



Telemedicine Centers USA

**Before the
Federal Communications Commission
Washington, D.C. 20554**

In the Matter of

Promoting Telehealth for Low Income Consumers

WC Docket No. 18-213

COMMENT TO FCC NOTICE OF PROPOSED RULE MAKING

William T. Johnson, CEO, J.D., LL.M

1111 SW 1st Avenue Suite 2414

Miami, FL. 33130

(614) 638-8526

Comment Date: August 29, 2019

FCC 18-112

Opening Statement

We applaud this Commission for its deliberations of the many Comments and Replies filed last year in supporting its deliberated conclusions underlying the July 10, 2019 decision to move forward with the Notice of Proposed Rule Making and inviting our further Comments. This follow through upon the clear legislative mission imperatives and purpose for this Commission's vision for the future in protecting and promoting use of precious spectrum communication high speed bandwidth for public benefit and encouraging exploitation of competitiveness is succinctly spelled out in the Introduction in last year's Notice of Inquiry:

The Commission's top priority is to increase digital opportunity for all Americans, and nowhere is this imperative more critical than in the area of health care. High-quality health care has become increasingly reliant on the widespread availability of high-speed connectivity, and broadband enabled telehealth services are assuming an increasingly vital role in providing care. Indeed, advances in technology mean that the delivery of high-tech services to patients are no longer limited to the confines of connected, brick-and-mortar health care facilities. Rather, there is a movement in telehealth towards connected care everywhere. Whether through remote patient monitoring technologies or mobile health applications that can be accessed on smartphones, tablets, or other connected devices, patients are seeing improved outcomes and significant cost savings through high-tech care that can be delivered directly to them regardless of where they are physically located.

Federal Communications Commission Notice of Inquiry Adopted August 2, 2019

The relevance and timeliness of this FCC Notice of Proposed Rule Making appears on the nation's economic and business agenda at a time when great anxiety exists with respect to the provider access inequity and the fractured cost control and delivery performance of the US health care infrastructure. Also, whether the Affordable Care Act will survive the current United States Supreme Court legal challenge thereby resulting in millions of Americans being stripped of health care protection raises concerns for the possible results of next year's National Elections for control of the White House, Senate and the House of Representatives, as well as control of state legislatures and state houses that may give movement to implementing "Medicare For All" or some non universal health care pursuit.

Of even greater concern to the millions of the emerged Majority-Minority US citizens living in rural and urban neighborhoods across America, and the millions of aged living-in-place citizens suffering from multiple complex chronic conditions-many because of multicultural, multilingual obstacles, lacking IT access technology and struggling with SDOH in zip codes barriers- is what can be done, including self-help, to fulfill the promise implicit in the Christian

belief and responsibility we share as citizens to help one another in illness and infirmity. This is even more so in 2019 as reported in media accounts that there is NO RIGHT to US health care in some states if we are discovered lying in the street because of a health condition, or reportedly discovered hiding in our homes being “of color” and without “papers” proving our status as citizens. Similarly, packing immigrant infants and children in detention cages without health provider access to health assessment and treatment care when remote qualified providers are willing and available to use connected care technology is unacceptable.

Hence, the explicit acknowledgment in the above cited FCC Introduction that a privileged tier of hi-speed technology supported connected health care delivery and direct concierge provider services access exists in the US for some, but not all citizens, is precisely what US health policy experts, former Surgeon Generals, and civil rights advocates have warned could occur where providers implement health care technology devices while choosing to ignore the wealth, health needs, educational/technical competency barriers much like such was described in the obscene Apartheid system universally criticized as racist and xenophobic.

If protections assuring inclusion in the creation of a connected health care system for the poor and technically challenged that can assist crossing the *digital divide* facilitating affordable provider access, services, and care monitoring/management to an endangered targeted population is not provided; that additional failure would dramatically aggravate US health inequity, increase the historical racial health treatment disparity and further significantly increase preventable deaths for underserved populations, and generate higher annual health care costs that threaten US national security and economic productivity.

