



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

In the Matter of

Promoting Telehealth for Low Income Consumers

WC Docket No. 18-213

COMMENTS TO NOTICE OF INQUIRY

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Opening Statement

Before proffering our comments on selected aspects of applying seed funding drawn from the Universal Service Fund for instituting pilot programs with the aim of providing viable models demonstrating affordable broadband for connected and remote health care delivery services to low-income home/community setting based patient-consumers and thereby achieving some targeted population health outcomes at reduced costs burdens; we hope the FCC

Commissioners will in this bold effort encompass the plight of millions of poor citizens that are both the uninsured/unserved-insured and are disproportionately dying *preventable* deaths while living in rural/urban hospital and doctor office *deserts* still ignored by our US health care system. For this population, preventable death is present in both urban and rural areas.

The Notice of Inquiry seeking specific comment is well-written and researched, and cites extensive remote health and connected care technology examples for provider models and demonstrations that are in active service use today without a dime of FCC money funneled through the Universal Service Fund to achieve the sustainable realization of lower cost, timely delivery and incredible provider access. The lure of another perceived “free money” pilot program supporting a beauty contest among telecom/hospital health provider applicants known historically to be poorly positioned and challenged to address the multitude of external and institutional- internal barriers surrounding transacting health care delivery services into the far more consumer-centric driven community-wide marketplace where building patient trust, transparency, comparative competitive initiatives across geographic, demographic, culturally sensitive populations may crowd out the opportunity for the FCC to attract more innovative and transformational applicants.

Just as reflected in the FCC National Broadband Study following the enactment of the Affordable Care Act, in AARP research, and the American Hospital Association’s statements following enactment of the ACA: “the US health care system is fractured and with 10,000 citizens becoming age 65 every day, most having reasons to distrust hospitals and their doctors; getting fragile elderly and multiple chronic health condition sufferers, patients with challenging physical, technology, economic and literacy and behavioral conditions to trust and embrace technology- driven home based medical care where they have the right to choose their health provider cannot be imposed by stranger hospitals and doctors”.

In this respect, there ought to be consumer-patient and medical care home options made available to what will become increasingly the home center for care treatment and health management since the shrinking base numbers of US hospitals can never realistically reach and support more than 200 million occupied US households. Annually, nearly \$900 billion dollars in private payout by caregivers and families just for medical care support of themselves or a family member in the US. Already we are seeing international and national non health care companies becoming new entrant health care investors seeking to disrupt and respond to the unmet needs of ALL the US patients outside the “brick and mortar” four walls of hospitals and doctor offices, and to support the hugely unmet provider access and affordability barriers for millions of low-income residents living in rural and urban neighborhoods without economic distinction. Most critical for success, these new entrants are willing to embrace the high hurdles to enrollment and signups by implementing

multiracial, multicultural, multilingual, multigender outreach solicitation and appreciating the cultural sensitivity in provider provisions. Partnering an ISP provider with a “brick and mortar” provider to solicit/serve low-income populations with the expectation of eventual self-sustainability without the Universal Service Fund after the pilot ends has been a well-read book. There are pilot program models where successful design at inception can result in sustainability and not another announcement of a closing and loss of continuing care services for those fragile patients are cut off.

We hope the FCC will consider encouraging pilot program partnerships including community expert experienced applicants that can more effectively deliver and equip and install HIPPA compliant medically prescribed connected care digital assessment devices, train patients and caregivers, and maintain capability for delivery of integrated primary care, behavioral health diagnosis/treatment and expand options for in-community stigma free and at home opiate treatment services. Additionally, this FCC initiative opens the door for sustainability of the delivery performance for those non institutionalized citizens that are at high risk as special populations in frequent contact with first responders, community wellness shelters and free clinics, quarantine and community wellness for infectious outbreaks, food banks, and need for pop up/temporary fixed sites FEMA/HSD health care support for fragile populations during community wide emergencies.

Further, the FCC Connected Care initiative can protect its use of Universal Service Funds by selecting pilot projects that can attract other dollars and participation of parties that have a vested interest in interoperability and entrepreneurial technology innovations to reduce obsolescence risks and the introductions of further technology that keeps driving down costs and patient acceptance. The Universal Service Fund initiative ought to be seen as a kick starter that stimulate pilots that isn’t just a way for existing applicants to further entrenched provider service models. As described in the Notice of Inquiry, billions of dollars for ACA demonstration projects were abandoned shortly after the supplied funds stopped. There are billions of nonprofit grant dollars and business collaborations that could put the FCC Connected Care initiative exactly where 47 U.S.C sec 254 is on solid ground as a stimulant.

