

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

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

COMMENTS OF OCHSNER HEALTH SYSTEM

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EXECUTIVE SUMMARY

Ochsner Health System applauds the FCC's proposal to examine the communications policy-based obstacles to the broader adoption of remote telehealth services in the United States. Ochsner has extensive experience in providing digital enhancements within and among hospital and clinical settings, as well as in launching pioneering remote health offerings that have had positive effects both on patient health outcomes and on care costs. If the Pilot program allows for a range of experimentation and aggregate information collected from experimentation to be shared, it can benefit the FCC and contribute to formation of public policy by demonstrating that there are viable paths to offering low-income and underserved patients healthcare that can be available anytime or anywhere there is a broadband connection.

Ochsner has developed a range of hospital and clinical setting capabilities that can collect and analyze data from patients, and Ochsner has recognized for some time the value of providing remote monitoring and service delivery to patients with chronic health conditions. Part of our experimentation in remote health monitoring has been to lower the barriers associated with the use of connected diagnostic devices by having these devices connect to the patient's existing wireless device, most often a smartphone, which then uploads patient data into their electronic health records. This approach to connection is simple to set up for a patient, and simple for a patient to use. The cost barrier to greater adoption has been the cost of the diagnostic devices, which while provided to patients by Ochsner, can still cost the patient something, and can still present a financial barrier to use of remote care, particularly for low-income individuals.

The Connected Care Notice asks questions that focus on two models of low-income Connected Care service provisioning; one where the Health Care Provider ("HCP") bulk purchases patient broadband connections, and the other where a remote monitoring company handles the

broadband procurement as an element of a packaged offering to the HCP. Neither of these are models used by Ochsner. Instead, patients make use of the data plans they have for their existing broadband service from their existing service providers to access Ochsner's digital programs. Ochsner sees no particular benefit to the Connected Care Notice proposals to require that the Pilot program participant HCPs structure their Pilots using a single broadband service provider to be selected by competitive bidding. This structure would be a disruptive and more expensive disintermediation of a broadband connection provider that the patient chose himself or herself, and Ochsner anticipates that that structure would lead to fewer low-income patients enrolling in and benefiting from remote health monitoring. The FCC is not required or limited to using competitive bidding to allocate universal service resources and it should not be the exclusive form of cost support in any Connected Care Pilot program.

Ochsner strongly supports the FCC's stated goals for its Connected Care Pilot program, which are to help improve health outcomes, to help reduce health care costs for patients, facilities, and the health care system overall and to support the trend toward bringing healthcare directly to the consumer. Ochsner can be a resource by showing how universal service support funding can positively affect existing telehealth initiatives. However, the structure advanced for comment in the Connected Care Notice appears to be a version of the FCC's established Rural Health Care ("RHC") program that has as its focus an entirely different issue and challenge; the connection of rural hospitals and clinics so that they have access to broadband and other qualified services on par with their urban counterparts. The FCC's stated goals for piloting remote health monitoring of low-income patients are different, and that requires a different approach, one that focuses tightly on the obstacles to providing Connected Care to low-income patients. To advance health outcomes

and access by remote Connected Care, the costs that are most problematic are not the broadband connection cost, but the cost of connected diagnostic devices and apps.

While the FCC must respect the statutory framework it has within section 254 to advance universal service objectives, it is not straightjacketed to repeating and applying its rules from the RHC program that will not achieve the FCC's stated goals for Connected Care. As a fundamental matter, the FCC, in this Pilot phase, should avoid constraining promising programs in telehealth and digital medicine or discourage HCPs with digital health experience from participation, or the FCC will lose valuable insight into how telehealth can transform the patient experience as well as achieve system-wide cost efficiencies. Ochsner suggests that the FCC look to recent updated CMS coverage rules for Connected Care and its own definition of information services to determine what an FCC Pilot program designed to target low-income populations can or should support. Because provisioning of broadband connections on a sole source basis is not a particularly efficient way to provide digital medical capabilities to patients, Ochsner believes it would be a mistake only to fund that service or structure.

Section 254 affords the FCC the flexibility to encourage the deployment of the types of facilities that will best achieve the principles of universal service. Determining at the outset that a remote health Pilot program should be constrained to support the same types of services in more or less the same way as in the current RHC program does would be very counterproductive. The purposes of the RHC program and the Pilot are very different. This approach would cut off new and potentially critical cost-effective digital medicine delivery innovations from study, review, and improvement and undercut the FCC's stated goal of learning more about the obstacles to remote health and sharing that information to encourage cost-efficient service options that can improve the lives and health outcomes of low-income and all patients.

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Ochsner Health System (“Ochsner”) submits these Comments in response to the Commission’s Notice of Proposed Rulemaking seeking comments on the scope of supported services and key areas of focus of a new three-year Connected Care Pilot Program using a proposed \$100 million in funding from the Commission’s Universal Service Fund (“USF”).¹ Ochsner remains strongly in support of the goals of the proposed Pilot program and believes that, if properly structured and implemented, the program can lead to better health outcomes for participants and, critically, can capture and share lessons learned about viable options to promote effective, cost efficient patient-centered connected care. There is no single solution to offering constructive telehealth or digital medicine programs that improve health outcomes, and the Commission’s Pilot actively should avoid constraining promising programs that already work by not applying a range of unnecessary requirements that discourage participation from established Health Care Providers (“HCPs”) with existing programs.

I. OCHSNER IS A LEADER IN CONNECTED CARE

Ochsner, headquartered in Louisiana, is a national leader in pioneering digital health applications. Since 1942, Ochsner has evolved into the largest private, not-for-profit healthcare system in its region, encompassing 40 owned, managed and affiliated hospitals and specialty

¹ See Promoting Telehealth for Low-Income Consumers, *Notice of Proposed Rulemaking*, FCC-19-64 (July 11, 2019) [hereafter *Connected Care NPRM or Notice*].

hospitals and more than 100 neighborhood health clinics and urgent care centers in both urban and rural areas.

A. Ochsner Focuses on Providing Innovative Telehealth Offerings to Rural Area and Low-Income Population.

According to 2018 data from the HHS Health Resources and Services Administration (“HRSA”), the state of Louisiana’s 4.6 million residents have a median household income that is \$10,942 below the US national median of \$57,652. HRSA classifies an appreciable number of Louisianans as geographically isolated, medically and/or economically underserved.² Ochsner provides a comprehensive range of health services through its network hospitals and clinics located throughout the Greater New Orleans, Baton Rouge and Bayou regions of Louisiana, as well as north and west Louisiana, including Lake Charles, Shreveport and Monroe. Some of these areas are largely rural, with a relatively low-income population struggling with a provider shortage in many specialty areas.

Ochsner has approximately 3,600 affiliated physicians, including 1,500 Ochsner-employed physicians, practicing in more than 90 medical specialties and subspecialties. These HCPs provide over 100 telemedicine services to more than 80 hospital and clinic partners, who treat a growing number of patients each year using telehealth platforms and devices.³ Ochsner also is a major referral center, serving patients throughout the Gulf South Coast and across the country with a wide array of nationally-ranked and specialized clinical services that treat some of the most challenging and complex medical conditions including: organ transplantation; oncology;

² HRSA data also shows that portions of 64 parishes in Louisiana are medically underserved and portions of 52 of the 64 counties are designated as rural.