The feedback and responses below to specific FCC questions is presented in a different paradigm and in its proper perspective of “Population Health Connected Care” in the 21st century rather than merely projecting a conflated view of stretching an entrenched 272 year old unfocused patient care undertaking process. Just as implicitly written throughout chapters of “The Innovator’s Dilemma,” disruptive innovation can make it plain that the industry’s purpose for being in the past may not survive technology breakthroughs merely by its grasping and selectively using shiny pieces of technology driven innovations that it didn’t create.

We proffer answers that may well have not been in the scope of the FCC in looking at the goals sought for the Connected Care Pilots in meeting the community’s health needs of its health burdened underserved populations, especially as the effects of displacing nature created disasters leaving areas of the nation without access to bricks&mortar office-centric providers, how first responders and FEMA can be interwoven into community vehicles to address climate related and uncontrolled exposures to contagions and illness in the quasi isolated and quarantined community left unmanaged by health providers that may already be shut down and unable to respond. New nimble participants left on the sidelines see the necessity for

integrating connected care technology and out-of-silo provider care direct-to-patient homes in addressing the pregnant Social Determinants of Health issues not attacked and ameliorated in the fractured performance of our health system.

There are less debt burdened entrants that have already carved a presence into the US health care sector's far more vulnerable consumer-centric driven community-wide marketplace, where building patient trust, transparency, comparative competitive initiatives across geographic, demographic, and culturally sensitive populations; may easily expand instead of crowding out the opportunity for the FCC to attract more innovative and transformational applicants to demonstrate Connected Care.

SELECTED COMMENT ON NOTICE OF PROPOSED RULEMAKING

1. Assume FCC funds 85% of costs for Internet connections that enable low-income patients and Vets to receive remote access telehealth services. What additional costs beyond the internet cost, including network equipment and software is necessary for provision of internet enabled telehealth services? COMMENT: Irrespective of the health care provider type or remote services proffered, there are custom install IT equipment costs, encryption/security integrated in IT router, camera/light kit, peripheral USB ports, power strip/surge protector for digital medical devices and personal home secured EMR software, and a CPU/display come to mind.
2. FCC has Authority for Connected Care Delivered Through Designated Provider Types: COMMENT: It's well within the Communications Act Section 254(3) and (4). [See also, Texas Office of Public Utility Counsel 183 F.3d 393,441-43 (5th Cir. 1999)] for the FCC to encourage demonstrations of use of its broadband spectrum to promote technology utilization and provide for public benefit. First Responders, Community based health and treatment organizations, existing and former FCC funded programs for public health providers to serve rural and medically underserved populations facing IT barriers. Hence, hospitals, primary care physicians, SNF's, FQHC's FQMHC's, ACOs, PCMH, and now for profit direct-to-patient providers funded by health insurance and drug stores and including Dietitians and Nutrition dentists, PT/OT and speech therapy, vision and hear, fitness training and coaching, professionals are emerging. In addition, retired and a new part time corps of licensed care providers willing to support remote connected care on a contract or volunteer basis in medical areas where a shortage of

providers exist. Self help health organizations are licensed to support Vets, Call911 suicide and mental health/behavioral crisis services, and funded NFP agencies set up to coordinate, monitor and provide care management services to eligible recipients of CHIPs and CMS programs for community living special populations [immigrants and inmates, parole and probation] with medical conditions, ASD and developmental disabled patient case management.

