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

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

COMMENTS OF THE VIRGINIA TELEHEALTH NETWORK

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The Virginia Telehealth Network ("VTN")[1] is pleased to submit these comments in support of the Commission's proposal to develop and implement a Connected Care Pilot Program, as detailed in its July 11, 2019, Notice of Proposed Rulemaking ("NPRM").[2] As VTN highlighted in its comments in response to the Notice of Inquiry in this proceeding,[3] such an initiative holds significant promise to improve clinical outcomes and achieve cost savings for this nation's most vulnerable individuals as well as the health care providers ("HCPs")[4] that serve them. VTN appreciates the Commission's attention to this issue and welcomes the continued opportunity to participate in shaping the pilot program.

INTRODUCTION AND SUMMARY

VTN is a non-profit organization dedicated to advancing the development, adoption, implementation, and integration of connected care solutions and related technologies throughout

[1] For more about VTN, see Virginia Telehealth Network, http://ehealthvirginia.org.

[2] *Promoting Telehealth for Low-Income Consumers*, Notice of Proposed Rulemaking, WC Docket No. 18-213, FCC 19-64 (July 11, 2019).

[3] Comments of the Virginia Telehealth Network, WC Docket No. 18-213 (Sept. 7, 2018) ("VTN NOI Comments"); *see also Promoting Telehealth for Low-Income Consumers*, Notice of Inquiry, 33 FCC Rcd. 7825 (2018).

[4] As set forth below, VTN urges the Commission to limit participation in the pilot program to non-profit and public "health care providers" as defined by Section 254 of the Communications Act, *see* 47 U.S.C. § 254(h)(7)(B).

Virginia. VTN members include academic medical centers, community hospitals, federally qualified health centers,[5] individual practitioners, broadband service providers, payers, the Medical Society of Virginia, and other entities involved in the provision of telehealth in the state. VTN fosters coordination and delivery of connected care by promoting the use of secure videoconferencing, "store and forward" technologies, remote patient monitoring, and mobile health services that improve both access to health care and clinical outcomes.[6]

A longtime champion of connected care initiatives, VTN has hosted telehealth-related conferences and facilitated advancements in such efforts statewide. Moreover, several members of VTN's Board of Trustees are involved in various other initiatives at the intersection of medicine and technology. The Chair of VTN's Board is an active participant in the American Medical Association's Digital Medicine Payment Advisory Group,[7] and its Vice Chair serves on the Universal Service Administrative Company's Board of Directors, where she represents rural health constituencies across the country.[8]

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[5] Federally qualified health centers are "safety net providers that primarily provide services typically furnished in an outpatient clinic," and "include community health centers, migrant health centers, health care for the homeless health centers, public housing primary care centers, and health center program 'look-alikes.' They also include outpatient health programs or facilities operated by a tribe or tribal organization or by an urban Indian organization." Ctrs. for Medicare & Medicaid Studies, *Federally Qualified Health Center* 3 (Jan. 2018), https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/fqhcfactsheet.pdf.

[6] *See What is Telemedicine/Telehealth*, Virginia Telehealth Network, http://ehealthvirginia.org/index.html#what (last visited Aug. 22, 2019).

[7] Karen Rheuban, M.D., VTN's Chair, also serves as a senior administrator at the University of Virginia ("UVA") School of Medicine and as the Medical Director of the UVA Center for Telehealth in Charlottesville, Virginia. She is a practicing pediatric cardiologist.

[8] Kathy Wibberly, Ph.D., VTN's Vice Chair, also serves as the Director of the Mid-Atlantic Telehealth Resource Center in Charlottesville, Virginia.

Recognizing the promise of connected care services, VTN members provide at-risk patients throughout Virginia with remote monitoring tools and other technologies to facilitate improved care coordination and clinical outcomes. Some VTN members also provide broadband Internet access service ("BIAS") to enable patients to use such tools when they otherwise lack such connectivity at home. To sustain and expand connected care services for medically at-risk and otherwise vulnerable patients, including those suffering from chronic illnesses, and to further demonstrate the efficacy of such models in treating veterans, low-income patients, and other underserved individuals, the Commission should adopt the Connected Care Pilot Program as proposed in the NPRM.

