Before the

Federal Communications Commission

Washington, D.C. 20554

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| In the Matter of  Promoting Telehealth for Low-Income Consumers | **)**  **)**  **)**  **)**  **)** | WC Docket. No. 18-213 |

**Comments of National Association of Community Health Centers**

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| October 10, 2018 |  |

**Executive Summary**

**Overarching Comments:**

* Community Health Centers (CHCs) are the backbone of the nation’s “primary care safety net” for low-income patients, with over 90% of our patients being low income half of whom are enrolled in Medicaid. We appreciate the FCC’s recognition of the valuable role that connected care technology can play in expanding access, decreasing costs, and improving health outcomes for low-income patients.
* To best demonstrate the potential impact of connected care, the FCC should work closely with the Centers for Medicare and Medicaid Services (CMS) to pair the CCPP with enhancements in Medicaid and Medicare reimbursement for connected care services.
* NACHC is very concerned the CCPP (and/or any future programs with similar goals) may be funded through reductions in the Lifeline program or other vital programs actively improving the telecommunications capabilities of low income Americans. Millions of CHC patients rely on Lifeline to be able to afford phone or Internet access and reducing Lifeline funding to pay for Connected Care could leave millions of our patients without basic telecommunication service.

**General Use of Funds**

* NACHC strongly supports the CCPP’s focus on low-income patients and encourages the FCC to ensure decisions about program design maintain this focus.
* CCPP funds should be focused on providing broadband access to low-income patients and equipment to patients and providers – not on broadband access for health care providers.

**Eligibility Criteria for Health Care Providers**

* Eligibility to apply for CCPP funds should be limited to outpatient providers for which a majority of patients are low-income and/or veterans who qualify for no-cost care, and to organizations that represent such providers. Specifically:
* “Primary eligibility” – meaning eligibility to apply for and receive CCPP funding directly -- should be limited to outpatient providers, as they are the ones that most consistently manage the types of conditions that are appropriate for connected care.
* Outpatient providers should be permitted to form consortia with other providers -- including inpatient providers, such as hospitals and rehab facilities – when designing and applying for their CCPP projects. However, the outpatient provider should retain primary responsibility for the project.
* The percentage of a health care provider’s patients who are on Medicaid is not an appropriate proxy for percentage of their patients who are low-income.
* “Low-income” should be defined as individuals in families with incomes at or below 200% of the Federal Poverty Level (FPL).
* “Providers who serve predominantly low-income patients” should be defined as those for which the majority of patients are below 200% FPL and/or veterans eligible for free care.
* Eligibility should be extended to organizations that represent groups of providers who would otherwise be eligible, individually.

**Eligibility Criteria for Low-Income Subscribers (i.e., patients)**

* Eligible low-income subscribers should: 1) have incomes at or below 200% FPL and/or be veterans eligible for free care, veterans, and 2) be actively participating in connected care.
* Participating health care providers should be permitted to select the specific health conditions or demographic characteristics that they will target.

**Financing and Uses of Equipment**

* Participation should not be limited to proposals where the broadband provider will donate the end-user equipment.
* Participating health care providers should be permitted to use their on-site CCPP equipment to provide care to any patient, regardless of whether the patient is a low-income subscriber participating in the CCPP.
* Health care providers should be permitted to determine what type of patient equipment is most appropriate for their care model.
* Equipment that is funded directly or indirectly through the CCPP should be provided to eligible patients for free and/or at a reduced fee based on income.

**Regulatory Barriers to Telemedicine**

* Regulatory barriers prevent health care providers – including but not limited to CHCs -- from being reimbursed for telemedicine, creating a significant impediment to the spread of this technology.

### Community Health Centers (CHCs) are further discouraged from engaging in telehealth by the significant uncertainty and burdensome requirements associated with getting their Federal malpractice insurance to cover these services.

* Conflicting state laws create barriers to providing care across state lines.

**Evaluation**

* When establishing evaluation parameters, the FCC should keep in mind the limits on the types of data that health care providers can access.
* The FCC should request support from CMS to access Medicaid and Medicare data.

