

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

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

COMMENTS OF THE AMERICAN HOSPITAL ASSOCIATION

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February 2, 2018

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On behalf of our nearly 5,000 member hospitals, health systems, and other health care organizations, and our clinician partners – including more than 270,000 affiliated physicians, 2 million nurses and other caregivers – and our 43,000 individual members, the American Hospital Association (“AHA”) appreciates the opportunity to respond to the Federal Communications Commission’s (“FCC” or “Commission”) Notice of Proposed Rulemaking (“NPRM”) in the above-captioned proceeding.¹ AHA conducts broad policy research in the areas of the cost of health care, telehealth, information technology, and other topics to assist our members and policymakers in understanding issues critical to America’s hospitals, health systems, and other related organizations.² With the growing importance of broadband-enabled health care solutions, the Commission’s focus on how it can improve the administration of its Rural Health Care (“RHC”) Program to ensure rural and underserved areas of the country have access to innovative telehealth and other advanced health care solutions is commendable.

¹ *In the Matter of Promoting Telehealth in Rural America*, Notice of Proposed Rulemaking and Order, WC Docket No. 17-310, 32 FCC Rcd 10631 (2017).

² See AHA, “Research and Trends,” <http://www.aha.org/research/index.shtml> (last visited Jan. 25, 2018).

I. INTRODUCTION

About 60 million Americans live in rural parts of the United States, and many of them have inadequate or reduced access to health care services. The number of rural hospitals has declined,³ and the number of rural medical professionals continues to be insufficient to meet demand.⁴ More than one-third of rural residents live in areas that the federal government has deemed to have insufficient medical health care professionals to meet the needs of their local population.⁵ As detailed in AHA's Task Force on Ensuring Access in Vulnerable Communities Report, lack of access makes it difficult for millions of rural Americans to get preventive health care services, leaving them and their communities susceptible to fragmented, episodic care and poorer health outcomes.⁶

Broadband-enabled telehealth solutions can help bridge the rural health care access gap, and, with the support of the RHC Program, the adoption of telehealth systems by health care providers has been on the rise.⁷ Access to reliable, affordable, and high-bandwidth broadband is

³ See NC Rural Health Research Program, 82 Rural Hospital Closures: Jan. 2010 – Present, <http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/> (last visited Jan. 24, 2018); Caitlin Ostroff & Ciara Bri'd Frisbie, "Millions of Americans Live Nowhere Near a Hospital, Jeopardizing Their Lives," CNN (Aug. 3, 2017), <http://www.cnn.com/2017/08/03/health/hospital-deserts/index.html> (last visited Jan. 24, 2018).

⁴ See Olga Khazan, "Why Are There So Few Doctors in Rural America," The Atlantic (Aug. 28, 2014), <https://www.theatlantic.com/health/archive/2014/08/why-wont-doctors-move-to-rural-america/379291/> (last visited Jan. 24, 2018).

⁵ National Advisory Committee on Rural Health and Human Services, 2009 Report to the Secretary: Rural Health and Human Services Issues at 5-6 (April 2009), <https://www.hrsa.gov/advisorycommittees/rural/2009secreport.pdf>. Primary care physicians, for example, are significantly less likely to work in rural counties than in urban counties. See J. Ripton & C. Winkler, "How Telemedicine is Transforming Treatment in Rural Communities," Becker's Health IT and CIO Review (April 8, 2016), <http://www.beckershospitalreview.com/healthcare-information-technology/how-telemedicine-is-transforming-treatment-in-rural-communities.html>.

⁶ AHA, Task Force on Ensuring Access in Vulnerable Communities at 7 (Nov. 29, 2016), <https://www.aha.org/system/files/content/16/ensuring-access-taskforce-report.pdf> ("AHA Vulnerable Communities Report").

