Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

In the Matters of	)
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Promoting Telehealth for Low-Income Consumers	) WC Docket No. 18-213
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REPLY COMMENTS OF MERCY VIRTUAL

Mercy Virtual, a division of Mercy ACO Providers' Services ("Mercy"), provides these reply comments in response to the Federal Communications Commission's ("FCC" or "Commission") Notice of Proposed Rulemaking ("NPRM") in the above-referenced proceeding.[1] Mercy Virtual submitted detailed comments to the Commission and reiterates support for those positions.[2] In response to the robust input the Commission received, Mercy Virtual provides targeted comments highlighting the record support for maximizing the impact of the pilot by providing program funding for end-user devices such as remote patient monitoring devices; to promote improved health care outcomes by requiring that pilot applicants must be associated with health care providers maintaining a physical presence; and, maximizing the use of pilot funds for telehealth and connected care services by minimizing the administrative costs and burdens for pilot participants.

I.   The Commission Should Support End-User Devices to Maximize Health Care Outcomes for Pilot Patients

The record in this proceeding reflects Mercy Virtual's experience that very limited and sometimes no reimbursement from Medicare and private insurance is currently available for

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[1] *Promoting Telehealth for Low-Income Consumers*, Notice of Proposed Rulemaking, WC Docket No. 18-213, FCC 19-64 (2019) ("NPRM").

[2] Comments of Mercy Virtual, https://www.fcc.gov/ecfs/filing/108292195529423 (filed Aug. 29, 2019).

telehealth services, remote patient monitoring, and/or end-user devices.[3] Mercy Virtual and the other commenting telehealth providers have been forced to cover the cost of end-user devices due to the slow adoption and recognition of connected care costs in the current insurance model. Mercy Virtual typically must incorporate device costs, such as the costs for a tablet devices, blood pressure cuffs, pulse oximeters, weight scales, vitals monitoring patches, etc. into its connected care offerings to enable quality patient care while balancing economic considerations. The lack of reimbursement for these technology needs is often the primary barrier for getting patients the devices necessary for providing quality care. The potential of telehealth services to greatly improve health outcomes while reducing healthcare costs and delays will not be fully realized if end-user devices are excluded from funding eligibly.

To achieve the most beneficial care outcomes from funded pilot programs, the Commission should provide support to offset or reduce the cost of needed remote monitoring devices. The record overwhelmingly supports funding end-user devices, like remote patient monitoring devices, with pilot funding.[4] While the Commission proposes to make end-user devices, medical devices,

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[3] OCHIN Comments at 3; American Association of Nurse Practitioners Comments at 2; American Hospital Association Comments at 8; AdventHealth Comments at 4; Ochsner Comments at 16; PATH Comments at 10-11; Connected Health Initiative Comments at 7; Co-Bank Comments at 7; *and see* Center for Medicare & Medicaid Services, *Contract Year 2020 Medicare Advantage and Part D Flexibility Final Rule (CMS-4185-F)*, https://www.cms.gov/newsroom/fact-sheets/contract-year-2020-medicare-advantage-and-part-d-flexibility-final-rule-cms-4185-f (Apr. 5, 2019) (expanding codes for telehealth, but limiting reimbursement to specific rural identifiers and not allowing in-home delivery of service).

[4] OCHIN Comments at 3; American Association of Nurse Practitioners Comments at 2; Virginia Telehealth Network Comments at 7-9; American Hospital Association Comments at 10; CTIA Comments at 8; Pharmacy Health Information Technology Collaborative Comments at 3; AdventHealth Comments at 3-4; CHRISTUS Health Comments at 7-8; University of Mississippi Medical Center Comments at 2; Doctor on Demand Comments at 1-2; Viraspex - The Virtual Vascular Specialists Comments at 5-6; Ochsner Comments at 21; PATH Comments at 5-6; Medical University of South Carolina Comments at 6; Gila River Telecommunications Comments at 3; Connected Health Initiative Comments at 7; Multistakeholder Digital Health Group Comments at 1; California Primary Care Association Comments at 2; Co-Bank Comments at 7; Hughes Network Comments at 4.

and mobile applications ineligible for support,[5] the record in the proceeding demonstrates that positive patient outcomes result from the use of remote patient monitoring devices.

End-user devices are an important component of providing "pro-active" care through telehealth services. In Mercy Virtual's experience, patient care is dramatically improved when health care providers are able to receive data from remote patient monitoring devices. For example, Mercy Virtual's vEngagement and vKids programs have 86% and 95% asynchronous daily digital touch with patients and families, respectively. As a result, both programs have been able to increase the provider to patient ratios, but still maintain 98.2% patient's satisfaction rating. By leveraging broadband, triage software, Bluetooth devices, and remote survey technology, Mercy Virtual maximizes its network of health care professionals and reduces the overall cost of care by targeting the right care to the patient at the right time. This approach greatly reduces unnecessary ER visits and hospitalizations. In addition, patients can interact on their own time schedules, which eliminates the burden on families to provide unnecessary transportation to clinics with remote monitoring or other devices necessary for the patient's needs. Without end-user devices, broadband, and the financial support of the FCC through the pilot program, improvements in health outcomes and reductions in costly inefficiencies will be limited due funding constraints.

