

February 12, 2019

The Honorable Alex M. Azar II
Secretary, U.S. Department of Health & Human Services
Office for Civil Rights (OCR)
200 Independence Avenue, SW, Room 509F
Washington, DC 20201

Re: Request for Information on Modifying HIPAA Rules To Improve Coordinate Care

Dear Secretary Azar,

The American Association of Nurse Practitioners (AANP), representing more than 270,000 nurse practitioners (NPs) in the United States, appreciates the opportunity to provide comment on ways to modify the HIPAA regulations to facilitate efficient care coordination and case management in the transition to value-based health care. We thank OCR for their focus on improving the transfer of health care information and we look forward to continuing to work together to achieve these goals.

NPs are advanced practice registered nurses (APRNs) who are prepared at the masters or doctoral level to provide primary, acute, chronic and specialty care to patients of all ages and walks of life. Daily practice includes: assessment; ordering, performing, supervising and interpreting diagnostic and laboratory tests; making diagnoses; initiating and managing treatment including prescribing medication and non-pharmacologic treatments; coordinating care; counseling; and educating patients and their families and communities.

NPs practice in nearly every health care setting including clinics, hospitals, Veterans Affairs and Indian Health Care facilities, emergency rooms, urgent care sites, private physician or NP practices (both managed and owned by NPs), nursing homes, schools, colleges, retail clinics, public health departments, nurse managed clinics, homeless clinics, and home health. NPs hold prescriptive authority in all 50 states and the District of Columbia. It is important to note that 87.1% of NPs are certified in primary care, the majority of whom see Medicare and Medicaid patients. NPs complete more than one billion patient visits annually. AANP's responses to certain OCR questions on information sharing and care coordination can be found below.

Promoting Information Sharing for Treatment and Care Coordination

(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?

Given the increasing prevalence of providers using electronic health records, HHS should look at shortening the response times for sending PHI between providers and other covered entities. Thirty days, or sixty days in the case of an extension, is a very long time for a provider to wait for necessary data when

evaluating a patient's clinical needs. This timeframe should decrease as we improve interoperability within EHR systems.

HHS further asked if there would be increased burden on the provider with shortened response timeframes. While there may be some increased burden on the provider, this is outweighed by the clinical needs of the patient to have all of their providers informed regarding their PHI. As mentioned above, this is also mitigated by the increased prevalence of EHRs. However, we do agree with HHS that provider burden is a major concern and should remain a focal point of the agency. We encourage the agency to continue to focus on removing provider burdens that inhibit and delay access to care. These include barriers within the Medicare and Medicaid programs that require nurse practitioners to obtain certifications from physicians for services provided within the scope of the NPs practice (e.g. home health and diabetic shoes), streamlined and reduced prior authorization requirements, and the removal of unnecessary documentation requirements (e.g. NP preceptors still having to redocument work in the medical record performed by their students).

(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?

We certainly value the importance of sharing health information between providers and other covered entities for the purposes of care coordination and improving patient treatment. However, we do not believe that HHS should move from a standard of permitting covered entities to disclose PHI, to one where they are required to disclose PHI. This would remove the discretion of the provider and the patient to not share PHI in instances where they feel that it is inappropriate, or they cannot verify the validity of the request. We are not aware of issues related to the current permissible standard, and do not feel that it needs to be amended.

OCR also asked further questions related to possible scenarios or exceptions to a requirement to disclose PHI if that requirement is enacted. While we appreciate that OCR is looking at all options to improve information sharing, enacting different standards depending on the type of information being shared, the purpose for sharing, or the entity it is being shared with, would create an overly complicated regulatory framework for providers. This would increase compliance costs and the risks of compliance violations for providers, which is not the intent of this RFI.

(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?

Aside from the current legal requirements to disclose PHI, such as HHS enforcement actions, PHI is the property of the patient, and thus the patient should have the opportunity to opt-out of disclosure. Patients should have the ultimate control over their PHI and where it is sent, absent legal requirements to the contrary, that decision should remain in the hands of the patient. This is also consistent with other HHS initiatives, such as the MyHealthEData, which gives patients greater access and control over their PHI. The current regulations do give covered entities the ability to disclose PHI in certain instances without patient consent, consistent with legal requirements. This is sufficient to balance the patient's right to protect their health information with the necessity of disclosing that information in specific scenarios.

(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?

OCR should modify the Privacy Rule to clarify the scope of covered entities' ability to disclose PHI to social services agencies and community-based support programs and OCR should utilize the minimum necessary standard. Health insurers and providers are increasingly incorporating non-traditional health care benefits into their coverage and treatment options to address issues related to social determinants of health. It is important that new entities involved in providing these benefits be able to receive and protect PHI consistent with HIPAA regulations. We would also note that entities that traditionally have not received PHI may have to update their policies and electronic record keeping systems to come into compliance with HIPAA, which can be time-consuming and costly. As any changes are implemented, we ask that HHS take this into consideration and provide support for these entities in this transition.

We thank you for the opportunity to comment on this request for information to improve the HIPAA regulations for the purposes of data sharing and care coordination and we look forward to continued work with OCR. We would welcome an opportunity to engage in further discussions regarding the role of nurse practitioners in this initiative. Should you have comments or questions, please direct them to MaryAnne Sapio, V.P. Federal Government Affairs, msapio@aanp.org, 703-740-2529.

Sincerely,

David Hebert
Chief Executive Officer