



CHIME
College of Healthcare
Information Management Executives

April 1, 2019

The Honorable Mike Thompson
United States House of Representatives
406 Cannon House Office Building
Washington, DC 20515

The Honorable David Schweikert
United States House of Representatives
1526 Longworth House Office Building
Washington, DC 20515

The Honorable Roger Wicker
United States Senator
555 Dirksen Office Building
Washington, DC 20510

The Honorable John Thune
United States Senator
511 Dirksen Senate Office
Washington, DC 20510

The Honorable Mark Warner
United States Senator
703 Hart Senate Office Building
Washington, DC 20510

The Honorable Peter Welch
United States House of Representatives
2187 Rayburn House Office Building
Washington, DC 20515

The Honorable Bill Johnson
United States House of Representatives
2336 Rayburn House Office Building
Washington, DC 20515

The Honorable Brian Schatz
United States Senator
722 Hart Senate Office Building
Washington, DC 20510

The Honorable Benjamin L. Cardin
United States Senator
509 Hart Senate Office Building
Washington, DC 20510

The Honorable Cindy Hyde-Smith
United States Senator
702 Hart Senate Office Building
Washington, DC 20510-2405

Re: CONNECT for Health Act Request for Information

Dear Member of the Congressional Telehealth Caucus:

The College of Healthcare Information Management Executives (CHIME) is pleased to respond to your request for information (RFI) concerning opportunities to leverage telehealth and remote patient monitoring (RPM) services to improve patient outcomes, reduce healthcare costs and expand access to care.

CHIME is a professional organization that represents more than 2,900 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 like telehealth and RPM 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."

Hospitals, health systems and other providers 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.

This can be less expensive and more convenient for patients, as well as improve access to specialists and expand care to patients in remote locations. 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. As a result, reimbursement is often a barrier to standardizing the provision of these valuable services.

Communications Requirements for Telehealth and Remote Patient Monitoring

In discussing the questions posed under the RFI, CHIME members highlighted that although the technology may be available, and interest exists among providers and patients to leverage telehealth and RPM technologies, the communications requirements to effectively use such technologies may render the programs useless.

Access to broadband

Our members highlight that one significant barrier hindering adoption of telehealth and RPM by patients and providers alike is broadband access.

A recent Agency for Health Research & Quality (AHRQ) report¹ states, “Rural primary care facilities may also experience challenges implementing health IT or telehealth solutions due to a lack of broadband access. Broadband availability is incredibly important for both providers and patients to use these innovative systems and platforms. According to the Federal Communications Commission's (FCC's) 2016 Broadband Progress Report, 23 million rural Americans lack access to broadband at benchmark speeds. Moreover, individuals and practices in rural areas who do have access to broadband may end up paying three times more for these services than their urban counterparts.” We agree that all of these areas represent barriers. We also see persisting barriers in rural areas and these areas must not be forgotten either. By some accounts approximately a quarter of those living in cities still don't have broadband access either.”

CHIME supports congressional efforts to address broadband access disparities across the nation and suggests the Caucus consider ways to expand access where broadband may not be possible. In fact, we recommended the FTC double the funding available under their Rural Health Care (RHC) Program from \$400 million annually to \$800 million. Ultimately the agency opted for a 40% increase to \$571 million, the first such increase since the program was created in 1992. This increase will allow greater reach of telehealth in rural and remote areas, yet more help is needed to keep pace with demand.

In considering the best way to reach rural and hard-to-serve communities (which include urban areas), we highlight the promise of 5G. The ultra-low latency and high-speed capability of the 5G networks may not only remove existing access barriers but also unlock the ability for the world's best doctors and specialist to diagnose and treat patients in these areas. Simply, 5G may connect patients with healthcare providers in ways not possible today and redefine every aspect of healthcare. The possibilities include video visits, patient monitoring, remote diagnostics, prescription adherence, connected internet of things (IoT) sensors and more. Thus, CHIME encourages the Caucus to pursue policies to enable the proliferation of 5G.

