Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, DC 20554

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

COMMENTS OF THE AMERICAN HOSPITAL ASSOCIATION

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On behalf of our nearly 5,000 member hospitals, health systems, and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and our 43,000 individual members, the American Hospital Association ("AHA") appreciates the opportunity to respond to the Federal Communications Commission's ("FCC" or "Commission") Notice of Inquiry ("NOI") in the above-captioned proceeding.[1]

I. INTRODUCTION AND SUMMARY.

The AHA agrees that "broadband-enabled telehealth services are assuming an increasingly vital role in providing care," and applauds the Commission's focus on how it can promote telehealth and "help advance and support the movement in telehealth towards connected care everywhere and improve access to the lifesaving, broadband-enabled telehealth services it makes possible."[2] The Commission's Rural Health Care Program ("RHC Program") – including the Healthcare Connect Fund, which was also initially launched via a pilot program – already has proven to be an essential tool for providing affordable broadband access for many health care providers, which in turn supports vital telehealth services that improve health outcomes for

[1] *Promoting Telehealth for Low-Income Consumers*, Notice of Inquiry, WC Docket No. 18-213, FCC 18-112 (rel. Aug. 3, 2018) ("NOI").

[2] NOI at ¶¶ 1-2.

underserved rural communities. Indeed, as advocated by the AHA, the FCC recently acknowledged the program's importance by increasing its funding cap to $571 million and committing to adjust the cap annually for inflation.[3] The AHA supports and is pleased to offer comments on the Commission's proposed Connected Care Pilot Program, as it is a continuation of the Commission's broader effort to "support[ ] broadband connectivity for those facing barriers to high-quality health care and maximiz[e] the benefits of telehealth for all Americans through enhanced digital access."[4]

II. THE BENEFITS OF TELEHEALTH ARE SIGNIFICANT AND WARRANT FURTHER FCC INQUIRIES INTO HOW ITS UNIVERSAL SERVICE PROGRAMS CAN ADVANCE TELEHEALTH FOR ALL AMERICANS.

Telehealth solutions have been shown to significantly improve health outcomes and lower overall health care system costs.[5] In particular, telehealth connects patients to vital health care services through video conferencing, remote monitoring, electronic consults, and wireless communications. Electronic health records enable efficient exchange of patient and treatment information by allowing providers to access digital copies of patient information, improving the continuity of care and reducing redundancies in treatment. Remote patient monitoring uses electronic communication to collect and transmit personal and medical data to remote health care providers, allowing those providers to monitor a patient's health in real time after the patient has left the health care facility. New and innovative mobile health applications enable better patient-provider communications, encourage better patient self-management and health literacy, and promote positive changes in health and lifestyle. And, telehealth is rapidly emerging as a cost-

[3] *Promoting Telehealth in Rural America*, Report and Order, WC Docket No. 17-310, FCC 18-82, ¶ 9 (rel. June 25, 2018).

[4] NOI ¶ 2.

[5] *See, e.g., id.* ¶¶ 3-10 and the examples cited therein.

effective solution for overcoming many of the obstacles to health care delivery faced in isolated communities.[6] According to the AHA's own data, 65 percent of hospitals in the United States have fully implemented telehealth in at least one unit (up from 55 percent in 2014), and more than 50 percent have implemented remote patient monitoring capabilities.[7]

By the same token, as the possibility of receiving remote care increases, it is important for the Commission to examine not just the connectivity needs of health care providers (which is the focus of the current RHC Program), but also the needs of patients who can be served remotely. Plainly, it is critical that health care providers ("HCPs") have sufficient broadband connectivity.[8] It is equally important, however, that patients have robust broadband options to take advantage of telehealth capabilities, and that they have access and the means to afford the necessary equipment and applications. Successful telehealth projects that work for all members of a community depend on multiple factors, including: (1) sufficient HCP connectivity; (2) sufficient connectivity for remote patients; (3) patient access to equipment and services necessary for telehealth; and (4) ensuring the ability of low-income patients to afford access to broadband connectivity, equipment and services. Many of the FCC's existing programs, including the RHC Program, the Connect America Fund/High-Cost program, and the Lifeline program, are designed to address different aspects of these factors. The Connected Care Pilot

[6] *See* Comments of the American Hospital Association, WC Docket No. 17-310, at 7 (filed Feb. 2, 2018) ("AHA RHC Program NPRM Comments"); Comments of the American Hospital Association, GN Docket No. 16-46, at 7-11 (filed May 23, 2017) ("AHA Connect2Health Comments").

[7] *See* American Hospital Association, *Fact Sheet: Telehealth* (April 2018), https://www.aha.org/system-/files/2018-04/fact-sheet-telehealth-2018.pdf.

