Before the
Federal Communications Commission
Washington, D.C. 20554

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

COMMENTS OF CHRISTUS HEALTH

I. Introduction

CHRISTUS Health (CHRISTUS) hereby submits these comments in the above captioned proceedings before the Federal Communication Commission ("Commission" or "FCC").[1] Consistent with these comments, CHRISTUS is supportive of the proposal put forward by the Commission in the Notice of Inquiry (NOI) on the establishment of the "Connected Care Pilot Program" ("CCPP") and urges the Commission to move forward expeditiously in establishing this opportunity.

II. Background

CHRISTUS Health is an international Catholic, faith-based, not-for-profit health system driven by its mission to ensure all Americans receive access to quality, affordable health care. Our organization is comprised of more than 600 services and facilities, with many sites in CHRISTUS Health designated "rural" for purposes of the Rural Health Care ("RHC") program or serving patients who live in areas that are rural, remote, and medically underserved.[2] CHRISTUS understands the increasing importance of remote patient monitoring and mobile health technologies in the delivery of health care, especially in rural settings where issues of affordability and broadband service limitations are more pervasive. As the Commission recognizes and CHRISTUS has experienced, broadband-enabled telehealth services improve access and quality of care while reducing costs to patients and providers. Barriers in accessing

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

[2] CHRISTUS Health is comprised of almost more than 600 services and facilities, including more than 60 hospitals and long-term care facilities, 350 clinics and outpatient centers, and dozens of other health ministries and ventures. https://www.christushealth.org/about.

broadband-enabled telehealth services in rural areas are real and as we discuss in these comments, and consistent with a letter we filed with the Commission in 2015 (attached), we urge the Commission to consider supporting the deployment of remote monitoring by providing universal service support through this Connected Care Pilot Program to eligible health care providers through the RHC program.[3]

III. Discussion

A. Goals of the Pilot Program

In the *2018 Telehelath NOI*, the Commission seeks comment on goals for the CCPP. Specifically, the Commission seeks comment on how such a program could: 1) improve health outcomes through broadband access; 2) support the trend toward ubiquitous care; 3) reduce costs for patients, facilities, and health care systems; 3) bridge gaps in the federal government's initiatives building on prior successes with regards to improving health care outcomes; 5) increase broadband deployment; and 6) increase broadband adoption among low-income households. While CHRISTUS is not able to address each of these goals, we can, based on past experience, address a number of them from a health care provider's perspective.

Improving Health Outcomes: In the *NOI*, the Commission sought comment on whether the CCPP should focus on particular health conditions, areas of medicine or health crises and whether there is any other relevant information or issues in determining how to most effectively allocate the pilot program's resources.[4] CHRISTUS has firsthand experience with the improvements that can come from telehealth. In 2012, for example, CHRISTUS implemented its own remote monitoring pilot in partnership with a carrier and remote monitoring vendor in Texas. Working with a care transition team focused on post-hospitalization treatment of patients with chronic heart conditions and diabetes, the CHRISTUS remote monitoring project sought to increase quality of care, while reducing the burdens on the certified care transition nurses responsible for monitoring remote patients. CHRISTUS found after 1 year of study that the project successfully reduced readmission rates by 24 percent and reduced the cost of care by an estimated $236,000/year for congestive heart failure patients enrolled in the pilot. Enrolled patients also experienced reductions in post-discharge complications, and reported higher patient satisfaction.

Based on that experience and others where we have deployed remote monitoring, we believe that the Commission should try to allow for as many use cases as possible under the program as monitoring of chronic conditions in areas beyond the scope of CHRISTUS's experience may prove equally fruitful. We understand there are limited dollars available, but that should not limit access where there is an opportunity to potentially greatly enhance the lives of patients. Should the Commission determine that it wants some limiting criteria, it could limit the eligibility pool to

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[3] See Letter from George S. Conklin, Senior Vice President and CIO, CHRISTUS Health, to Marlene H. Dortch, Secretary, Federal Communications Commission (Mar. 30, 2015), filed in WC Docket No. 02-60, available at https://ecfsapi.fcc.gov/file/60001041893.pdf.