Data Usage Limitations

While broadband access may be a challenge in rural areas, where our members are leveraging RPM technologies that are internet-enabled, patients on limited data plans may be prohibited from taking advantage of the services. One children's hospital CIO offered the example of a child outfitted with a Cochlear implant, a surgically placed electronic device, which can be transformative for a child's development and future. But it's not a one-and-done event. Because recipients haven't always been able to have the same speech-teaching interactions that hearing children do, life with a new Cochlear implant can involve significant, specialized

¹ “Implementing Medication-Assisted Treatment for Opioid Use Disorder in Rural Primary Care: Environmental Scan Volume 1.” Available at: https://integrationacademy.ahrq.gov/sites/default/files/mat_for_oud_environmental_scan_volume_1_1.pdf

speech therapy requiring weekly visits. One of the key questions when evaluating a child as a Cochlear implant candidate is whether he or she will be able to attend these visits. The innovative use of telespeech to bring speech therapy into patients' homes breaks down barriers to care for patients in remote areas who previously would have been denied access to Cochlear implants, or whose families would have had to make enormous sacrifices to travel for their therapies. However, if these families lack access to the internet for these telehealth visits, they too would be precluded from receiving the implant.

Addressing Reimbursement Challenges

In 2017 CHIME partnered with KLAS Research on a study titled "Telehealth Virtual Care Platforms 2017 An Early Look at the State of Telehealth." The study found, "The greatest limiting factor to the successful growth and expansion of telehealth is reimbursement—more than half of study respondents have concerns about this. Insurance companies, Medicare/Medicaid, and ACOs have been slow to reimburse telehealth visits, with Medicare lagging the most. When providers are reimbursed, it is often for less than the costs incurred; this disincentivizes providers since they can be paid more for in-person visits, and it makes it hard for some health networks to make a business case for telehealth solutions."²

Our members regularly cite their organizations' telehealth and RPM programs as being too limited as they do not align with existing healthcare business models in which payment is predicated on visits. Although Medicare has slowly incorporated additional telehealth services into their reimbursement models, including telestroke and teledialysis as outlined in the CONNECT for Health Act and ultimately 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.

Defining Telehealth Visits

CHIME calls on the Caucus to encourage CMS and payers to redefine what constitutes a telehealth visit. A CIO of a large health system said that her physicians get reimbursed for a telehealth visit if they spend 30 minutes with a patient. However, in leveraging telehealth the doctor often does not need to spend 30 minutes with the patient as they are likely to have their health history and, if combined with remote monitoring, access to additional data points to augment the patient consultation. Telehealth visits should not be constituted by the length of the visit, instead, for the services provided.

Qualifying Professionals for Telehealth Reimbursement

In some care settings, like rehabilitation hospitals or other post-acute providers, other care providers may be as valuable to improving patient outcomes as the physician. Thus, CHIME recommends that the Caucus ensure that the qualifying professional considered for reimbursement for virtual visits must not be limited to physicians alone.

Long-Term and Post-Acute Care (LTPAC) Telehealth and Remote Monitoring Use Cases

Long-term and Post-Acute Care facilities are increasingly seeing patients with more complex healthcare needs. Often rehabilitation hospitals must bring patients to post-surgical appointments by ambulance for routine follow-

² Telehealth Virtual Care Platforms 2017 An Early Look at the State of Telehealth, available at: <https://chimecentral.org/wp-content/uploads/2017/09/Telehealth-Virtual-Care-Platforms-2017-CHIME-Industry-Version-FINAL1.pdf>

up, a very costly and disruptive process. Ideally, telehealth could be leveraged from the LTPAC facility to the clinician with which the patient has an appointment rather than needing to leave the facility.

In a study published by the American Burn Association, the use of telehealth in a rehabilitation hospital was found to not just improve outcomes, but to also save money.

