AMERICAN ACADEMY OF FAMILY PHYSICIANS

August 28, 2019

Marlene Dortch, Secretary
FCC Headquarters
445 12th St. SW
Room TW–A325
Washington, DC 20554

Dear Secretary Dortch:

On behalf of the American Academy of Family Physicians (AAFP), which represents 134,600 family physicians and medical students across the country, I write in response to the proposed rule titled, "Promoting Telehealth for Low-Income Consumers" as published by the Federal Communications Commission (FCC) in the July 30, 2019 *Federal Register*.

The AAFP is pleased that the FCC proposes a three-year Connected Care Pilot program (Pilot) with a $100 million budget that would help eligible health care providers obtain universal service support to offer connected care technologies to low-income patients and veterans. We concur with the FCC proposal to limit this initial Pilot 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.

The Pilot would provide funding to selected Pilot project health care providers to defray the costs of purchasing broadband internet access service necessary to deliver connected care services directly to qualifying patients.

The AAFP's policy on Telehealth and Telemedicine supports expanded use of telehealth and telemedicine as an appropriate and efficient means of improving health, when conducted within the context of appropriate standards of care. The appropriateness of a telemedicine service should be dictated by the standard of care and not by arbitrary policies. Available technology capabilities as well as an existing physician-patient relationship impact whether the standard of care can be achieved for a specific patient encounter type.

The AAFP firmly believes that telehealth technologies can enhance patient-physician collaborations, increase access to care, improve health outcomes by enabling timely care interventions, and decrease costs when utilized as a component of, and coordinated with, longitudinal care. Responsible care coordination is necessary to ensure patient safety and continuity of care for the immediate condition being treated, and it is necessary for effective longitudinal care (for clarification, forwarding documentation by electronic means, including fax, is not acceptable for coordination of care with the primary care physician or medical home). As such, the treating physician within a telemedicine care encounter should bear the responsibility

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for follow-up with both the patient and the primary care physician or medical home regarding the telemedicine encounter.

Among the many questions asked in the proposed rule, the AAFP offers feedback on the following:

Whether the Pilot should focus on certain health conditions or geographic regions?

The AAFP believes the Pilot should not be restricted to specified geographic regions (urban or rural) or to specified health professional shortage areas or non-metropolitan statistical areas. As discussed by the Centers for Medicare & Medicaid Services (CMS) in a November 2018 document on Medicare Telehealth, while rural populations primarily face long distances to access care, low income urban populations face challenges such as child care, bus transfers, inconvenient office hours and absenteeism from work or school, which often result in inappropriate use of the emergency departments. We caution that inequitable expansion of access to telehealth services may further broaden disparities in care and health outcomes among vulnerable populations. The AAFP believes as telemedicine services are expanded and utilized to achieve desired aims, it is imperative that outcomes are closely monitored to ensure disparities in care are not widened among vulnerable populations, attributed to inequitable expansion of access to telemedicine and telehealth services.

Should the FCC adopt a specific definition of "health condition" for purposes of the Pilot?

No, the AAFP policy calls for telehealth and telemedicine to be an appropriate and efficient means of improving health, when conducted within the context of appropriate standards of care. The appropriateness of a telemedicine service should be dictated by the standard of care and not by arbitrary policies. The proposed rule indicates "the Pilot is intended to give health care providers latitude to determine specific health conditions and geographic areas that will be the focus of the proposed projects." The AAFP supports that proposal, and recommends participating physicians and providers are best positioned to determine whether care will be provided to a patient virtually through "connected care," based upon the patient's health condition(s).

The costs health care providers incur to purchase such services.

The AAFP believes that physicians should receive payment for services that are reasonable and necessary, safe and effective, medically appropriate, and provided in accordance with accepted standards of medical practice. The technology used to deliver the services should not be a consideration, only whether the service is medically reasonable and necessary.

The term "telemedicine" as using broadband internet access service-enabled technologies to support the delivery of medical, diagnostic, and treatment related services, usually by doctors.

The AAFP fully supports this definition.

The term "connected care" as a subset of telehealth that is focused on delivering remote medical, diagnostic, and treatment-related services directly to patients outside of traditional brick and mortar facilities.

The AAFP finds this acceptable, so long as there are not another set of policies tied to "connected care" that create another layer of administrative complexity. However, we call on the FCC to recognize that if this verbiage is used, then stand-alone/direct to consumer telemedicine and telehealth services should not be referred to as providing

"connected care" because those services are often not connected to the patient's usual source(s) of care or medical home.

The AAFP is concerned that the term "connected care," as proposed by the FCC, may inappropriately be applied to all telehealth services occurring across the landscape, including those services which are not supportive of continuous, comprehensive longitudinal care, but rather disjointed episodic care occurring in silos.

Specific types of health care providers or provider locations more likely to be unable to purchase these types of information services?

Rural providers sometimes have no adequate broadband coverage or no viable option to participate in these types of information services.

The structure of the Pilot to best ensure coordination between the Commission and other federal agencies, such as CMS?

In general, the lack of coordination and alignment among agencies typically creates unnecessary complexity. Not all telehealth services focused on delivering remote medical, diagnostic, and treatment-related services directly to patients outside of traditional brick and mortar facilities are providing truly connected care supportive of care continuity and longitudinal health. "Connected care" terminology carries additional connotations beyond simply being indicative of a communications technology bridge linking patients with doctors and care providers for medical, diagnostic and treatment-related services. This is especially true in terms of CMS and private payer initiatives to advance toward value-based care and payment models that promote coordinated care and effective resource utilization management.

The proposal to limit health care provider participation in the Pilot to non-profit or public health care providers (Post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; community health centers or health centers providing health care to migrants; local health departments or agencies; community mental health centers; not-for-profit hospitals; rural health clinics; skilled nursing facilities; and consortia of health care providers consisting of one or more entities.)

While we can understand why a pilot may need to be limited, the AAFP calls on the FCC to ensure that the Pilot is available for patients in all geographies and by different types of providers.

The proposal to require eligible health care providers to have prior experience with telehealth and long-term patient care.

Long-term patient care is ambiguous. Those providing longitudinal care should be preferentially selected for the Pilot as opposed to those who are not.

The proposal that the Pilot be open to both urban and rural eligible health care providers.

The AAFP adamantly believes the Pilot should be available to both rural and urban providers.

What criteria should determine whether a health care provider is located in a rural area?

While the AAFP deems it both unnecessary and unproductive to limit the Pilot to rural patients and providers, the AAFP encourages consistency in the definition of "rural" in the federal government, unless there is an explicit and demonstrable reason why one use of "rural" would mean something different. On a near-constant basis, not just clinical professionals but all types of American professionals now rely on email,

teleconferencing, videoconferencing, and other tools to conduct business and serve clients regardless of whether they are based in a rural or urban setting. Many industries use asynchronous email and/or synchronous video as communication tools and meeting substitutes even within their own office building, recognizing the associated efficiencies and cost savings. Acknowledging the continuing need for telemedicine for patients who live in both urban and rural areas, the AAFP urges the FCC not to restrict the Pilot to rural patients and providers.

We appreciate the opportunity to provide these comments. Please contact Robert Bennett, Federal Regulatory Manager, at 202-655-4908 rbennett@aafp.org with any questions.

Sincerely,

Michael Munger, MD, FAAFP
Board Chair