³ Generally speaking, Ochsner uses “telehealth” to refer to its in or among hospital or clinic patient monitoring and data use and “digital medicine” to refer to its direct-to-patient Connected Care services.

neurosciences; cardiovascular care; high-risk obstetrics; pediatric specialty care; and, programs focused on chronic diseases.⁴

Ochsner has developed an integrated delivery system that features a comprehensive range of clinical services, coordinated systems of patient care, sophisticated electronic health records (EHR), and the geographic reach, scale, and clinical capability necessary to manage and improve the health of a large and diverse patient population. As part of this commitment to innovation that meets the needs of patients, families, and communities – particularly those affected by chronic disease – Ochsner has developed numerous telehealth and digital medicine programs that are transforming the patient experience, enhancing health, and well-being, while reducing costs.⁵

Ochsner's focus on innovative telehealth and digital medicine offerings for its region continues to grow. In addition to its highly successful Hypertension Digital Medicine Program highlighted in the FCC's Connected Care Notice of Inquiry,⁶ Ochsner's innovationOchsner (iO)⁷

⁴ Further, Ochsner houses an academic medical center with nearly 300 full-time residents and fellows participating in 28 ACGME accredited graduate medical education programs and four additional specialty programs; a global medical school in partnership with The University of Queensland School of Medicine in Brisbane, Australia; and, programs of biomedical research.

⁵ For example, Ochsner's Telestroke, Psychiatry, and Ochsner Anywhere Care, Urgent Care and Behavioral Health services can be available and cover the state.

⁶ See Promoting Telehealth for Low-Income Consumers, *Notice of Inquiry*, 33 FCC Rcd 7825, para. 5 (2018) [hereinafter *Connected Care NOI or NOI*]. For more information on the Hypertension Digital Medicine program, please see Ochsner's previous comment letter to the Connected Care NOI, available at <https://ecfsapi.fcc.gov/file/10910277722605/Ochsner%20Digital%20Health%20and%20Technology%20Brief%202018.pdf> (last visited Aug. 28, 2019).

⁷ In 2015, Ochsner formed iO, an innovation lab whose mission is to reimagine and revolutionize the delivery and experience of healthcare and dramatically improve health outcomes using technology, data and new thinking. Through iO, Ochsner has been a pioneer in developing solutions in the areas of digital health, advanced analytics and artificial intelligence (AI), and precision medicine. These solutions have been successfully improving the patient experience of care, improving the health of populations, reducing the *per capita* cost of health care, and

and CareConnect 360 telehealth teams have led the design and implementation of numerous award-winning programs in digital medicine and they continue to identify potential new telehealth applications and service models. Ochsner's remote care initiatives have resulted in significant improvements in the care and management of patients with chronic disease and accelerated diagnoses and treatment for patients with acute and deteriorating medical conditions.

B. Ochsner Has Pioneered a Number of Successful Telehealth and Digital Medicine Programs.

There are a wide range of hospital and physician-based telehealth applications that can provide vital and real-time health information and continuous engagement with individual patients in hospital, home, and community-based settings, and Ochsner has pioneered a number of them, while consistently applying what it learns to make each project or application more effective or more user-friendly. Consistent with the goals envisioned by the FCC's Connected Care Pilot Program, Ochsner is eager to help more patients adopt and benefit from remote monitoring of patients in a manner that can have transformative health benefits. While there are a range of telehealth and digital medicine services Ochsner is already providing, some of which are described below, there are more patients that could be reached and more projects that could be explored if an FCC Pilot program were to fund some aspects of the offering.

Ochsner Anywhere Care for Primary and Urgent Care Needs: Ochsner has initiated direct-to-patient urgent and primary care, removing barriers to care for patients and providers alike; this allows non-emergent medical visits to happen with near immediate access while keeping our population healthier and happier at home, work, or school. Through this program, patients are able to download a mobile application on their own mobile device and meet with HCPs through

improving the work life of the provider of care.

videoconferencing. It enables HCPs to send prescription electronically to a pharmacy of the patient's choice and to provide the patient with a post-visit report in a portable format. This program is currently available in all 50 states, while Ochsner has already served patients in 19 states.

This service is delivered through a mobile application on the patient's wireless phone. The patient accesses on-demand video visit care by choosing a board-certified provider. Visits are conducted over an audio-visual connection and the patient must have a Wi-Fi connection to launch the video visit. Patients may pay directly for the service out-of-pocket, or file with their insurance company for coverage. Today, Ochsner Anywhere Health Kit is an out-of-pocket expense to the patient of \$299 for the Kit, exclusive of any per visit fee associated with the use of the Kit, which can depend upon the patient's health insurance coverage. Ochsner is working on additional options to assist patients in the cost of this Anywhere Health Kit, such as insurance coverage for the Kit.

Connected Maternity Online Monitoring (Connected MOM) Program for Expectant

Mothers: Connected MOM allows expectant mothers digitally to send weight, blood pressure readings, and urine protein test results to their medical team from the comfort of home and without the need to schedule an appointment. Deployment of this technology may reduce the number of in-person appointments when patient-generated data reflects that everything is within appropriate ranges. Patients appreciate this ability to share data, and at the same time, it allows any potential complications or risks to be detected and addressed sooner, improving access to care and treatment. Each participant in the program is provided with a wireless scale, a wireless blood pressure cuff, and dipsticks and cups for urine protein tests. These smart devices allow the sharing of medical data directly to electronic medical records at Ochsner, where the information

is monitored by the patient's care team. More than 900 mothers have had successful births after being part of the program and more than 500 expectant mothers are currently enrolled.

Expectant mothers must have personal data-enabled smartphones in order to participate in Connected MOM, as the readings from connected devices are seamlessly transmitted to the patient's electronic health care record directly from an installed smartphone app. Likewise, educational content is provided to participating mothers via digital technology, which also requires access to a personal smartphone. The program is available to expectant mothers in commercial insurance plans and Ochsner is in the early stages of enrolling Medicaid patients in the program as well. This Connected Care program improves a patient's ability to access care and treatment, and it also advances the ability of HCPs to coordinate care.

The “O Bar” for Personalized Health Technology: Connected health features can be simple to adopt when HCPs take the right approach and there is readily available technical support for patients. Ochsner recognized early on that digital tools, including smartphones, mobile apps and connected devices could empower patients to be able to contribute to their own health and wellness. Ochsner determined that it would help its patients, and the broader community, to learn about these tools and encourage their adoption as a way to improve health and health outcomes.

Ochsner offers patients the “O Bar,” a specialized type of “Genius Bar” for healthcare technology offerings. The O Bar makes it very simple for patients and communities to learn about, test and obtain health care-related apps and connected devices, directly onto their personal smartphones with help from an Ochsner-staffed expert. First established in 2014, the O Bar is currently in seven locations throughout locations in Jefferson Parish, New Orleans, Baton Rouge, Covington and Westwego. Earlier this year, Ochsner also launched a “Mobile O Bar” to bring the

Connected Care features it offers out into the community, where there may not be fixed healthcare service locations.

The O Bar offers a curated selection of physician-recommended apps focused on wellness, nutrition, fitness, diabetes, women's health, smoking cessation and more, as well as state-of-the-art medical devices including Bluetooth blood glucose monitors, wireless blood pressure monitors, activity trackers, and wireless scales. Because of the O Bar, Ochsner physicians can recommend and prescribe apps and devices for their patients, and O Bar staff can help patients get started by downloading and demonstrating the use of apps and diagnostic devices. This ensures that patients of all ages and skills can easily access and use these digital health tools.⁸ This one-stop shop for a number of remote care applications is one way to spread the costs for telehealth among many projects.

