

**Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, DC 20554**

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

COMMENTS OF AT&T

Cathy Carpino
Gary L. Phillips
David L. Lawson

AT&T Services, Inc.
1120 20th Street, N.W.
Suite 1000
Washington, D.C. 20036
(202) 457-3046 - telephone

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Its Attorneys

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I. INTRODUCTION

Since its founding more than 140 years ago, AT&T understood how connectivity changes and enhances lives. So too did Congress when it created the Federal Communications Commission in 1934 and declared that the agency’s mission should be to “make available, so far as possible, to all the people of the United States . . . a rapid, efficient, Nation-wide, and world-wide wire and radio communication service with adequate facilities at reasonable charges. . . .”¹ For much of both AT&T’s and the Commission’s histories, ubiquitous connectivity meant enabling all Americans to speak to one another by phone. Since the 1990s, however, ubiquitous connectivity has been all about the Internet. The Commission has been promoting universal access to broadband in earnest since its aptly named *USF/ICC Transformation Order*.² Through its Connect America Fund, Mobility Fund, and other high-cost programs, the Commission is making significant strides toward universal access to broadband.³ And that work continues.⁴

Not only has access to broadband enabled Americans to work and learn from home, it also is helping Americans remain healthy through telehealth services and applications. As the

¹ 47 U.S.C. § 151.

² *Connect America Fund et al.*, WC Docket No. 10-90 et al., Report and Order and Order and Further Notice of Proposed Rulemaking, 26 FCC Rcd 17663 (2011) (*USF/ICC Transformation Order*).

³ See, e.g., <https://docs.fcc.gov/public/attachments/DOC-335269A1.pdf> (announcing CAF Phase II awards to ten price cap carriers for almost \$9 billion over six years); <https://docs.fcc.gov/public/attachments/DOC-353840A1.pdf> (awarding over 100 CAF Phase II Auction winning bidders almost \$1.5 billion in funding over ten years); <https://docs.fcc.gov/public/attachments/DA-12-1566A1.pdf> (announcing Mobility Fund Phase I results).

⁴ See, e.g., *Connect America Fund, Universal Service Reform – Mobility Fund*, WC Docket No. 10-90, WT Docket No. 10-208, Report and Order and Further Notice of Proposed Rulemaking, 32 FCC Rcd 2152 (2017) (announcing a Mobility Fund Phase II Auction that will disburse up to \$4.53 billion over ten years); *The Uniendo a Puerto Rico Fund and the Connect USVI Fund et al.*, WC Docket No. 18-143, Order and Notice of Proposed Rulemaking, FCC 18-57 (rel. May 29, 2018) (establishing new high-cost funds for Puerto Rico and the United States Virgin Islands).

Commission rightly acknowledges in its *Telehealth NOI*, these technologies can improve patient health outcomes, increase patient satisfaction and dramatically reduce healthcare costs.⁵ As an innovator, AT&T recognized early on how the power of connectivity could be applied to digital health. As early as 2009, we were developing the software tools and networking platform that would allow patients to record their health measurements at home and securely transmit the information to their doctor's office for monitoring, follow-up, and remote consultation with providers.⁶ Since then, AT&T has worked with a broad range of healthcare innovators to provide the connectivity that supports, among other things, medication monitoring solutions,⁷ connected wheelchairs,⁸ and rugged telehealth backpacks that "beam" doctors into the most challenging disaster and emergency situations.⁹

To further seed innovation in the healthcare ecosystem, in 2016, AT&T partnered with the Texas Medical Center, the world's premier hospital and medical innovation community, to establish the AT&T Foundry for Connected Care. Our Foundry in Houston is dedicated solely to digital health innovations that can help caregivers and improve patients' quality of life. It features three main digital health test environments for start-ups, physicians, and others with ideas on connected healthcare innovation to develop new solutions: (1) Home (testing the elements related to home monitoring after a patient leaves the hospital); (2) Clinical (recreating

⁵ *Promoting Telehealth for Low-Income Consumers*, WC Docket No. 18-213, Notice of Inquiry, FCC 18-112 (rel. August 3, 2018) (*Telehealth NOI*).

