Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

In the Matter of	)	
	)	WC Docket No. 18-213
Promoting Telehealth for	)	FCC 18-112
Low-Income Consumers	)	

Comments of
NTCA–THE RURAL BROADBAND ASSOCIATION

September 10, 2018

NTCA–The Rural Broadband Association
4121 Wilson Blvd., Suite 1000
Arlington, VA 22203
703-351-2000
www.ntca.org

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EXECUTIVE SUMMARY

Telehealth promises beneficial results for rural America. Residents of rural areas experience greater incidences of chronic and other conditions as compared to their urban counterparts. When combined with distance from or lack of access to physicians and health care facilities and prevailing socioeconomic challenges, obstacles to the acquisition of affordable health care arise. Broadband-enabled applications can shatter these barriers and result in improved healthcare at lower costs, benefiting rural users while lowering National healthcare costs. Consumer expectations and health reform are driving a new market shaped by trends in healthcare workforce shortages, chronic diseases and aging. Policies addressing connectivity, performance and payment warrant attention as emerging technology and evolving public perceptions affect market demands.

NTCA submits that the Commission's pilot program is best focused to areas that have suitable broadband deployment. This will enable the gathering an analysis of important data without delay. Moreover, while patient income should be considered, it should not be dispositive in assessing whether a facility or prospective user is eligible to participate. The instant pilots should seek a broad range of usable data from rural areas, from which indicators aimed at developing specific programs can be drawn.

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To the Commission:

I. INTRODUCTION

NTCA–The Rural Broadband Association (NTCA)[1] hereby submits these comments in response to the Notice of Inquiry[2] issued in the above-captioned proceeding. In the NOI, the Commission seeks comment on establishing a pilot program to promote broadband-enabled telehealth services and applications for low-income Americans.[3] The NOI requests comment on the proposed goals of the pilot program as well as its structure. NTCA's members have played a vital role in bringing telehealth services to their communities and have seen significant benefits those services offer. Consequently, NTCA supports the Commission's proposal to establish a

[1] NTCA is an industry association composed of nearly 850 rural local exchange carriers (RLECs). While these entities were traditional rate-of-return-regulated telecommunications companies and "rural telephone companies" as defined in the Communications Act of 1934, as amended, all NTCA's members today provide a mix of advanced telecommunications and broadband services, and many also provide video or wireless services to the rural communities they serve.

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

[3] *Id.* at para. 15.

pilot telehealth program and offers the following comments based on NTCA members' involvement in supporting telehealth services in their communities.

II. TELEHEALTH OFFERS UNIQUE BENEFITS TO RURAL AMERICA

A. GOALS OF THE PROGRAM

1. The Commission Can Best Study the Improvement of Health Outcomes by Focusing Pilots on Areas with Broadband Deployments

National use and acceptance of telehealth is increasing. The practice of telemedicine is no longer characterized as "if," but "when." By way of example, in the first half of 2015, the number of telehealth interactions exceeded the cumulative amount of all that had preceded that point.[4] Likewise, in 2016, the Veterans' Administration (VA) provided more than 2.17 million telehealth interactions to more than 702,000 patients, or approximately 12 percent of veterans enrolled in the VA health care system.[5] Broadband-enabled telemedicine can shatter existing barriers to health care, especially among rural and low-income individuals where lack of access to a nearby medical facility (which can also implicate lost wages for the time needed to travel to a doctor) often results in individuals foregoing or delaying necessary medical care. Data from various sources, including those studying specific medical issues or those focused on discrete populations, reveal consistently the promise of telehealth adoption.[6]

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[4] *See* Jill Degraff Thorpe, "Doctors Without Wires," Consumer Electronics Show, Las Vegas (panel presentation, Jan. 5, 2016).

[5] "Telehealth and Remote Patient Monitoring Use in Medicare and Selected Federal Programs: Report to Congressional Committees," U.S. Government Accountability Office, GAO-17-365 (Apr. 2017) https://www.gao.gov/assets/690/684115.pdf (last visited Aug. 31, 2018).

