**Notes on Comments for WC Docket 18-213: Promoting Telehealth for Low-Income Consumers**

1. **Proposing a Connected Care Pilot Program**

* **17) “we propose implementing a flexible that will give health care providers some latitude to determine specific health conditions and geographic areas that will be the focus of the proposed projects...”**

The Muscogee (Creek) Nation (MCN) and Indian Country (IC) reflect many of the realities of this proposal. The majority of MCN jurisdiction and IC is determined to be rural by the Census Bureau and there are a number of epidemics tribal citizens face stemming from lack of access to continual care and prevention based health care plans: heart disease, diabetes, depression, suicide, substance abuse, chronic health conditions, etc., all of which require continual treatment and access to medical professionals. MCN fits and supports this proposal as the Tribe also runs two hospitals in rural communities as defined by the Census Bureau that serve both tribal citizens and non-tribal with the majority of both being beneficiaries of IHS or Medicaid. MCN also encourages the Commission to focus on persistently communities, where there is broadband support for telehealth, either in health facilities or through mobile devices, given telecommunication density and access.

* **18) “we seek comments on whether or not the Pilot program should focus on certain health conditions or geographic regions…”**

Many commenters asserted that the Pilot program (PP) shouldn’t be focused on specific conditions, but rather, based on the current information provided that connected care services benefit a number of different conditions. MCN concurs with this notion particularly for the Nation’s jurisdiction reflects many rural citizens may not have ease of access to health care in other ways and would greatly benefit from telehealth. In MCN’s case, this would include more than just tribal citizens, it would also include non-tribal citizens who utilize our hospital system. However, a focus can and should be given to a number of health conditions that are determined to be chronic and requiring long-term care and long-term access to care.

* **19) “we seek comments on supported services and the broadband connectivity clinics and clients would use to receive connected care…”**

MCN supports the other commenters position that funding should support either mobile or fixed broadband projects.

* **20) “we seek comments to address to what extent health care providers are already funding patient broadband connections…”**

MCN agrees that the funding shouldn’t be limited to expanding broadband connectivity, but for tribal communities, the remoteness often creates and economic burden for carriers to extend service and the costs are typically transferred to the health provider, so these should remain an allowable expenditure in the PP.

* **21) “we seek comments on defining telehealth and telemedicine using their definition…”**

The Nation finds the definition and sources provided defining telehealth and telemedicine to be sufficient to continue forward with the PP.

* **22) “we seek comments on common existing uses of connected care tech such as remote patient monitoring… records indicate that many are single use connectivity which do not allow for general internet usage, but are there instances which full internet access is provided and if so, why? What barriers exist and how would having general internet access mitigate those and advance the project forward?”**

Currently MCN provides “GUEST” WIFI. However, at health care terminals we would not allow patients to utilize that equipment for non-HC purposes because it could threaten the security of IT systems and connected devices to a greater degree than wifi, because it would be on our secured network. Should the Nation be a recipient of the PP, MCN would likely move to restrict internet access in the same fashion, if not solely designate such equipment as singularly for healthcare use.

* **23) “we seek comments on whether there are packages or suites of services that healthcare providers (HCP) use to provide telehealth to their patients.. is there a common turnkey set up…”**

There are turnkey set ups that support our existing EHR. MCN has utilized those options in the past.

* **24) “we seek comments on whether Pilot project should fund network equipment that is necessary to make a broadband service functional while safeguarding against duplication of funding and services provided via other RHC programs…”**

MCN stands in agreement in regards to the duplication of funding, however our assumption would be that though the adjacent Healthcare Connect Fund Project (HCFP) supplies funds for those tools, there is no guarantee of every rural HCP having access to the HCFP and if they do, they may have obligated funds for other purposes outside of the scope of the PP. Therefore, the PP should be able to fund such equipment when necessary, provided there is proof of no duplication of goods and services. MCN also believes the PP to be much less feasible project for some recipients should the purchase of equipment not be applicable under the PP, considering that every recipient will not also be recipients of the HCFP or other programs offered through the Commission.

* **25) “we seek comments on approach for PP to not include support for HCP administrative costs…”**

MCN approves the proposal. In the event MCN finds it does not have internal capacity, the Nation would contract for that. MCN does propose, however, an admin cap for total funding for 5 to 10 percent.

* **26) “we seek comments on provision of end user medical equipment, mobile applications, and HCP admin expenses…”**

MCN supports funding for these items absent duplication or supplanting of tribal/federal resources. MCN suggest a cap on spending here to be further discussed.