“At the rehabilitation hospital, 146 ambulance transports were averted during the study period, resulting in a cost savings of \$101,110. In addition, assuming a weekly 3-hour visit to the burn center, which includes travel and prep time on both ends, the rehabilitation hospital saved an average of 2 to 3 days per hospital admission secondary to unnecessary travel and improved throughput. Throughout the study period, the rehabilitation hospital estimated an average of three rehab days saved per patient, totaling 87 bed days gained³.”

Telemedicine for Substance Use Disorder Treatment

The Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act of 2018 included several valuable provisions expanding access to telehealth for various patient populations, including a provision to expand telehealth services for treating Opioid Use Disorder. The provision expands Medicare coverage of telehealth services to beneficiaries in their homes and reimburses services at the same rates as in-person visits. CHIME enthusiastically supports Congressional efforts to build on the progress of the SUPPORT Act and develop policies to foster the reimbursement of telehealth services for patients with substance use disorder and behavioral health needs, especially in the home.

Health Conditions and Populations Demonstrating High Return on Investment (ROI) for Telehealth Usage

KLAS Research conducted a study titled, “Remote Patient Monitoring 2018 High Potential in a Shifting Landscape”⁴ that found that many provider organizations start with one or two specific patient conditions and then expand their monitoring to others over time as they became more comfortable and confident in their vendor’s solutions and in their own capabilities. Among the 25 organizations that participated in the study, heart disease and chronic obstructive pulmonary disease (COPD) were the most common conditions treated under programs, followed in frequency by diabetes and hypertension.

Heart Failure

One CIO detailed how his institution is self-paying for the technology and staff time to monitor patients with heart failure. His organization has experienced significant cost reduction and outcomes improvement since the enactment of the telehealth offering.

Gastroenterology

Conditions such as inflammatory bowel disease (IBD) or Crohn’s Disease may warrant regular follow-up. These visits are generally more conversational in nature rather than exam-based, thus conducive with even some of the most basic telehealth technology offerings.

Other Conditions for Consideration

High acuity obstetrics, Parkinson’s disease and Amyotrophic lateral sclerosis (ALS) were also cited by our members as other telehealth programs worth consideration by the Caucus. Transportation for these patients as their diseases progress becomes incredibly difficult and it is unrelated to whether they are in an urban or rural area. They still need care and transportation is an issue. This patient population requires regular medical care,

³ “Urban Telemedicine: The Applicability of Teleburns in the Rehabilitative Phase,” by Yuk Ming Liu, MD, MPH, Katie Mathews, BA, Andrew Vardanian, MD, Taylan Bozkurt, MBA,* Jeffrey C. Schneider, MD, Jaye Hefner, MD,† John T. Schulz, MD, PhD, Shawn P. Fagan, MD, and Jeremy Goverman, MD, 2017, Journal of Burn Care & Research, Copyright © 2016 by the American Burn Association.

⁴ Remote Patient Monitoring 2018 High Potential in a Shifting Landscape, available at: <https://klasresearch.com/report/remote-patient-monitoring-2018/1273>

including costly urgent care and emergency care as their condition worsens. Opportunities exist to augment in-person visits for this patient population with video telemedicine visits. Our members view the clinical needs, patient population and challenges to accessing care for Parkinson's and ALS similar to the End-stage Renal Disease (ESRD) care, which CMS recently improved reimbursement by including urban areas and the patient's home as an approved originating site. One member noted, "While access to quality data regarding telemedicine with these patient populations is limited, I see reimbursement as the main limiting factor as to why providers have not adopted telemedicine more in caring for these populations. The exception to this is the Department of Veterans Affairs, who does remote patient monitoring and video visits into the home for ALS patients."

Licensure Challenges Persist

Further, the Caucus 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.

One member gave the example of a patient being monitored for IBD and is traveling, while a virtual visit may be appropriate, the provider licensing restrictions will hinder that encounter from happening. Instead the patient will likely seek more expensive care at an urgent care facility and be subject to unnecessary additional imaging and diagnostics.