⁷ See American Hospital Association (AHA) Connect2Health Comments, GN Docket No. 16-46, at 10 (filed May 23, 2017) (citing AHA analysis of the AHA Annual Survey – Information Technology Supplement for 2016) ("AHA C2H Comments").

essential to providing modern health care. Electronic health records, technology-based patient engagement strategies, health information sharing for coordinated care, and remote-monitoring technologies all require robust broadband connections. Such telehealth technologies can help in overcoming many of the obstacles to health care delivery that particularly confront isolated and rural communities. As the Commission has observed, “[a]t a time when rural Americans make up nearly 25 percent of the nation’s population, but only 10 percent of the nation’s physicians practice in rural America, the growth in the RHC Program translates into greater access to medical care across the country.”⁸

The RHC Program is thus essential to providing affordable broadband access to rural health care providers (“HCPs”) and supporting telehealth services that improve health outcomes in rural communities. However, the Program’s full potential is limited by a spending cap that is insufficient to meet the costs associated with delivering high-capacity broadband-enabled telehealth services. Further, modifications to Program administration are needed to streamline and greater incentivize program participation. Specifically, AHA recommends:

- Retroactively increasing the RHC Program cap for fiscal year (“FY”) 2017 and on a going forward basis at the rate of inflation, and making unused RHC funding from previous funding years available for subsequent funding years, consistent with the Commission’s E-rate program;
- Maintaining the current rule requiring proration if the cap is met in a given funding year;
- Continuing existing policies that encourage provider participation in health care consortia, including non-rural and for-profit hospitals;

⁸ *Wireline Competition Bureau Provides A Filing Window Period Schedule for Funding Requests under the Telecommunications Program and the Healthcare Connect Fund*, Public Notice, WC Docket No. 02-60, 31 FCC Rcd 9588, 9589 (2017), https://apps.fcc.gov/edocs_public/attachmatch/DA-16-979A1_Rcd.pdf (citing Southwest Rural Health Research Center School of Rural Public Health, The Texas A&M University System Health Science Center, 1 Rural Healthy People 2010: A Companion Document to Healthy People 2010 at 45-46, <https://sph.tamhsc.edu/srhrc/docs/rhp-2010-volume1.pdf>).

- Addressing concerns over program efficiency and potential outlier costs in the Telecom Program while ensuring that health care providers continue to receive support necessary to meet growing demands;
- Revising the definition of “rural” to be more inclusive; and
- Taking steps to ensure program integrity without adding unnecessary burdens to program participants.

Ensuring that rural communities can take full advantage of the benefits of telehealth solutions requires broadband at both ends of the connection – at the rural health care provider as well as within the home of the remote patient. The FCC plays a critical role in making that connectivity possible at each end of the equation. AHA is, therefore, pleased to offer these comments on how to best provide sufficient connectivity to HCPs via the RHC Program. We also reiterate the importance of the Commission’s efforts to provide broadband connectivity to rural communities via the Connect America Fund because, unfortunately, the rural communities who would most benefit from the connectivity necessary for telehealth also have the least access to quality broadband services. According to the most recent FCC data, while 10 percent of Americans lack access to high-speed broadband, the number skyrockets to 39 percent in rural areas and 41 percent on Tribal lands.⁹

AHA appreciates the Commission’s focus on closing the digital divide in rural America and its commitment to ensuring robust broadband connectivity for rural health care providers. By making targeted changes to the RHC Program, the Commission can maximize program participation, further expand broadband connectivity, and ultimately, improve health outcomes for rural Americans.

⁹ *Inquiry Concerning the Deployment of Advanced Telecommunications Capability to All Americans in a Reasonable and Timely Fashion*, Report, GN Docket No. 15-191, 31 FCC Rcd 699, 701 ¶ 4 (2016), https://apps.fcc.gov/edocs_public/attachmatch/FCC-16-6A1_Rcd.pdf (“2016 Broadband Progress Report”).