As set forth in further detail below, VTN urges the Commission to structure the Connected Care Pilot Program to attract well-qualified participants and to foster impactful projects, including by establishing reasonable funding and project limits, extending funding beyond BIAS, and reducing or eliminating administrative burdens without forsaking the program's integrity. VTN also encourages the Commission to fund experienced non-profit and public HCPs serving this nation's most vulnerable patient populations. Finally, the Commission should implement reasonable data collection and reporting requirements to assess the impacts of connected care services on clinical outcomes and of universal service funding on such services' deployment.

DISCUSSION

I. VTN STRONGLY SUPPORTS THE COMMISSION'S PROPOSAL FOR THE CONNECTED CARE PILOT PROGRAM

VTN strongly supports the Commission's proposal to develop and implement a pilot program that will facilitate the delivery of connected care services to vulnerable patient populations and generate the data necessary to evaluate the impacts of such efforts. As the

Commission has recognized, connected care programs reduce hospital readmission rates and improve clinical outcomes while achieving meaningful cost savings for the American health care system.[9] VTN's experience confirms these benefits. By deploying a remote monitoring and care coordination initiative, the University of Virginia ("UVA") Health System's Connected Care Diabetes Program, in partnership with the UVA School of Medicine's Division of Endocrinology & Metabolism and Tri-Area Community Health (a regional network of federally qualified health centers), has demonstrably improved patient engagement and outcomes for diabetic patients with elevated hemoglobin A1c levels, who face increased risks of vision loss, kidney failure, and vascular and heart disease, among other morbidities. In fact, the program's use of connected care solutions has helped participating patients to reduce their hemoglobin A1c levels from a mean of 9.9 percent (indicative of uncontrolled diabetes) to 7.7 percent (indicative of controlled diabetes).

Unfortunately, this nation's most vulnerable patient populations—particularly low-income individuals and the elderly, but also veterans and rural communities—often lack access to the broadband connectivity necessary to benefit from such connected care services.[10] Moreover, HCPs—especially non-profit and public entities—frequently lack the resources necessary to fund the widespread deployment of such solutions for their patients.[11] For these reasons, VTN shares the Commission's goals of "(1) improving health outcomes through connected care; (2) reducing health care costs for patients, facilities, and the health care system; (3) supporting the trend towards connected care everywhere; and (4) determining how USF

[9] *See* NPRM ¶¶ 10-11.

[10] *See id.* ¶ 13 & n.26.

[11] *See id.* ¶ 38.

funding can positively impact existing telehealth initiatives,"[12] and agrees that the proposed Connected Care Pilot Program will advance these objectives. Indeed, VTN has previously commended the Commission for its efforts directed at improving access to connected care and related telehealth services, including by administering the Rural Health Care programs.[13] To date, these initiatives have enabled increased connectivity among brick and mortar health care facilities.[14] By concentrating on these four objectives, the Commission's proposed pilot program represents a logical next step in its ongoing efforts to facilitate widespread access to connected care services, now moving beyond traditional clinic environments.

II. THE CONNECTED CARE PILOT PROGRAM SHOULD BE STRUCTURED TO ATTRACT WELL-QUALIFIED PARTICIPANTS AND TO FOSTER IMPACTFUL PROJECTS

The Commission proposes the Connected Care Pilot Program be comprised of "a three-year funding period and separate ramp-up and wind-down periods of up to six months in order to give projects time to complete set up and other administrative matters."[15] VTN agrees with this approach and suggests that the pilot program be structured so as to attract well-qualified HCPs and broadband service providers, and to ensure that projects are provided with the resources necessary to contribute meaningfully to the Commission's objectives. In particular, the Connected Care Pilot Program should impose reasonable limits on per-project funding and the number of projects to which support is extended. Moreover, while the NPRM appropriately recognizes that funding should not be limited to eligible telecommunications carriers ("ETCs"), VTN respectfully submits that the proposal to limit funding to BIAS, excluding end-user

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[12] *See id.* ¶ 78.

[13] VTN NOI Comments at 4.

[14] *See* NPRM ¶ 6.

[15] *See id.* ¶¶ 35-36.

devices, would hamper the success of the pilot program. And, in all events, the Commission should ensure the program's integrity without imposing undue administrative burdens on participating patients, HCPs, and broadband service providers.