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**Comments of the National Association of Community Health Centers**

The National Association of Community Health Centers (NACHC) hereby comments on the Commission’s Notice of Inquiry (NOI) regarding the establishment of Connected Care Pilot Program (“CCPP”).[[1]](#footnote-1)

NACHC is the national membership organization for America’s Community Health Centers (also called CHCs or Federally Qualified Health Centers.) As discussed below, CHCs are the backbone of the nation’s primary care safety net”, assuring access to affordable primary care for over 28 million medically-underserved patients, in both rural and urban areas. Over 90% of health center patients are low-income, with almost 70% of them having incomes below the Federal poverty level.

Our comments are structured as follows:

* ***Background on Community Health Centers:*** To provide context for our comments and interest in the CCPP.
* ***Overarching Comments***: General comments that apply to all aspects of the CCPP
* ***Comments on Specific Design Elements of the CCPP:*** These comments respond to specific issues raised in the NOI.

# Background on Community Health Centers

## Community Health Centers are the backbone of the nation’s “primary care safety net” for low-income patients.

A Community Health Center (CHCs) is a health care provider that is authorized under Section 330 of the Public Health Service Act[[2]](#footnote-2). As a backbone of the “health care safety net”, all CHCs are required by law to:

* provide a wide range of medical services. These always include primary and preventive care, and generally include pharmacy, dental, mental health, and addiction treatment.
* care for all individuals who present for treatment, regardless of whether they have insurance or ability to pay.
* target geographic areas and populations that the Federal government has determined to be “medically underserved.”
* be non-profit or public, and be governed by a Board, a majority of whose members are CHC patients.
* provide services that support patients in accessing and using health care services appropriately, such as interpretation/translation; support to apply for public benefits, such as health insurance, affordable housing or food stamps; job search assistance; and education about healthy eating, exercise, etc. By addressing the social factors that contribute to poor health, these services help low-income patients maximize the benefit of the health services they receive.

Nationally, over 11,000 CHC sites provide care to over 28 million medically‐underserved individuals. Almost 70% of CHC patients have incomes below the Federal Poverty Level (FPL); if uninsured or underinsured, these individuals pay no more than a nominal fee for their care. Another 22% of CHC patients have incomes between 101% and 200% FPL; if uninsured or underinsured, they are charged based on a sliding fee scale. Roughly half of CHC patients are enrolled in Medicaid, and close to 10% have Medicare coverage, with 23% uninsured.

Because of their focus on ensuring health care access for at-risk populations, CHCs are experts on the health care challenges faced by low-income individuals across the country. This includes strategies and services to help individuals access and utilize care appropriately, and to address the social factors that contribute to poor health (e.g. poor quality and/or instable housing, food insecurity, transportation challenges, financial limitations, behavioral health issues). Because CHCs are managed by their own patients, they focus intently on meeting their community’s needs. As a core component of the safety net for underinsured and uninsured individuals, federally qualified health centers generally run on margins of less than one percent.

# Overarching Comments:

## Community Health Centers appreciate the FCC’s recognition of the valuable role that connected care technology can play in expanding access, decreasing costs, and improving health outcomes for low-income patients.

As the FCC explains in the NOI, connected care has great potential to expand access, improve health outcomes, and lower costs across the US health care system – all while improving both the patient and the provider’s experience of care. But, as connected care is starting to spread, it is also widening the digital divide, as these services are rarely accessible to lower-income consumers. CHCs see this growing divide first-hand, as our patients often cannot afford the broadband access and equipment necessary to take advantage of these new care options. Complicating this, CHCs are rarely reimbursed for their costs of providing telehealth services.

For this reason, NACHC sincerely appreciates the FCC’s recognition that the digital divide is expanding into health care, as well as the Commission’s efforts to address this divide through the creation of the Connected Care Pilot Program (CCPP.) We welcome the opportunity to provide input on how this pilot program should be designed and we look forward to collaborating with you to demonstrate how connected care can benefit low-income patients and communities.

## To best demonstrate the potential impact of connected care, the FCC should work closely with the Centers for Medicare and Medicaid Services (CMS) to pair the CCPP with expansions in Medicaid and Medicare reimbursement for connected care services.

