

February 2, 2018

The Honorable Ajit Pai
Chairman
Federal Communications Commission
445 12th Street, SW
Washington, DC 20554

Dear Mr. Pai:

On behalf of the Healthcare Information and Management Systems Society ([HIMSS](#)) and the Personal Connected Health Alliance (PCHAlliance), we appreciate the opportunity to respond to the Federal Communication Commission's (Commission) [Promoting Telehealth in Rural America](#) Notice of Proposed Rulemaking (NPRM). We offer these comments and recommendations in an effort to assist the Commission in continuing to find ways to improve access to high quality healthcare in rural America, while simultaneously ensuring that rural healthcare providers get the support they need, guarding against waste, fraud, and abuse.

HIMSS is a global voice, advisor, and thought leader of health transformation through health information and technology with a unique breadth and depth of expertise and capabilities to improve the quality, safety, and efficiency of health, healthcare, and care outcomes. HIMSS designs and leverages key data assets, predictive models and tools to advise global leaders, stakeholders, and influencers of best practices in health information and technology, so they have the right information at the point of decision.

HIMSS drives innovative, forward thinking around best uses of information and technology in support of better connected care, improved population health, and low cost of care. HIMSS is a not-for-profit, headquartered in Chicago, Illinois, with additional offices in North America, Europe, United Kingdom, and Asia.

Not-for-profit PCHAlliance publishes and promotes the global adoption of the Continua Design Guidelines, an open framework for user-friendly, interoperable health data exchange in personal connected health. The Continua Design Guidelines are recognized by the International Telecommunication Union (ITU), an agency of the United Nations, as the international standard for safe, secure, and reliable exchange of data to and from personal health devices. Continua is a major initiative within the PCHAlliance focused on developing an eco-system of open plug-and-play interoperable personal connected health devices and services which are validated in accordance with the Continua certification program.

As technology and telehealth assume an increasingly critical role in healthcare delivery, a well-designed Rural Healthcare (RHC) Program is more vital than ever. Trends suggest that rural communities across the country are falling behind when it comes to the availability of high-quality healthcare. By improving rural healthcare provider access to modern communications services, the RHC Program can help in overcoming some of the obstacles to healthcare delivery faced in

isolated communities. HIMSS and PCHAlliance applaud the efforts by Commission's [Connect2Health FCC Task Force](#), which has illustrated the significant impact communications services can have on addressing the healthcare needs of persons living in rural and underserved areas, and how communities are leveraging broadband-enabled health technologies to improve access to health and care throughout the country.

HIMSS and PCHAlliance support the Commission's efforts to ensure the continued funding and support for rural healthcare providers while reducing waste, fraud, and abuse in the current RHC Program. We concur with the Commission's assessment that current demographic pressures on healthcare will only accelerate, rapidly increasing the need for telehealth and other Internet-enabled technologies to ensure the health of rural populations. The Carsey Institute at the University of New Hampshire, and other researchers, identify several demographic trends for rural America that have persisted for decades and will continue to increase future healthcare challenges. These trends include the prevalence of child poverty and shifting populations with many rural areas continuing to become more rural over time.¹ While some rural areas are seeing a "rural renaissance," many continue to see population loss, compounding their challenge to attract healthcare providers.

As the Commission notes, Internet-enabled technologies of all kinds will become important means of rural care delivery. The NPRM references the possibility of automatic prescription dispensing machines alleviating the travel burdens for patients far-removed from a local pharmacy. The delivery of efficacious health care relies more and more on 21st century information communication technologies. The standards for clinical care and today's best practices for some of the most prevalent conditions (heart failure, diabetes, chronic obstructive pulmonary disease, multiple chronic conditions) rely upon provider-patient communication of biophysical data and care management in synchronous, near synchronous, and asynchronous means.

We strongly encourage the Commission to adopt policies that prepare the RHC Program to support technologies beyond telehealth where possible, within statutory limitations, and in a manner that preserves or increases the total available funding for the RHC Program. In the fall of 2017, HIMSS made this a key component of our [Congressional Ask](#). We fully support the idea that remote patient monitoring of vital signs, psychiatric counseling via mobile-enabled technologies, and other direct-to-patient connected health technologies will be necessary to continue to provide quality and cost-effective care to rural populations.