Further, the record demonstrates that even when a patient possesses a personal mobile device, such as a tablet or smartphone, challenges exist in utilizing the device due to differing mobile platforms, operating software version age, and the extent of broadband service capabilities of the patient's personal mobile device.[6] Additionally, the data requirements of telehealth

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[5] NPRM at para 26.

[6] OCHIN Comments at 3; Virginia Telehealth Network Comments at 7-9; American Hospital Association Comments at 10-11, 18-19; Pharmacy Health Information Technology Collaborative Comments at 3; AdventHealth Comments at 3-4; CHRISTUS Health Comments at 7-8; Doctor on Demand Comments at 1-2; Ochsner Comment at 21; PATH Comments at 5-6.

monitoring services often, if not always, include continuous streaming of patients' biometric data, which requires certain minimum hardware requirements that older consumer devices may not meet. The transmission of patient data can quickly exceed the limits of a patient's personal wireless data plans. This is especially true for patients in medically underserved areas. Remote monitoring allows health care providers ready access to patient status data and thus enables more efficient and effective patient-health care provider interactions focused on needed medical attention rather than the logistics of transmitting patient data. For these reasons, the Commission should fund end-user devices.

II. The Commission Should Limit Eligibility to Experienced Telehealth Providers with Physical Presence in the Proposed Service Area

The Commission proposed to use the existing statutory definition of non-profit or public health care providers within section 254(h)(7)(B) and sought comment on additional considerations for eligibility, like prior telehealth experience.[7] Mercy Virtual shares the view of those commenters seeking to limit eligibility to health care providers that have a background in telehealth and have "brick and mortar" locations in proximity to patients.[8] A requirement that limits participation to experienced telehealth providers will ensure the greatest outcomes for the pilot's funding and accurately measure the effects of telehealth on health care. Further, Mercy has observed that providing telehealth services without a "brick and mortar" location creates gaps in the quality and reliability of the "connected care" provided. Without the ability to bring patients into a local healthcare location, the health care provider is not able to provide the full continuum of care. Fragmented care creates confusion for the patient and can delay necessary care, which

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[7] NPRM at paras. 37-40; 47 U.S.C. § 254(h)(7)(B).

[8] Virginia Telehealth Network Comments at 10-12; American Hospital Association Comments at 10-11; Ochsner Comment at 29-30; myNexus Comments at 12-13; Association of State and Territorial Health Officials Comments at 4-5.

leads to higher cost, lower satisfaction and negative patient outcomes. Telehealth and connected care promotes proactive monitoring and management, but full patient care necessitates in-person interactions at appropriate times that require the participating health care provider to have some local presence.

III. The Commission Should Design Applications to Consider Health Care Provider Qualifications While Permitting Flexibility in Network Design and Procurement

Limiting the administrative costs and burden for potential pilot participants will increase participation in the application stage and maximize the pilot's funding for patient care. Several parties urged the Commission to minimize the administrative burdens in the program and especially at the application stage.[9] In contrast to the Commission's proposed detailed application process[10] that could deter applicants from participating in the pilot program, the commenting health care providers recommend taking steps to limit the administrative burden on applicants during the initial application process. Mercy Virtual continues to support application requirements calling for information regarding the health care provider's experience and prior telehealth qualifications and believes the 120-day period would be sufficient for providing qualifications and pilot program proposals. However, requiring applicants to have detailed estimates of total eligible and ineligible costs including estimates for the proposed broadband connectivity *prior* to the applicants knowing which patients will be participating in the program will pose onerous administrative requirements that will deter applicants.

The difficulty in predicting with accuracy the cost of providing broadband connectivity to a patient base not yet identified outweighs the benefits to the pilot program in assessing

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[9] Virginia Telehealth Network Comments at 9-10; OCHIN Comments at 1-3; American Hospital Association Comments at 11-12; Ochsner Comment at 26-27; PATH Comments at 11-12; myNexus Comments at 13-14; State of Colorado Comments at 21-24.

[10] NPRM at para. 50.

applications. Mercy Virtual continues to recommend providing overall cost estimates during the application phase, then establishing a secondary cost approval process during the ramp-up period *after* the participating patients have been identified. This sequence improves cost estimates and lowers the administrative burden during the application phase, thus promoting greater health care provider participation in the program.

Specifically, Mercy Virtual recommends a secondary post-application process flow to occur within the six-month ramp-up period for the pilot where the pilot participant would: 1) identify patients for the pilot within the defined condition group; 2) assess the broadband and equipment needs of the patient base; 3) evaluate possible service providers and receive bids for providing broadband service; and, 4) select service provider(s) and file costs with the Commission. This application and cost filing process promotes the Commission's goals of selecting diverse and experienced health care providers while maintaining flexibility for providers to select broadband connectivity plans based on patients' needs. The initial application should focus on the health system's record and current ability to reach out to rural/low income populations with the willingness to participate in the pilot. Then, once approved for total cost and scope of the pilot, the health care provider can design an appropriate broadband connectivity plan for the participating patients.

IV. Conclusion

Mercy Virtual continues to support the Commission's efforts with the Connected Care Pilot program and further funding for telehealth services. Commission action will have a significant impact on the health care outcomes for patients by limiting or removing cost barriers to obtaining the necessary broadband connectivity and other related services and devices. Mercy Virtual encourages the Commission to utilize Mercy Virtual's extensive telehealth experience as it establishes the Connected Care program.

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