Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, DC 20554

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

COMMENTS OF THE CONNECTED HEALTH INITIATIVE

I. Introduction and Statement of Interest

ACT | The App Association's Connected Health Initiative (CHI) respectfully submits its views in response to the Federal Communications Commission (Commission's or FCC's) Notice of Proposed Rulemaking (NPRM) in the above-captioned proceeding.[1] CHI supports the Commission's goals in its proposed Connected Care Pilot and urges for the Commission to maximize its potential.

CHI is the leading multistakeholder policy and legal advocacy effort driven by the consensus of stakeholders from across the connected health ecosystem. CHI aims to realize an environment in which Americans can see improvement in their health through policies that allow for the potential of connected health technologies to advance health outcomes and reduce costs. CHI members are developers and users of connected health technologies across a wide range of

[1] *In the Matter of Promoting Telehealth for Low-Income Consumers*, WC Docket No. 18-213, Notice of Proposed Rule Making (Connected Care Pilot NPRM) (2019). Available at https://www.federalregister.gov/documents/2019/07/30/2019-16077/promoting-telehealth-for-low-income-consumers.

use cases. We are active advocates before Congress, numerous U.S. federal agencies, and states legislatures and agencies, where we seek to advance responsible pro-digital health policies and laws in areas including reimbursement/payment, privacy/security, effectiveness/quality assurance, FDA regulation of digital health, health data interop, and the rising role of artificial intelligence/machine learning in care delivery. Notably, CHI has a history of strong advocacy for the Commission playing a larger role in bringing the benefits of a connected care continuum to underserved Americans.[2]

II. CHI Supports the Commission's Connected Care Pilot's Goals

CHI supports the Commission's efforts to advance broadband infrastructure and connectivity generally, and in the healthcare context specifically, particularly in rural parts of the United States overwhelmed with both chronic diseases (e.g., diabetes, heart disease, and COPD) and a lack of accessible healthcare facilities.[3] For example, in Mississippi, the American Diabetes Association approximated that 371,662 Mississippians (15.4 percent of the state's adult population) live with diabetes and about 810,000 Mississippians (37.5 percent of the state's adult population) have pre-diabetes blood glucose levels.[4] Despite alarming rates of diabetes, Mississippi has only 53 physicians per 100,000 people, painting a dire picture for the treatment of this otherwise manageable condition.[5]

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[2] *See* CHI Comments, GN Docket No. 16-46 (May 24, 2017); *see also* CHI Comments, WC Docket No. 17-310 (February 2, 2017).

[3] Rural Health Information Hub, Chronic Disease in Rural America (Dec. 4, 2017) *found here*: https://www.ruralhealthinfo.org/topics/chronic-disease.

[4] American Diabetes Association, The Burden of Diabetes in Mississippi (last visited Jan. 22, 2018) *found here*: http://main.diabetes.org/dorg/PDFs/Advocacy/burden-of-diabetes/mississippi.pdf.

[5] *See* Association of American Medical Colleges, "Mississippi Physician Workforce Profile" (2016), *available at* https://www.aamc.org/download/484556/data/mississippiprofile.pdf.

However, leveraging broadband-enabled health technologies tools proves to be a crucial way to address such challenges and to preserve health providers' resources. For example, in addressing the challenges described above in Mississippi, the University of Mississippi Medical Center (UMMC)—a CHI steering committee member—today leverages a wide range of connected health technologies to provide more than 35 telehealth specialty services to more than 200 non-affiliated sites in Mississippi to combat chronic diseases and to provide affordable healthcare in those rural areas;[6] remote patient monitoring (RPM) tools[7] that collect patient-generated health data (PGHD) for consistent transmission to caregivers, enabling eased identification of health trends, more proactive care planning decision-making, and improved engagement and investment by the patient themselves in their own care (among other benefits). The first 100 patients enrolled in UMMC's diabetes telehealth program saw an average 1.7 percent reduction in their A1C (a blood test for type 2 diabetes and pre-diabetes) levels and did not require an emergency room visit or check into a healthcare facility.[8] The program helped save those diabetes patients $339,184 collectively.[9] UMMC's Telehealth Center has been so successful that the Health Resources and Service Administration at the Department of Health and Human Services (HHS) recognized the program as a "National Center of Excellence."[10] We emphasize that UMMC is but one of numerous stories, in addition to a growing body of evidence

[6] *See* UMMC Health Care, Telehealth (last visited Jan. 22, 2018) *found here*: https://www.umc.edu/Healthcare/Telehealth/Files/telehealth_brochure.pdf*; see also*, University of Arizona, Arizona Telemedicine Program (last visited Jan. 22, 2018) *found here*: http://telemedicine.arizona.edu/servicedirectory/ummc-center-telehealth.