[4] *2018 Telehealth NOI* at paras. 18-20.

focus on a specific health condition subset like chronic disease management patients who are detrimentally affected by the rural areas they inhabit.

Reduce Costs for Patients, Facilities, and Health Care Systems: In the NOI, the Commission seeks comment on how the pilot program can improve health care affordability for low-income Americans and counteract the burdens of increasing out-of-pocket expenses, including transportation costs for rural and remote patients. The Commission also seeks comment on how the pilot program can reduce health care expenditures for participating HCPs and their qualifying patients.[5]

Again, as our 2012 experience taught us, there is a real opportunity to reduce the cost of delivering health care to patients, while improving the quality of care and increasing patient satisfaction.

Further, the Commission itself has recognized in previous decisions the potential value telehealth has to reduce costs for patients and providers. In its *Technology Transitions Order*, the Commission found that technological advances hold great promise to allow the elderly to age in place, in their homes with remote monitoring. The Commission went on to note that the Department of Veteran Affairs' (VA) telehealth initiative resulted in substantial reductions in days spent in the hospital by patients (59 percent reduction) and hospital admissions (39 percent reduction) saving the VA over $2,000 per patient per year.[6] These types of savings would be a great benefit to all aspects of the health care system from patients to providers. Ensuring that projects meet such benchmarks is a laudable goal for the program to have.

Support the Trend Toward Ubiquitous Care: In the *NOI*, the Commission seeks comment on the costs and benefits of the shift towards ubiquitously connected care. CHRISTUS would simply note that given the improved health results for patients, reduced costs for providers and opportunity to allow patients a greater insight into their care, ubiquity of connected care should be promoted by whatever means we can and the CCPP proposal put forward by the Commission can help further define the opportunities telehealth presents.

As for the other goals the Commission seeks comment on, they are possibly better addressed by other commenters in the record. We would simply note that whatever steps the Commission can take to promote deployment and adoption of broadband should be taken, as broadband has become increasingly important to all aspects of our daily lives.

B. Structure of the Program

In the *2018 Telehelath NOI*, the Commission seeks comment on a number of structural aspects of the program. CHRISTUS will provide comment on eligibility of health care providers and low-income consumers, supported services, and the duration of the program.

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[5] *2018 Telehealth NOI* at para. 22.

[6] Technology Transitions, et al., GN Docket No. 13-5 et al., Order, Report and Order and Further Notice of Proposed Rulemaking, Report and Order, Order and Further Notice of Proposed Rulemaking, Proposal for Ongoing Data Initiative, 29 FCC Rcd 1433, 1504, para. 225 (2014) (Technology Transitions Order).

Eligible Health Care Providers: In the *NOI*, the Commission seeks comments on how to determine provider participation eligibility. CHRISTUS would recommend limiting eligibility to health care systems with facilities providing at least 15 percent of their care to the uninsured and underinsured. Eligible hospitals would be designated as "rural" by the Centers for Medicare and Medicaid Services. Additionally, the goals of the program would be best served if the eligible health care providers have partnerships with smaller rural facilities and/or critical access hospitals that allow the provider to access and support the individuals in the rural communities being served.

Eligible Low-Income Subscribers: CHRISTUS agrees with the Commission's requirement that participating health care providers use the pilot program benefits exclusively to benefit low-income patients. This limitation includes focusing eligibility criteria on Medicaid patients and veterans as well as the uninsured and underinsured. For a more focused approach, beneficiaries could include a specific population set such as an identified underserved minority group. Should the Commission decide to focus its efforts on certain medical conditions, which we reiterate may limit the potential benefits of the pilot program, CHRISTUS would urge the Commission to target funding to low-income populations and/or underserved minority groups that are disproportionately affected by the health conditions.

