March 6, 2022

Honorable Mariannette J. Miller-Meeks, MD
Member of Congress
Longworth HOB, Room 1716
Washington, DC 20515-1502

Honorable Morgan Griffith
Member of Congress
Rayburn HOB, Room 2202
Washington, DC 20515-4609

Honorable Mike Kelly
Member of Congress
Longworth HOB, Room 1707
Washington, DC 20515-3816

Re: Request for Information Concerning Digital Modernization Efforts in the United States Healthcare System, Including Wearable Devices and Telemedicine

Dear Representative Miller-Meeks, Kelly, and Griffith,

On behalf of OCHIN, I appreciate the opportunity to offer comment on the Modernization Subcommittee’s Request for Information relating to health care modernization and technology. OCHIN is a national nonprofit health information technology and research network of locally-controlled members which includes nearly 1,000 community health care sites with 21,000 providers in 45 states, reaching more than 6.5 million patients. The use of health technology, including telemedicine and remote patient monitoring using wearable technologies, have expanded rapidly in recent years, a trend dramatically accelerated by the federal and state flexibilities and waivers put in place to increase capacity and access due to the COVID-19 public health emergency. As technology continues to develop and evolve, it has become imbedded in health care. While these innovations provide benefits to patients, providers, and the overall health care delivery system, it is vitally important that rural and other underserved communities are not left behind.
For over two decades, OCHIN has advanced health care solutions and improved health outcomes by leveraging the strength of our network’s unique digital data set and the practical experience of our members to drive technology innovation for patients and providers. In addition to federally qualified health centers (FQHCs) and other community clinics, including those in rural areas, we support local public health agencies, Critical Access Hospitals, Tribal community providers, certified community behavioral health clinics (CCBHC), complex specialty mental health organizations, and school-based health programs.

OCHIN is in a unique position to offer recommendations to address health care technology modernization and its integration in rural and other underserved communities. Highlighted below are OCHIN’s priority recommendations for driving digital modernization in healthcare and a more detailed response is included in the appendix:

1. **Extend permanent coverage and reimbursement parity of Medicare and Medicaid telehealth (including audio-only) services without onerous requirements, such as mandated in-person encounters before or after virtual visits.** Prior to the COVID-19 public health emergency (PHE), the complex patchwork of federal and state laws governing payment for virtual services were further complicated by the varied policies of commercial health insurers. The lack of adequate telehealth coverage and payment were insurmountable, particularly for providers such as federally qualified health clinics (FQHCs) and rural health clinics (RHCs) that serve a large percentage of individuals covered by Medicaid or who are uninsured and underinsured. The COVID-19 telehealth flexibilities and coverage expansions for telehealth, as well as other modalities such as store-and-forward, demonstrate the value and need for virtual care in order to meet patients where they are and in lower cost sites of care. This is particularly important for FQHCs and RHCs serving patients who face persistent structural barriers that hinder access to in-person health care. Medicare and Medicaid policies that permanently extend telehealth and other virtual service flexibilities to providers in underserved areas will reduce utilization in higher-cost care sites (such as emergency departments), while minimizing care delays that can lead to more acute or emergent events. **In addition, we strongly urge the removal of geographic and originating site restrictions under section 1834(m) of Social Security Act as well as extremely onerous service area site restrictions that apply to FQHCS and RHCs.** Finally, it is essential that the current flexibilities for clinicians who can bill for services should remain in place as FQHCs and RHCs do not have the same staffing arrangements as providers with large numbers of commercially insured patients.

2. **Invest in community-based networks with established track records in underserved communities to deliver virtual specialty care services.** There is a pressing need to fund a telehealth specialty network for patients and community-based clinics in rural and other underserved communities for FQHCs and RHCs. Primary care providers and their patients require streamlined access into a specialty care leveraging telehealth, where appropriate. In underserved areas, it is critical that a primary care provider or other clinician (such as a social worker) be able to consult with a specialist. For example, clinicians need to consult or
refer a patient to ensure patients are able to obtain or make changes to a prescription from a psychiatrist. Further, achieving whole patient care and moving to value-based models of health care delivery in the safety net is simply not possible given persistent and growing specialty shortages with expanding availability through a virtual specialty network.