[8] *See, e.g.*, AHA Connect2Health Comments at 11-13 (discussing minimum speed requirements for HCPs).

Program offers a way to create synergies among the programs with an additional focus on specific telehealth services and applications and the patient benefits they enable.

The AHA supports in particular the NOI's focus on services and applications delivered remotely to patients in their homes and communities.[9] Such an approach is consistent with the AHA's previous comments on the importance of remote patient monitoring and with the AHA's requests that the Commission make such service an eligible RHC Program expense.[10] While the Connected Care Pilot Program should not be limited to only one type of project, it offers an opportunity to provide funding for and an assessment of the benefits of remote patient monitoring and how it could be permanently supported by the RHC Program. In light of the improved outcomes and decreased costs that result from remote patient monitoring – particularly for those populations suffering from chronic conditions – the Commission should explore how the Connected Care Pilot Program can support costs for remote patient monitoring, including the cost of equipment, as an eligible expense.[11]

Lastly, the AHA agrees that the Commission has the legal authority to adopt the Connected Care Pilot Program.[12] Section 254(h)(2)(A) of the Communications Act, as amended, directs the Commission to establish competitively neutral rules "to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and

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[9] NOI ¶ 11.

[10] *See* AHA Connect2Health Comments at 17-18; AHA RHC Program NPRM Comments at 10.

[11] *See* AHA Connect2Health Comments at 18 ("If the Commission were to subsidize the wireless broadband services that health care providers purchase from wireless carriers for remote monitoring, health care providers would not only obtain support for the cost of connectivity to other health care providers but also for connectivity to individual patients. This relatively minor expenditure for broadband services can result in considerable savings in health care costs, making it entirely consistent with the purposes of the [Rural Health Care] program.").

[12] NOI ¶ 15.

information services for all . . . health care providers . . . ."[13] The Commission can ensure that the Connected Care Pilot Program is "competitively neutral" by allowing health care providers to select any technology and any broadband service provider "partner" who satisfies the program's eligibility requirements.[14] "Technical feasibility" can be achieved insofar as the program does not require applicants to develop new technologies, and the proposed $100 million funding level is sufficiently limited to satisfy the "economic reasonableness" requirement.[15] Further, the fundamental purpose of the program can be easily reconciled with the broader universal service principles Congress established in Section 254(b) (*e.g.*, availability of quality services at just, reasonable, and affordable rates; access to advanced telecommunications and information services in all regions of the United States; access to services and rates comparable to those offered in urban areas; and promotion of HCP access to advanced telecommunications services).[16]

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[13] 47 U.S.C. § 254(h)(2)(A). As pointed out in the NOI, the Commission relied on Section 254(h)(2)(A) as the basis for its authority to adopt the 2006 Rural Health Care Pilot Program. NOI ¶ 14 n.44, *citing Rural Health Care Support Mechanism*, Order, 21 FCC Rcd 11111, 11115-16, ¶¶ 1, 10-11, 14-15 (2006) ("*RHC Pilot Order*").

[14] *Compare RHC Pilot Order*, 21 FCC Rcd 11114 ¶ 11.

[15] *Id.* (noting that in discussing economic reasonableness, the Commission has generally focused on the effect any new rules would have on growth in the size of the Fund). Increasing the Fund by $100 million would amount to an increase of approximately one percent and is thus economically reasonable.

[16] 47 U.S.C. § 254(b)(1), (2), (3) and (6). *See also* NOI ¶ 14; *In the Matter of Lifeline and Link Up Reform and Modernization*, Report and Order and Further Notice of Proposed Rulemaking, 27 FCC Rcd 6656, 6798 ¶ 330 (2012) (*2012 Lifeline Reform Order*) ("Congress made clear in section 254 that the deployment of, and access to, information services -- including "advanced" information services -- are important components of a robust and successful federal universal service program. Also, the statute is clear that universal service support should include addressing low-income needs. Using a discrete, time-limited broadband pilot program to determine whether the low-income program can successfully be used to increase broadband adoption among low-income consumers is therefore consistent with the purposes of section 254. Accordingly, we find authority under section 254, as supported by section 4(i), to provide limited USF support through a Low-Income Broadband Pilot Program and to require ETCs receiving

Moreover, in defining universal service, Section 254(c) indicates that "[u]niversal service is an evolving level of telecommunications service that the Commission shall establish periodically…taking into account advances in telecommunications and information technologies and services."[17] Indeed the statute requires the consideration of the extent to which telecommunications services "are essential to …public health" in determining the services that are supported by universal service support mechanisms.[18] It also contemplates the designation of additional services being eligible for universal service support under the mechanisms established to support healthcare providers.[19] The use of a pilot program is an ideal approach to assist the Commission in considering additional services that could potentially be supported.