A. The Commission Should Impose Reasonable Limits on Per-Project Funding and the Number of Projects Funded

VTN applauds the Commission's willingness to provide universal service support for the deployment and evaluation of connected care services and believes that $100 million is an appropriate amount of funding for this three-year pilot program. The NPRM asks how this budget should be allocated among projects and, in particular, whether the Commission should "establish a ceiling on the amount of the total budget that can be allocated to a single project."[16] To enable the pilot program's discrete budget to support a variety of projects, VTN urges the Commission to impose such a limit and submits that a $10 million per-project funding cap is reasonable, as it would allow for relatively large-scale projects while ensuring that at least 10 different projects receive support. Relatedly, VTN encourages the Commission to establish a limit—a maximum of 20 projects would be appropriate—to ensure that each has the scale necessary to participate meaningfully and contribute to the Connected Care Program's data collection efforts.[17] Given the variability of costs associated with providing connected care services, applicants should be permitted to request varied funding amounts, subject to these limitations.

[16] *See id.* ¶ 33.

[17] *See id.*

B. While the NPRM Appropriately Recognizes that Funding Should Extend to All Broadband Internet Access Services, Regardless of Whether Provided by an ETC, the Commission Should Permit Funding of End-User Devices to Ensure a Successful Pilot

The NPRM also seeks comment on the extent to which HCPs currently provide connected care services (as well as the costs associated with providing such services) and whether the pilot program should fund "end-user devices, connected care medical devices, [and] connected care mobile applications" in addition to BIAS.[18] Several VTN members, including UVA Health System, contract with third-party vendors to provide their patients with a suite of telehealth-related devices, applications, and services. The costs associated with providing these tools vary according to a patient's medical needs and their existing access to such technologies. Typically, patients without broadband connectivity also lack the broadband-capable devices—such as tablets, peripherals, and applications—that are needed to receive connected care. Indeed, such components are no less crucial to the provision of connected care than BIAS itself. Where other sources of funding for tablets, peripherals, applications, and similar technologies are already available, the pilot program's limited budget should be allocated elsewhere. However, by extending support beyond BIAS to include "end-user devices, connected care medical devices, [and] connected care mobile applications"—to the extent that other sources of funding are unavailable or have been exhausted—the Commission will encourage greater interest in the pilot program and will enable participating HCPs "to extend service to additional patients [and] treat additional health conditions," and to do so more comprehensively.[19] Conversely, failure to cover such costs would threaten to chill participation in and hamper the effectiveness of the pilot program.

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[18] *See id.* ¶ 26.

[19] *See id.* ¶ 20.

In addition, VTN supports the Commission's proposal to defray eligible costs through a fixed discount of 85 percent, an approach that is both "administratively simple, predicable, and equitable" and that incentives efficient use of the pilot program's budget.[20] It urges the Commission, however, to remain flexible in other respects. For example, although the NPRM contemplates "cap[ping] the monthly amount of support that can be paid … to a[n] [HCP] for each participating patient,"[21] VTN submits that, in light of the highly variable and largely unpredictable costs associated with deploying connected care services, no such limits be imposed.

Furthermore, the Commission should streamline the mechanisms by which funding is requested, calculated, and disbursed. Thus, rather than being required to submit new funding requests each year, HCPs should be permitted to submit a single request at the outset of the program and supplement it only if necessary.[22] Moreover, to obviate the need to develop and implement a complex cost-allocation scheme, and to reduce the risk of fraud and abuse, devices, applications, and services funded by the pilot program should be used by participating patients and HCPs exclusively for telehealth-related purposes.[23] Finally, instead of distributing funds to patients or broadband service providers, disbursements should be made directly to HCPs, many of which have preexisting relationships with third-party vendors of connected care solutions.[24]

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[20] *See id.* ¶ 30.

[21] *See id.* ¶ 31.

[22] *See id.* ¶ 71.

[23] *See id.* ¶ 34.

[24] *See id.* ¶ 74.

