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August 7, 2018

Secretary Marlene H. Dortch
Federal Communications Commission
Washington, DC 20554
Delivered via the Electronic Comment Filing System https://www.fcc.gov/ecfs/

COMMENTS OF EMHS*
Before the
Federal Communications Commission
Washington, D.C. 20554

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

*Note: EMHS will become Northern Light Health on October 1, 2018

Dear Secretary Dortch and Members of the Commission:

EMHS appreciates the opportunity to respond to the Federal Communication Commission's Notice of Inquiry regarding "Promoting Telehealth for Low-Income Consumers", WC Docket No. 18-213. EMHS is an integrated healthcare system of 9 hospitals, primary and specialty care practices, a home health division, hospice care, nursing homes, and emergency ground and air transport that serves the people of Maine from Portland to the Canadian border. With the growing importance of broadband-reliant telehealth, we commend the Commission for addressing how to improve access and delivery to rural and underserved areas of the country.

In healthcare, we strive to care for our patients in the most appropriate setting providing the right level of care. With technology and home care/hospice support, many can stay or return home, where the patient and family want to receive care. Yet, we are fundamentally challenged with lack of rural broadband coverage and flawed Medicare policies that create unnecessary barriers to the provision of telemedicine services.

Maine has pressing needs for services that bring health care from the facility to the patient's home. Maine has the oldest population in the nation, with a large number of Maine's older adults living in rural and remote parts of the state. Many Maine residents have multiple chronic health conditions. Yet, Maine has a shortage of healthcare workers at every level including home care workers, nurses, and a variety of specialists, in many rural areas, impacting delivery of care and health outcomes. Medicare is the primary source of health coverage for our older adults. Approximately 28% of Medicare beneficiaries receive Medicaid assistance.

Although broadband is available in 90% of the state, it is not accessible everywhere or at all times or by everyone who needs it. Broadband is not in the homes of all residents, especially the poor, elderly, and disabled residing in rural Maine. In part, this is because adequate infrastructure has not been laid to expand access beyond the hospital and school and out into every home. Economic barriers also exist as people can't afford the equipment and service. Long distances, remote locations, health provider shortages and Maine's harsh and wintry weather contribute both to the need for home telehealth monitoring and telemedicine services and the difficulty of supplying and maintaining it.

Infrastructure - The criticality of a patient's condition dictates the level of reliability required of the telemonitoring infrastructure. A broadband network is only as good as its weakest component and redundancy is critical to creating an effective system. Maine's broadband is generally of poor and variable quality, with limited bandwidth, slow transmission speeds, and lack of redundancy. With low upload and download capacity, the telehealth system is limited in its ability to provide basic communication, to transmit diagnostics and any video images, especially compared to data. Potential future applications involving augmented reality and/or haptics seem unattainable with today's current state. Lack of reliability and capacity in rural remote locations make it too risky for a healthcare system to responsibly use facility-to-home telemonitoring in many critical and chronic conditions, as well as post-discharge. Often, it precludes community paramedics from transmitting information to facility-based providers, receiving e-prescriptions, and delivering immediate and *in situ* care. Expanding broadband to the home requires technology and infrastructure organizations to create the capacity that healthcare providers can then access to expand services.

Affordability – Maine has a high rate of poverty, especially among older adults and those with chronic conditions. Even if reliable broadband were available, access would be unaffordable for many. In addition, many older adults who have broadband in their homes cannot afford and/or do not have routers and wireless capabilities, needed for home-based monitoring, diagnostics, and care delivery.

Regulatory Barriers - Medicare telemedicine regulations are a primary barrier to expanding access to telemedicine services in rural Maine and to rural residents in their homes.
Originating Site - Per Medicare policy an originating site is the location of an eligible Medicare beneficiary at the time the service furnished via a telecommunications system occurs. Medicare beneficiaries are eligible for telehealth services only if they are presented from an originating site located in a county outside of a Metropolitan Statistical Area (MSA). This regulation is a primary barrier to expanding telemedicine in Maine. The MSA counties are large geographic regions with rural patients distant from the urban population dense areas. The home is expressly disqualified as an originating site for the patient to receive Medicare covered telemedicine services.

Distant Site Practitioners: Practitioners at the distant site who may furnish and receive payment for covered telehealth services (subject to State law) are Physicians, Nurse practitioners (NPs), Physician assistants (PAs), Nurse-midwives, Clinical nurse specialists (CNSs), Certified registered nurse anesthetists, Clinical psychologists (CPs), Clinical social workers (CSWs), Registered dietitians/Nutrition professionals. CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838.

We recommend that the list of practitioners be expanded to include a variety of professionals including physical therapy, speech therapy, occupation therapy and registered nurses. If a service is a Medicare covered service and can be delivered via technology then the service should be covered by Medicare telemedicine policies. Medicare policy barriers must be addressed to increase telemedicine access into the home.

Populations – We recommend increasing access to telemedicine and tele-home monitoring
1) For patients based on health status, rather than income or insurance coverage,
2) Access to specialists and primary care in the home
3) Access to technology supported home care including therapists, social work, nurses and community paramedicine
4) Access to behavioral and addiction treatment services
5) For people living with challenges that would prevent their getting to healthcare providers – living in remote locations including offshore islands, winter weather, and transportation barriers. (Maine has very little public transportation.)

Workforce – Expanding telemedicine and telehealth services will create efficiencies that help to address health professional shortages. Maine providers are aging and we experience significant shortages of specialists including psychiatrists and addiction treatment clinicians. Increasing the use of technology creates demand for information technology staff and resources to fund the technology support needed for the clinical services. State licensing board and provider/insurer credentialing standards will need to support the professional practice via technology. With respect to workforce training, as new training tools become available, including advanced 'hands-on' technologies, current transmission speeds severely limit the potential for simulation and haptic teaching, which will be important to reaching providers across our rural state.

Future Development – We suggest Four Key Focus Areas:

1. Expand Broadband infrastructure to the home with redundancy capacity and speed to ensure consistency in service
2. Modernize Medicare telemedicine policy to support expanded access
3. Align FCC and FDA to create efficiencies in the approval process for new technology
4. Evaluate successful telemedicine technology in other countries for adoption on America.

Pilot Design – While we applaud the launch of this pilot, we caution that $5M per pilot is not enough money to do all this and generate data with statistical significance. We encourage you to be

inclusive of non-rural originating sites in order for us to be able to access the breadth of specialists and truly create a network for the care continuum.

Respectfully submitted,

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