

July 27, 2018

The Honorable Mike Kelly
U.S. House of Representatives
1707 Longworth House Office Building
Washington, DC 20515

The Honorable Ron Kind
U.S. House of Representatives
1502 Longworth House Office Building
Washington, DC 20515

The Honorable Markwayne Mullin
U.S. House of Representatives
1113 Longworth House Office Building
Washington, DC 20515

The Honorable Ami Bera, M.D.
U.S. House of Representatives
1431 Longworth House Office Building
Washington DC, 20515

Re: Health Care Innovation Caucus Request for Information

Dear Congressman Kelly, Congressman Kind, Congressman Mullin and Congressman Bera,

On behalf of the College of Healthcare Information Management Executives (CHIME), which represents more than 2,700 chief information officers (CIOs), chief medical information officers (CMIOs), chief nursing information officers (CNIOs) and other senior healthcare IT leaders at hospitals, clinics and other health organizations nationwide, we thank you for the opportunity to provide input on how innovation can improve the quality of healthcare and lower costs.

CHIME members are responsible for the selection and implementation of clinical and business technology systems that are facilitating healthcare transformation. CHIME members are among the nation's foremost health IT experts and are at the forefront of leading healthcare transformation through technology. CHIME shares the vision outlined by the Caucus of a value-driven health system focused on improved outcomes and high-quality care.

Technology adoption and robust data sharing are vital to enhancing the quality of care and efficiency of the nation's healthcare system. Healthcare CIOs, CMIOs and CNIOs have experience implementing technology that must interoperate with dozens of independent systems, ranging from diagnostic imaging and biomedical devices to financial and remote access systems. Several converging factors, including the passage and ongoing implementation of the 21st Century Cures Act, present federal regulators and congressional leaders with a unique opportunity to pursue and implement policies to bolster the digital infrastructure that will play a pivotal role in transforming care delivery.

Since enactment of the Health Information Technology for Economic and Clinical Health Act of 2009 (HITECH), the healthcare industry has made a significant shift in the way technology is used to treat and engage with patients. The prolific adoption of electronic

health records (EHRs) and other health IT resources by clinicians and patients will pay dividends as the nation's clinicians transition to value-based care. We applaud your focus on value-based care and agree with the importance of ensuring the regulatory landscape allows innovation to flourish. We have tailored our response to a few of your questions that focus on healthcare technology.

Value-Based Provider Payment Reform

What barriers in each of the following areas limit the full potential of innovation in Medicare and Medicaid?

- **Payment and reimbursement**
- **Policy and regulation**
- **Data and Reporting**

One of the greatest barriers impeding innovation in health systems is the current state of interoperability. While today most providers and health systems have adopted EHRs the ability to easily and quickly share meaningful patient data presented in a manner that is within a clinician's workflow remains a significant challenge.

Among the policy barriers that should be highlighted is the current prohibition on the use federal funds to promulgate or adopt a patient identifier which has been carried forth in Labor-Health and Human Services Appropriations bills since fiscal year 1999¹. Foundational to coordinated care is the need to accurately identify patients and match them with their healthcare data across providers, systems and states. A national approach to patient identification is prerequisite for health information exchange and the lack of a national standard for patient identification only serves to intensify our industry's technical challenges. Without a standard patient identification solution, the creation of a longitudinal care record is simply not feasible. We encourage the Caucus to examine the issue of patient identification as a means to facilitate nationwide interoperability, enhance patient safety and enhance health outcomes.

Further, Congress should pursue legislation that harmonizes other privacy, security and information risk management requirements to eliminate the complex patchwork of regulations across industries and state lines. Currently, healthcare organizations dedicate highly valuable resources to navigating these complexities to demonstrate compliance with its regulators and to meet patient demands; if a streamlined regulatory framework were in place these resources could focus more time on actively monitoring and protecting patient privacy and securing our health system. This effort should include a robust dialogue about patient privacy and consent laws, especially as they relate to sensitive health conditions. CHIME was pleased to support the Overdose Prevention and Patient Safety Act (H.R. 6082), which would remove an outdated regulatory barrier to allow providers to have access to the full medical history of patients suffering from substance use disorders.