II. BROADBAND-ENABLED TELEHEALTH SERVICES IMPROVE HEALTH OUTCOMES FOR UNDERSERVED RURAL AREAS.

It is increasingly vital for health care providers to have reliable and robust broadband connections to manage daily operations and critical telehealth applications. Telehealth connects patients to vital health care services through videoconferencing, remote monitoring, electronic consults, and wireless communications. Electronic health records enable efficient exchange of patient and treatment information by allowing providers to access digital copies of patients' information, improving the continuity of care and reducing redundancies in treatment.¹⁰ Remote patient monitoring uses electronic communication to collect and transmit personal and medical data to remote health care providers, allowing providers to monitor a patient's health in real time after the patient has left the health care facility. New and innovative mobile health applications enable better patient-provider communications, encourage better patient self-management and health literacy, and promote positive changes in health and lifestyle.¹¹ Telemedicine and mHealth are rapidly emerging as cost-effective solutions to overcoming many of the obstacles to health care delivery faced in isolated communities. As AHA has previously observed:

“Video consultation and remote monitoring applications remove geography and time as barriers to care, enabling instant contact with health care professionals and allowing patients to receive hospital services at home. Tele-emergency specialty consults improve outcomes and reduce need for transfers, while telehealth physician visits reduce admissions from nursing homes, ameliorating the economic challenges faced by rural hospitals.”¹²

¹⁰ Sixty-five percent of hospitals have implemented telehealth and the Office of the National Coordinator for Health IT reports that nearly five out of every six hospitals have adopted a basic electronic health records system. See AHA C2H Comments at 10.

¹¹ Frequently Asked Questions, HealthIT, <https://www.healthit.gov/providers-professionals/frequently-asked-questions/486#id155> (last accessed Jan. 25, 2018).

¹² AHA C2H Comments at 8.

The RHC Program must therefore be designed to ensure that all Americans can benefit from a broadband-connected health care system, regardless of where they live.

III. THE RURAL HEALTH CARE PROGRAM MUST BE UPDATED TO KEEP PACE WITH THE GROWING CONNECTIVITY NEEDS OF HEALTH CARE PROVIDERS.

A. The RHC Program Funding Cap Should Be Significantly Increased To Keep Pace With Growing Connectivity Demand.

Just as the FCC has expanded spending in the high-cost universal service program and the E-rate program in recent years, the RHC Program funding cap must also be increased to support the growing demand for broadband at rural health care providers. Of the four universal service programs administered by the FCC, the RHC Program is by far the smallest. In the most recent Universal Service Monitoring Report, RHC Program disbursements accounted for less than five percent of total spending.¹³

For the reasons described above, funding for broadband-enabled health care is needed today more than ever, and the \$400 million cap established 20 years ago is no longer sufficient to meet burgeoning demand. Therefore, consistent with the E-Rate Program,¹⁴ the Commission should, at a minimum, annually adjust the RHC Program cap for inflation using the Gross Domestic Product Chain-type Price Index (“GDP-CPI”).¹⁵ The Commission should retroactively increase the cap for FY 2017 based on an inflation-adjusted “catch up” and use that cap as the

¹³ Federal-State Joint Board on Universal Service, Universal Service Monitoring Report (2016), https://apps.fcc.gov/edocs_public/attachmatch/DOC-343025A1.pdf.

¹⁴ See *Schools and Libraries Universal Service Support Mechanism, A National Broadband Plan for our Future*, Order, CC Docket No. 02-6, GN Docket No. 09-51, 25 FCC Rcd 18762, 18780-83, ¶¶ 35-40 (2010).

¹⁵ See 47 C.F.R. § 54.507(a)(1) (“In funding year 2016 and subsequent funding years, the \$3.9 billion funding cap on federal universal service support for schools and libraries shall be automatically increased annually to take into account increases in the rate of inflation”). The E-rate Program uses the Gross Domestic Product Chain-type Price Index (GDP-CPI). See 47 C.F.R. § 54.507(a)(2); National Income and Product Accounts Table, Bureau of Economic Analysis, tbl. 1.1.4, available at <https://www.bea.gov/iTable/iTable.cfm?reqid=19&step=2#reqid=19&step=2&isuri=1&1921=survey>, maintained by the Bureau of Economic Analysis of the Department of Commerce.

basis for funding going forward. As the Commission observed in the NPRM, if it had adjusted the \$400 million cap annually for inflation since 1997 based on the GDP-CPI, the RHC Program cap would have been approximately \$571 million for FY 2017.¹⁶

