

**Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, DC 20554**

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

REPLY COMMENTS OF THE AMERICAN HOSPITAL ASSOCIATION

The American Hospital Association (“AHA”) hereby submits its reply comments in response to the Federal Communications Commission’s (“FCC” or “Commission”) Notice of Inquiry (“NOI”) in the above-captioned proceeding.¹

I. INTRODUCTION.

In its Sept. 10, 2018 comments, the AHA supported the Commission’s proposed Connected Care Pilot Program and applauded the NOI’s focus on services and applications delivered remotely to patients in their homes and communities. A separately funded pilot program focused specifically on promoting the use of broadband-enabled telehealth services could nicely complement the existing Rural Health Care Program. The record strongly supports the Commission’s proposal to establish a pilot program, and the AHA encourages the FCC to expeditiously move forward.

¹ *Promoting Telehealth for Low-Income Consumers*, Notice of Inquiry, WC Docket No. 18-213, FCC 18-112 (rel. Aug. 3, 2018) (“NOI”). As stated in the AHA’s initial comments in this proceeding, the AHA’s membership includes nearly 5,000 hospitals, health systems, and other health care organizations. The AHA’s clinician partners include more than 270,000 affiliated physicians, two million nurses and other caregivers. In addition, the AHA has 43,000 individual professional members. Comments of American Hospital Association, WC Docket No. 18-213, at 1 (filed Sept. 10, 2018) (“AHA Comments”).

The AHA made recommendations regarding how the program should be structured.² In these reply comments, the AHA focuses on, among other things, how the Commission can encourage health care provider (“HCP”) participation in the program. Specifically, HCPs will bear much of the responsibility for managing individual pilots, and thus are less likely to participate in the Connected Care Pilot Program if funding is not sufficient to support solid project management. The Commission must take this issue into account when determining how much funding should be made available, and how it should be allocated to each eligible project. HCPs also are less likely to participate if the program’s application process is unduly complex or restrictive, or if the Commission does not use realistic and relevant metrics for measuring program success. Further, the Commission should consider refining the concepts of “eligible health care provider” and “eligible patient” to encourage greater participation by qualified providers and promote wider distribution of telehealth services to those who need them the most. Lastly, equipment (including end-user devices) should be eligible for funding, with the understanding that there is no “one-size-fits-all” equipment solution for all HCPs. Different HCPs may need to specify different equipment to ensure compatibility with their existing technologies.

² Specifically, the AHA advocated that the program be administratively simple; that the Commission identify realistic metrics for measuring program success; that individual pilots receive adequate funding to cover equipment, including end-user devices; that the program encourage innovative approaches that incentivize community-focused projects; and that the Commission not impose patient privacy requirements on program participants beyond those required under the Health Insurance Portability and Accountability Act of 1996 (“HIPPA”). AHA Comments at 8-12. In addition, the AHA agreed that the Commission has the legal authority to adopt the Connected Care Pilot Program. *Id.* at 5-7.

II. DISCUSSION

A. Funding Must Be Sufficient and Appropriately Targeted to HCPs to Support the Wide-ranging Role HCPs Will Play in Managing Pilot Projects.

The NOI states that the Commission expects to set aside a total of \$100 million for the Connected Care Pilot Program, and that “each telehealth pilot project could receive up to \$5 million in funding to support broadband connectivity to low-income patients and increased capabilities for the health care provider.”³ It must be noted, however, that HCPs will have substantial obligations under the program, and that HCPs are less likely to participate if the Commission does not factor those obligations into the funding equation.

For instance, an HCP will be required to:

- Identify eligible patients, engage them in the program and coordinate service with its communications services and telehealth application partners;
- Ensure that patients have the appropriate telehealth technology and teach them how to link that technology to the participating HCP; and
- Troubleshoot issues patients experience along the way.

In addition, each pilot will need a program manager, whose responsibilities will include project planning, working with clinical staff to change work flows as necessary to support the program, contracting, outreach and communications, and technology choice and acquisition.⁴ All of this work will require significant effort and entail both start-up and

³ NOI ¶ 13.