[6] *See, e.g.,* "Empowering Patients with Telehealth," Deloitte (Jan. 2016) at p. 1 ("Telehealth … is a powerful tool that can support healthier patients.") https://www2.deloitte.com/content/dam/Deloitte/us/Documents/public-sector/us-fed-empowering-patients-with-telehealth.pdf (last visited Aug. 31, 2018). *See also*, Rodate R. Martiniano *et al*, "Case Studies of Telehealth Programs in New York," Center for Health

Telehealth is only possible, however, if sufficient, reliable, and robust high-speed broadband connections are available to individuals and health care providers. Telehealth services commonly include remote monitoring that may require wired and/or wireless services, as well as wired connections that boast the security and capacity to underpin full-video capabilities for diagnoses and treatment interactions. Broadband networks must be able to support high-resolution results for items such as video, X-rays, CT scans, and MRIs taken at a distant location and transmitted to experts that are frequently located tens of miles away if not further. Furthermore, patient care is not limited to diagnostics, but may also include visual monitoring of the patient. An accurate diagnosis can include assessing the patient's complexion, posture or gait. Elder care can also benefit: by way of example, NTCA member Skyline Membership Corporation in West Jefferson, North Carolina, installed technology in an assisted living center that supports video and other monitoring equipment to ensure patient safety and security.[7] The system relies upon 1080p commercial cameras with IR LEDs and night vision capability and contains built-in standards to mitigate the risk of compromising intrusions. The capacity demanded by this system requires a fiber connection between the center and Skyline.

The Commission asks whether and how areas with existing deployment should be prioritized in the pilot program.[8] NTCA submits that due to (a) the time needed to build out broadband networks and (b) the desire to obtain results from the pilot program relatively quickly

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Workforce Studies, School of Public Health, SUNY Albany (Jan. 2018) http://www.chwsny.org/wp-content/uploads/2018/01/NY_Telehealth_Case_Studies_2017.pdf (last visited Aug. 31, 2018).

[7] This installation was supported in part through matching funds provided by the NTCA Smart Rural Community initiative. *See* https://www.ntca.org/member-services/programs/smart-rural-community.

[8] NOI at para. 33.

in order to expand telehealth to more areas, the pilot program should focus on locations that have already deployed high-speed broadband networks. To be sure, and as the Commission notes, many rural areas lack adequate access.[9] But, the efficacy of telemedicine can be tested *only* where telemedicine can be supported, much the way the quality of a car's tires can be tested only in vehicles that have an engine. By establishing existing high-speed broadband capabilities as a prerequisite for program applicants, the Commission will be able to direct the program's funds most effectively, while simultaneously allowing applicants, consumers and the Commission to assess the direct costs and benefits of offering telehealth services. In turn, other programs, such as the Commission's Connect America Fund initiatives, can more rightly focus upon closing the digital divide by enabling and sustaining broadband-capable infrastructure in rural areas. Such a "division of labor" will further help ensure that the two initiatives work in thoughtful concert as discussed further below, with each program serving an important and distinct need in lieu of "competing" with one another to enable the deployment of networks in high-cost rural areas that are unable to support even a single network without support of some kind.

2. Rural America Faces Particularly Challenging Health Issues that Can be Addressed Through Telemedicine

The imperative to deploy telehealth is accentuated in rural areas, where residents have lower income and face longer distances to medical facilities. Many rural residents also suffer from higher amounts of chronic illnesses and substance abuse than urban peers[10] as well as

[9] NOI at para. 33.

[10] *See Substance Abuse in Rural Areas,* Rural Health Information Hub, https://www.ruralhealthinfo.org/topics/substance-abuse (last visited Aug. 31, 2018). *See also, Rural Populations and Health: Determinants, Disparities and Solutions: Book Review,* Preventing Chronic Disease, Centers for Disease Control and Prevention, Vol. 10 (Jun. 27, 2013), https://www.cdc.gov/pcd/issues/2013/13_0097.htm (last visited Aug. 31, 2018) (CDC).

increased incidences of diabetes and coronary heart disease.[11] Higher rates of high-risk behaviors including smoking, physical inactivity, poor diet and limited use of seatbelts are also present in rural areas.[12] Rural health challenges are further compounded by physician shortages and a lack of access to nearby health care facilities. According to the National Rural Health Association, for instance, there are 53.3 physicians per 100,000 residents in urban areas versus 39.8 physicians per 100,00 residents in rural areas.[13] Furthermore, these 100,000 residents, and physicians, are far more spread out in rural areas than in urban areas.