While adjusting for inflation is consistent with the E-rate program – a similarly structured program with the same basic objectives for ensuring broadband connectivity in schools and libraries – the Commission also should undertake a detailed assessment of the future demand for broadband-enabled health care services to more accurately set a program cap based on projected demand necessary to meet the needs of rural health care providers and their patients. Doing so would be consistent with the Commission’s effort to modernize the E-rate program in 2014. At that time, after a rigorous data analysis, it set the E-rate cap at a level that exceeded an inflation-based cap adjustment based on a determination of what would be necessary to connect all schools and libraries to broadband at speeds necessary to meet the needs of schools and students.¹⁷

Finally, and also consistent with the E-rate program, in addition to raising the Program cap and adjusting it to reflect inflation, all unused RHC funding from previous funding years should be made available for subsequent funding years.¹⁸

¹⁶ NPRM at ¶ 16.

¹⁷ *Modernizing the E-rate Program for Schools and Libraries*, Notice of Proposed Rulemaking & Order, WC Docket No. 13-184, 29 FCC Rcd 8870, ¶¶ 22-54 (2014) https://apps.fcc.gov/edocs_public/attachmatch/FCC-14-99A1_Rcd.pdf.

¹⁸ The E-rate Program currently uses a mechanism for unused funds that ensures funds committed to an E-rate participant and collected from contributors are used in future years to reduce E-rate program demand. *See* 47 C.F.R. § 54.507(a)(5) (“All funds collected that are unused shall be carried forward into subsequent funding years for use in the schools and libraries support mechanism in accordance with the public interest and notwithstanding the annual cap.”).

1. REMOTE PATIENT MONITORING SHOULD BE INCLUDED AS AN ELIGIBLE EXPENSE.

As the Commission evaluates the proper spending level for the RHC Program, it should strongly consider including remote patient monitoring as an eligible program expense.¹⁹ Remote patient monitoring involves the collection and transmission of a patient's personal health and medical data via electronic communication technologies to a health care provider at a different location, allowing the provider to track a patient's data even after the patient has been released to his or her home or another care facility. Remote patient monitoring allows providers to better manage care for patients with chronic conditions by increasing provider oversight to ensure compliance with treatment plans, pre-empting acute episodes and, for recently-discharged patients, reducing the likelihood of disruption and unnecessary readmissions.

Given the improved health care outcomes and lower costs associated with remote patient monitoring, it should be included as an eligible expense.

2. THE COMMISSION SHOULD TARGET ADDITIONAL SUPPORT FOR TRIBAL HEALTH CARE PROVIDERS.

Over five million individuals self-identify as American Indian or Alaska Native, representing two percent of the total U.S. population, who are served by some 612 Indian Health Service facilities located mostly on or near reservations.²⁰ The Indian Health Service is drastically underfunded: compared to a national average of \$7,717 per person in health care spending, Indian Health Service spending for patient health services was a mere \$2,849 a person.²¹ As a result, American Indians and Alaska Natives face persistent disparities in health

¹⁹ AHA C2H Comments at 17.

²⁰ Misha Friedman, "For Native Americans, Health Care Is A Long, Hard Road Away," NPR (April 13, 2016), <https://www.npr.org/2016/04/13/473264076/for-native-americans-health-care-is-a-long-hard-road-away/>.

²¹ NCAI Fiscal Year 2016 Budget Request at 56 (2015), http://www.ncai.org/policy-issues/tribal-governance/budget-and-appropriations/07_FY2016_Health_NCAI_Budget.pdf.

and health care, including high-uninsured rates, significant barriers to needed care, and poor health status. For example, among nonelderly adults, American Indians and Alaska Natives are significantly more likely than the overall population to report being in fair or poor health, being overweight or obese, having diabetes or cardiovascular disease, and experiencing frequent mental distress.²² American Indian and Alaska Native children and adolescents also are at higher risk for health problems than their peers.

The rural and remote nature of Tribal lands make telehealth services particularly powerful solutions for the vulnerable populations in those areas. Because the Indian Health Service is overextended and underfunded, the burden that Tribal lands place on adjacent health care providers is significant. Any additional support that can be provided to ensure the benefits of modern health care services reach Tribal populations should be provided and accounted for in the analysis of needed funding discussed above.²³

3. THE COMMISSION SHOULD MAINTAIN ITS PRACTICE OF EQUALLY PRORATING REDUCTIONS FOR ALL APPLICANTS WHERE QUALIFYING FUNDING REQUESTS EXCEED THE CAP.

