

March 23, 2020

The Hon. Mitch McConnell  
Majority Leader  
United States Senate  
Washington, DC 20510

The Hon. Nancy Pelosi  
Speaker  
United States House of Representatives  
Washington, DC 20515

The Hon. Charles Schumer  
Minority Leader  
United States Senate  
Washington, DC 20510

The Hon. Kevin McCarthy  
Minority Leader  
United States House of Representatives  
Washington, DC 20515

Dear Congressional Leaders:

Thank you for the steps you have taken thus far to ensure digital health and health IT can be fully leveraged to detect, treat, and prevent the spread of COVID-19. We commend you on the steps taken thus far, including allowing the Secretary of Health & Human Services (HHS) to waive Medicare telehealth reimbursement restrictions for the remainder of the COVID-19 public health emergency.

While our country has faced epidemics and pandemics before, never have we had the same technological and data analyzing capabilities that now exist and continue to evolve at a rapid pace. It is essential that Congress support these technologies and their use, while also recognizing the unprecedented challenge facing health care providers. Digital health tools can help providers and patients, but Congress must also do its part.

We support many provisions in the recently introduced *Coronavirus Aid, Relief, and Economic Security (CARES) Act*, including:

- Sec. 3212 – Support for Telehealth Resource Centers
- Sec. 3221 – Allowing one-time written consent for sharing of substance use disorder treatment records
- Sec. 3224 – Requiring HHS to issue guidance on sharing of patient health information during the public health emergency
- Sec. 3701 – Allowing high-deductible plans to cover telehealth services prior to a patient meeting his/her deductible
- Sec. 3703 – Removing the requirement for a provider to have seen a Medicare patient within the last three years in order to treat a Medicare patient via telehealth
- Sec. 3704 – Allowing federally qualified health centers and rural health clinics to utilize telehealth services to see Medicare patients during the COVID-19 public health emergency
- Emergency appropriations for telehealth provided under Division B, including \$200 million for the Federal Communications Commission for telecommunications systems to support telehealth

While we support these provisions, we urge Congress to consider further steps. Specifically, we ask Congress to address the following issues:

### **Telehealth and Remote Patient Monitoring**

Congress took an important first step by giving authority to the Secretary of HHS to waive Medicare telehealth reimbursement restrictions for the remainder of the COVID-19 public health emergency. Medicare beneficiaries – the highest risk category for COVID-19 – can now receive necessary care remotely – avoiding stressed hospitals as well as risk of exposure. We also appreciate that HHS, including its Office of Civil Rights, has extended enforcement discretion to certain HIPAA privacy restrictions in order to enable rapid expansion of telehealth services.

We urge Congress to take additional steps to fully leverage telehealth. Specifically, Congress should explicitly add additional urgent care and inpatient services to the list of Medicare covered telehealth services, as well as allow all licensed health professionals to furnish telehealth and remote patient monitoring services. While the current waiver allows services to be offered in patients' homes, it does not expand the list of Medicare covered telehealth services, nor the list of providers who can be reimbursed for telehealth services. Critically, telehealth can be used to both bring elements of an inpatient setting into a patient's home as well as reduce staff contact for those already admitted to hospitals. "Hospital at home" programs and telehealth carts/robots are revolutionizing the inpatient experience and can be critical in minimizing provider exposure to COVID-19, yet many of the codes associated with these services are not Medicare covered telehealth services. Congress should direct the Centers for Medicare & Medicaid Services (CMS) to add related codes to the list of Medicare covered telehealth services.

For inpatient services that are currently Medicare telehealth covered services, CMS guidelines stipulate that providers can only bill for inpatient services every three days. Congress should direct CMS to lift this restriction in light of the current pandemic.

In addition to telehealth services, remote patient monitoring (RPM) technologies will help providers to monitor the acute and chronic health needs of their patients, while keeping them out of the hospital and/or provider office. Providers can presently use RPM tools to proactively monitor ongoing chronic symptoms of COVID-19. We urge Congress to grant HHS additional waiver authority for enforcement discretion of RPM technologies to make them readily available for patients during this acute phase of disease treatment, and specifically grant HHS authority to waive patient co-payments, requirements for existing provider-patient relationships, anti-kickback statute prohibitions against provider provisioning of RPM tools, and easing HIPAA applicability and enforcement actions during this time of emergency response.