⁶ <https://www.fastcompany.com/1139318/atts-telehealth-wirelessly-monitors-patients-health>.

⁷ https://policyforum.att.com/wp-content/uploads/2018/03/ATTInnovation_IoT_Medication_031518.pdf; <https://www.ajc.com/business/enabled-smart-pill-bottles-now-available/2JiHl5Cx8yHwiQryuuYTjP/>.

⁸ <https://permobilus.com/>.

⁹ https://about.att.com/story/connected_health_mwc.html; <http://swymed.com/dot-telemedicine-backpack/>.

the connected hospital environment); and (3) Nurse Station (helping to bridge patient care in the hospital and the home to give caregivers more visibility and remote access to meaningful patient data in real-time).

All of AT&T's Foundries, including the Foundry for Connected Care, focus on collaborating with start-ups, developers, and other innovative thinkers.¹⁰ The goal is to go from concept to commercialization faster than previously possible. Twelve-week, sprint development cycles are the norm. Among other start-ups that AT&T has partnered with in recent years are Permobil, which offers connected wheelchairs equipped with pressure sensors to keep users more comfortable, help prevent lumbar problems and combat bedsores, as well as monitor wheel pressure and battery levels;¹¹ Dictum Health, which offers Virtual Exam Room (VER) solutions;¹² Aira, which created smart glasses that give blind and visually impaired persons greater accessibility;¹³ and Softbox, with whom we recently trialed delivering temperature sensitive medicines safely to difficult to reach terrains via unmanned aerial vehicles.¹⁴ Connectivity is an essential component in all of these diverse game-changing and life-enhancing

¹⁰ AT&T's other Foundries are located in Atlanta (focusing on edge computing, advanced access, smart cities, and entertainment); Israel (dedicated to 5G, cybersecurity, entertainment, and software-defined networking); Mexico City (specializing in IoT, software development, and new technology trials for emerging markets); Palo Alto (focusing on edge computing, quantum networking, and machine learning); and Plano (specializing in IoT, manufacturing, retail, and data analytics). *See* <https://about.att.com/innovation/foundry>.

¹¹ *See, e.g.,* https://about.att.com/story/att_permobil_unveils_connected_wheelchair.html.

¹² *See, e.g.,* https://about.att.com/story/att_connectivity_powers_dictum_health.html; <http://www.dictumhealthsa.co.za/Insights/Default.aspx?artID=6>.

¹³ *See, e.g.,* https://about.att.com/innovationblog/aira_school.

¹⁴ *See, e.g.,* <https://about.att.com/innovationblog/softbox>.

products, and AT&T is committed to working with innovators across the healthcare ecosystem to improve patient care and health outcomes, no matter how remote the location.

In keeping with the spirit of a Notice of Inquiry, the Commission proposes a number of bold and creative ideas for a telehealth pilot program. Through its *Telehealth NOI*, the Commission will gather important information from a broad cross-section of telehealth stakeholders, but it is vital to recognize that this is the first step in a longer process. Equipped with more information about this vast, complex, and quickly evolving industry, the Commission can develop a more targeted Notice of Proposed Rulemaking (NPRM) proposing telehealth pilot program rules that fit within the confines of the Commission's statutory authority. There are larger forces at work causing rural hospitals and other medical facilities to shutter, which the Commission is powerless to change. But we agree with the Commission that there is a statutorily-based role for the Commission to alleviate some of the adverse consequences of these widespread closures on low-income and geographically isolated consumers through its proposed pilot program.

II. DISCUSSION

A. The Commission's Proposed Pilot Program Rules Should Be Consistent with Its Statutory Authority under Section 254 to Support "Services."

