February 7, 2019

Roger Severino, Director
Office for Civil Rights
US Department of Health and Human Services
RE: HHS-OCR-0945-AA00
Room 509F
Hubert H. Humphrey Building
200 Independence Ave, SW
Washington, DC 20201

Submitted electronically

RE: Request for Information on Modifying HIPAA Rules to Improve Coordinated Care [HHS-OCR-0945-AA00]

Dear Director Severino:

On behalf of our more than 100,000 member physical therapists, physical therapist assistants, and students of physical therapy, the American Physical Therapy Association (APTA) is pleased to submit comments to the US Department of Health and Human Services (HHS) Office for Civil Rights (OCR) in response to the Request for Information (RFI) on Modifying the Health Insurance Portability and Accountability Act (HIPAA) Rules to Improve Coordinated Care. The mission of APTA is to build a community to advance the physical therapy profession to improve the health of society. Physical therapists play a unique role in society in prevention, wellness, fitness, health promotion, and management of disease and disability by serving as a dynamic bridge between health and health services delivery for individuals across the age span. While physical therapists are experts in rehabilitation and habilitation, they also have the expertise and the opportunity to help individuals improve overall health and prevent the need for avoidable health care services. Physical therapists’ roles may include education, direct intervention, research, advocacy, and collaborative consultation. These roles are essential to the profession’s vision of transforming society by optimizing movement to improve the human experience.

APTA supports OCR’s efforts to update HIPAA regulations and provide additional guidance that will enable covered entities to more easily share data in this evolving value-based payment environment that relies heavily on technology. We appreciate the opportunity to respond to the questions posed by OCR. Please find our detailed comments below.
a. Promoting information sharing for treatment and care coordination

APTA supports OCR’s efforts to expand public outreach and education on existing provisions of HIPAA that permit uses and disclosures of protected health information (PHI) for care coordination and/or case management. We recommend that OCR issue additional clarification regarding the existing data-sharing provisions of HIPAA, in the form of sub-regulatory guidance, frequently asked questions, publicly available webinars, and more; and continue to update this guidance as value-based care evolves.

1) How long does it take for covered entities to provide an individual with a copy of their PHI when requested pursuant to the individual’s right of access at 45 CFR 164.524? How long does it take for covered entities to provide other covered entities copies of records that are not requested pursuant to the individual’s right of access? Does the length of time vary based on whether records are maintained electronically or in another form (e.g., paper)? Does the length of time vary based on the type of covered entity? For instance, do some types of health care providers or plans take longer to respond to requests than others?

2) How feasible is it for covered entities to provide PHI when requested by the individual pursuant to the right of access more rapidly than currently required under the rules? (The Privacy Rule requires covered entities to respond to a request in no more than 30 days, with a possible one-time extension of an additional 30 days.). What is the most appropriate general timeframe for responses? Should any specific purposes or types of access requests by patients be required to have shorter response times?

APTA supports efforts to require covered entities to respond in a timely manner to PHI requests from individuals and other covered entities. PHI requests may be based on the need for approval of necessary care, and, as such, more aggressive timeframes may be appropriate if necessary care will be delayed. Specifically, enabling covered entities to respond in as long as 30 days is not timely and may do very little to improve certain aspects of care. For example, Provider A refers a patient to Provider B. Permitting Provider A up to 30 days to transmit the patient’s data to Provider B fails to promote safe, efficient, and high-quality care, as more than likely the patient has visited Provider B at least once, if not several times, before Provider B ever receives the information from Provider A. Further, there cannot be an “auto push” of the data until Provider A knows the patient will visit Provider B. It is vital that PHI is easily accessible to covered entities and individuals.

Further, while it may be beneficial under certain circumstances for covered entities to share PHI to promote care coordination or case management without obtaining the individual’s authorization, we urge OCR to consider the risks associated with sharing PHI based on a request from a covered entity without patient authorization. Therefore, we strongly recommend that OCR institute safeguards to ensure that PHI is accessible only by the appropriate parties.

