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February 2, 2018

Federal Communications Commission

445 12th St., S.W.

Washington, D.C. 20554

**Re: FCC 17-164 (WC Docket No. 17-310): In the Matter of Promoting Telehealth in Rural America**

Dear Commission,

The National Rural Health Association (NRHA) is pleased to offer comments as stakeholders on how to help enable the adoption and accessibility of broadband-enabled health care solutions in rural and underserved areas of the country.

NRHA is a non-profit membership organization with more than 21,000 members nation-wide that provides leadership on rural health issues.  Our membership includes nearly every component of rural America’s health care infrastructure, from hospitals to individual patients.  We work to improve rural America’s health needs through government advocacy, communications, education and research.

Access to quality, affordable health care is essential for the 62 million Americans living in rural and remote communities. Rural Americans are more likely to be older, sicker and poorer then their urban counterparts. Specifically, they are more likely to suffer with a chronic disease that requires monitoring and follow up care, making convenient, local access to care necessary to ensuring patient compliance with the services that are necessary to reduce the overall cost of care and improve the patients’ outcomes and quality of life. Yet, many rural Americans live in areas with limited health care resources, restricting their available options for care, including primary care.

Rural Americans face a number of challenges when trying to access health care close to home. Seventy-seven percent of rural counties in the U.S. are Primary Care Health Professional Shortage Areas while nine percent have no physicians at all. Rural seniors are forced to travel significant distances for care, especially specialty services. In an emergency, rural American travel twice as far as their urban counterparts to receive care. As a result, while 20 percent of Americans live in rural areas, 60 percent of trauma deaths occur in rural America.

NRHA is pleased the commission understands some of the challenges of providing healthcare in rural America including shortages of health care providers, the impact of patient demographics, and consequences of challenging geography. While broadband is not a complete answer to the challenges of rural health care it is a component, a necessary supplement to a robust local workforce. Broadband access enables rural providers to transfer large EHR files, run telehealth services, monitor and develop assistive technologies, and to keep up with other emerging health technologies. Robust health IT systems are essential for narrowing the access gap in rural America by leveraging health care providers in rural communities as well as those that connect through telemedicine, interoperable electronic health records, and other health technologies that continue to develop.

Rural America’s health providers face significant barriers in access to a robust broadband network.  Lack of clear financial incentives and access to capital, coupled with long distances between sites, contributes to a system in which rural providers are in danger of being left behind in the digital divide.  In contrast, the benefits of broadband and a fully integrated health information technology system have the potential to address many of rural America’s current health care hurdles.

While many positive steps have been taken by the federal government to expand broadband access to rural America, there is still a great deal of work to be done. NRHA believes there are some hurdles within the current framework that can be eliminated in order to achieve our shared objectives.

We urge increased efforts to foster interagency collaborations, including use of common definitions from health care programs. While we applaud the use of the specialized expertise of the various federal agencies, we believe that this approach has led to silos of information and programs that compete rather than complement other programs with similar aims. While the RHC program is clearly a telecommunication program, it is also undeniably a health care program. And more specifically is designed to serve those providing health care, with a goal of facilitating the provision of rural health care. As such NRHA urges using health care terms as defined by Health and Human Services (HHS). Terms such as Rural Health Clinic (RHC) have specific definitions to health care providers and utilizing these shared definitions will build consistently with the policies established by the Health Resources and Services Agency (HRSA) or Center for Medicare and Medicaid Services (CMS). By using terminology as defied by the health care agencies the program is simplified for both the FCC, which would not need to adjudicate its own unique definition, but also for the health care entities wishing to participate in the program, who know their status under HRSA and CMS and will no longer need to delve into a whole new set of definitions and standards to determine their classification for eligibility.

The Rural Health Care program was included as a part of the Universal Services Fund (USF) to provide up to $400 million annually to rural health care providers for telecommunications and broadband services to provide telehealth and telemedicine. However, this rural health program has been underused since its inception. The low utilization of these funds is not because the funds are not desperately needed, but instead because the bureaucratic hurdles making the process unnecessarily burdensome and spreading the impression that the limited funds actually distributed are not worth the headaches of the application and administration.

Until recent changes in the program, use of the funds has been limited even though the need for these funds was evident and growing. The creations of the Rural Health Care Pilot Program has dramatically increased the demand for RHC funds. While NRHA supports this step by the FCC to increase utilization of the RHC funds, it is important to ensure the money is going to rural health care and not being spent for the sake of saying the money has been spent. Appropriate safeguards must be established to ensure that the money is helping to rural health care.

While NRHA is sensitive to the need to reduce fraud, waste, and abuse we believe this necessary and laudable goal can be achieved without increasing administrative complexity. NRHA is concerned that many providers face significant burdens in navigating the complicated application and administrative process associated with this program.  Further, difficulties in hiring and retaining staff with the skills necessary to navigate complex federal requirements coupled with the technological skills is difficult in rural America. Many rural health providers, though eligible, will not receive benefits simply due to the associated paperwork and filing requirements overtaxing their available staff. The fact that most successful grant applicants utilize consultants and professional grant writers demonstrates the excessive burden and keeps the money from many of the facilities and communities most in need of the funding.

