Guidebook

for

Effective Interaction

with

Federal and State Governments

Prepared By

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Revised 1998.

Acknowledgement

This Guidebook was developed under the direction of the AHIMA Legislative Advisory Council in conjunction with GRQ, Inc, a Washington, DC based consulting firm. It was updated in 1998 by the AHIMA Washington, DC Office

The Council's primary goal in the development of the Guidebook is to enhance the role of our Component State Associations at both the Federal and State levels of government. Through cooperative interaction among all AHIMA members we can direct our efforts to working with health policymakers at all levels of government, assuring that decisions that affect all of us are made on the basis of reliable, accurate, and thorough information.

1991 - 92 Legislative Advisory Council

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Introduction

Most Americans agree that Abraham Lincoln described our ideal political system best when he referred to a government of the people, by the people and for the people. As we near the 21st century, the practical application of these principles is tested at every election as politicians sometimes distance themselves from the electorate to whom they are responsible.

Our society has, in many ways, become a society of competing special interests, putting voters into a mixture of special interest groups represented by associations, corporations, unions and management. Politicians are caught in the crossfire between competing interests, sometimes unwilling to make unpopular but admittedly difficult decisions.

The healthcare arena includes dozens of trade associations, including AHIMA. Virtually every allied health profession has its own association, as do most physician specialties. Hospitals have their own specialty organizations, as do other providers and health insurers.

AHIMA is committed to assuring for its members the appropriate input into the development of national health policy. We have expanded our presence in Washington, DC, best illustrated by our own office which is easily accessible to The White House, Congress and the Department of Health and Human Services. Although the AHIMA Washington office and the Chicago office are limited by our resources, both financial and otherwise, we will continue to represent the AHIMA member effectively.

Our strength is in our members and this handbook is designed to give you all the pertinent information you need to interact directly with Federal and State health policymakers. Not only do we explain the basics of the legislative and regulatory process, but we give you tools for your active participation. For example, you will find sample letters to legislators along with specific ways to keep abreast of issues in your state. We have designed the information so that after each election new inserts will be forwarded to you, identifying key players in the health arena nationwide. We have also devoted a section to building coalitions, a practical guide for determining who are our allies.

If we use this information wisely, it will enhance our stature professionally. But we are confident you will also feel a strong sense of personal satisfaction that, together, **we can make a difference.**

The Legislative Process

"There are two things you should never witness – the way we make sausages or laws" Mark Twain

It is unfortunate that working with the Congress should be as complicated as it is. Frankly, it should be as easy as picking up the telephone and getting a civil answer to a civil question. But there are close to 20,000 Congressional staffers in Washington, serving on the personal staff, committee staff, subcommittee staff, or within related agencies such as the Congressional Budget Office, the Congressional Research Service, the General Accounting Office, etc. How can anyone know whom to call?

In reality, there is a fair amount of logic to the way Congress has organized itself. Even today Congress moves in ways that are very similar to what we all learned in Civics 101.

How a Bill Becomes a Law

The Congress, like all states except Nebraska, includes two chambers - the House of Representatives and the Senate. There are 435 members in the House of Representatives and 100 in the Senate. It is understandable that each member cannot be an expert in healthcare, defense, agriculture, labor, energy, and all the other issues facing Congress. To ease this burden, almost since its inception, the Congress has committees, and most committees have subcommittees.

Healthcare issues fall under the jurisdiction of several committees in the House and Senate. In the House of Representatives, the breakdown is as follows:

- The Committee on Ways and Means and its Subcommittee on Health have jurisdiction over Medicare Part A and share jurisdiction over Medicare Part B with the Energy and Commerce Committee.

- The Energy and Commerce Committee and its Subcommittee on Health and the Environment share jurisdiction with the Ways and Means Committee over Part B Medicare and have sole jurisdiction over Medicaid and virtually all other Federal health programs (e.g., the Public Health Service, including FDA, NIH, CDC, etc.).

- The House Appropriations Committee and its Labor, HHS Subcommittee appropriate the money necessary for all health programs *except* Medicare and Medicaid. Medicare and Medicaid are entitlement programs and do not go through the appropriations process. [NOTE: Administrative costs of the programs are subject to the appropriations process; costs associated with services to beneficiaries are not].

- The Subcommittee on Government Management, Information, and Technology of the House Government Reform and Oversight Committee has maintained primary jurisdiction over health information confidentiality legislation.

In the Senate, the Committees include:

- The Finance Committee. The committee has jurisdiction over Medicare and Medicaid. The Subcommittee on Health Care addresses all health care issues, primarily those financed by a specific tax or trust fund.

- The Labor and Human Resources Committee. The committee has jurisdiction over virtually all other Federal health programs (e.g., the Public Health Service, including FDA, NIH, CDC, etc.). Health issues are handled by the full committee.

- The Appropriations Committee and its Labor, HHS Subcommittee appropriates the money necessary for all health programs *except* Medicare and Medicaid. Medicare and Medicaid are considered entitlement programs and do not go through the appropriations process.

- The Senate Special Committee on Aging. Like its House counterpart, the committee holds hearings on a wide range of health matters but it has no specific legislative jurisdiction. Therefore, the Committee cannot act formally on pending legislation.

Introducing legislation: Any member of Congress can introduce legislation. Once formally introduced, a bill is assigned a number in order of introduction during each Congress. For example, HR 1500 is the 1500th bill introduced in the House of Representatives during that Congress. Each term of Congress runs two years, divided into two yearly sessions. The bill is referred to the appropriate Committees in the respective Chamber where it was introduced. At the discretion of the Committee Chairman and the Subcommittee Chairman, hearings may be held to examine issues raised by the legislation.

Hearings: Hearings are held to give Members and the public the opportunity to comment on all aspects of the proposed legislation. Individuals or organizations wishing to testify before a Subcommittee generally must make a formal request to the Subcommittee/Committee. Understandably, there are often more requests to testify than time permits, so, as an option, the formal record of the hearing is kept open so that parties may submit their comments in writing. Such comments generally have the same weight as the more visible, oral testimony although there is certainly a benefit to delivering your comments before a panel of Congressmen or Senators.

Mark-up: Once a subcommittee believes that it has received enough information regarding the issues raised by the legislation, the Chairman determines that he may want to proceed further by "marking up" the bill. During mark-up each member of the subcommittee has the opportunity to amend the bill as he/she sees fit, knowing that it will take a majority of the members to agree to such an amendment.

Once markup is completed, the Subcommittee *reports* the bill to the full committee usually with detailed information explaining certain aspects of the bill. The *subcommittee report* includes all the changes made during the mark-up along with the explanations. The explanations are generally called *report language.* Occasionally, the bill may be re-introduced as a new *clean* bill and assigned a new number. Therefore, a bill that began as HR 1500 may now be HR 1750.

The full committee chairman now determines the fate of the bill, scheduling a full committee markup or delaying the bill, effectively killing it. If mark-up is scheduled, the bill is subject to amendment by members of the full committee, not just the subcommittee members. New matters can be added, while controversial issues may be dropped from the bill. At the end of mark-up, assuming that a majority agrees to report the bill, clean legislative language is developed along

with new report language. Committee staff writes a formal committee report. Again, the bill may have a new incarnation, now pending action by the full House as HR 1900.

Rules: In order for any legislation to move to the floor of the House of Representatives, the legislation must go to the Rules Committee. The committee determines the basic rules for floor debate:

Open rule. All amendments are acceptable for consideration

Modified rule. Only certain amendments, usually submitted beforehand, are acceptable for consideration

Closed rule. The bill stands by itself with no amendments permitted

Modified rules are typically the most frequent, with closed rules somewhat less common. Open rules are rare because of the need to limit debate among the 435 members.

Floor debate and vote: A bill that has received its rule is scheduled for floor action by the leadership of the political party that maintains a majority of members in that particular chamber. Time for debate is divided equally among both parties, with the Chairman and the most senior member of the minority party (traditionally called the ranking minority member) determining who speaks on behalf of or against the bill. At the completion of debate, the vote is taken. 218 votes are necessary to approve a bill in the House of Representatives.

Once again, the bill may have been amended on the floor A report is redrafted reflecting the specific changes in legislative language. Accompanying report language is written by Committee staff.

Through this outlined process, the bill has moved through only the House of Representatives. A similar process may occur in the Senate, moving through its Committee structure. But there are a few important differences between the House and Senate:

- Although the Senate Finance Committee has a Subcommittee on Health Care, generally only the full Committee marks up legislation.

- The Senate Labor and Human Resources Committee handles health issues at the full Committee level. There is no health subcommittee,

- The Senate does not have a Rules Committee comparable with the House of Representatives. All bills are subject to debate and amendment.

Because the Senate does not have a Rules Committee, the length of debate in the Senate is limited only upon consensus of both Democrats and Republicans. This process is called *unanimous consent.* In most cases, any Senator who wishes to speak may speak as long as he/she chooses unless debate is limited by *unanimous consent.*

- The Constitution requires that all tax bills originate in the House (before the Ways and Means Committee).

Conference: Except in rare situations, the bill passed by the House and the Senate are different. Usually the differences are minute, but there are often significant differences in how each

Chamber addresses a perceived problem. To iron out differences, each chamber appoints a small group of its members, *conferees*, to meet with a small group from the other chamber.

When agreement is reached, the agreement is returned to each Chamber for another vote, in effect formally ratifying the agreement of the conferees. Sometimes one chamber will agree to the *conference report*, but it is not unusual for one Chamber to agree and one to disagree, rejecting the agreement. Under these circumstances, conferees must meet again to determine if compromise is possible.

If agreement is reached, the legislation is forwarded to the President for approval or veto.

Influencing the Legislative Process

"Some [legislators] are created more equal than others!" George Orwell

Influencing the legislative process involves all members of AHIMA, working together to assure that our voice is clear and unified. There are numerous opportunities for AHIMA input through our Washington office and through grass roots assistance of our membership.

An important premise of influencing the legislative process is the recognition that all members of Congress are not equal. As chairman of a committee or subcommittee, a member wields significant influence on the movement of legislation under his/her jurisdiction. Likewise, the party with the political majority wields more influence than the minority because of the sheer numbers. [NOTE: The composition of Committees generally reflects the composition of the entire Chamber. If Democrats outnumber Republicans 3:2 in the House of Representatives, each committee will reflect that composition as well.]

Introducing legislation: In the event that AHIMA determines that it wishes to introduce legislation, we will focus on members of the committee(s) that have jurisdiction over our specific issue. Under ideal circumstances, a bill introduced by the Chairman immediately signals the seriousness afforded to the legislative proposal.

The opposite is true as well. Bills introduced by Members that do not sit on the appropriate committee(s) often indicates the lack of receptivity by the primary health policymakers.

Once a bill is introduced, it is necessary to encourage the Chairman to schedule hearings on the legislation. Action without hearings is extremely rare.

This pressure may take several forms:

- *Face- to face meetings* with AHIMA staff and appropriate Congressional staff and Members
- *Letter writing* from constituents of the Chairman
- *Letter writing* from nonconstituents of the Chairman
- *Letter writing* from constituents to other members of the subcommittee, encouraging them to pressure the Chairman to hold hearings
- *Letter writing* to other members of Congress
- *Phone calls* to Congressional offices
- *E-Mail* to Congressional offices (To reach Congress on the web: http://thomas.loc.gov)

Letters directed to the Chairman generally request his assistance in scheduling hearings. Letters directed to other Members generally request their assistance in contacting the Chairman *as well as a formal request for co-sponsorship.* A bill which has 10 cosponsors within the Subcommittee carries significant weight, as would a bill with 50 co-sponsors scattered throughout the Chamber.

"Dear Colleague" letters are also extremely helpful. These letters are written by Members of Congress to their fellow Members, notifying them about legislation recently introduced. Generally, such letters ask for co-sponsorship directly. In turn, grass roots letters from AHIMA members may refer to a "Dear Colleague" letter sent by the original sponsor (in fact, AHIMA may assist the sponsor in writing the letter).

Phone calls to congressional offices can also be effective in communicating concerns on major issues that have received media attention, most Congressional offices will have receptionists tally the phone calls to indicate support on a particular matter. On specific technical issues, it is best to ask for the legislative assistant who handles health matters. As in letter writing, be brief and concise. It is certainly a good idea to have notes in front of you before calling so that your thoughts are organized in a logical way. And it never hurts to follow-up a phone call with a more formal letter, reiterating the specific context of your telephone conversation.

As you can see, letter writing is the primary method for applying grass roots pressure. Sample letters to members of Congress are included at the end of this section, but it is important to use these letters only as models. **Letters and e-mail should be individually tailored whenever possible. E-mail can substitute for letter writing in all instances where a Member of Congress of Senator accepts e-mail.**

Hearings: Once hearings are scheduled, the AHIMA Washington Office works intimately with the Subcommittee staff identifying possible witnesses and generally helping with all the necessary legwork involved in a hearing.

AHIMA input may come from several directions. First and foremost is the opportunity to testify before the subcommittee. Written comments are generally required to be submitted before the hearings so that Members' briefing materials can be prepared. In addition to oral testimony, which is frequently limited to five minutes, more detailed written statements are submitted for the record.

It is reasonable and appropriate for the AHIMA Washington office to ask the AHIMA Legislative Committee, specialty sections and/or specific CSAs to submit comments supporting official AHIMA positions. When this happens, the AHIMA Washington office will supply the CSAs with all relevant information such as the issues, AHIMA position(s), and language to be used in letters.

Mark-up: The most intense lobbying in Washington surrounds subcommittee and full committee mark-up. It is here where legislation is amended, adding and deleting provisions in response to pressure from special interest groups, constituents, and other political pressure points. Grass roots letter writing is vital at this stage in the legislative process:

- *Letter writing* to Members of the subcommittee, encouraging them to support particular provisions of the bill, or to support anticipated amendments at the mark-up session.

- *Letter writing* to Members of the full Committee, alerting them to the actions of the Subcommittee, seeking support as appropriate.

On occasion, floor action is scheduled shortly after full committee markup, limiting the amount of time that letter writing can be effective. Therefore, it is likely that letter writing to all Members of Congress would occur in anticipation of possible swift floor scheduling.

Through the AHIMA rapid response communications network, letter writing is coordinated in response to specific action in Washington, DC. Understandably, not all AHIMA members are contacted on all matters, simply because of political considerations. For example, AHIMA members who live in the district of a Member of a key health subcommittee are likely to be more active with grass roots letter writing than AHIMA members who live where their representative sits on Agriculture and Armed Services committees. A sample list of key legislators is also included at the end of this section.

Additional Resources Available to Congress

It is easy to appreciate the frustration of Members of Congress who must consider on a daily basis the intricacies and nuances of national policies affecting health, energy, trade, environment, defense, and so on. Members of Congress, therefore, rely heavily on support agencies to assist them in developing positions.

The Congressional Research Service (CRS) is an arm of the Library of Congress devoted to objective research on all issues facing the Congress. Its health branch responds to specific requests from Members of Congress for information on virtually any topic. While the general public cannot tap into this resource on its own, it is reasonable to request that a Member of Congress ask CR5 to research a particular issue.

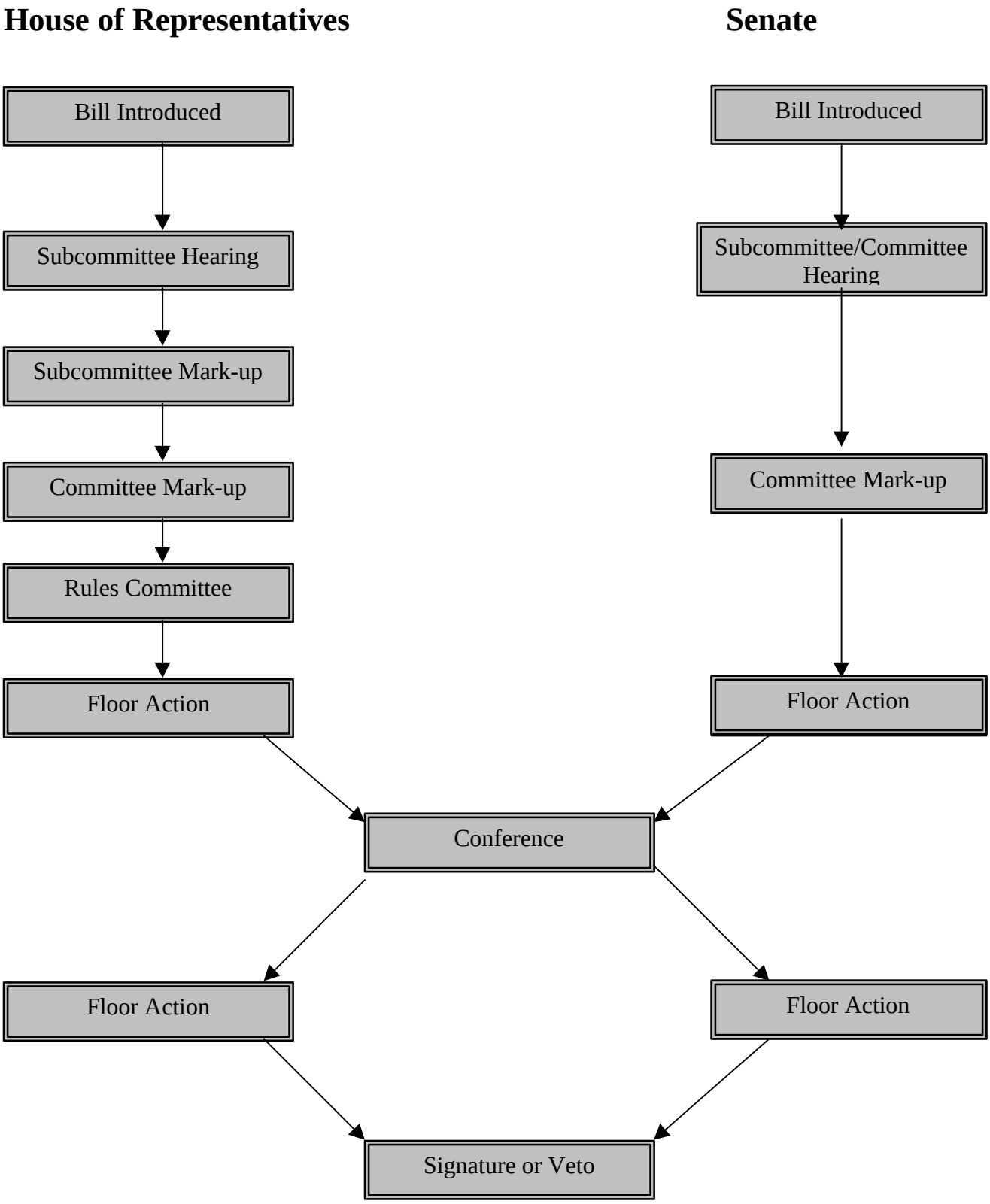
The Congressional Budget Office (CBO) is also a nonpartisan arm of the Congress which has the responsibility for making specific budget estimates for the Congress. Historically, CBO has been used to verify or question cost estimates developed by the Office of Management and Budget (0MB), an extension of the Executive Office of the President.