Supported Services: The Commission seeks comments on various aspects of the services that should be supported through this pilot program.[7] CHRISTUS suggests that the program provide support to offer devices with service for remote patient monitoring in addition to broadband coverage. These services have demonstrated that they can provide tangible benefits for patients and further funding will help promote these opportunities. In addition, CHRISTUS supports providing funding for direct-to-consumer telehealth services with medical doctors. Using funds for these purposes can help reach rural low-income patients that can benefit greatly from additional access points to the health care system that do not require transportation. In addition, this can help providers reduce costs of providing care. CHRISTUS also supports the Commission's proposal to use funding to provide connectivity, which is a critical component to the Commission's charge under the Rural Health Care program. This should be done in a technology-neutral manner to the extent possible and based on the needs of the applicant and their proposed project.

Duration: In the NOI, the Commission seeks comment on how long funding should be made available for program participants. CHRISTUS would recommend that the minimum length of funding should be three years and would urge the Commission to adopt an even longer timeline. We suggest this because in order for the Commission to determine the success of the program, multiple years of data will be necessary. Moreover, by providing multiple years of funding, the Commission will attract participants that are willing to make the investment the Commission is seeking.

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[7] *2018 Telehealth NOI* at paras. 42-48.

C. Ensuring the Effective, Fiscally Responsible Use of Pilot Program Funds

The Commission also seeks comment on how best to measure the effectiveness of the CCPP.[8] With regards to the metrics needed to measure improvements in health of qualifying patients, CHRISTUS would suggest that the Commission consider measures such as patient 30-day readmission for illness, patient satisfaction with the care provided through the CCPP, patient adherence to medication and care plan. These measures could be tailored to measure results on a disease-specific basis.

IV. Conclusion

CHRISTUS Health is deeply committed to providing quality, accessible, and affordable care for individuals within all of the communities we serve. We hope our comments assist and underscore the need to proceed with making the Connected Care Pilot Program a reality. This program would be a positive step towards overcoming current barriers to providing cost-effective telehealth services that rural providers and the patients they serve desperately need. We look forward to engaging further with the Commission as it seeks to refine this proposal and make it a reality.

Respectfully submitted,

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[8] *2018 Telehealth NOI* at paras. 53-54.

CHRISTUS

MARCH 2015 LETTER

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March 30, 2015

VIA ECFS

Marlene H. Dortch, Secretary
Federal Communications Commission
445 Twelfth Street, N.W.
Washington, DC 20554

Attn: Radhika Karmarkar
Regina Brown
Wireline Competition Bureau

Re: CHRISTUS Health
CC Docket No. 02-60

Madam Secretary:

We write regarding the increasing importance of remote home health monitoring to the delivery of health care, particularly in rural settings. The experience of CHRISTUS Health aligns with the Commission's recognition that remote monitoring improves the quality of care while reducing costs to patients and providers. We urge the Commission to consider supporting the deployment of remote monitoring by providing limited universal service support to eligible health care providers through the Rural Health Care ("RHC") program. A streamlined RHC application mechanism that supports remote monitoring – if only on a limited pilot basis – will help rural hospitals who are facing a crisis that is undermining healthcare delivery in rural America.

CHRISTUS Health is an international Catholic, faith-based, not-for-profit health system comprised of almost 350 services and facilities, including more than 60 hospitals and long-term care facilities, 175 clinics and outpatient centers, and dozens of other health ministries and ventures.[1] Jointly sponsored by the two religious congregations of the Sisters of Charity of the Incarnate Word in Houston and San Antonio, the mission of CHRISTUS Health is to extend the healing ministry of Jesus Christ. To support its health care ministry, CHRISTUS Health employs approximately 30,000 associates and has more than 9,000 physicians.

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[1] *See* http://www.christushealth.org/workfiles/2015SystemProfile.pdf (last visited Mar. 11, 2015). CHRISTUS Health is the lead entity and member of the Texas Health Information Network Collaborative ("TxHINC"), a RHC pilot program awardee. However, with this letter, CHRISTUS Health and Mr. Conklin, who is the Chief Information Officer for CHRISTUS Health and Project Manager of TxHINC, are representing CHRISTUS Health and not TxHINC.