If the cap is reached in a given year, the Commission should maintain its existing administratively simple method of equally prorating reductions for all applications. At the present time, overly complex alternatives for prioritizing funding proposed in the NPRM, while well-intentioned, should not be adopted. However, given the challenges faced in some communities that face chronic and severe health care provider shortages, if doing so can be done in a predictable and administratively simple manner, the Commission should consider whether it

²² Samantha Artiga, Rachel Arguello & Philethea Duckett, “Health Coverage and Care for American Indians and Alaska Natives,” Kaiser Family Foundation (Oct. 7, 2013), <https://www.kff.org/report-section/health-coverage-and-care-for-american-indians-and-alaska-natives-issue-brief/>.

²³ NPRM at ¶ 40.

could effectively utilize health professional shortage area (“HPSA”) designations from the Health Resources and Services Administration (“HRSA”) to prioritize RHC funding. HPSAs for primary care face recruitment and retention issues and have less than one physician for every 3,500 residents.²⁴ Nearly 20 percent of Americans live in such areas.²⁵ The Commission could consider permitting RHC Program applicants to self-report where the HCP is located in an area that has been designated a HPSA for three or more consecutive years and provide priority for such applications to ensure that qualifying HCPs do not receive cuts to their RHC funding after the program cap is reached. The Commission could consult with HRSA to develop an appropriate metric of areas with chronic shortages of health professionals. Further, because the benefits of telehealth are particularly impactful in such areas, the Commission also should consider increasing the discount level from 65 percent to 85 percent in such areas during the application process. Such proposals are worthy of further consideration if sufficient and accurate data is available and it can be administered in an administratively simple manner.

B. The Commission Should Incentivize, Not Weaken, Non-Rural Hospital Consortia Participation in the Healthcare Connect Fund.

Many participants in the Healthcare Connect Fund (“HCF”) are part of health care provider consortia that facilitate the process of program participation and contracting for broadband services. These consortia serve a valuable role; as the FCC has observed, consortia connect rural members with “specialists who are often located in urban areas” and facilitate rural adoption of “communications-based trends in health care delivery, such as the move towards electronic health records.”²⁶ The Commission intended to both promote the use of broadband

²⁴ AHA Vulnerable Communities Report at 7.

²⁵ *Id.*

²⁶ NPRM at ¶ 7.

services and facilitate the formation of health care provider consortia under the HCF Program, and the current rules have indeed been successful in encouraging consortia participation in the HCF.

Despite the FCC's embrace of health care provider consortia, the Commission's proposal to increase the percentage of rural entities in a consortium beyond a simple majority will result in weaker and potentially fewer consortia.²⁷ The policy objective for this modification is unclear; such a rule will not incentivize greater rural provider participation, but it will likely have the effect of disincentivizing the consortia participation of non-rural health care providers that deliver institutional knowledge, specialization, and expertise to underserved rural communities. Absent their participation, the effect will be fewer rural HCPs electing to participate in the program, not more. There is no evidence that the current rule is problematic, and it is unclear what benefits will accrue to rural HCPs or patients by increasing the percentage of rural providers required to participate in a consortium.

For the same reasons, it remains critical that for-profit hospitals remain eligible to participate in the HCF consortia, even if they cannot receive support from the RHC Program due to statutory constraints²⁸ or pay the share of an eligible HCP's contribution required to participate in the HCF.²⁹ In the *Healthcare Connect Fund Order*, the Commission appropriately acknowledged that "there are a wide variety of contexts in which it may be more cost-effective for eligible HCPs to share costs with ineligible entities" (i.e., for-profit hospitals).³⁰ Therefore, the Commission made clear that nothing in the FCC's rules prevents a for-profit HCP from

²⁷ See *id.* at ¶ 37.

²⁸ 47 U.S.C. § 254(h)(1)(A).

²⁹ *Rural Healthcare Support Mechanism*, Report and Order, WC Docket No. 02-60, 27 FCC Rcd 16678, 16725 ¶ 102 (2012) (*Healthcare Connect Fund Order*).