As discussed above, NACHC sincerely appreciates the FCC’s efforts to make connected care available to low-income patients. Financial support for patients’ broadband and equipment costs is an important element of achieving this goal. However, we are concerned that this support, by itself, will not be sufficient to unlock the full potential of connected care. Rather, to reach this potential, it is critical that support for patients’ costs be paired with reimbursement for providers’ time.

A major impediment to the spread of connected care is the fact that health insurers often do not reimburse health care providers for the time or expenses required to provide care via telehealth modalities. Also, since connected care often replaces a face-to-face office visit – which is reimbursable by insurers – providers who use connected care not only incur the cost of that care, but also lose payment for the face-to-face visit. These financial implications are particularly significant for Community Health Centers, who generally operate on slim margins of less than 1 percent. For example, Medicare strictly limits reimbursement for telehealth services, and many state Medicaid programs have similar rules.

As such, NACHC strongly urges the FCC to work closely with the Centers for Medicare and Medicaid Services (CMS) to explore ways in which the CCPP could be paired with flexibility in Medicare and Medicaid reimbursement. CMS has waiver and demonstration authority under both programs, which it could use to ensure the CCPP providers are fairly reimbursed for the services they provide via connected care. An FCC-CMS partnership – with the former providing support for low-income patients and the latter ensuring adequate reimbursement for providers – would be a powerful combination that could unlock connected care’s true potential to support low-income patients.

* **NACHC is very concerned the CCPP (and/or any future programs with similar goals) may be funded through reductions in the Lifeline program or other vital programs actively improving the telecommunications capabilities of low income Americans. Millions of CHC patients rely on Lifeline to be able to afford phone or Internet access and reducing Lifeline funding to pay for Connected Care could leave millions of our patients without basic telecommunication service.**

While NACHC is very supportive of the creation of the CCPP, we would be very concerned if this program were to be financed using funds from the Lifeline program. For millions of health center patients, Lifeline is exactly what its name suggests – a lifeline that enables them to obtain the voice and broadband connectivity services critical to participate and function in today’s digital world. NACHC would have serious reservations if funding for the CCPP created a scenario where expanding connected care would come at the expense of patients’ basic access to communications services.

# Comments on Specific Design Elements of the CCPP

## GENERAL USE OF FUNDS

### NACHC strongly supports the CCPP’s focus on low-income patients and encourages the FCC to ensure decisions about program design maintain this focus.

As discussed above, NACHC sincerely appreciates the FCC’s recognition of the valuable role that connected care technology can play in expanding access, decreasing costs, and improving health outcomes for low-income patients, including but not limited to veterans who qualify for free care through the VA (referred to hereafter as “qualified veterans”). Given the potential of connected care to transform the entire healthcare system – for all patients, not just those with limited incomes – it is understandable that many types of providers and patients would be interested in participating in the CCPP. However, as the FCC has stated, the primary goal of the CCPP is to “improve outcomes among participating low-income patients.” To ensure that this focus is maintained, ***all decisions about program design should be framed in terms of how to best expand access for low-income populations***. This principle underlies several of the comments we offer below.

### CCPP Funds should be focused on providing broadband access to low-income patients and equipment to patients and providers – not on broadband access for health care providers.

In several places throughout the NOI, the FCC implies that a potential use of CCPP funds would be to expand broadband access to health care providers (e.g., paragraphs 33 and 36.) NACHC’s view is that the FCC should focus CCPP funds on providing low-income ***patients*** with the broadband access needed to receive connected care, and on ensuring that both patients and providers have the necessary equipment to engage in connected care. While NACHC supports the FCC’s efforts to expand broadband to all providers -- particularly those in rural areas -- the FCC already has programs explicitly designed for this purpose (the Healthcare Connect and Telecom Funds.) To the extent that CCPP funds would be used to expand broadband for providers, there will be less funding available for broadband access and equipment for low-income patients – and therefore less opportunity to demonstrate the potential of connected care for these individuals.

## ELIGIBILITY CRITERIA FOR HEALTH CARE PROVIDERS

### Eligibility to apply for CCPP funds should be limited to outpatient providers for which a majority of patients are low-income and/or veterans who qualify for no-cost care, and to organizations that represent or are comprised of such providers.