As noted, VTN supports the proposal to allow HCPs to acquire BIAS from non-ETCs for purposes of the Connected Care Pilot Program.[25] Today, various entities beyond those defined as ETCs provide broadband connectivity.[26] In fact, cable operators currently serve more homes than any other type of service provider,[27] and even electric utilities are engaged in broadband deployment, particularly in rural communities that stand to benefit the most from enhanced access to connected care services.[28] To limit participation in the pilot program to ETCs, therefore, would substantially reduce the number of options available to HCPs seeking to offer broadband connectivity as part of their projects; in turn, that would "artificially limit participation in the [p]ilot program and could also limit the effectiveness of the … program" itself.[29]

C. The Commission Should Strike a Balance Between Administrative Efficiency and Program Integrity

In addition to streamlining the funding process (as described above), the Commission should seek to avoid undue administrative burdens, whose existence would risk dissuading qualified HCPs from participating in the Connected Care Pilot Program. For example, VTN urges the Commission to simplify the various forms participants will be required to complete and submit, which in their current form are generally viewed as unnecessarily complex.

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[25] *See id.* ¶¶ 47-48.

[26] *See generally* FCC, Wireline Competition Bureau, *Internet Access Services: Status as of June 30, 2017* (Nov. 2018), https://docs.fcc.gov/public/attachments/DOC-355166A1.pdf.

[27] *See id.* at 24.

[28] *Cf.* Press Release, FCC, FCC Authorizes First Wave of Funding for Rural Broadband from Connect America Fund Auction (May 14, 2019), https://docs.fcc.gov/public/attachments/DOC-357434A1.pdf.

[29] *See* NPRM ¶ 46.

At the same time, maintaining the integrity of the pilot program is crucial to it success. Therefore, VTN is generally supportive of the various mechanisms the Commission proposes implementing to prevent waste, fraud, and abuse, including maintaining its typical competitive bidding requirements[30] and "adopting [five-year] document retention and production requirements for [HCPs] and [broadband] service providers participating in the [p]ilot program[] and … making individual projects subject to random compliance audits."[31] Indeed, by striking a balance between administrative efficiency and program integrity, the Commission will ensure that the Connected Care Pilot Program appeals to HCPs and broadband service providers while preventing waste, fraud, and abuse that could thwart its objectives.

III. THE CONNECTED CARE PILOT PROGRAM SHOULD SUPPORT EXPERIENCED NON-PROFIT AND PUBLIC HEALTH CARE PROVIDERS' TREATMENT OF VULNERABLE PATIENT POPULATIONS

The nation's most vulnerable patient populations stand to benefit the most from enhanced access to connected care services. Unfortunately, such patients—and the non-profit and public HCPs on which they often rely for care—typically lack the resources necessary to facilitate the deployment of such services.[32] VTN therefore encourages the Commission to commit the pilot program's budget to projects in which qualified non-profit and public HCPs will utilize connected care to serve vulnerable patient populations.

As a preliminary matter, the NPRM seeks input on a number of definitions that will circumscribe the types of projects eligible to benefit from the pilot program's funding, including "health condition," "telehealth," "telemedicine," and "connected care."[33] To avoid inadvertently

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[30] *See id.* ¶¶ 66-68.

[31] *See id.* ¶ 76.

[32] *See id.* ¶ 38.

[33] *See id.* ¶¶ 18, 21.

excluding otherwise promising projects aligned with the pilot program's objectives, the Commission should define and construe these terms broadly. In particular, as to the term "health condition," the Commission should note the federal regulations governing health care access and insurance coverage, which define the substantially similar term "medical condition" as "any condition, whether physical or mental, including but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation."[34] This definition—on which the U.S. Department of Health and Human Services relies—is broad enough to encompass the myriad health conditions for which connected care services may prove beneficial. VTN also considers the NPRM's proposed definitions of the terms "telehealth," "telemedicine," and "connected care" similarly appropriate, as they embrace the kinds of services that are typically deployed by programs to which the pilot program should consider lending its support.

Ultimately, however, whether the Connected Care Pilot Program achieves its objectives will depend on the type and quality of the particular projects funded, and therefore VTN appreciates the Commission's focus on defining specific eligibility criteria for HCPs and the patients they propose to serve. In broad strokes, VTN encourages the Commission to direct the pilot program's funding to (1) non-profit and public HCPs with experience providing connected care services that propose to treat (2) vulnerable patient populations, including veterans, low-income individuals, and rural and/or tribal communities.

[34] *See* 45 C.F.R. § 144.103.