III. THE PILOT PROGRAM SHOULD HAVE CLEAR GOALS AND MUST BE ADMINISTRATIVELY SIMPLE TO ENSURE SUFFICENT PARTICIPATION AND EFFECTIVELY MEASURE SUCCESS.

A. PROGRAM GOALS AND RELATIONSHIP TO OTHER PROGRAMS

To ensure the success of the Connected Care Pilot Program, the FCC must clearly articulate what it seeks to accomplish and how success will be measured. The AHA therefore supports the goals discussed in the NOI, as they provide a reasonable blueprint from which to construct the program.[20]

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support through the Pilot Program to offer either a bundle of voice and broadband services or standalone broadband service.") (footnotes omitted).

[17] 47 U.S.C. § 254(c).

[18] *Id*. § 254(c)(1)(A).

[19] *Id*. at § 254(c)(3).

[20] The goals articulated in the NOI are (1) improving health outcomes through broadband access; (2) supporting the trend towards connected care everywhere; (3) reducing health care costs for patients, facilities and the health care system; (4) determining how universal service funding can positively impact existing telehealth initiatives; (5) increasing broadband deployment in unserved and underserved areas; (6) and increasing adoption of broadband among low-income households. NOI ¶¶ 16-27.

By the same token, to maximize efficiency and promote optimal distribution of funding, the program should not duplicate the FCC's existing programs that address last-mile residential connectivity (Connect America Fund/High-Cost program), rural HCP connectivity (RHC Program), and support for low-income Americans (Lifeline Program). Nor should the program duplicate other existing telemedicine programs sponsored by other agencies (*e.g.*, the Department of Agriculture Distance Learning & Telemedicine Grant Program or Department of Health and Human Services programs). Rather, the program should explore how pilot projects can enable synergies among existing FCC programs and, potentially, other government funded telehealth efforts, to promote increased awareness and adoption of telehealth services.

B. PROGRAM STRUCTURE

The AHA recommends that the Commission consider the following principles when determining how to structure the Connected Care Pilot Program:

First, while ensuring program integrity, the Commission should design a program that is administratively simple and does not otherwise impose unnecessary barriers to participation. As the AHA has previously stated, the administrative burdens of the RHC Program are significant and have proven to be the highest barrier to participation.[21] Likewise, a pilot program that is too administratively burdensome will discourage HCPs from participating. While it is important that the Commission ensures the integrity of universal service spending, it can and should do so without imposing onerous administrative burdens on program participants. This includes requirements that providers engage in extensive screening of patients or extensive reporting. The Commission also should not adopt overly prescriptive minimum service

[21] AHA RHC Program NPRM Comments at 17-18.

standards for participating service providers.[22] Instead, the program should give applicants the freedom to devise projects that they believe will achieve the program's goals, and to outline in their applications how their projects will achieve those goals.

Second, the Commission should identify realistic metrics for measuring program success. It is important that the Connected Care Pilot Program measure the impact of the remote monitoring interventions it supports. However, we caution that program measurement should be kept simple and focus on proximal outcomes rather than distal outcomes. Given the complexity of human health, it can be very difficult to link a single intervention to outcomes such as mortality or even hospitalizations. Thus, the program should consider more specific measures that are directly linked to the interventions that are funded. These could include tracking of patient interactions via remote monitoring and assessments of whether biometrics associated with a given condition are improved. For example, have diabetics been able to manage their blood glucose levels or have individuals with hypertension achieved better control of their blood pressure? Remote monitoring tools also could be used to collect data on how healthy individuals feel and whether they feel in control of their health. The limitations on measurement are greater given the relatively small size and duration of the program. The FCC may want to ask applicants to specify reasonable metrics based on the targeted interventions they plan to undertake.

Third, the Pilot Program should have a sufficient overall budget and ensure individual pilots receive adequate funding to cover all necessary costs, including equipment costs, throughout all phases of the project. The AHA supports the Commission's proposed overall budget of $100 million for the Connected Care Pilot Program, provided that such funding

[22] *See* NOI ¶ 43.

is separate and apart from RHC Program funding.[23] While the Connected Care Pilot Program will necessarily produce costs to ratepayers, those costs are likely to be outweighed by the program's substantial benefits, not the least of which will be significant savings in health care expenditures.[24] In addition, while the program should encourage projects from multiple participants, per-project funding must be significant enough to ensure successful pilots. Fewer sufficiently funded projects producing tangible and measurable results will be more useful than numerous underfunded projects that yield less helpful results.