³⁰ *Id.* at ¶ 180.

participating in networks that receive HCF support, as long as the for-profit HCP pays its fair share of a consortium's costs.³¹ This is critical because there are currently fewer than 2,000 rural community hospitals serving some 60 million Americans, and 11 percent of rural hospitals are for-profit entities.³²

Finally, requiring demonstration of a direct health care-service relationship between an HCF consortium's non-rural and rural health care providers that receive program support would be burdensome and likewise impose an undue burden on program participants.³³ Implementing and enforcing reporting of a direct health care-service relationship would be difficult to administer, and any potential benefits would be far outweighed by the burdens imposed on applicants. Instead of introducing new administrative hurdles for potential consortia participants, the Commission should improve the processing of consortia applications and various HCF forms and streamline the treatment of individual health care sites.³⁴

C. In Improving Program Efficiency, The Commission Must Ensure That Health Care Providers Continue To Receive Support Necessary Under The Telecom Program To Meet Their Growing Demands.

AHA supports the Commission's objective of ensuring that health care providers have the ability and incentives to efficiently select services that meet their connectivity demands at affordable rates. While the Commission should take steps to identify any unjustified increases in pricing that drive up program costs, the Commission's policy response cannot be to increase the out-of-pocket expenses for health care providers. Many factors play into the demands for RHC

³¹ *Id.* at ¶¶ 102, 179.

³² AHA Vulnerable Communities Report at 5.

³³ NPRM at ¶ 39.

³⁴ *See id.* at ¶ 98.

Program funding – pricing, the number of providers receiving funds, and the level of connectivity required. The assessment into increases into program spending must account for all factors.

While attempting to identify outlier funding requests to apply a heightened review of such requests may make sense on the surface, the Commission should proceed cautiously before establishing benchmarks and using them to automatically reduce the amount of support provided to certain HCPs. At most, the use of benchmarks should be used to apply an enhanced review process to such applications to ensure applicants have justified their funding requests. The service costs of some applicants, as the Commission has correctly recognized, are “legitimately high due to their unique geography and topography,” and are also due to a variety of other demographic, cultural, and practical factors, including pricing, the number of providers receiving funds, and the level of connectivity required.³⁵ Thus, while conceptually, there may be some value in identifying outlier applications whose costs are well above similarly situated HCPs to determine program outliers, if the Commission elects to pursue this path, it is critical that the methodology used to compare applicants and to set benchmarks be carefully considered.

The Commission’s track record in using benchmarks to reduce support levels for outlier applicants in other settings is, at best, mixed. For example, in the *USF/ICC Transformation Order*, the Commission adopted a benchmarking rule in the high-cost program designed to create incentives for more efficient investment so that carriers with higher expenditures than their similarly situated peers would moderate their expenditures, thus freeing up more funding for more efficient spenders.³⁶ The rule was subsequently eliminated, however, because it did not

³⁵ *Id.*

³⁶ See *Connect America Fund et al.*, Order & FNPRM, WT Docket No. 10-208, WC Docket Nos. 10-90, 14-58 and 07-135, CC Docket No. 01-92, 29 FCC Rcd 7051, ¶ 127 (2014).

work as intended.³⁷ While not completely analogous to the current proposals, the unintended consequences of reliance on a benching mark rule in the high-cost program should serve as a cautionary tale for the Commission before it undertakes a similar course of action in the RHC Program.

AHA supports the Commission's objective of ensuring that health care providers have the ability to select services that meet their connectivity demands at affordable rates. The Commission's focus on improved efficiency is laudable, but any actions the Commission takes must ensure that health care providers – even those receiving particularly high levels of support – continue to receive support for necessary telecommunications services under the Telecom Program.

