



June 5, 2019

The Honorable Lamar Alexander  
United States Senate  
Chairman, Senate Committee on Health,  
education, Labor and Pensions  
428 Dirksen Senate Office Building  
Washington, DC 20510-2602

The Honorable Patty Murray  
United States Senate  
Ranking Member, Senate Committee on Health  
Education, Labor and Pensions  
428 Dirksen Senate Office Building  
Washington, DC 20510

RE: Lower Health Care Costs Act of 2019 Discussion Draft

VIA E-MAIL

Dear Chairman Alexander and Ranking Member Murray:

Thank you for the opportunity to provide feedback on the discussion draft of the Lower Health Care Costs Act of 2019.

The American Health Information Management Association (AHIMA) is the national non-profit association of health information management (HIM) professionals. Serving 52 affiliated component state associations including the District of Columbia and Puerto Rico, AHIMA represents over 103,000 health information management professionals with the mission of empowering people to impact health. AHIMA's credentialed and certified HIM members can be found in more than 40 different employer settings in 120 different job functions—consistently ensuring that health information is accurate, timely, complete, and available to patients and clinicians.

We appreciate the Committee's bipartisan commitment to reducing healthcare costs and enhancing patient access to their electronic health information. AHIMA continues to champion efforts that enhance the ability of patients to gain access to their health information while improving the workflow of health information professionals tasked with providing such access.

AHIMA offers the following input for the Committee's consideration.

**Section 305: Timely bills for patients**

AHIMA supports the Committee's intent to require healthcare facilities and practitioners to provide timely billing to patients. However, we are concerned that the proposed 30-business-day timeline is too short. Claims cannot be released to a payer until medical coding is completed. However, a number of factors impact the amount of time it takes to code a patient's encounter, including the completeness of the documentation. For instance, under CMS guidelines, providers have up to 30 days from discharge to complete their records. As a result, coding may not occur until several days after the 30-day completion date. Further delays to coding completion include documentation clarification requests by the facility and/or provider staff, wait time for transcription of a dictated report by the provider, as well as final pathology or laboratory results.

The length and complexity of the encounter is another factor that may impact the amount of time it takes to code a patient encounter. For example, an outpatient encounter to a radiology department for a single chest x-ray may be coded (and the claim completed) more quickly than a 20-day hospital stay for a patient with multiple diagnoses or procedures. We recommend the Committee clarify in lines 17-18 of the discussion draft that “health care facilities and practitioners. . . send all bills to the patient within 30 business days upon adjudication of a claim by the payer and remittance to the provider.” Often times, a patient’s portion of a bill may be unknown until the payer processes the claim and makes a coverage determination. In other circumstances, a payer in reviewing the claim may also request copies of the beneficiary’s medical record—further delaying processing of the claim. Inclusion of this triggering event will establish a clear bright line by which providers must provide billing to the patient. Alternatively, the Committee could not require a triggering event and instead require facilities and practitioners to send bills to a patient within 60 but no more than 90 business days. We believe this time period would be sufficient to ensure that all medical documentation, including coding, is complete.

**Section 503: GAO study on the privacy and security risks of electronic transmission of individually identifiable health information to and from entities not covered by HIPAA**

AHIMA supports the inclusion of a GAO study to evaluate the privacy and security risks of electronic transmission of individually identifiable health information to and from entities that are not covered by the Health Insurance Portability and Accountability Act (HIPAA).

AHIMA recognizes that the HHS Office for Civil Rights recently stated that if a third-party app chosen by an individual to receive his or her request for electronic protected health information (ePHI) was not provided by or on behalf of a covered entity, the covered entity will not be liable under HIPAA for any subsequent use or disclosure of ePHI received by the app.<sup>1</sup> However, we are concerned that the existing regulatory landscape lacks sufficient guardrails around HIPAA non-covered entities to protect the privacy and security of a patient’s electronic health information. Patients may be largely unaware that once they authorize a covered entity and/or business associate to push their health information to a third-party app and such an entity is a HIPAA non-covered entity, the rights afforded under HIPAA no longer apply. Additionally, patients may be unaware of how an app intends to use their health information, leaving them at the mercy of an application developer’s terms of service and/or privacy policy unless an act on the part of the application developer meets the “unfair or deceptive acts or practices” standard under the Federal Trade Commission (FTC) Act. A recent cross-sectional study of 36 top-ranked apps for depression and smoking cessation revealed that only 16 apps described secondary uses.<sup>2</sup> 81 percent of the 36 apps transmitted data for advertising and marketing purposes to two commercial entities, Google and Facebook, but only 43 percent transmitting data to Google and 50 percent transmitting data to Facebook disclosed this.<sup>3</sup> Failure to provide appropriate, transparent privacy and security practices could invite opportunities for “bad actors” to enter the market and potentially use such sensitive data for nefarious activities. We believe that inclusion of a GAO study will help further identify existing privacy and security risks in the marketplace as well as critical steps that

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<sup>1</sup> Available at: <https://www.hhs.gov/hipaa/for-professionals/privacy/guidance/hippa-access-right-health-apps-apis/index.html>.