Rural poverty increases the risk of complications from chronic conditions while decreasing the likelihood of health insurance that can enable consistent treatment and preventative care.[14] When combined with distance from, or lack of access to, physicians and health care facilities, obstacles to obtaining affordable health care are significant. Residents of rural areas can benefit greatly from telehealth services by gaining immediate access to physicians and specialists in all areas, while not having to miss work – and therefore wages – to visit a medical professional. This is especially significant for individuals with chronic conditions who require many repeat visits as well as for individuals who, not uncommonly, must travel over an hour to visit a specialist or find a medical professional covered by their insurance.

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[11] "About Rural Health Care," National Rural Health Ass'n, https://www.ruralhealthweb.org/about-nrha/about-rural-health-care (last visited Sep. 10, 2018) (NRHA).

[12] CDC, *supra* n. 10.

[13] NRHA, *supra* n.11.

[14] *See, e.g.*, Robin Warshaw, "Health Disparities Affect Millions in Rural U.S. Communities," AAMCNews (Oct. 31, 2017), https://news.aamc.org/patient-care/article/health-disparities-affect-millions-rural-us-commun/ (last visited Aug. 31, 2018).

3. NTCA Member Efforts Demonstrate Effective Partnerships that Rely Upon Robust Rural Broadband Deployment.

As the Commission noted in the NOI, despite numerous Federal agencies' programs to support telehealth, "lack of connectivity remains a significant barrier to telehealth adoption."[15] Rural areas, which have the greatest concentration of chronic conditions and veterans, along with the greatest distance to medical facilities, are not only the most likely areas to benefit from telemedicine, but also offer the best "control" and "test" groups by which the impact of telemedicine can be studied. On the one hand, many rural areas have robust broadband capabilities: the most-recently published survey of NTCA member data reports that nearly 67% of NTCA members' subscribers can access speeds greater than 25 Mbps[16] and 75.9% of hospitals and clinics in NTCA members' service areas are served by FTTP.[17] In fact, more than 150 NTCA members have been certified as "Gig capable" providers.[18] On the other hand, many rural areas lack access to broadband. USF ensures that providers in rural areas can economically deploy, and residents can afford, broadband services. Focusing telehealth pilots on areas served by USF-supported broadband will leverage the powerful impacts of that successful program.

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[15] NOI at para. 24.

[16] 2016 Broadband/Internet Availability Survey Report, NTCA–The Rural Broadband Association (Jul. 2017), at 7 (https://www.ntca.org/sites/default/files/documents/2018-01/2016ntcabroadbandsurveyreport.pdf) (last viewed Sep. 7, 2018, 11:36).

[17] Rural Anchor Institution Survey Report, NTCA–The Rural Broadband Association (Aug. 2018), at 7 (https://www.ntca.org/sites/default/files/documents/2018-08/NTCA%20Rural%20Anchor%20Institution%20Survey%20Report_Final.pdf) (last viewed Sep. 7, 2018, 11:38).

[18] *See* Gig Capable provider list, https://www.ntca.org/member-services/awards-recognition/certified-gig-capable-provider/gig-capable-providers-list (last viewed Sep. 7, 2018, 11:39).

Coordination with other Federal and state agencies can also help expand the availability and awareness of telehealth services (and thus the benefit of having broadband service) while also targeting the services to specific needs. For example, NTCA is working closely with the VA to develop a telehealth program for veterans located in rural communities. The VA has a comprehensive telehealth solution, but the benefits of those offerings can be unlocked only through broadband access. The Virtual Living Room^{SM} (or "VALOR") model leverages the expertise and community commitment of NTCA's nearly 850 locally-operated rural broadband providers by creating "Virtual Living Rooms" at which rural veterans can access VA telehealth services at no cost and with peer and technical support. The Virtual Living Room initiative is intended to enable a greater population of veterans to enjoy these health care improvements and savings by increasing access to, familiarity with, and use of VA telehealth services.

The accessibility of free technology allows users to not only obtain the immediate benefits of VA telehealth services, but also to consider the value proposition of a home subscription, which brings those telehealth services closer and can also enable 24-hour access. However, regardless of whether a user undertakes a home subscription, the Virtual Living Room site remains accessible to the veteran and enables mitigation of the third potential barrier to usage, namely, unfamiliarity with the technology or hesitance to engage telehealth. This is overcome not only by siting VALORs in community spaces that are familiar to the user, but also by furnishing the site as a comfortable, inviting space. The pilot site in McKee, Kentucky, is a model of cooperation among the VA, the local rural broadband provider, a county public library, and NTCA, and its initial health care offerings are being expanded.