Proposals under serious consideration invariably must have a CBO cost estimate to determine the relative cost or savings involved if the legislation is to be adopted. In fact, many members of Congress ask CBO for estimates prior to formal introduction of legislation, knowing if the price tag is unreasonable, the proposal frequently never makes its way to formal bill introduction.

The General Accounting Office (GAO) watches the purse strings of Congress and conducts studies related to the financial implications of existing Federal programs. GAO also conducts research that may, in fact, embarrass Congress, i.e., audits of the House Bank.

These resources and others can be part of an effective legislative initiative coordinated by AHIMA. Our Washington Office staff frequently discusses various policies with individuals from these offices, making sure that accurate information is included in reports, budget estimates, and other relevant materials.

How A Bill Becomes A Law



Sample Letter
Letter to Chairman to Urge Hearings

Your Address
Hometown, USA 12345

Date

The Honorable John Doe
Chairman
Subcommittee on Health
House Ways and Means Committee
Room ____, _____ Building
Washington, DC 20515

Dear Mr. Chairman:

As a member of the (State) Health Information Management Association (Acronym), I am writing to urge you to schedule hearings on HR _____, *the Health Information Confidentiality Act*. HR ____ was introduced by Representative (Name) on (Date) and has (number) cosponsors. This important legislation intends to… For your information, I have enclosed a brief summary of the bill's provisions.

(Acronym) represents over (number) of health information management professionals in (State). We are the (state) component state association of our national association, the American Health Information Management Association (AHIMA). As experts in clinical data and information management, the 38,000 professional members of the American Health Information Management Association (AHIMA) are vital to the healthcare industry. The unique knowledge and skills that AHIMA members possess are critical for classifying and analyzing health information, transitioning from paper to computer-based medical records, and enhancing data quality—all accomplished while maintaining patient confidentiality and information security. With a 70-year tradition of advancing quality healthcare through quality information, AHIMA is also instrumental in developing industry standards, advocating relevant legislation, and providing education in health information.

Thank you for your attention to this matter. As subcommittee chair, we hope you can schedule hearings on this legislation at the earliest possible date. If there is any further information (Acronym) or AHIMA can provide, you can reach me at (phone number) or you may contact the AHIMA Washington, DC Office at (202)218-3535.

Sincerely,

Your Name
Your Title

Sample Letter
Letter to Member of Subcommittee
Requesting Assistance in Urging Chairman to Schedule Hearings

Your address
Hometown, USA

Date

The Honorable Jane Doe
U.S. House of Representatives
Room ____, _____ Building
Washington, DC 20515

Dear Congresswoman Doe:

As a member of the (State) Health Information Management Association (Acronym), I am writing to request your assistance with urging Chairman _____ to schedule hearings before the _____ Subcommittee on HR _____, *the Health Information Confidentiality Act.* HR ____ was introduced by Representative (Name) on (Date) and has (number) cosponsors. As a member of the Subcommittee, your assistance is crucial to the consideration of this important matter. For your information, I have enclosed a brief summary of the bill's provisions.

(Acronym) represents over (number) of health information management professionals in (State). We are the (State) components state association of our national organization, the American Health Information Management Association (AHIMA). As experts in clinical data and information management, the 38,000 professional members of the American Health Information Management Association (AHIMA) are vital to the healthcare industry. The unique knowledge and skills that AHIMA members possess are critical for classifying and analyzing health information, transitioning from paper to computer-based medical records, and enhancing data quality—all accomplished while maintaining patient confidentiality and information security. With a 70-year tradition of advancing quality healthcare through quality information, AHIMA is also instrumental in developing industry standards, advocating relevant legislation, and providing education in health information.

Thank you for your attention to this matter. I am hopeful that the important issues raised by HR ____ will receive the appropriate attention from your subcommittee at the earliest possible date. If there is any further information (Acronym) or AHIMA can provide, you can reach me at (phone number) or you may contact the AHIMA Washington, DC Office at (202)218-3535.

Sincerely,

Your Name
Your Title

Sample Letter

Letter to Member of Congress
Requesting Assistance with Urging Chairman to Schedule Hearings

Your Address
Hometown, USA

Date

The Honorable Jane Doe
U.S. House of Representatives
Room ____, _____ Building
Washington, DC 20515

Dear Congresswoman Doe:

As a member of the (State) Health Information Management Association (Acronym), I am writing to request your assistance with urging Chairman _____ to schedule hearings before the _____ Subcommittee on HR _____, *the Health Information Confidentiality Act.* HR ____ was introduced by Representative (Name) on (Date) and has (number) cosponsors. Although you are not a member of the (Committee or Subcommittee), your assistance is crucial to the consideration of this matter. For your information, I have enclosed a brief summary of the bill's provisions.

(Acronym) represents over (number) of health information management professionals in (State). We are the (State) component state association of our national organization, the American Health Information Management Association (AHIMA). As experts in clinical data and information management, the 38,000 professional members of the American Health Information Management Association (AHIMA) are vital to the healthcare industry. The unique knowledge and skills that AHIMA members possess are critical for classifying and analyzing health information, transitioning from paper to computer-based medical records, and enhancing data quality—all accomplished while maintaining patient confidentiality and information security. With a 70-year tradition of advancing quality healthcare through quality information, AHIMA is also instrumental in developing industry standards, advocating relevant legislation, and providing education in health information.

Thank you for your attention to this matter. I am hopeful that the important issues raised by HR ____ will receive the appropriate attention from Congress. If there is any further information (Acronym) or AHIMA can provide, you can reach me at (phone number) or you may contact the AHIMA Washington, DC Office at (202)218-3535.

Sincerely,

Your Name
Your Title

Sample Letter

Letter to Member of Subcommittee to Support Provisions of a Bill or to Support Anticipated Amendments at Mark-up Session

Your address
Hometown, USA

Date

The Honorable Jane Doe
U.S. House of Representatives
Room ____, _____ Building
Washington, DC 20515

Dear Congresswoman Doe:

As a member of the (State) Health Information Management Association (Acronym), I am writing to request your support for HR ____, *the Health Information Confidentiality Act.* Of particular note are Sections ____ which provide for _____. As this bill moves through mark-up, I hope we can count on your support to assure that these provisions remain intact.

In addition, we have been working with Representative _____, and she will be introducing an amendment during mark-up which will _____. We ask that you support this important amendment.

(Acronym) represents over (number) of health information management professionals in (State). We are the (State) component state association of our national organization, the American Health Information Management Association (AHIMA). As experts in clinical data and information management, the 38,000 professional members of the American Health Information Management Association (AHIMA) are vital to the healthcare industry. The unique knowledge and skills that AHIMA members possess are critical for classifying and analyzing health information, transitioning from paper to computer-based medical records, and enhancing data quality—all accomplished while maintaining patient confidentiality and information security. With a 70-year tradition of advancing quality healthcare through quality information, AHIMA is also instrumental in developing industry standards, advocating relevant legislation, and providing education in health information.

Thank you for your attention to this matter. If there is any further information (Acronym) or AHIMA can provide, you can reach me at (phone number) or you may contact the AHIMA Washington, DC Office at (202)218-3535.

Sincerely,
Your Name
Your Title

Sample Letter

Letter to Member of Committee Alerting Her to the Actions Of the Subcommittee and to Seek Support as Appropriate

Your address
Hometown, USA

Date

The Honorable Jane Doe
U.S. House of Representatives
Room ____, _____ Building
Washington, DC 20515

Dear Congresswoman Doe:

As a member of the (State) Health Information Management Association (Acronym), I am writing to request your support for HR ____, *the Health Information Confidentiality Act.* As you may know, the _____ has marked-up HR ____. Passage of this legislation is extremely important to (Acronym) members. Of particular importance are Sections _____ which provide for _____. As this bill moves to full committee mark-up, I hope that we can count on your support.

In addition, we have been working with Representative _____, and she will be introducing an amendment during mark-up which will _____. We ask that you support this important amendment.

(Acronym) represents over (number) of health information management professionals in (State). We are the (State) component state association of our national organization, the American Health Information Management Association (AHIMA). As experts in clinical data and information management, the 38,000 professional members of the American Health Information Management Association (AHIMA) are vital to the healthcare industry. The unique knowledge and skills that AHIMA members possess are critical for classifying and analyzing health information, transitioning from paper to computer-based medical records, and enhancing data quality—all accomplished while maintaining patient confidentiality and information security. With a 70-year tradition of advancing quality healthcare through quality information, AHIMA is also instrumental in developing industry standards, advocating relevant legislation, and providing education in health information.

Thank you for your attention to this matter. If there is any further information (Acronym) AHIMA can provide, you can reach me at (phone number) or you may contact the AHIMA Washington, DC Office at (202)218-3535.

Sincerely,
Your Name
Your Title

Sample Key Legislators

TEXAS--Key Contact:

Name:
Hospital/Facility:
Address:

Telephone:
Fax:
CSA Officer (give position)/Member:
AHIMA Officer (give position)/Member:

UNITED STATES SENATE

Senator Lloyd Bentsen (Chairman - Committee on Finance)
109 Hart Senate Office Bldg.
Washington, DC 20510
202 - 224-4515

Key Health Aide(s)
Marina Weiss

UNITED STATES HOUSE OF REPRESENTATIVES

Congressman J.J Pickle (Cmte on Ways and Means)
242 Cannon House Office Bldg
Washington, DC 20515
202 - 225 - 4865

Key Health Aide
Vacant

Congressman Michael Andrews (Cmte on Ways and Means)
303 Cannon House Office Bldg.
Washington, DC 20515
202 - 225 - 7508

Key Health Aide
Dave Kendall

Congressman Ralph Hall (Health Subc., Cmte on Energy & Commerce)

2236 Rayburn House Office Bldg.
Washington, DC 20515
202 - 225 - 6673

Key Health Aide
William Cargill

Congressman John Bryant (Health Subc., Cmte on Energy & Commerce)
208 Cannon House Office Bldg.
Washington, DC 20515
202 - 225 - 2231

Key Health Aide Barbara Crapa
Scheleen Johnson

Congressman Jack Fields (Health Subc., Cmte on Energy & Commerce)
108 Cannon House Office Bldg.
Washington, DC 20515
202 - 225 - 4901

Key Health Aide
Jennifer Shaw

Congressman Joe Barton (Cmte on Energy & Commerce)
1225 Longworth House Office Bldg.
Washington, DC 20515
202 - *225* - 2002

Key Health Aide
Jeff MacKinnon

The Regulatory Process

This section…contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules. Federal Register

The Federal rulemaking process (sometimes referred to as "administrative law") is explained in some detail below. These rules, when published in the *Federal Register* (commonly referred to as "promulgated"), have the same force of law as those enacted by the President (i.e., an Executive Order) or the Congress.

The Federal Register Act was passed by Congress in 1935 and requires that certain documents be filed with the Office of the Federal Register, available for public inspection, and published in the *Federal Register.* The *Federal Register* is published on every Federal Government working day and is an excellent resource that is available to the public for an annual subscription price of $375. The *Federal Register* is also available for perusal at certain public libraries at no cost, and there are no restrictions on the republication of material appearing in the *Federal Register.* The *Federal Register* can also be accessed on the Internet at http://www.access.gpo.gov/nara.

It is important to understand all of the influencing factors/constraints placed *on* the process so that one can interact properly and most advantageously with "the system" and be aware of one's rights. Therefore, after a brief description of the types of rules that would most often impact an AHIMA member, this manual explains the external (i.e. outside of the agency formulating the rule) forces that significantly impact the rulemaking process. These are explained in some detail so that you can not only understand the rulemaking process but also be able to ascertain if and when an agency does not conform to the constraints surrounding the rulemaking process (e..g., provide the basis for a challenge of an agency's rule).

Definition of Rule: In general, the term "rule" (i.e., regulation) is defined as an agency statement of general or particular applicability and *future effect.* Rules may be applied retroactively if the inequities produced by such application are counterbalanced by significant statutory interests. Most rules contain a statement about the basis and purpose of the rule (commonly referred to as the "preamble") and the actual regulatory language itself. The preamble must adequately articulate the reasons for the agency's decisions. *(*This is discussed in detail below.)

Rule Format: Each rule that is published will notify the public of such things as: the agency that is publishing the rule, what type of rule it is, the effective date of the rule (if a final rule), the date comments are due (if applicable). Every proposed or final rule must include a preamble which will inform the public of the basis and purpose of the rule or proposed rule. The preamble will be followed by regulatory text, the actual "rules" which the agency is promulgating. In between the preamble and the regulatory text, the reader will find the agency's responses to other requirements that are described later (e.g., regulatory impact analysis, paperwork burden, etc.).

Types of Rules: Generally, there are six types of rules that impact AHIMA members. These are the types of rules most often used by the Department of Health and Human Services, which has the Health Care Financing Administration and the Agency for Health Care Policy and Research as two of its components. (See the end of this section for organizational charts.)

The types of rules are:

- General Notices/Notices These regulations do not impose requirements on the public but, rather, alert the public to such things as meetings, forming of advisory committees, future regulation agendas, etc

- Notice of Proposed Rulemaking (NPRM) - This type of rule is the vehicle for an agency to describe to the public what requirements it proposes to impose on the public and allows the public to comment on the proposal(s); it is discussed in detail below.

- Final Rule This rule sets forth the agency's final policy, taking into consideration comments received, and sets an effective date for the requirements. (See below for further discussion of this type of rule.)

The following are two variations of final rules:

- Interim Final Rule with Comment Period- This type of rule is used infrequently but is most often used for complex rules (e.g., covering many subjects) when commenters have raised issues or the agency has changed somewhat its policies from those published in the NPRM. Following a comment period, the agency is obligated to publish a final rule. In the "interim," the already published rule is final.

- Final Rule with Comment Period - These rules are not frequently used. When they are used, it is usually the result of statutorily imposed deadlines or dictates from the courts. Following the comment period, the agency may or may not publish another rule. This rule has the force of law from the effective date of the rule.

- Correction Notice This type of rule makes corrections to an already published rule.

Notice of Proposed Rulemaking: Because agencies have been under increased scrutiny by the Congress, the President, and the courts to demonstrate the need for and rationale about the rules they adopt, the processes that precede rulemaking have become significantly more important. Rulemaking varies in the pace of development, and the events or external pressures that instigate the rulemaking process may affect the way rulemaking evolves. Thus, the public, the courts, or Congress may be instrumental in causing an agency to pursue rulemaking. There are some preliminary procedures an agency can use, such as an Advance Notice of Proposed Rulemaking and Negotiated Rulemaking, these are almost never used by the agency that impacts the health information management professionals most often, the Department of Health and Human Services.

The notice-and-comment procedures are intended to encourage public participation in the process, help educate the agency, and achieve more informed agency decision-making. To obtain meaningful participation from the public, the NPRM must apprise interested persons of the issues in the rulemaking. If, for example, a final rule differs to a great extent from the proposed rule, one could hold that the public was not apprised of the issues. This, in no way, should be construed as saying that an agency may not alter the proposal in its final rule. Instead, the final rule must so differ from the proposal when the evidence warrants the change. One way an agency can set forth specific proposals in an NPRM and retain flexibility in drafting the final rule

is to include in the NPRM several alternatives that are under consideration.

A second round of notice and comment maybe useful in a number of instances, although it is virtually never used. It may help the agency avoid vulnerability in court about the issue of the adequacy of the notice, especially where it appears that the final rule will materially differ from the proposed rule. Two opportunities to comment should be offered when commenters bring new issues to the attention of the agency: when the agency anticipates that the issues will be unusually complex; or the first notice contains only a general description of the subject and issues. Other factors supporting a second comment period might be: the availability of new studies or experiments and supervening legal developments, such as statutes, regulations, or court decisions that significantly affect the rule.

Final Rule: Between the close of the comment period and the publication of a final "major" rule, the agency must prepare a final regulatory impact analysis and submit the analysis and the draft final rule to OMB for review. "Non-major" rules must be submitted to 0MB at least 10 days prior to publication.

Except for a few exceptions agency rules may not be made effective until 30 days after publication in the *Federal Register*.

While the agency is compelled to explain the statement and purpose in the preamble, this was not intended to require an elaborate analysis of rules or of the detailed considerations upon which they are based. Rather, it is designed to enable the public to obtain a general idea of the purpose of, and a statement about the basic justification for the rules. Agencies often use the statement to advise interested persons how the rule will be applied, to respond to questions raised by commenters, and as a history that can be referred to in future applications of the rule.

It is equally important for the agency to deal fully with major alternative solutions for the issues, explaining clearly why they were rejected in favor of the option(s) selected. The agency must explain how the regulation furthers the policies of the enabling statute. Where the final rule varies from the proposed rule, the preamble must explain in detail how the final rule is a logical outgrowth of the proposed rule.

Generally, any published data criteria, standards, and similar material not produced by the agency may be incorporated by reference into a rule if it is reasonably available to and usable by the class of persons affected by the rule.

Politicizing the regulatory process: In response to numerous political pressures, several important "wrinkles" in the traditional rulemaking process have developed:

- Agencies are required to prepare an inflation impact statement for each "major" rule prior to publication of the notice of proposed rulemaking (NPRM). The Director of the Office of Management and Budget (OMB) is empowered to administer the program.

- Agencies are required to publish semi-annual agendas, describing and giving the legal basis for, any "significant" regulations under development.

- An executive order issued in 1981 (Executive Order No. 12291) increased presidential control over executive branch rulemaking. It was designed to reduce the burdens of existing and future regulation, increase agency accountability, provide for Presidential oversight, minimize duplication and conflict in regulations and ensure well-reasoned regulations. This executive order also gives OMB rulemaking review functions beyond those established in the Paperwork Reduction Act of 1980 by which Congress statutorily established the Office of Information and Regulatory Affairs in OMB to review and approve or disapprove agency information collection requests.