3) Should covered entities be required to provide copies of PHI maintained in an electronic record more rapidly than records maintained in other media when responding to an individual’s request for access? (The Privacy Rule does not currently distinguish, for timeliness requirements, between providing PHI maintained in electronic media and PHI maintained in other media). If so, what timeframes would be appropriate?
Covered entities are subject to varying payer policies, documentation requirements, audit and appeal deadlines, etc. Therefore, to limit the amount of burden on such entities, APTA recommends that the timeframes be consistent. We also recommend that OCR, working in conjunction with Congress and/or federal agencies, undertake efforts to harmonize HIPAA regulations with other federal statutes and regulations. Modernizing HIPAA without addressing inconsistencies in other laws will not lead to regulatory conformity.

4) What burdens would a shortened timeframe for responding to access requests place on covered entities? OCR requests specific examples and cost estimates, where available.

It depends upon the timeframe and conditions under which the shortened timeframe would apply.

5) Health care clearinghouses typically receive PHI in their role as business associates of other covered entities, and may provide an individual access to that PHI only insofar as required or permitted by their business associate agreement with the other covered entity, just as other covered entities, when performing business associate functions, may also provide access to PHI only as required or permitted by the business associate agreement(s) with the covered entity(ies) for whom they perform business associate functions. Nevertheless, the PHI that clearinghouses possess could provide useful information to individuals. For example, clearinghouses may maintain PHI from a variety of health care providers, which may help individuals obtain their full treatment histories without having to separately request PHI from each health care provider.

   a) How commonly do business associate agreements prevent clearinghouses from providing PHI directly to individuals?

      We believe this is fairly common.

   b) Should health care clearinghouses be subject to the individual access requirements, thereby requiring health care clearinghouses to provide individuals with access to their PHI in a designated record set upon request? Should any limitations apply to this requirement? For example, should health care clearinghouses remain bound by business associate agreements with covered entities that do not permit disclosures of PHI directly to an individual who is the subject of the PHI?

APTA recommends that health care clearinghouses continue to remain bound by business associate agreements (BAAs) with covered entities that do not permit disclosures of PHI directly to an individual who is the subject of the PHI. This is particularly important, as information relating to patients’ social determinants of health is increasingly incorporated into electronic health records (EHRs). Without such safeguards, APTA has concerns that clearinghouses will have the ability to share all patient information, such as income and social status, as this information will now be included in the patient’s record.

   c) Alternatively, should health care clearinghouses be treated only as covered entities—i.e., be subject to all requirements and prohibitions in the HIPAA Rules concerning the use and disclosure of PHI and the rights of individuals in the same way as other covered entities—and not be considered business associates, or need a
business associate agreement with a covered entity, even when performing activities for, or on behalf of, other covered entities? Would this change raise concerns for other covered entities about their inability to limit uses and disclosures of PHI by health care clearinghouses? For example, would this change prevent covered entities from providing assurances to individuals about how their PHI will be used and disclosed? Or would covered entities be able to adequately fulfill individuals’ expectations about uses and disclosures through normal contract negotiations with health care clearinghouses, without the need for a HIPAA business associate agreement? Would covered entities be able to impose other contractual limitations on the uses and disclosures of PHI by the health care clearinghouse?

The greater the gap between direct capture and use of the data, and the potential to disclose the data, the greater the potential for misuse or compromise. The BAA should determine access to and distribution of data.

d) If health care clearinghouses are not required to enter into business associate agreements with the other covered entities for whom they perform business associate functions, should such requirement also be eliminated for other covered entities when they perform business associate functions for other covered entities?

Health care clearinghouses perform services for covered entities. When clearinghouses receive PHI, they are performing a service for a provider; as such, clearinghouses are business associates and must enter into a BAA. We recognize that OCR is exploring whether clearinghouse status as a business associate is preventing clearinghouses from creating a service to directly provide PHI to individuals upon their request. However, we do not perceive that entering into a BAA invokes any barriers to delivering care. As such, APTA recommends that health care clearinghouses maintain their current status and continue to be required to enter into a BAA with covered entities.

6) Do health care providers currently face barriers or delays when attempting to obtain PHI from covered entities for treatment purposes? For example, do covered entities ever affirmatively refuse or otherwise fail to share PHI for treatment purposes, require the requesting provider to fill out paperwork not required by the HIPAA Rules to complete the disclosure (e.g., a form representing that the requester is a covered health care provider and is treating the individual about whom the request is made, etc.), or unreasonably delay sharing PHI for treatment purposes? Please provide examples of any common scenarios that may illustrate the problem.

There are barriers to timely access to data particularly as it relates to transitions of care.