3. **Clarify that already authorized and appropriated COVID-19 rescue and infrastructure funds should include health information technology modernization and should be targeted to community clinics, critical access hospitals, behavioral and mental health providers, and local public health agencies.** Connecting communities through digital innovation does not stop with mid- and last-mile broadband connectivity but must include modernizing the health information technology systems of providers in rural and other underserved communities as well as among providers that were not included in previous efforts to drive electronic health record system adoption such as behavioral and mental health providers. We cannot deliver telehealth and other virtual modalities integrated into clinician workflow and existing health IT systems, without modern systems with resources to update regularly and maintain cybersecurity capabilities. Further, modern health IT systems (including electronic health records) are essential in order to transform payment and delivery models, realize the benefits of artificial intelligence systems for a wide range of functions and applications from operations, population health management, clinical services, research, to public health readiness.

4. **Ensure community-based clinics and other providers’ have targeted funding for health IT workforce development and training to expand the pipeline of community clinic, local public health agency, and critical access hospital operational and support staff.** The rate limiting factor for digital adoption and technology transformation is not innovation, but the capacity of the workforce to adopt and optimize the use of new technology. At the foundational level, accurate digital data collection and use requires trained staff. Yet, local communities are facing significant challenges in recruiting and retaining operational and support staff with these essential skill sets. Investments in workforce pipelines and upskilling in health information technology will enhance clinical care, public health, research, and set the stage for further innovation (given the essential role that digital data collection, use, and exchange play in this area).

5. **Prioritize data and technical standards development and testing as well as technical assistance to support widespread adoption of national digital health digital standards and use of health information technology for community clinics, critical access hospitals, and providers other underserved communities.** OCHIN urges continued support for health centered controlled networks (HCCNs) that have played a key role in supporting health information technology adoption among providers in the safety-net. Technical assistance will support improved health outcomes, scale 21st Century public health, enhance health care delivery, and expand population health capabilities. It will also improve data quality, research, and policy insights as well as innovations leveraging AI systems.
6. Provide resources to community-based providers in underserved communities to account for the growing volume and varied quality of the data generated through consumer wearables (as distinct from clinician prescribed remote patient monitoring and management digital tools and devices). The tidal wave of data that clinicians and their care team are confronted with grows daily. Clinicians in underserved communities are already confronting high burn-out rates in part due to the growing data documentation requirements of federal and state programs in addition to commercial payers. Further, integrating the data into workflows is hampered by lack of data standardization and interoperability, and questionable validity and reliability of the devices of consumer wearables, particularly when not regulated devices by the Food and Drug Administration. There are key concerns and issues that have yet, as a result, to be addressed including liability, data stewardship, the extent to which the information should be included in the medical record.

Health information technology innovations promises to drive improved outcomes and experiences of care for patients and providers. The continuous integration of health technology into every aspect of care enables superior treatment, interoperability and documentation, and patient outcomes. These technological innovations are not without their hurdles; conflicting rules and regulations surrounding telehealth, other virtual modalities, as well as data standards and security, antiquated payment models, and unnecessary carve-outs of specific health data all work to stymy innovation and technological development. OCHIN is ready and willing to be of assistance in working to alleviate these barriers. Please contact me at stollj@ochin.org to discuss how OCHIN can help inform health technology policy and your efforts moving forward.

Sincerely,

Jennifer Stoll
Executive Vice President
External Affairs
APPENDIX

Permanently Extend Telehealth and Other Virtual Modalities COVID-19 PHE Flexibilities. Rolling back current federal health care program coverage and payment parity for telehealth — including audio-only telehealth, particularly for FQHCs and RHCs — would dismantle a lifeline to essential and medically necessary health care services for patients in rural and other underserved communities. From the outset of the COVID-19 public health emergency, OCHIN has been actively working with our members to reconfigure the care delivery system to ensure continued access by rapidly scaling telehealth capabilities.

