains. For example, to show that individuals or groups requiring electronic access to risk analysis documentation (i.e., IT teams, security teams, management, legal counsel, etc.) screen shots could be used to show the availability of the risk analysis documentation by showing document properties, mapped drive permissions, etc. that indicate that the individuals or groups required to have access to such documents have such access.
78	Our security policies have an effective date as well as a historical record of annual revisions. I assume that will suffice for the six year requirement of what "was" in place?	Yes
79	Since the questions seem similar in nature, we discerned that the S2 questions were about the documentation of policy/procedures, and S3 is about the "what you actually did" ... is this correct?	The subject of S2 is risk analysis--the conduct of an accurate and thorough assessment of potential risks and vulnerabilities to the confidentiality, integrity and availability of ePHI. The subject of S3 is the risk management plan implemented to reduce those identified risks and vulnerabilities to a reasonable and appropriate level. Documentation of the entity's policies and procedures is required as well as documentation showing that the activities required by the policies and procedures have been conducted.
80	We received notice of a Security audit and it has been stated that we won't be receiving notice of a Privacy audit; however, it was then mentioned via comment that a provider received a Security audit notice at one site and a Privacy audit notice at a different site. We are a hybrid entity so could that mean we could also receive a Privacy audit notice since we have multiple sites? We have interpreted the notice that it is a Security audit on our entire hybrid entity covered component departments and programs? Is that a correct assumption/	Yes, your assumption is correct that you are the subject of a Security Rule audit of your covered entity (all covered components).
81	If the current risk analysis is 2015, the most recently conducted prior risk analysis is 2014?	Current means what is in place and in use as of the date of the notification letter you received--July 11, 2016. The most recently conducted prior risk analysis would be the one conducted prior to the current one.
82	To validate S2.2, would a simple organization chart of the security organization suffice? Maybe include committee minutes?	Supporting documentation should show that the entity makes appropriate documentation available to appropriate individuals or groups in order for those individuals or groups to perform their job duties with respect to implementing procedures of the security rule to which the documentation pertains. For example, to show that individuals or groups requiring electronic access to risk analysis documentation (i.e., IT teams, security teams, management, legal counsel, etc.) screen shots could be used to show the availability of the risk analysis documentation by showing document properties, mapped drive permissions, etc. that indicate that the individuals or groups required to have access to such documents have such access. Another example could be committee meeting minutes documenting the efforts the entity has in place to ensure appropriate personnel have appropriate access to the documentation required to implement the procedures of the security rule to which the documentation pertains. To the extent that an organizational chart could assist in the identification of individuals or groups identified in the supporting documentation, such organizational information should also be submitted.

#	WEBINAR QUESTIONS	OCR CLARIFICATION
	BUSINESS ASSOCIATES	
83	We have collected BAAs for several years. We have not collected some of the information fields as described by OCR (e.g., secondary point of contact, website URLs, etc.). Will this be a problem with submission for the BAA listing?	We encourage you to obtain from your business associates all of the requested information. However, you should submit whatever information you have by the deadline.
84	I only received one e-mail. I did not receive the e-mail requesting a list of BA's.	Review the email that contained information on the webinar. It also contains the business associate request. The information is also available at http://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/audit/batemplate/index.html. Be sure to provide your entity name and contact information in the submitted document and in the email transmission you use to submit the document by July 22, 2016
85	Because we were selected, do you recommend we notify our Business Associates? If yes, how do you recommend we do so?	This is not a required element of the audit program.
86	We did not receive an email requesting the list of BA's. What should I do?	Review the email that contained information on the webinar. It also contains the business associate request. The information is also available at http://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/audit/batemplate/index.html. Be sure to provide your entity name and contact information in the submitted document and in the email transmission you use to submit the document by July 22, 2016
87	The email request for the BA listing that was sent separately, would this have been emailed on 7/11/2016 as well.	Yes, the notifications emails were sent on 7/11/2016. Review the email that contained information on the webinar. It also contains the business associate request. The information is also available at http://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/audit/batemplate/index.html. Be sure to provide your entity name and contact information in the submitted document and in the email transmission you use to submit the document by July 22, 2016
88	We have 10s of thousands of agents who we consider our Business associates. Do you want us to provide a list of every agent.	Yes, report the requested information for all of your business associates. We encourage you to obtain from your business associates all of the requested information. However, you should submit whatever information you have by the deadline.
89	We did not receive an email for business associates, was not everyone selected for that portion?	All entities must provide the listing of business associates. Review the email that contained information on the webinar. It also contains the business associate list request. The information is also available at http://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/audit/batemplate/index.html. Be sure to provide your entity name and contact information in the submitted document and in the email transmission you use to submit the document by July 22, 2016
90	Are we to submit our business associate spreadsheet to OSOCRAudit@hhs.gov?	Yes, the business associate lists are to be submitted to OSOCRAudit@hhs.gov
91	Will you be reaching out to at least one business associate from each of the 167? Or is it random pick?	Business associates will be selected through a randomized process.
92	Regarding the reporting of business associate point of contact (POC) - is that POC within our practice or of the business associate we have a signed a BAA with?	The POC of the BA, not your staff.
93	·In our Business Associate list, do you want BAs for entities with whom we no longer have a current business relationship (e.g., contract termed, entity underwent merger or acquisition and new BAA executed, etc.).	Only information for current business associates needs to be reported.