7) Should covered entities be required to disclose PHI when requested by another covered entity for treatment purposes? Should the requirement extend to disclosures made for payment and/or health care operations purposes generally, or, alternatively, only for specific payment or health care operations purposes?

APTA recommends that covered entities continue to be required to disclose PHI when requested by another covered entity for treatment purposes. When a patient’s care has transferred to
another individual or institutional entity, that entity needs immediate access to data to appropriately and safely provide care. For example: A home health agency discharges a Medicare beneficiary to receive physical therapy services covered under Medicare Part A. The beneficiary subsequently visits an outpatient physical therapist private practice to receive physical therapy covered under Medicare Part B. Unfortunately, there often is a significant delay in transmitting PHI from one covered entity to another. This could be due to volume requests or lack of EHR interoperability between providers—the latter resulting at least in part from the exclusion of many health care provider types from the former Meaningful Use program (now Promoting Interoperability within the Merit-based Incentive Payment System, or MIPS)—and lack of funding and other support.

We request that this requirement also extend to disclosures made for payment and/or health care operations.

a) Would this requirement improve care coordination and/or case management? Would it create unintended burdens for covered entities or individuals? For example, would such a provision require covered entities to establish new procedures to ensure that such requests were managed and fulfilled pursuant to the new regulatory provision and, thus, impose new administrative costs on covered entities? Or would the only new administrative costs arise because covered entities would have to manage and fulfill requests for PHI that previously would not have been fulfilled?

Disclosing PHI for the purposes described above will improve care coordination and case management. Burden associated with such disclosures is likely due to the need to respond to the timeliness of the request.

APTA recommends that OCR clarify its policy on what constitutes health care operations, to ensure that covered entities as well as the general public understand that the terms health care operations and/or treatment include care coordination and case management.

b) Should any limitation be placed on this requirement? For instance, should disclosures for healthcare operations be treated differently than disclosures for treatment or payment? Or should this requirement only apply to certain limited payment or health care operations purposes? If so, why?

Disclosures for treatment and timeliness requirements for such disclosures should be afforded the highest priority.

8) Should any of the above proposed requirements to disclose PHI apply to all covered entities (i.e., covered health care providers, health plans, and health care clearinghouses), or only a subset of covered entities? If so, which entities and why?

The above proposed requirements should apply to all covered entities.
9) Currently, HIPAA covered entities are permitted, but not required, to disclose PHI to a health care provider who is not covered by HIPAA (i.e., a health care provider that does not engage in electronic billing or other covered electronic transactions) for treatment and payment purposes of either the covered entity or the non-covered health care provider. Should a HIPAA covered entity be required to disclose PHI to a non-covered health care provider with respect to any of the matters discussed in Questions 7 and 8? Would such a requirement create any unintended adverse consequences? For example, would a covered entity receiving the request want or need to set up a new administrative process to confirm the identity of the requester? Do the risks associated with disclosing PHI to health care providers not subject to HIPAA’s privacy and security protections outweigh the benefit of sharing PHI among all of an individual’s health care providers?

While there are significant risks to the patient if a treating provider does not have access to all information necessary to safely provide care, we acknowledge that there are concerns associated with sharing PHI with non-covered entities, who are not subject to HIPAA’s privacy and security protections.

10) Should a non-covered health care provider requesting PHI from a HIPAA covered entity provide a verbal or written assurance that the request is for an accepted purpose (e.g., TPO) before a potential disclosure requirement applies to the covered entity receiving the request? If so, what type of assurance would provide the most protection to individuals without imposing undue burdens on covered entities? How much would it cost covered entities to comply with this requirement? Please provide specific cost estimates where available.

While the requirements for all providers and health insurers should be consistent, when a non-covered entity requests PHI from a covered entity, the non-covered entity should be required to complete a standardized, consistent form used by all non-covered entities that requires the signatory to certify the identity of such entity. Moreover, non-covered entities, while not subject to HIPAA’s rules and regulations, should be required to comply with disclosure requests in the same timeframe as are covered entities.

11) Should OCR create exceptions or limitations to a requirement for covered entities to disclose PHI to other health care providers (or other covered entities) upon request? For example, should the requirement be limited to PHI in a designated record set? Should psychotherapy notes or other specific types of PHI (such as genetic information) be excluded from the disclosure requirement unless expressly authorized by the individual?