Delivering Cost-Effective Care for Chronic Disease Using Digital Tools - Ochsner Digital Medicine: In contrast to traditional models of primary care, which are based on episodic data points and physician visits, the Ochsner Digital Medicine program offers a comprehensive continuous care model to manage chronic disease virtually, using digital tools. Patients submit regular home-based digital readings from a connected device (such as a wireless blood pressure cuff), and these readings are automatically transmitted to the patient's electronic health record. That data is reviewed by a care team who can identify the trends and proactively intervene to make changes to the patient's medication and provide support on lifestyle and social needs. Each patient's care team is comprised of both a clinician, such as a clinical pharmacist or advanced practice provider, and a health coach, such as a social worker, dietician, health educator, or public

⁸ The O Bar and Hypertension Digital Medicine Program have been featured on CNBC; the report can be viewed at <https://www.cnbc.com/2015/06/09/take-this-app-and-ill-call-you-in-the-morning.html>.

health specialist. Together, using evidence-based guidelines, the care team can provide each patient with individualized, proactive, preventive interventions to manage their chronic disease.

Ochsner Digital Medicine has been shown to improve substantially adherence and health outcomes, also while reducing costs. In a recent study, more than 71% of patients, who were previously out of control, achieved control within 90 days of entering Ochsner Digital Medicine, compared to 31% percent of patients following the traditional care model.⁹ Ochsner Digital Medicine currently offers programs for people with hypertension and/or type II diabetes, which since 2015 have enrolled over 7,000 patients between the two, and is administering a pilot program for patients with chronic obstructive pulmonary disease. Additionally, Ochsner Digital Medicine plans to expand to treat other chronic conditions such as asthma or arthritis. Chronic disease accounts for 75% of deaths and 86% of healthcare costs in the United States, so innovative models of care like these dramatically improve health outcomes are critical in our quest to save and change more lives.

Other Ochsner Telehealth Services and Digital Programs: Through emergency virtual psychiatric services, Ochsner has been able to cut emergency room wait times for psychiatric care at partner sites by 50% and is able to manage about 200 intensive care unit beds daily across systemwide teleICU network. Similar technology and expertise allows Ochsner to monitor laboring mothers with an obstetric program (“Telestork”). HCPs in multiple subspecialties are able to see patients either in remote clinics or in their homes – many miles from Ochsner’s hub facilities.

⁹ Milani RV, et al., *Improving Hypertension Control and Patient Engagement Using Digital Tools*, Am J Medicine 2017;130:14-20.

Each of these and other programs Ochsner has launched and continue to support have costs associated with them, but they also have transformative positive effects for patients and can promote efficiencies in the delivery of quality healthcare nationwide. For example, by reaching more underserved or low-income patients than brick-and-mortar medical facilities, Ochsner's direct-to-consumer programs provide urgent and primary care that help more patients manage their health better and avoid preventable hospitalization. By providing household-based services, Ochsner's digital medicine programs significantly reduce higher costs associated with acute care facilities. In short, when patients' health outcomes improve, health care costs go down.¹⁰

II. THE FCC'S ARTICULATED GOALS CANNOT BE REALIZED USING THE PROPOSED MEANS FOR THE PILOT

Ochsner's existing Digital Medicine programs demonstrate the progress already made towards bringing healthcare directly to the consumer wherever they are. These programs significantly improve health outcomes and reduce the health care costs for patients, facilities, and the healthcare system overall, but there is room for more experimentation and projects. Ochsner constantly evaluates new remote projects that can address known chronic health issues.

Ochsner's programs and efforts in telehealth closely align with each of the FCC's articulated goals for its Connected Care Pilot Program, namely: to "help improve health outcomes through connected care," to "help reduce health care costs for patients, facilities, and the health care system overall," and to "support the trend toward bringing health care directly to the

¹⁰ See Y. Zhao, S.L. Thomas, S.L. Guthridge, J. Wakerman, *Better health outcomes at lower costs: the benefits of primary care utilisation for chronic disease management in remote Indigenous communities in Australia's Northern Territory*, U.S. NAT'L LIBRARY OF MEDICINE NAT'L INST. HEALTH (Oct. 4, 2014), available at <https://www.ncbi.nlm.nih.gov/pubmed/25281064> ("Investing \$1 in primary care in remote Indigenous communities could save \$3.95-\$11.75 in hospital costs, in addition to health benefits for individual patients.").

consumer.” Ochsner seeks to be a resource to help the FCC “determine how USF funding can positively impact existing telehealth initiatives.”¹¹

Ochsner applauds the FCC’s proposal to launch a three-year Connected Care Pilot Program.¹² As a not-for-profit organization focused on the innovation and promotion of telehealth and digital medicine, the FCC’s renewed focus “on delivering remote medical, diagnostic, and treatment-related services directly to patients outside of traditional brick and mortar facilities” is a meaningful step forward in advancing the overall goal of bringing “innovative telemedicine technologies to medically underserved populations.”¹³

Unfortunately, the FCC’s Connected Care Notice contains proposed limitations on the services that can or should be supported in a Pilot that, if adopted, will curtail the eligibility for funding of Ochsner’s program costs. Ochsner’s direct-to-consumer programs make use of a patient’s own device and underlying service provider for the digital broadband connection. This reduces barriers to telehealth adoption by significantly simplifying the provisioning of the vital connection to provide digital healthcare in remote settings. This model is very straightforward, and one that is well accepted and favored by the patients Ochsner encounters.

Nevertheless, the Notice proposes FCC Pilot funding support only for competitively bid single source broadband connections that are provisioned by a winning broadband service provider.¹⁴ This of course could mean that a person willing to participate in a Pilot telehealth

¹¹ Connected Care NPRM, paras. 78-88.

¹² Ochsner also supports the FCC’s proposal to distribute each selected project’s funding over the three-year funding period. *Id.* para. 28.

¹³ *Id.* para. 21.

¹⁴ *Id.* para. 66 (“[W]e propose requiring the participating health care providers to conduct a competitive bidding process, and select the most cost-effective service, as is required by the Healthcare Connect Fund program.”).

project with some level of FCC support might have to switch their communications service provider or move from mobile to an in-home broadband provider if that is the service provider entity chosen by the HCP or HCP consortia in a Pilot to provide connections. The patient may be satisfied with his or her service provider and should not have to have dual or even multiple service providers for their general or specialized broadband connections.

A Pilot program that takes advantage of existing digital devices and broadband service arrangements avoids these types of unnecessary service dislocations. This important aspect of the success of Ochsner's digital medicine programs should not be overlooked by the FCC as it considers Pilot program structures. Ochsner's team determined as it designed its remote monitoring programs that it would be better to be entirely agnostic as to the patient's broadband service provider when it offers digital medicine applications in home or in other remote patient settings. The FCC would be well-served by adopting a more flexible scope of supported services that at the very least includes a patient provisioned broadband connection as part of the range of supported services in its Pilot.