[7] UMMC Health Care, Remote Patient Monitoring (last visited Jan. 22, 2018) *found here*: https://www.umc.edu/Healthcare/Telehealth/Remote%20Patient%20Monitoring.html.

[8] Eric Wicklund, *UMMC Earns National Telehealth Center of Excellence Designation*, mHealthIntelligence (Oct. 6, 2017) https://mhealthintelligence.com/news/ummc-earns-national-telehealth-center-of-excellence-designation.

[9] *See id.*

[10] *See id.*

and data, demonstrating the power of connected health technologies in making drastically improved care accessible to America's most underserved populations. Nationally, more than 320 million people in the United States could require healthcare services at any time.[11] With nearly 280,000 primary care physicians on hand, growing healthcare disparities become even more stark.[12]

As of January 2018, only 65 percent of Americans had internet connectivity,[13] with the overall cost of broadband deployment to providers—either wireline or wireless— as a leading contributor to the lack of availability for consumers. Subsequent surveys demonstrated a 6 percent drop in broadband adoption in 2015.[14] Meanwhile, new and innovative internet of things (IoT) technologies and deployments, requiring increasingly robust mobile broadband connections, are almost ubiquitous in today's economy.[15] The critical nature of the healthcare sector, which stands to benefit immensely from the IoT effect, mandates improvements to America's critical infrastructure to support its continued advancement. This includes broadband infrastructure and measures to give healthcare providers the ability to use connected health technology products and services throughout the continuum of care, both inside and outside the doctor's office.

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[11] *In the Matter of FCC Seeks Comment on Accelerating Broadband Health Tech Availability,* Public Notice. GN Docket No. 16-46 at p. 4 (rel. Apr. 24, 2017) (PN).

[12] *See id.* p. 5-6.

[13] Pew Research Center, "Internet/Broadband Fact Sheet" (accessed Sept. 20, 2018), *available at* www.pewinternet.org/fact-sheet/internet-broadband/.

[14] Pew Research Center, http://www.pewinternet.org/three-technology-revolutions/.

[15] Amy Nordrum, *Popular Internet of Things Forecast of 50 Billion Devices by 2020 is Outdate*, IEEE Spectrum (Aug. 18, 2016, 1:00 PM) *founder here:* http://spectrum.ieee.org/tech- talk/telecom/internet/popular-internet-of-things-forecast-of-50-billion-devices-by-2020-is-outdated.

CHI supports increased connectivity for rural healthcare and recognizes that the Commission identified numerous barriers to wireless infrastructure deployment and appreciate its thoughtful proposals to address these barriers.[16] CHI also applauds the Chairman's efforts to close the digital divide by establishing his "Gigabit Opportunity Zone" program, which would "bring broadband and digital opportunity to our nation's most economically challenged areas."[17] CHI urges the Commission to continue this trajectory to ensure that the necessary infrastructure is in place to make robust mobile broadband solutions available to healthcare providers.

While the Commission's Rural Healthcare Fund (RHCF) is a useful means for connecting eligible healthcare facilities, the RHCF simply does not do enough. Support for connectivity and the advanced connected health tools increasingly powered by AI are necessary to realize the potential of PGHD to improve the care for countless rural American patients. The Commission's Connected Care Pilot is poised to explore what more the Commission can do to bring broadband-enabled healthcare services to underserved rural patients and veterans. CHI supports the Pilot's goals and urges the Commission to break the mold of the RHCF as much as possible in meeting these goals. We also believe that the Pilot, if it reaches its full potential, can provide invaluable data to inform future policymaker decisions (at the Commission and elsewhere) when making further changes to embrace connected health technologies.

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[16] *E.g., In the Matter of Accelerating Wireless Broadband Deployment by Removing Barriers to Infrastructure Investment*, WT Docket No. 17-79, Second Report and Order (2018). Available at https://www.federalregister.gov/documents/2018/05/03/2018-08886/accelerating-wireless-broadband-deployment-by-removing-barriers-to-infrastructure-investment.