NACHC strongly supports limiting eligibility for the CCPP to health care providers that predominantly serve low-income patients. Beyond this “threshold criteria,” we recommend further clarifying the definition of eligible health care providers as follows:

* “Primary eligibility” – meaning eligibility to apply for and receive CCPP funding directly -- should be limited to outpatient providers, as they are the ones that most consistently manage the types of conditions that are appropriate for connected care. The NOI lists several types of health conditions which may be appropriately managed via connected care (including diabetes, substance abuse disorder, heart disease, stroke, mental health disorders, and high-risk pregnancy). For all of these conditions, long-term management – the type of care that is best suited for connected care – is most appropriately provided by outpatient providers. In fact, if a patient’s condition is serious enough to require hospitalization, then, by definition, the patient needs and is receiving face-to-face care. For this reason, primary eligibility – meaning eligibility to apply for and receive CCPP funding directly —should be limited to outpatient providers.
* Outpatient providers should be permitted to form consortia with other providers—including inpatient providers such as hospitals and rehab facilities – when designing and applying for CCPP projects. However***, the outpatient provider should retain primary responsibility for the project.*** While the disease conditions described in the NOI are best managed over the long-term by outpatient providers, there are times when inpatient and/ or emergency care may be needed. For this reason, some outpatient providers may choose to collaborate with inpatient providers on their CCPP projects in order to coordinate their patients’ care. While such inpatient-outpatient consortia should be permitted under the CCPP, the primary eligibility and responsibility for the project should remain with the outpatient provider. It should be at the discretion of the primary project organizer to determine if funds should be utilized in such a manner that the inpatient entity receives the ability to provide equipment furnished through CCPP funds in collaboration with and under justification/oversight of the outpatient entity. Such an allowance would afford the opportunity for greater care continuity, especially in the context of the identified long-term health conditions.
* The percentage of a health care provider’s patients who are on Medicaid is not an appropriate proxy for percentage of their patients who are low-income***:*** NACHC appreciates the FCC’s efforts to suggest measures for determining the percentage of health care provider’s patients who are low-income. However, the percentage of patients on Medicaid is not an appropriate proxy for this purpose, as there are enormous differences in Medicaid eligibility rules across states. For example, in Texas and Alabama Medicaid covers adults with incomes up to 18% of the Federal Poverty Level (FPL), while in the District of Columbia it covers adults up to 221% FPL.[[3]](#footnote-3) Additionally, particularly in rural areas, the social and economic conditions may be such that an individual and/or family possesses assets that deem them ineligible for Medicaid, despite having incomes well below the Federal Poverty Level.
* “Low-income” should be defined as individuals in families with incomes at or below 200% of the Federal Poverty Level (FPL):NACHC recommends that “low-income patient” be defined as individuals in families with total income at or below 200% FPL. This is a standard threshold amount used in to determine eligibility for many health and related benefits in both the public and non-profit sectors, including, but not limited to, the reduced-cost services at Community Health Centers, the AIDS Drug Assistance Program, the Medicare QDWI program, and SNAP (formerly Food Stamps).
* “Providers who serve predominantly low-income patients” should be defined as those for which the majority of patients are below 200% FPL and/or veterans eligible for free care.Since the CCPP’s purpose is to evaluate the effectiveness of connected care in reaching low-income patients (including low-income veterans), primary eligibility should be limited to organizations that focus on caring for these populations. While other provider types may serve some low-income patients, these providers are less likely to have the expertise and services that are most appropriate for supporting low-income patients. For example, as discussed above, all CHCs provide a range of serves that support their low-income patients in accessing and using health care services appropriately. These include, but are not limited to: interpretation/translation; support to apply for insurance, housing, or food assistance; job search assistance; and education about healthy eating, exercise, etc. Health care providers who do not work regularly with low-income patients may lack an awareness of the full range of challenges these patients face and may not offer services to address them. Therefore, for the CCPP to best expand access and demonstrate an impact for low-income populations, eligibility should be limited to the providers who have the most experience working with them.

