IN THE MATTER OF PROMOTING TELEHEALTH IN RURAL AMERICA
(WC DOCKET NO. 17-30)

The communications requirements for U.S. health sector activity are accelerating and becoming more widespread. There is an increasing volume of broadband episodes for health care and many of them outside the confines of a hospital, clinic or even a healthcare provider's office. There are an increasing number of broadband endpoints for health care delivery, reaching out to the individual consumer, regardless of location. Consumers increasingly rely on the internet for access to an on-demand, 24/7 network of appropriate and available medical information and assistance from a wide variety of health professionals. Additionally, health information is increasingly digital and dependent on telecommunications and technology infrastructure that can collect, process, exchange, store and analyze information. Thus, the major needs of 21st century health care are for connections, capacity and reach among consumers and providers regarding health services and health data.

There is no doubt that telemedicine is increasingly mainstream – and becoming a tool used routinely for health care delivery. We estimate that at least 25 million Americans will benefit from the use of telemedicine in 2018. Its use is both growing in the number of clinical services and subspecialties delivered, number of providers engaged, and the number of patients served. Once confined to rural pilot projects demonstrating the technology, telemedicine today is in use in every major health system and increasingly used to expand services beyond providers' offices to the home, workplace and wherever it is needed.

Our first major recommendation addresses the need for a national broadband vision to guide public and private development, operation, investment, governance, and research. Since the Commission's National Broadband Plan of almost eight years ago, there have been significant changes and newer opportunities, such as 5G and the Internet of Things.

Certainly, there is a particular need regarding such a vision for health care delivery. A common national goal should be a nationwide telecommunications arrangement for health services and patient data that is open architecture, internet-based, and meets best practices for security and privacy. As with telephone service, ultimately any consumer should have access to any provider or other consumer. With the Commission's responsibilities and expertise, its leadership is needed to make this happen – and such vision is needed for its performance.

Our second major recommendation is that the Commission's Rural Health Care Program should be reoriented and restructured now to focus on A) the public return on investment, and B) moving toward a nationwide telecommunications arrangement for health services and patient data. In addition to a growing number of nationwide or multi-state health plans and employers, health professionals are increasingly serving nationwide or multi-state. A good

example is the Department of Defense, where providers need only one state license or the physicians' licensure compact now to be able to practice across 22 states.

Based on current RHC data, it is unlikely that there will be sufficient available funding for all support requests for the foreseeable future. There is a need for a better way to ration funding than first come, first serve. This is an appropriate time to reassess fully the needs and purposes for universal service support. In particular, we recommend the program focus on--

- Traffic - amount of use (rather than simple connections) and health services use (rather than general internet use).

- Networking - linking networks, such as creating a path for each RHC recipient to connect with every other recipient.

- Scale - promoting communications' economies of scale, such as larger numbers of participating providers for an application to reduce relative overhead costs

We have some additional recommendations on key aspects of the RHC program:

- ATA strongly supports increasing the cap on RHC support. We support adjusting it retroactively for FY 2017 and adjusting it annually for future years. We suggest that the primary reason that the cap has been reached is the growth in the use of telehealth, notably as third-party coverage has increased. For example, 34 states now require that health insurance policies offered in their states cover telehealth-provided services as they do in-person services.

- That the total amount applied has finally reached the cap is not due to inflation or other economic measures. Those measures alone fail to capture the nuances that need to be considered when adjusting the cap. We believe that it would be more appropriate to use some indexing measure relevant to the program's purposes, notably the difference between rural and non-rural broadband connection costs.

- We recommend that all unused funding from previous years be made available for the current funding year. Any unspent funds rolled over to the subsequent funding year should be generally available.

- That the current support mechanism is too unpredictable because the current program opportunities are not as limited as program funding. We suggest that the program requirements be scaled annually so that the maximum number of proper applications as administratively possible are fully funded.

- We recommend the funding process be much less prescriptive for applicants and much more competitive for awards. To be less prescriptive we recommend paperwork and reporting requirements be reduced to essentials and use of the broadest conceivable definition of rural for those aspects so restricted by statute. For example, using TRICARE's definition of rural would immediately double the eligible population.

- That the Commission fully fund the request that most meets the prioritization criteria and then the next highest ranked continuing in this manner until funds are fully obligated.

- We urge that level of rurality be a criterion for funding. In considering "rural" health services it is important to distinguish between rural patient locations, often referred to as originating sites, and provider locations, often referred to distant sites. The provider locations are often non-rural, especially for specialty services such as stroke diagnosis and opioid addiction counseling. The Commission's focus ought to be on the patient's location and allow RHC applicants flexibility for obtaining clinical services.

- Another criterion for funding should be how an eligible "health care provider" uses its broadband service to improve patient communications and other patient services, such as online patient portals and appointment scheduling.

- We suggest that the Commission redirect the Program away from construction toward other infrastructure costs, such as cost-effective end-point wireless connectivity.