March 1, 2019

The Honorable Lamar Alexander
U.S. Senate
Chairman
Committee on Health, Education, Labor and Pensions
438 Dirksen Senate Office Building
Washington, DC 20510

Re: Health Cost Request for Information

Dear Chairman Alexander,

The College of Healthcare Information Management Executives (CHIME) is pleased to respond to your request for information concerning the need to address rising healthcare costs. As senior health information technology leaders, we welcome the opportunity to share our perspectives on how technology impacts healthcare costs and if harnessed correctly, will both improve outcomes and increase efficiency within the healthcare system.

CHIME is a professional organization that represents more than 2,800 Chief Information Officers (CIOs) and other senior healthcare IT leaders. CHIME enables its members and business partners to collaborate, exchange ideas, develop professionally and advocate for the effective use of information management to improve the health and care in the communities they serve. CHIME members are responsible for the selection and implementation of clinical and business systems that are facilitating healthcare transformation through technology. Our members represent some of the earliest and most prolific adopters of electronic health records (EHRs) and other health IT resources for clinicians and patients. Our mission is, "To advance and serve healthcare leaders and the industry improving health and care globally through the utilization of knowledge and technology."

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 myriad of provisions included in the 21st Century Cures Act, such as reducing administrative burdens resulting from health IT, the Trusted Exchange Framework and Common Agreement, the EHR Reporting Program, the Health IT Advisory Committee (HITAC), the definition of what does not constitute information blocking and reports on patient access and patient matching will prove to have significant impacts on the health IT and healthcare delivery ecosystem in the future. Further, the passage of the SUPPORT for Patients and Community Act highlighted the potential for technology to be leveraged to combat the nation's opioid crisis.

Technology adoption and robust data sharing are vital to enhancing the quality of care and efficiency of the nation's healthcare system. The healthcare system has evolved from siloed and paper-based to an interconnected, digital system that provides clinicians with vast quantities of data to make informed decisions. Connected medical devices enable patients to track their conditions or proactively pursue healthier lifestyles. Technologies now allow patients to see clinicians from home or allow clinicians to optimize their time by using telemedicine to monitor patients off-site in real time. Significant advancements in healthcare technology have been made possible through policy, however, often overly stringent and

prescriptive mandates have added to healthcare costs, impeded innovation and increased burdens on clinicians.

Federal Mandates Drive Costs

Despite the infusion of nearly $40 billion for healthcare providers to adopt electronic health records (EHRs), the costs to maintain those systems and ensure they are capable of enabling successful participation in federal programs comes with steep price tags. The 21st Century Cures Act recognized the need to bring transparency, especially around costs, to the EHR purchasing process, but there are many other financial burdens associated with participating in federal reporting programs. As one member put it, "The patient record and supporting infrastructure is only part of a very expensive HIT ecosystem that requires lots of 'care and feeding.'"

Promoting Interoperability Program

The electronic health record (EHR) Incentive Program, initially known as the Meaningful Use program and now the Promoting Interoperability (PI) program, fundamentally altered the trajectory of EHR adoption. However, despite the incentives to spur adoption, countless costs have continued to plague health systems to maintain compliance with the program mandates. The costs associated with new versions of certification, interface fees, quality reporting tools and patient engagement modules have forced health systems to choose between innovation or clinician requests and meeting federal mandates.

The PI program requirements shift frequently, leaving both vendors and health systems in a constant state of development and implementation. Capital budgets are limited and as federal mandates amp up expectations, more and more resources continue to be dedicated to the Centers for Medicare and Medicaid Services (CMS) or the Office of the National Coordinator's (ONC) wishes, rather than those of the patient or clinician. Congress must work with the administration to continue to infuse flexibility into the PI program, so it better aligns with patient and clinician needs.

Quality Measurement

The burden of quality measurement that our members shoulder to meet reporting requirements levied by CMS is significant. 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 clinical quality measures (CQMs) are used among different reporting programs, they tend to require different technical specifications, 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, improving individual outcomes and reducing duplicity in reporting measures.

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. Currently, hospitals and physicians are required to report CQMs to several public and private entities. Many CHIME members submit over 20 reports across federal, state and private sector programs each month; in many cases the measures they report on are very similar to one another yet require duplicative reporting. CHIME urges the committee to support policies that will harmonize quality measure reporting across federal programs to eliminate the duplicative and burdensome reporting of meaningless measures.

HIPAA Compliance Doesn't Equal Good Cybersecurity

Cybersecurity attacks are highly disruptive and can be crippling to healthcare entities, as illustrated by the WannaCry and Petya ransomware attacks in 2017. The attacks impacted more than a dozen hospitals and countless other entities spanning the globe, reaching a reported 150 countries. Healthcare is deemed a critical infrastructure by the Department of Homeland Security (DHS) and as such, patient safety and patient data should be viewed as a public good; protecting those things should be a national priority.