Consumers already use the broadband providers of their choice and by and large already have a digital connection that enables the transmission of the data vital to providing telehealth services. As a result, Ochsner supports the proposal in the Notice to not impose a requirement that supported services must be purchased from eligible telecommunications carriers ("ETCs") similar to the Rural Health Care ("RHC") program.¹⁵ More broadly, however, Ochsner sees no cost justification or efficiencies that might be gained from requiring that FCC Connected Care Pilots be structured in a way that forces HCPs to select a broadband service provider for each patient wanting to be part of a remote care Pilot project. For the same reason, Ochsner also opposes the

¹⁵ *Id.* para. 46.

FCC’s proposal to limit HCPs’ source of funding for supported services because it inevitably will dictate whom the HCPs must partner with to provide patients with the supported services, in addition to requirements imposed by other federal or state laws on HCPs’ ability to select service providers.¹⁶ Disintermediating existing broadband service providers will discourage patient participation in remote care, and would certainly make provisioning any Pilot telehealth project more costly and cumbersome than would otherwise be the case.

Furthermore, unlike the RHC Health Care Fund program that only supports designated telecommunications services and broadband connections, neither of which need to be tailored to specific medical conditions or treatment, the “connected care” and “telemedicine” services that are supposed to be covered by this Pilot are much more condition-specific and may require specialized remote diagnostic devices and administrative support to make sense of the data being received. This distinction necessarily means that the provision of these “connected care” and “telemedicine” services cannot be measured by a simple comparison of quantifiable factors such as which vendor or service costs the least and how much bandwidth is necessary for a particular application. After all, the ultimate goal of this Pilot is to support “healthcare” to targeted populations and not “broadband coverage.” The most “cost-effective” single source vendor does not necessarily yield best results for all healthcare programs because health care cost effectiveness cannot be measured in that way.¹⁷ The FCC’s articulated goals of improving health outcomes and of supporting the

¹⁶ *Id.* para. 32.

¹⁷ See *Underlying Causes of Rising Health Care Costs: Hearing Before the Committee on Finance*, 103th Cong. 98 (1993) (statement of Joseph P. Newhouse, John D. MacArthur Professor of Health Policy and Management, Harvard University) (“[I]t is always difficult for a price index to incorporate quality enhancements. . . . Suppose a noninvasive test replaced an invasive test but at a higher cost. How much should be netted out to adjust for any reduction of pain or risk of side effects from the new test?”); Mark V. Pauly, *The Public Policy Implications of Using Outcome Statistics*, 58 Brook. L. Rev. 35, 50-51 (1992).

trend toward bringing healthcare directly to the consumer should be the focus of the services to be supported.

The Notice seeks comment on how HCPs such as Ochsner purchase and assemble the various elements of their connected care offerings.¹⁸ Ochsner purchases the medical diagnostic devices, such as Bluetooth blood pressure cuffs or dipsticks directly from medical suppliers. Ochsner does not rely upon third parties to package these devices with wrap around services or monitoring functionality, as Ochsner provides those monitoring service directly to ensure access to care and care coordination. Ochsner collects actionable data in the patients' EHR and seamlessly monitors patient data as it becomes available, thereby enhancing the near real time monitoring of patients who are nowhere near a clinical setting. Ochsner provides these devices to the patient, and in most cases, incurs the costs related to the device itself, as well as the personnel and other costs associated with running telehealth and digital medicine platforms and services.

Thus, while Ochsner incurs costs for providing remote monitoring for a range of chronic medical conditions, Ochsner does not fund the costs of patient broadband connections or dictate which broadband service provider any patient use.¹⁹ This approach has many advantages for providing remote health services. It is also administratively simple. Because Ochsner is not funding the patient's broadband service costs, there is no need as a policy matter to allocate that cost of using the connection between a healthcare and a non-healthcare purpose. No particular documentation is needed to ensure that there is no fraud waste or abuse of funding in broadband connections, as no allocations or factors are needed with this structure, at least as to the HCP

¹⁸ Connected Care NPRM, para. 19.

¹⁹ *Id.* para. 20.

provider. While there may be HCPs that use or may prefer a centralized broadband service provider model, it is not necessarily the most efficient and cost-effective way to deliver remote health offerings. If the FCC determines that broadband connections should be subsidized as part of the Pilot program, then it would appear that patient vouchers of some fixed amount could be used and applied to the monthly broadband service charges of service providers to encourage patients to make use of their already existing broadband connections to promote better health outcomes. Failure to include this as an option would overlook a proven and popular structure used by Ochsner in its successful telehealth programs.

A. Obstacles to the Adoption of Connected Care Models Abound; The FCC Cannot Effectively Address Them By Only Providing Subsidies for Patient Broadband Connections.

Ochsner agrees that broadband “connectivity gap” may hinder the adoption of Connected Care services in many geographic areas. However, broadband connectivity is not the only obstacle patients face when struggling to obtain healthcare in underserved areas. In Ochsner’s experience, many patients whom this Pilot intends to benefit already have digital connections that enables the transmission of the data vital to providing telehealth services. In fact, among the over 800,000 patients whom Ochsner cared for in 2018, Ochsner observed that a significant percentage did not enroll in telehealth or digital medicine programs due to lack of payment options for the end-user diagnostic devices or due to insurance reimbursement restrictions.

Even with subsidized or their own broadband connections, patients whom this Pilot aims to benefit are often unable to pay for the diagnostic devices, or perhaps even their smartphones, without reimbursement from either their insurance provider or the HCPs. As of 2015, only 21 states had telemedicine parity statutes for private insurers.²⁰ Without state law mandate, private

²⁰ See Heather Slawson, *Telemedicine: The Affordable Care Act’s Forgotten Frontier of Rural Health Care*, 19 Holy Cross. J. 193, 230 (2015).

insurance plans in practice do not cover services provided via telemedicine or place stringent restrictions on reimbursing patients of telehealth services – some may deny coverage for “virtual interactions” with patients and some may only reimburse live videoconferencing but not other modes of communication with equal content and validity.²¹ Due to the concern that their insurance plan will deny reimbursement, many patients may be reluctant to explore and utilize these services.

As a result, patients whose private insurance plans do not cover telehealth or patients without insurance will be far less likely to participate in a digital telehealth program. HCPs such as Ochsner bear the cost of the research, development, implementation, and distribution of wireless IT solutions, but are rarely financially incentivized to create new programs with the potential of improving clinical outcomes.²² When the cost of providing telehealth service to each patient goes up, the number of patients who can benefit from the HCP’s telehealth program will decrease.

The relatively low adoption rate of remote patient monitoring in the United States generally for telehealth services is similarly attributable to other obstacles such as lack of patient education in ways that maximize the benefit of telehealth applications and services, challenges in maintaining confidentiality of patients’ protected health information through secured transmission of telehealth data, and complicated regulatory approval of telehealth-related

²¹ See *Telehealth to Digital Medicine: How 21st Century Technology Can Benefit Patients: Hearing Before the Subcommittee on Health of the Committee on Energy and Commerce*, 113th Cong. 142 (2014) (statement of the Honorable Renee Ellmers, U.S. Representative for North Carolina).

²² See *Overcoming Rural Health Care Barriers: Use of Innovative Wireless Health Technology Solutions: Hearing before the Subcommittee on Health of the Committee on Veterans’ Affairs*, 111th Cong. 87 (2010) (statement of Kerry McDermott, Expert Advisor, Federal Communications Commission).

communications devices.²³ Improving patient education, improving security design for telehealth applications, and certain administrative costs such as seeking regulatory approval of telehealth-related communications devices are all necessary and directly related to offering telehealth services to patients consistent with the goals of this Pilot. If the FCC provides funding to them or at least a significant discount on incurred costs, successful patient monitoring and mobile application programs such as Ochsner's will be able to benefit even more patients who currently lack the means to participate.