As it crafts its proposed pilot program rules, the Commission should remain mindful that section 254 of the Communications Act of 1934, as amended, imposes real limits on the Commission's use of universal service funds. Read together, sections 254(c) and (h) limit universal service support provided to eligible healthcare providers (HCPs) to telecommunications services and information services, both of which, by definition, include a transmission component. In addition to proposing discounts on broadband service, the

Telehealth NOI also seeks comment on whether the pilot program should provide funding for end-user devices and telehealth applications.¹⁵ As the Commission notes, its Healthcare Connect Fund provides discounts for “network equipment necessary to make broadband service functional in conjunction with providing support for the broadband service.”¹⁶ Providing discounts for necessary broadband network equipment is a logical outgrowth of the Commission’s statutory authority. However, providing discounts for end-user devices (*e.g.*, tablets, smartphones, remote patient monitoring (RPM) equipment) and telehealth apps is not.¹⁷

The Fifth Circuit upheld the Commission’s authority to designate certain information services and “internal connections” as “additional services” eligible for support under section 254(c)(3), when read in conjunction with subsection (h)(2)(A).¹⁸ But in doing so, the court made very clear that the Commission was operating near the bounds of its statutory authority. Although the court found that “the best reading of the statute [did] not authorize the agency’s actions,” the court ultimately concluded that the statute was “sufficiently ambiguous” with regard to the specific services at issue that the Commission’s interpretation was entitled to deference under *Chevron*.¹⁹ Providing discounted or free tablets, smartphones, RPM equipment, and mobile health applications for low-income consumers is certainly a worthy goal and may be within the prerogative of other federal, state, and/or local governmental entities. However, this

¹⁵ *Telehealth NOI* at ¶¶ 47-48.

¹⁶ *Id.* at ¶ 46 (quoting *Rural Health Care Mechanism*, Report and Order, 27 FCC Rcd 16678, ¶ 157 (2012)).

¹⁷ *Cf. id.* at ¶ 47.

¹⁸ *Texas Office of Public Utility Counsel v. FCC*, 183 F.3d 393, 442-43 (5th Cir. 1999).

¹⁹ *Id.*, 183 F.3d at 441.

Commission does not have authority to provide universal service support for such end-user devices and apps. Doing so even in a pilot program would stretch the meaning of “services” as used in section 254(c) beyond the breaking point.

B. The Commission Should Use the Proposed Pilot Program Funding to Reduce the Cost of Connectivity Included in Telehealth Services, Not to Deploy Broadband.

With a proposed budget of \$100 million to be awarded to multiple projects during a two- to three-year period, AT&T does not believe the telehealth pilot program has either the resources or the need to fund broadband deployment projects.²⁰ The Commission’s larger-budgeted and longer-term high-cost programs (*e.g.*, the Connect America Fund and Mobility Fund) are the appropriate universal service support mechanisms to fund the deployment of broadband service to unserved areas. Instead, as we discuss below, we recommend the Commission propose using this pilot program to provide support amounts to eligible HCPs to defray the cost of connectivity included in telehealth services, like RPM services, provided to eligible patients.²¹

The Commission cites lack of connectivity as a significant barrier to telehealth adoption.²² By the end of 2016, over 92 percent of the Nation’s population had access to both fixed broadband at speeds of at least 25 Mbps download/1 Mbps upload and mobile LTE at

²⁰ *Telehealth NOI* at ¶ 25 (seeking comment on using the pilot program to promote broadband deployment).

²¹ However the Commission defines patient eligibility (*e.g.*, relying on Medicaid eligibility), it is essential that it refrain from giving service providers any role in making that determination. As we discuss below, service providers generally have no interaction with patients using RPM services and other telehealth services. While we look forward to reviewing the record to provide additional thoughts, the Commission’s proposal to rely on Medicaid eligibility and income-based, cost-free health care through the Department of Veterans Affairs to identify eligible low-income patients seems reasonable. *See id.* at ¶ 39.

²² *Id.* at 24.

speeds of at least 5 Mbps download/1 Mbps upload,²³ and the Commission's high-cost programs are effectively targeting the remaining unserved areas. It is also noteworthy that the RPM solutions on which the Commission primarily focuses in its *Telehealth NOI* are increasingly running on the nation's mobile LTE networks, to which more than 99 percent of the U.S. population has access, according to this year's Broadband Deployment Report.²⁴ Affordability also is an impediment to broadband adoption by low-income consumers, but the Commission's Lifeline program, which distributes over a billion dollars a year, is specifically designed to tackle that issue. Rather than attempting to duplicate the Commission's already substantial efforts on broadband deployment and adoption, we suggest that the Commission design the pilot program to focus more specifically on telehealth and RPM technologies – and motivate their adoption by HCPs that serve rural and low-income populations.