B. STRUCTURE OF THE PROGRAM

1. Elements of the Application

The Commission seeks comment on the structure of the program, including, *inter alia,* the budget; application process; eligible health and telecommunications providers; and eligible low-income subscribers. NTCA submits that the pilot program is best focused in areas that have suitable, existing broadband capabilities. This will enable the Commission to measure the results of telehealth that is offered with the most capable technological foundation to support the pilot. The results of this "test group" can be evaluated against the results of "control groups," areas that either have or do not have broadband - but which do not have telehealth deployments. It would be virtually impossible to obtain usable telehealth results from a region that lacks broadband and, hence, is unable to support telehealth. Furthermore, unless this program is structured to ensure that no existing networks will be overbuilt, using this initiative to fund network construction risks undermining existing connectivity and/or other Commission efforts such as the Connect America Fund. Therefore, only areas that have already deployed broadband should be considered as pilot regions.

The Commission proposes that a prospective health care provider participant in the pilot program would be required to submit the following information as part of the application process:

(1) a description of the pilot program, including its ability to deliver health care beyond the walls of a clinic or other facility;

(2) a description of the low-income population that would benefit from the pilot;

(3) a description of how the health care provider will evaluate the results;

(4) the broadband service provider with which the applicant will work;

(5) the services the broadband firm would provide.[19]

NTCA submits that these are sound starting points for an application. However, the health care provider applicant should also provide information describing its expertise in the field of medicine that it seeks to test, as well as other physicians with which it plans to operate. The health care provider should also demonstrate the number of patients it reasonably expects to serve through the pilot. NTCA offers this recommendation with the perspective that, by way of example, a nephrology practice will be better suited and attuned to oversee a pilot focusing on kidney disease than a general practitioner, and that the efficacy of such a program is strengthened when implemented in an area that is affected heavily by kidney illness or disorder. However, NTCA also submits that the lack of specialists in rural areas (as described above) argues for telehealth pilots that enable general practitioners to work closely with specialists "over distance." Although the Commission expresses interest in care that is "delivered directly to patients beyond the walls of physical health care centers," the fullest benefits of telehealth will be realized when local patients *and* physicians can avail themselves of distantly-located expertise and specialists.

Critically, as well, the application must demonstrate that the local broadband provider is fully capable of supporting telemedicine without the need to deploy new broadband infrastructure. This will ensure that scarce pilot resources are used to support health care, rather than infrastructure build-out. Moreover, it will assure the most effective way to measure the impact of investments in health care as no investment will be "split" into different purposes.

[19] NOI at para. 31.

2. Demographic and Health Care Issues

The Commission asks whether the health care pilots should focus on a particular demographic or health care issue.[20] NTCA submits that both goals can be served through the structure the Commission has identified. Regarding demographics, the focus of the instant NOI to address low-income individuals itself captures a broad demographic that faces formidable challenges in obtaining proper health care. No further demographical division - whether by race, sex, or other indicator - should be imposed. Low-income people throughout the Nation face health care challenges, and the development of telehealth pilots is a necessary and advisable step toward solving those problems. However, and as discussed more fully below, low-income should not be a dispositive factor for authorizing or participating in a pilot.

A factor that is exceedingly important to consider in the development of these pilots is the geographic proximity of prospective patients to health care providers and/or specialists. To be sure, home medical monitoring equipment that is used to assist with chronic conditions is beneficial in both rural and urban settings. However, when looking at a community's population as a whole, those devices are generally *more* useful in rural settings where distance is a common barrier for all would-be participants. In an urban area, a patient is more likely to be geographically closer to a physician than in a rural area, and more likely to have access to viable private or public transportation options to visit the physician's office; in an urban area, residents may also have more access to home health care organizations that can provide check-in and nursing services than in rural areas. Accordingly, and without discounting the health care needs of patients throughout the Nation, NTCA submits that the unique health care challenges in rural

[20] NOI at para. 32.

America argue for priority siting of pilots there. Stated simply, if the challenges of *rural* health care can be met through telehealth, then *urban* health care challenges assuredly can be met through telehealth as well.