In addition, as discussed below, participating health care providers should be permitted and expected to use their CCPP-provided equipment to connect with all of their patients, regardless of whether the patient is eligible to participate in the CCPP. Restricting this equipment to communications only with CCPP patients would be excessively burdensome and wasteful, as individual providers would need to determine each patient’s eligibility before reaching out to them via CCPP equipment. Given this, if CCPP eligibility were extended to health care providers who serve a majority of higher-income patients, then the majority of the benefits of this equipment would accrue to higher-income patients – in contradiction to the CCPP’s goals.

Finally, please note that the Federal Department of Health and Human Services has programs to identify “safety net” health care providers (who are likely to meet this majority-low-income standard) and collects information on the income breakdown of many providers’ patient mixes. At the request of the FCC, NACHC has the capability to connect FCC staff with appropriate HHS staff, so that the FCC could use these data in eligibility determinations.

* Eligibility should be extended to organizations that represent groups of providers who would be eligible, individually.Since health centers are small, community-based organizations, the costs of managing a CCPP project could be too extensive for many of them to handle individually. However, there are membership organizations that consist of CHCs, as well as other small safety net providers, such as certain rural health clinics. These organizations include State Primary Care Associations and Health-Center Controlled Networks. To allow for economies of scale, eligibility for CCPP grants should be extended to organizations whose members consist largely or entirely of health care providers who would be eligible individually.

## ELIGIBILITY CRITERIA FOR LOW-INCOME SUBSCRIBERS (I.E., PATIENTS)

### Eligible low-income subscribers should: 1) have incomes at or below 200% FPL, and/or be veterans who qualify for free care, and 2) be actively participating in connected care.

* + ***Below 200% FPL and/or qualified veteran:*** To ensure consistency across the program, eligibility requirements for low-income patients should reflect eligibility requirements for the health care providers that apply to participate in the CCPP. Consistent with our recommendations above, NACHC recommends that to receive support through the CCPP, a patient should either be below 200% FPL or be eligible for free care through the VA (i.e., a “qualified veteran.”)
  + ***Active participant in connected care:*** In addition, to be eligible for CCPP support, the patient should be actively participating in connected care. This means that a patient’s participation (i.e. broadband access, equipment) should end if either of the following conditions are met:
    - The patient’s medical condition changes such that he or she no longer meet the medical criteria for participating (e.g. after a woman with a high-risk pregnancy gives birth), or
    - The patient consistently fails to participate in the connected care activities. (The specific threshold for when to disenroll a patient should be determined by the health care provider and explained in their CCPP application.)
    - ***No restriction based on current broadband status:*** NACHC does not recommend restricting participation to patients who do not currently have broadband access. Such a requirement would penalize patients could encourage “gaming” the system (i.e. dropping access immediately before applying for CCPP.)
    - Participating health care providers should be permitted to select the specific health conditions or demographic characteristics that they will target.

NACHC recommends that participating health care providers be permitted to select the particular group of low-income patients and/or health conditions that they will target with their pilot projects. Given that the CCPP’s central goal is to explore the potential impact of connected care on low-income patients, restrictions on the types of low-income patients and/or health conditions (e.g. only the elderly, or those with diabetes) will unnecessarily place a limit on the scope and depth of information that can collected and utilized in the review of the effectiveness of the project(s). To maximize the potential impact of the CCPP – and gain useful information for any future programs with similar goals – it is important to allow participating health care providers to target the patients that they feel best equipped to serve via connected care. However, it may be construed as the FCC doing its diligence, should the FCC desire to consult with appropriate entities (e.g. CMS) to identify a specific list of health conditions from which project applicants can choose as elements in their project and application.

## FINANCING AND USES OF EQUIPMENT

### Participation should not be limited to proposals where the broadband provider will donate the end-user equipment.

While it would be very beneficial for the internet service provider (ISP) to donate the end-user equipment for CCPP projects, NACHC does not think that this should be a requirement for a proposal to be funded. CHCs’ experience suggests that ISPs in some parts of the country are much more willing to donate equipment than those in other parts. Thus, a requirement for donated equipment could unfairly penalize health care providers and low-income patients in areas where ISPs are less likely to make donations.

### Participating health care providers should be permitted to use their on-site CCPP equipment to provide care to any patient, regardless of whether the patient is a low-income subscriber participating in the CCPP.