CHRISTUS Health has facilities in Texas, Louisiana, Arkansas, Georgia, Iowa, and New Mexico (as well as facilities in Mexico and Chile). Many sites in the CHRISTUS Health system are either designated "rural" for purposes of the RHC program, or serve patients who live in areas that are rural, remote, and medically underserved.

Growing Importance of Remote Patient Monitoring

Remote monitoring helps doctors manage post-operative care and patients with chronic conditions such as heart disease and diabetes.[2] Devices attached to patients use wireless broadband to transmit measurements back to the hospital where they can be monitored and medications or other treatments adjusted. Detecting problems early improves the quality of patient care, avoids unnecessary visits to a doctor or emergency room, and reduces costs to patients, hospitals, and insurers. As a result of Medicare penalties based on patient readmission rates, it also improves the bottom-line for hospitals. This opportunity to improve care and lower costs makes remote monitoring an increasingly important sector of our health care system.

CHRISTUS Health has long been an innovator and, in 2012, implemented its own remote monitoring pilot in partnership with a carrier (AT&T) and remote monitoring vendor (Vivify Health), both based in Texas.[3] Working with a care transition team focused on post-hospitalization treatment of patients with chronic heart conditions and diabetes, the CHRISTUS Health remote monitoring project sought to increase quality of care, while reducing the burdens on the certified care transition nurses responsible for monitoring remote patients. The project successfully reduced readmission rates, all with very high patient satisfaction.[4]

Crisis Facing Small Rural Healthcare Providers

Many small rural hospitals in America are in crisis, facing a "perfect storm" of demographic, regulatory, and economic challenges that threaten their continued viability.[5] Since 2010, there has

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[2] *See generally, e.g.*, Jonathan D. Rockoff, *Remote Patient Monitoring Lets Doctors Spot Trouble Early*, WALL ST. J., Feb. 16, 2015.

[3] *See* Rajiv Leventhal, *Innovator Semifinalist Team: Improving Home Health at CHRISTUS Health With RPMS*, HEALTHCARE INFORMATICS, Feb 18, 2014, available at http://www.healthcare-informatics.com/article/innovator-semifinalist-team-improving-home-health-christus-health-rpms.

[4] *Id.* at 2.

[5] *See* Jayne O'Donnell and Laura Ungar, *Rural Hospitals in Critical Condition*, USA TODAY, Nov. 12, 2014, available at http://www.usatoday.com/story/news/nation/2014/11/12/rural-hospital-closings-federal-reimbursement-medicaid-aca/18532471/; *see also* Guy Gugliotta, *Rural hospitals, beset by financial problems, struggle to survive*, WASH. POST, Mar. 15, 2015, available at http://wapo.st/1BHy5re ("[R]ural hospitals . . . suffer from multiple endemic disadvantages that drive down profit margins and make it virtually impossible to achieve economies of scale. These include declining populations; disproportionate numbers of elderly and uninsured patients; the frequent need to pay doctors better than top dollar to get them to work in the hinterlands; the cost of expensive equipment that is necessary but frequently underused; the inability to provide lucrative specialty services and treatments; and an emphasis on emergency and urgent care, chronic money-losers.").

been a dramatic increase in the number of rural hospital closures.[6] Rural hospitals serve "some of the sickest and poorest" patient populations in the nation and these closings are reducing the availability of emergency and other care to these populations, resulting in avoidable deaths and medical complications.[7] Managing care for these "sickest and poorest" is a particular challenge for rural hospitals, and readmission penalties associated with their care are one factor in the perfect storm these hospitals are facing.[8]

The FCC has an opportunity to help these hospitals, all of which are intended beneficiaries of the RHC program – a program, which fifteen years after being established, remains undersubscribed.[9] Indeed, this crisis among rural hospitals demonstrates that undersubscription of the RHC program is not due to a lack of need for RHC support among targeted beneficiaries.