B. The FCC's Pilot Program Should Take a Similar Approach to CMS in Supporting the Reimbursement of Remote Patient Monitoring Services.

As the Notice observes, the Centers for Medicare and Medicaid ("CMS") recently issued new rules that expanded Medicare patient coverage and provider reimbursement for Connected Care services, including remote patient monitoring and virtual video check-ins.²⁴ This was a positive step towards encouraging greater patient access and overall systemic efficiencies in healthcare delivery. Ochsner urges the FCC to view its Pilot program as having a similar program scope and purpose within the constraints of the FCC's authority over communications.

Ochsner's streamlined telehealth and digital medicine structure for care has proven to be efficient; however, with the FCC proposing that only Connected Care broadband connections be funded with discounts, it is misaligning its proposed resources based on incorrect assumptions. In effect the FCC is proposing that it substantially fund something that consumers by and large either already pay for or get through service provider programs or from other USF programs; their broadband connection. Requiring a telehealth only use or requiring the establishment of a

²³ See Meghan Hamilton-Piercy, *Cybersurgery: Why the United States Should Embrace This Emerging Technology*, 7 J. HIGH TECH. L. 203, 215-17 (2007).

²⁴ Connected Care NPRM, paras. 12, 27.

whole new connection for a patient to use remote monitoring would be extremely inefficient.

Existing federal laws potentially restrict how Ochsner may directly distribute or provide funds to patients. Any form of discount offered to a new telemedicine subscriber may risk exposure under the Civil Monetary Penalties Law and the Anti-Kickback Statute, both of which prohibit offering or paying remuneration to a Medicare or Medicaid beneficiary with the intent of encouraging the patient to continue using healthcare services from a particular provider.²⁵ Without the Pilot's funding for remote patient monitoring medical devices, Ochsner is hampered in its ability to reach and to help more patients, especially beneficiaries of other federal programs, to participate in Ochsner's Digital Medicine programs.

Under the new rule, CMS now includes the costs of remote patient monitoring as allowable administrative costs.²⁶ CMS defines "remote patient monitoring" as:

the collection of physiologic data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or both to the home health agency. Visits to a beneficiary's home for the sole purpose of supplying, connecting, and/or training the patient on the remote patient monitoring equipment, without the provision of another skilled service are not separately billable. These services do constitute services included in the expense of providing remote patient monitoring allowed as administrative costs.²⁷

These CMS rules intend to allow the physicians and other healthcare professionals to seek reimbursement for the collection and interpretation of physiologic data (even for the purposes of augmenting the care planning process and not the actual provision of healthcare).²⁸ This scope was well-received by commenters, who generally agreed with the CMS that this

²⁵ See 42 U.S.C. § 1320a-7b(b) (2018); Michael W. King, *Telemedicine: Game Changer or Costly Gimmick?*, 95 Denv. L. Rev. 290, 326 (2018).

²⁶ 83 Fed. Reg. 56,408 (2018).

²⁷ 83 Fed. Reg. 56,525, 56,527 (2018).

²⁸ *Id.*

inclusive definition will incentivize greater involvement of nurses and physicians in the patient's treatment plan while decreasing the expenses on travel.²⁹

Facing the same governmental programmatic concerns about the potential for fraud, waste, and abuse, the CMS took the approach of actively monitoring how HCPs utilize the subsidized remote patient services to ensure that these services accomplish intended healthcare goals and do not take away a patient's option for face-to-face visits.³⁰ CMS also clarified that equipment installation visits and patient education are not subject to reimbursement without the provision of another skilled service in the same service episode.³¹ These measures are consistent with the FCC's original proposal in the Connected Care NOI to select projects based on submitted information and data on how the subsidy can provide necessary support to Connected Care services and evaluate selected projects' fiscally responsible use of Pilot program funds by requiring HCPs to report certain data and to subject themselves to audits periodically.³²

Ochsner urges the FCC to revert back to its original approach in the NOI and refrain from imposing hyper-technical metrics for Pilot program selection and evaluation. Because of the complexity of the regulatory landscape concerning health care, Ochsner urges the FCC to adopt a similar approach to CMS when clarifying to what extent remote patient monitoring and remote monitoring devices are eligible for subsidy under the Pilot program.

²⁹ *Id.*

³⁰ 83 Fed. Reg. 56,525-26 (2018).

³¹ 83 Fed. Reg. 56,525-26 (2018).

³² Connected Care NOI, paras. 31-33, 53-54.

C. Remote Patient Monitoring Applications and Devices with “Store-and-Forward” Functionality Should be Considered for Pilot Support.

The Connected Care Notice suggests that the FCC may be open to considering other “packages or suites of services that health care providers use to provide Connected Care services” including “remote patient monitoring and remote monitoring devices” “that are not currently funded under the existing RHC support programs . . . as information services.”³³ Ochsner urges the FCC to adopt this as a part of the Pilot program and clarify to what extent remote patient monitoring mobile applications and remote monitoring devices might be considered for Pilot support.

Notably, the FCC has not been granular in its definitions of the term “information service” in the context of its RHC programs in the more than two decades since the enactment of section 254.³⁴ There is no dispute that broadband Internet access is not the only information service now available and that may be eligible to receive subsidy from the USF.³⁵ “Information

³³ Connected Care NPRM, para. 23.

³⁴ The Communications Act of 1934 defines “information service” as the “the offering of a capability for generating, acquiring, storing, transforming, processing, retrieving, utilizing, or making available information via telecommunications, and includes electronic publishing, but does not include any use of any such capability for the management, control, or operation of a telecommunications system or the management of a telecommunications service.” 47 U.S.C. § 153(24) (originally enacted as Communications Act of 1934, § 3(20), 48 Stat. 1064, amended by Telecommunications Act of 1996, § 34(a)(2), 110 Stat. 56).

³⁵ See, e.g., Application of Wisper ISP Inc. for Designation as an Eligible Telecommunications Carrier, *Order*, 2019 WL 919182 (Ind. U.R.C. 2019) (Voice-over Internet-Protocol service is “information service” under the Telecommunications Act); Wireline Competition Bureau Announces Release of 2019 Telecommunications Reporting Worksheets and Accompanying Instructions, *Public Notice*, DA-19-84, App’x B, 3 (Feb. 14, 2019) (call moderation and call transcription services are “information services” under the Telecommunications Act); Petitions for Declaratory Ruling on Regulatory Status of Wireless Messaging Service, *Declaratory Ruling*, 33 FCC Rcd. 12075 (2018) (short message service (“SMS”) and multimedia messaging service (“MMS”) are information services for purposes of the Communications Act); Rural Health Care Support Mechanism, *Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking*, 18 FCC Rcd. 24546, paras. 19, 22-24 (2003) (“In light of the development of medical applications for the Internet since 1997, [the FCC] conclude[d] that

services” in the past has been recognized as “enhanced services [that] offer[] over transmission facilities used in interstate communications and employ computer processing applications that act on the format, content, code, protocol, or similar aspects of the subscriber’s transmitted information; provide the subscriber additional, different, or restructured information; or involve subscriber interaction with stored information.”³⁶ The FCC and other federal courts also noted that the essence of “information service” is data-storage and data-processing capabilities.³⁷

A large portion of remote patient monitoring software, mobile add-on applications, information systems, or equipment have “store-and-forward” functionality. This allows a patient to store clinical information like data or images collected from a monitoring device and then forward it to a provider for clinical evaluation when the patient monitoring device is connected through a smartphone to the Internet or at a certain pre-set interval.³⁸ For example, Ochsner’s

encouraging access to this information service will improve the level of care available in rural areas.”); *Vonage Holdings Corp. v. Minn. Pub. Utils. Comm’n*, 290 F. Supp. 2d 993 (D. Minn. 2003) (Voice-over Internet-Protocol service is “information service” under the Telecommunications Act).