A. The Commission Should Limit Funding to Non-Profit and Public Health Care Providers with Connected Care Experience

As the NPRM proposes, the Commission should "limit … participation in the [p]ilot program to non-profit or public [HCPs]" as defined in Section 254 of the Communications Act.[35] Whether or not Section 254 requires the Commission to impose such a limitation, doing so is consistent with the pilot program's objectives. Non-profit and public HCPs typically lack the resources necessary to facilitate the deployment of connected care services on their own.[36] Thus, dedicating the Connected Care Pilot Program's budget to such entities will have the greatest impact on access to telehealth services, which otherwise might not be available in certain communities or to certain individuals.

Establishing an operational and reliable telehealth service is exceptionally complex and likely could not be accomplished within the relatively short six-month "ramp-up" period proposed in the NPRM. VTN therefore encourages the Commission to limit participation in the Connected Care Pilot Program to HCPs that can "demonstrate their experience providing telehealth services."[37] However, although Telehealth Resource Centers and Telehealth Centers of Excellence by definition possess the requisite capabilities—and should be given preference in the selection process—other qualified entities' proposals should be considered as well.

Relatedly, while experience with long-term patient care certainly will be beneficial for any participant in the pilot program, such experience should not necessarily be required.[38] Indeed, women facing high-risk pregnancies, who are among the individuals that stand to benefit

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[35] *See* NPRM ¶ 37.

[36] *See id.* ¶ 38.

[37] *See id.* ¶ 45.

[38] *See id.* ¶ 44.

the most from increased access to connected care services, are not typically served by long-term care providers. At the same time, VTN cautions the Commission against permitting telehealth providers that engage in limited patient contacts to participate in the pilot program—whose success will depend on the collection of longitudinal data—and encourages the Commission to define eligibility and/or evaluate proposals accordingly.

B. The Connected Care Pilot Program Should Fund Projects Benefiting Vulnerable Patient Populations

The pilot program focuses on serving vulnerable patient populations, which typically have limited access to, but stand to benefit the most from, connected care services. Therefore, VTN supports the NPRM's proposal to "limit[] participation … to [HCPs] that are located in or serve" underserved or lower-income areas or that "provide care to at least a certain percentage of uninsured and underinsured … or … Medicaid patients."[39] Similarly, it would make sense to "award[] additional points to proposed projects that would serve geographic areas or populations where there are well-documented health care disparities … or that [would] treat certain health crises or chronic conditions," particularly those that disproportionately impact vulnerable individuals. These include "opioid dependency, diabetes, heart disease, mental health conditions, and high-risk pregnancy."[40] VTN also encourages the Commission to partner with the federal Health Resources & Services Administration—which is charged with "improving health care to people who are geographically isolated, economically or medically vulnerable"[41]—to identify such priority populations. Still, the Commission should not

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[39] *See id.* ¶ 43.

[40] *See id.* ¶ 56.

[41] *See* Health Resources & Services Administration, *About HRSA* (last updated Mar. 2019), https://www.hrsa.gov/about/index.html.

categorically deny support to projects focused on other geographic areas, populations, or conditions. In particular, although the Commission should prioritize projects that benefit rural patient populations, the pilot program also should consider high-quality proposals that will benefit urban patient populations, which too may be composed of vulnerable individuals.

To determine which individuals may participate in a project funded by the pilot program, the Commission should adopt objective and easily applied standards, such as a patient's Medicare or Medicaid eligibility or veteran status.[42] Defining patient eligibility in this manner is beneficial in several respects. First, it will ensure that the pilot program's budget in fact benefits the vulnerable patient populations to which it should be directed. Second, it will help to ensure that a patient's payer of record—rather than the patient herself—will contribute the non-discounted portion of the eligible costs. Finally, it will necessarily align the Commission with state and federal agency partners that already have robust data collection, reporting, and analysis processes in place.

IV. REASONABLE DATA COLLECTION AND REPORTING ARE NECESSARY TO ASSESS THE IMPACT OF CONNECTED CARE ON CLINICAL OUTCOMES AND OF UNIVERSAL SERVICE FUNDING ON DEPLOYING SUCH SERVICES

The NPRM correctly recognizes that, to properly assess the health-related impacts of connected care services as well as the effects of universal service funding on the deployment of such services, HCPs should regularly collect and report patient- and project-related data.[43] To this end, the Commission seeks input on the types of data that should be collected and reported.[44] For purposes of assessing the impact of universal service-funded connected care services on

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[42] *See* NPRM ¶ 62.