3. **Type of Connected Care Services for Establishing and Structuring the Pilot.** COMMENT: A wide range of the remote Connected Care services are delivered to those who can afford the connectivity, the technical interfaces and displays, integrated with 2-way secured interactivity using digital diagnostic assessment and monitoring equipment. Managing care and monitoring needs for timely acute intervention for poor neglected underserved patients suffering from cardio conditions, COPD, diabetes, hypertension and dementia as complex chronic conditions consumes a substantial portion of the annual US health care spending. The studies show as well, these areas of health care accounts for the highest rate of morbidity/mortality as “preventable deaths” in the US primarily from lack of affordable access, shortage of providers and stretched and limited access to providers worksites.
4. **How are patient care costs typically paid for in a Connected Care Pilot Program in the marketplace has depended upon a variety** of limited connectivity options where a phone line, cell phone website internet connection, FaceTime on a menu ala carte basis, or for some services a flat bundle of items for a negotiated cost. Some connected care remote services are set up on a pre-paid yearly or monthly flat fee for a time bundle of services (called Concierge arrangement). These patients pay for their own connectivity to their provider.
5. **Is there a list of Connected Care services beneficial for low-income underserved, and rural and urban medically needy neighborhood communities that is not already being provided?** COMMENT: JAMA just released a study disclosing that within the Black and other “of color” multicultural and multiracial populations there is a shocking rise in “preventable deaths” from stroke, high blood pressure, diabetes, and COPD requiring timely alerts and acute intervention upon onset of crisis. For this reason, the cellphone and tablets used connectivity for limited services isn’t suitable for continuous real time monitoring and capture of PHI in EMR for analysis to manage complex health

conditions. Added to this list of beneficial services are medical monitoring for high risk maternal care, healthy infant care, opiate treatment and counseling interventions due to lack of residential placements, obesity and nutrition coaching, and mental health integration with primary care to include management of untreated comorbidities.

6. **COMMENT:** The equipment necessary for capturing the patients PHI vitals into EMR for experts in real time requires encrypted VPN and higher quality connectivity. Broadband is the preferred connectivity to deploy telemedicine applications of monitoring and management driving 2-way video/audio exams connecting digital devices to capture vitals in EMRs, conduct tests of COPD, vision, cardio and supporting multipoint video conferences with other providers and care management team members.
7. **COMMENT:** Minority low-income women with multiple chronic conditions are the fastest growing demographics that are eligible for living in SNFs, and that sector population prefer to live in the community as aging in place independents for as long as possible. This population also is finding that care of a dementia and Alzheimer patient at home is challenging and affordable nursing home care is difficult to find. Thus, connected care home assessment, management is less costly for home care and beneficial for therapy. Use of broadband for remote wellness connected care health status checks can also extend this lower cost of care to a population known to be the costliest to support in the ER and hospital admission. Logically and business sense makes it an easy call for this population to eliminate unnecessary ER visits and admissions, but also support this sector's attention to the warning signs where acute intervention may be timely and at lower risk and cost.
8. **COMMENT:** Further, use of direct to patient via telemedicine visits in SNFs, millions of residential homes, and in senior housing communities using broadband technology similarly can provide remote patient monitoring management at less cost than ER transport and costly observation status or dubious hospital admission. Especially so when MedPAC fines and penalties for preventable readmissions can affect operating margins and health outcomes reflected in PCP performance measures contributing to value care billing payment schemes.
9. **COMMENT:** We can expect positive health outcomes by focusing broadband telehealth services to include immigrant and multicultural neighborhoods and sectors of the

community by bringing the technology right into homes and community social welfare and public congregate sites through EMT rounding, teaming with already paid community care workers and case management, primary and charter schools and head start preschools and special schools for ASD and developmental challenged children where multilingual and multicultural care and communication services will be optimized.

