August 29, 2019

Netsmart Comments
Federal Communications Commission
Noticed of Proposed Rulemaking (NPRM)
Promoting Telehealth for Low-Income Consumers
Docket No. 18-213

We thank the Federal Communications Commission for the opportunity to comment on the Notice of Proposed Rulemaking, Promoting Telehealth for Low-Income Consumers (Docket No. 18-213).

Netsmart is the technology partner -- and bridge to the rest of healthcare -- for human services and post-acute provider organizations nationwide. We provide electronic health records (EHRs), health information exchange and other solutions for behavioral health, substance use and addiction management, child and family services, developmental disabilities, autism, home care, hospice, palliative care, skilled nursing, assisted living, independent living, long-term acute care hospitals and inpatient rehabilitation facilities. Our clients include more than 560,000 providers in 30,000 facilities that improve the quality of life for more than 25 million persons each day.

We applaud the proposal by the FCC to establish a Pilot program within the Universal Service Fund (USF) to support connected care for low-income Americans and veterans and are pleased to provide comments we believe will help the program fully leverage the benefits of connected, integrated care to improve health outcomes.

Provider Eligibility

There is a compelling need to include human services and post-acute care providers in eligibility for the Pilot Program. These providers serve the underserved -- high-risk patients, many with multiple untreated co-occurring health conditions. Their patients are among the highest utilizers of health services, and the providers are significantly underfunded in comparison to acute care health systems in the face of an increased demand for services.

These providers also align with the NPRM proposal (p. 8, Sec. 17) to "limiting the Pilot program to projects that primarily focus on health conditions that typically require at least several months or more to treat – such as behavioral health, opioid dependency, chronic health conditions (e.g., diabetes, kidney disease, heart disease, stroke recovery), mental health conditions and high risk pregnancies."

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Access to affordable Internet access and telehealth technology that includes these providers will expand access to care, help mitigate the impact of severe staffing shortages, and enable coordinated, integrated care for persons with multiple co-occurring conditions.

Substance Use Disorder (SUD) Treatment Providers

We recommend that Substance Use Treatment Providers be included in Pilot Program eligibility. SUD treatment providers are on the front lines of the opioid crisis, including in rural areas where hiring and retaining staff, especially clinicians, is a major challenge to providing coordinated care. Alcohol and drug-related illnesses and injuries cause one in ten deaths for adults of working age.[1] Medically ill inpatients who also have alcohol or drug disorders are at a greater increased risk of rapid re-hospitalization after discharge and greater health care use and costs.[2] And patients who have medical illnesses, such as diabetes or cardiovascular disorders -- and who also have a substance use disorder -- use health care services 2-3 times more often than their peers with just diabetes or heart problems, and the cost of care is similarly much higher.[3] In addition, untreated, alcohol or drug use during pregnancy dramatically increases risk of poor birth outcomes, neonatal intensive care use and greater infant and maternal health care use. ***Specifically, we recommend that methadone and opioid treatment providers be included for Pilot program eligibility because of their key role in helping mitigate the opioid crisis.***

Community Mental Health Centers

We agree with the NPRM's inclusion of Community Mental Health Centers as an *Eligible Health Care Provider (p. 17, Sec. 37)*. Comorbidity between mental and medical conditions is the rule rather than the exception. Specifically, people with schizophrenia and bipolar disorder are up to three times more likely to have three or more chronic medical/surgical conditions compared to Americans without these mental disorders. In the Medicaid/Medicare context, it's estimated that fully one-third of the 9 million dually eligible beneficiaries have a primary diagnosis of severe mental illness. An earlier study published in a Centers for Disease Control and Prevention (CDC) publication, *Preventing Chronic Disease,* found that patients/consumers served in state mental health systems die 25 years sooner than other Americans while experiencing evaluated levels of morbidity.[4] To put these studies into context, the available data seems to show that people with mental illnesses like schizophrenia and bipolar in the U.S. have average life expectancy similar to

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[1] Stahre M, Roeber J, Kanny D, Brewer RD, Zhang X. Contribution of excessive alcohol consumption to deaths and years of potential life lost in the United States. Prev Chronic Dis 2014;11:130293.