With over 1.3 billion non-institutionalized ambulatory patient-doctor office visits annually, most all not coordinated, this FCC Connected Care initiative can spur and sustainably drive an entirely new community facing health care transformational and disruptive engine to take advantage of broadband connectivity integrated with intermittent and continuous PHI and bio sensory remote monitoring technologies that can save lives through timely intervention. For the first time the marketplace for support through palliative and hospice services can lower end of life cost burdens, and using unleashed 5G IOT medical and health related

monitoring and early alerts for onset of adverse warning for patient's vitals status can be implemented ubiquitously and affordably despite existence of health provider *deserts*.

Finally, the FCC Connected Care initiative could usher in new fields of Community Health workers, revamped licensing of independent out-of-silos telemedicine MedTechs, Midwives equipped to manage community caseloads, and thousands of licensed PAs, EMTs and wellness providers that have never been able to breakthrough low-income community barriers to provide health care delivery.

Last year, the American Hospital Association candidly admitted that MedPAC audits leading to fines and penalties reflect steady growth in high percentage post-discharge patient avoidable readmissions and increasing preventable deaths for mostly low-income and demographically fragile populations. This is a loss of billions annually despite its member hospitals already claiming it's providing the best technologies and professionals, and is as at a point that the AHA is urging the public to accept that millions dying in the post discharge care status is the standard for now. Scholarly journals report that more than half of US doctors, faced with shortages in its numbers, do not see a responsibility to their patient's wellness beyond the health/medical condition presented [knowing that there are many community factors and forces adversely impacting patient improvement].

National headlines recently described the universal failures of US maternal and infant care leading to preventable death and suffering. Patient's wonder if the best care is not being provided in the "bricks and mortar four walls", why shouldn't the patient-consumer contract for interventions that more creatively provide moms with pre and post-natal services and post discharge follow-up monitoring and management that is available to the wealthy. The FCC Connected Care initiative can level the playing field supporting greater competition and interventions right to the home/community setting that if left as it is concentrated in "bricks and mortar facilities" accounts for the USA ranking among the world's poorest in care providers of infants and mothers.

As the Mayo Clinic confirms, hundreds of millions in dollars annually spent for preventable deaths, reducing needless pain and loss of physical and cognitive losses, preventable disability and for rehabilitation following a heart attack could have been saved had home and community setting TeleStroke capability been available outside the hospital "bricks and mortar four walls". The low-income families and patients living in unserved hospital *deserts* and most all patients transported and admitted from underserved rural and urban safety net hospitals, need to know about and have the opportunity to take advantage of the FCC Connected Care capabilities that can save their life at the last mile.

SELECTED COMMENT ON NOTICE OF INQUIRY

1. **Support for Connected Care:** We strongly encourage this initiative
2. **FCC Legal Authority for Connected Care:** Is 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).
3. **FCC Analysis for Establishing and Structuring the Pilot:** I urge the pilots be broadly structured to support low-income Americans wherever than try to limit service to those that meet the income threshold but for some reason are residing outside the targeted geographic area. Otherwise you create the horrific result where the wealthy and healthy can afford the services anywhere, but the eligible low-income person will be disqualified because of an artificial geographic design.
4. **Goal of Pilot Program:** Broadband is the preferred connectivity to deploy telemedicine applications driving 2way video/audio exams connecting digital devices to capture vitals in EMRs, conduct tests of COPD, vision, cardio and multipoint video conferences with other providers and care management team members. During the exam on broadband multiple devices can be connected simultaneously reporting PHI and loading into EMRs and can include hearing heart sounds while seeing the other relevant PHI output in real time, and also sharing that data in encrypted real time to any remote PCP or caregiver connected. The costs incurred by the technology for use of the origination site is less than the \$30 charge paid by CMS on the approved CPT Code.
5. **We have found that minority low-income women with multiple chronic conditions are the fastest growing demographics that are eligible for living in SNFs, and that sector prefer to live in the community as aging in place independents for as long as possible. Use of broadband for remote wellness health status checks can extend this lower cost of care, eliminate unnecessary ER visits and admissions, but also support attention to the warning signs where acute intervention may be timely and at lower risk and cost. Further, use of direct telemedicine visits in SNFs and in senior housing communities using broadband similarly provide remote monitoring management at less costs than ER transport and costly observation hospital admission. Especially 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.**

