Southcentral Foundation

January 31, 2018

Chairman Ajit Pai
Commissioner Mignon Clyburn
Commissioner Michael O'Reilly
Federal Communications Commission
445 12th Street, S.W.
Washington, D.C. 20554

In the Matter of Promoting Telehealth in Rural America	)	WC Docket No. 17-310
	)	

Southcentral Foundation submits these comments in response to the FCC Notice of Proposed Rulemaking WC Docket NO. 17-310 published in the 83 Fed. Reg. 303 (January 3, 2018.)

I. INTRODUCTION

Southcentral Foundation (SCF) is an Alaska Native Tribal health organization designated by Cook Inlet Region, Inc, and eleven federally-recognized tribes – the Aleut Community of St. Paul, Igiugig Village, Village of Iliamna, Kokhanok Village, McGrath Native Village, Newhalen Village, Nikolai Village, Nondalton Village, Pedro Bay Village, Telida Village, and Takotna Village—to provide health care services to beneficiaries of the Indian Health Service pursuant to contract with the United States government under the Authority of the Indian Self-Determination and Education Assistance Act (ISDEAA).

SCF provides a variety of medical services including dental, optometry, behavioral health and substance abuse treatment to over 65,000 Alaska Native and American Indian people. This includes 13,000 residents in 55 rural Alaska villages. SCF covers an area exceeding 100,000 square miles and employs more than 2,200 people to administer and deliver these critical health care services.

Telemedicine and 21st century technology have allowed SCF to dramatically improve access to care, accelerate diagnosis and treatment, avoid unnecessary medivacs, and expand local treatment options. In the villages we serve, we rely on satellite transmission circuits to ensure our patients get the best care possible. Our clinical staff, the primary care doctors and specialty doctors can now see in real time what is being entered into the patients' medical records. This has greatly improved medication management, reduced hospital re-admittance, and increased patient safety.

The FCC has not provided an increase in the Rural Health Care Universal Service Support program since it was originated in 1997 with $400 million. This is true despite the drastic increase in the cost to deliver medical care, increased reliance on technology, and the

expansion of the types of providers eligible for this program. Consequently, in 2016, the demand for this program exceeded the FCC's $400 million allocation. In response to this, the FCC made the unilateral determination to prorate the amount of the qualifying funding requested after the initial filing window to 92.5% of the qualified amount. For SCF, that meant a shortfall of approximately $250,000. For some Tribal health care providers, the shortfall was in excess of $1 million.

Tribal health care providers do not charge our patients beyond what third-party insurers can pay, and most of our patients are covered not by private insurers but by government coverage, such as Medicaid, Medicare or SCHIPS. Thus, there is no way that we can increase any fees to cover the increased costs of telecommunication services.

After receiving comments about the disproportionate impact that the FCC's unilateral decision to pro-rate would have on rural Alaska health care providers (in the Notice's Preamble the FCC recognizes that almost 30% of all RHC program funding goes to Alaska. FCC CIRC 1712-02 ¶11 at 8.), the FCC made the determination to allow a one-time waiver for service providers to voluntarily reduce their rates. See FCC Order, *In the Matter of Rural Health Care Support Mechanism*, WC Docket No. 02-60 (June 30, 2017). This waiver applied to both the Telecom Program and the Healthcare Connect Fund Program. As a consequence, SCF's service provider voluntarily reduced their rate.

We appreciate the FCC's desire to help health care providers to provide the best possible health care that modern technology allows regardless of the remote or rural environment that care is provided in. In undertaking this, the FCC must ensure that its actions are consistent with existing federal law and comply with the federal trust responsibility to provide health care to Alaska Native and American Indian people. The most definitive statement of the responsibility can be found in the Indian Health Care Improvement Act, which states:

> Congress declares that it is the policy of this Nation, in fulfillment of its special trust responsibilities and legal obligations to Indians – (1) to ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy; (2) to raise the health status of Indians and urban Indians to at least the levels set forth in the goals contained within the Healthy People 2010 initiative or successor objectives; (3) to ensure maximum Indian participation in the direction of health care services so as to render the persons administering such services and the services themselves more responsive to the needs and desires of Indian communities; (4) to increase the proportion of all degrees in the health professions and allied and associated health professions awarded to Indians so that the proportion of Indian health professionals in each Service area is raised to at least the level of that of the general population; (5) to require that all actions under this chapter shall be carried out with active and