³⁶ Wireline Competition Bureau Announces Release of 2019 Telecommunications Reporting Worksheets and Accompanying Instructions, *Public Notice*, DA-19-84, App’x B, 3 (Feb. 14, 2019) (call moderation and call transcription services are “information services” under the Telecommunications Act).

³⁷ See Petitions for Declaratory Ruling on Regulatory Status of Wireless Messaging Service, *Declaratory Ruling*, 33 FCC Rcd. 12075, paras. 6, 19-23 (2018) (explaining that both SMS and MMS wireless messaging services and email service are information services under the Telecommunications Act because of their ability to generate electronic message and to store-and-forward the message); *Nat’l Cable & Telecomm. Ass’n v. Brand X Internet Services*, 545 U.S. 967 (2005) (upholding the FCC’s declaratory ruling that cable modem service is “information service” because of the service’s data-processing capabilities); see also Investigation into Regulation of Voice over Internet Protocol (VoIP) Services, 2018 WL 835315, at *15 (Vt. P.S.B. Feb. 7, 2018) (“The distinction between telecommunications services and information services had its origin in a 1980 FCC decision related to data-processing services.”).

³⁸ See *Advancing Telehealth Through Connectivity: Hearing Before the Subcommittee on Communications, Technology, Innovation, and the Internet*, 114th Cong. 235, 101 (2015) (statement of Mary R. Grealy, President of Healthcare Leadership Council).

Connected MOM program allows expectant moms to track weight and blood pressure readings, and then send the data on their schedule directly to their medical record at Ochsner for clinical analysis by their care team. Ochsner, and other digital medicine providers, choose store-and-forward capability and functionality due to their significant healthcare cost-saving potential.³⁹ These remote patient monitoring software, mobile add-on applications, information systems, or diagnostic equipment can fit comfortably within the past parameters established for “information services” and therefore should be considered for Pilot support.⁴⁰

D. Support for End-User Medical Devices Is Essential to the Adoption of Connected Care Services in Low-Income or Underserved Populations.

As discussed above, Ochsner’s Digital Medicine programs typically use Bluetooth-enabled devices that connect to Ochsner via a patient’s smartphone or other digital device. These end-user medical devices are essential to the provision of digital medicine on a remote basis. For example, the Connected MOM program would not be possible without a patient having the necessary digital devices to measure a pregnant woman’s weight and blood pressure, and also requires a digital data link by smartphone so that the data collected can be sent wherever it needs to go for analysis and care coordination. This is the case for other connected diagnostic devices as well.

³⁹ See *id.* at 95 (statement of Dr. Kristi Henderson, Chief Telehealth and Innovation Officer, University of Mississippi Medical Center) (discussing the Veterans Health Administration’s use of store-and-forward technology in their telehealth program, which saved \$38.81 per consultation in fiscal year 2013).

⁴⁰ Cf. *Fed. Trade Comm’n v. Am. eVoice, Ltd.*, 242 F. Supp. 3d 1119, 1123 (D. Mont. 2017) (noting that FCC had considered electronic store-and-forward as an “enhanced service” in 1999).

III. SECTION 254 DOES NOT COMPEL LIMITING SUPPORTED SERVICES TO BROADBAND CONNECTIONS.

Congress institutionalized a “universal service support mechanism” in 1996 to support the ubiquitous delivery of affordable telecommunications services nationwide by the enactment of Section 254 of the Telecommunications Act of 1996 (“Section 254”).⁴¹ The statute generally refers to advancing telecommunications or information services, both nominally communications services.⁴² Among other things, section 254 directed the FCC to stand up a rural healthcare high-cost telecommunications subsidy program, one that codified “the existing practice of geographic rate averaging and rate integration for interexchange, or long distance, telecommunications rates to ensure that rural customers continue to receive such service that are comparable to those charged to urban customers.”⁴³ This reflected Congressional concern about the affordability of telecommunications services for rural health care providers and by extension rural communities. The FCC then created specific mechanisms and fund to help facilitate affordable access for these communities.⁴⁴

Section 254 also directed the establishment of a formal federal USF rural healthcare program to distribute funds to eligible recipients and in ways that ensure HCPs in rural areas would “have access to “universal service” and “additional services for such support mechanisms.”⁴⁵ To

⁴¹ 47 U.S.C. § 254.

⁴² *Id.*

⁴³ *Id.*

⁴⁴ S. Rep. No. 104-230, at 129 (Conf. Rep.).

⁴⁵ See 47 U.S.C. §§ 214(e), 254(a)(1), 254(a)(6), 254(c)(1), 254(c)(3); 47 C.F.R. § 54.602; Connected Care Pilot Program Notice of Inquiry, para. 14; Federal-State Joint Board on Universal Service, *Report and Order*, 12 FCC Rcd. 8776, para. 634 (1997) [hereinafter *1997 Universal Service Order*]; see also S. Rep. No. 104-230, at 132 (Conf. Rep.); Rob Frieden, *Killing with Kindness: Fatal Flaws in the \$6.5 Billion Universal Service Funding Mission and What Should Be Done to Narrow the Digital Divide*, 24 Cardozo Arts & Ent. L.J. 447, 458 (2006) (discussing four separate USF programs established by the FCC: the low income

that end, Congress gave the FCC “specific authority to alter the definition [of ‘universal service’] from time to time, and to provide a different definition for schools, libraries, and health care facilities.”⁴⁶ Thus, the FCC has some discretion to determine what is “universal service” as communications technologies, capabilities and uses evolve, as long as any FCC definition of the term for purposes of rural healthcare “take[s] into account advances in telecommunications and information technology” and meets the four enumerated statutory criteria.⁴⁷

A. The FCC Has the Statutory Authority to Cover a Range of Services under a Pilot Program.

As such, Section 254 “expressly authorizes the FCC to define periodically the types of telecommunications services” that a USF program may cover. In 2014, the Tenth Circuit Court of Appeals concluded: “[N]othing in the language of subsection (c)(1) serves as an express or implicit limitation on the FCC’s authority to determine what a USF recipient may or must do with those funds.” The Tenth Circuit explicitly declined to invalidate the FCC’s 2012 decision to expand the scope of services eligible for USF subsidy to include broadband internet access and Voice-over-Internet Protocol services, services that were not considered telecommunications services as that term is defined in the Communications Act.⁴⁸

program, the high-cost program, the schools and libraries “e-rate” program, and the RHC program).

⁴⁶ S. Rep. No. 104-230, at 131 (Conf. Rep.).