Funds also should be available for equipment, including end-user equipment.[25] While it is true that the Commission has elected not to fund end-user equipment in other USF programs,[26] more recently those decisions have been a policy choice, not a legal barrier. For example, in the context of the 2012 Lifeline Pilot Program, the Commission decided not to subsidize equipment purchases in "keeping with the Commission's historic approach to using the Fund."[27] Similarly, in a 2016 Lifeline decision, the Commission declined to support equipment for low-income consumers because "[p]ast Commission precedent makes it clear that Lifeline, with the exception of a brief period after Hurricane Katrina, has been used to fund services, and not equipment."[28] Even there, the Commission acknowledged that in one instance, albeit a limited period, the Commission did support end-user devices within the Lifeline program.[29] In the Healthcare

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[23] *Id.* ¶ 29.

[24] *See, e.g., id.* ¶¶ 7-8.

[25] *Id.* ¶ 47.

[26] *Id.* nn.72-73.

[27] *2012 Lifeline Reform Order*, 27 FCC Rcd at 6804-05 ¶ 349 (2012).

[28] *Lifeline and Link Up Reform and Modernization*, Third Report and Order, Further Report and Order, and Order on Reconsideration, 31 FCC Rcd 3962, 4005, ¶ 125 (2016) (footnote omitted).

[29] *Fed.-State Joint Bd. on Universal Serv. Sch. & Libraries Universal Serv. Support Mechanism Rural Health Care Support Mechanism Lifeline & Link-Up*, Order, 20 FCC Rcd 16883, 16889-

Connect Fund Order, the Commission similarly determined not to fund computers and end-user wireless devices such as smartphones and tablets, but again the justification was the fact that "the Universal Service Fund (USF) historically has not supported end user devices."[30] In none of these instances did the Commission cite a legal barrier to funding end-user devices. Here, for the purposes of a discrete, time-limited pilot program, the Commission should exercise its broad discretion under Section 254[31] to support the funding of end-user equipment given the fact that meaningful adoption of telehealth services by low-income consumers (and, thus, the success of the Connected Care Pilot Program) requires affordable access to end-user equipment. We note that the anti-kickback statutes prohibit HCPs from giving items of value, such as monitoring equipment, as they could be seen as an inducement. Funding of these costs directly through the program would, therefore, be particularly beneficial.[32]

Fourth, encourage innovative approaches that incentivize community-focused projects, rather than "one-off" HCP or company-driven projects. Projects driven by local communities that bring together HCPs in partnership with broadband providers, telehealth service/application providers, and community leaders should be preferred over projects proposed by a single HCP or company that will be of limited reach. One way to promote a community-wide focus would be to extend program eligibility to RHC Consortia. By allowing rural HCPs to

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90 ¶ 13 (2005) (adopting temporary rules to include the provision of a free handset along with voice service to those directly impacted by Hurricane Katrina).

[30] *Rural Health Care Mechanism*, Report and Order, 27 FCC Rcd 16678, 16754, ¶ 167 n.455 (2012).

[31] *See supra* pages 4-6 for discussion on legal authority.

[32] American Hospital Association, *Legal (Fraud and Abuse) Barriers to Care Coordination and How to Address Them*, at 7-8 (2017), https://www.aha.org/system/files/content/16/barrierstocare-full.pdf.

participate as a group, the Commission will encourage projects that have a wider geographic reach and thus are more likely to provide community-wide services.

The AHA also recommends that the Commission consider prioritizing some of its support for areas that have been statistically shown to have HCP shortages while recognizing that these shortages are experienced in all communities. The Commission could identify such areas by using health professional shortage area ("HPSA") designations from the Health Resources and Services Administration ("HRSA"). HPSAs for primary care face recruitment and retention issues and have less than one physician for every 3,500 residents. Nearly 20 percent of Americans live in such areas.[33] Finally, while focusing on the inclusion of low-income individuals is a worthwhile approach, the identification of such individuals should not be limited to Medicaid-eligible patients. HCPs serve many low-income patients that are not Medicaid participants.[34]

Fifth, protect patient information. To limit the administrative burdens of the Connected Care Pilot Program, the Commission should not impose additional patient privacy requirements on program participants. Compliance with the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") should be deemed sufficient.[35]

IV. CONCLUSION

The Connected Care Pilot Program is a critical next step towards delivering affordable telehealth services to those Americans who need it the most. The AHA looks forward to working with the Commission as it moves closer to finalizing and implementing the program. If

[33] American Hospital Association, *Task Force on Ensuring Access in Vulnerable Communities*, at 7 (Nov. 29, 2016), https://www.aha.org/system/files/content/16/ensuring-access-taskforce-report.pdf.

[34] NOI ¶ 39.

[35] *Id.* ¶ 55.

you have any questions or need further information, please do not hesitate to contact me or Chantal Worzala, AHA's vice president of health information and policy operations, at cworzala@aha.org.

Respectfully submitted,

By: /s/

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