> meaningful consultation with Indian tribes and tribal organizations, and conference with urban Indian organizations, to implement this chapter and the national policy of Indian self-determination; (6) to ensure that the United States and Indian tribes work in a government-to-government relationship to ensure quality health care for all tribal members; and (7) to provide funding for programs and facilities operated by Indian tribes and tribal organizations in amounts that are not less than the amounts provided to programs and facilities operated directly by the Service.

25 U.S.C. §1602. Moreover, the Telecommunications Act of 1996 provides:

> A telecommunications carrier shall, upon receiving a bona fide request, provide telecommunications services which are necessary for the provision of health care services in a State, including instruction relating to such services, to any public or nonprofit health care provider that serves persons who reside in rural areas in that State at rates that are reasonably comparable to rates charged for similar services in urban areas in that State. A telecommunications carrier providing service under this paragraph *shall be entitled* to have an amount equal to the difference, if any, between the rates for services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in comparable rural areas in that State treated as a service obligation as a part of its obligation to participate in the mechanisms to preserve and advance universal service.

47 U.S.C.§ 254(h)(1)(A), *emphasis provided*. In its preamble, the FCC itself acknowledges that it is a legislative mandate to provide support for these services in remote and rural America. See, FCC CIRC 1712-02 ¶4 at 4.

Thus, while we appreciate the FCC's recent Order to ensure that the $400 million that it has allocated to the RHC will fund all of the qualifying funding requests for both the Telecom Program and the Healthcare Connect Fund Program, we submit that the law requires that all of the qualifying Telecom Program requests be fully funded regardless of the level of funding provided for in the RHC. *See*, 47 C.F.R. § 54.675(a). This mandate is analogous to the mandate that the Supreme Court recognized not once but twice when interpreting the Indian Self-Determination Education Assistance Act and the United States' obligation to pay contract support costs to tribal contractors under that Act. See, *Cherokee Nation v. Leavitt*, 543 U.S. 631 (2005); *Salazar v. Ramah Navajo*, 567 U.S. 2181 (2012). We think the FCC's Order should be amended to recognize the law as the mandate that Congress intended.

However, we support the proposals put forward in the Order to roll over unused funds and to allow providers to voluntarily forego payments. This will ensure that health care providers will not find themselves short with regard to broadband costs that are supported by the HCF.

II. RESPONSE TO SPECIFIC QUESTIONS RAISED IN THE NPRM

A. Increasing the RHC's $400 million annual cap and creating a prioritization mechanism in the event of demand exceeding the cap.

Again, the Telecom Program of the RHC is mandatory and should be treated as such. The FCC should utilize its best efforts to estimate this cost, but the law requires that FCC provide "an amount equal to the difference, if any, between the rates for services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in comparable rural areas in that State." 47 U.S.C.§ 254(h)(1)(A). Thus, as to the Telecom Program there should be no cap.

However, the Telecom Program is only one part of the RHC; the other is Healthcare Connect Fund (HCF). This Program should be indexed for inflation costs, as well as adjusted for the estimated number of providers who are expected to participate in the program. These are two primary factors that resulted in the oversubscription of the RHC in 2016. We also support reallocating any year's unspent funds to the next year and beyond.

As to prioritization, Southcentral Foundation submits that the law and the federal trust responsibility require that eligible rural Tribal health care providers must be prioritized first. The underlying spectrum and the fees that are being generated from those using this spectrum are federal resources, arguably resources that originally belonged to the original inhabitants of this land. Consequently, these fees must be prioritized first where the United States has the ultimate responsibility to provide health care. Tribal health care providers have stepped into the shoes of the United States through Indian Self-Determination and Education Assistance contracts and they are entitled to the same resources that the federal government would have to provide this care, including access to critical infrastructure necessary to operate a medical facility in the 21st century. Tribal health care providers are not like any other rural health care providers in that they are fulfilling the most sacred of the United States' obligation to Indian and Alaska Native people – providing health care. Thus, as the FCC considers a prioritization, at the top of that list must be rural Tribal health care providers.