6. We can expect positive health outcomes by focusing broadband telehealth services to immigrant and multicultural neighborhoods and sectors of the community by bring the technology right into homes and community social welfare and congregate sites through rounding, teaming with already paid community care workers and case management, schools and preschools where multilingual and multicultural care and communication services will be optimized.
7. Your Comment #21 is excellent and appropriate given the recent entrance of Amazon and CVS, Walgreens and Wal Mart into the direct to consumer care market. These are huge businesses with buying power to easily scale health care services to not only its millions of self-funded employees and members, but this validates the concerns and observation stated above in my opening statement that such a Connected Care pilot can open wider the gateway—floodgate even—to making self-sustaining that which if left to the possible ISP and hospital led approved applicants could easily become an USF subsidy pipe not easily turned off later. We have a pending innovative proposal for connected care involving a multi-site minority FQHC that with exactly the home infrastructure IT broadband contemplated in your pilot, can transform the capability for care delivery 24/7, connect the FQHC to direct school care tied to home health monitoring and in partnering with the safety net hospital and America's #1 medical center 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.
8. Of course, responding to your Comment inquiry #22, the FQHC, hospitals and PCP 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 patients under contract. This has tremendous potential for taxpayer savings and incentivizing disruption by new entrants to exploit this opportunity that cannot be easily matched by "brick and mortar" burdened providers increasingly unable to scale and compete on a comparable basis.
9. Your Comment inquiry #28 would justify a book, and mindful of the limitations on proffering information deemed a presentation and confidential, we are open to whatever way the FCC decides to structure the pilot program initiative after being mindful that the disruption taking place in the currently vertically integrated provided

marketplace while eyeing inroads by new consumer centric health providers taking claim to large self-funded employers that recognize they can deliver less costly health care access to its low-income patient employees by scaling Connected Care right from the home to its own health/medical providers. HHS already got the message, and is out there encouraging new entrants to collaborate to lower patient care costs by using technology, and by DOJ stepping up enforcement of Stark Law violations and massive false and other billing fraud on all patients that accounts for nearly \$1 Trillion dollars annually to taxpayers.

10. **Application Process and Types of Pilots:** Your Comment #31 is probably the best way to go to avoid political pressure and beauty contest decisions of winners. Also, it has to be clear by now that many past applicants have jumped into similar FCC initiatives to just maintain revenue and options as a reseller of IT bandwidth. This FCC Comment #31 hits the right tone by letting everybody applying know that this Connected Care initiative is not just providing IT services alone. Something on both ends has to be provided, installed, maintained, updated that also meets HIPPA and implicitly the ONC and even the FDA and FBI cybersecurity compliance warnings because of the risks to exposures to patient life safety.
11. **Priority to Particular Pilot Projects:** Providing health care to low-income Americans is no different than care required across the continuum of life phases for all patients, except poverty is exacerbated by the lack of timely and affordable provider access. It would seem unfair to limit pilot applicants to a pool of participating hospitals that have some sort of contracted or limited scope telephone based patient self-reporting health operation between the patient's home and the provider. Little wonder such needed low-income Americans who don't have affordable broadband access to timely monitoring and appropriate treatment intervention exists that this FCC initiative seeks to remedy. Surely, if hospitals have the pilots in place reaching this fragile population there would not be a need for the USF supported initiative. Every hospital would be doing it and low-income Americans would have the same access as the higher income population.
12. **Partner with ETC Applicant:** The design behind providing for connectivity between the home patient and a plethora of health providers and for attaching connected health devices to capture and manage PHI and support 2way interactive exam/consultation is more than installing broadband to the house. The loss of privacy, confidential patient health information and the reports of massive breach of privacy and fines imposed because health providers in existing "brick and mortar" and its mobile facilities, as well

have a record of HIPPA and related violations. Accordingly there ought to be a bright highway of encryption that protects the direct home health customer from non-health patient customers on both ends of the secured private PHI data.

Conclusion:

There are a number of FCC Comments in the Notice of Inquiry that may best be considered in light of the FCC Reply to Comment when submitting a pilot proposal. From reading the FCC Comments, we see the major issues pushing up against each have been considered and with the reply may provide the thrust of comparative competitive pilot applications. Thank you for inviting our Comments.

Telemedicine Centers USA

WTJ E-Signature

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