[43] *See id.* ¶ 94.

[44] *See id.* ¶ 98.

health outcomes, the Commission should require HCPs to collect and report project-specific data such as the number and demographics of patients served as well as patient-specific data such as clinical status (i.e., hospital admissions, readmissions, and emergency department visits), condition-specific metrics (e.g., hemoglobin A1c levels), and participant satisfaction. Furthermore, to "evaluate whether the [p]ilot program is an administratively feasible method of distributing funding for connected care services," the Commission should obtain information from participating HCPs and broadband service providers "regarding their experience with the [p]ilot program," including time spent and costs incurred.[45]

As to the frequency with which such data should be reported, VTN submits that the Commission should require reports at the beginning of the project and every six months thereafter, to "minimize [participants' reporting] burden while still providing a mechanism for participants to provide valuable information."[46] To ensure that projects reliably collect and report such data, the Commission should require participating HCPs to have experience conducting clinical trials or that they partner with an entity that has such experience (e.g., an academic medical center, a state Medicaid agency, or the Veterans Health Administration). VTN also supports the NPRM's proposal to condition continued funding disbursements on compliance with data collection and reporting requirements.[47] Moreover, to protect patients' privacy and maintain program integrity, the Commission should require that all protected health information and personally identifiable information be de-identified prior to dissemination and that, in all events, data be released publicly only after the pilot program has been concluded.

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[45] *See id.* ¶ 102.

[46] *See id.* ¶ 97.

[47] *See id.* ¶ 75.

V. THE COMMISSION POSSESSES CLEAR LEGAL AUTHORITY TO ESTABLISH THE CONNECTED CARE PILOT PROGRAM

The NPRM correctly concludes that "the Commission's rural health care legal authority in [S]ection 254(h)(2)(A) of the Act supports the proposed [Connected Care Pilot Program]."[48] Section 254 grants the Commission clear authority to provide non-profit and public HCPs with funding to subsidize the cost of BIAS and broadband-connected technologies for patients. In particular, Section 254(h) confers broad discretion on the Commission to "designate … support mechanisms for … [HCPs]" if doing so would "enhance [those HCPs'] access to advanced telecommunications and information services."[49]

The Commission has previously recognized that Section 254(h)(2)(A) of the Act provides it with the requisite authority to establish connected care funding mechanisms. Indeed, it has already relied on Section 254(h)(2)(A) to establish funding mechanisms "to enhance public and non-profit [HCPs'] access" to BIAS and the "network equipment necessary to make the [BIAS] functional."[50] That same authority supports the development and implementation of the Connected Care Pilot Program, which, as set forth above, should fund both broadband connectivity and related devices and applications, all of which are necessary to enhance access to connected care services for this nation's most vulnerable patient populations and the non-profit and public HCPs that serve them.

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[48] *See id.* ¶ 105.

[49] *See* 47 U.S.C. § 254(c)(3), (h)(2)(A).

[50] *Rural Health Care Support Mechanism*, Order, 21 FCC Rcd. 11111 ¶ 1 (2006); *Rural Health Care Support Mechanism*, Report and Order, 27 FCC Rcd. 16678 ¶ 105 (2012).

CONCLUSION

The Commission's proposed Connected Care Pilot Program promises to improve clinical outcomes and achieve cost savings for this nation's most vulnerable individuals as well as the HCPs that serve them. To attract well-qualified participants and foster impactful projects, the Commission should impose practical per-project funding caps and limit the number of projects funded, extend support to end-user devices as well as BIAS, and take steps to ensure program integrity without imposing undue administrative burdens. Furthermore, the Commission should limit the pilot program's funding to non-profit and public HCPs with connected care experience that will serve veterans and/or individuals that are Medicaid or Medicare eligible. Finally, to assess connected care services' impact on clinical outcomes and the effects of universal service funding on the deployment of such care, the pilot program should impose tailored data collection and reporting requirements. Again, VTN applauds the Commission's attention to this issue and looks forward to continue working to shape the Connected Care Pilot Program.

Respectfully submitted,

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