- This executive order mandates that for major rules a Regulatory Impact Analysis must be performed that describes: 1) the rule's potential benefits and who will derive them; 2) the potential costs and who will bear them; 3) the net benefit[s]; and 4) alternative approaches that could achieve substantially the same goal and an explanation of why such alternatives were not adopted. Also noteworthy is the fact that this executive order defined a "major" rule as one that would result in:

- An annual effect on the economy of $100 million or more;

- A major increase in costs or prices for consumers; individual industries, Federal, State or local government agencies; geographic regions; or

- Significant adverse effects on competition, employment, investment, productivity, innovation, or on the ability of United States-based enterprises to compete with foreign-based enterprises in domestic or export markets.

- In 1985, an executive order (Executive Order No. 12,498) was issued to augment the executive order issued in 1981. This new executive order mandates that the head of each agency must determine at the beginning of the regulatory process whether a proposed regulation is consistent with the goals of the Administration. Thus, at the beginning of each fiscal year, agency heads are to develop a plan for managing the agency's most significant regulatory actions; OMB then reviews the plan for consistency with the Administration's program and publishes the coordinated agency plans in a government-wide document, entitled: *Regulatory Program of* the *United States Government.*

OMB requires that the public always be given a chance to comment on proposed collections of information. In rulemaking, this is accomplished by including in the NPRM reference to the fact that the rule has been submitted to OMB for review and that comments may be sent to the OMB desk officer for the particular agency The rules also require that the agency place a notice in the *Federal Register,* advising the public about the availability of information such as: a brief statement of the need for the collection of information, a description of how the information/ recordkeeping will be conducted and the likely respondents and an estimate of the total annual reporting and recordkeeping burden that will result. All collection of information requirements in rules must display an OMB control number.

Understandably, Presidential review of agency rulemaking, as implemented through OMB has been criticized by Democratic Members of Congress and public interest groups based on constitutional, statutory, and management principles. Some state that OMB violates constitutional separation of powers when it seeks to “control” agency rulemaking authority that has been vested in the agency by Congress.

Influencing the Regulatory Process

Requests for Formal Comments: This is the most important part of the rulemaking process for AHIMA. As noted earlier, rules in the Federal Register which affect AHIMA may take several forms, and a particular period for submitting written comments is specified. Any organization needs time to coordinate a response or to authorize an expenditure of funds to do the research needed to produce informed comments. Given those organizational constraints. it is important to remember that comments must be *received* by the agency by the date stipulated in the NPRM to ensure agency consideration. Comments received after the stipulated date are not read or considered.

Regulatory agencies such as the Health Care Financing Administration rely heavily on comments submitted during the rulemaking process.

- When submitted comments on an issue appear to be contradictory, a regulatory agency must make judgements about the information submitted, oftentimes choosing one position over another. Likewise the agency could attempt to find middle ground.

- When general consistency in submitted comments on a specific issue occurs, it is much more difficult for regulators to finalize a rule which does not in some way reflect that consensus within the regulated industry.

- **In the absence of comments, regulators generally believe that their proposals are reasonable!**

It is important for each AHIMA member, and the organization as a whole, to submit comments when proposed policies impact the profession. It cannot he stressed enough that the comments should be clear, concise/succinct, and be as objective as possible (e.g., it is not good enough to say that one does not "like" a proposed rule; one must say why the proposed rule should not be promulgated. Specific suggestions for improvement are generally worthwhile).

When AHIMA submits comments to HCFA or another regulatory agency, it is unusual that we will need grass roots support through additional letter writing. However, on occasion, regulations are published that are of such magnitude that the AHIMA leadership will request your assistance in submitting additional, individualized, comments. It is also likely that you will receive specific instructions regarding content and timing so that you will have time to write your own letter, following the guidelines cited above.

Agencies (and regulators within agencies) take various approaches to handling "ex parte" communications (i.e. "off-the-record") There, understandably, is unfavorable public reaction when the agency receives information in private discussions with persons outside the agency. Nonpublic, candid contacts between the agency and interested parties, however, can be useful in working through policies. Off-the-record communications even among agencies raise concerns about integrity and fairness. These interactions raise concerns that such actions may countermand congressional mandates, reduce incentives for independent actions on the part of regulators, undermine the Administrative Procedures Act, and serve as undisclosed conduits for biased information reaching rulemakers. For example, the propriety of OMB contacts with agencies has been raised in several instances.

Role of Congress: Congress has a pervasive influence on agency rulemaking by granting the fundamental authority to an agency to engage in policy making through rulemaking. Congress has also sought to control and expedite agency rulemaking by imposing statutory deadlines for completing rulemaking. Typically, these deadlines can be enforced only by the courts; however, in some cases Congress has added penalties if an agency fails to take timely action. In addition, Congress has exercised its oversight authority. formally or informally, to oversee agency rulemaking activities.

The conflicts between a Congress controlled by the Democrats and the Executive Branch controlled by the Republicans have resulted in a significant degree of direct congressional intervention into the rulemaking process. In fact, it is no longer unusual for Congress to address in legislation issues which had previously been addressed through regulation. For example:

- Congress frequently inserts into authorizing legislation specific dates for promulgation of regulations, thereby requiring action by a particular time;

- The statutory phrase, “The Secretary shall..." has limited HHS's ability to administer its programs;

- Congress limits Executive Branch authority through implementation of technical limitations. For example, section 1102(b) of the Social Security Act requires the Secretary to prepare a regulatory impact analysis if a proposed rule may have a significant impact on the operations of a substantial number of small rural hospitals (defined as hospitals with fewer than 50 beds located outside a Metropolitan Statistical Area).

Frequently, members of Congress will contact the regulatory agencies, either on the advice of their own staff or in response to pressure from constituents. These communications may be simple, direct inquiries as to the logic of a particular position or, at the other extreme, detailed critiques strongly urging a specific regulatory policy.

It is reasonable to believe that AHIMA will ask its members to contact key members of Congress when critical regulatory issues arise. Therefore, in addition to writing to HCFA, you may be requested to write to your legislators about a regulatory matter that affects you. After all, a letter written to the Secretary of HHS by several members of Congress will have more impact than those same words written by members of AHIMA.

Because agencies have been under increased scrutiny by the Congress, the President, and the courts to demonstrate the need for and rationale about the rules they adopt, the processes that precede rulemaking have become significantly more important. Rulemaking varies in the pace of development, and the events or external pressures that instigate the rulemaking process may affect the way rulemaking evolves. Thus, the public, the courts, or Congress may be instrumental in causing an agency to pursue rulemaking.

Agencies Publishing Regulations Impacting AHIMA

As a general rule the following agencies are the ones most likely to publish a regulation that would impact the health information management professional. (This does not mean that there are no exceptions to the rule)

- Department of Health and Human Services

  -Health Care Financing Administration

  -Agency for Health Care Policy and Research

  -Substance Abuse and Mental Health Services Administration

  -Centers for Disease Control and Prevention

  -Food and Drug Administration

  -National Center for Health Statistics

- Department of Defense

  -Department of the Army

  -Department of the Navy Department of the Air Force

-CHAMPUS

- Department of Labor
- Department of Veterans Affairs

Therefore, it is important for one to monitor rulemaking promulgated by these departments to ascertain if the rulemaking impacts one as a health information management professional.

Other Entities Influencing the Rulemaking Process

In addition to OMB, there are other entities that influence an agency's rulemaking. A perfect example is the interaction between HCFA and the Medicare Payment Advisory Commission (MedPAC). Congress combined the Prospective Payment Assessment Commission and the Physician Payment Review Commission to form MedPAC. MedPAC submits a report to HCFA and the Congress every year. HCFA, in its yearly prospective payment rule, accepts or rejects MedPAC recommendations. Also, Congress often enacts legislation based upon MedPAC recommendations.

The following are examples (not all inclusive) of other entities that impact agency rulemaking:

- Medicare Payment Advisory Commission
- Practicing Physicians Advisory Council
- National Committee on Vital and Health Statistics
- General Accounting Office

Other Vehicles for Policy Dissemination

Apart from rulemaking, there are a variety of informal means by which agencies disseminate policies. Among these are press releases speeches, statements, letters, advisory opinions, rulings, manuals, and other types of communications. The extent to which these informal means of expressing policy are binding varies. As a general rule, these informal methods are less binding than policies issued through the rulemaking process.

Most agencies have a system whereby program issuances are created, disseminated, and updated. For example, HCFA has a host of vehicles for policy dissemination, such as:

- Medicare Intermediary Manual
- Medicare Hospital Manual
- Medicare Skilled Nursing Facility Manual
- Medicare Home Health Manual
- Intermediary Program Memorandum

Policies developed and disseminated through these administrative mechanisms usually are

developed by the agency without public input and there is no proposed policy dissemination with a comment period. This does not preclude one from writing to voice objections to policies disseminated using these types of vehicles. Indeed, one can challenge the agency's legal authority to issue policy through this type of mechanism, pointing out to the agency that it has violated the notice-and-comment requirements of the Administrative Procedures Act.

January 20, 2000

U. S. Department of Health and Human Services
Assistant Secretary for Planning and Evaluation
Attention: Privacy-P
Room G-322A Hubert H. Humphrey Building
200 Independence Avenue, SW
Washington, D. C. 20201

Re: 45 CFR, Parts 160 through 164: Standards for Privacy of Individually Identifiable Health Information

Dear Sirs:

The American Health Information Management Association (AHIMA) appreciates the opportunity to comment on the notice of proposed rule-making regarding standards for privacy of individually identifiable health information. AHIMA commends the Department of Health and Human Services (DHHS) on the provisions of the proposed rule.

AHIMA is committed to the enactment of comprehensive federal legislation to protect the confidentiality of health information. The current legal obligation of healthcare providers to maintain the confidentiality of health information is based on what the Office of Technology Assessment found to be a patchwork quilt of federal and state laws. AHIMA is disappointed that Congress did not pass comprehensive legislation by its August 21, 1999 self-imposed deadline. However, we commend DHHS for proposing standards consistent with the administrative simplification provisions of the *Health Insurance Portability and Accountability Act of 1996 (HIPAA)*. It is important to note that the proposed rule recognizes that "A clear and consistent set of privacy standards would improve the effectiveness and efficiency of the health care system."

AHIMA has consistently endorsed the following health information confidentiality principles, most of which are expressly addressed in the NPRM:

AHIMA Confidentiality Principles	HHS' Proposed Privacy Standards
Preemption—Federal efforts must preempt state laws and regulations to create a single national standard for treating and handling health information.	***160.203.*** *HIPAA provides that the rule promulgated by the Secretary may not preempt state laws that are in conflict with the regulatory requirements AND that provide greater privacy protections.*
Patient's Right to Know—Each patient, directly or through a representative, must have the right to know by whom and for what purpose his or her healthcare information is maintained.	***164.512.*** *Establishes that an individual has a right to adequate notice of the policies and procedures of a covered entity that is a health plan or a health care provider with respect to protected health information.*
Minimum necessary—A collection of health information should be restricted to only the	***164.506.*** *Provides that a covered entity must make all reasonable efforts not to use or disclose more than the*

AHIMA Confidentiality Principles	HHS' Proposed Privacy Standards
extent necessary to carry out the legitimate purpose for which it was collected.	*minimum amount of protected health information necessary to accomplish the intended purpose of the use or disclosure.*
Restrictions on Collection—Individual healthcare information must be collected only for legitimate purposes, such as medical research, enhancing public health, and combating fraud. **Use of Information—**Healthcare information must be used only for necessary and lawful purposes. **Restriction—**Healthcare information must not be used for purposes other than for those for which it is collected, except as provided by law.	***164.506.*** *Establishes that a covered entity may not use or disclose an individual's protected health information, except as otherwise permitted or required by this part or as required to comply with applicable requirements of this subchapter (164.506)*
Notification—Any entity maintaining healthcare information must prepare and make available to patients upon request a written statement outlining its information practices.	***164.512.*** *Establishes that an individual has a right to adequate notice of the policies and procedures of a covered entity with respect to protected health information. Provides that a notice of information practices be provided to individuals upon request AND establishes specific requirements for health plans and health care providers.*
Patient Access—Each patient, directly or through a representative must have access to his or her healthcare information and the right to copy, amend, and or correct it.	***164.514.*** *Establishes that an individual has a right of access to, which includes a right to inspect and obtain a copy of, his or her protected health information in designated record sets of a covered entity, including such information in a business partner's designated record set that is not a duplicate of the information held by the provider or plan, for so long as the information is maintained.* ***164.516.*** *Establishes that an individual has a right to request a covered entity to amend or correct protected health information about him or her in designated record sets of the covered entity for as long as the covered entity maintains the information.*
Safeguards—Any entity maintaining individually identifiable healthcare information must be required to implement reasonable security safeguards.	***164.518(c).*** *A covered entity must have in place appropriate administrative, technical and physical safeguards to protect the privacy of protected health information.* *Will also be addressed by the proposed rule for Security and Electronic Signature Standards published on August 11, 1999.*
Penalties—Both criminal and civil penalties must be provided for persons who violate privacy laws and regulations.	*Addressed by summary and purpose. Recommends federal legislation to include punishment for those who misuse personal health information and redress for people who are harmed by its misuse. Criminal and civil penalties are supported.*

Our comments are intended to help strengthen the proposed rule and increase it's consistency with the intent of *HIPAA's* administrative simplification provisions.

APPLICABILITY

AHIMA recommends that the scope of the rule be extended to include all individually identifiable health information, including purely paper records, maintained by covered entities. AHIMA will support legislation to expand the scope of this regulation.

Under the proposed rule, health information management professionals will be required to manage paper and electronic record systems differently. This will be a difficult and costly requirement at best and administratively impossible at worst. Electronic health records should not be afforded greater privacy protections than records maintained on paper. It is the information content that is to be protected, not its storage medium. Information should be protected by standards that are technologically neutral -- standards that are strict and will protect health information in a changing technological environment.

Further, this distinction does not serve the needs of the patients who are not likely to understand why electronic records are held to a different standard. Patients should not have to determine the electronic or non-electronic status of their health record to understand their rights and to be assured their health records are protected.

The intent of the administrative simplification standards of *HIPAA* is to "improve…the efficiency and effectiveness of the health care system, by encouraging the development of a health information system through the establishment of standards and requirements for the electronic transmission of certain health information." By establishing standards for electronic and electronically transmitted information only, AHIMA fears that this proposed rule may not meet the intent of HIPAA and also inadvertently act as a disincentive for entities to migrate to electronic record systems.

AHIMA also believes that the disparate standards for electronic and electronically transmitted data may encourage the creation of "shadow" health records. We discuss "shadow" records more thoroughly in our comments on the definition of "psychotherapy notes."

160.103 AND 160.504 DEFINITIONS

Health Care Operations—AHIMA recommends that the words "risk reduction activities" be added to the definition of "health care operations" under subpart 1 or 5.

We recommend the expansion of the definition of "health care operations" to explicitly cover those activities associated with incident (adverse occurrence) reporting, investigation, and follow-up. Risk managers carry out processes designed to prevent situations that could give rise to patient care accidents. Not all of these activities can be classified as either "quality assessment and improvement" or "in anticipation of or for use in legal proceedings", although risk managers are indeed involved in both of these activities. For example, most of the incidents which risk managers investigate are never expected to result in litigation, and they may not fall within the boundaries of the organization's quality improvement efforts. A narrow reading of this definition might make those incident reports and investigations available to the patient who is the subject matter, and such a reading would lead to regular court challenges seeking such incident reports. It does not appear to be the Secretary's intent to make this information available, as it would likely have a chilling effect on incident reporting programs, which do contribute to improvements in patient care. By explicitly mentioning "risk reduction activities, such as incident reporting and investigation" in Section 164.504's definition of "health care operations," under number (5), "Compiling and analyzing information in anticipation of or for use in a civil or criminal legal proceeding," we believe the Secretary's intent to exempt this information from disclosure would be made more clear.

Individual—Disclosures pursuant to power of attorney. AHIMA requests further clarification on "the person informally designated as the patient's healthcare decision maker."

It is not clear what is meant by "the person informally designated as the patient's healthcare decision maker." More guidance is needed on this issue. When reference is made regarding healthcare decisions, consistent reference should be made to the healthcare power of attorney. The explanatory information concerning "informal designation" of a patient's healthcare decision-maker is inconsistent with current practices. We believe this could place the healthcare provider in the middle of family disagreements about who should be the "healthcare decision-maker."

It is unclear as to what sort of "informal designation" would be sufficient. Does accompanying a patient on an office visit qualify an individual as an informal "healthcare decision-maker? Is it enough that if they are in the hospital room when the doctor discusses options with the patient? Although this course seems well intentioned and undoubtedly is intended to enable providers to more openly discuss patient details with family members and significant others, we see a great potential for misunderstandings and conflict.

AHIMA believes that on the occasion that a person chooses to share decision-making about a particular treatment episode with another party, this should not result in a wholesale abandonment of their right to control the flow of information to that party.

AHIMA recommends amending the definition of psychotherapy notes to ensure their appropriate inclusion in the medical record. AHIMA recommends that the definition recognize a distinction between psychotherapy notes and the case notations maintained by the therapist.

The proposed definition of psychotherapy notes varies from actual clinical practice. Reports of psychotherapy are part of the medical record. While therapists may maintain separate notations of therapy sessions for their own purpose, this does not preclude the need to summarize psychotherapy in the medical record.

The proposed definition may encourage the creation of "shadow" records, entries by therapists apart from the official medical record. The creation and existence of such records may be dangerous to the patient and may increase liability for the health care providers if, for example, the patient requires emergency treatment. For example, a patient may be delivered to an emergency department in an unconscious state and require immediate treatment. If a "shadow" file exists that contains critical health information, the existence of such a file will most likely not be known by anyone other than the provider who created the file. If the creating provider is unreachable or overzealous in sequestering the data, the emergency provider will not be privy to all necessary information to treat the patient. Therefore, the emergency provider's treatment decisions may cause irreparable harm to the patient. Further, "shadow" records increase costs and confound accountability.

164.506 INTRODUCTION TO GENERAL RULES

AHIMA recommends treating all health information equally, regardless of its type.

Because the misuse of any individually identifiable health information is potentially destructive to the health and well-being of patients—sometimes leading to discrimination in employment, insurance, and healthcare—AHIMA strongly believes that all health information must be protected equally. As destructive as the unauthorized dissemination of, for example, genetic, psychiatric, or HIV/AIDS information, so too may be the unauthorized dissemination of information regarding chronic conditions, such as heart disease or cancer. Restricting the legitimate use of any type of individual health information, however, could impede the quality of care and thwart one of the principle purposes for which it is gathered—research in pursuit of more effective cures.