Regarding particular health issues, NTCA submits that the Commission's approach of allocating approximately $5M to 20 pilots offers the Commission a logical opportunity to conduct a broad survey of telehealth applications. Unfortunately, there is no shortage of health care concerns or issues faced by Americans. Chronic and acute conditions, including diabetes, COPD, substance abuse, cancer, mental health therapy, aging, neonatal care, and physical challenges, to name just a few, are prevalent throughout the Nation and contribute to significant national health care costs.[21] NTCA suggests that rather than "boil the ocean," the Commission leave itself open to considering pilot applications as they are submitted to adjudge which offer the best opportunity to evaluate the impact of telehealth *without predisposition or weighting* toward a particular health care issue. However, NTCA suggests that the Commission may be guided by a goal of identifying the health condition(s) intended to be addressed by pilot applications. As a general matter, however, NTCA suggests that the universe of health care pilots include, at the least, the following five health care concerns: (1) diabetes; (2) substance abuse, including the opioid epidemic; (3) mental health; (4) aging, including the impacts of isolation, depression and physical decline; (5) cardiovascular disease and COPD.

[21] *See* Rick Schadelbauer, "Conquering the Challenges of Broadband Adoption," Smart Rural Community, NTCA (2014), https://www.ntca.org/sites/default/files/documents/2017-12/SRC_whitepaper_CCBA.pdf (last visited Aug. 31, 2018), citing Organization for Economic Cooperation and Development, http://stats.oecd.org/Index.aspx?DataSetCode=SHA ("In 2015, the United States spent $9,450 per capita on health care, representing 16.9% of GDP.").

3. Eligible Health Care Providers

The Commission asks whether the pilot program should be limited to "health care providers that predominantly serve low-income patients, such as clinics or hospitals serving patients eligible for Medicaid or veterans receiving cost-free medical care based on income."[22] NTCA submits that while this approach may well capture the target population, it would ignore the opportunity to assist many low-income participants who are served by facilities that also serve higher-income clients. Stated differently, limiting distributions to facilities that serve a majority-Medicaid clientele would effectively foreclose these benefits to low-income patients who, through no "fault" of their own, use facilities that serve a majority *non-Medicaid* population.

The Commission also seeks comment on whether location should be a factor in selecting participating clinics or hospitals. The Commission asks whether it should prioritize participating hospitals or clinics in rural areas.[23] NTCA encourages the Commission to accord rural areas priority. As noted above, rural areas are particularly suited to telehealth because of inherent physician and specialist shortages and distance from health care facilities. These are precisely the conditions telehealth can solve. Although telehealth offers promise in urban areas, it offers *more* promise in rural areas because rural residents have less access to health care resources than urban residents. NTCA also supports Commission efforts to ensure participation by hospitals or clinics serving Tribal lands.[24] The Indian Health Services reports that life expectancy on Tribal lands is

[22] NOI at para. 34.

[23] NOI at para. 35.

[24] *Id.*

more than five years less than non-Tribal U.S. regions.[25] Moreover, the incidence of chronic illnesses and other medical conditions in Tribal regions are at rates that echo, and in some instances, exceed that which is recorded in rural areas, generally. In 2009, American Indians and Alaska Natives were found to have the highest prevalence of diabetes among all racial and ethnic groups in the United States (16 percent diagnosed as compared to 8.7 percent of non-Hispanic Caucasians).[26] Accordingly, the Commission should ensure that hospitals and clinics serving Tribal lands can participate in the pilot program.

4. Partnering with Facilities-Based Eligible Telecommunications Carriers

The Commission seeks comment on requiring broadband service providers participating in the pilot program to be facilities-based eligible telecommunications carriers (ETCs).[27] The Commission notes that limiting participating to facilities-based ETCs would be consistent with the goal of increasing broadband deployment in unserved or underserved areas. NTCA supports these conclusions. In the first instance, and as noted above, the unique challenges of rural health care establish the likelihood that telehealth solutions that are successful in rural areas indicate similar expectations of success in urban areas which start with greater health care resources. Accordingly, those areas that are served by facilities-based ETCs should be given priority in pilot locations. Furthermore, the *lack* of health care resources in rural areas - due either to

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[25] *See* Indian Health Service Fact Sheets: Disparities, https://www.ihs.gov/newsroom/factsheets/disparities/ (last viewed Sep. 4, 2018, 15:45).