### **Rural Broadband Funding**

Along with the reimbursement opportunities for technology-enabled care delivery, Congress must ensure strong telecommunications network capacity. As providers shift to providing more care digitally, our nation's telecommunications networks must keep pace. Rural areas lag in high-speed broadband adoption and must be supported during this time. We support the \$200m in funding included for the FCC and we urge Congress to continue to support rural health care

and broadband providers as they seek to deploy telehealth. We also encourage Congress to remove restrictions in the Rural Health Care Broadband Program that will limit its usefulness in this pandemic – specifically, the requirement providers be non-profit or public to receive funds.

### **Patient Matching**

President Trump’s March 18<sup>th</sup> additional COVID-19 funding request to Congress included \$21 million for the Office of the National Coordinator for Health IT (ONC) to fund a “patient lookup system.” The administration states that “[t]his expansion would use an online database to help medical response teams access critical patient information to enable care coordination.” We strongly support this request and ask that funding include specific support for effective patient matching capabilities, including use of advanced enterprise master patient index models, biometrics, and an explicit relaxation of any constraints on HHS to pursue and implement patient matching tools and strategies, including patient identifiers.

On this latter need, for the past 20 years, Congress has included a ban in annual HHS funding bills that prevents the agency from using any funds toward development of a unique patient identifier (UPI). HHS has strictly interpreted this ban and it has prevented the federal government – the largest healthcare payer in the country – from adopting a patient matching strategy, much to the detriment of the system as a whole.

We urge Congress to remove the UPI ban – not just for this system, but also for on-going health information exchange. Congress has recognized this through inclusion of provisions focused on easing impediments to exchange such as laws related to the exchange of substance use disorder records and sharing of information during this national emergency. This is an important first step; however, once information is exchanged, it is critical it can be quickly and accurately matched to a patient. Removing the UPI ban will allow HHS to engage in meaningful discussions on how to move patient matching forward on a national scale.

### **Funding for and Rapid Testing of Emerging Technologies**

We now have advanced computing and data analytics capabilities that can rapidly and nimbly be leveraged to combat many health issues. Artificial intelligence, including machine learning (ML) tools are already being deployed to combat COVID-19 – aiding in prediction, detection, response, and recovery.

We urge Congress to include additional directed funding for use and testing of emerging technologies, like ML and AI, in combatting the crisis. Funding should be directed to HHS agencies focused on utilizing these tools, such as the CDC and FDA, and the National Institute of Standards and Technology (NIST), which is focused on testing.

### **Broad Hardship Exemptions**

We have only begun to see the impact of this pandemic on our health care system and providers. Technology can help create efficiencies and safety mechanisms for providers in treating patients – it is critical that providers are able to focus all energy on their most vulnerable patients.

Therefore, we urge Congress to include broad regulatory relief for providers who are most impacted by the pandemic. On March 22<sup>nd</sup>, CMS issued broad hardship exemptions for providers under the Quality Payment Programs (QPP) and for hospitals under hospital reporting programs. However, on March 9<sup>th</sup>, HHS finalized two major health IT regulations focused on interoperability and information blocking - *21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program* and *Medicare and Medicaid Programs; Patient Protection and Affordable Care Act; Interoperability and Patient Access for Medicare Advantage Organization and Medicaid Managed Care Plans, State Medicaid Agencies, CHIP Agencies and CHIP Managed Care Entities, Issuers of Qualified Health Plans on the Federally-facilitated Exchanges, and Health Care Providers*. In these rules, deadlines for compliance start as early as six months after publication, which is likely not feasible given the current pandemic. Although data access and liquidity are of paramount importance to responding to this pandemic, we urge that HHS address implementation and compliance with a high level of flexibility, focused on reducing compliance and implementation burdens and uncertainty while maximizing the value of these rules. Further, when new deadlines are set, Congress must require HHS to notify stakeholders 90 days in advance.

## Conclusion

Thank you for your leadership to stem the tide and address the impacts of COVID-19. Digital health leaders stand ready to help and we look forward to continuing to work with you on these important issues.

Sincerely,

Allscripts  
American Health Information Management  
Association (AHIMA)  
Biofourmis Inc.  
Cerner  
Change Healthcare  
College of Healthcare Information  
Management Executives (CHIME)  
eHealth Exchange  
eHealth Initiative and Foundation  
Engaging Patient Strategy  
Greenway Health  
Health Catalyst  
Inovalon  
LifeWIRE Group

Marshfield Clinic  
Medical Group Management Association  
(MGMA)  
Nebraska Health Information Initiative  
(NEHII)  
NextGate  
Optimize Health  
Reemo Health  
Reflexion Health  
ResMed Inc.  
Strategic Health Information Exchange  
Collaborative (SHIEC)  
The Learning Corp.  
Validic  
Varian  
WellDoc