AHIMA believes that segregating and creating special categories of healthcare information ultimately would be more dangerous than beneficial. The current patchwork of at least 50 different sets of standards

impedes our ability to protect confidentiality. Additionally, special requirements for handling certain types of information—such as genetic information and mental health information—actually may be counterproductive to privacy. Special requirements both stigmatize the information and can give away the information's type. For example, when the requirement existed for healthcare professionals to wear latex gloves when working with HIV/AIDS patients, just treating the patient was enough to announce the condition. When the policy changed requiring the wearing of latex to treat all patients, the conditions, in most cases, became invisible.

Establishing a single national standard will protect information and help healthcare providers and patients better understand and manage the flow of health information.

164.506(b) Minimum Necessary Use and Disclosure

AHIMA supports the concept of "minimum necessary use and disclosure." However, AHIMA urges the DHHS to establish a "good faith" standard for covered entities who disclose the information with a statement that prohibits the use of the information for other than the stated purpose and requires destruction of the information after the stated need has been fulfilled. AHIMA further recommends that covered entities be deemed in compliance with the "minimum necessary use and disclosure" standard with regard to internal uses and disclosures if their computer-based patient record (CPR) systems use the appropriate safeguard mechanisms and meet the forthcoming security requirements.

The concept of "minimum necessary use and disclosure" is one of AHIMA's principles for health information confidentiality. Even so, as the proposed standard is currently drafted, the requirement that a covered entity make all reasonable efforts not to use or disclose more than the minimum amount of protected health information necessary to accomplish the intended purpose of the use or disclosure will be impracticable to manage. The definition of minimum amount is highly subjective and there is no clear guidance or bright line test to provide guidance to covered entities. Therefore, alternative means to meet this standard must be devised.

Establishing a "good faith" standard for covered entities is an approach that would require the covered entity to decide what reasonably meets the needs of the requestor of the information. In AHIMA's publication *Release and Disclosure: Guidelines Regarding Maintenance and Disclosure of Health Information (Attachment 1)* , AHIMA recommends the following:

> "…That the responsibility for disclosure of health information be centralized under the direction of the provider's health information management professional to ensure compliance with legal requirements and the provider's policies for disclosure. Only a few qualified individuals should be authorized to disclose health information, and they should be carefully trained and supervised."

AHIMA further recommends that:

> "A statement that prohibits use of the information for other than the stated purpose and requires destruction of the information after the stated need has been fulfilled, should accompany any disclosure of health information to external requestors."

The following health information management manuals have been attached to assist DHHS in developing clear guidance for the minimum necessary standard:

1. *Release and Disclosure: Guidelines Regarding Maintenance and Disclosure of Health Information (Attachment 1)*
2. *HIV and Confidentiality: Guidelines for Managing Health Information Relating to HIV Infection (Attachment 2)*
3. *Faxing Safeguards: Guidelines for Transmitting Patient Health Information (Attachment 3)*
4. *Security and Access: Guidelines for Managing Electronic Patient Information*

(Attachment 4)

In most instances, the knowledge of confidentiality procedures and the qualifications of the requestor of the information are not known. Therefore, for the "minimum standard" requirement to work, we believe the ultimate decisions must be made by those who have been adequately trained and educated in release and disclosure requirements. Health information management professionals are prepared by education and experience to make such important determinations.

Covered entities should be deemed in compliance with the "minimum necessary use and disclosure" standard with regard to internal uses and disclosures if their computer-based patient record (CPR) systems use the appropriate safeguard mechanisms and meet the forthcoming security requirements. This will encourage covered entities to fully utilize the security capabilities offered by a CPR. AHIMA strongly supports the migration of patient records to the electronic environment. As opposed to paper-based record systems, CPR systems can more readily limit who has access to information, determine what information to disclose depending on the request, and track the flow of the information. These functions are critical to provide privacy and security for individually identifiable health information.

164.506(C) RIGHT OF AN INDIVIDUAL TO REQUEST RESTRICTIONS ON USES AND DISCLOSURES

AHIMA recommends deleting the proposed standard "Right of an individual to request restriction on uses and disclosures."

AHIMA does not support the concept that individuals be able to request that a covered entity restrict the protected health information that results from an encounter from further use or disclosure for treatment, payment and healthcare operations. Since covered entities would not be required to agree to restrictions requested by individuals, this proposal appears meaningless.

While we believe individuals should have the right to access, copy, amend, and correct their information, giving them the right to request restricting its uses and disclosures is in contrast with the intent of the proposed rule. When addressing the need for privacy standards, the proposed rule states:

> "The maintenance and exchange of individually identifiable health information is an integral component of the delivery of quality health care. In order to receive accurate and reliable diagnosis and treatment, patients must provide health care professionals with accurate, detailed information about their personal health, behavior and other aspects of their lives. Health care providers, health plans and health care clearinghouses also rely on the provision of such information to accurately and promptly process claims for payment and for other administrative functions that directly affect a patient's ability to receive needed care, the quality of that care, and the efficiency with which it is delivered."

Permitting patients to dictate the flow of their health information for treatment, payment and health care operations will seriously hamper the ability to achieve the intentions stated above. The lack of complete and accurate information will only hinder the ability to provide quality care, process claims, and complete other necessary and beneficial administrative functions.

164.506 (D) CREATION OF DE-IDENTIFIED INFORMATION

AHIMA supports this concept but requests further clarification on removing information from the body of the medical record that may indirectly identify the individual. AHIMA recommends the DHHS establish a "good faith" standard for covered entities who make reasonable efforts to de-identify information when required. Additionally, we recommend that the receiver of the de-identified information be required to sign an agreement not to re-identify or link the information to the individual(s) to whom it pertains. AHIMA believes that the proposed rule should make it a violation to attempt to re-identify or re-link the previously de-identified information to the individual(s) to whom it

pertains.

The proposed rule's intent to encourage the creation and use of de-identified information is positive. However, the list of 19 potential identifiers that must be removed from a record to create de-identified health information establishes a difficult standard as some identifiers may be buried in lengthy text fields. Nonetheless, this is a worthy standard and the migration to the CPR will greatly enhance compliance.

Establishing a "good faith" standard for covered entities is an approach that requires the covered entity to decide what reasonably can be removed from the patient's health information. As an additional precaution, AHIMA believes that a signed agreement between the covered entity and the receiver of the de-identified information would be an adequate deterrent, under the threat of violating the rule, to any attempts by the receiver to re-identify or link the information to the individual(s) to whom it pertains.

164.506(E) BUSINESS PARTNERS

AHIMA recommends that transcription services be specifically included as business partners.

Outsourcing transcription services is a regular business practice of healthcare facilities. These services can be provided from an individual's home, a central business location, or even beyond the borders of the United States. No matter where transcription services are located they normally receive highly sensitive and identifiable health information creating jurisdictional and enforcement problems for state and federal agencies. Therefore, AHIMA recommends that transcription services be specifically included as business partners.

164.506(F) DECEASED PERSONS

AHIMA recommends that the privacy standards for deceased persons be the same as those for living persons.

AHIMA sees no compelling reason to set a different privacy standard for deceased individuals. It has been standard practice to release individually identifiable health information of deceased individuals with a valid consent of the executor, next of kin, or specific court order. We recommend that this practice be upheld in the regulations.

164.508 INDIVIDUAL AUTHORIZATION

AHIMA recommends that authorizations be required to specify an expiration date not to exceed one-year. AHIMA also recommends that the use of "prospective" authorizations (authorizations signed prior to the treatment episode from which the information is requested) be prohibited. In all cases, AHIMA recommends that it be a violation of the rule if the information is redisclosed beyond what was authorized by the patient or the patient's legal representative.

It is in the patient's and covered entity's best interest to tighten authorization practices. Our recommendations will stem the tide of unlimited and lengthy authorization requests for information; information that, in many cases, has not yet even been created. A valid authorization not to exceed one year offers the patient an opportunity to reevaluate and reauthorize the consent. The "any and all information" authorization has been abused and patients have been basically required to sign away the rights to their most personal information. Additionally, the use of prospective authorizations precludes intelligent decision-making on the part of the patient, as they are asked to authorize the release of the information that does not yet exist.

Further, protections against redisclosure of the information are necessary. As stated in AHIMA's publication *Release and Disclosure: Guidelines Regarding Maintenance and Disclosure of Health Information (attachment 1):*

"When information from health records is provided to authorized external users, this information should be accompanied by a statement:

- Prohibiting use of the information for other than the stated purpose;
- Prohibiting disclosure by the recipient to any other party without written authorization from the patient, or the patient's legal representative, unless such information is urgently needed for the patient's continuing care or otherwise required by law; and
- Requiring destruction of the information after the stated need has been fulfilled."

164.510(F) LAW ENFORCEMENT

AHIMA recommends that, except in the cases described in Section 164.510 (f)(2), Limited information for identifying purposes, a warrant, subpoena, or court order be required for the release of protected health information.

While the proposed requirements are an improvement over the Secretary's original recommendations to Congress, AHIMA does not believe that the requirements are restrictive enough. The proposed rule would substantially weaken current privacy practices with respect to access by law enforcement officers. Under the current language, all an officer needs to access health information on any citizen is simply to request that information and verify his own identity as a law enforcement employee. Health information management professionals across the United States have reported numerous conflicts with local, state, and federal law enforcement officials attempting to access an entire health record, when only very limited information is needed. Current practices at the State level generally require an officer or law enforcement employee to obtain a warrant, subpoena, or court order to obtain health information, and that requirement should be upheld. We would, however, support the limited disclosure of health information for use solely in identifying a suspect, fugitive, material witness, or missing person, under the requirements and qualifications outlined in the proposed rule. We feel this strikes a reasonable balance in meeting the needs of law enforcement, while still protecting health information from inappropriate uses.

164.512 RIGHTS AND PROCEDURES FOR A WRITTEN NOTICE OF INFORMATION PRACTICES

AHIMA supports the requirement that any entity maintaining healthcare information must prepare and make available to patients upon request a written statement outlining its information practices and posting the notice in a clear and conspicuous manner. AHIMA does not support the idea of obtaining a signed acknowledgement from the individual upon the receipt of a notice of information practices.

In the proposed rule, DHHS requests comment regarding requiring a covered entity to obtain a signed acknowledgement by an individual. There are many covered entities for which it would not be practical or enforceable. The administration of such a task would be overly burdensome and inconsistent with the intent of the administrative simplification requirements of HIPAA. Also, due to the number of patients who are incompetent or unconscious, it would not make sense to require that a signed acknowledgement be obtained.

164.514 ACCESS FOR INSPECTION OR COPYING

AHIMA supports the reasonable, cost-based fee standard for copying health information pursuant to this section. In addition, AHIMA recommends that a covered entity be permitted to charge a reasonable, cost-based fee for inspection of the record and be able to establish the procedures for the review process.

Depending on the size of the entity, copying and inspection costs could vary significantly. AHIMA recommends that the following factors be taken into consideration in determining the fee:

- Labor costs for verification of requests
- Labor and software costs for logging of requests
- Labor costs for retrieval
- Labor costs for copying
- Expense costs for copying
- Capital cost for copying
- Expense costs for mailing
- Postal costs for mailing
- Billing and bad-debt expenses
- Labor costs for refiling

164.515 ACCOUNTING OF DISCLOSURES

AHIMA does not support the proposed requirement that covered entities maintain an accounting of disclosures for as long as the entity maintains the protected health information. AHIMA recommends that the accounting of disclosures of records be maintained for a period of six years.

Many covered entities maintain health information based on state record retention statutes and regulations. It would be impractical for covered entities to retain an accounting of disclosure for as long as the entity maintains the protected health information. Maintaining an accounting of disclosure for a period of six years would be consistent with the record keeping requirements for authorization forms and contracts used with business partners as well as other documents specified in the rule.

164.516 RIGHTS AND PROCEDURES FOR AMENDMENT AND CORRECTION

AHIMA supports the proposed requirement that covered plans and providers be required to accommodate requests for amendment or correction for as long as the entity maintains the protected health information.

AHIMA believes that the proposed rule should not have a specific duration requirement for amending and correcting records. Individuals should be able to request amendments or corrections for as long as the covered entity maintains the protected health information. There are

many instances in which individuals do not discover errors in their health information until years later when, for example, renewing a life insurance policy. It would set a bad precedent to deny a patient the ability to correct a health information error from years prior.

164.518(A) DESIGNATION OF A PRIVACY OFFICIAL

AHIMA supports the proposal that covered entities designate a privacy official. AHIMA strongly recommends that the privacy official be a credentialed health information management professional.

In the proposed requirement, the privacy official is to "serve as the official responsible for the development of policies and procedures for the use and disclosure of health information." This describes the role that health information management professionals have traditionally held. Health information management professionals are qualified by education and experience to be privacy officials as they are educated and pass a certification examination that cover the 12 knowledge clusters shown in the attachment entitled "Curriculum Content for Health Information Administration" (attachment 5). This education includes legal, regulatory and voluntary standards concerning health record content, release, disclosure, confidentiality, and information management technology.

AHIMA commends the DHHS for highlighting the importance of this role.

164.518(B) TRAINING

AHIMA supports the concept of requiring recertification once every three years and retraining in the event of material changes in the policy.

As noted in the proposed rule, AHIMA's publication *Release and Disclosure: Guidelines Regarding Maintenance and Disclosure of Health Information* recommends the following:

> "That healthcare providers have their employees, students, and volunteers sign a nondisclosure agreement at the time of their employment or assignment. For employees who will have access to confidential information as part of their duties, signing the nondisclosure agreement should be required as a condition of employment. In addition, AHIMA recommends that each employee, student, or volunteer sign a nondisclosure acknowledgement on an annual basis to remind the individual of his or her ongoing responsibility."

AHIMA is willing to forego our recommended annual recertification acknowledgement and support the proposed rule's call for recertification once every three years.

AHIMA strongly supports the recommendation that providers educate and train their employees concerning privacy, confidentiality and security. Institutional policies and procedures should describe the responsibility of individual employees in maintaining confidentiality, as well as the consequences of unauthorized use or disclosure of individually identifiable health information.

RELATIONSHIP TO STATE LAWS

AHIMA continues to support federal preemptive legislation as a necessary ultimate solution. While recognizing the limitations of the HIPAA statute with respect to state laws and regulations, AHIMA recommends that federal efforts must preempt state laws and regulations to create a single national standard for handling health information. AHIMA will continue to pursue health information confidentiality legislation that preempts state laws and regulations, treats all health information equally, and establishes a strong, single, national standard for the use and disclosure of health information.

AHIMA's situation analysis and position statement entitled *Confidentiality of Medical Records (attachment 6)* has been attached for your review along with a flow chart named *Patient Health Information: Where does it go? (attachment 7)* The flow chart diagrams the flow of health information both inside and outside our healthcare system. Its complexity helps illustrate why it is necessary to preempt state laws and regulations to establish a high federal ceiling for protecting medical information.

It has been argued by those who oppose a single national standard that states may have enacted a higher standard. However, in most cases, state laws and regulation address specific aspects of health information for example, mental health and home care. None has enacted a comprehensive and strong standard.

State boundaries are less and less relevant in regulating healthcare and health information management practices. With the growth of metropolitan areas crossing state lines, continental travel, multi-state commuting, multi-state health systems, the Internet, national managed care plans, and other factors, our healthcare system is no longer a local resource. Health information crosses state lines and between facilities on a continuous basis.

Health information management professionals handle millions of pieces of health information each day. We understand that the legislative/regulatory actions of one state directly impact health information

management practices in another. The only way to ensure that all health information is managed consistently and protected equally is by establishing a strong and uniform national standard with penalties for the wrongful disclosure of health information.

Conclusion

AHIMA and the nation's health information management professionals stand ready to support your efforts by working to effectively implement final regulations to improve the privacy of individually identifiable health information. Thank you for the opportunity to provide these comments. If you have any questions, please do not hesitate to contact me or Donald D. Asmonga, Government Relations Manager, at 202-218-3535.

Sincerely,

Linda L. Kloss, MA, RHIA
Executive Vice President/CEO

cc: Margaret Skurka, MS, RHIA, President

Sample Letter

Letter to Agency submitting comments about a proposed regulation.
(AHIMA's 4/14/98 letter to HCFA on the Conditions of Participation follows)

Date

Health Care Financing Administration
Department of Health and Human Services
Attention: **Insert Regulation Number (e.g., BPD-712-F)**
P.O. Box **Insert Box Number Given in First Part of Rule**
Baltimore, Maryland 21207

To Whom It May Concern:

On behalf of the American Health information Management Association (AHIMA), I am hereby submitting comments on the proposed regulations published in the *Federal Register* on **Insert Date.**

As experts in clinical data and information management, the 38,000 professional members of the American Health Information Management Association (AHIMA) are vital to the healthcare industry. The unique knowledge and skills that AHIMA members possess are critical for classifying and analyzing health information, transitioning from paper to computer-based medical records, and enhancing data quality—all accomplished while maintaining patient confidentiality and information security. With a 70-year tradition of advancing quality healthcare through quality information, AHIMA is also instrumental in developing industry standards, advocating relevant legislation, and providing education in health information.

Outline any general concerns about the proposed regulation. Then discuss specific concerns, preferably in the order in which they appear in the regulation. Clearly identify the section number of the regulation or the title of the section of the preamble and the page number where the discussion appears.

General Comments

AHIMA is concerned about the accuracy of the data abstraction performed by the Utilization and Quality Control Peer Review Organizations (PROs). Since the data are abstracted from the hospital medical records, there is a chance for abstractor error. Additionally, there is the possibility that the confidentiality of the data can be compromised before or during the transmission process to HCFA. Therefore, AHIMA recommends that the Notice of New System of Records must include the following:

- The method of validating the abstracted data before it is forwarded by the PRO to HCFA; and

- The security provision(s) that apply to the data.

Specific Comments

Section (c)(3)(A). AHIMA supports deleting this provision. It permits additional use or disclosure of health records beyond the original intent of the regulation. It is difficult to identify a situation where a researcher or evaluator would encounter an emergency circumstance affecting the health or safety of any individual, and the PRO would not have identified the same situation.

Thank you for allowing us the opportunity to submit our comments for your thoughtful consideration.