[17] FCC Chairman Ajit Pai, Digital Empowerment Agenda, *available at* https://apps.fcc.gov/edocs_public/attachmatch/DOC-341210A2.pdf.

III. The Commission's Connected Care Pilot Should be Inclusive of the Diverse Array of Innovative Connected Health Tools and Stakeholders

A well-established (and growing) body of use cases and evidence demonstrate how the wide array of connected health technologies available today improve patient care, reduce hospitalizations, help avoid complications, and improve patient engagement, particularly for the chronically ill.[18] These tools, which include wireless health products, mobile medical device data systems, telemonitoring converged medical devices, and cloud-based patient portals, are revolutionizing the medical care industry by allowing the incorporation of PGHD into the continuum of care. CHI believes that the Pilot must go much further than the existing Healthcare Connect Fund (HCF) does today, and we do not believe that the past practices of the Commission in funding healthcare-related connectivity costs should necessarily dictate the scope of the Pilot.

CHI strongly encourages the Commission's Pilot to include "turnkey" solutions such as software, RPM tools, and patient broadband internet access,[19] which can find support under the Commission's interpretation of the section 254(h)(2)(A) and permitted as information services.[20] As noted above the various types of innovations are transforming the healthcare space and in

[18] *See*, Hindricks, et al., The Lancet, Volume 384, Issue 9943, Pages 583 - 590, 16 August 2014 doi:10.1016/S0140-6736(14)61176-4.

[19] Connected Care Pilot NPRM at para. 23.

[20] 7 U.S.C. §§ 254(b)(1), (3), and 254(j). *See also, e.g.*, American Hospital Association Comments at 6 ("Further, the fundamental purpose of the program can be easily reconciled with the broader universal service principles Congress established in 254(b) (*e.g.*, the availability of quality services at just, reasonable, and affordable rates; access to advanced telecommunications and information services in all regions of the United States; access to advanced telecommunications and information services in all regions of the United States, access to services and rates comparable to those offered in urban areas; and promotion of [health care provider] access to advanced telecommunications services."); University of Arkansas for Medical Sciences and Arkansas e-Link Comments at 2 ("UAMS and Arkansas e-Link believe that sections U.S.C. § 254(b)(1), (2), (3), (6); U.S.C. § 254(h)(2)(A), and U.S.C. § 254(c)(1); U.S.C. § 254(c)(3) support FCC authority to create a Pilot program and waiver for advanced services and technologies as marketplace status evolves.")

order for the Commission's Pilot to be meaningful and effective, Pilot projects must include these tools as supportive components of the project.

CHI strongly supports Pilot projects incorporating the use of innovative technologies, end-user devices, and software platforms in addition to broadband connectivity and network equipment. The Commission can support such technologies' use in Pilot projects by, among other steps, putting Pilot project evaluation, approval, and reporting criteria in place that require (or at minimum, provide strong preference for) proposed Pilot projects to include end-user devices, medical devices, and connected care applications (even if self-funded or supported with outside funding) that leverage PGHD collected outside of the healthcare provider's facilities. Further, CHI encourages the Commission to ensure that physicians and other healthcare professionals are reasonably incented to use connected health technologies in serving the beneficiaries targeted in Pilot projects by putting Pilot project evaluation, approval, and reporting criteria in place that requires (or at minimum, provide strong preference for) healthcare provider Pilot applications to ensure or provide reimbursement and/or payment consistent with the Centers for Medicare and Medicaid Services' approach to remote patient monitoring in Medicare Part B.[21]

[21] Effective January 1, 2019, CMS has provided a coverage expansion in Part B for RPM through the activation and payment of three new CPT codes that cover both the technical and professional aspects of RPM. These codes and their descriptors are as follows:

- CPT code 99453, "Initial set-up of technology and patient education (technical component),"
- CPT code 99454, "Device supply with daily recordings, programmed alerts transmission, monthly (technical component)," and
- CPT code 99457, "Collection, interpretation of physiologic data, 20 minutes or more per month requiring interactive communication with patient by physician, QHPs, and other clinical staff (professional component)."

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1693-F.html.

At the same time, the Pilot should not be overly-prescriptive so as to allow for the appropriate solutions to be plugged into various Pilot projects based on unique population, geographic, etc., needs, and the Commission should use outcome-driven requirements (as opposed to technology-specific requirements).