B. Establishing a process for evaluating outlier funding requests and reforming the calculation of urban and rural rates in the Telecommunications Program to improve fairness and transparency.

SCF is concerned with the FCC's assertion that "A healthcare provider using the rural/urban differential pays only the urban rate, so it has little incentive to control the overall cost of the services." FCC-CIRC 1712-02, ¶12 at 9. As a healthcare provider in rural Alaska,

our choice of telecommunications providers is limited; in many cases we have no choice or ability to control the overall cost of the services. Certainly, telecommunications providers should be held accountable for their charges and we applaud the FCC's objective in doing so in the Proposed Rule. However, the preamble to the Proposed Rule seems to imply a measure of collusion between the telecommunications provider and health care provider that simply does not exist.

Furthermore, some of the cost controls that the FCC proposes are inconsistent with SCF's long history of providing state of the art health care to Alaska Natives. *Promoting Telehealth in Rural America*, FCC NRPM WC-Docket No. 17-310, 83 Fed. Reg. 308 ¶ 41 (January 3, 2018). Specifically, the FCC asks if support should be limited to "costs needed to provide the healthcare provider's minimum needs." The answer to this question is absolutely not. The United States has an obligation to provide Alaska Natives the best care available, and this requires much more than the bare minimum. Integrating 21st century technology into health care is intended to give health care providers the tools they need to greatly improve and enhance the care that their patients receive. The federal government cannot expect rural Tribal health care providers to meet the goals identified to improve the health status of Native people if we are only allowed the minimum of tools to do so. Essentially the FCC is asking if we can still do the best job possible with the minimum resources available. The answer is no.

The FCC proposes "benchmarks" and capping requests that exceed "benchmarks." Again, service in Alaska is unique in that our costs are what our costs are. We do not have the ability to control what telecommunications providers charge us, as competition is little to non-existent in most of rural Alaska. Thus, setting some arbitrary benchmark for requests that we will likely exceed is not reasonable or acceptable.

Again, we support the FCC's effort to control telecommunication provider's rates, both urban and rural, and would encourage this effort in the Proposed Rule. We support the suggestion that USAC establish a database containing all the rate information submitted each year.

With regard to Section 54.609(d) of the rules, SCF believes it is should be up to the health care provider to determine the service that is most cost effective for that provider. What may be more cost effective for one applicant may be different for another.

Furthermore, we submit that not all bandwidth, wide area networking, network services and service providers are equal. In our view, with a valid and transparent competitive bidding process the market should set itself in terms of price. SCF does not support capping the level of support for service.

Regarding the issue of cost-effectiveness, while in concept it would seem appropriate that the RHC should not subsidize more services than a healthcare provider needs to provide to deliver optimum patient care. We agree that this would amount to waste. However, in the delivery of health care, "cheaper" and "minimums" are not likely to improve the health status of

our patients. Technology changes almost daily, as do treatment modalities. Thus, we must have the flexibility to adapt to these changing environments, and we fear that being left to choose the cheapest services that provide only the minimum necessary will impede our ability to adapt and provide the best care available. Furthermore, forcing providers to choose the cheapest services will impact their overall healthcare delivery costs, as telemedicine lowers travel and other provider costs.

C. Improving Oversight of the RHC Program.

We support improving oversight. SCF has stringent procurement rules and believe all in the industry should exercise this level of care. We also support the proposal to harmonize invoice deadlines in both the Telecom and HCF programs. We support efforts to streamline the RHC form and application process. Many Tribal health care providers do not have the personnel necessary to secure compliance with the FCC's current application requirements. Making this process easier and accessible will reduce administrative costs for these health care providers.

SCF supports multiple filing windows. We believe this will provide the opportunity to request services for new clinics at various times of the year to ensure full coverage.

III. CONCLUSION

Broadband telemedicine is essential to providing health care in the vast expanse of rural Alaska. The Rural Health Care Program is an important component of the delivery of services to our patients.

We appreciate the opportunity to submit the comments and look forward to further tribal consultation on this matter.

Sincerely,

Katherine Gottlieb, MBA, DPS
President/CEO