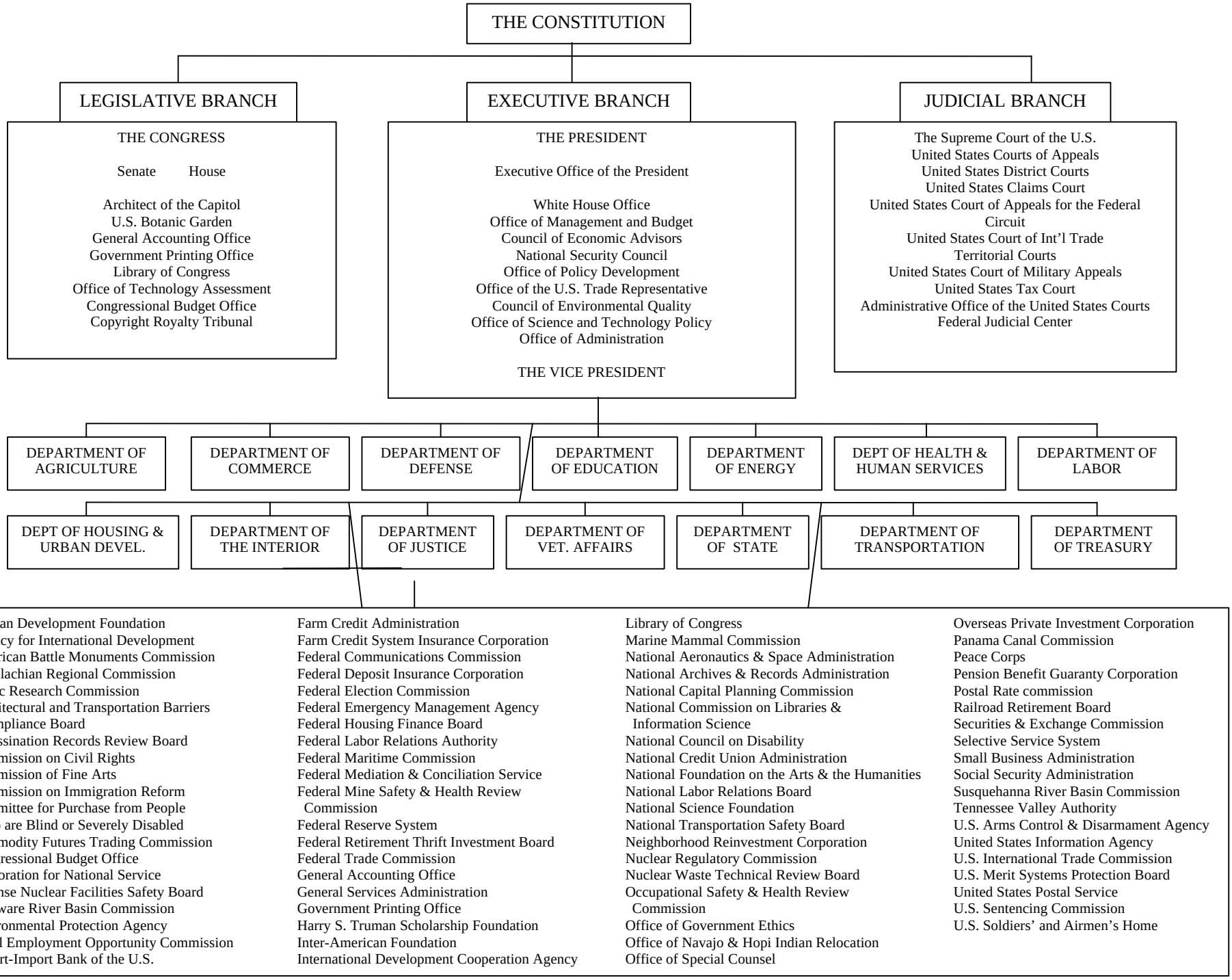
Sincerely yours,

Department of Health & Human Services Officials*

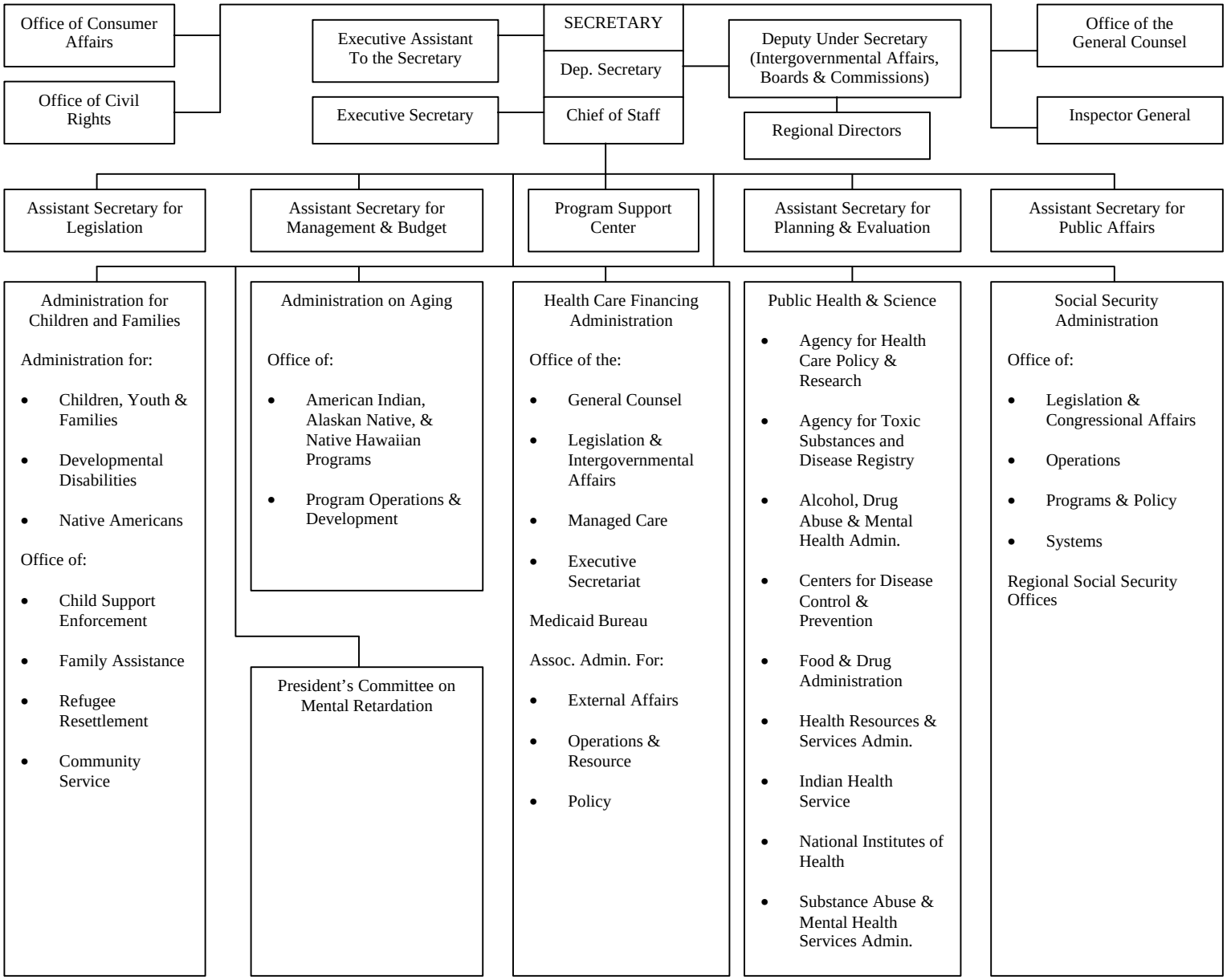
Secretary	Donna E. Shalala
Deputy Secretary	Kevin L. Thurm
Chief of Staff	William Corr
Inspector General	June Gibbs Brown
Asst Secretary/Management & Budget	John J. Callahan
Asst Secretary/Legislation	Richard J. Tarplin
Asst Secretary/Planning & Evaluation	Margaret A. Hamburg, M.D.
Asst Secretary/ Public Affairs	Melissa T. Skolfield
Asst Secretary/Adm on Aging	Jeanette C. Takamura, Ph.D.
Adm for Children & Families	Olivia A. Golden, Ph.D.
Asst Secretary/Health & Surgeon General	David Satcher, M.D.
Agency for Health Care Policy and Research	John M. Eisenberg, M.D., M.B.A.
Centers for Disease Control & Prevention	Claire Broom, M.D.

Health Care Financing Administration

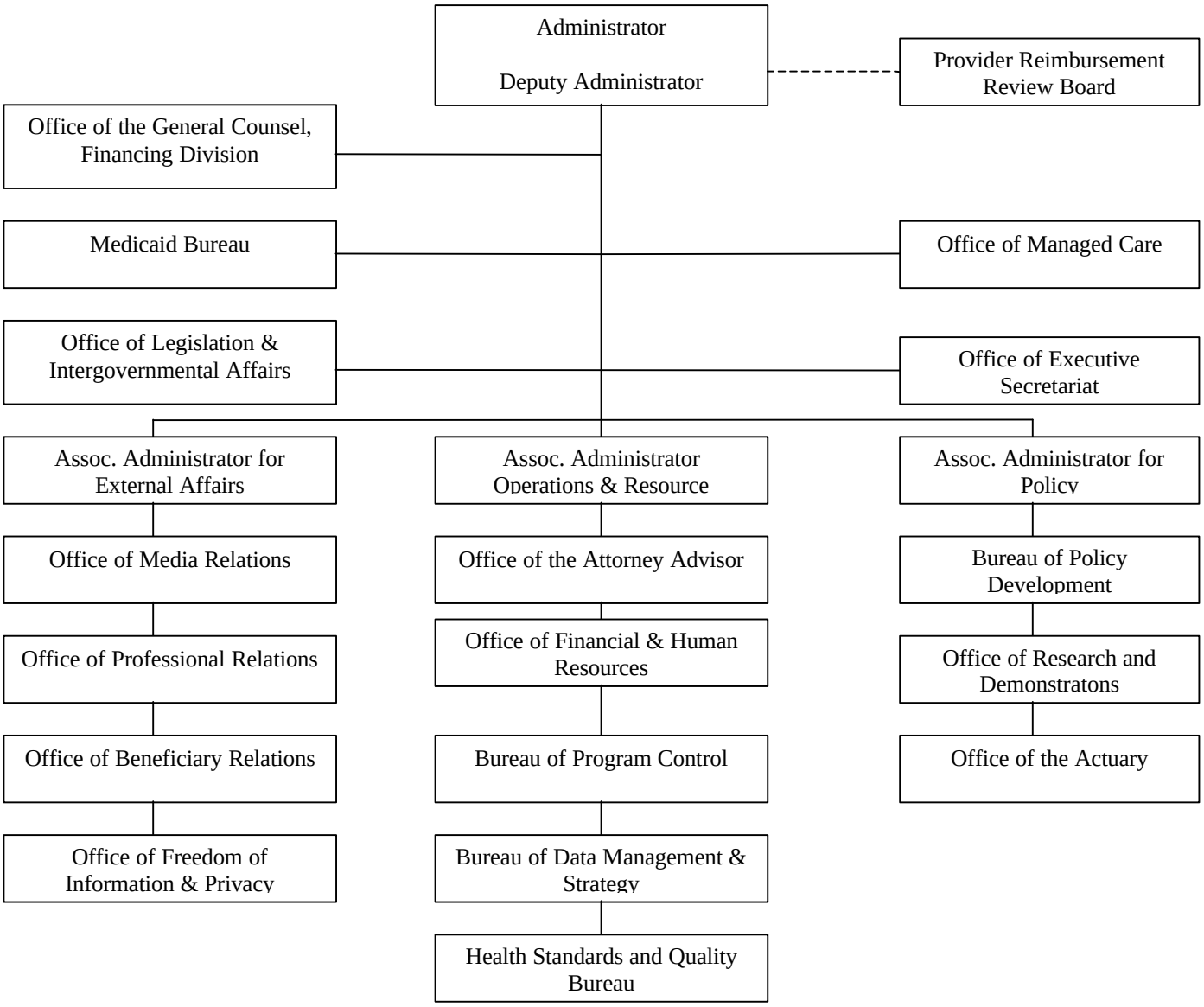
Administrator	Nancy-Ann Min Deparle
Deputy Administrator	Michael Hash
Press Office-Director	Chris Peacock
Office of Legislation-Director	Deborah I. Chang
Office of Strategic Planning-Director	Barbara Cooper
Office of the Actuary-Chief	Rick Foster
Center for Beneficiary Services-Director	Carol Cronin
Center for Health Plans and Providers-Director	Robert Berenson, M.D.
Center for Medicaid and State Operations-Director	Sally K. Richardson
Chief of Operations-Director	Steven D. Pelovitz
Office of Internal Customer Support-Director	Michael Odachowski
Office of Equal Opportunity and Civil Rights-Director	John Hitchcock
Office of Information Services-Director	Gary G. Christoph, Ph.D.
Office of Financial Management-Director	Elizabeth Cusick
Office of Clinical Standards and Quality-Director	Jeffrey L. Kang, M.D.
Office of Communications and Operations Support-Director	Pam Gentry


THE CONSTITUTION
LEGISLATIVE BRANCH
EXECUTIVE BRANCH
JUDICIAL BRANCH
THE CONGRESS
Senate House
Architect of the Capitol
U.S. Botanic Garden
General Accounting Office
Government Printing Office
Library of Congress
Office of Technology Assessment
Congressional Budget Office
Copyright Royalty Tribunal
THE PRESIDENT
Executive Office of the President
White House Office
Office of Management and Budget
Council of Economic Advisors
National Security Council
Office of Policy Development
Office of the U.S. Trade Representative
Council of Environmental Quality
Office of Science and Technology Policy
Office of Administration
THE VICE PRESIDENT
The Supreme Court of the U.S.
United States Courts of Appeals
United States District Courts
United States Claims Court
United States Court of Appeals for the Federal Circuit
United States Court of Int'l Trade
Territorial Courts
United States Court of Military Appeals
United States Tax Court
Administrative Office of the United States Courts
Federal Judicial Center
DEPARTMENT OF AGRICULTURE
DEPARTMENT OF COMMERCE
DEPARTMENT OF DEFENSE
DEPARTMENT OF EDUCATION
DEPARTMENT OF ENERGY
DEPT OF HEALTH & HUMAN SERVICES
DEPARTMENT OF LABOR
DEPT OF HOUSING & URBAN DEVEL.
DEPARTMENT OF THE INTERIOR
DEPARTMENT OF JUSTICE
DEPARTMENT OF VET. AFFAIRS
DEPARTMENT OF STATE
DEPARTMENT OF TRANSPORTATION
DEPARTMENT OF TREASURY
African Development Foundation
Agency for International Development
American Battle Monuments Commission
Appalachian Regional Commission
Arctic Research Commission
Architectural and Transportation Barriers Compliance Board
Assassination Records Review Board
Commission on Civil Rights
Commission of Fine Arts
Commission on Immigration Reform
Committee for Purchase from People Who are Blind or Severely Disabled
Commodity Futures Trading Commission
Congressional Budget Office
Corporation for National Service
Defense Nuclear Facilities Safety Board
Delaware River Basin Commission
Environmental Protection Agency
Equal Employment Opportunity Commission
Export-Import Bank of the U.S.
Farm Credit Administration
Farm Credit System Insurance Corporation
Federal Communications Commission
Federal Deposit Insurance Corporation
Federal Election Commission
Federal Emergency Management Agency
Federal Housing Finance Board
Federal Labor Relations Authority
Federal Maritime Commission
Federal Mediation & Conciliation Service
Federal Mine Safety & Health Review Commission
Federal Reserve System
Federal Retirement Thrift Investment Board
Federal Trade Commission
General Accounting Office
General Services Administration
Government Printing Office
Harry S. Truman Scholarship Foundation
Inter-American Foundation
International Development Cooperation Agency
Library of Congress
Marine Mammal Commission
National Aeronautics & Space Administration
National Archives & Records Administration
National Capital Planning Commission
National Commission on Libraries & Information Science
National Council on Disability
National Credit Union Administration
National Foundation on the Arts & the Humanities
National Labor Relations Board
National Science Foundation
National Transportation Safety Board
Neighborhood Reinvestment Corporation
Nuclear Regulatory Commission
Nuclear Waste Technical Review Board
Occupational Safety & Health Review Commission
Office of Government Ethics
Office of Navajo & Hopi Indian Relocation
Office of Special Counsel
Overseas Private Investment Corporation
Panama Canal Commission
Peace Corps
Pension Benefit Guaranty Corporation
Postal Rate commission
Railroad Retirement Board
Securities & Exchange Commission
Selective Service System
Small Business Administration
Social Security Administration
Susquehanna River Basin Commission
Tennessee Valley Authority
U.S. Arms Control & Disarmament Agency
United States Information Agency
U.S. International Trade Commission
U.S. Merit Systems Protection Board
United States Postal Service
U.S. Sentencing Commission
U.S. Soldiers' and Airmen's Home

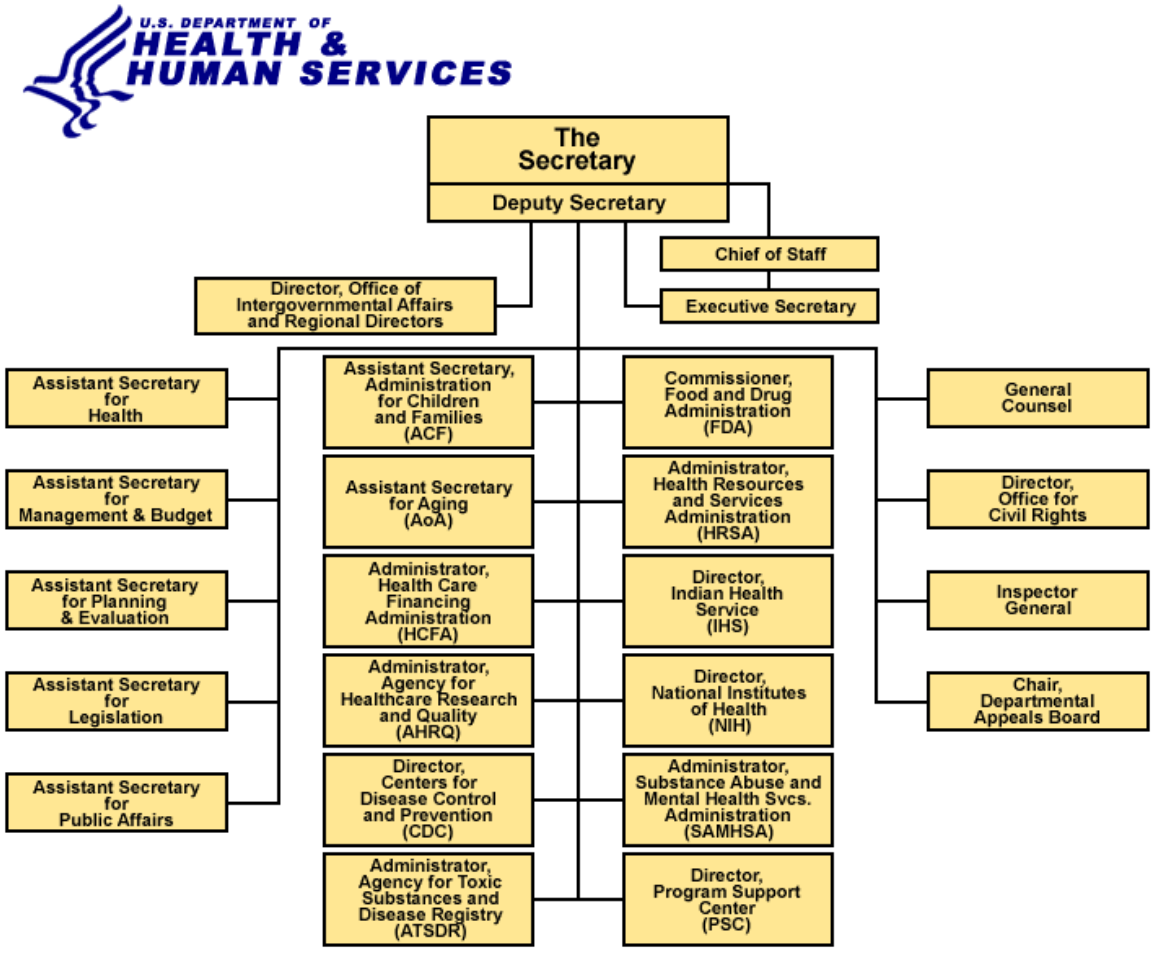
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICE



DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION
HCFA LEADERSHIP



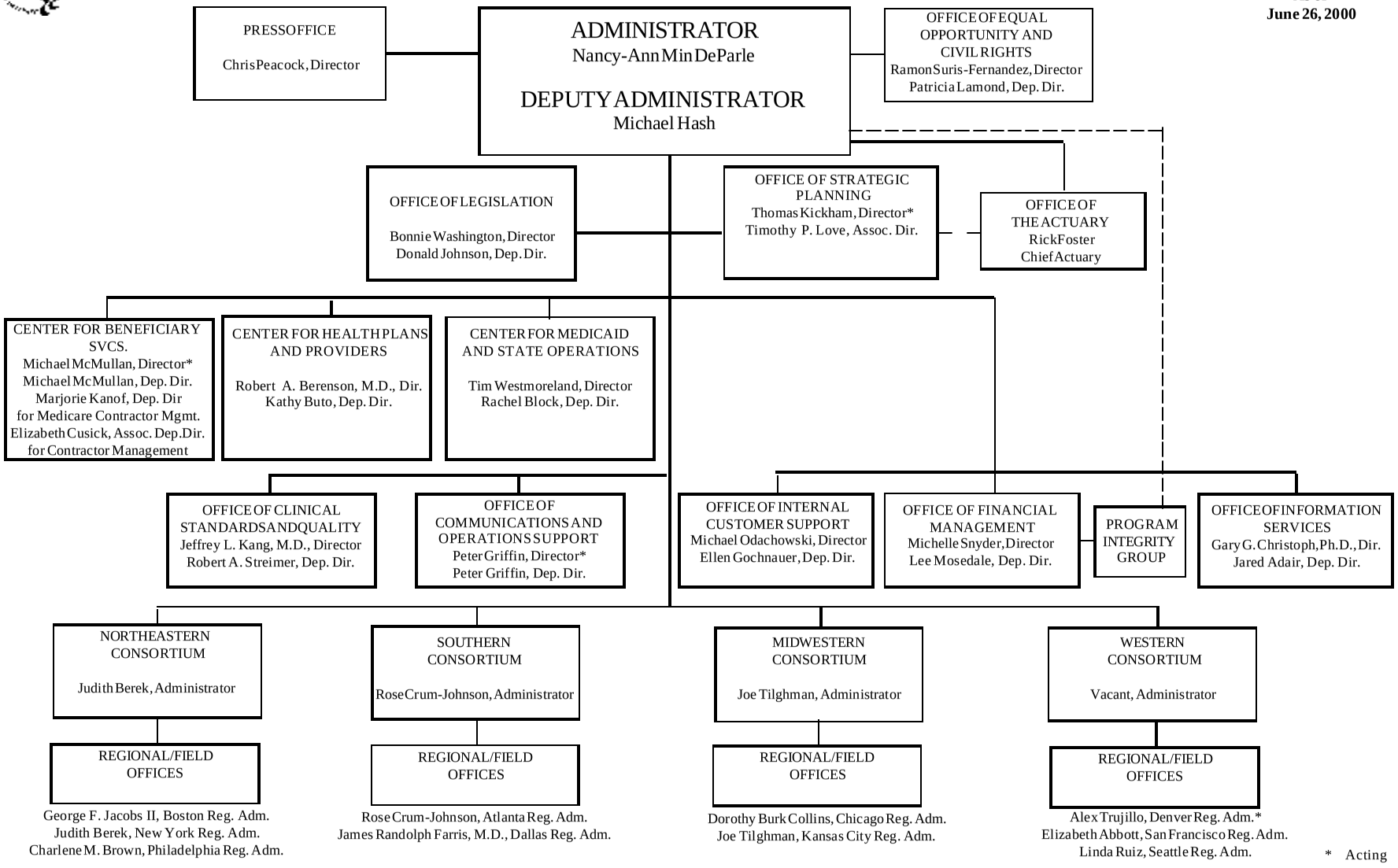
ORGANIZATIONAL CHART



DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

APPROVED LEADERSHIP

As of June 26, 2000



* Acting

State Government

"All politics is local." **Tip O'Neill**

AHIMA is a national professional membership association with an important commitment to monitoring and influencing legislative and regulatory healthcare policy. The ultimate success of AHIMA's overall efforts will depend in large part on the degree to which Component State Associations (CSAs) actively participate in the formulation of health policy in their individual States.

CSA involvement at the state level is critical to AHIMA's efforts for three reasons:

- **The overall national strategy of AHIMA, or any national professional association, to participate in and influence healthcare policy essentially is based on the success of 50 distinct CSA efforts.** Just as a 50 piece puzzle is not successfully completed without all pieces in proper place, a national strategy is not successful unless all 50 CSAs perform their proper role at the State level.

- **The interaction each CSA has with political and public policy officials at the State level sets up and complements the degree of success the CSA ultimately can achieve at the Federal level.** The natural by-product of active CSA involvement at the State level is an enhanced image among U.S. Senators and Congressmen serving in Washington. These elected officials respect and listen to organizations that are active "back home."

- **The vast majority of U.S. Senators and Congressmen first served in office at the State level and this tendency is likely to continue.** Therefore**,** relationships developed by CSAs at the State level today can pay important future benefits at the Federal level. This is particularly the case with newly elected members of Congress who tend to seek advice or accept input from those organizations or individuals with which he/she is already familiar.

To interact successfully with State health policymakers and influence policy decisions, each CSA's leadership must have a fundamental understanding of how the political/policy process works, and what specific actions a CSA can undertake to influence the process.

This section of the *Guidebook* focuses on the State process and CSA activities to influence the process. Although the legislative and regulatory processes among the 50 States are generally similar, sufficient distinctions among the 50 States preclude a simple explanation of how State government works. For that reason, the "Legislative Process" at the State level will be reviewed briefly in this section with the major focus placed on how to influence the process. Although CSAs will be working with different systems of State policymaking, each CSA will be using the same techniques to pursue the same goal of interacting with and influencing State officials.

The Legislative Process

The earlier section of this manual on the legislative process at the Federal Government level opened with the Mark Twain quote "there are two things you should never witness - the way we make sausages or laws." Although it has long been disputed as to what level of government he was speaking, any observer of State legislatures would argue that he made the comment after viewing a Statehouse in action. The "sausage factories" tend to exist at the State level for two reasons that make it critically important for CSAs to maintain an active effort:

- State legislative bodies tend to be more informal and less structured than the U.S. Congress. Consequently, it is important to be aware of not just the process but the personalities and personal relationships at the State level.

- Unlike the U.S Congress where sessions last 9-11 months, State legislative sessions generally are very short. This leads to legislation moving along a fast track and requires quick input and/or intervention by CSAs.

All States, except Nebraska, include two chambers. The legislative process in all States, including Nebraska, is generally similar to the process outlined in the earlier section on the legislative process at the federal level. It is not possible to specifically spell out the State legislative process due to the differences among the States, but the following guidelines generally apply at the State level:

- In the 49 States, with two legislative bodies, one is the State Senate and the other is generally the House of Representatives. In some States, the House is referred to as the Assembly or the House of Delegates. The number of constituents represented by Senators is somewhat larger than the number of constituents represented by House members (e.g., 1 Senator represents 1/12 of the State's population, and 1 House member represents only 1/36 of the State's population). For this reason, like the United States Congress, the State Senates are smaller legislative bodies than their House counterparts.

- Unlike the U.S. Congress, State legislatures generally meet in short sessions rather than year round (only a few weeks in some States) and the responsibility of being a State Senator/ Representative is considered to be part-time. In fact, in most States, these elected officials merely take a leave of absence from their real profession to serve in the legislature when it is in session.

- In the majority of States, Senators and Representatives will only have a small office in the State Capitol during the period of time the legislature is in session and have no official office back in the district. Any meetings they would have with constituents in the district would generally be held in their regular business office, their home, or in an agreed upon meeting site.

- In the majority of States, other than members of the leadership and committee chairmen, Senators and Representatives do not have large personal staffs like you would find in Washington. In most States, each member would have only one or two assistants to personally assist them. **It is very important to get to know these assistants, as this is often crucial to getting your job done.** For much of their legislative work, they rely on assistance from legislative staff assigned to the committees on which they serve.

- Many States have "Legislative Agencies" which provide research and advice to all members. These agencies also often hold education/informational hearings and are staffed by individuals with backgrounds or expertise in specific issue areas and often play a critically influential role in the legislative process at the State level. With legislators in most States serving only a few weeks a year, they must rely heavily on the work of these legislative agencies in drafting or voting on legislation. In many States, these agencies function year round even if the legislature is in session for only a few weeks or months. During these periods, the agencies continue to research issues and develop possible legislative items for the next session of the legislature.

- The introduction of legislation comes from two sources: individual members on their own behalf or legislation which is introduced by a member on behalf of the Governor.

- As at the national level, the legislative process is based on the committee system with each legislative body broken into various issue specific committees. These committees generally hold hearings and act on legislation before passing it on for action by their respective chambers. You will recall that most legislative action in the U.S. Congress takes place first at the Subcommittee level than Committee level before going to the House or Senate floor. This is not the case at the State level. Subcommittees often do not exist at the State level and the initial legislative focus is, therefore, at the committee level.

- In each State, a specific committee(s) in the Senate/House generally has jurisdiction over healthcare legislation. (See reference material at the end of this section). These committees and the members who sit on these committees should be the focus of much of the effort by CSAs to influence healthcare policy at the State level.

- A public announcement is always made prior to committee hearings and, as with the U.S. Congress, individuals or organizations wishing to testify before a committee must make a request to do so. It varies from State to State as to how formal a request to testify must be. In some States, a written request in advance of a specified deadline is required, while in some States a mere phone call requesting an opportunity to testify will suffice.

- After formal hearings, legislation must be approved by the appropriate committee(s), passed on to the full Senate/House and ultimately be passed by both chambers in identical form and signed by the Governor before it effectively becomes the law of the State. If the Governor should veto a bill, all States allow opportunities for the legislative bodies to "override" the Governor's veto, but the required process and number of votes to override varies from State to State.

Although the above review briefly outlines the general aspects of the legislative process at the State level, it is important for you to review closely the reference material at the end of this section which is specific to your State. These materials are designed to provide you with the necessary information to "fill in the blanks" with reference to the legislative process in your State.

Influencing the Process

To participate successfully and influence health policy at the State level, CSAs must first educate policymakers with respect to the health information management profession and the important role the profession plays in the overall healthcare delivery system. The natural by-product of such an effort will be an enhanced role and greater influence for CSAs in the policy process.

Within the legislative process, the most important targets of CSA activity should be the committee(s) which have jurisdiction over healthcare legislation relevant to the health information management profession. For any CSA to be an active participant in the State legislative process. it is imperative that the relevant Senate/House committee chairmen and their staff be aware of the CSA and the CSA's interest in issues related to the profession. Beyond these legislative committees, attention must also be focused on the Legislative Agencies serving the committees and members of the Governor's staff involved in issues important to the CSA.

CSAs should not overlook the roles of other health professionals and the relative strengths they may bring to the political arena. Coalition building is discussed later in this chapter, but it is important to emphasize that some health professionals may be natural allies while others may oppose CSA initiatives. It is always wise to have a clear understanding about their respective positions so that you are able to answer questions posed by legislators and staff relative to "consensus" within the health-care community. **It is always wise to know where the State hospital association and State medical society stand on CSA issues.**

CSAs can effectively establish and/or maintain the necessary visibility and involvement with these policy makers through use of the activities summarized below. The functional value and degree of success individual CSAs realize from these recommended actions will vary depending on the size and characteristics of the CSA and the State legislative bodies they are attempting to influence.

Access to Information: A CSA can only participate in the legislative process if it has proper access to anticipated legislative activity To assure that this is the case the CSA must undertake and maintain an effort to be fully informed on all relevant legislative matters which may be of interest or concern. To achieve this the following efforts should be a part of any CSA's overall legislative action plan:

- Call or write to all relevant legislative committees, agencies, offices (preliminary *sample* listing included at the end of this section) and request to be put on the appropriate mailing list(s). Success in this effort will vary among States, but most CSAs will find that a regular mailing of some type is available regarding upcoming legislation. If you are informed that no regular mailing is available in your State ask what other source, if any, is available to you regarding legislation of interest to your CSA.

- Call or write the major healthcare associations you are aware of in your State and see if you can receive a courtesy copy of their newsletter (hospital association, nursing home association, etc.). Also ask if they have any regular listing of legislation which they make available to groups such as your CSA.

Maintaining Contact and Involvement: As already stated, within the legislative bodies, the principal focus is on the relevant committees and committee staff. CSAs have several regular opportunities to routinely maintain contact with these policy makers including:

- Following every general election, the CSA should send a routine letter of congratulations to all Senate/House leadership and members of relevant committees. (See sample letter at the end of this section).

- A letter explaining AHIMA, your CSA and the health information management profession should be sent to Senate/House leadership and members of relevant committees at the beginning of each legislative session. (See sample letter).

- Any time your CSA becomes aware of major healthcare legislation that may be of concern to your membership, you should write or call the member who has introduced the bill (or the appropriate chairman) and request a meeting. (See sample letter).

- Anytime your CSA becomes aware of a hearing on legislation of interest and you desire to testify, you should write or call the appropriate office and submit your formal request. It is generally advisable to call immediately in case the practice in your State is to hold open testimony slots for individuals or groups expressing "first interest."

- Even if no relevant legislation appears on the horizon within a particular legislative session, it is important that appropriate members of the CSA schedule a "courtesy meeting" at least once a year with key legislative members. Without such a meeting, it is next to impossible for a CSA to maintain appropriate visibility among key legislators.

- Probably no opportunity to influence State health policymakers is more conveniently available to CSAs than their annual meeting. This is particularly the case if the meeting is held in the State capital. The setting provides the CSA with an annual opportunity to involve State officials through speaking invitations, awards presentations and social invitations. (For a detailed explanation of how your annual meeting should be an important part of your effort to influence State officials, see *"AHJMA Legislative Initiative: The Role of the CSA," Journal of AHIMA, 1992, Vol.63, No.8.)*

Coalition Building: A final activity (performed at the national level by AHIMA's Washington Office) that CSAs can undertake at the State level to achieve the twin goals of accessing information and maintaining contact with policymakers, is networking through coalitions. To effectively network with other health related groups the CSA must actively seek to identify any formal coalitions which may exist. This effort can be undertaken when calling groups regarding courtesy copies of their newsletters and other publications. It is also important to note that some coalitions form to address single issues and disband after the issue is resolved. Similarly, other coalitions exist on an ongoing basis, constantly reviewing policies and picking issues when consensus develops. It is also important to emphasize that coalition members invariably retain the right to take their own individual position, regardless of the stance of the coalition,

There are numerous groups which undoubtedly will maintain a significant presence at the State Capitol, particularly physicians, hospitals, nurses, nursing homes, and several allied health groups. It is always wise to know where these groups stand on health issues because of their collective abilities to influence legislators. Offering your assistance on matters that may not directly impact CSA members may be of some benefit because this strengthens your ability to secure their support on issues that are critical to you but may be only tangential to them.

If no formal health coalitions exist, it is still important that your CSA seek to make personal contact with the elected leadership of other professional associations in the healthcare community. These contacts can become invaluable as information sources as well as potential allies in future political battles. Even though you may at some future date find yourselves on opposite sides of an issue, your ultimate efforts will be enhanced by having a personal relationship with your adversary.

CSAs should not be hesitant in utilizing any of the activities reviewed above. It is important to keep in mind that elected officials at the State level generally do not have the sophisticated information resources available to them which nationally elected officials do. At the same time, State legislators are increasingly being asked to grapple with complex legislative matters with important implications for AHIMA members. For the most part these legislators are dedicated to the public good and you will find them genuinely receptive to your input and counsel. These are elected officials who very much desire your support and have an equally important need for the valuable information you can provide to them. Always keep in mind that despite the political stature of any particular elected official in your State, he or she will never be able to match your valuable expertise in health information management issues.

The Regulatory Process

As with the legislative process at the State level, the regulatory process will vary among the States. As a practical matter, however, all States will have an agency or department (Department of Health, Department of Human Services, etc.) which essentially functions as the primary administrative or regulatory office within State government with respect to policy matters regarding healthcare. (See the listing of relevant departments or agencies for your State in the reference materials following this section.)

The individuals who work in these offices are not elected officials. In fact, other than the top echelon of these departments, they generally are career State employees. The top officials are generally appointed by the Governor and would change if a new Governor comes into office. In addition to the major department with responsibility for administering State health programs, many States may also have various advisory or ad hoc committees or commissions with some responsibility or involvement in the effort to monitor or carry out State health policy. Generally such special committees or commissions will have a specified period of time to complete a specifically defined project and report to the Governor or to the legislative bodies. Such efforts can present important opportunities for CSAs to be involved in State health policy.