Participating health care providers should be permitted and expected to use their on-site CCPP-provided equipment to connect with all of their patients —regardless of whether the patient is eligible to participate in the CCPP. If providers were permitted to use their CCPP equipment to communicate only with CCPP patients, then every time a provider wanted to reach out to a patient remotely, he or she would need to determine if the patient were a CCPP participant – a very burdensome step for the provider, and a potential deterrent to using the CCPP equipment at all.

This underscores our comment above, that eligibility should be limited to health care providers for whom a majority of their patients are low-income (including veterans who qualify for free VA care.) If health care providers can use their on-site CCPP equipment to communicate with any patient (and a majority of their patients are higher-income), then a majority of the benefits resulting from that equipment would accrue to higher-income patients – which is contrary to the CCPP’s central goal of expanding connected care to low-income patients.

### Health care providers should be permitted to determine what type of patient equipment is most appropriate for their care model.

NACHC recommends that health care providers be permitted to choose the type of equipment that will be provided to participating patients. We are aware that some projects may propose giving patients equipment that can be used for purposes beyond health care, such as tablets or mobile phones. In some circumstances, these devices may be the most cost-effective way to provide the patient with the necessary access. Therefore, we recommend that applicants be required to describe in their CCPP applications the type of equipment they plan to provide to patients, and why it is the most appropriate selection.

**Equipment that is funded directly or indirectly through the CCPP should be provided to eligible patients for free and/or at a reduced fee based on income.**

If patient-use equipment is funded directly or indirectly through the CCPP (either by being purchased with CCPP funds or being donated by an ISP participating in the program), then eligible patients (as defined above) should either receive this equipment for free, or be charged a reduced rental fee based on their income. They should also be expected to return the equipment when they stop participating in the program. Patients who do not meet the eligibility criteria outlined above should also be permitted to receive the equipment, but these costs should not be absorbed by the CCPP; rather, they should be covered by the grantee, who may elect to charge these patients to purchase or rent the equipment.

## REGULATORY BARRIERS TO TELEMEDICINE

### Regulatory barriers prevent health care providers – including but not limited to CHCs -- from being reimbursed for telemedicine, creating a significant impediment to the spread of this technology.

As discussed in our overarching comments, a major impediment to the spread of connected care is that insurers often do not reimburse health care providers for the time or expenses required to provide care in this manner. The lack of reimbursement is particularly problematic for safety net providers like CHCs, who generally cannot absorb these costs, while operating under such small margins. For this reason, we encourage the FCC to work with the Centers for Medicare and Medicaid Services to identify ways in which the CCPP could be paired with their waiver authority to allow for reimbursement for connected care services provided to Medicare and Medicaid patients.

### Community Health Centers (CHCs) are further discouraged from engaging in telehealth by the significant uncertainty and burdensome requirements associated with getting their Federal malpractice insurance to cover these services.

Community Health Centers that receive Federal grant funding are eligible to receive government-funded medical malpractice insurance through the Federal Tort Claims Act (FTCA.) At present, the rules addressing whether FTCA will cover services provided via remote technology (e.g., telehealth visits, remote patient monitoring) are extremely complex and burdensome. For example, for each service provided in this manner, the sites where both the patient and the provider are located at the time of the service must be officially registered and approved by the Federal agency that oversees the CHC program, prior to the service being provided. Also, any patients who are cared for remotely must be strict requirements around residing in the health center’s service area. Due to these rules and associated burden, many health centers end up purchasing separate “gap” malpractice insurance to ensure that they are covered for these services. For many other CHCs, the uncertainty around FTCA coverage combined with the lack of insurance reimbursement makes it prohibitively expensive for them to engage in connected care.

### Conflicting state laws create barriers to providing care across state lines.

State laws frequently create barriers to health care providers practicing across state lines.[[4]](#footnote-4) Most noticeably, individual health care providers must be licensed in each state where they have a patient whom they care for remotely. In addition to the paperwork and fees associated with getting multiple state licenses, providers must also adhere to the unique clinical practice standards and continuing medical education requirements in each state.