To illustrate: Among members utilizing OCHIN Epic, 99% of their behavioral health and mental health encounters were conducted via telehealth at the outset of the COVID-19 public health emergency in April 2020. While in-person visits have since returned to levels more consistent with pre-pandemic figures, telemental health encounters have increased overall during this time. Prior to COVID-29, telemental health encounters accounted for .003% of all behavioral health encounters in September of 2019 but accounted for 44% in September of 2021. This underscores the ongoing need to ensure that telehealth remains readily available, particularly in underserved communities. Making sure this modality is an option for patients reduces no-shows, increases the opportunity for provider connection, and improves patient satisfaction. Telehealth expansion does not occur in a vacuum, however, and requires several overlapping solutions.

Policies that limit coverage and reimbursement parity while rescinding FQHC and RHC coverage for telehealth (including audio-only telehealth) would negatively impact patient outcomes and overall costs, creating a structural disadvantage for FQHCs and RHCs and the patients they serve. OCHIN’s analysis of 2020 data underscores how telehealth (including audio-only) dismantles the structural inequality that is a feature of in-person only services. It’s especially important to note that telehealth in general, and audio-only in particular, are often the only options available for patients displaced by environmental and natural disasters. These patients often need to connect with their established providers to maintain continuity of care. This is particularly true for medically complex patients who, for example, may need medication replacement or ongoing active therapeutic management.

As telehealth is a modality (and not a service) distinct from what is billed when delivered in-person, deciding whether to use this modality for service delivery is a clinical practice determination. Accordingly, regulating medical practice through coverage policy by limiting access based upon originating or distant site of service — or whether the encounter was preceded by an in-person encounter — does not reflect clinical best practice. Clinicians and patients must evaluate a range of patient-centered and clinical factors when determining the appropriate modality. A significant evidence base existed prior to the COVID-19 PHE, which included clinical practice guidelines based upon specialty and service type.¹ The COVID-19 PHE

has expanded the data-driven evidence base around appropriate clinical use. As a result, numerous provider and clinician organizations have leveraged lessons learned to develop best practices for implementation, scaling, and continual quality improvement. For example, the California Telehealth Resource Center (CTRC) is distributing *A Healthy Balance: Hybrid Virtual Care Models for Optimal Patient Experience*. This document reflects continuous learning and best practices for deployment in primary care clinical settings that drive improved access and patient outcomes. Prior to the COVID-19 PHE, the American Medical Association (AMA) developed guidance for telehealth deployment in clinical practice and launched the Telehealth Initiative to improve access to quality health care. The number of clinical practice guidelines that inform clinician use of telehealth (including audio-only services) also continues to grow in primary care, plus areas such as behavioral and mental health. Community clinics continue to report that coverage and payment for this modality are needed to overcome structural inequalities, thereby providing access to patients facing the most significant barriers to care.

An increase in telemental health service utilization coincides with a well-documented mental and behavioral health crisis that is also a public health emergency. Utilization therefore reflects an increased medical necessity, as opposed to inappropriate use. Additionally, telemental services have an established evidence base to support their use. For all telehealth modalities, clinicians must typically review the patient’s medical history, conduct an exam, assess the patient, and determine testing and treatment needs. Reporting and documentation requirements are similarly consistent. The clinician remains responsible for care coordination and appointment follow-up. This may involve support staff services, particularly when utilizing telehealth. Thus, the cost of care is comparable.

To facilitate transition to new payment and delivery models, FQHCs and RHCs need a pathway to expand telehealth as part of an integrated continuum of care. This modality represents a proven means to address key social determinants of health, such as lack of transportation and homelessness, that negatively impact access and outcomes. Community clinics need time to fully integrate learnings and experience with this modality, and rescinding coverage places FQHCs and RHCs at a disadvantage. Limiting access to telehealth over time will drive higher

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costs when patients who are clinically and socially complex are not able to access care early before conditions become chronic, acute, or emergent. Establishing telehealth payment parity and audio-only coverage for all Medicare and Medicaid beneficiaries is necessary to drive delivery modernization, thereby paving the way for improved patient health and further practice transformation.