Yes. APTA recommends that OCR institute a limit that restricts PHI disclosure to only the information that impacts care; however, all covered entities sharing PHI should be required to issue the same pertinent patient data using a standardized format. OCR also should designate a specific set of PHI that is excluded from the disclosure requirement unless authorized by the individual.

12) What timeliness requirement should be imposed on covered entities to disclose PHI that another covered entity requests for TPO purposes, or a non-covered health care provider
requests for treatment or payment purposes? Should all covered entities be subject to the same timeliness requirement? For instance, should covered providers be required to disclose PHI to other covered providers within 30 days of receiving a request? Should covered providers and health plans be required to disclose PHI to each other within 30 days of receiving a request? Is there a more appropriate timeframe in which covered entities should disclose PHI for TPO purposes? Should electronic records and records in other media forms (e.g., paper) be subject to the same timeliness requirement? Should the same timeliness requirements apply to disclosures to non-covered health care providers when PHI is sought for the treatment or payment purposes of such health care providers?

As previously stated, timelines should be consistent across entities. Frequently, an entity is unaware whether another entity uses EHRs, as well as the system used and its level of interoperability, or whether the entity relies on a fax machine. Given the large framework under which multiple entities interact, consistency in requirements wherever possible is critical.

13) Should individuals have a right to prevent certain disclosures of PHI that otherwise would be required for disclosure? For example, should an individual be able to restrict or “opt out” of certain types of required disclosures, such as for health care operations? Should any conditions apply to limit an individual’s ability to opt out of required disclosures? For example, should a requirement to disclose PHI for treatment purposes override an individual’s request to restrict disclosures to which a covered entity previously agreed?

We do not recommend allowing individuals to opt out of sharing PHI that has been designated for required disclosure for treatment purposes. Providers could be placed in a tenuous position, and care could be compromised, if every patient could potentially withhold necessary information.

14) How would a general requirement for covered health care providers (or all covered entities) to share PHI when requested by another covered health care provider (or other covered entity) interact with other laws, such as 42 CFR Part 2 or state laws that restrict the sharing of information?

A requirement to share PHI when requested would provide greater consistency overall and likely would reduce burden on providers. However, prior to adopting a general requirement for all covered providers, it would be beneficial for OCR to conduct a 50-state analysis to assess where state law tends to significantly vary from federal law. Adopting a general, standardized federal requirement that is as aligned as is feasible with more stringent state laws would reduce the potential for providers to mistakenly disclose information due to inconsistencies between organizational, state, and federal law.

15) Should any new requirement imposed on covered health care providers (or all covered entities) to share PHI when requested by another covered health care provider (or other covered entity) require the requesting covered entity to get the explicit affirmative authorization of the patient before initiating the request, or should a covered entity be
allowed to make the request based on the entity’s professional judgment as to the best interest of the patient, based on the good faith of the entity, or some other standard?

No new requirement should be imposed on covered health care providers to obtain explicit affirmative authorization before initiating the request.

17) Should OCR expand the exceptions to the Privacy Rule’s minimum necessary standard? For instance, should population-based case management and care coordination activities, claims management, review of health care services for appropriateness of care, utilization reviews, or formulary development be excepted from the minimum necessary requirement? Would these exceptions promote care coordination and/or case management? If so, how? Are there additional exceptions to the minimum necessary standard that OCR should consider?

The minimum necessary standard should be evaluated in terms of its negative impact on the activities identified above, as some modification likely is appropriate. Extending the exception to the minimum necessary standard for care coordination and case management disclosures would better promote population health models and initiatives. For example, an accountable care organization (ACO) relies on care coordination and case management to successfully improve quality and reduce costs. However, an ACO often does not receive the entire data set, which is necessary to be successful in such endeavors. The lack of access to such data discourages efficient care delivery, limits the ability of the ACO to improve care quality, and reduces the likelihood the ACO would be willing to take on greater risk in the future.

18) Should OCR modify the Privacy Rule to clarify the scope of covered entities’ ability to disclose PHI to social services agencies and community-based support programs where necessary to facilitate treatment and coordination of care with the provision of other services to the individual? For example, if a disabled individual needs housing near a specific health care provider to facilitate their health care needs, to what extent should the Privacy Rule permit a covered entity to disclose PHI to an agency that arranges for such housing? What limitations should apply to such disclosures? For example, should this permission apply only where the social service agency itself provides health care products or services? In order to make such disclosures to social service agencies (or other organizations providing such social services), should covered entities be required to enter into agreements with such entities that contain provisions similar to the provisions in business associate agreements?