⁴ See e.g. Comments of Henry Schein, Inc./Medpod, WC Docket No. 18-213, at 6 (filed Sept. 10, 2018) (stating that key success factors for a telehealth project include a “clearly articulated implementation plan, a team, a project manager with project management skills and executive support” and the importance of a change management and communications plan because “key constituents (patients, administrators, providers, payors) require attention and lots of two-way communication in order to be brought on board and engaged in making a successful program.”).

implementation costs, which may be particularly burdensome for understaffed and/or underfinanced HCPs.

In the NOI, however, there is little specific discussion of providing financial support directly to HCPs for the tasks described above or the program manager position in particular. As noted below, HCPs are already having difficulties meeting the extensive administrative demands of the Rural Health Care Program. Accordingly, they are unlikely to embrace a pilot program (particularly one that will require off-site patient monitoring) if funding is insufficient and not appropriately targeted to HCPs to support effective project management. The AHA urges the Commission to keep this in mind when evaluating how much funding will be available, and how it will be allocated among eligible projects and participants. To ensure sufficient resources are available for HCPs, the Commission should consider whether it could partner with other agencies that fund telehealth programs, such as the Rural Utilities Service (“RUS”) which administers a Distance Learning and Telemedicine Program and the various grant and other programs overseen by the Health Resources & Services Administration (“HRSA”) and other programs under the auspices of the U.S. Department of Health & Human Services.⁵

B. The Commission Can Encourage HCP Participation by Ensuring a Simple Application Process and Identifying Realistic and Relevant Metrics for Measuring Program Success.

In designing the application process and other elements of the Connected Care Pilot Program, the Commission must not impose excessive administrative burdens on

⁵ See Comments of ACT | The App Association’s Connected Health Initiative, WC Docket No. 18-213, at 7 (filed Sept. 10, 2018); Comments of CTIA – The Wireless Association, WC Docket No. 18-213, at 11-12 (filed Sept. 10, 2018) (“CTIA Comments”); Comments of Medical University of South Carolina, WC Docket No. 18-213, at 4 (filed Sept. 10, 2018); Comments of United Health Group, WC Docket No. 18-213, at 4 (filed Sept. 10, 2018) (“United Health Comments”); Comments of Virginia Telehealth Network, WC Docket No. 18-213, at 10-11 (filed Sept. 10, 2018).

program participants. The administrative burdens of the Rural Health Care Program are already significant and have proven to be the highest barrier to HCP participation. To avoid repeating that result here, the Commission should simplify the Connected Care application process as much as possible and refrain from adopting overly prescriptive minimum service standards or other rigid “threshold” requirements for applicant proposals.⁶ The AHA believes that HCPs are more likely to participate if they are afforded the flexibility to design projects that meet community needs while remaining true to the larger goals of the program.

Likewise, the methodology of measuring a program’s success should be kept simple and relevant to what an individual project is designed to do. Given the complexity of human health, it can be very difficult to link a single telehealth intervention to outcomes, such as mortality or even hospitalizations. Thus, the Commission should consider permitting more specific measurement methodologies that are directly linked to the interventions that are funded. These could include tracking of patient interactions via remote monitoring and assessments of whether the biometrics associated with a given condition are improved. 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 Commission may want to ask applicants to specify reasonable metrics based on the targeted interventions they plan to undertake.⁷

⁶ See Comments of AT&T, WC Docket No. 18-213, at 11 (filed Sept. 10, 2018) (“[G]iven the short duration of the program, the Commission should try to minimize administrative costs of participating in this program and adopt streamlined administrative and reporting procedures.”); Comments of the Schools Health and Libraries Broadband Coalition, WC Docket No. 18-213, at 5 (filed Sept. 10, 2018) (“SHLB Comments”); Comments of National Association of Accountable Care Organizations, WC Docket No. 18-213, at 2 (filed Sept. 10, 2018) (“NAACOS Comments”); Comments of the College of Healthcare Information Management Executives, WC Docket No. 18-213, at 2 (filed Sept. 10, 2018).

⁷ See AHA Comments at 9.