Additionally, we would like to highlight for the Caucus the burden of quality measurement that our members shoulder to meet reporting requirements levied by the Centers for Medicare and Medicaid Services (CMS.) Hours of work and expertise are required to comply with these reporting demands and such burdens are exacerbated by a lack of technical harmonization. In other words, even when the same CQMs are used among different reporting programs, they tend to require different technical specifications,

¹ Original Language - Section 516, Title V, Omnibus Consolidated and Emergency Supplemental Appropriations for FY 1999, H.R. 4328 (P.L. 105-277), October 21, 1998

diminishing gains inherent to alignment. We remain concerned that the complexity of generating valid, reliable and accurate electronic clinical quality measures (eCQMs) without human intervention is too often underestimated. Harmonizing measures across CMS programs would be invaluable and would free up resources within health systems and technology providers for innovation. We appreciate that CMS' Meaningful Measures effort begins to address some of these issues by prioritizing core issues that are the most critical to providing high-quality care and improving individual outcomes and reducing duplicity in reporting measures.

How can we develop better outcomes measures that accurately reflect quality, safety, and value without hurting innovation?

As the future of value-based reimbursement is contingent on the ability to improve performance, Congress should prioritize a unified strategy for measuring, capturing and communicating quality in healthcare. As stated above, the current state of clinical quality measurement is extremely burdensome on providers and technology vendors. A study published in *Health Affairs*² in March 2016 showed medical practices in just four specialties spend an estimated \$15.4 billion each year reporting whether they are meeting their quality targets, which on average costs them \$40,069 per physician or 785 manpower hours.

CHIME appreciates the Caucus' recognition that useful quality measures will be imperative to track patient treatments and outcomes. We wholeheartedly agree that outcomes measures must reflect a focus on quality, safety and value. However, we would urge the Caucus to refrain from suggesting the creation of new measures until there has been proper maturity of provider and government measurement capabilities. The process for EHR vendors to update code to allow for the collection of new quality measures should not be underestimated, and proper transition time must be granted before new measures be mandated by CMS. Moreover, time is needed to allow CMS to reorient quality measurement reporting requirements under their Meaningful Measures effort.

Technology and Health IT

What impact does health IT and data interoperability have on successfully running value-based payment models and contracting? What are some ways to improve interoperability and the sharing of data?

Interoperability and the ability to easily and quickly share a patient's complete health record is paramount to current and future efforts to improve health outcomes and reduce healthcare spending. CHIME calls on the Caucus to pursue policies with the intent of increasing the secure exchange of health data, facilitating the compilation of a longitudinal healthcare record, to enable informed decision making for providers and patients alike.

Value-based arrangements hinge on the ability to share patient data. While the issue may be less pronounced if these arrangements take place within a single organization, if multi-organizational agreements are in place or if a provider is using multiple EHR platforms,

² Casalino, Lawrence P., David Gans, Rachel Weber, Meagan Cea, Amber Tuchovsky, Tara F. Bishop, Yesenia Miranda, Brittany A. Frankel, Kristina B. Ziehler, Meghan M. Wong, and Todd B. Evenson. "US Physician Practices Spend More Than \$15.4 Billion Annually To Report Quality Measures." *Health Affairs* 401-406 35.3 (2016). [Http://healthaffairs.org/](http://healthaffairs.org/). Mar. 2016. Web. 16 Mar. 2016.

interoperability challenges can abound. Robust population health initiatives are essential for success in alternative payment models (APMs) and value-based arrangements, therefore a robust technology infrastructure and interoperability are necessities for population health.

