



February 2, 2018



Marlene H. Dortch, Secretary
Office of the Secretary
Federal Communications Commission
445 12th Street SW
Washington, DC 20554

RE: *Promoting Telehealth in Rural America (WC Docket No. 17-310; FCC 17-164)*

Dear Secretary Dortch:

CHRISTUS Health (“CHRISTUS”) appreciates the opportunity to submit the following comments in response to the Federal Communications Commission (FCC) *Promoting Telehealth in Rural America* Proposed Rule as published in the Federal Register on January 3, 2018. CHRISTUS is an integrated, not-for-profit international health system that includes nearly 350 services and facilities, including more than 50 hospitals in seven U.S. states.

CHRISTUS commends and supports the FCC’s efforts to improve the Rural Healthcare Program’s (RHC) “capacity to distribute telecommunications and broadband support to health care providers – especially small rural, healthcare providers – in the most equitable, effective, efficient, clear and predictable manner as possible.” As information and communication technology (ICT) capabilities grow at an exponential pace, it is fitting that the RHC’s rules should be updated to reflect current provider capabilities and needs of patients, consumers and service providers.

CHRISTUS’ comments are in great part informed by its participation in the FCC Rural Health Care Pilot Program. CHRISTUS was the consortium lead for the Texas Pilot Program which allowed it to work closely with the Universal Service Administrative Company (USAC) as well as with health care facilities and service providers. While home to four of the largest cities in the country, Texas is also one of the most rural states in the country. CHRISTUS will address specific questions raised in the Proposed Rule as well as broader issues, apprised by its experience as a participant in the RHC programs and as a multistate health care provider organization with urban and rural facilities.

Societal Trends that Impact Care Delivery in Rural America

CHRISTUS believes there are two societal trends that must be considered in defining the goals of the RHC. These include the continuing move towards a mobile society and the ubiquitous nature of ICT with its implications for place based activities, including where care is delivered. Because the ICT costs more where population densities are low, the RHC program should consider the following:

1. The FCC acknowledged that telecommunications continues its transition to being internet based and that telecommunication networks and the internet have converged in its 2011 order to “support the deployment, adoption and utilization of both fixed and mobile broadband” and away from supporting voice telephone services. CHRISTUS applauds the FCC for its vision to support both fixed and mobile broadband through its Universal

Service programs.

2. Health Professional Shortage Areas (HPSA) will continue to be an issue in many parts of the country and may not be limited to rural regions.
3. All businesses, governmental agencies and individuals need broadband, not just health care facilities. These needs should be aggregated to enable more cost effective, competitive broadband acquisition and to make it commercially feasible for service providers to invest in core ICT infrastructure in these areas.
4. The ability to create virtual care teams and share health information is becoming commonplace and will only continue to grow, in great part by HHS' move to a value based health care system.
5. The location of where care is delivered will continue to relocate away from brick and mortar health care facilities.

In addition, the RHC program was designed before the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009. ONC reports that as of 2015, "nearly all (96 percent) reported hospitals possessed certified Electronic Health Record (EHR) technology." This growth in the use of EHRs is almost universal and is one of the factors contributing to the increased demand for broadband services by health care facilities and providers.

Due to these realities, CHRISTUS strongly recommends that the FCC consider going beyond its proposed harmonization of the two programs and collapse them into one. The need for two separate programs is no longer necessary when the same forms, timelines and policies can be used for both. The major difference is the method of calculating financial support which can remain as is.

CHRISTUS also strongly recommends that the FCC accelerate its support to rural communities that aggregate demand across industries and maintains a need of enabling the highest speed at the lowest cost. Aggregating government, public and private needs into one RFP for infrastructure results in more economically feasible investments in broadband infrastructure than a RFP limited to health care facilities only. Precedence exists for this approach. CHRISTUS requests that the FCC prioritize rural infrastructure investments that aggregate overall demand for broadband throughout the community. There are sufficient methods to assure that the RHC program subsidizes only the infrastructure for eligible health care purposes while meeting its mission of Universal Service.

CHRISTUS concurs with the Commission's assessment that current demographic trends will only accelerate, rapidly increasing the need for connected care and other Internet-enabled technologies to ensure access to care for rural populations. Population trends indicate that many rural areas will become more rural over time. While some rural areas are seeing a "rural renaissance," many continue to see population loss, compounding their ability to attract healthcare providers.