Influencing the Process: Although there may be exceptions in some States, CSAs generally have three important points of contact with regard to participating in and influencing the State regulatory process. These three points of contact are:

The Governor's office
The State Department of Health (or its equivalent in your State)
Advisory or Ad Hoc Administrative Committees or Commissions

A CSA's efforts with respect to policy making in any of these offices is essentially the application of the same techniques recommended for the legislative process.

Access to Information: As with the legislative process, the CSA must undertake and maintain an effort to be fully informed on all relevant administrative/regulatory matters of interest or concern. To achieve this the CSA should contact the relevant departments, agencies, commissions, etc. and request to be put on any available mailing list for announcement of hearings, meetings, release of special reports, etc.

Maintaining Contact and Involvement: CSAs have several opportunities to routinely maintain contact and remain involved with these policy makers including:

- A letter explaining AHIMA, your CSA and your strong interest in issues important to your profession should be sent at the beginning of each legislative session to the appropriate officials within each relevant regulatory office.

- Any time you become aware of a change in personnel at the top of any relevant office a congratulatory letter with an appropriate explanation of your interest in issues should be sent to the new official.

- Any time your CSA becomes aware of a potential administrative action, public hearing, or meeting regarding an interest or concern of your membership, contact should be made with the appropriate officials.

- As with the legislative process, if no issue or event requires active interaction with the key administrative offices the CSA should schedule a "courtesy meeting" to keep your leadership and your interests on the appropriate officials' "radar screens."

- Again, as with the legislative process, take advantage of your annual meeting to notify and include State regulatory officials when possible.

- Be sure to check your CSA roster to determine if any members are working for the State government and could be influential in attaining your goal(s).

The importance of administrative/regulatory officials is too often overlooked by many CSAs. Unlike the legislative process which is driven by elections and therefore subject to substantial turnover, many State health officials remain in positions of responsibility for long periods of time. This tendency can lead to an "institutional memory bank" that provides a valuable resource to the legislative process. The CSA's opportunity to indirectly be a part of this resource bank is only achieved through a successful effort to maintain contact and visibility among these un-elected State health policy makers.

Working with a Lobbyist at the State Level

If a CSA is faced with a critically important legislative/regulatory matter at the State level and has financial resources available, it may be worthwhile to seek out professional assistance from a law firm or lobbying firm. In virtually all 50 States, legislative and regulatory officials understand and respect that groups may require such services. If your CSA's budget will not support such an effort, you might be able to "piggy-back" on the lobbyist used by other health professional organizations (Medical Society, State Hospital Association, State Nurses' Association, etc.), since many of the positions/interests you share are common. The pitfall to this occurs when you have differing positions; remember, that the lobbyist cannot serve two masters with divided interests.

If your CSA seriously considers retaining the services of a lobbyist at the State level, you may want to keep the following recommendations in mind:

- Appoint an individual or **small** committee to initially be responsible for obtaining a short list of prospects

- Actively seek the advice and recommendations of other healthcare related professional associations regarding potential prospects. Seek out recommendations of your own facility. You may have a colleague in your own facility active with a professional association at the State level.

- Assuming no conflict of interest, do not be hesitant to ask another professional association if they would want to share the cost of retaining a lobbyist for a particular bill or period of time,

- Although your first choice would obviously be someone with knowledge of the healthcare information management profession, do not make this a prerequisite. In the world of State policies and politics, your first concern should be retaining someone who knows the pressure points and personalities that comprise the process. An appropriate member of your CSA leadership can accompany the lobbyist to meetings that require a uniquely technical expertise.

- Beware of any prospective candidate who requests or even urges you to sign a long-term agreement. If the lobbyist is to be paid on an hourly basis, require that there be a maximum number of hours for which your CSA would be required to pay.

- If you do decide to retain a lobbyist, make certain you have a clear and regular channel of communication. Most importantly, make certain the lobbyist is only required to answer or report to one individual. It should be the responsibility of that AHIMA member to assure that appropriate CSA leadership are informed or involved.

- If you retain a firm make certain it is clearly agreed upon as to which individual within the firm you will have access to or with whom you will work. Beware of agreeing with a firm only to find that your work and contact is with someone two levels down whom you do not know.

The bottom line in retaining professional assistance is to retain an individual or firm with whom you feel totally comfortable on a personal level. Your relationship with a lobbyist is much like a marriage, it must be based on mutual trust, respect, communication, and genuine liking, or divorce is inevitable,

Sample Letter
Congratulating Member upon Reelection
President of CSA or a Member if He/She Knows Elected Official or is from District

Your address
Hometown, USA

Date

The Honorable John Smith
House of Representatives
Room 1234, ____ Building
Annapolis, MD 54321

Dear Representative Smith:

Congratulations on your reelection to the Maryland House of Representatives. The (number) members of the Maryland Health Information Management Association (MHIMA) wish you the best for your upcoming legislative session.

MHIMA is the Maryland component state association of our national organization, the American Health Information Management Association (AHIMA). As experts in clinical data and information management, the 38,000 professional members of AHIMA are vital to the healthcare industry. The unique knowledge and skills that AHIMA members possess are critical for classifying and analyzing health information, transitioning from paper to computer-based medical records, and enhancing data quality—all accomplished while maintaining patient confidentiality and information security. With a 70-year tradition of advancing quality healthcare through quality information, AHIMA is also instrumental in developing industry standards, advocating relevant legislation, and providing education in health information.

Again, congratulations on your victory. We look forward to working with you in the upcoming legislative session. If I can provide you with any information, please do not hesitate to contact me at (your phone number).

Sincerely,

Your Name
Your Title

Sample Letter
To Senate/House Leadership and Members of Relevant Committees
At Opening of Legislative Session

Your Address
Hometown, USA

Date

The Honorable John Smith
House of Representatives
Room 1234, ____ Building
Annapolis, MD 54321

Dear Representative Smith:

Congratulations on your reelection to the Maryland House of Representatives. The (number) members of the Maryland Health Information Management Association (MHIMA) wish you the best for your upcoming legislative session. As your committee prepares for the legislative session, we look forward to having the opportunity to work with you and your staff on those issues maintaining importance to the MHIMA member. **OR** As the House/Senate prepares for the legislative session, we look forward to having the opportunity to work with you and your staff on those issues maintaining importance to the MHIMA member.

MHIMA is the Maryland component state association of our national organization, the American Health Information Management Association (AHIMA). As experts in clinical data and information management, the 38,000 professional members of AHIMA are vital to the healthcare industry. The unique knowledge and skills that AHIMA members possess are critical for classifying and analyzing health information, transitioning from paper to computer-based medical records, and enhancing data quality—all accomplished while maintaining patient confidentiality and information security. With a 70-year tradition of advancing quality healthcare through quality information, AHIMA is also instrumental in developing industry standards, advocating relevant legislation, and providing education in health information.

Again, congratulations on your victory. We look forward to working with you in the upcoming legislative session. If I can provide you with any information, please do not hesitate to contact me at (your phone number).

Sincerely,

Your Name
Your Title

Sample Letter
To Member/Senator Requesting Meeting

Your Address
Hometown, USA

Date

The Honorable John Smith
House of Representatives
Room 1234, ____ Building
Annapolis, MD 54321

Dear Representative Smith:

I am writing to inquire about your availability for a meeting to discuss your recently introduced legislation HR 111, *the Health Data Quality Act.* As a member of the Maryland Health Information Management Association (MHIMA), our (number) members are vitally interested in HR 111 and any other legislation which may have an impact on health information issues.

MHIMA is the Maryland component state association of our national organization, the American Health Information Management Association (AHIMA). As experts in clinical data and information management, the 38,000 professional members of AHIMA are vital to the healthcare industry. The unique knowledge and skills that AHIMA members possess are critical for classifying and analyzing health information, transitioning from paper to computer-based medical records, and enhancing data quality—all accomplished while maintaining patient confidentiality and information security. With a 70-year tradition of advancing quality healthcare through quality information, AHIMA is also instrumental in developing industry standards, advocating relevant legislation, and providing education in health information.

I will contact your office on (Give 5-7 days) to discuss your availability. We look forward to working with you on HR 111. In the meantime, if I can provide you with any information, please do not hesitate to contact me at (your phone number).

Sincerely,

Your Name
Your Title

Sample Letter
To Chairman Requesting Meeting

Your Address
Hometown, USA

Date

The Honorable Les Money
Chairman
Committee on Health
Room 1234, ____ Building
Annapolis, MD 54321

Dear Mr. Chairman:

I am writing to inquire about your availability for a meeting to discuss HR 111, *the Health Data Quality Act.* As you may know, this legislation was introduced by Representative John Doe on (DATE) and was referred to your committee for consideration. As a member of the Maryland Health Information Management Association (MHIMA), our (number) members are vitally interested in HR 111 and any other legislation which may impact health information management professionals.

MHIMA is the Maryland component state association of our national organization, the American Health Information Management Association (AHIMA). As experts in clinical data and information management, the 38,000 professional members of AHIMA are vital to the healthcare industry. The unique knowledge and skills that AHIMA members possess are critical for classifying and analyzing health information, transitioning from paper to computer-based medical records, and enhancing data quality—all accomplished while maintaining patient confidentiality and information security. With a 70-year tradition of advancing quality healthcare through quality information, AHIMA is also instrumental in developing industry standards, advocating relevant legislation, and providing education in health information.

I will contact your office on (Give 5-7 days) to discuss your availability. We look forward to working with you on HR 111 and any other issues effecting health information management professionals. In the meantime, if I can provide you with any information, please do not hesitate to contact me at (your phone number).

Sincerely,

Your Name
Your Title

Sample Letter
To Member Requesting Courtesy Meeting

Your Address
Hometown, USA

Date

The Honorable Sandy Beech
Maryland State Senate
Room 1234, ____ Building
Annapolis, MD 54321

Dear Senator Beech:

I am writing to inquire about your availability for a meeting to discuss the Maryland Health Information Management Association (MHIMA) and those issues important to our more than (number) members. The Health Subcommittee, of which you are a member, maintains primary jurisdiction over the issues relevant to health information management professionals.

MHIMA is the Maryland component state association of our national organization, the American Health Information Management Association (AHIMA). As experts in clinical data and information management, the 38,000 professional members of AHIMA are vital to the healthcare industry. The unique knowledge and skills that AHIMA members possess are critical for classifying and analyzing health information, transitioning from paper to computer-based medical records, and enhancing data quality—all accomplished while maintaining patient confidentiality and information security. With a 70-year tradition of advancing quality healthcare through quality information, AHIMA is also instrumental in developing industry standards, advocating relevant legislation, and providing education in health information.

I will contact your office on (Give 5-7 days) to discuss your availability. We look forward to working with you on those issues effecting health information management professionals. In the meantime, if I can provide you with any information, please do not hesitate to contact me at (your phone number).

Sincerely,

Your Name
Your Title

Sample Letter
To State Department of Health Officials Requesting Courtesy Meeting

Your address
Hometown, USA

Date

William L. Johnson
Director
Office of Data Policy
Maryland Department of Health
Room 1234, ____ Building
Annapolis, MD 54321

Dear Mr. Johnson:

I am writing to inquire about your availability for a meeting to discuss the Maryland Health Information Management Association (MHIMA) and those issues important to our more than (number) members. Due to the numerous health information management issues that are under the jurisdiction of your department, we would like to meet with our at your earliest convenience.

MHIMA is the Maryland component state association of our national organization, the American Health Information Management Association (AHIMA). As experts in clinical data and information management, the 38,000 professional members of AHIMA are vital to the healthcare industry. The unique knowledge and skills that AHIMA members possess are critical for classifying and analyzing health information, transitioning from paper to computer-based medical records, and enhancing data quality—all accomplished while maintaining patient confidentiality and information security. With a 70-year tradition of advancing quality healthcare through quality information, AHIMA is also instrumental in developing industry standards, advocating relevant legislation, and providing education in health information.

I will contact your office on (Give 5-7 days) to discuss your availability. We look forward to working with you on those issues effecting health information management professionals. In the meantime, if I can provide you with any information, please do not hesitate to contact me at (your phone number).

Sincerely,

Your Name
Your Title

Sample Letter
To State Department of Health Officials
Requesting Meeting Regarding Upcoming Hearing

Your address
Hometown, USA

Date

William L. Johnson
Director
Office of Data Policy
Maryland Department of Health
Room 1234, ____ Building
Annapolis, MD 54321

Dear Mr. Johnson:

I am writing to inquire about your availability for a meeting to discuss the Maryland Health Information Management Association (MHIMA) and those issues important to our more than (number) members. It is our understanding that your department is going to schedule public hearings on data quality issues. Our members are vitally interested (strongly supports, opposes, has concerns, would like to testify, etc) in this issue and would like to discuss it with you at your earliest convenience.

MHIMA is the Maryland component state association of our national organization, the American Health Information Management Association (AHIMA). As experts in clinical data and information management, the 38,000 professional members of AHIMA are vital to the healthcare industry. The unique knowledge and skills that AHIMA members possess are critical for classifying and analyzing health information, transitioning from paper to computer-based medical records, and enhancing data quality—all accomplished while maintaining patient confidentiality and information security. With a 70-year tradition of advancing quality healthcare through quality information, AHIMA is also instrumental in developing industry standards, advocating relevant legislation, and providing education in health information.

I will contact your office on (Give 5-7 days) to discuss your availability. We look forward to working with you on the department's data policy proposal and any other issues effecting health information management professionals. In the meantime, if I can provide you with any information, please do not hesitate to contact me at (your phone number).

Sincerely,

Your Name
Your Title

Sample Letter
Invitation to Appear at Annual Meeting

Your address
Hometown, USA

Date

William L. Johnson
Director
Office of Data Policy
Maryland Department of Health
Room 1234, ____ Building
Annapolis, MD 54321

Dear Mr. Johnson:

On behalf of the (number) members of the Maryland Health Information Management Association (MHIMA), I extend you this invitation to speak at our Annual Meeting on (Date) from 11:00 a.m.-12:00 p.m. The Annual Meeting will include a three-day educational program and be held at the Omni-Shoreham Hotel in Baltimore's Inner Harbor. MHIMA is anticipating the attendance of over 500 individuals from across the state. A preliminary copy of the meeting program is enclosed for your review.

MHIMA is the Maryland component state association of our national organization, the American Health Information Management Association (AHIMA). As experts in clinical data and information management, the 38,000 professional members of the American Health Information Management Association (AHIMA) are vital to the healthcare industry. The unique knowledge and skills that AHIMA members possess are critical for classifying and analyzing health information, transitioning from paper to computer-based medical records, and enhancing data quality—all accomplished while maintaining patient confidentiality and information security. With a 70-year tradition of advancing quality healthcare through quality information, AHIMA is also instrumental in developing industry standards, advocating relevant legislation, and providing education in health information.

Thank you for your consideration of this request. I will contact your office on (Give 5-7 days) to discuss your availability to address the MHIMA Annual Meeting. In the meantime, if I can provide you with any further information, please do not hesitate to contact me at (your phone number).

Sincerely,

Your Name
Your Title

Testifying at a Public Hearing

Importance of Public Hearings

Giving testimony at committee hearings may be the single most important action you perform. In most legislative structures, bills are heard in committee before they go to the floor of the legislative body for debate and vote. As a general rule, legislative assemblies give serious weight to the favorable or unfavorable recommendation of the committee which investigates the bill. In some states, an unfavorable recommendation is enough to kill the bill, by rules of protocol. Even a statement offering "no recommendation" by the hearing committee may serve to functionally kill a bill or seriously disable it by protocol.

Committee Hearing Process

Public hearings are a feature of all legislative systems. While format will differ from one locale to the next, you will likely find some structure which requires that you register prior to giving testimony, indicating whether you are a proponent or opponent. You may be asked to give copies of your written testimony to a clerical aide at the point of registration. Registration gives an opportunity to see who else is present to give testimony. Often there is a waiting period for your bill to be reviewed and this gives you an opportunity to talk with the others who are giving testimony that day. You may gain insights, and you have an opportunity to educate, lobby, form new coalitions, and develop last minute strategies.

If there is a long wait for testimony and debate on your bill, you will have an excellent opportunity to observe the committee in action on other bills. An understanding of the committee mood, interest, and key personalities may prove invaluable in the presentation of your own testimony. Learn the committee members' names; a pictorial roster is a helpful aid in matching names to faces.

Presenting Testimony

When you give your testimony, it is generally acceptable to read from your prepared statement; however, you should be sensitive to the timing and mood of the committee. Frequently it is better to summarize your testimony and then entertain the questions of committee members. Remember, your written testimony will have been distributed to the members by this point and they can review the fine points of your position on their own. Also, if others have testified before you on a bill, many of the issues may have been already aired. Avoid pointless repetition. Get right to the heart of the matter, i.e., your support or opposition to the bill and why.

Testimony is generally given only once by an organization or association, and usually by only one person representing that association. At times, having AHIMA members speak as private citizens affected by the proposed legislation is warranted.

Many groups conducting hearings place a time limit on oral testimony, usually anywhere from three to 10 minutes. If you are told you have 10 minutes to give your testimony, prepare for that, but also be ready on the spot to reduce your testimony to three-to-five minutes. A good gauge to use is double-spaced text on one sheet of 8 ½ x 11" paper that can be read in one minute.

The best approach for presenting oral testimony is to speak from an outline, or have notes on 3" x 5" cards, or whatever is the most comfortable for you.

Engage the hearing officials by looking them in the eye. Do not be discouraged if only a few are present, and they are reading your written testimony, whispering to a neighbor, or listening to an aide. Consider that a challenge to get their attention.

Always conclude your oral testimony by thanking the officials for the opportunity to present your views and by offering to answer any questions they may have.

Answering Questions

Committee questions should be answered honestly and simply. If you do not know the answer to a particular question, don't he afraid to say so, but do tell the committee you will find out the answer and submit it in writing for the record. After you testify, remain in or near the hearing room for a few minutes so you may answer any inquiries.

Alternatives to Testifying in Person

If for some reason a representative from your association cannot attend the hearing, be sure to send your written testimony to the committee in time for the hearing. with an explanatory cover letter. Written testimony does not always take the form of a statement. Often, and especially at the state level, it may he presented in a letter.

Finally, there may be occasions where you cannot or do not wish to take a formal position by testifying at the public hearing. This may be due to insufficient information, vague wording or unclear intent of the bill, lack of opportunity to meet the sponsor, or insufficient time for preparation of position. It is still important to attend the public hearings to gain greater understanding of the bill's intent and the surrounding issues, to meet with other interested parties, and to let your presence as an interested group be known.