How the FCC Could Help

Allowing rural hospitals to obtain a discount on wireless broadband costs associated with providing remote monitoring to patients is one way the Commission could help. The remote monitoring kits employed by health care providers ("HCPs") consist of different kinds of remote monitoring equipment such as blood pressure cuffs and fingertip blood-oxygen meters that are integrated with a wireless broadband service provided by a wireless carrier. These can also include tablet computers, however the equipment supplied by the HCP is locked down and can only be used for healthcare related purposes. (No streaming movies on an HCP-provided tablet computer, for example.) The kits are sent home with patients on a temporary basis, maintained by the hospital, and reusable (after being sterilized).

Patients in rural areas may have difficulty obtaining reliable broadband for remote monitoring. At a minimum, such patients often do not have multiple wireless broadband providers to choose from. However, the area served by an HCP may span a wide region with no single carrier able to serve

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[6] *See* O'Donnell and Unger, *supra* note 5, at 1 ("Since the beginning of 2010, 43 rural hospitals — with a total of more than 1,500 beds — have closed, according to data from the North Carolina Rural Health Research Program. The pace of closures has quickened: from 3 in 2010 to 13 in 2013, and 12 already this year. Georgia alone has lost five rural hospitals since 2012, and at least six more are teetering on the brink of collapse"); *see also* Coshandra Dillard, Dying rural hospitals affect most vulnerable, TYLER MORNING HERALD, Feb. 14, 2015, available at http://www.tylerpaper.com/TP-News+Local/213794/dying-rural-hospitals-affect-most-vulnerable (profiling closing of East Texas Medical Center in Gilmer, TX); Alex Smith, Facing Layoffs And Closures, Rural Hospitals Push For Medicaid Expansion, KCUR Kansas City Public Radio, Feb 11, 2015, available at http://hereandnow.wbur.org/2015/02/24/rural-hospitals-medicaid (profiling closing of Sac-Osage Hospital in Osceola, Missouri).

[7] *See* O'Donnell and Unger, *supra* note 5, at 1.

[8] *See* Dillard, *supra* note 6 ("The Affordable Care Act was designed to provide more access to health care, helping rural hospitals stay afloat. However, new penalties for performance-based measures, such as re-admission rates, stifled already strapped hospitals.").

[9] The RHC has not shown dramatic growth since the Healthcare Connect Fund ("HCF") was launched in January 2013. *See* USAC Rural Health Care Funding Information, http://usac.org/rhc/healthcare-connect/funding-information/default.aspx (showing less than $200 million in total funding requests for funding year 2013) (last visited Mar. 25, 2015).

all of the patients served by the HCP. As a result, HCPs may need different remote monitoring kits that work with different wireless broadband providers.[10] The kits and associated wireless broadband contract costs are paid for by the HCP, not the patient.

The Commission should consider subsidizing under the RHC program the wireless broadband contracts between the HCP and wireless carriers HCPs use for remote monitoring. This could be done in some cases under the existing $10,000 competitive bidding exemption[11] or perhaps by establishing a new exemption (on a pilot basis) for rural HCPs purchasing services at publicly-available commercial mobile broadband rates. A simple reimbursement mechanism that is administratively easy to implement and easy to apply for could directly and immediately benefit rural hospitals. Enhancing access to advanced services in this way would encourage the deployment of technologies that benefit rural health care providers and the patients they serve.

The legal basis for funding mobile broadband connectivity between eligible HCPs and patients under the RHC program is addressed below.

The Rural Health Care Program Should Continue to Foster Innovation

The Commission has in the past used the Rural Health Care Program to explore innovative ways to "enhance . . . access to advanced telecommunications and information services" for eligible health care providers.[12] For example, in 2007 the RHC pilot program allocated $417 million spread over several years to fund network projects across the country "designed to bring the benefits of innovative telehealth and telemedicine services to areas of the country where the need for those benefits is most acute."[13] While individual pilot projects saw varying degrees of success, the overall effort proved hugely beneficial and provided Commission policy-makers with the practical basis for establishing the Healthcare Connect Fund in 2012 (as a component of the overall RHC program).