C. Through the NPRM Process, the Commission Should Ensure It Obtains Ample Information about the Structure of the RPM Market, Existing Financial Support Available for RPM Solutions, and the Role of the Connectivity Provider in an RPM Solution.

Keeping in mind the Commission's long-running high-cost and Lifeline programs addressing broadband deployment and affordability, respectively, the Commission's telehealth NPRM should focus on what problems are hindering broader HCP use of telehealth and RPM solutions and which of these problems can be addressed, at least in part, by the pilot program. To answer such questions, the Commission will need, among other things, detailed information about how the RPM market is structured. For instance, in AT&T's experience, telehealth and

²³ See *Inquiry Concerning Deployment of Advanced Telecommunications Capability to All Americans in a Reasonable and Timely Fashion*, GN Docket No. 17-199, 2018 Broadband Deployment Report, 33 FCC Rcd 1660, Table 3a (2018).

²⁴ *Id.* at Table 2a.

RPM solutions often bring together inputs from a variety of different sources. To name just a few, software developers, cloud solutions and hosting providers, equipment manufacturers, and connectivity providers all may contribute to the typical RPM product on which the *Telehealth NOI* seems to focus.²⁵ As we noted above, only some of these inputs properly qualify for universal service support.

Beyond the structure of the solutions themselves is the complicated issue of who buys them and how they are delivered. In AT&T's experience, large, integrated healthcare systems like the Veterans Administration have been the earliest adopters of telehealth and RPM. They may have been the first to see the healthcare and cost-savings potential for these technologies and, more importantly, to have the strongest financial incentive to pursue them. But many other providers play important roles in the nation's healthcare system and may have been slower to adopt. Rural and community health centers, individual medical practices, not-for-profit clinics, smaller facilities and hospital systems could likely all benefit from the adoption incentive that the Commission seeks to create with this pilot program.

As the *Telehealth NOI* recognizes, another important part of the puzzle is what financial support already exists for the solutions that may qualify for universal service support and meet the needs of the target patient population. The Commission rightly aims to avoid duplicating support that already comes from other sources. Three primary payers already support telehealth to at least a limited degree – Medicare, Medicaid and private insurance. Each of them is a study in complexity and contradiction in its own right. Medicare has been slow to warm to telehealth

²⁵ We restrict our discussion of RPM solutions to those clinical Internet of Things (IoT) technologies that an HCP purchases for the benefit of its patients. These solutions will typically be regulated by the Food and Drug Administration. Excluded from these comments are the consumer-oriented, health-and-wellness applications that typically reside on an individual's smart phone. As discussed above, AT&T does not believe the Commission has the authority to provide universal service support for such individual, direct-to-consumer applications.

and RPM solutions. It has long been largely restricted to paying for telehealth services provided to patients in the most remote areas – and even then with significant limitations on the type and structure of services. However, more recently, a combination of legislation and regulatory action has improved the reimbursement environment for these solutions.²⁶

Medicaid reimbursement for telehealth and RPM solutions varies significantly from state to state,²⁷ so it will be important for the Commission to avoid duplicating that support for the particular projects selected under the pilot program. Finally, private insurers' approach to RPM also varies widely, with the most favorable payment policies typically adopted by large, integrated payer-providers that see the most direct financial benefit. All of this to say that the Commission faces a substantial challenge in designing the pilot program to effectively incent adoption of RPM technologies, while still avoiding support for solutions for which another payer is already providing reimbursement. A major component in ensuring against such duplication will be choosing the right entity to reimburse for supported services and to look to for program compliance. The HCP contracting for the RPM services is likely in the best position to know the reimbursement environment and effectively certify to the Commission that a particular telehealth technology is not already subject to reimbursement from a different payer.

²⁶ The Bipartisan Budget Act of 2018 significantly improved Medicare reimbursement for RPM and telehealth applications relating to dialysis and stroke treatment, and it lifted geographic limitations on reimbursement for certain categories of providers. *See* <https://www.healthcarelawtoday.com/2018/02/14/top-5-ways-telehealth-will-change-under-the-new-federal-funding-bill/>.