* **27) “we seek comments on other program considerations…”**

MCN finds the statements provided by the Commission to be accurate, as most states won’t reimburse for telehealth costs because CMS has quality assurance metrics, not simply delivery. MCN suggests the Commission require PPs to provide de-identified, aggregate data related to health outcomes of patients involved in telehealth.

* **28) “we seek comments on potential budget of $100 million…”**

MCN suggests that funding for the total obligation be available at the beginning of the award due to potential infrastructure investments that may need to be done in a single year for efficiency and efficacy. So if there’s a $9 million award it should be obligated to the awardee upon award and available to them through the full three years.

* **29) “we seek comments on pursuing funding for PP from USAC which is separate from the existing RHC programs…”**

MCN very much supports this notion. Creating a new program, particularly in the overburdened HC field, shouldn’t detract or minimize funding for other needed programs.

* **30) “we seek comments on determining a set number of recipients @ 20 with $5 million apiece and provide a uniform percentage of eligible services or equipment that can be funded through the PP…”**

MCN agrees with this approach, as it will mirror nearly all existing grant funding infrastructure with the recipients needing to match some of the costs to prevent total dependency on such programs and find ways to make the services rendered more sustainable without the explicit use of federal funds. The reasons given for requiring patients to incur some of the costs does come with pros and cons that should be explored both from the POV of the patient, the HCP and the funder, for terms of equity, sustainability and best practice HC service.

* **31) “we seek comments on proposed discount level being a uniform 85%.. if proposing another rate please comment why…”**

MCN agrees to this uniform discount level.

* **32) “we seek comments on policy that HCP is required to pay the non-discounted share of the eligible costs from eligible sources…”**

MCN believes there should be no limitation. As long as the source is aware, then it should be allowed. This promotes private-public partnerships.

* **33) “we seek comments on view of keeping number PP recipients and amount of funding for each open for and diversified vs. having a set number of recipients and awarding each would receive…”**

MCN finds this to be an agreeable proposal by the Commission: creating an artificial number of recipients during the PP and before any proposals, might hinder the overall goals of the PP. The needs of one community may not be met by the proposed limitations, while others may be overly funded for the functions of the PP and for the scope of their work. MCN believes, the Nation and Indian Country should have the flexibility to determine and request funding based on flexible, yet predetermined funding levels; i.e. there could be different tiers of funding available based on need and justification of funds.

* **34) “we seek comments on cost allocation…”**

MCN proposes a cap on cost allocation back to patients.

* **35) “we seek comments on duration of funding…”**

MCN favors a shorter funding period + ramp up and ramp down periods would be most beneficial for the PP to create proposals and continue the project of bringing broadband to those in need of telehealth. Three years + ramp up/down would allow for expedient proposals to be made and highlight the needs the PP was intended for--whether for more time and flexibility--while still maintaining momentum. The plight of HCPs will not be alleviated by any known source or cohort of medical providers in the coming years, so the more effective the PP can be in a shorter time frame the better, if the goal is to increase HC access to rural or hard to reach populations. As cited in the proposal some tribes and agencies prefer a longer period which may be in large part due to the lack of infrastructure to support the administering of the PP goals; these concerns should be thoroughly addressed in a direct manner with the agency or HCP applying for the PP.

* **36) “we seek comments on 3 year + ramp up/down and fixed funding…”**

MCN is concerned with capping period funding or fixed due to potentially high infrastructure costs and capital expenditures.

* **37) “we seek comments on designating a list of accepted HCPs…”**

MCN believes the application should ask for documentation to support their eligibility, rather than rely on a list, because the information in Indian Country isn’t always reliable from the government.

* **38) “we seek comments on limiting participation to those designated HCPs in item 37…”**

MCN finds this proposal favorable, but reiterates the need for clear and concise language inclusive to tribes and their IHS and other HC facilities.

* **39) “we seek comments on definition of HCP which may exclude certain providers but allow for many HCPs serving medically underserved communities…”**

MCN finds this interpretation to be fair as it includes IHS and VA services, however MCN requests direct language inclusive to tribal agencies outside of this particular clarification. Additionally, MCN believes that each applicant for PP funding should be able to demonstrate a level of competence to monitor and track the function of the PP funding prior to being awarded, therefore ensuring that data received will be able to reflect the impact of the PP.