In response to specific questions posed by the FCC, we believe the following is vital and must be incorporated into a modernized Rural Health Fund:

1) **A. Addressing RHC Program Funding Levels, 1. Revisiting the Funding Cap**

CHRISTUS appreciates that the FCC is considering updating and ensuring that RHC funding is sufficient to meet the needs of both programs. We support raising the caps as proposed by allowing prior allocated and unused funds to be available and used by the

RHC program and raising the cap to reflect inflation and today's need for broadband connectivity to enable vast portions of care delivery. Reasons for this include:

- Broadband connectivity has become an integral part of health care delivery and is foundational to a large and growing number of health care delivery functions as well as being integral to its administrative functions. Broadband connectivity today is an evidence based component of chronic care management, routine care delivery and the remote use of medical devices for monitoring patient conditions.
- The cost of health care continues to increase. The \$400 million cap simply does not extend as far as it did when the fund was first established.
- Inflation is an economic reality and must be accounted for.

2) **A. Addressing RHC Program Funding Levels, 2. Prioritizing Funding if Demand Reaches the Cap**

While we understand the FCC'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 patient's access to health care. Evidence based telehealth is pioneering the delivery of health care to rural patients when there are not 'providers' available in a reasonable vicinity. The University of Mississippi's project to transform diabetes care in the Delta, cited by the FCC, is a prime example of this type of care model. We urge the FCC 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 everywhere, and it is especially meaningful to persons living in rural areas. When broadband is ubiquitous, a more efficient, patient centered health care system will develop.

Questions 12, 13, & 14: CHRISTUS recommends that the Commission maintain the current prorated methodology for awarding funds. While prioritization based upon the various proposed methods may have merit, the FCC should fund as many requests as possible.

Questions 16 & 20: CHRISTUS recommends against adopting a scheme based on the "rurality" of a county for prioritization of funding requests. Of all the methods mentioned in the proposed rule, the VA example cited in question 20 appears to be the most reasonable approach. Unlike the transportation requirements of the VA cited, however, distance is not always the driving factor of cost in rural telecommunications. Geography and proximity to other infrastructure which may help offset the costs of communications infrastructure may play a big role in determining baseline costs. For example, in areas of the country where topography is suitable and encourages line of sight, fixed wireless broadband has the potential to cost-effectively provide connectivity over great distances, reducing the costs for many rural counties in relative flat areas such as West Texas. However, hilly terrain reduces the coverage area of fixed wireless, the cost-effectiveness of this technology is greatly diminished and costs may be higher regardless of a county's rurality. Any scheme attempting to provide different funding levels should take into account factors unique to telecommunications infrastructure, of which distance (measured by rurality) is only one.

3) **B. Promoting Efficient Operation of the RHC Program to Prevent Waste, Fraud, and Abuse, 2. Reforming the Rules for Calculating Support in the Telecom Program, b. Defining Similar Services**

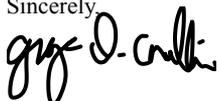
The FCC seeks input on whether the Commission could support patient home monitoring services. CHRISTUS applauds the FCC for asking this question, as CHRISTUS petitioned the FCC to be allowed to do this more than two years ago. Remote monitoring of patients has become essential to improving care outcomes as well as being necessary for furthering evidence based care and the triple aim.

The equipment and connectivity typically used for remote patient monitoring is owned by the provider entity and is loaned to the patient for a period of time after which it is returned to the provider entity. Connectivity is limited to provider patient communications associated with evidence based care delivery and is an integral standard of care. This provider entity supplied remote patient monitoring equipment includes connection/broadband costs associated with provider – patient communication. The remote home monitoring is conducted with provider provided equipment that is ‘locked’ to serve the sole purpose of monitoring chronic conditions, patient education for self-management of that chronic condition, and, modification of care plan/medications. Both the American Heart Association and the American College of Cardiology recognize the value and success of remote monitoring and recommend its use. Many of these programs are hospital based for inpatients recently discharged from the hospital and for clinics that support persons with chronic conditions.

All that would be required is a contracting method with service providers that is not predicated on a fixed location for a multi-year period.

CHRISTUS appreciates the opportunity to provide input regarding the Proposed Rule. CHRISTUS is committed to continually improving its systems and services, as increasing evidence shows that telemedicine, particularly in rural areas, can improve the quality of care and outcomes for patients. We look forward to continuing to work with the FCC as it aims to embrace emerging technologies in our health care system.

Sincerely,



1 George S. Conklin
Senior Vice President and CIO
CHRISTUS Health