⁴⁷ These statutory criteria are: 1) the covered services “are essential to education, public health, or public safety”; 2) the covered services “have, through the operation of market choices by customers, been subscribed to by a substantial majority of residential customers”; 3) the covered services “are being deployed in public telecommunications networks by telecommunications carriers”; and 4) the covered services “are consistent with the public interest, convenience, and necessity.” 47 U.S.C. § 254(c)(1); S. Rep. No. 104-230, at 131 (Conf. Rep.); *see also* 1997 Universal Service Order, paras. 610, 814.

⁴⁸ *Direct Commc’ns Cedar Valley, LLC et al. v. Fed. Commc’n Comm’n*, 753 F.3d 1015, 1044-46 (10th Cir. 2014).

The FCC can by rule expand or limit the scope of USF rural healthcare program subsidies so long as the expansion remains tethered to the purposes of Section 254.⁴⁹ And Section 254 authorizes the FCC to design funding mechanisms according to a flexible standard. Logically then, programs such as this Pilot, which by their very nature are experimental, should allow for experimentation consistent with the principles of Section 254. The provision of advanced communications services or capabilities as part of a remote telehealth trial setting can and should be broadly and flexibly interpreted. Only after the FCC has the results and data that it seeks from its Pilot should the agency turn towards adoption of a potentially more prescriptive approach to eligibility of supported services. Given Ochsner's experience in how to structure and run successful telehealth and digital medicine programs, it is concerning that the Notice's proposals on what would be supported services and how the Pilot program would be structured to offer support would create straightjackets on experimentation. These constraints are not necessary and should be removed in favor of allowing HCPs to propose plans to use Pilot funding in ways that will add to the FCC's understanding of how to encourage efficient adoption of telehealth to low income or other populations.

Section 254 also "afford[s] the FCC the flexibility . . . to encourage the deployment of the types of facilities that will best achieve the principles" of USF. This authority, for example, could allow the FCC to allocate USF funding to support any communications facilities or equipment operated by a HCP or group of HCPs in a Pilot remote monitoring or care project.⁵⁰

⁴⁹ See *AT&T, Inc. v. Fed. Commc'n Comm'n*, 886 F.3d 1236, 1249-50 (D.C. Cir. 2018) (upholding the FCC's interim orders requiring carriers to continue providing essential landline telephone services were "reasonable and adequately reasoned" because they are temporary rules based on "difficulties of predicting the results of a regulatory shift").

⁵⁰ *Direct Commc'ns Cedar Valley, LLC et al. v. Fed. Commc'n Comm'n*, 753 F.3d 1015, 1046-47 (10th Cir. 2014).

The Commission's now well-established RHC programs have a range of requirements, structures and procedures designed to ensure that the millions of dollars in annual funding are awarded fairly and are being put to an allowable use. This is both necessary and understood. However, determining at the outset that a remote telehealth or digital medicine Pilot program should be constrained to support only the same types of services in more or less the same way as in the current RHC program does is counterproductive. It appears to cut off new and potentially critical cost-effective health delivery innovations from study, review, and improvement.

B. Section 254 Does Not Require the FCC to Use a Competitive Bidding Process for All USF Programs.

Nor does Section 254 require the types of competitive bidding and sole source provisioning of supported services that the Notice proposes.⁵¹ On its face, Section 254 only requires and service providers to HCPs provide service in rural areas in a State “at rates that are reasonably comparable to rates charged for similar services in urban areas in that State.”⁵² The Commission, on its own initiative, determined in other contexts that competitive bidding for USF supported services is an appropriate vehicle to “ensure that the fund supports services . . . at the lowest possible price.”⁵³ It is not the only means the FCC has to allocate funding, and should not be used in circumstances where a sole source provisioning structure may be ill-suited to provide patients with services adequate to address differing and specific medical needs. This is because

⁵¹ Connected Care NPRM, para. 66 (“[W]e propose requiring the participating health care providers to conduct a competitive bidding process, and select the most cost-effective service, as is required by the Healthcare Connect Fund program.”)

⁵² 47 U.S.C. § 254(h)(1)(A).

⁵³ Request for Review of Decisions of the Universal Service Administrator by Joseph M. Hill et al., *Order*, 26 FCC Rcd. 16586, para. 23 (2011) (discussing the enforcement of competitive bidding process for the E-rate program).

the lowest possible pricing of a broadband connection is only one element of the many components of a low-income digital health Pilot.

The Commission recognizes that its USF competitive bidding rules stem from its interpretation of Section 254's statutory principles rather than from requirements in the statute itself.⁵⁴ The Commission also has acknowledged that Section 254 does not impose competitive bidding requirements on any of the FCC's USF programs.⁵⁵ Past waivers issued by the Commission to healthcare providers seeking to participate in the Rural Health Care program similarly demonstrate that the FCC's competitive bidding requirement for service providers is a regulatory rule, not a statutory requirement.⁵⁶

As discussed above, Ochsner deliberately chose as part of its remote monitoring and other telehealth project design not to dictate to patients which communications service provider or communications device they must use in order to participate in a program. This is a vastly more simple way to allow for the necessary broadband connections that support remote Connected Care projects. Using that as one possible model, there is no need for an intermediary broadband service provider that must be selected by HCPs through a time-consuming Request for Proposals ("RFP") development and bid evaluation process.

Ochsner's approach also speeds offerings to the public and is both popular with patients and is intuitive. In Ochsner's experience, this patient-directed model quickly gains acceptance, as the broadband connection used to transmit data or video is one the patient already has, either at their home or on their smartphone or even a shared family phone or tablet.

⁵⁴ See e.g., Federal-State Joint Board of Universal Service, *Tenth Order on Reconsideration*, 14 FCC Rcd. 5983, para. 39 (1999); see also *Hill v. FCC*, 496 Fed. App'x 396, 403 (5th Cir. 2012).

⁵⁵ See 26 FCC Rcd. 16586, para. 23 (2011).

⁵⁶ See, e.g., Rural Health Care Support Mechanism, *Order*, 32 FCC Rcd. 7532, para. 7 (2017).

Like all other consumers, patients are accustomed to the process of downloading apps and using them, and that connection, coupled with appropriate diagnostic devices are provided to the patient so that progress can be measured by use of the app, has proven to be a very simple, direct way of delivering Connected Care. There is no middleman remote monitoring company, no package of services that Ochsner must first purchase, and no need to engage in a broadband service provider sole source competitive bidding process.

Ochsner has found that the medical transmission or communications aspect of Connected Care is far more readily accepted and used when it is incorporated into whatever digital communications service the patient is already using. Instructing patients that the only way they can use Connected Care is to accept a new device or range of devices, as well as broadband service from a new entity, simply raises more barriers to use and makes the entire project more expensive for HCPs to manage and administer.

If there are Pilot projects that can benefit from using a competitive bidding, sole source provider model for broadband connections, Ochsner has no concern about the FCC allowing that as an option, so long as it is not the only option for Pilot participation. As noted above, Congress intended the FCC to adopt USF rules that are flexible, that are technology-neutral, and that encourage broad participation by a variety of entities. This flexible approach should be the watchword for the FCC as it allows HCPs to experiment with a range of Connected Care models so that the FCC can have the benefit of learning from more than a single type of Pilot project.