Unfortunately, today the patient data most regularly shared between providers, as mandated by the initiative formerly known as the Meaningful Use program, are “consolidated” clinical document architecture (CCDA) attachments. These CCDAs are a way to move patient data but do little to inform patient care. Members report to us that clinicians routinely ignore CCDAs and prefer paper or faxed summaries of care. Moreover, the content of CCDAs remains bulky and is far from a succinct snapshot of the information most clinicians seek. While we acknowledge that sharing any patient data is an advancement, we also point out that these documents are not standardized, not digestible and can be overly exhaustive in detail of a single care encounter. Further, often these documents do not contain the type of information that is helpful for accountable care organizations or other value-based arrangements. The 2015 Certified Electronic Health Record Technology (CEHRT) will begin to address some of these concerns, but we are far from the ability to exchange data when, where and how it is needed across providers. Additionally, we expect the requirements by CMS to use application programming interfaces (APIs) under the 2015 CEHRT -- these capabilities are not widely deployed or used today among most providers and much stands to be learned from their use.

The concept of a longitudinal healthcare record should reflect the patient’s experience across episodes of care, payers, geographic locations and stages of life. It should consist of provider-, payer- and patient-generated data, and be accessible to all members of an individual’s care team, including the patient, in a single location as an invaluable resource in care coordination. As noted above, given the current absence of a national solution for linking patients to their healthcare data across disparate healthcare providers, it will be impossible to accomplish the ideal of a longitudinal healthcare record.

Our members have long-championed the importance of a standards-driven health IT infrastructure. While a focus on standards may seem overly simplistic, a more defined technical infrastructure is needed to catalyze innovations in digital health. We recognize the work is underway to tackle these challenges, nonetheless barriers remain and maintaining the status quo will stifle future progress. The federal government should continue to drive standards identification and adoption. We encourage the engagement of impacted stakeholders across the care continuum should be consulted to ascertain what data needs to be exchanged (and in a standard format) such as long-term post-acute care providers,

We would also emphasize the impact of discrepancies in technology adoption across the care continuum. While the Meaningful Use program incented the adoption of EHR technology by most providers, hospitals and critical access hospitals (CAHs), other care settings were not included. Today long-term care facilities and behavioral health providers often do not have the resources to implement and use EHR technology. For this reason, CHIME supports the House-passed H.R. 3331 to promote testing of incentive payments for behavioral health providers for adoption and use of certified electronic health record technology. This model should be considered for the long-term post-acute care community as well. To have true interoperability, records should be complete and include all care encounters, not just those in clinician offices or hospitals.

What technology is needed to integrate physician networks to be able to effectively manage a population's health?

While the adoption of EHR systems was a necessary step forward in the ability of providers to manage a population's health, it is just one tool. There is a role for health information exchanges (HIEs) and regional health information organizations (RHIOs) to assist in aggregating data for a population.

We would again reiterate the importance of ensuring the full care continuum is digitized. Population health management is difficult when patient records are incomplete if they have received care outside of a clinician office or hospital. Efforts must be made to assist the long-term post-acute care and behavioral health providers to ensure a complete, longitudinal health record is available.

Our members have also cited the benefit of having near real-time access to CMS claims data via a Fast Healthcare Interoperability Resource (FHIR) API. While the FHIR in itself is viewed as the next frontier of healthcare interoperability, our members have suggested to CMS that access to claims data would be a great asset for population health and patient identification purposes.

Additionally, a great deal of innovation is underway to develop population health tools and other new technologies that will be critical for advancing provider success in APMs. CMS and Congress must avoid a heavy-handed approach to determining what technologies providers must use.

What new technology exists to lower costs, improve efficiency, or improve the quality of care that isn't already widely-deployed?

