June 22, 2015

Senator Orrin Hatch
Chairman
Senate Committee on Health, Education,
Labor & Pensions
428 Dirksen Senate Office Building
Washington, DC 20510

Senator Ron Wyden
Ranking Member
Senate Committee on Health, Education,
Labor & Pensions
428 Dirksen Senate Office Building
Washington, DC 20510

Senator Johnny Isakson
131 Russell Senate Office Building
Washington, DC 20510

Senator Mark Warner
475 Russell Senate Office Building
Washington, DC 20510

Dear Senators:

Thank you for the opportunity to provide recommendations to improve care for people with chronic conditions. The Health IT Now Coalition (HITN) is a diverse coalition of health care providers, patient advocates, consumers, employers, and payers who support the adoption and use of health IT to improve health care and to lower costs.

Overall, HITN believes that health information technology (health IT) is integral in coordinating care, reducing costs, and improving health outcomes – especially for those with chronic conditions. However, we believe that current policies need to be reformed in order to realize the promise of health IT. To this end, we urge your consideration of policy changes that incent the use of interoperable health IT, and the expanded use of telehealth in Medicare.

Our specific comments, which may not reflect the views of individual members, are outlined below.

Telehealth

Study after study has demonstrated the benefits in use of applied telehealth, remote monitoring, and other health IT. These studies show reductions in hospitalizations, ER visits, length of stay, office visits, and related reductions in costs from modest investments in technology to provide care via current technology.[1] These studies add to the long list of evidence supporting one of

[1] References to a few studies:

Case Study: Collaborative Cardiac Care Service – Collaborative Teams Improve Cardiac Care with Health Information Technology, Kaiser Permanente, available at http://xnet.kp.org/future/ahrstudy/032709cardiac.html. The study found CCCS participants were an average $60 less per day than the other group, or about $21,900 less per patient annually (Merrill, *Healthcare IT News*, 10/25).

HITN's core beliefs – that the use of telehealth can lower costs and improve outcomes by providing the right care at the right time.

Recognizing the potential, the VA and DoD have moved to lower cost sharing and dramatically expand the use of telehealth to not only meet the needs of returning troops and veterans, but to also to lower costs. In the private sector, at the VA and DOD, new technologies are being integrated directly into the acute medical benefit. For example, Aetna and Anthem are two insurers who will cover telehealth as a paid medical benefit for their employer populations within the next two years.

Despite these facts, in 2014 Medicare reimbursed $14 million for telehealth services out of a total of approximately $615 billion, or 0.0023 percent of total spending. This reflects the low priority placed on telehealth by Congress and in updating the Medicare law to ensure seniors and the disabled have access to new ways of delivering care to those with and without chronic illnesses.

1. Licensure Barriers

In order for telehealth to be useful for people with chronic conditions, Congress must address physician licensure barriers. Currently, physicians must be licensed in the state where their patient is located. Many patients with chronic conditions require specialty care, and often specialists are few and far between. It is concerning that our current system requires patients to travel substantial distances when telehealth technologies can provide safe and effective care in patients' homes or at their local clinic.

In order to allow for effective coordinated care, Medicare physicians who see patients across state lines using telehealth should not be required to also obtain additional state licenses to provide care to participating beneficiaries. This would follow the model Congress authorized for DoD and VA providers who contract with the federal program to provide services to federal beneficiaries. To promote access to care and efficiency, Congress approved a singular license structure in the DoD. We support a similar structure for the federal Medicare program as it is similar to the DoD in that CMS contracts with providers to deliver federal benefits to beneficiaries. Reducing licensure barriers in Medicare would reduce costs for taxpayers and facilitate access and lower costs for beneficiaries.