In addition, HIMSS and PCHAlliance strongly urge the Commission to adapt the RHC Program to complement and support other Federal programs designed to ensure the health of rural Americans. For example, Medicare, starting in January of 2018, provides reimbursement for the clinician time spent reviewing patient biophysical data developed from 'remote monitoring,' acknowledging the need to incorporate remote patient monitoring in order to transform and improve care for patients with chronic conditions. Further, since 2016 Medicare has covered chronic care management, which can be provided through remote patient monitoring systems for patients with multiple chronic conditions. Rural Americans are disadvantaged in their access to

¹ Johnson, Kenneth M., "Demographic trends in rural and small town America" (2006). *The Carsey School of Public Policy at the Scholars' Repository*. 5. <https://scholars.unh.edu/carsey/5>

these programs by high rural broadband rates. Therefore, we urge the Commission to take actions that extend connectivity beyond rural clinics to individual patients when possible, as the locus of care delivery rapidly moves deeper into the community and into the patient's home.

One example of the shifting locus of care are emerging "hospital-at-home" (HaH) models, described by Bruce Leff, MD in a February 2017 article in the *New England Journal of Medicine*.² He notes that evidence continues to show that many patients can be treated safely and more effectively at home than in a hospital for many conditions, even those requiring diagnostic tests traditionally found only in in-patient settings. He states:

"The HaH care team is available 24/7 for urgent issues. If needed, blood tests, X-rays, echocardiography, ultrasound, EKGs, and skilled therapies are provided at home. If the patient requires a diagnostic test that cannot be done in the home (a rare occurrence), she is transported to the hospital for the test and returned home."

Moreover, Dr. Leff reports, "A 2012 meta-analysis of randomized controlled trials of HaH showed a 38% lower 6-month mortality rate for HaH patients than hospitalized patients." Hospital-at-Home models are already in use for Medicare Advantage patients by Presbyterian Health Services in Albuquerque, NM; the Department of Veterans Affairs, which offers HaH at 11 sites; and in Cedars- Sinai Medical Center in Los Angeles. The promising results of the Hospital-at-Home program further emphasize that 21st Century care will require access to 21st Century information and communications technology all the way into individual homes.

As healthcare delivery adapts to 21st century needs, the rapid exchange of information will play a critical role for providers as well as patients. Healthcare providers increasingly rely on the electronic transfer of health information to coordinate patient care, on advanced imaging techniques that allow for less-invasive diagnostics, and on point-of-care testing that is driving traditional lab-based services into primary care offices. All of these technologies require robust, highly available connectivity. In order to most efficiently steward funds supporting these changes, we encourage the Commission to work closely with other federal and state agencies to harmonize programs, processes, and definitions whenever possible. We encourage the Commission to work on a definition of "rural" for the purposes of this program, but also to work on a consistent definition of what is rural with other agencies involved in healthcare provision including the Centers for Medicare and Medicaid Services, the Department of Veterans Affairs, the Indian Health Service, and the United States Department of Agriculture. Additionally, we strongly encourage the Commission to harmonize application processes within the Universal Services Administrative Corporation (USAC) for both the E-Rate and RHC programs save valuable resources.

In response to specific questions proposed in the NPRM, we believe the following are vital and must be incorporated into a modernized RHC Program.

Section II A 1: Revisiting the RHC Program Funding Cap

² Leff, Bruce "Why I Believe in Hospital at Home", February 5, 2017, accessed at: <https://catalyst.nejm.org/why-i-believe-in-hospital-at-home/>

We appreciate that the Commission is considering updating and ensuring the RHC Program funding meets the need for telecommunications enabled healthcare services. We support raising the caps as proposed by allowing prior allocated and unused funds to be available and used by the RHC Program, and by raising the cap to reflect inflation and today's need for broadband connectivity to enable vast portions of care delivery.

HIMSS and PCHAlliance recommend that funds be increased at a rate that accounts for inflation and the rising costs of care since its inception in 1997, and as noted above this was a key component of our [2017 Congressional Asks](#). The \$400 million cap simply does not extend as far as it did when the fund was first established. Funds should be increased at rates that reflect the integral role of broadband connectivity to an increasing number of healthcare delivery functions. For example, when the Fund was first established, broadband connectivity was used primarily for electronic administrative functions, radiology, and limited amounts of telehealth. Today, broadband connectivity is an evidence-based component of chronic care management and routine care delivery.