[2] Boyd C, Leff B, Weiss C, Wolff J, Hamblin A, & Martin L (2010). Faces of Medicaid: Clarifying multi-morbidity patterns to improve targeting and delivery of clinical services for Medicaid populations. Center for Health Care Strategies. Walley A, Paasche-Orlow M, Lee EC, Forsythe S, Chetty VK, Mitchell S, & Jack BW. (2012). Acute care hospital utilization among medical inpatients discharged with a substance use disorder diagnosis. J Addict Med, 6(1), 50-56. Bradley KA, Rubinsky AD, Sun H, Bryson CL, Bishop MJ, Blough DK & Kivlahan DR. (2011). Alcohol screening and risk of postoperative complications in male VA patients undergoing major non-cardiac surgery. J Gen Intern Med, 26(2), 162-169.

[3] Rehm J, Mathers C, Popova S, Thavorncharoensap M, Teerawattananon Y & Patra J. (2009). Global burden of disease and injury and economic cost attributable to alcohol use and alcohol-use disorders. Lancet, 373(9682), 2223-2233.

[4] Colton, CW & Manderscheid, R.W. (2006) Congruencies in increased mortality rates, years of potential life lost, and causes of death among public mental health clients in eight states. *Preventing Chronic Disease: Public Health Research, Practice, and Policy,* 3(2), 1-14.

the citizens of sub-Saharan African nations (who lack access to clean water and vaccinations against preventable communicable diseases).

Home Health Providers
We recommend that Home Health Providers be included in Pilot program eligibility. Home health care's rapid growth and increased demand for services make it a compelling candidate for inclusion in the Pilot program and for the use of telehealth services. Small home health providers are resource-challenged due to low payment rates, and many larger home health providers do not find it cost-effective to serve rural areas.

A June 2019 Harris Poll survey of 2,000 adults commissioned by American Well to measure usage and sentiments toward telehealth found that 67 percent of seniors said they were open to using video visits to manage chronic conditions.[5] The report also cited data from the CDC's Morbidity and Mortality Weekly Report, 2017 that 87 percent of seniors have at least one chronic disease and 68 percent of Medicare beneficiaries have multiple chronic conditions. Addressing chronic health conditions is a stated focus of the NPRM.

In addition, the home health cost reporting requirements which now include reporting of telehealth costs (not currently covered by the Medicare payment system) will yield data on telehealth effectiveness, which could be leveraged as one measure of Pilot program success.

Skilled Nursing Facilities
We agree with the NPRM's inclusion of Skilled Nursing Facilities as an *Eligible Health Care Provider* (p. 17, Sec. 37). Skilled nursing facilities are a key component in improving the health of persons with chronic conditions. The CMS funded a pilot program in Florida using telemedicine aimed to curb the $11 billion lost in savings in less than a decade. These skilled nursing facilities use telemedicine to determine if off-hours virtual care can reduce hospitalizations and rehospitalizations. They found that with only **four** participating nursing facilities the annualized Medicare savings exceeded $1.3 million. [6]

Local Health Departments or Agencies
We agree with the NPRM's inclusion of Local Health Departments Agencies as an *Eligible Health Care Provider* (p. 17, Sec. 37). Local Health Departments play a critical role in developing and managing integrated health systems, including engaging with partners to plan, implement, and evaluate strategies to improve the health of their communities.

Counties Treating Incarcerated Persons for Mental Illness and Substance Use Disorders
We recommend adding counties treating persons for mental health and substance use disorders to Pilot program eligibility. According to the National Association of Counties[7], local jails admit nearly 11 million individuals each year. County governments operate 2,875 of our nation's 3,160 local jails, and they are used increasingly to house individuals with mental health, substance abuse and/or chronic health

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[5] Telehealth Index: 2019 Senior Consumer Survey, American Well. June 2019
[6] ACHA Grant No. GFA061 Final Report, The TRECS Institute. June 11, 2018
[7] Federal Policy Impacts on County Jail Inmate Healthcare and Recidivism. National Association of Counties. March 2019

conditions, including an estimated:

» 50 percent with a serious chronic health condition
» 64 percent with a major mental health illness
» 53 percent with drug dependency or abuse, and
» 49 percent with co-existing mental health and substance abuse conditions

Data also show that adults with mental illnesses tend to stay longer in jail and upon release are at a higher risk of recidivism than people without these disorders; and county jails spend 2-3 times more on adults with mental illnesses that require interventions compared to those without these treatment needs.