Lastly, to further minimize administrative burdens on HCPs, the AHA recommends that HCPs not be responsible for distributing program funding to broadband service providers and other third parties connected to a pilot (e.g., equipment suppliers, patients, etc.). While support should be provided to HCPs and HCPs should play a central role in the overall management of pilot projects, any funding to other pilot participants should be provided to them by the Commission, or the Universal Service Administrative Company.

C. The Commission’s Definition of “Eligible Health Care Provider” Should Ensure That Any HCP Positioned to Support a Pilot in Areas of Need is Able to Participate.

The Commission asks whether the Connected Care Pilot Program should prioritize participating clinics and hospitals in rural areas.⁸ The AHA believes that rural HCPs should be afforded partial priority, but that the Commission also should give consideration to areas that have been statistically shown to have HCP shortages, rural or otherwise. The Commission could identify such areas by using health professional shortage area (“HPSA”) designations from the HRSA.⁹ As noted by the American Association of Nurse Practitioners, “[m]any Health Professional Shortage Areas (HPSAs) are located near metropolitan areas. They also are in great need of telehealth services and may not receive the necessary funding to treat their larger patient populations if prioritization is based solely on rurality or remoteness.”¹⁰ With that said, given the demonstrated benefits of telehealth services to Americans living in rural

⁸ NOI ¶ 35.

⁹ AHA Comments at 12. 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. *Id.*

¹⁰ Comments of American Association of Nurse Practitioners, WC Docket No. 18-213, at 1 (filed Sept. 10, 2018). See also Comments of NCTA – The Internet & Television Association, WC Docket No. 18-213, at 4 (filed Sept. 10, 2018) (“In order to maximize the utility of the pilots, the Commission should select pilot projects that represent a range of different geographies, technologies, and patient populations.”).

America who may not have sufficient access to health care services, the AHA supports giving partial prioritization for projects with rural HCPs.¹¹

The Commission also should not exclude for-profit HCPs from participating in networks funded by the program, notwithstanding the fact that for-profit HCPs are not eligible for funding under section 254(h) of the Communications Act. For-profit HCPs bring human, financial and technological resources that non-profit HCPs may not have (particularly in underserved areas), and can expand a project's scope and capabilities.¹² The AHA understands that due to statutory limitation, for-profit HCPs are not able to receive universal service support. Given the critical role that such entities can play in assisting rural patients, the AHA supports a change in the statute to allow direct funding to for-profit HCPs participating in the program.

In addition, the AHA reiterates its call for the Commission to permit participation by rural health care ("RHC") consortia. By allowing rural HCPs to participate as a group (either on their own or in tandem with urban HCPs), the Commission will encourage projects that have a wider geographic reach and thus are more likely to provide community-wide services.¹³ Also, a consortium can improve program efficiency by

¹¹ Comments of Hughes Network Systems, LLC, WC Docket No. 18-213, at 19 (filed Sept. 10, 2018) ("when striking that balance between urban, suburban, and rural populations, consideration must be given to which communities are more likely to benefit most from telehealth services."); Comments of NTCA – The Rural Broadband Association, WC Docket No. 18-213, at 10-12 (filed Sept. 10, 2018).

¹² See, e.g., *Rural Health Care Support Mechanism*, Report and Order, 27 FCC Rcd 16678, 16760 ¶ 180 (2012) ("2012 RHC Report and Order") (footnote omitted) ("In the case of statewide or regional health care networks, it may be useful for health care purposes to have both eligible and ineligible HCPs participate in the same network, and share certain backbone or network equipment costs between all participants in the network. Having both eligible and ineligible entities contribute to shared costs may lead to lower overall costs for the eligible HCPs, and enables HCPs to benefit from connections to a greater number of other HCPs, including for-profit HCPs that are not eligible for funding under section 254 but nevertheless play an important role in the overall health care system.").