10. **COMMENT:** There are more than 200 million occupied US households that would need to be set up for utilization of Connected Care health care services sometime in the next decade. Currently, close to a trillion dollars a year is spent by caregivers and patient-consumers for home support of a loved one to address health and wellness concerns. 5G and IOMT technology breakthroughs will prove to be a disruptive tool transforming the infrastructure and delivery capability for how health care is provided, and will impact the equipment and software that will drive population health in the US. In its present office-centric form, hospitals and licensed providers are facing competition from new entrants and technology driven by demanding consumers angry of high costs, lack of transparency, high rates of preventable deaths, and lack of access to culturally sensitive providers they can trust.
11. The challenge existing entrenched providers face in investing in fast changing connected care equipment, software and manpower/technicians required to wire up, service and train an entirely new external population health care workforce to support direct-to-patient homes for universal access for connected care is a huge obstacle. Given the recent entrance of Amazon and CVS, Walgreens and Wal Mart into the direct-to-consumer care market, the seeds are now gestating for the creation of a national connected care health services entrepreneurs at the community level that addresses the Social Determinants of Health issues and is “trusted” to work within the previously poorly served high risk multicultural and multilingual populations.
12. Presently, US health care providers have mostly invested in or collaborated with contracted third party vendors to supply the investments for connected care equipment, software and implementation while it pursued its entrenched business models. As connected care services have become widely acceptable to the satisfaction of the consumer-patient, and billions of dollars in venture capital and investment connected care start ups have proven to be competitive and are often supported by

huge multinational businesses, and other sectors of the US healthcare infrastructure; all the costs and capital expenditures for creating and installing equipment, and liability therefore, to provide the remote connected care services, including secure connectivity, will have to become the responsibility of willing US health care providers ready to compete for market share of consumers living in areas it knew it did not fully serve.

13. **COMMENT:** At the rate of hospital closures and shuttering of “safety net” health bricks&mortar locations, the public is being forced to rely upon [and face rejection for poverty reasons] costly upfront payment Urgent Care services in storefronts and the few open ER rooms willing to not divert their ambulance arrival. Hence, all costs incurred for connected care, including connectivity and broadband would be absorbed by the hospital/provider, or its competitors anxious to seize the market share.
14. **COMMENT:** There are substantial costs the FCC demonstration pilot program would not have to cover that will solely burden the connected care health services providers to the market place. The biggest will be the cost of insurance, malpractice, flawed equipment, obsolescence, and the business competitive risks from less debt burdened larger vertically integrated competitors seeking to grab a share of the \$4.3 trillion dollar annual US health care spending.
15. **COMMENT:** The FCC asked what types of patient populations [could] health providers treat with connected care services, AND should the FCC demonstration pilots focus on that population. I added brackets and wrote in “could” because virtually none of the beneficial connected care services described herein above and known to be available to the wealthy healthy and technically savvy population are not in existence presently for reaching the millions of underserved patients at the last mile that need it.
16. **COMMENT:** For example of types of patient populations underserved for connected care and at high risk for preventative deaths; let me share just a few case studies of targeted populations within medically underserved and health care deserts that could be benefited for the population health of the emerged Minority-Majority demographic that do not control or influence their own health future.

17. **Case Study 1:** A pending innovative proposal for connected care involving a multi-site minority FQHC that with exactly the home infrastructure IT broadband contemplated in the FCC proposed Connected Care Demonstration Pilot, that can transform its patient throughput impacting its financial and productivity capability for care delivery 24/7. A pilot could connect the FCHC to direct school care patients tied to home health monitoring and in partnering with the safety net hospital and America's #1 medical center [now interested in addressing SDOH issues and collaborate with the large neglected "of color" community] expand the hospital's "brick and mortar inside four walls" right into any of its discharged patients home supported by that FQHC that also can prevent avoidable ER visits and substantially reduce hospital readmissions.
18. **Case Study 2:** SNFs, hospitals and PCPs under contract with ACOs and contract insurance/managed care providers see this FCC Connected Care broadband health delivery capability as not limited just to low-income populations, but as preferable to overcome the OIG criticism for not being able to document case management services to millions of low-income Medicare Advantage and Medicaid patients under contract.

Thank you for inviting our Comments.

Telemedicine Centers USA

WTJ E-Signature

William T. Johnson, CEO, J.D., LL.M