IV. THE PILOT PROGRAM'S SCOPE SHOULD BE DISTINCT FROM THAT OF THE RURAL HEALTH CARE PROGRAM.

As the Commission recognizes, “[t]here is now a continuum of care options available that range from services provided inside connected facilities to direct-to-patient and remote telehealth

options.”⁵⁷ However, while the Notice of Inquiry introduced the idea that Pilot programs would be funded by fixed dollar awards, the Connected Care Notice proposes to change this proposed structure from a set amount to be used by a successful applicant to one where the only permissible subsidy support to be offered is a deep discount on patient broadband connections, as well as potentially to a mere handful of not-yet-identified “information services.”⁵⁸ This overly restrictive proposed scope of supported services appears to mirror many of the aspects of the FCC’s established RHC program, including its bureaucracy, and that may significantly diminish the interest HCPs with remote care health experience have in participating in the Pilot program.⁵⁹ It also risks losing a range of innovative telehealth proposals that would otherwise be made by HCPs by its overly prescriptive, bureaucratic structure and process.

Ochsner agrees that the Pilot should not duplicate existing healthcare funding, such as for Internet connections between healthcare providers as that “would be duplicative with the existing RHC programs.”⁶⁰ For this reason, Ochsner supports the Notice’s tentative conclusion that the FCC should exclude network equipment from supported services of the Pilot because they are already eligible to receive USF support from the existing RHC program.⁶¹ But Ochsner is not at all convinced that the FCC will get as much useful information from Pilots if they are as tightly constrained as the Notice proposes. Other than familiarity, there does not appear to be a compelling reason why so many aspects of the RHC program are proposed for use in a Pilot when they may

⁵⁷ Connected Care NOI, para. 4.

⁵⁸ Connected Care NPRM, paras. 17, 20, 23.

⁵⁹ *Id.* para. 29.

⁶⁰ *Id.* paras. 8, 20.

⁶¹ *Id.* para. 24.

be ill-suited to the very different circumstances of developing ways to cost effectively provide remote patient care to targeted patient demographics.

V. THE FCC SHOULD ENCOURAGE SUFFICIENT DIVERSITY IN PARTICIPATING PROGRAMS TO COLLECT DATA AND TEST EFFICACY.

As the FCC moves forward with a Pilot telehealth program, Ochsner supports the proposals in the Notice that appear to seek the participation of hospital-based entities with a history of successful telehealth implementations.⁶² Entities such as Ochsner that have established successful telehealth programs offer the FCC with an important near term opportunity to collect and analyze care models and outcome data that can better inform the shape of a future, broader program. HCPs with some telemedicine or remote monitoring experience will be in a better position to provide the FCC with actionable information more quickly than entities that are starting without any base of practical experience or a pool of potential patients that might fit within the FCC's target demographics.

Ochsner also supports the FCC's prior proposal to fund up to 20 projects with awards of \$5 million each.⁶³ This allocation structure strikes the right balance so that each project can enjoy adequate funding to meaningfully meet patient demand and collect sufficient data, while also allowing a diverse pool of applicants that specialize in different medical conditions to serve different groups of eligible patients in different geographical area.

While it is important to ensure that any proposal accepted to this Pilot primarily serves one of a number of targeted demographic groups such as veterans, low-income patients, as well as patients in tribal lands, rural areas, and underserved areas, Ochsner believes that the Pilot should fund a variety of projects to be most useful in learning from different entities what

⁶² *Id.* para. 55.

⁶³ *Id.* paras. 30-33.

worked and what did not and why. This is especially true when differences in geography, patient demographics and available infrastructure can all pose unique challenges to would-be telehealth providers. Data from different types of projects that are structured differently would be more helpful to the FCC in making policy than would numerous homogenous projects. In fact, the more flexible the structures, the more the FCC will learn from the Pilots.

Ochsner agrees that there should be some limitations on the types of health conditions that are optimal for Pilot program funding, as conditions that are chronic or that persist for at least several months often can be addressed well in a remote patient setting. Data from these types of projects is more likely to show progression in health outcomes more readily than one-time consultations. The FCC should accept proposals that fall in this category, without being overly prescriptive about determining at this stage what constitutes a chronic condition or condition requiring at least several months of care. Ochsner's view is that the FCC will get the most out of a Pilot by setting broad parameters on the types of conditions to be covered, which will in turn be a factor to consider when evaluating whether a specific proposal will likely to advance the FCC's goals in improving health outcome and in helping the FCC to collect and test Pilot data.

The Notice also seeks comment on whether support staff and service providers such as Emergency Medical Technicians, connected health kiosks, as well as school clinics are all an integral part of Connected Care services and might be included in the Pilot and recognized under the USF authority under section 254(h)(7)(B).⁶⁴ FCC also seeks comment on whether related services including virtual meeting rooms, community centers, or other locations that provide broadband connections for patients to engage with technology and connect with the professionals

⁶⁴ *Id.* para. 39.

providing them with medical care are also essential to the patients' adoption of Connected Care services.⁶⁵

In the same spirit of maximum experimentation in a Pilot, Ochsner submits that so long as the costs of the services that would be supported are identified by a Pilot applicant and are both necessary and directly related to offering telehealth or digital medicine services that the FCC deems to be eligible, then the FCC should fund them, or at least provide a significant discount on documented, incurred costs for the supported services.

In general, for the types of chronic health conditions that Ochsner has used for remote monitoring of patients, *i.e.*, hypertension, diabetes, pregnancy, and for other conditions that Ochsner would like to study or expand its existing efforts, the Notice's proposed timing of a Pilot design ramp-up and wind-down periods (each for 6 months) in addition to the 3-year program period makes sense. This proposed window, plus a reasonable ramp up and wind down period should give participating HCPs time to plan for and address aspects of the projects undertaken.

The Notice also seeks comment in the desirability of having geographical diversity and limiting Pilot program participation to HCPs that serve particular areas with designations as medically underserved. The Notice also seeks comment on whether Pilots should be restricted, either alternatively or in addition, to only eligible HCPs that currently provide care to at least a certain percentage of underinsured or uninsured patients, or to a certain percentage of Medicaid patients.⁶⁶ While Ochsner understands that the FCC wants to ensure that its Pilot has a measureable and meaningful effect on low-income populations and areas that have health access

⁶⁵ *Id.* para. 39.

⁶⁶ *Id.* para. 43.

issues, having a series of demonstrations or screens that weed out potential Pilot participants that have experience and have something to offer at this stage appears relatively arbitrary. For example, focusing only on an area designation or a percentage of a particular patient population could preclude the involvement of specialists in a particular health practice or discipline who may not be located in a health care access area the FCC might designate. That would seemingly defeat the goal of getting underserved populations more care remotely. Ochsner believes that at the stage of a Pilot, applicants should provide information that they think qualify them for consideration. Being overly formulaic risks missing true innovation happening in telehealth and digital medicine delivery.

VI. CONCLUSION

For the foregoing reasons, Ochsner respectfully requests that the Commission consider carefully the ways HCPs are already providing telehealth and digital medicine to patients, including to low-income patients. The FCC's Pilot program should strive to not constrain specific delivery models that have already proven their worth. The FCC should not be picking winners and losers in telehealth in its Pilot program by adopting cumbersome and costly structures and requirements that appear to weed out much prospect for the agency to discover

true healthcare innovation that can reach widely while also being cost effective. Ochsner supports the FCC's goals for a Pilot and remains enthusiastic in its support of the FCC's efforts in this critical area.

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Respectfully submitted,

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