More recently, the Commission has twice considered RHC program initiatives that would have continued to explore and support innovation in healthcare delivery. In 2012, the Commission announced a $50 million pilot program to consider the benefits of funding connections from eligible health care providers to skilled nursing facilities ("SNFs").[14] The Commission recognized

[10] This is similar to a consumer selecting a smartphone from a carrier that has the best coverage where they live or work. Note, if particular patients are unable to obtain wireless broadband service capable of supporting remote monitoring from any provider, HCPs are in a position to report this information to the Commission for use in other universal service proceedings.

[11] 47 C.F.R. § 642(h)(1). This exemption could be sufficient for many rural hospitals. Assuming a monthly mobile broadband data rate of $50 per month per active connection, this would equal $600 per year per connection. In this example, sixteen connections active for every month of the year would equal $9600 per year – potentially eligible for $6240 in HCF subsidy.

[12] 47 U.S.C. § 254(h)(2)(A).

[13] *See Rural Health Care Support Mechanism*, WC Docket No. 02 60, Report and Order, 27 FCC Rcd 16678, 16684-85, ¶ 13 (2012) (*HCF Order*) (describing RHC pilot program).

[14] *See generally HCF Order*, 27 FCC Rcd at 16815-18, ¶¶ 345-350.

the important goal of using advanced services to improve patient outcomes and saw SNFs as a critical part of the care continuum for patients.[15]

While the Commission ultimately did not implement the SNF pilot, in 2014, it sought comment on a proposal to use the $50 million in unused SNF funding for a series rural healthcare broadband experiments that would be "consumer oriented" and could "improve patient access to health care."[16] The *Technology Transitions Order* specifically highlighted the benefits of remote monitoring, explaining:

> [T]echnological advances hold great promise to enable the elderly to age in place, in their home, with remote monitoring of key health statistics through a broadband-enabled device. Likewise, the Department of Veteran Affairs has implemented a telehealth initiative which has reduced the number of days spent in the hospital by 59 percent, and hospital admissions by 35 percent for veterans across the country, saving over $2000 per year per patient, including even when factoring in the costs of the program. These programs are critical to achieving savings in healthcare costs, and reducing the amount of time patients are away from home, but a critical gap remains in ensuring that patients, such as the elderly and veterans, have access to sufficient connectivity at home to transmit the necessary data for telemedicine applications such as remote health care monitoring, to enable patients to access the health care provider's patient portal, and for other broadband-enabled health care applications.[17]

The FCC's Connect2Health Task Force has also recognized the clear benefits of remote monitoring for rural and underserved communities. The Task Force described first-hand encounters with these benefits while on a recent visit to Ruleville, Mississippi (pop. 3,007):

> While at North Sunflower [County Medical Center], two diabetes patients, "Ms. Annie" and "Ms. Jackie," shared moving firsthand accounts of how wireless broadband and remote monitoring have helped them control their diabetes and avoid the debilitating consequences of the disease experienced by other family members.
>
> We also learned that, as a direct result of the broadband-enabled remote monitoring effort in Ruleville, hospital admissions for diabetes-related illness are plummeting.[18]

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[15] *See id.* at 16816, ¶ 346.

[16] *Technology Transitions, et al.*, GN Docket No. 13-5 et al., Order, Report and Order and Further Notice of Proposed Rulemaking, Report and Order, Order and Further Notice of Proposed Rulemaking, Proposal for Ongoing Data Initiative, 29 FCC Rcd 1433, 1504, ¶ 224 (2014) (*Technology Transitions Order*).

[17] *See id*. at 1504, ¶ 225 (footnotes omitted).