[26] McLaughlin, Sue, "Traditions and Diabetes Prevention: A Healthy Path for Native Americans," 23 Diabetes Spectrum 4 (Oct. 2010) (available at http://spectrum.diabetesjournals.org/content/23/4/272) (last viewed Sep. 7, 2018, 11:08).

[27] NOI at para. 37.

physician or specialist shortages or rural hospital closings - predisposes the *greater need* for a telehealth solution in those rural areas. Additionally, limiting participation to facilities-based ETCs offers assurance that the broadband basis of any application will be technologically capable of supporting telemedicine and that the applicant will have the necessary roots in the community to assure corporate longevity, rather than a provider who may appear as a fleeting shadow to advantage itself of pilot opportunities before fading. Finally, limiting participation to facilities-based ETCs is a sound, logical and prudent way to leverage high-cost support that is extended to those carriers, and to amplify the "return on investment" on those networks by facilitating their greater use for larger goals.

This approach is also consistent with the goal of increasing broadband deployment and adoption. A critical aspect of a consumer's decision to purchase broadband is the perceived value of broadband to the subscriber.[28] Toward this end, users who perceive or, better yet, actually realize value from broadband should be more likely to adopt it or to increase usage. Telehealth applications that improve or ease users' health care would likely be perceived as valuable and therefore encourage adoption or greater usage among users. A beneficial by-product of the health care pilot could be the user's exploration of broadband for other functions, including education, employment, or other valuable uses.

[28] *See, i.e.,* Schadelbauer, Rick, "Conquering the Challenges of Broadband Adoption," Smart Rural Community, NTCA (2014) (available at https://www.ntca.org/sites/default/files/documents/2017-12/SRC_whitepaper_CCBA.pdf) (last viewed Aug. 27, 2018, 13:50).

5. Eligible Low-Income Subscribers

The Commission seeks comment on requiring participating health care providers to use the pilot program exclusively for low-income patients.[29] NTCA submits that although this is a noble goal, it is fraught with potential hazards and disincentives that could undermine the ultimate success of the program. In the first instance, requiring health care providers to limit participation to low-income participants would place health care providers in an unusual (if not unwanted) position of collecting income and other financial data from patients. Even if patients were willing to share this information with their health care provider on a voluntary basis, such a requirement could handicap the effectiveness of the pilot by potentially disqualifying otherwise eligible candidates simply because they do not want to compromise their privacy by revealing their income or wealth levels to their physician. This problem would be exacerbated, of course, if the participating health care provider did not have a prior-existing relationship with the patient. In those instances, a "complete stranger" would be asking a patient to reveal information that many hold to be among the most private. Health care providers seeking this information might then bear the risk of liability if their participation in the program relies upon the authenticity of income information provided by a patient. Some form of immunity would need to be created to protect health care providers who might be misled by intentionally or unintentionally misleading information by the prospective patient. Most importantly, however, limiting the pilot to low-income users would rob the Commission of vital data that is critical to developing a fuller understanding of the benefits of broadband-enabled healthcare.

Sickness and illness know no financial-demographic bounds. It is true that access to treatment is likely easier for those with greater financial resources, and that personal income can

[29] NOI at para. 39.

play heavily into a patient's investment in preventative and on-going care. However, the overarching goal of the pilot program should be to study the effectiveness of telehealth in overcoming a lack of readily available access to physicians, facilities and specialists. The results of those pilots can then be used to support targeted programs for specific demographics or medical conditions. To be sure, certain populations in regions that suffer from persistent poverty may realize greater benefit, and the Commission may factor the per-capita income of a community when evaluating applications. However, the overall evaluation of the benefits of telehealth will be culled by studying its impact across a range of populations, from which the more tightly focused impacts on low-income populations can be extrapolated. This, however, is wholly different from identifying and then potentially disqualifying *individual patients* from participating in trials. Moreover, limiting the population of participants will disable the health care provider's ability to gather a larger universe of data that can assist with a finer understanding of the pilot impacts. For these reasons, NTCA advises the Commission to not place any limitations on patient participation based on individual wealth or income.