**Remove In-Person Coverage Requirement.** While we supported congressional action to make post-pandemic access to telemental health services permanent -- regardless of a patient’s geographic or physical location -- OCHIN, like most stakeholders, was concerned that the Consolidated Appropriations Act seemed to impose an in-person evaluation prior to certain telemental services once the PHE expires. We urge Congress to remove this requirement altogether. It offers no clinical benefit and, based upon OCHIN data, there is compelling evidence that patients in underserved communities utilize telehealth to sustain mental health service access. In addition, given the clinical evidence and utilization patterns among underserved patients, OCHIN does not support the initial requirement of an in-person visit within six months of the telemental visit. Likewise, we do not support requiring an in-person visit every six months thereafter. This will create substantial barriers to care for the most underserved patients.

**Expand Covered Clinicians Due to Persistent Shortages.** When a different practitioner in the same practice may need to offer services to an eligible telehealth individual, the patient should not be penalized due to a clinician’s lack of availability. We urge Congress to ensure that CMS clarifies that patients may see any clinician who is part of the same practice in federal health care programs. Again, patients in underserved communities and their providers have access to limited resources and are disparately impacted by clinician shortages.

**Audio-Only Coverage Essential to Dismantle Structural Barriers.** OCHIN strongly supports coverage and reimbursement parity for audio-only services, which are particularly vital for patients in rural and underserved communities who lack access to affordable, high-quality broadband and often experience other barriers to accessing in-person care or telehealth via video conferencing platforms.

In the analysis of California member patient telehealth utilization, OCHIN found that roughly 26% of patients served used audio-only telehealth in 2020. Among these patients:

- Patients experiencing housing insecurity were 10% more likely to have an audio-only visit compared to those without housing insecurity.
- Patients with transportation needs were almost three times as likely to have an audio-only visit compared to those without transportation needs.

This underscores that parity for audio-only telehealth encounters is crucial to advancing access.

Clinicians must review the patient’s medical history, conduct an exam, assess the patient, and determine testing and treatment needs for all telehealth modalities. Reporting and documentation requirements are similarly consistent. The clinician remains responsible for care
coordination and appointment follow-up. This may involve support staff services, particularly when utilizing telehealth. Thus, the cost of care is comparable. Implementing differential reimbursement will negatively impact those providers and their patients who rely on audio-only services to sustain access.

**Licensure and Underserved Communities and Providers.** For community clinics, including in rural communities and other providers of underserved patients, we urge Congress to support targeting resources as well as policies to streamline the time, cost, and complexity of state-based licensure while driving states to participate in interstate compacts and modernization efforts. The burden of state-based licensure falls heaviest on patients and community-based providers in rural areas and other underserved communities. They have limited resources, and the geographic distance and lack of transportation coupled with long-standing and growing provider shortages, means that licensure restrictions exact an administrative cost that diverts from patient care or forecloses access to care altogether. States and licensing boards need to leverage technology and upgrade systems to incorporate user-centered design. This should be accelerated through state compacts and reciprocity arrangements.

**Modernization and Workforce.** We urge Congress to target funding for health information technology workforce development and training programs to rebuild community clinic staff (operations and support staff) who are essential and need upskilling as we modernize health care delivery for telehealth, remote patient monitoring, advance population health analytics to support population health and new payment models as well as implement even more complex regulatory requirements (such as the No Surprises Act good faith estimate).

Local health centers remain the frontline, and in some instances the only line of defense, as three public health emergencies have converged—COVID-19 along with the opioid epidemic and the mental health crisis. The community clinic operational and support staff workforce has been devastated. Community clinics are struggling to maintain capacity and cannot scale to meet growing demand - an alarming trend, since health centers play a critical role in reducing burden on local emergency departments, particularly in rural and underserved communities. Well-trained operational and support staff are able to assume a broader range of administrative functions within clinics in order to reduce the burden on clinicians (which should alleviate some of the strain and burnout experienced by clinicians). The need for technology-trained support and operational staff will only grow with the adoption and implementation of modernized health information technology, which is urgently needed to modernize clinical care delivery and improve public health capabilities at scale.