To offer an overarching recommendation for the committee's 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 committee 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.

Specifically, the complexities with meeting HHS privacy and security requirements can be staggering. Audits by the Office for Civil Rights (OCR) are perceived as being punitive and not assisting the organization to recover and learn from a breach. Providers today must dedicate highly valuable resources to navigate a complex and often unbalanced and punitive regulatory landscape. Resources and efforts are often focused on compliance with OCR requirements, which may not always represent the greatest threats faced by a healthcare provider, diminishing rather than aiding their ability to guard protected health information (PHI).

It is vital that Congress and HHS identify a pathway for ensuring providers do not unduly shoulder the burden of protecting PHI in situations outside their control. To further enhance proactive collaboration, safe harbors from Resolution Agreements as an incentive for organizations that demonstrate, and certify, cybersecurity readiness should be offered, which may warrant Congress to amend provisions of the HITECH Act. This will encourage the investment into cybersecurity from the providers in an age when it is understood no organization can prevent all cybersecurity attacks. Further, it may be necessary for Congress to consider revising some of the definitions set forth in HITECH, such as the definition of a breach, as to not presume guilt.

HHS must start by offering providers better guidance for assessing threats that they can control as opposed to those that are out of their domain. Additionally, OCR should acknowledge and recognize provider efforts and investments to safeguard information and information systems when assessing the scope and magnitude of enforcement actions. For instance, the U.S. Department of Health & Human Services (HHS) should be encouraged to pursue policies which reward providers and other covered entities for engaging in good faith efforts to prevent cybersecurity attacks rather than unduly punitive ones. An example of this would be demonstrating sufficient compliance with the National Institute of Standards and Technology's (NIST) Cybersecurity Framework (CSF.). Providers must be able to maximize protections allowed under business associates agreements (BAAs) by redistributing responsibility for security more evenly among covered entities and their business associates (BAs.)

Moving the Nation Closer to Interoperability

The inability to ubiquitously share data across the care continuum is undoubtedly resulting in increased costs and hinders outcomes.

Patient Identification

A high degree of data fluidity is imperative to reducing waste and improving quality within the U.S. healthcare system. CHIME calls on the committee to continue to pursue policies aligned with those in the 21st Century Cures Act with the intent to increase the exchange of health data. This will facilitate the compilation of a longitudinal healthcare record and enable informed decision making for providers and patients alike. 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.

Foundational to coordinated care is the need to accurately match patients with their healthcare data across providers, systems public health agencies 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 aggravate our industry's technical challenges. The 21st Century Cures Act included the directive for a Government Accountability Office (GAO) report on patient matching, released earlier this year. While a national approach to patient matching would be an important step toward true interoperability, without a standard patient identifier, the creation of a complete and accurate longitudinal care record is

simply not feasible. A longitudinal healthcare record, supported by widely adopted standards, also should improve a patient's ability to manage consent privileges and diminish privacy concerns related to the digitization of personal health information.

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 1999[1]. Without a standard patient identification solution, the creation of a longitudinal care record is simply not feasible. We encourage the committee to examine the issue of patient identification to facilitate nationwide interoperability, enhance patient safety and enhance health outcomes.

Harmonizing Privacy and Consent Laws
The exchange of data among providers in various locations and settings will require the harmonization of state and federal privacy laws. As an example, consent policy varies by jurisdiction and personal health information type, and similar to most privacy policy, there is no national consent policy. Consent challenges have been highlighted in efforts to thwart the opioid epidemic through data sharing, specifically the impediment to sharing substance use disorder (SUD) data imposed by the lack of alignment with Health Insurance Portability and Accountability Act (HIPAA) and 42 CFR Part 2. CHIME calls on Congress to lead an open dialogue to help states align privacy and consent policies that enable cross-border exchange of health information in a secure manner, including SUD data. This should include re-examining certain provisions of HIPAA. While the Office for Civil Rights (OCR) has begun a review, Congressional action will be needed.

Interoperability Across the Care Continuum
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 supported the provision included in the SUPPORT Act that promotes 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.

Rethinking of Federal Telehealth Policies
Hospitals and health systems are embracing the use of telehealth technologies because they offer benefits such as the ability to perform high-tech monitoring without requiring patients to leave their homes, which can be less expensive and more convenient for patients. Telehealth services come in many forms, from post-discharge remote monitoring programs resulting in reduced hospital readmissions, to emergency departments using remote video consultations to enable patients to receive a telepsychiatric screening. Yet whether public and private payers cover telehealth services and adequately reimburse hospitals and other healthcare providers for providing those services, is a complex and evolving issue and, as a result, a possible barrier to standardizing the provision of these valuable services.