IV. CHI Supports Broad Pilot Eligibility Past 254(h)(7)(B)'s Limited Definition

The Commission considers in its NPRM whether to utilize the existing USF-related definition of eligible healthcare provider, and whether to permit both rural and urban healthcare providers to participate in the Pilot.[22] CHI supports a broad and inclusive approach to Pilot eligibility. While the Commission discusses at length its existing definitions and approaches to healthcare provider eligibility, CHI does not believe these past practices should tie the Pilot to such a limited scope. In other words, the purpose of a Pilot is to explore areas beyond the way the Commission has done things, and we believe it would be a wasted opportunity to limit eligibility in this way.

Therefore, we discourage the Commission's proposal to limit healthcare provider participation in the Pilot program to non-profit or public healthcare providers within section 254(h)(7)(B) and urge the Commission to permit applications from any "healthcare provider" as defined in section 1171(3) of the Social Security Act. This definition of healthcare provider includes "any other person or organization who furnishes, bills, or is paid for healthcare in the normal course of business," and will ensure that the Commission can evaluate the broadest range of proposals and ideas, after which it can make an informed decision in awarding Pilot projects.

[22] Connected Care Pilot NPRM at para. 37-42.

We also support eligibility for both rural and urban healthcare providers. Because this is a Pilot meant to explore new and exciting possibilities, we see no reason why the Commission should confine itself to the way it has done things in the past.

V. CHI Recommends a Reasonable Number Pilot Program Recipients to Ensure Useful Data is Collected and Evaluated

In the NPRM, the Commission requests input on the number of projects that the Pilot should support, and whether a per-project cap should be put into place.[23] We note that, should Pilot project funding be spread too thin (either through a high number of projects and/or a per-project cap), the only healthcare providers likely to be able to successfully leverage Pilot project funding will be those providers who already have a connected health infrastructure in place. While Pilot funding should support new programs in underserved rural areas that may have some infrastructure in place, CHI believes that the Pilot should truly enable innovative healthcare providers to serve disadvantaged populations in rural areas where such infrastructure may not already exist. We, therefore, support the Pilot awarding no more than five projects.

VI. The Commission Should Streamline Pilot Program Recordkeeping and Reporting Requirements

CHI appreciates the Commission's request for input on reporting and recordkeeping requirements.[24] The Commission is wise to prioritize streamlined paperwork requirements for Pilot project grantee healthcare providers, who all already grapple with numerous federal and state recordkeeping and reporting requirements. At the same time, accountability for Pilot

[23] Connected Care Pilot NPRM at para. 33.

[24] Connected Care Pilot NPRM at para. 94-103.

program grantees is important, and America will certainly benefit from the data produced by each Pilot project. CHI supports the Commission's efforts to ensure that the recordkeeping and reporting requirements of the Pilot are not overly burdensome, and the Commission to utilize existing reporting structures to the maximum extent possible.

VII. CHI Urges the Commission to Coordinate its Connected Care Pilot (and Healthcare Efforts Generally) with Other Key Federal Actors

The Commission's proposed Pilot is commendable but is not occurring in a vacuum. Noting its support for the Commission's role in supporting connected healthcare, CHI urges the Commission to coordinate with other key agencies as it builds the Pilot, namely HHS. To provide for this coordination, CHI believes that the Commission should seek to develop a memorandum of understanding (MOU) with HHS, specifically its Centers for Medicare and Medicaid Services (CMS) and Office of the National Coordinator for Health Information Technology (ONC) to memorialize the shared goal of advancing the uptake of connected health innovations in U.S. healthcare. CMS (in overseeing the Medicare and Medicaid programs and their shift to a value-based system under the Medicare and CHIP Reauthorization Act) and ONC (in advancing connected health through, among other efforts, developing its certified electronic health record technology criteria and developing an enforcement regime to prevent illegal healthcare information blocking) would have much to offer the Commission as the Pilot is shaped. Further, as it stands up the Pilot and tracks its success, the Commission's collaboration with both CMS and ONC would benefit all agencies involved. For example, CMS could provide the Commission with insights related to its new support in Medicare for the caregiver services that utilize PGHD to inform the Commission's metrics.

VIII. Conclusion

CHI appreciates the Commission's request for public input in this proceeding and urges consideration of the views and data provided herein.

Respectfully submitted,

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