Section II A 2: Prioritizing Funding of Demand Reaches the Cap

While we understand the Commission's goal to establish clear priorities if funding requests exceed the funding allocation, we are concerned with proposals that prioritize provider location and do not consider patient access and how telehealth transforms rural patients' access to care. In fact, evidence-based telehealth is pioneering the delivery of care to rural patients when clinicians are physically unavailable in a reasonable vicinity. The University of Mississippi's project to transform diabetes care in the Mississippi Delta, cited by the Commission, is a prime example of this type of care model. We urge the Commission to develop a priority system that focuses on rural patient access to providers rather than on the location of providers. In health care, innovation in information and communications technology is transforming access and care for patients living in rural areas, and when broadband is ubiquitous, a more efficient, patient centered health care system will develop.

Section II B 2 b: Promoting Efficient Operation of the RHC Program to Prevent Waste, Fraud, and Abuse; Reforming the Rules for Calculating Support in the Telecom Program; Defining Similar Services

Question #69

Effective communication between patients and providers is the cornerstone of high-quality healthcare. HIMSS and PCHAlliance suggest that the RHC Program must cover connectivity from providers to patients to support remote monitoring and Hospital at Home programs. We think this is statutorily permissible because these programs use a "telecommunications service" that meets the definition noted in 47 USC § 153(53) and because these programs involve the interpretation of readings by a qualified clinician affiliated with a healthcare provider as defined in 47 USC § 254(h)(7)(B). HIMSS and PCHAlliance note that the inclusion of a qualified clinician differentiates these programs from general wellness programs utilizing consumer technology. We further think the Commission is empowered by 47 USC § 254(c)(3) ("In addition to the services included in the definition of universal service under paragraph (1), the Commission may designate

additional services for such support mechanisms for schools, libraries, and health care providers for the purposes of subsection (h),”) to include these advanced services in the RHC Program.

HIMSS and PCHAlliance encourage the Commission to consider provider-supplied remote monitoring or telehealth equipment placed in a patient’s home an extension of a healthcare provider’s network for the purposes of RHC Program funding. To control waste, fraud, and abuse, we encourage the Commission to adopt sensible rules to ensure that covered devices belong to the healthcare provider; that they are lent to patients for short durations (covering an episode of care, or perhaps 30 - 120 days). We encourage rules that ensure such equipment is returned to the provider and that it is “locked” to serve the sole purpose of monitoring chronic conditions, providing patient education for self-management of that chronic condition, and for modification of care plan/medication regimens. We refer to the description of RPM and the case examples that were outlined in the National Quality Forum paper on measuring telehealth quality titled [Creating a Framework to Support Measure Development for Telehealth](#).

Given the rapid pace of health technology innovation, HIMSS and PCHAlliance strongly encourage the Commission to adopt a schedule allowing for frequent re-evaluation of any restrictions on healthcare technology in the final rule. We recommend this frequent and periodic review is imperative for the Commission to meet the Universal Service Principle of 47 USC § 254(b)(6), that “... healthcare providers ... should have access to advanced telecommunications services...” and 47 USC § 254(h)(2)(A) “The Commission shall establish competitively neutral rules ... (A) to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for all public and nonprofit elementary and secondary school classrooms, health care providers, and libraries.”

HIMSS and PCHAlliance are committed to being valuable resources to the Commission to help enable the adoption and accessibility of best possible healthcare to those Americans living in rural communities. We welcome the opportunity to meet with you and your team to discuss our comments in more depth. Please do not hesitate to contact [Eli Fleet](#), HIMSS Director of Federal Affairs, at 703.562.8834, with questions or for more information.

Thank you for your consideration.

Sincerely,



Denise W. Hines, DHA, PMP, FHIMSS
CEO
eHealth Services Group
Chair, North America Board of
Directors



Horst Merkle
Director Information Management
Systems Diabetes Care
Roche Diagnostics Corp. Inc.
Chair, PCHAlliance



Harold F. Wolf III
President & CEO
HIMSS