¹³ AHA Comments at 11-12.

servicing as a coordinating body for individual projects, eliminating redundant applications and thereby conserving Commission resources.¹⁴

D. The Commission’s Definition of “Eligible Patient” Should Be Flexible.

The Commission seeks comments on limiting HCPs’ use of pilot program funding to the treatment of Medicaid-eligible patients and veterans who qualify based on income for cost-free health care benefits through the Department of Veteran Affairs.¹⁵ Eligible low-income patients should not be limited to Medicaid-eligible individuals, as HCPs serve many low-income patients who are not Medicaid participants.¹⁶ The definition of “eligible patient” also should include individuals (including veterans) that satisfy their HCPs’ financial assistance policies, regardless of whether they participate in Medicaid. Such individuals invariably are “low income” and do not have ready access to telehealth services. Moreover, funding should be set aside for provision of telehealth services to residents of Tribal lands, such that, for example, Tribal health beneficiaries in Alaska are identified for inclusion in pilot programs.¹⁷

To ensure a successful project, it is critical that eligible patients retain their eligibility for the entirety of a pilot program. That is, the Commission should continue to fund a patient’s participation in a pilot program even where that patient’s eligibility status changes during the program’s term. This is particularly important if the Commission ties

¹⁴ 2012 RHC Report and Order, 27 FCC Rcd at 16681 ¶ 2 (2012) (“The [Rural Health Care] Pilot Program also proved the benefits of a consortium-focused program design, encouraging rural-urban collaboration that extended beyond mere connectivity, while significantly lowering administrative costs for both program participants and the Fund. . . The consortia were often organized and led by large hospitals or medical centers, which contributed administrative, technical, and medical resources to the other, smaller HCPs providing service to patients in rural areas.”) (Footnotes omitted).

¹⁵ NOI ¶ 39.

¹⁶ AHA Comments at 12.

¹⁷ See NOI ¶ 32 (asking whether proposed pilot projects should serve, among others, residents of Tribal lands).

eligibility to Medicaid participation, since Medicaid has significant patient turnover from month to month.

Finally, while the AHA appreciates the need to maintain program integrity, the Commission must balance that need against the burdens on HCPs (and the consequent costs) of administering each pilot, including certification and documentation of patient eligibility. As discussed in Section II, *A supra*, HCPs will have a substantial role in managing each pilot, and it is not entirely clear from the NOI that those tasks will be fully funded. Mandating that HCPs comply with excessive eligibility certification and documentation requirements will only increase the program's complexity, raise implementation costs, and discourage HCP participation.

E. The Commission Should Not Predetermine the Types of Equipment and End-user Devices That HCPs May Use and Should Encourage Broad Participation from Broadband Service Providers.

To be successful, the Connected Care Pilot Program will need to fund equipment necessary for the effective use of broadband service, including end-user devices, as they are critical to patient adoption of telehealth solutions.¹⁸ As shown in AHA's initial comments, the Commission's more recent decisions not to fund end-user equipment have been a policy choice, not a legal barrier, and the Commission otherwise has broad discretion under section 254 to fund end-user equipment.¹⁹

By the same token, the Commission must refrain from predetermining what types of equipment and end-user devices will be entitled to funding under the program.²⁰ Each pilot may utilize different equipment and end-user devices, depending on a variety of

¹⁸ See AHA Comments at 10-11.

¹⁹ *Id.*

²⁰ United Health Comments at 3; NAACOS Comments at 2.

factors. The Commission should permit applicants to use whatever equipment and end-user devices are most compatible with their proposed technical design. This will promote cost efficiencies and give HCPs the freedom to choose technologies that optimize patient care rather than satisfy arbitrary regulatory restrictions.

Finally, successful pilot projects will require the participation of broadband service providers. The Commission should therefore not adopt overly restrictive requirements that limit the ability of any interested companies from participating.²¹

III. CONCLUSION

The Connected Care Pilot Program is an important next step towards delivering affordable telehealth services to those Americans who need it the most. The AHA therefore urges the Commission to proceed to a Notice of Proposed Rulemaking in this proceeding, in a manner consistent with these reply comments and with the AHA's initial comments. If you have any questions or need further information, please do not hesitate to contact me or Chantal Worzala, vice president of health information and policy operations, at cworzala@aha.org.

Respectfully submitted,

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²¹ NCTA Comments at 1, 4-5; SHLB Comments at 7; CTIA Comments at 12; Comments of American Cable Association, WC Docket No. 18-213, at 5 (filed Sept. 10, 2018).