* **40) “we seek comments of recommendation that HCPs have telehealth and long-term patient care experience…”**

The Nation finds the proposed recommendation for applicants to comply with the eligibility requirements for the Healthcare Connect Fund Program (HCFP) to be fair and a viable route as an existing example of supportive infrastructure. However, asking or requiring prior telehealth experience would be a negatively limiting factor and would prevent many HCPs that would stand to benefit most from an effective telehealth PP. MCN concurs, however, that HCPs should be able to demonstrate a reasonable and high degree of long-term patient care that could be enhanced by the scope of the PP. MCN and many Indian Country HCPs easily fit this portion of the proposal.

* **41) “we seek comments on proposal to adopt many of the same policy and framework used in other RHC programs…”**

MCN approves the proposal with the condition to make adjustments as necessary following proposals once PP period is over should they be needed.

* **42) “we seek comments on proposal to allow both rural and urban HCP applicants…”**

MCN approves this proposal. MCN and Indian Country represent both spectrums of these applicants with the majority of IC lying within rural territory but with a majority of our citizens moving towards urban areas. MCN supports patients from either place geographically, but believes the PP should prioritize delivery to rurally isolated patients.

* **43) “we seek comments on proposal to designate eligible HCPs to professional shortage areas or medically underserved areas…”**

MCN approves the proposal.

* **44) “we seek comment on whether HCPs that solely provide connected care qualify to apply to the PP as they wouldn’t otherwise meet the standards of standard HCPs…”**

MCN would need to see long-term data that would prove these connected care only HCPs are effective in addressing the needs of their patients before voting yay or nay on this matter. MCN also believes most standard HCPs would be able to demonstrate long-term care provisions and shortcomings when asked and applying, particularly those within IC.

* **45) “seek comments on proposal to limit PP HCPs to those with experience with telehealth…”**

MCN finds this proposal to be detrimental to the means of the PP. The Nation believes many HCPs would jump at the opportunity to be a PP recipient for telehealth and there are many ways means to gage the ability of an HCP to effectively implement a telehealth program. The overarching goal of this program is to provide internet services and telehealth to those who otherwise would not receive adequate healthcare coverage through other means. It should not seek to limit interested HCPs that have capacity to implement the PP.

* **46) No comments on “Eligible Service Providers”.**
* **47) “we seek comment that HCPs should not be restricted to utilizing ETCs solely for broadband internet services…”**

MCN approves this proposal.

* **48) “we seek comments on how participation from diverse ranges of HCPs and ETCs impacts mission of PP…”**

MCN approves the proposal made by the Commission. For such a large scope of work there needs to be an investment from a number of parties involved for true impact. The Commission could ensure the PP leverages and supports HCPs as the main driver of the PP even if the funds are mostly paid to ETCs via quarterly reports tracking spending in relation to patients served under this program that could not be served in other ways due to rural status or other limiting factors.

1. **Application Process, Proposal Evaluation, and Selection of Projects**

* **49) “we seek comments on regulation of whether HCP applicants must provide an internet service provider at the time of application…”**

MCN has multiple sources of broadband service including the potential of being its own broadband service provider. The Nation supports each HCP providing a list of potential providers with the potential to identify a new internet provider as needed.

* **50) “we seek comments on the proposed application information required…”**

MCN approves the proposed requirements as they are already in use for other Commission programs.

* **51) “we seek comments on additional information FCC should require from PP HCPs…”**

MCN believes the current information requirements to be sufficient to ensure effective implementation of the PP and does not believe there should necessarily be a threshold of patients to be met under this PP. There may be unforeseen challenges face by some HCPs not encountered by others, that may hinder success in meeting the threshold, while still proving the need for the PP.

* **52) “we seek comments on whether to require HCPs to self identify qualifications for telehealth…”**

MCN believes HCPs should demonstrate a high level of feasibility when awarding PP HCPs by way of effectively obligating the PP funds, documentation, and having the resources to fund the ineligible portions of telehealth. One way to determine the feasibility for HCPs to administer the PP awards funds would be review their award and obligation of funds for other grant projects.

* **53) “we seek comments on the proposed 120 day submission period…”**

120 days should be enough to put together a meaningful PP application for HCPs considering application, but only following a sufficient solicitation period.

* **54) “we seek comments on which other federal agencies FCC should contact for reviewing of applications…”**

MCN believes the Commission should directly include tribal folks on their review committee, as well as a voice be given to both IHS and BIA operations as they would have more concise expertise on working with tribes and their capacities.

* **55) “we seek comments on whether FCC should decline proposals for PP for HCPs that not have a plan for how participating patients will obtain necessary connected care devices…”**

MCN finds this to be a fair requirement going back to project feasibility and the awarded agency’s capacity. However, discrepancy should be given to agencies who are in great need of such funding and display willingness, ability, and plans of action to obtain funding in other ways for such devices.