To better understand how healthcare organizations currently use telehealth solutions and identify barriers to its adoption, CHIME, with KLAS Research, conducted a detailed study in 2017 of 104 organizations currently administering telehealth programs.

The study found healthcare organizations used their virtual care platform vendor in one or more of three primary visit types:

- *Scheduled/patient focused – to increase patient access by allowing patients to schedule and conduct a clinical visit virtually*

[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

- *On-demand/consumer focused, to decrease the costs for patients and providers by dealing with urgent/nonemergency medical needs of patients on-demand*
- *consultations – to improve the clinical outcomes of patients by increasing their access to needed specialists.*

The study raised questions about cost, reimbursement, available technology, value, the patient experience and integration. The majority surveyed said they plan to either expand the number of specialties served or expand patient access to providers using telehealth systems. They listed patient convenience among the top benefits. This is promising for telehealth; whose success ultimately hinges on patients' embrace of this healthcare delivery vehicle. Three-quarters of respondents reported that they were actively planning to either expand the number of specialties served or expand patient access to providers using their present solution.

Some key findings include:

- 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
- 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
- 70 percent of respondents said their telehealth platforms have no integration with their electronic health record (EHR)

Although Medicare has slowly incorporated additional telehealth services into their reimbursement models, including telestroke and teledialysis as included in the Balanced Budget Act of 2018, there are still significant geographic and definitional limitations. Geographical limitations currently restrict coverage of telehealth services. The demand for "parity" in reimbursement for services provided in-person by a physician and those via telemedicine has never been greater. The realignment of federal payment structures is a key factor to increasing access to telehealth services and warrants further Congressional action.

Inconsistencies in the definition and reimbursement policies of telehealth services in federal and state programs are hurdles to widespread adoption. While Medicaid encourages states to use flexibility to create innovative payment methodologies for services that incorporate telemedicine, there are still significant coverage gaps from state to state. Differences in state laws, definitions and regulations create a confusing environment for hospitals and health systems that may care for a patient across state lines.

Further, the committee should 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. CHIME supports policies to 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 his or her home.

National Evidence-based Telehealth Strategy

Moreover, beyond Medicare and Medicaid, many federal agencies either administer telehealth programs, like the Department of Veterans Affairs (VA), or fund telehealth programs, like the Health Resources and Services Administration (HRSA.) The disjointed nature of Medicare and Medicaid telehealth policies are well-known, but it is unclear as to the level of coordination across the federal agencies on telehealth. The nation could benefit from an evidence-based review and national strategy for telehealth. What may work for one patient population could potentially be leveraged by the Centers for Medicare and Medicaid Innovation (CMMI) or should potentially be the subject of a federal grant. To our knowledge, this level of cross-Department and cross-Federal Agency coordination is lacking. Developing an evidence base may assuage some of the concerns about the value of telehealth or potential for over utilization.

Leveraging Technology for Price Transparency

Price transparency as a means to educate consumers and lower costs is a laudable goal but has been a challenge for the industry. True price transparency is a work in progress, and despite being in early stages, there are examples of how health IT can arm clinicians and patients with more information about the costs associated with a procedure or treatment.

Imagine a setting where physicians have at their fingertips not only the cost of a medication, a lab test or of a scan but also the adverse drug reactions, the estimated blood loss and consequent risk of anemia or the patient's cumulative exposure to radiation from imaging tests. Add to this scenario that the information appears unobtrusively with no clicking and on any electronic medical record (EMR) at any point of care.

Fernando Martinez, the chief digital officer at Texas Hospital Association (THA) and the president and CEO of the THA Foundation, was recognized by CHIME with the 2017 CHIME Innovator of the Year Award for an innovative approach to significantly address two major pain points commonly raised by Texas hospital CEOs: management of cost and variability of care. The THA Smart Ribbon is a digital tool to help clinicians make informed decisions based on cost and clinical data. Implementation of the THA Smart Ribbon using 55 providers at the Parkland Health and Hospital System in Dallas resulted in a cost savings of $430,444 over 71 days. The pre-post intervention study also demonstrated the predicted reduction in variation of care.

Many of our members are engaged in innovative programs that, like the THA Smart Ribbon, have the potential to simultaneously lower costs and improve care. We encourage the committee to support policies that incentivize providers to leverage their healthcare IT in this way.

CHIME commends the committee for its willingness to engage stakeholders in an effort to pursue policies to lower healthcare costs and improve healthcare delivery. We hope our comments are useful and look forward to a continued dialogue with the committee 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,

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