- Electronic Medical Records and the Efficiency of Hospital Emergency Departments**,** *Med Care Res Rev,* February 2011, 68: 75-95,first published on June 16, 2010
- A study conducted by Kaiser Permanente's Institute for Health Research of more than 788,000 patient visits in eight primary care clinics of Kaiser Permanente's health care system in Colorado found that real-time physician alerts reduced unnecessary use of a blood test used to help diagnosis blood clots in elderly patients.http://www.healthdatamanagement.com/news/study-blood-clots-tests-alerts-kaiser-41304-1.html
- Trappenburg et al. (2008), looked at remote monitoring for lung disease and found hospitalizations were reduced by 41 percent versus control.
- Finkelstein et al, (2006) found use of physiological monitoring and video visits reduced hospitalizations and nursing home admissions by 58 percent compared to control for patients with heart, lung, diabetes and chronic wounds.

2. Take Congress Out of the Coverage Process

Under current law, preventive benefits are added to Medicare as clinical evidence demonstrates their value to beneficiaries as determined by the National Preventive Services Task Force. Congress put in place the Task Force to help ensure that as medicine and science developed, Medicare would cover preventive services and evolve as science evolved. This helps ensure that Medicare's coverage policies are driven by clinical benefit, and not Congressional politics.

HITN recommends Congress create a Telehealth Task Force modeled on the current Preventive Services Task Force. It would be an independent volunteer panel of national experts who would seek to improve the health of all Americans by making evidence-based recommendations about current and emerging telehealth technologies that expand care beyond the traditional brick and mortar settings to improve access to care, reduce costs, and improve outcomes. Task Force members would be from the fields of research and primary care, including: internal medicine; family medicine; pediatrics; mental health; obstetrics and gynecology; physical, speech-language, and occupational therapy; neurology; surgery; and nursing, and who have extensive experience in leveraging technology to improve lives. Congress should require the Task Force to first look at allowing beneficial telehealth services offered by diabetes educators and physical, occupational, and speech-language therapists.

The Task Force would issue coverage recommendations to HHS based on a rigorous review of existing peer-reviewed evidence and actuarial studies on cost savings, for health technologies that can be used to interact beyond traditional settings, better meet patients' needs, and lower healthcare costs. In formulating recommendations, the Task Force should be required to consult private sector insurers and employers, who are already offering extensive telehealth benefits. The recommendations would be assigned a letter grade (an A, B, C, or D grade or an I statement) based on the strength of the evidence and the balance of benefits and harms of health technologies. In developing the recommendations, the Task Force could not include a recommendation to cover an item or service if it did not reduce Medicare spending. An A grade would be assigned to those services and technologies that had overwhelming cost saving and clinical improvement evidence. Grades of B would be assigned to those services or technologies that either lowered costs or improved outcomes, but not both. HHS would be required to issue national coverage determinations for any recommendation with an A. HHS could issue a national coverage determination for items and services with a B. HHS could not cover items with a grade less than a B.

In making determinations regarding the coverage of a new service, the Secretary may conduct an assessment of the relation between predicted outcomes and the expenditures for such service and may take into account the results of such assessment in making such determination.

We believe such a process will help ensure that Medicare can keep up with coverage innovations in the private sector.

3. *Improvements to Medicare Advantage for patients living with multiple chronic conditions*

CMS does not allow Medicare Advantage plans to offer telehealth as a "basic benefit." CMS has stated Medicare Advantage plans are subject to the same statutory restrictions as traditional Medicare as they offer Part A and B services. HITN calls on Congress to revise bidding structure for plans by deeming Medicare coverage for telehealth applying to all beneficiaries, without geographic restriction, as a standard benefit.

As previously stated, studies continue to show the benefit of telehealth for treating chronic conditions. A study published in September 2014 found that for three chronic conditions – congestive health failure, stroke, and chronic obstructive pulmonary disease – there were reductions in use of service, including hospital admissions/readmissions, length of hospital stay, and emergency department visits.[2] The study also finds that it is important to allow for flexibility in telehealth benefit offerings. For example, while long-term telemonitoring for disease management may work best for congestive heart failure, other telehealth interventions may work best for other diseases.

Given the flexibility in benefit design that Medicare Advantage plans are allowed under current law, we believe that Congress should make this a more integral aspect of annual Medicare Advantage call letters.