* **56) “we seek comments on proposing additional points to PP that would serve areas or populations that have well documented HC disparities including tribal lands, rural areas and veteran populations”**

Likewise, to the above proposal, MCN finds this proposal to be agreeable, but also with the fair warning that many proposed limitations for applicants already inhibit many theoretical applicants from those listed areas. MCN and IC at large demonstrate every last point made concerning chronic health disparities and need for care both rural and urban, which could be redressed in part by effective connected care.

* **57) “we seek comments on how additional points awarded to the aforementioned potential applicants from #56”**

MCN meets many of the proposed thresholds both rural and urban, both tribal and non-tribal that would be of the utmost importance should MCN apply, and this is applicable to many other Indian Nations operating hospitals and health centers in their jurisdictions.

* **58) “we seek comments for how criteria should be used and determined in rural areas…”**

MCN’s recommendation is to follow the designations by the Census Bureau designations, as well as information that HCPs could provide like patients’ travel distance and access to transportation.

* **59) “we seek comments for certification of Tribal HCPs…”**

MCN finds definition provided to be sufficient, but do not find that limiting to rural tribal HCPs agreeable, as there are other mitigating factors like access to transportation and lack of quality HC for urban patients as well. MCN’s IC demonstrates both.

* **60) “we seek comments for certification of veterans and the threshold of service…”**

MCN can’t comment to the validity of these benchmarks set for veterans, but will concur with what is suggested and proven to be appropriate for the care of veterans.

* **61) “we seek comments on awarding additional points for projects that are primarily focused on treating certain chronic health conditions or conditions that are considered health crises, such as opioid dependency, heart disease, high risk pregnancies, diabetes, or mental health conditions…”**

MCN concurs with these findings with the only additional comments be that in all of these highlighted and identified chronic health conditions and epidemics, that there needs to be much greater and specific language inclusion of Native Americans in all of the realms of the PP not just those that are tribal specific. There are many urban based Natives who would not have access to connected care offered to tribal agencies if the ruling is specifically for rural based HCPs. STIs and immuno-conditions should also be clearly stated and considered in this quest of providing chronic care as they fit the definition of need for chronic, ongoing care.

* **62) “seek comments regarding the kinds of patient the scope of the PP will focus on, namely those who are wholly covered under Medicaid/Medicare, low income, VA patients, uninsured or underinsured…”**

MCN approves these proposed parameters as they will meet the needs of the vast majority of those who seek adequate health care in rural areas. However, given the notation of being rural, there will be patients with adequate health insurance, but no access to nearby adequate HC therefore they may benefit from this PP. Those patients should likewise be considered if the scope of work is to be largely focused on rural America.

1. **Program Administration and Requirements**

* 63) MCN approves the proposal by the Commission to adopt many of the robust rules of the Healthcare Connect Fund program.
* 64) MCN approves the proposal by the Commission regarding Select Service Providers being procured solely through the HCP.
* 65) MCN has both contracted with broadband providers in the past as well as offered turn-key systems and will make determination of which route to pursue based on budget, demand and funding through the PP.
* 66) MCN approves the proposal by the Commission regarding competitive bidding process.
* 67) MCN approves the proposal by the Commission regarding using the existing Request for Services Form for the HCFP and regarding the Letter of Agency.
* 68) MCN approves the proposal by the Commission regarding ETCs declaring interest publicly.
* 69) MCN approves the proposal by the Commission regarding prohibiting gifts from service providers to HCPs.
* 70) MCN approves the proposal by the Commission regarding using the same forms and processes utilized in the HCFP.
* 71) MCN approves the proposal by the Commission regarding the deadline for initial funding requests and does not believe that funding requests should be required each year, provided HCP is obligating funds in accordance with their budget.
* 72) MCN approves the proposal by the Commission regarding the potential requirement for selected projects to certify that PP funding will only support the purposes of the PP.
* 73) MCN believes that disbursements should be made HCPs.
* 74) MCN approves the proposal by the Commission regarding the proposed issuing of disbursements to follow other existing Commission RHC programs.
* 75) MCN approves the proposal by the Commission requiring HCPs to submit necessary data and reports prior to receiving disbursements as a means of accountability for award funds.
* 76) MCN approves the proposal by the Commission to adopt the document retention and production requirements as defined by the HCFP, section 54.648(a).
* 77) MCN approves the proposal by the Commission regarding OMDB to conduct targeted audits and accept the 5-year document retention period, as these are consistent with many other existing grant funds.