Since the FCC lacks the authority to override state laws, NACHC recommends that the Commission prohibit individual providers from operating outside their scope of practice (the range of services they are legally permitted to provide) and in geographic areas for which they do not have a license.

## EVALUATION

### When establishing evaluation parameters, the FCC should keep in mind the limits on the types of data that health care providers can access.

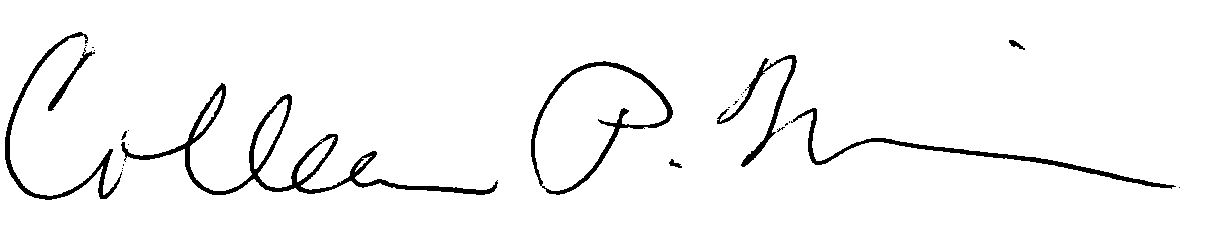
NACHC recommend that any ***mandatory*** evaluation measures (i.e., measures that all participating providers are required to report) focus on factors that are within those providers’ control. For example, while changes in patients’ use of urgent care or emergency rooms could be valuable measure, not all health care providers will be able to access these data. Small community-based providers may encounter particular difficulties, as they may lack the market power to be able to convince hospitals and urgent care facilities to share these data. In such instances, an exception should be included, wherein health care providers should not be required to report on those measures for which they can demonstrate a lack of ability to acquire the necessary data.

Alternative evaluation measures may need to be developed (or an opportunity to propose such measures should be afforded) to include factors such as changes in clinical status (e.g. reductions in A1c levels for diabetes patients), trips to the provider’s office, and/or patient and provider satisfaction. Again, NACHC would suggest consulting with appropriate entities, such as CMS, in determining what would constitute an appropriate, alternative measure. However, in general, health care providers should be permitted to identify evaluation measures for their projects, within general parameters specified by the FCC.

### The FCC should request support from CMS to access Medicaid and Medicare data

For patients on Medicaid and Medicare, data on the types and amount of care they received -- in addition to the costs of that care -- will be valuable measures for evaluating the impact of the CCPP. CMS collects Medicare data, so NACHC encourages the FCC to reach out to CMS to request access to that data. In contrast, Medicaid data are collected and stored by individual states and many states may be reluctant to share it with individual providers. However, CMS can be a valuable partner in accessing this state-held data. Thus, when the FCC staff talk with CMS about reimbursement issues, it is recommended that their support in accessing Medicare and Medicaid data for evaluation purposes is solicited.

Respectfully submitted,



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1. *Promoting Telehealth for Low-Income Consumers*, WC Docket No. 18-213 [↑](#footnote-ref-1)
2. Section 330 of the PHSA authorizes four types of health centers: Community Health Centers (CHCs), and health centers who target: migrant workers; persons experiencing homelessness; and residents of public housing. As CHCs comprise over 80% of all health centers, and all four types of health centers are subject to the similar rules, the term “Community Health Centers” is commonly used to refer to all four types. The term Federally Qualified Health Center (FQHC), which is found in the Social Security Act, is also sometimes used to refer to Section 330 Health Centers. In this document, we use the terms Community Health Center to refer to all health centers authorized under, and subject to the rules of, Section 330 of the PHSA. [↑](#footnote-ref-2)
3. https://www.kff.org/health-reform/state-indicator/medicaid-income-eligibility-limits-for-adults-as-a-percent-of-the-federal-poverty-level/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Parents%20(in%20a%20family%20of%20three)%22,%22sort%22:%22asc%22%7D [↑](#footnote-ref-3)
4. For an overview of these regulatory barriers, see http://www.milkenreview.org/articles/telemedicine-across-state-borders [↑](#footnote-ref-4)