D. The RHC Program Definition Of “Rural” Should Be Revised To Be More Inclusive.

As AHA has previously suggested,³⁸ the Commission should reconsider the definition it uses to determine whether health care providers are “rural” and, therefore, eligible for support.³⁹ The definition of rural used by the FCC is quite restrictive: a “rural area” is limited to an area that is entirely outside of a Core-Based Statistical Area (CBSA); is within a CBSA that does not have any Urban Area with a population of 25,000 or greater; or is in a CBSA that contains an Urban Area with a population of 25,000 or greater but is within a specific census tract that itself does not contain any part of a Place or Urban Area with a population of greater than 25,000. As a result of the 2010 census and the most recent nationwide CBSA designations, some areas that

³⁷ *Id.* at ¶ 131.

³⁸ AHA C2H Comments at 17-18.

³⁹ *See* NPRM at ¶ 30.

were previously considered rural are now deemed non-rural, irrespective of whether the affected populations have gained better access to health resources.

Other federal agencies, such as HRSA's Office of Rural Health Policy, have adopted alternative definitions of rural that may be more inclusive and equitable. While we recognize the need for the FCC to develop specific rules to define what is rural, we recommend that the Commission evaluate how restrictive and equitable the current definition is, and whether an alternative approach would be more inclusive, equitable, and consistent with program objectives. The goal of the program should be to support all health care providers that provide essential health care services to persons who reside in rural areas, notwithstanding their status according to the census.

E. Administration Of The RHC Program Must Be Streamlined.

AHA's members cite administrative burdens among the highest barriers to RHC Program participation. It is important that the Commission ensure the integrity of the program, but, in doing so, the Commission must not impose unnecessarily onerous administrative burdens.⁴⁰ A program that is too administratively burdensome will discourage health care providers from participating.

The Commission should streamline and upgrade the RHC Program for those who participate so that the available funds can be fully deployed in support of a broadband-connected

⁴⁰ Chairman Pai has frequently opined on the need to reduce regulatory burdens for universal service fund program participants. See, e.g., Statement of Ajit Pai at 5, Commissioner, Federal Communications Commission, Subcommittee on Financial Services and General Government, Senate Committee on Appropriations, "FY2015 Funding Request of the Federal Communications Commission" (Mar. 27, 2014), <https://www.appropriations.senate.gov/imo/media/doc/hearings/Pai%20Senate%20Testimony%20March%202014.pdf> (describing the E-Rate application process as "arcane" and "opaque" and recommending "cutting the red tape so that the initial application is just one page and there's only one other form needed before funds are disbursed"); Press Release, Statement of Ajit Pai: Announcing His Plan to Support Broadband Deployment in Rural America (June 29, 2015), https://apps.fcc.gov/edocs_public/attachmatch/DOC-334153A1.pdf (proposing revisions to streamline provider requirements under the high-cost program).

rural health care system. AHA supports the NPRM proposal to harmonize rules and forms between the Telecom program and the HCF. For example, unlike the HCF Program, the Telecom Program currently lacks a deadline for service providers to complete and submit their online invoices to the Universal Service Administrative Company (USAC). As the NPRM observes, “the HCF Program invoicing deadline has resulted in more efficient administration of the HCF Program’s disbursement process, as well as faster funding timetables. It also provides specific guidance to applicants and service providers when submitting applications for universal service support.”⁴¹ Establishing the same invoicing deadline for the Telecom Program as the deadline applicable to the HCF Program would ensure that those efficiencies inure to both programs.

Further, the HCF and Telecom programs each have their own online forms to collect information, leading to a total of seven FCC forms, and the FCC has observed that “the use of multiple online forms for the RHC Program can cause confusion on the part of applicants and reduces the administrative efficiency of the application process.”⁴² AHA agrees that the FCC should condense the HCF and Telecom Program application processes into fewer forms.

IV. CONCLUSION

AHA greatly appreciates the Commission’s commitment to meeting the broadband connectivity needs of rural health care providers and thereby improving the lives of rural Americans. The forgoing proposed program changes will encourage more provider participation, connect more rural communities with advanced telehealth solutions, and improve health care outcomes, while ensuring that Commission retains the flexibility it needs to ensure program

⁴¹ NPRM at ¶¶ 94-95.

⁴² *Id.* at ¶ 96.

integrity. If you have any questions or need further information, please do not hesitate to contact me or Chantal Worzala, AHA's vice president of health information and policy operations, at cworzala@aha.org.

Respectfully submitted,

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February 2, 2018