Essential Elements of Prepared Testimony

Two things are important in preparing written and oral testimony: what you say and how you say it. Whether oral or written, all testimony should contain the following information:

1. Identification of yourself and/or the group you represent, and the specific proposal (bill) on which you are testifying. Note that written testimony submitted on behalf of a group does not customarily carry an individual's name. Rather, the testimony is submitted in the group's name.

2. Once you have identified a bill by its number or short title, use that same number or short title throughout your testimony.

3. A brief statement of your general position on the proposal. You need only say that your association supports the proposal, or opposes it, or supports it with certain modifications that you will explain shortly. This statement gives hearing officials an immediate indication of where you stand. Another approach, if appropriate, is to state that you are neutral (or not qualified to comment) on most of the provisions of the proposal but want to present your position on a few of them.

4. A brief description of the group you represent and a brief definition of your profession. These descriptions are necessary because many public officials may not know the role and the function of your profession and, thus, may not understand how the proposal under consideration relates to it.

5. A brief summary of the proposed bill as you understand it and your reasons for supporting it, opposing it, or wanting it modified. This section leads into the core of your testimony by summarizing the proposal you are discussing relative to its effects on your profession, by stating your position on the proposal and by identifying the reasons for your position.

6. After you have stated the reasons for your position, supply a detailed explanation of them. In your remarks, do not assume that the hearing officials understand your issues or positions. A general rule regarding the length of explanations is to give enough information to support your position adequately, but not so much as to confuse the primary issues. Some testimony requires a long explanation to counter opposing positions or unfavorable data.

7. While it is acceptable to cite or briefly summarize extensive data, reports, studies, and other supporting information in the body of the testimony, do not include them there in full. If a table of figures or the full text of a study would help your argument, append it to your statement.

8. In closing, repeat where you stand and state how the proposed bill could be improved to accommodate your concerns. Express complete opposition to a proposal when it is warranted, but if you do, try to present an alternative. At the end of the testimony, offer to answer questions, clarity points, and work with the officials to modify the proposal. Remember, you are the expert and those who enact the bills are not.

Media Relations

All the news that's fit to print.
The New York Times

One of the opportunities CSAs overlook to enhance their images among local and state officials is in the area of media relations. Many CSAs do not routinely provide their local or state press with news releases, nor do they undertake a systematic outreach program with respect to the press.

The opportunities for effectively generating press coverage of CSA activity are growing. Over the past couple of years, the press and the general public have expressed growing concerns about a key issue that AHIMA members grapple with every day. Specifically, the issue of "maintaining the delicate balance between requests for health information and the patient's right to privacy." There is a story to be told, and no one in the healthcare community is better positioned to tell it at the state level than health information management professionals.

Successfully generating press coverage of the profession or your CSA activity pays important dividends in the public policy arena. Quite simply, such press coverage creates a certain legitimacy in the eyes of public officials. Most U.S. Senators and Congressmen retain news clipping services that clip news articles from literally every newspaper in their states or Congressional districts. The Internet has compounded the ability to access news sources. These same elected officials are particularly sensitive to indications of activities or issues in which organized professional groups are involved. Beyond that, state health policy officials keep a close eye on the same sort of activities. Generating press coverage essentially earns your CSA a place on the political/policy map.

CSA success in enhancing press coverage will vary dramatically from state to state. Generally, CSAs in less populated rural states will receive better responses to routine press releases. Obviously, you are more likely to see the headline *"Local Woman Elected President of Professional Association"* in a town of 20,000 than in Chicago. Regardless of the size of your state, however, your CSA should seriously consider some of the following efforts:

- If your CSA has not yet organized a press list, use the form found at the end of this section to do so. Keeping this form updated will assure that you are ready to send out press information.

- Invite a reporter (newsprint or television) to visit your facility and do a story on the increasingly important and sensitive role your membership and profession play. This would work especially well in conjunction with National Health Information Management Week. The bigger the media market the better you have to be at catching the reporter's interest. (See sample letter and/or sample news release at the end of this section.)

- Consider mailing a survey to your membership asking some simple questions about their expertise. Reporters love poll/survey results and generally provide some degree of coverage-- *"Survey Shows 10 Megazillion Patient Records on File."* (See sample news release at the end of this section.)

- Effectively promote your annual meeting. News releases should be sent to any medical or healthcare publication that covers healthcare association meetings. Assure that a news release announcing new elections of officers is sent to the hometown newspaper of each newly elected officer, to relevant state health officials, and other healthcare professional organizations This is one of the simplest and easiest ways to keep your CSA on the minds of important officials and updated in their rolodexes. (See sample news release at the end of this section.)

- If your CSA is not already doing so, it is strongly recommended that you establish some type of annual award to present to an appropriate public official. If your CSA does undertake this effort, make certain that you send out a news release announcing the presentation of the award. (See sample news release at the end of this section.)

The issues and profession of health information management have become more visible and more respected. It is imperative that your CSA take advantage of these opportunities as part of an energized effort to generate press coverage.

NOTE TO CSAs: In establishing your press list you should call each of the major TV and newspaper outlets in your state. It is important to call rather than write to assure that you get the information you desire. When you call, explain that you are calling on behalf of your CSA in order to update your press lists. Follow up your call with a thank you letter or e-mail message that explains a little about your CSA and the health information management profession.

PRESS LIST

Newspaper/TV: ____
Mailing Address: ____
____
Health Reporter: ____
(or assignment editor)
Phone: ______________________________ Fax: ______________
e-mail address:
Is there a regular health report or day? ______________________________
Deadline for releases to make an edition? ______________________________

Newspaper/TV: ____
Mailing Address: ____
____
Health Reporter: ____
(or assignment editor)
Phone: ______________________________ Fax: ______________
e-mail address:
Is there a regular health report or day? ______________________________
Deadline for releases to make an edition? ______________________________

Newspaper/TV: ____
Mailing Address: ____
____
Health Reporter: ____
(or assignment editor)
Phone: ______________________________ Fax: ______________
e-mail address:
Is there a regular health report or day? ______________________________
Deadline for releases to make an edition? ______________________________

Newspaper/TV: ____
Mailing Address: ____
____
Health Reporter: ____
(or assignment editor)
Phone: ______________________________ Fax: ______________
e-mail address:
Is there a regular health report or day? ______________________________
Deadline for releases to make an edition? ____________________

Sample Press Release

NOTE TO CSAs: All Press Releases Should Be on Letterhead

(INSERT DATE)

For More Information Contact:
Judy Jones
Director
Health Information Services
Good Health Hospital
111 First Street
Happy Valley, CA 11111

Phone: (111)111-1111

X Million Californians' Medical Records on File

More than x million medical records exist in California according to a recent survey by the California Health Information Association (CHIA). CHIA the professional association representing _____ health information management (HIM) professionals in hospitals and health facilities in California, conducted the survey of _____ members from _____ to _____.

HIM professionals are specialists in balancing requests for health information against the patient's right to privacy, in the context of myriad laws, regulations and procedures that dictate the release of such information. "Rapid advances in technology, such as computerized billing, combined with HIM professionals' historical commitment to patient confidentiality, places increasing demands on our members," Judy Jones said. Jones, Director of Health Information Services at Good Health Hospital in Happy Valley, is the current President of CHIA.

Other findings of the survey were:

(NOTE TO CSAs: List 3 or 4 other important facts/findings, if possible, that would of interest to the average reader)

Sample Annual Meeting Press Release

NOTE TO CSAs: All Press Releases Should Be on Letterhead

(INSERT DATE)

For More Information Contact:
Ann Smith
President
Ohio Health Information Management Association
111 First Street
Columbus, OH 11111

Phone: (111) 111-1111

Health Information Management Professionals Hold Annual Meeting

"Patient Confidentiality" Focus of Health Information Management Professionals

More than x members of the Ohio Health Information Management Association (OHIMA) (will meet) (met) in Columbus this week to discuss topics ranging from _____ to _____ OHIMA is the professional association representing _____ health information management professionals (HIM) in hospitals and health facilities in Ohio. HIM professionals are credentialed specialists who must balance requests for health information and the individual's right to privacy, in the context of myriad laws, regulations and procedures that dictate the release of such information.

Sample Election of New Officers Press Release

NOTE TO CSAs: All Press Releases Should Be on Letterhead

(INSERT DATE)

For More Information Contact:
Ann Smith
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Ohio Health Information Management Association
111 First Street
Columbus, OH 11111

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Health Information Management Professionals Elect New Officers

The membership of the Ohio Health Information Management Association (OHIMA) recently elected new officers OHIMA is the professional association representing health information management professionals in hospitals and health facilities statewide. Health information management professionals are credentialed specialists who daily must balance the requests for health information against the individual's right to privacy, in the context of myriad laws, regulations and procedures that dictate the release of such information.

The new officers are:

Sue Jones, President, Smilcy Hospital, Columbus etc.

etc.

Sample Annual Award Press Release

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OHIMA Honors Brown with Arthur Ashe Award

The membership of the Ohio Health Information Management Association (OHIMA) recently honored Mary Sue Brown, Administrator of Queen of Mercy Hospital in Cleveland, by bestowing upon her its coveted Arthur Ashe Award. Mary Sue Brown was singled out for this award because of the exemplary fashion in which she has diligently worked to assure the confidentiality of computerized medical records. In so doing, she established privacy standards that are recognized and utilized across the nation.

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Glossary of State Government Terms

ad hoc	Brought together for a special purpose.
alert system	A communication system set up for alerting members of a group to crises or other important situations. The people reached by an alert system often have previously specified jobs to do whenever they are notified.
amendment	A change or addition to a bill or motion - the change or addition must usually be germane to the subject matter.
appropriation	The setting aside by a legislature of a specific sum of public money for a particular public purpose. A lump sum may be appropriated, or an itemized appropriation maybe made. The former allows for greater executive discretion. The latter permits expenditures only for a narrow purpose specified by the legislative body.
bill	The form in which proposed laws are introduced into the legislature. Bills move by agreement (usually majority) through the various legislative stages - reference to committee; consideration within and amendment by committee; report to full body; debate and amendment on the floor of the house; passage by the chamber; similar action in the other chamber; signature by the executive (or passage over the executive's veto) to become law.
calendar	A group of bills and/or other items of legislative business listed in order of their intended presentation to a legislative chamber. The calendar informs anyone who is interested of the chamber's anticipated business.
caucus	The members of a legislature belonging to the same party, organized in a body to determine joint legislative action; also, recently, other subgroups within the legislative body such as a Black caucus or women's caucus; also, a meeting of such a body
chamber	A place where legislators meet together as a body to consider legislation and conduct other business.
clean bill	Changes and revisions incorporated by a subcommittee or committee in an original bill may be reintroduced as a "clean bill." The new measure is then sent to the full committee or the floor for consideration. This often is a time-saver, as committee-recommended changes do not have to be considered one at a time by the chamber.
cloture	The ending of debate and amendment and the bringing of the question to a vote, usually by mere majority vote on the previous question. Occasionally referred to as "closure."
coalition	An alliance, often temporary, among persons or factions interested in a common goal.

committee A grouping of members of a legislative body that gives special or detailed consideration to pending bills on a given subject. A standing committee of a legislature is essentially permanent. Joint committees are appointed by the two houses to consider matters together. Special, select, or ad hoc committees are appointed for special matters.

committee print When a proposed bill will require many amendments in order to pass, the committee to which it has been referred may prepare and report a substitute bill incorporating all such changes. Such a bill is refereed to as a committee print. If carefully drafted it may pass without further amendment, thus saving the house deliberation time.

committee of the whole A house acts as a Committee of the Whole when it sits with all the members present in a deliberative rather than a formal legislative capacity. This permits informal debate, preliminary consideration of matters awaiting action and informal action. Since a record vote cannot be taken while sitting in such a manner, the doings of the body may escape adequate public notice. Debate tends to be informal, and a member may speak as often as he can get the floor The Committee of the Whole procedure may be abused to let members escape the accountability of having to cast recorded votes on preliminary matters, some-times quite important ones. When acting as a Committee of the Whole, a house is in effect reporting to itself.

companion bill One of two identical bills introduced in both houses.

conference A meeting among representatives of two houses to reconcile differences between a bill passed by one house and an altered version of the same bill by the other.

conference committee A committee appointed by both houses to reconcile legislative differences between the two. To ensure fill discussion of divergent viewpoints, an attempt is usually made to appoint representatives of each major point of view.

cost estimate The anticipated cost of paying for a desired program or service. A cost estimate should accompany bills with fiscal impact.

debate Legislative discussion and argument about the merits of a bill, a resolution or a parliamentary motion.

departmental request bill A bill that is requested by a department of state government.

do pass report A report on a bill which has been considered by its subject committee and has received a majority of ayes. Such a bill is forwarded to the parent body. "Do not pass" reports are also possible.

effective date	The date on which a law becomes effective. Emergency clauses are commonly employed to bring statutes into effect as soon as the executive signs the bill or a veto is overridden.
emergency clause	A clause that permits a bill to take effect before the fixed period after the closing of the legislative session usually required for the coming into effect of laws.
enacting clause	The clause at the beginning of every bill that states the authority by which it will be made into law. The exact words are often delineated in the state constitution.
executive request bill	A bill proposed by the Governor.
first reading	The formal reading of a bill by the clerk of a house before that house for the first time. Bills must be formally "read in" to be considered. This is usually done in a pro forma manner with only a reading of the title of the bill necessary.
fiscal note	A cost estimate which is attached to a bill to indicate its fiscal impact.
floor	Any action, whether it be debate or votes, by a full legislative body such as the House or Senate occurs on the "floor" of the chamber.
gallery	The area from which the public can observe a legislative chamber.
hearing	An occasion during which evidence and points of view on a specific bill or subject are brought before a legislative body.
hopper	Bills are said to be "tossed into the hopper" when they are first submitted by sponsoring members.
house/senate rules	The rules by which each legislative body conducts its business, usually adopted annually to permit changes.
item veto	A power vested in the governor of a state to veto parts (items) of an appropriation bill without affecting other provisions of the bill. In some states a governor may also reduce an amount of money prescribed by an appropriations bill. In certain states, a governor may veto parts (items) of nonfinancial bills.
joint committee	A committee with members appointed by either house to consider matters of common interest, Such committees can speed up the legislative process by consolidating time for hearings.
joint resolution	Resolutions concurred in by both houses of the legislature.

joint rules	Rules of procedure adopted by and applicable to both houses of the legislature.
lobbyist	A person, usually representing a special public or private interest, who visits the legislature to transact business with legislators in the hope of influencing the legislative procedures.
legislative council	A body of members of the legislature, sometimes including administrative officers, which meet between sessions to investigate state needs and propose legislative programs and measures.
legislative digest	A digest of bills classified by subject, title, and current status. The digest may be published either by the state or privately to help people follow legislative business.
minority leader	A member designated by the caucus of the majority party to carry out party strategy on the floor of the House and lead the party during the session.
mark up	Going through a measure, usually in committee or subcommittee, taking it section by section, revising or adding new phrases, etc. If a bill is extensively revised, the new version may be introduced as a separate bill. With a new number, or as a substitute bill with the original number.
motion	A proposal formally made before any deliberative body such as a legislature. Under parliamentary rules, certain kinds of motions have precedence over others. All legislative business is moved through the legislative process by motions.
order of business	The order in which business is transacted before the legislative body or its committees. Under the rules, changes in the order of business may be made.
point of order	An objection made by a member of a deliberative body to the chair that a question, motion or measure cannot be considered because it conflicts with the rules, orders or proceedings already established by the legislature.
quorum	The number of members established by rule who must be present in a deliberative body before business can lawfully be transacted. In certain instances, any members present may constitute a quorum. Usually. however, it is a majority of the members.
recommittal of a bill	The return of a bill by a house to a committee. A bill may be recommitted at any time before its final passage.

reconsideration of bills This opens the entire bill for further action. Upon adoption of a motion for reconsideration the presiding officer must again put the bill to a vote. Legislatures have specific rules for reconsideration including time limits within which the motion must be made and who may make such a motion.

report Both a verb and a noun. A committee that approves a bill reports its findings and discharges it for floor action. This process is called reporting a bill. A report is the document setting forth each committee's explanation of its action and intent and, therefore, constitutes an important part of the legislative history of the bill. Most reports favor a bill's passage. When a committee disapproves a bill, it simply fails to report it at all.

rider An amendment, usually not relevant or germane, to a bill which has a good chance of passage. Riders become law if the bills embodying them do.

roll call The calling of names of members of the body to determine if a quorum is present and if business may be transacted.

rule A regulation controlling action or procedure of a legislative, administrative or judicial body. In the case of the legislature. the rules secure order and provide for the regular processing of legislative business in a predictable way.

second reading Bills receive a second reading after having been reported from their subject committees to the full house, and after they have been calendared by the Rules Committee for debate and action before the house.

select committee A committee appointed to have charge of a special subject. Conference committees are select committees.

speaker The presiding officer, usually of the more populous house. The lieutenant governor is often the presiding officer of the upper house or senate. The speaker is usually elected by the majority party in the house. In acting as speaker he must be impartial.

sponsor A legislator who introduces a bill or resolution before the legislature.

status sheet A publication, usually published daily during a session, which gives the current status of all measures that have come before the legislature for consideration including those bills which have been enacted into law. The status sheet is a publication different from the legislative digest.

suspension of the rules A temporary withdrawal (to) the effect of the rules of a legislative body in connection with consideration of a particular measure.

table	The motion to "lay on the table" is not debatable in either house, and is usually a method of killing a bill or amendment.
tally	A count of the “ayes” and “nays” of a vote. The clerk of each body is in charge of its official tallies.
third reading	The formal reading of a bill before a chamber votes on its passage.
title	A heading or preliminary part of a bill that briefly designates its subject and purpose, and states what laws the bill may amend. Legislative and constitutional provisions usually require the body of a bill to include only the general subject that has been indicated in its title.
veto	The return by the governor to the legislature of a bill without his approving signature, which is necessary for a bill to become law. The legislature may override an executive veto by a vote - usually a two-thirds majority - specified in the state constitution. The governors of all states except North Carolina have some sort of veto power.
voice vote	An oral vote conducted by the presiding officer, as distinguished from an individually recorded or tallied vote. The presiding officer judges the outcome by the sound of the voices.
whip	The name given to the legislator designated by his party caucus to keep or attempt to keep count and control of party members on party issues.

Source:

Smith**,** Dorothy. *In Our Own Interest: A Handbook for The Citizen Lobbyist in State Legislatures.*