Although counties are required by federal law to provide adequate health care for persons admitted to county-operated jails, the federal Medicaid Inmate Exclusion Policy (MIEP) suspends federal health benefits to persons when they are booked into jail. As a result, counties incur a significant budget impact from medical costs (ranging from a minor injury to major surgery) for incarcerated persons for the duration of time they are in the county jail even before they are adjudicated.

Affordable access to telehealth technology could help rural counties provide more timely diagnosis and treatment for those incarcerated in their jails and mitigate some of the associated costs.

Recommended changes to p. 17, Sec. 37
Eligible health care providers. We propose to limit health care provider participation in the Pilot program to non-profit or public health care providers within section 254(h)(7)(B): (i) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (ii) community health centers or health centers providing health care to migrants; (iii) local health departments or agencies; (iv) single centers; (v) not-for-profit hospitals; (vi) rural health clinics; (vii) skilled nursing facilities; (viii) home health providers; (ix) opioid treatment providers; (x) methadone treatment providers; (xi) counties treating incarcerated persons for mental illness and/or substance use disorders; (~~viii~~xii) and consortia of health care providers consisting of one or more entities described in clauses (i) through (~~vii~~xii).[8]

Remote Patient Monitoring
We agree with the NPRM proposal to allow eligible health care providers to obtain up to 85 percent of the costs of the broadband needed to provide remote patient monitoring and

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[8] 47 U.S.C. § 254(h)(7)(B). *See* OCHIN comments at 4 (asserting that eligibility requirements should be consistent with the rural health care program but should be applied more broadly). *But see* Survivor Health Comments at 3 (encouraging the Commission to consider a broad range of health care providers, and that eligibility should include health care providers that fall under section 254(h)(5)(B) [*sic*] or are associated through a range of contractual arrangements with those providers); Kansas State Representative Tom Sloan states that the FCC should instead solicit grant proposals from federal and state agencies providing, or planning to provide telehealth services directly through contract health care providers, such as providing grants to the VA or states. *See* Tom Sloan Comments at 1.

similar connected care technologies to their patients, and that the program would support a limited number of projects over a three-year period with controls in place to measure and verify the benefits, costs, and savings associated with connected care. *(p. 75).* We recommend that previous experience with remote patient monitoring not be included in the Final Rule as a criterion to be an eligible health care provider. This is not an applicable capability for many providers otherwise included as an *Eligible Health Care Provider* outlined on *p. 17, Sec. 37* and elsewhere in the NPRM.

Longitudinal vs. Episodic Care
To fully measure the impact of connected care services and the role of connected care on patient health outcomes *(p. 2, Sec. 2)*, it is our strong view that the Final Rule should be defined to encompass longitudinal, continuous care (Example: Multi-month care plan for a mental illness) as well as episodic care/encounters (Example: One-time visit to an emergency dept.).

Clinical Trials
Should participating health care providers have experience, or be required to partner with research bodies or firms with experience, conducting clinical trials in order to ensure statistically sound evaluation of patient outcomes? (p. 21, Sec. 45)

Should we require applicants to certify that they have the capacity to conduct a valid clinical trial? (p. 24, Sec. 52) and (p. 21, Sec. 45)

We strongly recommend that experience with or capacity to conduct clinical trials *not* be a requirement for participating health care providers. Many smaller providers who could benefit from Pilot program participation would not likely have the financial resources, staffing levels or customer based needed for involvement in a clinical trial. Also, there are examples of impactful research-based initiatives developed without a clinical trial, such as the Recovery After an Initial Schizophrenic Episode (RA1SE) program from the National Institute of Mental Health.[9]

Funding Amount
We recommend funding of $300 million to fully accomplish the goals of this key pilot program

Netsmart commends the Commission for proposing this Pilot program to improve access to quality health care in some of our nation's most underserved areas. Inclusion of the human services and post-acute care providers outlined above is essential to achieving the goals of empowering health care providers to connect directly with their patients; bridging the gap between providers, patients and information systems to enable interoperability across disparate health information networks; and establishing an interoperable continuum of care to improve patient outcomes. An increase in the funding dollars will allow for the

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[9] Dixon LB, Goldman HH, Srihari VH, Kane JM. Transforming the Treatment of Schizophrenia in the United States: The RAISE Initiative. Annual Review of Clinical Psychology, Volume 14 2018, pp. 237-258

incorporation of these vital market segments and increase the licensures those with the targeted diagnoses have access to in their rural communities.

Sincerely,

Kevin Scalia
Executive Vice President, Corporate Development
Netsmart