Dear Healthcare Innovation Caucus,

On behalf of OCHIN, we appreciate the opportunity to comment on the Health Care Innovation Caucus’s request for feedback on Value-Based Provider Payment Reform, Value-Based Arrangements, and Technology and Health IT. OCHIN applauds the Caucus’s efforts to seek public comment around payment reform and technological advancements in healthcare, and we look forward to actively participating in the process to inform and educate on behalf of the OCHIN collaborative.

OCHIN is a 501(c)(3) nonprofit community-based health information technology collaborative based in Portland, Oregon. OCHIN receives support from the U.S. Department of Health and Human Services Administration (HRSA) and is a HRSA-designated Health Center-Controlled Network (HCCN). OCHIN’s mission is to pioneer the use of health information technology in caring for the medically underserved. As such, OCHIN serves community health centers (CHCs), including Federally Qualified Health Centers (FQHCs), rural and school-based health centers, safety-net providers and public health and corrections facilities across the nation. OCHIN’s comments are based on our experiences with the members we serve.

Technology provides extensive opportunities to innovate Medicare and Medicaid in a variety of areas. OCHIN is an enormous proponent of improving care and reducing costs through virtual care and e-consults. The benefits of expanding this method of care to the safety net have already been seen in Los Angeles County, where they implemented virtual screening for diabetic retinopathy, which increased annual screening rates by 16%, reduced wait times by 89%, and avoided more than 14,000 unnecessary specialist referrals.1 E-consults in a Connecticut study also saved almost $500 per patient over a sixth month period in Medicaid costs, as well as reduce the rates of no-shows.2

---

1 A study published in the Journal of American Medicine in March 2017 found that the technology and referral network led to a significant increase in access to specialty eye care for patients in need of diabetic retinopathy (DR). Results included an 89.2% decrease in wait times for screening and a 16% increase in annual screening rates; further, it was determined that 68.8% of patients did not require a referral for eye care.

2 A study published in the American Journal of Managed Care performed through the Community Health Center and the University of Connecticut Health Center found virtual consults with a specialist resulted in a mean savings of...
Virtual screening, e-consults, tele-counseling, and remote patient monitoring are just a few of the ways that this technology can be utilized to keep patients connected and in communication with their providers, avoid costly trips in uncertain states of medical urgency reducing hospitalizations, and provide specialist consultations across great distances through live video. These possibilities certainly improve the experience for patients, but also provide relief for providers facing increasing rates of burnout. Not only are there clinician shortages, but also constantly changing technology and reporting requirements causing a never-ending learning curve and duplication of work. As reliance on these methods for access improves, they will become more streamlined through increased feedback from both providers and patients and subsequent innovation.

There is currently a ballooned demand for specialist care, but this is aggravated in a safety net setting. Geographic and transportation barriers, lack of specialists, and lack of reimbursement parity reduce accessibility. The accessibility offered through telehealth and virtual care also boosts the appeal for new practitioners by allowing them more flexibility in their location of operation while maintaining a high patient volume virtually.

Increasing the use of e-consults expands the reach of specialists as well as mental, behavioral, and primary care providers. We can see even more success in both primary and specialist treatment when paired with e-consults from behavioral specialists who can assist in identifying other social impediments which may reduce the effectiveness of treatment. This system can then become more robust by networking in community support programs to help overcome obstacles such as transportation, housing, food security, and even employment. This kind of collaboration between healthcare and community sectors can increase efficiency and reduce costs in the long-term. Accordingly, OCHIN encourages Congress to call upon the Centers for Medicare & Medicaid Services (CMS) and the Center for Medicare & Medicaid Innovation (the Innovation Center) to undertake a demonstration to explore payment options to reimburse eConsults at parity with in-person visits.

When Medicare and Medicaid reach parity with in-patient visits and allow for homes and schools to become originating sites, the technology will become even more highly utilized, leading to increased innovation and general expansion of virtual care services. This technology can also be paired with patient feedback provided via phone or website applications, which can help track wait times and patient satisfaction which can be translated to improve the value of care. Systems for claims and clinical data must also be improved to allow researchers to perform analytics. Once these three systems are in place, Medicaid and Medicare will become increasingly efficient and improve the value of care.

In terms of data sharing and interoperability, federal leadership and action are still required to move the nation more expeditiously to reach interoperability. OCHIN urges the Caucus to support CMS and the Office of the National Coordinator for Health Information Technology as they work to implement the 21st Century Cures Act. Specifically, the Cures Act requirement to employ a national framework as opposed to regional healthcare information systems will prevent failures in patient matching and allow patients’ electronic health records to follow them regardless of their national location. This national framework, such as Carequality, also reduces provider burden by allowing clinicians to enter data into a single system, while providing the necessary transfer of data to relevant practitioners and professionals.

$655 per patient adjusted costs, or when adjusted for non-normality, a mean savings of $466. It also showed improved access to care for underserved patients as well as reducing the no-show rate.
insurance companies. This process provides increased data security by reducing unnecessary duplications and transfers which could be infiltrated by destructive parties. Carequality is built into a number of certified electronic health record technologies and can be activated with no additional cost to the provider.

OCHIN appreciates the opportunity to share our feedback on policy ideas with the Caucus and stands ready to work together in the transformation to value-based payment and care delivery. Thank you again for your consideration and interest. Should you have any questions about this response, please contact Jennifer Stoll at stollj@ochin.org.