1. **Pilot Program Goals and Metrics**

* 78) MCN approves the proposal by the Commission to focus on four primary program goals; metrics and methodologies will need to be studied a bit more with the intention of providing further comments in the comment reply section.
* 79) MCN agrees with the conclusions made by the Commission regarding the proposed goals of the PP.
* 80) MCN agrees with statements provided by the Commission.
* 81) MCN agrees with the findings provided by the Commission and the directed they will lead the PP.
* 82) MCN approves the proposal by the Commission to adopt reducing overall HC costs as a goal of the PP.
* 83) MCN agrees with the statement provided by the Commission.
* 84) MCN approves the proposal by the Commission to establish trend of bringing HC directly to the consumer.
* 85) MCN agrees with the statement made by the Commission and desire to adopt the move towards connected care to help bridge existing service gaps within rural HC.
* 86) MCN approves the proposal by the Commission to determine how USF funding can positively impact existing telehealth initiatives.
* 87) MCN agrees that the Commission should consider working with HHS, ONC< HRSA and IHS.
* 88) MCN believes that using all of the existing programs offered either through the Commission or through other federal agencies allow many different types of HCPs to access funding that assists in bridging certain gaps, and due to the specific nature of many grants, having more funding options is favorable, despite having to work through administrative obstacles to not duplicate goods and services. However, due to the interrelated nature of many existing telehealth and telemedicine initiatives, HCPs may be able to utilize funding from several programs to meet the needs of certain patients.
* 89) MCN agrees with the proposed metrics offered by the Commission, with the notation that those metrics will be reviewed for any necessary changes post PP.
* 90) MCN will ponder the limitations and impact of universal service support.
* 91) MCN will ponder additional ways connected care will reduce cost and boost HC provided, but offers that separation of a connected care patient who is either sick or at risk will offer protection to all patients, shielding all parties via isolation and will eventually reflect in lower cases of sickness spreading through vulnerable populations while getting HC at HC facilities.
* 92) MCN believes the Commission should monitor and look for an overall reduction in hospital visits and expenditures regarding the connected patient.
* 93) MCN approves the proposal by the Commission to seek how to determine whether the PP supports existing Commission and federal efforts to promote telehealth.

1. **Data Gathering and Reporting**

* 94) MCN agrees with the tools and procedures the Commission sets forth to monitor progress for the PP.
* 95) MCN agrees with stringent reporting requirements and would be favorable to a quarterly or semi-annually report interval.
* 96) MCN believes all projects should be required to conduct randomized controlled trials to determine the effect of the treatments on patients’ health.
* 97) MCN feels confident in the ability to conduct meaningful reports as required by the Commission.
* 98) MCN approves the proposal by the Commission to monitor the progress of each project.
* 99) MCN approves the proposal by the Commission to require HCPs to conduct regular surveys of participating patients.
* 100) MCN approves the proposals made by the Commission to collect additional information at the time of enrollment to better understand the impact of the PP regarding the aforementioned goals.
* 101) MCN approves the proposal by the Commission to aggregate and anonymize the data to be uploaded and to be viewed by the public to comply with HIPAA and to demonstrate accountability to highlighted goals.
* 102) MCN approves the proposal by the Commission for participants to provide information regarding their experience with the PP.
* 103) MCN believes the Commission should use existing forms as much as possible, but also should create forms as needed and to be specialized to fit the needs of the PP.

1. **Legal Authority**

* 104) MCN approves the proposed interpretations of legislation by the Commission to have legal authority to create the PP and carry out the mission.
* 105) MCN agrees with the Commission’s reading of the statute 254(h)(2)(A) regarding rural health care legal authority.
* 106) MCN agrees that 254(h)(2)(A) can be interpreted to give the Commission the legal authority to create the PP.
* 107) MCN agrees that 254(h)(2)(A) can be interpreted to rely on the rural healthcare authority.
* 108) MCN approves the interpretation of 254(h)(2)(A) to authorize the Commission to provide funding under the PP for HCPs to purchase services eligible for HCFP when applicable.
* 109) MCN agrees with the interpretations offered by the Commission to enable HCPs to provide connected care technologies to eligible low-income patients.
* 110) MCN agrees with the findings of the Commission in this proposal.
* 111) MCN believes that relying on the Commission’s low income legal authority would benefit most rural patients in need, but may bar certain patients from needed services should the HCP not have multiple awards via the existing RHC programs.
* 112) MCN believes that the Commission could support additional capacities as needed by HCPs.
* 113) MCN participates in many programs geared towards providing internet and cell reception to Indian Country which could supplement the infrastructure needed to effectively implement the PP.