Currently, a pathway exists for covered entities to disclose PHI to social service agencies or community-based support programs when it is for treatment purposes. We acknowledge that there is a general lack of understanding and awareness among covered entities about when this disclosure is permitted; however, adding a provision that explicitly permits such disclosures is unnecessary. Rather, we recommend that OCR clarify through sub-regulatory guidance, additional FAQs or other educational resources and tools when it is appropriate for covered entities to share PHI with such organizations. Additionally, APTA has concerns that these organizations are not equipped to accept or protect PHI. Accordingly, we recommend that OCR
require covered entities and these organizations to enter into agreements that explicitly discusses the administrative, technical, and physical safeguards they will employ to protect PHI.

19) Should OCR expressly permit disclosures of PHI to multi-disciplinary/multi-agency teams tasked with ensuring that individuals in need in a particular jurisdiction can access the full spectrum of available health and social services? Should the permission be limited in some way to prevent unintended adverse consequences for individuals? For example, should covered entities be prevented from disclosing PHI under this permission to a multi-agency team that includes a law enforcement official, given the potential to place individuals at legal risk? Should a permission apply to multi-disciplinary teams that include law enforcement officials only if such teams are established through a drug court program? Should such a multi-disciplinary team be required to enter into a business associate (or similar) agreement with the covered entity? What safeguards are essential to preserving individuals’ privacy in this context?

APTA supports implementation of a permissive disclosure permitting an entity to share PHI with multidisciplinary teams; however, the scope of such permission should be limited to prevent unintended adverse consequences.

20) Would increased public outreach and education on existing provisions of the HIPAA Privacy Rule that permit uses and disclosures of PHI for care coordination and/or case management, without regulatory change, be sufficient to effectively facilitate these activities? If so, what form should such outreach and education take and to what audience(s) should it be directed?

Yes. We recommend that OCR issue frequent sub-regulatory guidance, regularly update its FAQ on the HHS.gov website, offer online consumer training, and hold quarterly calls with stakeholders to provide further education and clarification and to seek feedback on what additional issue areas need clarifying and the most appropriate modes of sharing such information with individuals and covered entities.

22) What changes can be made to the Privacy Rule to help address the opioid epidemic? What risks are associated with these changes? For example, is there concern that encouraging more sharing of PHI in these circumstances may discourage individuals from seeking needed health care services? Also is there concern that encouraging more sharing of PHI may interfere with individuals’ ability to direct and manage their own care? How should OCR balance the risk and the benefit?

APTA has concerns that increased PHI sharing is unlikely to help resolve the opioid crisis and is likely to discourage individuals from seeking needed health care services. Rather, emphasis should be on providing patients with greater education and information on the available treatment options—such as physical therapy services—to prevent or treat acute or chronic injury and illness. We fail to see the benefit of sharing more PHI and urge OCR to proceed cautiously if it intends to seek changes to the Privacy Rule as a means to address the opioid crisis.
23) How can OCR amend the HIPAA Rules to address serious mental illness? For example, are there changes that would facilitate treatment and care coordination for individuals with SMI, or ensure that family members and other caregivers can be involved in an individual’s care? What are the perceived barriers to facilitating this treatment and care coordination? Would encouraging more sharing in the context of SMI create concerns similar to any concerns raised in relation to the previous question on the opioid epidemic? If so, how could such concerns be mitigated?

Increasing parental and caregiver involvement in the treatment of individuals with mental illness by sharing PHI may discourage patients from seeking or continuing treatment. If a covered entity believes involving family or a caregiver will benefit the patient, the entity should be required to document and certify the rationale for sharing such information and obtain authorization from the patient.

25) Could changes to the Privacy Rule help ensure that parents are able to obtain the treatment information of their minor children, especially where the child has substance use disorder (including opioid use disorder) or mental health issues, or are existing permissions adequate? If the Privacy Rule is modified, what limitations on parental access should apply to respect any privacy interests of the minor child?