[18] Just Around the Broadband Bend, Posting of P. Michele Ellison, Chair, Connect2HealthFCC Task Force, Official FCC Blog, http://www.fcc.gov/blog/just-around-broadband-bend (Feb. 23, 2015).

The *Technology Transitions Order* also asked whether Section 254 provides the legal authority to fund broadband experiments focusing on "providing advanced telecommunications and information services to consumers in rural areas, with a particular focus deploying broadband that is sufficient to meet consumers' healthcare needs" and sought comments "on experiments that would provide support to health care providers."[19] (The existing RHC programs provide funding to service providers, who then provide discounted services to eligible health care providers.)

Can Universal Service Support Broadband Connectivity Underlying Remote Monitoring?

The broadband connectivity that makes remote monitoring possible easily fits within the definition of "advanced services" eligible for universal service support in the Healthcare Connect Fund.[20] The current rule, Section 54.634(a) provides:

> Eligible health care providers may request support from the Healthcare Connect Fund for any advanced telecommunications or information service that enables health care providers to post their own data, interact with stored data, generate new data, or communicate, by providing connectivity over private dedicated networks or the public Internet for the provision of health information technology.

What is new would be allowing HCPs to obtain support for the cost of connectivity to individual patients rather than to other HCPs. Review of the statutory language authorizing the RHC programs, however, show the challenge is more practical than legal.

Although RHC has traditionally supported connectivity between entities, there is nothing in the statute limiting support to entity-to-entity connections. Section 254(h)(1)(A) provides support to rural HCPs for "telecommunications services which are necessary for the provision of health care services"; while Section 254(h)(2)(A) authorizes the FCC to create rules that enhance HCP access to "advanced telecommunications and information services for all public and non-profit . . . health care providers. . . ."[21] These two statutory provisions are intended to assist both patients and HCPs in obtaining basic health care services that now include remote monitoring.

From a funding standpoint, the practical obstacle involves how these services are procured. It is at best impractical for a small rural hospital to conduct a competitive bidding process for the commodity mobile broadband service that underpins remote monitoring kits. In selecting service providers, hospitals will consider foremost the availability of adequate mobile broadband service at the location (or locations) where the patient will be monitored (typically but not necessarily their private residence). In cases where more than one service provider could be selected, other factors such as price can be expected to come into play.

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[19] *See id.* at 1506, ¶ 230.

[20] *See HCF Order*, 27 FCC Rcd at 16720-30, ¶¶ 110-111; *see also id.* at 16732-34, ¶¶ 116-119 (declining to impose minimum bandwidth requirements on HCF support).

[21] *See* 47 U.S.C. § 254(h).

Even in cases where multiple broadband providers could provide the needed service, a competitive bidding exemption makes sense. First, services are needed for a limited period of time that will vary and be uncertain in duration: it could be weeks, months, or years, depending on the patient and the medical conditions being monitored. Conducting a traditional RHC competitive bidding process annually for each situation would make no sense. Even if services were procured in bulk for a range of patients in a particular region for a set period of time (one year for example), because mobile broadband pricing is a commodity in most cases, program savings would be minimal and the complexity of the RHC procurement process and requirements would discourage participation by the small rural hospitals that urgently need this support.

Instead, the Commission should consider a competitive bidding exemption that allows rural hospitals to request funding for the costs of mobile broadband supporting remote monitoring purchased at publicly available commercial rates, and to submit invoices for reimbursement at the 65% HCF flat discount rate. Because the number of rural hospitals is limited[22] and the amount of these costs will be relatively low, there is little risk this would be a dramatic drain on limited RHC funding. Moreover, proceeding on a limited time pilot basis – three years, for example – would allow the Commission to assess the demand, impact, and benefits of such an approach.

We appreciate any attention you can give to this important matter and look forward to discussing this issue further.

Respectfully submitted,

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cc Connect2HealthFCC Task Force

[22] In 2012, the Commission estimated there were 1,674 rural hospitals eligible for RHC support. *See HCF Order*, 27 FCC Rcd at 16723-24, ¶ 98, n.266.