A National Approach is Necessary for Telehealth

National Evidence-based Telehealth Strategy

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 the level of coordination across the federal agencies on telehealth is unknown. 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 address some of the concerns about the value of telehealth or potential for over utilization.

National Telehealth Coordinator

Our members cited the need not just for a coordinated national strategy, but the need for a federal voice of authority on telehealth and RPM. Just as we need to build the evidence base by establishing a central repository of telehealth data, our members raise the importance of considering how the safety, security and efficacy of some telehealth and remote patient monitoring tools are evaluated.

Our members see value in improving the transparency of how telehealth and RPM platforms are evaluated, as not all must go through the Food and Drug Administration approval pathway, nor are they certified like EHRs are by the Office of the National Coordinator for Health Information Technology (ONC.) While we recognize the importance of enabling innovation in this rapidly progressing arena, we must highlight concerns about the ability for healthcare providers to have confidence in the data generated, needing to understand how the data being transmitted via RPM is created as to ensure the correct calibration of the device, as well as, how these platforms interoperate with other systems like EHRs

Another necessary function of a coordinating body for telehealth would be the establishment of additional grant programs or demonstration projects. Our members implore the Caucus and CMS to consider some of the previously mentioned disease states and ensure that funding opportunities, even in limited fashions, are made available to organizations to pilot different programs. The data collected during such pilots should be collected and shared with the community to leverage best practices or avoid mistakes. Further, if demonstration projects,

such as those that could potentially be funded through CMMI, prove to have significant outcomes improvement or cost savings, they should be considered under CMS' broader reimbursement schemes.

Adoption of Telehealth Standards

Just as providers have struggled with interoperability between EHRs, those organizations that have begun to adopt telehealth technologies describe challenges affiliated with the interoperability between telehealth platforms and EHRs. CHIME partnered with KLAS Research on a 2017 study titled, "Telehealth Virtual Care Platforms 2017 An Early Look at the State of Telehealth." Of the nearly 100 study participations, 70 percent of participants cited no integration with the electronic health record while only 10 percent cited bidirectional information exchange with their EHR platform.⁵

One of our members in the LTPAC community described a pilot they had for remote monitoring with a technology vendor. The program was gathering data from medical devices onto a patient's phone, but the data did not integrate with the EHR. Our member cancelled the program because gathering data that cannot be leveraged by clinicians in the EHR defeated the purpose.

As more data is flowing between telehealth and remote patient monitoring (RPM) programs it will be important for policymakers to account for the need to ensure the data generated and shared between the provider, devices and patients must be secure and private. As industry standards are identified, security must also be considered.

Ensuring All American Have Access to Telehealth and RPM Technology

Our members began our discussion by describing the importance of the communications networks needed to facilitate a telehealth encounter or an RPM program, but we must also stress that particularly for RPM programs, patients need access to smart devices. We encourage the Caucus to explore ways to ensure that lesser-resourced Americans that may not have a personal smart phone or tablet still have access to these important and innovative care offerings. Whether it is being able to leverage the funds in a flexible spending account (FSA) or ensuring that the Stark and Anti-kickback laws do not interfere with providers offering technology to patients, our members stressed that a patient's financial means should not prohibit them from participating in telehealth or RPM programs.

CHIME commends the Caucus for its willingness to engage stakeholders to pursue policies to leverage telehealth to lower healthcare costs and 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 telehealth and remote patient monitoring technologies. Should you have any questions or if we can be of assistance to the Caucus, please contact Leslie Krigstein, Vice President of Congressional Affairs, at lkriegstein@chimecentral.org.

Sincerely,



Russell P. Branzell, CHCIO, LCHIME
President and CEO
CHIME

⁵ Telehealth Virtual Care Platforms 2017 An Early Look at the State of Telehealth, available at: <https://chimecentral.org/wp-content/uploads/2017/09/Telehealth-Virtual-Care-Platforms-2017-CHIME-Industry-Version-FINAL1.pdf>