Increased administrative complexity means that more providers turn to consultants with specific expertise in applying for Universal Services Fund (USF) programs. NRHA does not oppose the use of consultants however, NRHA supports disclosure requirements for the use of consultants including the terms of the contract with the health care entity. These terms may be kept confidential by the FCC with aggregate reporting of common contract terms including ranges of percentage contracts. This disclosure of contact terms will serve the dual purpose of keeping the FCC apprised of the portion of funds being diverted from the goals of the program, as well as allowing for better detection of administrative fees hidden within these contracts, and educating small rural health care providers of the customary and acceptable contract terms.

As the very name of the program implied, the RHC program is a health care program and not just a telecommunications program. As such, priority should be given to coalitions that are based around the provision of health care services as opposed to those that are purchasing consortia based around an entrepreneurial consultant instead of demonstrated health care connections.

The Pilot Program opened participation up to consortia of providers so long as the group included at least 50 percent rural participants. While NRHA understands the provision of telehealth services often involves the participation of urban providers such participation no longer regularly costs the urban provider. Historically dedicated connections between and rural and urban area may have justified use of RHC funds for the urban providers costs, however, currently these connections are achieved through a connection to the cloud that is already required for other purposes. Paying for urban providers costs that are not for the direct and sole benefit of the rural participant is not in line with the purpose of the RHC program. Urban participants are compensated for providing health care via telemedicine through reimbursement rates that pay for the providers time and expertise. Particularly in a time when the RHC program is exceeding its caps it is essential that these limited funds are utilized for the purpose of rural health care.

NRHA supports the inclusion of strong safeguards to ensure the funds are going to bolster rural health care. This is especially crucial since as of January 2017 Skilled Nursing Facilities (SNFs) are eligible for Rural Health Care Program funding, a welcome expansion of eligibility that expands the pool of truly rural recipients eligible for the funding however, with the program funding approaching the $400 million limit it is essential these important caregivers are able to access funds. While NRHA is not proposing a complete bar to urban participation, funding must be demonstrated to be purely for the benefit of the rural participants in the consortia.

NRHA believes the USAC is best positioned to determine the urban and rural rate standards. Health care providers are not well positioned, nor do they have the relevant expertise to determine these rates. While this activity is undeniably a resource intensive task, however, requiring the applicant to determine these rates results in a duplication of efforts since each applicant is required to determine this information. Furthermore, requiring this sort of intensive action on the part of the applicant, all but ensures that they cannot complete their application without outside assistance, creating a further barrier for the most disadvantaged applicants.

While NRHA supports the self-certification by applications, a clear and enforceable penalty structure is necessary. Health care entities presume the penalties are similar to those within the health care programs they participate through HHS. However, the penalties are far more draconian including imprisonment. While one would presume draconian penalties result in greater adherence this is broadly not found, especially where the improper self-certification is not egregious. Where an array of penalties are available, and are actually imposed, self-certification is deemed by parties as an more important check on the system and is more likely to result in careful consideration of their certifications, resulting in reduced fraud, waste and abuse while avoiding more extensive documentation requirements.

Furthermore, in light of the historic failure to provide the full program funds to rural providers, NRHA believes the $400 million annual cap should be raised. An action within FCC authority. This will account for the historic failure to distribute funds and ensure providers serving the most rural patients will have access to the funding that was intended to benefit the patients they serve. Furthermore, the program cap has not be increased to demonstrate the increases of inflation nor to reflect the changes in technology and its use in health care that drive the need for the support of the RHC program.

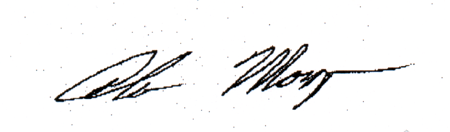
Additionally, while we understand the rhetorical point Figure 2 is attempting to make the fact that program changes, resulting in a change in applicant behavior, were made obscures the reality of the program. Furthermore, as the text of this order clearly states the average hides a great deal if variation and the extensive use in Alaska, where effective discount rates are highest, overshadow other rural providers that continue to receive much lower discounts. An understanding of the range and distribution of the discount rates would be a more accurate portrayal of the program.

Urban and rural rate standards were historically done by USAC but it became expensive (so in a cost cutting move this was delegated in 2001 to health care providers) – this has led to more of a role for consultants (who can search out the best rates for their clients – searching for best urban rate not best rural rate which ultimately means the FCC is paying the most) – health care providers are not equipt to do this.

Finally, administrative simplification must be robustly and effectively considered. While NRHA strongly supports reducing the number of forms from seven to four we believe this is only a first step. A thorough review of the forms should be undertaken to ensure they are simplified and clear with an eye towards ensuring they can be completed by those working for the rural health care entities the program is designed to serve without requiring special skills or expertise that cannot be easily and reasonably achieved by those in health care. While we strongly support efforts to reduce fraud, waste, and abuse the majority of health care practitioners seeking to participate are doing so in good faith. Placing barriers to entry for those good faith participants in order to dissuade unscrupulous actors is more likely to dissuade the good faith participants and undermine the goals of the program. The program must look to ensure not only that people are actually taking part in the program but in ensuring that program funds are going towards rural health care.

Thank you again for the chance to offer comments as a stakeholder.  We very much look forward to continuing our work together to ensure our mutual goal of improving quality of and access to care for all rural Americans.  If you would like additional information, please contact Diane Calmus, NRHA government affairs and policy manager, at [dcalmus@NRHArural.org](mailto:dcalmus@NRHArural.org), or 202-639-0550.

Sincerely,



Alan Morgan

Chief Executive Officer

National Rural Health Association