We see very limited benefits in establishing new PHI disclosure pathways for covered entities to share PHI with family members, caregivers, and others to improve treatment. Adopting a permissible disclosure by expanding the capability of providers to share PHI with family members will have serious unintended consequences, resulting in patients being more reluctant to seek care, out of embarrassment, fear, or any other reason. Such disclosures will not improve or expand access to care.

39) If covered entities are unable to modify existing systems or processes to generate a full accounting of disclosures for TPO (e.g., because modification would be prohibitively costly), should OCR instead require covered entities to conduct and document a diligent investigation into disclosures of PHI upon receiving an individual’s request for an accounting of disclosures for TPO? If not, are there certain circumstances or allegations that should trigger such an investigation and documentation by a covered entity? How much time should a covered entity be allowed to conduct and provide the results of such an investigation?

We support requiring covered entities to conduct and document an investigation into disclosures of PHI upon receiving an individual’s request in limited circumstances. However, we recommend that individuals be required to complete a standard form that clearly outlines the rationale for the request and to pay a reasonable fee (determined by OCR) to the covered entity.

41) The HITECH Act section 13405(c) only requires the accounting of disclosures for TPO to include disclosures through an EHR. In its rulemaking, should OCR likewise limit the right to obtain an accounting of disclosures for TPO to PHI maintained in, or disclosed through, an EHR? Why or why not? What are the benefits and drawbacks of including TPO disclosures made through paper records or made by some other means such as
orally? Would differential treatment between PHI maintained in other media and PHI maintained electronically in EHRs (where only EHR related accounting of disclosures would be required) disincentivize the adoption of, or the conversion to, EHRs?

Differential treatment between PHI maintained in other media and PHI maintained in an EHR could discourage the conversion to EHRs, as it would increase scrutiny on providers that have made the change.

42) Please provide any other information that OCR should consider when developing a proposed rule on accounting for disclosures for TPO.

d. Notice of Privacy Practices

43) What is the burden, in economic terms, for covered health care providers that have a direct treatment relationship with an individual to make a good faith effort to obtain an individual’s written acknowledgment of receipt of the provider’s NPP? OCR requests estimates of labor hours and any other costs incurred, where available.

Modifying the obligation for health care providers to obtain an acknowledgement of the receipt of the provider’s Notice of Privacy Practices (NPP) upon the individual’s first visit would definitively decrease burden on providers. We are not aware of concrete evidence that demonstrates that patients who provide written acknowledgement of receipt of the provider’s NPP helps them understand the rule and their rights better, nor does it appear to improve the delivery of care or the patient’s experience. Providers currently undertake reasonable efforts to obtain the patient’s signature, and in most instances the patients ignore the language when signing the document. In other instances, a provider may ask the patient to read and sign off on the NPP but then inadvertently fail to provide a copy of the signed document to the patient.

Therefore, we suggest that OCR modify the regulations to require providers to make a good faith, reasonable effort to provide the NPP to the patient but not require the patient to acknowledge receipt of the document via signature.

44) For what percentage of individuals with whom a direct treatment provider has a relationship is such a covered health care provider unable to obtain an individual’s written acknowledgment? What are the barriers to obtaining it?

Barriers to obtaining an individual’s written acknowledgement include language differences, reading comprehension and education level, and time constraints.

45) How often do individuals and covered entities mistake the signature or acknowledgment line that accompanies NPPs as contracts, waivers of rights, or required as a condition of receiving services? What conflicts have arisen because of these or other misunderstandings?

While we lack direct knowledge of conflicts that have arisen due to misinterpretation of what the NPP constitutes, we assume these types of misunderstandings occur frequently. In general,
individuals desire to understand what they are signing and will not do so if they fear there is an associated cost or waiving of their rights.

Conclusion

APTA thanks HHS for the opportunity to provide comments on the RFI on Modifying HIPAA Rules to Improve Coordinated Care. We look forward to working with the agency as it identifies provisions of the HIPAA privacy and security regulations that may impede the transformation to value-based health care or that limit or discourage coordinated care among individuals and covered entities. Should you have any questions regarding our comments, please contact Kara Gainer, director of regulatory affairs, at karagainer@apta.org or 703/706-8547.

Thank you for your consideration.

Sincerely,

Sharon L. Dunn, PT, PhD
Board-Certified Clinical Specialist in Orthopaedic Physical Therapy
President

SLD: krg