In late 2017, the Centers for Medicare and Medicaid Services announced that Medicare would begin reimbursing for 30 minutes per month of physician time spent on collection and review of remote monitoring data for chronic care patients. The agency has also proposed reimbursement for virtual check-ins with a patient's doctor by phone or video chat. *See* <https://www.urac.org/blog/cms-expands-reimbursement-remote-patient-monitoring>; <https://mhealthintelligence.com/news/cms-proposes-more-medicare-reimbursement-for-telehealth-rpm>.

²⁷ <http://www.cchpca.org/telehealth-medicaid-state-policy>.

The Commission will be able to more effectively design its telehealth pilot program if it has answers to questions like those noted above as well as, what relationship, if any, does the HCP have with the telehealth connectivity provider? In the clinical IoT category of services on which we focus our comments,²⁸ the RPM provider typically furnishes the HCP with a suite of equipment for patients' home use to monitor particular medical conditions. Included in this equipment is either a wireless tablet or some other device that facilitates wireline or wireless connectivity. The HCP then provides a set of this equipment to the individual patients it enrolls in its RPM program. In this widely prevailing model, a connectivity provider such as AT&T generally has no direct relationship with either the HCP or the patient. In our experience, the connectivity providers partner directly with RPM providers, which, in turn, combine the other inputs discussed above and offer telehealth services to HCPs. The HCP then offers the telehealth services, including the associated medical and connectivity equipment, to the HCP's individual patients. For these clinical IoT services, AT&T (the connectivity provider) contracts with and is paid by the RPM solution provider.

D. AT&T Recommends the Commission Model Several Key Pilot Program Rules on its E-rate Rules and Be Mindful of the Short Pilot Program Term When Establishing Administrative and Reporting Requirements.

Because the telehealth connectivity provider often has no direct relationship with the HCP or the patient, we recommend that the Commission *not* structure the pilot program like its existing Rural Health Care and Lifeline programs, which reimburse the service provider for having provided discounted service to the beneficiary (in this instance, an HCP or qualified low-income consumer). For a limited pilot program, we do not believe it makes sense to disrupt the RPM market's present structure and existing business models by requiring connectivity

²⁸ See *supra* n.25.

providers to contract directly with the HCP so the HCP may obtain discounted broadband service. Instead, we recommend the Commission model this pilot program after the E-rate program, with funding paid directly to the HCP, and telehealth connectivity provided by both eligible telecommunications carriers (ETCs) and non-ETCs (as well as non-facilities-based providers).²⁹ Eligible HCPs receiving direct pilot program funding to support the connectivity component of their telehealth solution might well be motivated to contract for RPM services where the cost had previously been too great of a deterrent.

Finally, we agree that two to three years is a reasonable period of time for a pilot program. But, given the short duration of the program, the Commission should try to minimize administrative costs of participating in this program and adopt streamlined administrative and reporting procedures. For example, requiring participating HCPs to file detailed reports on their patients' health outcomes ranging from hospital re-admissions to compliance with medication instructions as suggested in the *Telehealth NOI* seems unusually burdensome and intrusive.³⁰ The benefits of telehealth are well established and do not need to be reaffirmed through this pilot program. Requiring connectivity providers and/or HCPs to report on patients' telehealth vs. non-telehealth usage, also suggested in the *Telehealth NOI*, is similarly troubling and could be a deterrent to participation.³¹ Rather, the measure of the program's success should be the extent to which it helps to motivate adoption of RPM technologies to serve the healthcare needs of the target population of poor and rural patients and veterans.

²⁹ Cf. *Telehealth NOI* at ¶¶ 37-38.

³⁰ See, e.g., *id.* at ¶¶ 61-63.

³¹ *Id.* at ¶ 53.

III. CONCLUSION

The Commission's proposed Connected Care Pilot Program is another innovative step by the Commission to bring its universal service support mechanisms into the 21st Century. AT&T looks forward to working with the Commission and other stakeholders to make this pilot program a success.

Respectfully Submitted,

/s/ Cathy Carpino

Cathy Carpino

Gary L. Phillips

David L. Lawson

AT&T Services, Inc.

1120 20th Street NW

Suite 1000

Washington, D.C. 20036

(202) 457-3046 – phone

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