December 9, 2019

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
US Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Administrator Verma:

We applaud your commitment and leadership to creating an interoperable healthcare system in which patients can access their data when, where and how they want it. As you articulated earlier this year at HIMSS19, patient identity and record matching is a "critical issue that has plagued data-sharing efforts for years, and we must find a solution." We appreciate your willingness to have the Centers for Medicare and Medicaid Services (CMS) be a leader on this critical patient safety and interoperability issue and we share your vision for a patient-centric healthcare system.

For nearly two decades, innovation and industry progress has been stifled due to a narrow interpretation of the appropriations rider that prohibits the US Department of Health and Human Services (HHS) from spending any federal dollars to promulgate or adopt a national unique patient identifier (UPI). When the UPI funding ban was first imposed in FY1999, electronic health records (EHRs) were rudimentary at best. Today, certified EHR adoption rates are 96 percent in non-federal acute care hospitals and 79.7 percent among office-based physicians.[1] Despite this progress, a survey by the American Hospital Association in 2017 found that 45 percent of large hospitals reported that difficulties in accurately identifying patients across health information (IT) systems limited health information exchange.[2] Accordingly, removing the antiquated ban that currently prevents appropriate health information flow would assist in transitioning the US to a healthcare delivery system that focuses on high value, cost-effective, and patient-centered care.

Importantly, without the ability of clinicians to accurately connect a patient to their medical record, lives have been lost and medical errors have needlessly occurred. There are patient safety implications when data is matched to the wrong patient and when essential data is lacking from a patient's record due to identity issues. The *2016 National Patient Misidentification Report* cites that 86 percent of respondents said they have witnessed or know of a medical error that was the result of patient misidentification.[3] These are situations that could have been avoidable had patients been able to have been accurately identified and matched with their records. This problem is so dire that one of the nation's leading patient safety organizations, the ECRI Institute, named patient misidentification among the top ten threats to patient safety.[4] Having the ability to accurately identify a patient to their health information would also be a valuable tool in combatting the opioid epidemic as recommended in the 2018 *Roundtable on Data Sharing Policies, Data-Driven Solutions, and the Opioid Crisis* report, co-hosted by the HHS Office of the Chief Technology Officer (CTO) and the nonprofit, Center for Open Data Enterprise (CODE).[5]

Given the Administration's commitment to lowering the cost of healthcare while reducing regulatory burdens on clinicians, it is important to note that the absence of a consistent approach to accurately identifying patients has also resulted in significant costs to hospitals, health systems, physician practices,

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[1] ONC Data Brief No. 35, Available at: https://dashboard.healthit.gov/evaluations/data-briefs/non-federal-acute-care-hospital-ehr-adoption-2008-2015.php, ONC Office-based Physician Electronic Health Record Adoption, Available at: https://dashboard.healthit.gov/quickstats/pages/physician-ehr-adoption-trends.php.
[2] AHA, *Trendwatch: Sharing Health Information*. Available at: https://www.aha.org/system/files/2018-03/sharing-health-information.pdf.
[3] 2016 National Patient Misidentification Report, Available at: https://pages.imprivata.com/rs/imprivata/images/Ponemon-Report_121416.pdf
[4] Top 10 Patient Safety Concerns for Healthcare Organizations, Available at: https://www.ecri.org/EmailResources/PSRQ/Top10/2017_PSTop10_ExecutiveBrief.pdf
[5] Available at: http://reports.opendataenterprise.org/HHS-Opioid-Roundtable-Report.pdf.

long-term post-acute care (LTPAC) facilities, and other providers. According to a 2016 study of healthcare executives, misidentification costs the average healthcare facility $1.2 million per year in denied claims and potential lost revenue.[6] Another survey indicates that patient misidentification costs the US healthcare system over $6 billion annually.[7]

Unfortunately, the UPI funding ban has been included in every Labor-HHS appropriations bill since FY1999 without any significant discussion, until now. On June 12, 2019, the US House of Representatives voted to remove the UPI funding ban from HR 2740, the Departments of Labor, Health and Human Services, Education, and Related Agencies Appropriations Act of 2020.

We encourage the Administration to share its views with Congress on the impact of lifting the ban. We believe that removing the prohibition on the use of federal funds to promulgate or adopt a national UPI will provide HHS the ability to evaluate a range of patient identification solutions and enable it to work with the private sector to explore potential challenges and identify a solution that protects patient privacy and is cost-effective, scalable, and secure. We also encourage CMS to continue to identify opportunities to leverage CMS' programmatic authority to address patient identification.

We appreciate your consideration and we look forward to working with you to pursue an appropriate solution to enable accurate patient identification and matching throughout our nation's healthcare system.

Sincerely,

American Academy of Neurology
American Academy of Ophthalmology
American College of Cardiology (ACC)
American College of Physicians
American College of Surgeons
American Health Care Association (AHCA)
American Health Information Management Association (AHIMA)
American Medical Informatics Association (AMIA)
American Society of Consultant Pharmacists (ASCP)
America's Health Insurance Plans (AHIP)
Cerner
Children's Hospital of Alabama
Children's Hospital Association
Children's Mercy Hospital (Missouri)
College of Healthcare Information Management Executives (CHIME)
CoverMyMeds
Duke Center for Health Informatics
ECRI Institute
EP3 Foundation
Experian Health
Federation of American Hospitals (FAH)
Healthcare Leadership Council
Healthcare Information and Management Systems Society (HIMSS)
Health Innovation Alliance
himagine solutions inc.
HIMSS EHR Association
Imprivata
Intermountain Healthcare
Just Associates

[6] 2016 National Patient Misidentification Report, Available at: https://pages.imprivata.com/rs/imprivata/images/Ponemon-Report_121416.pdf.
[7] Black Book survey, Available at: https://blackbookmarketresearch.newswire.com/news/improving-provider-interoperability-congruently-increasing-patient-20426295.

LeadingAge
LeadingAge Center for Aging Services Technologies (CAST)
Logica (formerly the Healthcare Services Platform Consortium)
LTPAC Health IT Collaborative
4medica
Medical Group Management Association (MGMA)
National Association for the Support of Long Term Care (NASL)
National Association of Healthcare Access Management (NAHAM)
Nemours Children's Health System
NextGate
NextGen Healthcare
Premier healthcare alliance
Quadramed
Regenstrief Institute
Strategic Health Information Exchange Collaborative (SHIEC)
The Joint Commission
The Sequoia Project
Trinity Health
WebShield

CC: National Coordinator Don Rucker, Office of the National Coordinator for Health Information Technology