**National Digital Data and Technical Standards and Framework.** We urge Congress to require the use of national digital data and technical standards for digital data collection, exchange, and reporting and to include funds for technical assistance, and incentives that drive adoption.

A widely adopted national digital health data framework that drives harmonization and standardization of medical and public health data and technical standard is needed. This will
reduce the cost, complexity, errors, and burden of data capture, analysis, and reporting. The consequences of proliferating data and technical standards fall the heaviest on providers and public health agencies in rural and other underserved communities—which undermines our ability as nation to modernize and protect against pandemics and other natural disasters. In addition, policies that limit interoperability of critical health information, such as 42 CFR Part 2 limitations, pose a significant threat to mental health and substance use disorder treatment in the normal course of health care delivery as well as during public health emergencies such as natural disasters and pandemics.

Seamless data exchange (interoperability), care coordination, research, and public health are hampered by the lack of widely adopted applicable national digital data standards. The myriad of varied (and sometimes conflicting) data requirements at the state and federal level related to demographic data and patient identifiers are a clear example. **OCHIN strongly urges increased resources to accelerate the U.S. Core Data for Interoperability work of the Office of the National Coordinator for Health Information Technology.** Providers are further burdened by numerous and uneven requirements and standards for collecting data elements and categories.

**Health IT Infrastructure.** Since the Health Information Technology for Clinical and Economic Health (HITECH) Act, several generations of technological evolutions have occurred. Yet, small community-based providers have not had the significant resources needed to replace obsolete systems that do not enable automated exchanges with public health agencies, nor integrated virtual modalities such as telehealth, remote patient monitoring, and e-consults nor power population health analytics. Further, local public health agencies, nursing facilities, and behavioral and mental health providers were not included in HITECH. Funding for front line systems meets an immediate need to respond to COVID-19 as well as other public health crises and is a sound long-term investment since these are also the systems such practices need in order to implement new patient-centered, value-based delivery models. Digital modernization is contingent on providers, public health agencies, and community-based organizations’ ability to modernize and maintain needed updates to their health information technology systems (or acquire them) through incentives, grants, and technical assistance programs in order to increase access in public health, population health, and whole patient care.

Because of the OCHIN network health IT capabilities, our members have been able to trigger over 1 million COVID-19 electronic case reports to public health agencies. Despite the foregoing, there are local public health agencies that utilize antiquated data collection systems that cannot utilize these reports. Similarly, OCHIN network members have undertaken over 1 million digitally documented social determinants of health patient evaluations that assist members to address population health social complexity, for example, but cannot make electronic referrals nor coordinate seamlessly with community-based organizations and state social service agencies because the latter do not have adequate health information technology. SDOH goes hand in hand with digital determinants of health, from access to telemedicine to the capacity to utilize wearable technology properly, enhancing national standards and emphasizing SDOH will improve patient outcomes.
**National Privacy Framework and Whole Patient Care.** Establish a unified national privacy and security framework to ensure that patients and more broadly consumers, particularly those most vulnerable to discriminatory or other adverse consequences are not harmed through disclosure of patient clinical information. This includes mental and behavioral health-related information; and SDOH data shared by entities that are not subject to the Health Insurance Portability and Accountability Act (HIPAA), and which are not bound by ethical obligations to patients. On the other hand, there remain restrictions on the secured exchange of substance use disorder (SUD) clinical information even in the context of HIPAA. This undermines patient safety because clinicians do not have access to medical information that impacts care. It also hampers exchange of relevant clinical data, as some regional health information exchanges prohibit inclusion of this information. OCHIN urges Congress to consider amending or repealing this section so that once 42 CFR Part 2 data is transmitted or retransmitted, there is no requirement to segregate a patient’s 42 CFR Part 2 data from the rest of a HIPAA database.