Telehealth

Telehealth technologies offer a multitude of benefits to patients and clinicians. Increasingly our members are leveraging telehealth and remote monitoring services in a variety of ways to meet patient care needs. CHIME and KLAS Research conducted a detailed [study](#) in 2017 of 104 organizations currently administering telehealth programs. Some of the key findings include:

- 59 percent of respondents identified reimbursement as the biggest factor limiting expansion of telehealth services
- 34 percent of respondents noted cost or resources as a factor limiting expansion of telehealth services
- 59 percent of respondents cited improved patient access as a benefit of telehealth
- 35 percent of respondents cited improved clinical outcomes as a benefit of telehealth

All too often, telehealth is viewed solely as a benefit to small and rural hospitals that need to connect to clinicians at larger tertiary facilities. In fact, telehealth brings value to the entire delivery system. For instance, disease monitoring services can be a less expensive, more efficient and more convenient for patients with chronic conditions to stay connected with their care team. Telehealth services can also help minimize the risk of a readmission, or bring video consultations to emergency departments. We are also seeing increased use of telepsychiatric screening.

The committee should also consider how to address cross-state licensure concerns, often imposing troublesome legal barriers to a physician wishing to offer telehealth services to a patient in another state. Policies should allow licensed healthcare providers to offer services to patients, using telemedicine, regardless of what state a patient resides in, notwithstanding whether the patient is within a traditional care setting or in one's home. We applaud the Department of Veterans Affairs for taking on this issue for their patient population, and support the new rule that is now in place, "[Authority of Health Care Providers to Practice Telehealth](#)." We hope that we can learn from this VA initiative and address cross-state care provision concerns for the broader patient population.

Remote Patient Monitoring

Providers and health systems are encouraged by the potential, but are still grappling with the realities of the wide-spread integration of remote patient monitoring devices, such as wearables, into the provision of care. Our members acknowledge the value in collecting additional data, not always real-time, but policies and procedures are still nascent. We would encourage the Caucus to consider the value of wearables and remote monitoring technologies and ensure reimbursement paradigms are in place to support their expanded use.

Blockchain

Our members recognize the emergence of blockchain and the applicability to healthcare. While blockchain holds much promise, it has yet to be fully evaluated and meaningfully implemented across healthcare. Applications of the technology could be to improve the cybersecurity posture of healthcare organizations.

Artificial Intelligence

While some of our more advanced members are integrating artificial intelligence (AI) technology into care delivery today, most are not. Identified by our members as a promising technology, additional evaluation will be necessary. For example, as clinical decision support (CDS) will increasingly rely on machine learning and predictive modeling, more oversight in this arena will be warranted.

Our members recognize the potential for AI to relieve some of the onerous administrative requirements and reporting burdens described at length above.

To offer an overarching recommendation for the Caucus' consideration, as patient health data becomes digital and more fluid, we must ensure the implementation of stringent privacy and security standards. CHIME calls upon the Caucus to address the growing nature of cybersecurity threats to patient data and ensure that security is included in any policy recommendations. As we increase interoperability, additional threats to data integrity will arise. Without proper safeguards, the safe and secure transmission of sensitive data will continue to be a challenge and will hinder efforts to care outcomes.

As the Caucus monitors the implementation and administration of value-based arrangements and alternative payment models, we urge you to ensure providers have access to technology necessary to facilitate their success in new payment models and drive care improvements for patients while ensuring CMS pursues reasonable policies that will reduce provider burden, facilitate greater care coordination, and direct the maximum amount of attention on the care delivered to patients.

CHIME commends the Caucus for its willingness to engage stakeholders and bipartisanship demonstrated by the Caucus' efforts to pursue policies to improve healthcare delivery. We hope our comments are useful and look forward to a continued dialogue with the Caucus regarding legislative solutions for improving healthcare for patients through the use of health information technology. Should you have any questions or if we can be of assistance to the Committee, please contact Leslie Krigstein, Vice President of Congressional Affairs at lkrigstein@chimecentral.org.

Sincerely,

A handwritten signature in blue ink, appearing to read "Cletis Earle". The signature is fluid and cursive, with the first name "Cletis" and last name "Earle" clearly distinguishable.

Cletis Earle, Chair
CHIME Board of Trustees Vice President,
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