<sup>2</sup> Huckvale K, Torous J, Larsen ME. Assessment of the Data Sharing and Privacy Practices of Smartphone Apps for Depression and Smoking Cessation. *JAMA Netw Open*. 2019;2(4):e192542. doi:10.1001/jamanetworkopen.2019.2542.

<sup>3</sup> Id.

both the public and private sector should take to mitigate such risks while enhancing the access and availability of individually identifiable health information.

AHIMA also urges the Committee to consider the following for inclusion as part of the Lower Health Care Costs Act:

### **Patient Matching**

Today, there is no consistent approach to accurately match a patient to their health information, which has led to significant costs to hospitals, health systems, physician practices, long-term, post-acute care (LTPAC) facilities, and other providers. According to a 2016 study of healthcare executives, misidentification costs the average healthcare facility \$17.4 million per year in denied claims and lost revenue.<sup>4</sup> Lack of a consistent and accurate approach to patient matching has also hindered the advancement of health information exchange across the care continuum. A 2017 study by the American Hospital Association indicates that 45 percent of large hospitals reported that difficulties in accurately identifying patients across health information technology (health IT) systems limits health information exchange.<sup>5</sup>

Patient identification errors often begin during the registration process and can initiate a cascade of costly errors for patients including wrong site surgery, delayed or lost diagnoses, and wrong patient orders. Incorrect or ineffective patient matching can have ramifications well beyond a healthcare organization's four walls as data exchange increases throughout the healthcare ecosystem. Precision medicine and disease research will continue to be hindered if records are incomplete or duplicative. Further, as our nation combats a growing opioid epidemic, successfully matching patients with their records is critical. Accurately identifying patients and matching them to their data is not only essential to coordination of care and a requirement for health system transformation but also a critical, common-sense step Congress could take to help reduce healthcare costs. Along these lines, AHIMA recommends that the Committee include language as part of the Lower Health Care Costs Act that directs the Office of the National Coordinator for Health IT (ONC) and/or the Centers for Medicare and Medicaid Services (CMS) to lead and contribute to efforts to advance creative, innovative and effective approaches to addressing patient misidentification nationwide. Such approaches could include but are not limited to the creation of a set of voluntary agreed-upon metrics to evaluate algorithm performance across the industry, as well as the creation of a set of metrics developed in part by ONC and industry stakeholders to evaluate database duplicate rate, duplicate creation rate, and true match rate.

### **S. 1012, Protecting Jessica Grubb's Legacy Act**

AHIMA also urges the Committee to include S. 1012, the Protecting Jessica Grubb's Legacy Act as part of the Lower Health Care Costs Act. Medical costs associated with treating patients with chronic medical and comorbid mental health/substance use disorder conditions are often two to three times higher on average compared to the costs of beneficiaries that do not have comorbid mental health/substance use

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<sup>4</sup> 2019 National Patient Misidentification Report, Available at: [https://pages.imprivata.com/rs/imprivata/images/Ponemon-Report\\_121416.pdf](https://pages.imprivata.com/rs/imprivata/images/Ponemon-Report_121416.pdf).

<sup>5</sup> AHA, Trendwatch: Sharing Health Information, Available at: <https://www.aha.org/system/files/2018-03/sharing-health-information.pdf>.

disorder conditions.<sup>6</sup> A report by Milliman Research in 2018 found that most of the increased cost for those with comorbid mental health/substance use disorder conditions was attributable to medical services versus behavioral services, and that 9 to 17 percent of the total additional spending could be saved through effective integration of medical and behavioral care.<sup>7</sup>

That said, 42 CFR Part 2 continues to serve as a barrier to integrating medical and behavioral services. Because health information covered by 42 CFR Part 2 must often be kept separate unless patient consent is given, providers are often unaware of the risks to their patient from multiple drug interactions and co-existing medical problems, even though substance use disorders can have a cascading effect on an individual's health and must be carefully managed and coordinated. Inclusion of S. 1012 in the Lower Health Care Costs Act will help ensure that clinicians have the information needed for purposes of treatment, payment or healthcare operations to provide safe, cost-effective, high-quality treatment and care.

We thank you for the opportunity to submit comments on this important legislation and for your continued leadership on these crucial matters. Should you or your staff have any additional questions or comments, please contact Lauren Riplinger, Vice President, Advocacy, at [lauren.riplinger@ahima.org](mailto:lauren.riplinger@ahima.org), (202) 839-1218.

Sincerely,



Dr. Wylecia Wiggs Harris, PhD  
Chief Executive Officer  
AHIMA

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<sup>6</sup> Available at: <https://www.psychiatry.org/File%20Library/Psychiatrists/Practice/Professional-Topics/Integrated-Care/Milliman-Report-Economic-Impact-Integrated-Implications-Psychiatry.pdf>.

<sup>7</sup> Id.