6. Supported Services

The Commission seeks comment on what services and equipment might be supported by the pilot program. NTCA submits that a successful telehealth pilot must provide a basis by which the Commission, health care providers and researchers can study the impact of telemedicine at its most capable deployment. Accordingly, the Commission should adopt minimum service standards for the telehealth pilot. These should include facilities-based capabilities that enable medically- and therapeutically-useful synchronous communications between patients and health care providers, and between local health care providers and larger, regional facilities. Ideally, patients should be able to undertake communications such as video conferencing at home and

applications that demonstrate this ability should be noted as such. However, NTCA recognizes that a lack of both sufficiency and predictability in high-cost support have depressed investment by rural providers[30] and that in some instances deployments similar to the NTCA Virtual Living Room[SM] pilot may be useful as an *initial step* toward more robust telehealth deployments in the home. To the extent the program limits broadband providers to facilities-based ETCs, there is no reason to impose additional performance obligations on those carriers, as they are currently subject to various measures that are consistent with, and encourage adherence to, those goals.[31]

The Commission also seeks comment on whether the program should fund connectivity for emergency medical service facilities, such as ambulances.[32] NTCA supports consideration of this proposal, subject to the input of emergency medical professionals in this proceeding. Emergency medical technicians in NTCA member service areas have made NTCA aware of the very long distances that patients must be transported following traumatic or other events. Furthermore, these critical time delays may be expanded because it can take nearly the same amount of time for first responders to reach the patient initially. Expansive communications capabilities with attending physicians upon reaching the patient, and while transporting the patient to the nearest medical facility, particularly in the case of strokes or traumatic injury, can improve survival and other patient outcomes significantly. Similar considerations relate to the

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[30] *See* NTCA 2017 USF Budget Control Impact Survey Results, available at https://www.ntca.org/sites/default/files/documents/2018-01/062017_resultsusfbudgetcontrolimpactsurvey.pdf (last viewed Sep. 7, 2018, 11:42).

[31] *See Connect America Fund: Order,* Docket No. 10-90, DA 18-710 (2018). *See, generally, Connect America Fund - Performance Measures for Connect America High-Cost Universal Service Support Recipients: Comments of NTCA–The Rural Broadband Association,* Docket No. 10-90 (filed Dec. 6, 2017).

[32] NOI at para. 45.

Commission's question regarding whether the program should support end-user devices.[33] The success of a pilot program will rely upon the most extensive use of it, which may necessitate distributing customer premises equipment to prospective users (especially low-income users who would otherwise be unable to self-purchase equipment). Providing support for end-user devices will also enable uniformity among participants, thereby creating more consistent and comparable results among program participants.

7. Protecting Patient Information

The Commission seeks comment on protecting patient information.[34] NTCA submits that sufficient safeguards currently exist to ensure the protection of patient information, and that in no manner, shape or form should the creation of a telehealth pilot alter, amend or add to those obligations. Medical information is covered by the Health Insurance Portability and Accountability Act (HIPAA),[35] while other information that broadband providers might encounter is covered by their obligations under relevant Federal guidelines as are administered by the Federal Trade Commission (FTC). The Commission ordered explicitly last year that privacy matters be restored to the FTC, which the Commission described as "the agency with the most experience and expertise in privacy and data security" and "better reflects Congressional intent, and creates a level playing field when it comes to Internet privacy."[36] At most, therefore, the Commission could consider reminding participants of relevant privacy regulations.

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[33] NOI at para. 46.

[34] NOI at paras. 55, 56.

[35] Public Law No. 104-191, 110 Stat. 1936 (1996).

[36] *Restoring Internet Freedom*, Declaratory Ruling, Report and Order, and Order, FCC 17-166, 33 FCC Rcd 311, 420 at para. 183 (Jan. 4, 2018).

As noted above, however, to the extent that care providers are put in the position of collecting sensitive financial information from individual patients to determine eligibility for participation based upon income levels, this may give rise to the need for a separate set of protections related to maintenance of such data. Accordingly, NTCA recommends health care providers not be placed in the position of determining eligibility based upon collection and retention of such information.

III. CONCLUSION

Telehealth has a demonstrated ability to improve health outcomes regardless of income or location while also saving patients, and providers, money. However, telehealth cannot exist without robust, high-speed broadband networks. Therefore, NTCA is encouraged by the Commission's NOI and supports the Commission's goal of using universal service funding to develop a pilot telehealth program.

Respectfully submitted,

/s/ Tamber Ray
Joshua Seidemann
Tamber Ray
NTCA–The Rural Broadband Association
4121 Wilson Blvd., Suite 1000
Arlington, VA 22203
703/351-2000
www.ntca.org

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