Meaningful Use Program and Interoperability

1. *Reforms to Medicare's current fee-for-service program that incentivize providers to coordinate care for patients living with chronic conditions*

HITN believes Congress must make reforms to Medicare's Meaningful Use program to allow for interoperability of electronic health records (EHRs), thus allowing for care coordination. We are very concerned the HITECH Act is not achieving the goals set out by Congress, namely increased efficiency, improved health outcomes and better access to electronic information. We believe this is largely because the program has failed to facilitate interoperation across systems and providers. We are likewise concerned that Meaningful Use is becoming more and more of a burden on health care providers with little improvement in patient care quality or health and where the costs of the program may outweigh the program's benefits. There are several reasons for this, including: a process that produces poor results; misaligned time frames; poorly defined priorities; and a lack of focus on achievable short-, mid- and long-term outcomes.

This is unfortunate, because we believe the Meaningful Use program is necessary – even foundational – in efforts to coordinate care for those with chronic conditions. Patients with chronic conditions often see many providers who, for a number of reasons, do not have access to the entirety of their patients' health information. This not only leads to waste in the system, it also can produce adverse health outcomes. We believe it is important to ensure that every health

[2] Bashshur, PhD, R. (2014). The Empirical Foundations of Telemedicine Interventions for Chronic Disease Management. Telemedicine and E-Health, 20(9), 769-800. doi:10.1089/tmj.2014.9981

care provider has access to longitudinal data on their patients to make evidence-based decisions, coordinate care, and improve health outcomes. However, current lack of interoperability greatly hinders care coordination.

We encourage you to consider the following policies to allow for widespread interoperability:

- Fix the process. Empower the private sector to develop and propose interoperability standards by reforming the current standards process.

- Enable Private-Sector Architecture and Standards. Require the Administration to adopt mature interoperability standards developed by the private sector for certified health IT systems, require vendors to publish their open application program interfaces, and prioritize information sharing among clinicians and consumers.

- Enforce Program Rules. Authorize new enforcement tools so that providers know the products they buy will work as advertised, including the ability to de-certify poorly performing products and exclude from Medicare and Medicaid programs vendors and providers who engage in information blocking behavior.

Currently, providers are forced to use EHR products that do not work for them or their patients, or they face a penalty. There are no incentives for vendors to create interoperable EHRs and it is burdensome and costly for providers to share patient health information. If Congress passes legislation addressing the points above, HITN believes that providers will be able and more willing to share patient health information and better coordinate care.

Patient Engagement Tools

1. *Options for empowering Medicare patients to play a greater role in managing their health and meaningfully engaging with their health care providers*

In order to incentivize patients to play a greater role in managing their health and meaningfully engaging with their health care providers, HITN strongly supports the inclusion of patient-generated health data in EHRs. There should be a distinction between patient-generated and device-generated data and providers should have the ability to review data sources as part of the record similar to a track change function. Providers often do not include patient-generated health data in records because they are not able to authenticate the accuracy or authenticity of the data.

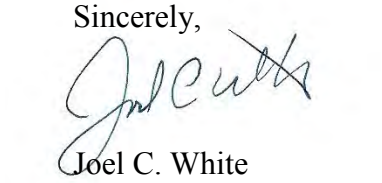
HITN also supports the use of APIs to allow patients access to their health information. For many years, CMS has relied on patient portals in order to allow patients access to their health information. HITN believes APIs are preferable to patient portals because they allow patients to aggregate data from multiple providers and have all health data in one easily accessible place. Vendors should be required, through the Meaningful Use program, to provide secure APIs as a part of their EHR. Again, CMS has proposed the use of APIs in Stage 3, which HITN supports; however, it is essential that Congress clarifies that APIs must be open and published. If APIs are not open and published, they will not be beneficial to patients in managing their health or

engaging with providers because third party developers will not be able to build platforms to accommodate aggregation.

Conclusion

We appreciate the opportunity to share our thoughts on policy options that will allow for better chronic care coordination. We look forward to continuing to work with you on this important subject.

Sincerely,



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