Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, DC 20554

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

JOINT COMMENTS OF FRANCISCAN HEALTH ALLIANCE AND PARKVIEW HEALTH SYSTEM

These joint comments ("Comments") have been prepared on behalf of Franciscan Alliance Inc.[1] and Parkview Health System, Inc.[2] (collectively, the "Commenters") in response to the Federal Communications Commission's ("FCC") December 14, 2017 Notice of Proposed Rulemaking and Order[3] ("NPRM") regarding the Rural Health Care Program ("RHC Program").

INTRODUCTION

As regional health systems serving the needs of rural patient populations, and return participants in the RHC Program, the Commenters appreciate this opportunity to provide some thoughts on ways the FCC may be able to improve the RHC Program to better suit the current realities facing healthcare providers ("HCPs"), while at the same time ensuring that any fraud, abuse and waste in the RHC Program is addressed. In the first section of these Comments, the Commenters provide an overview of their respective operations and participation in the RHC Program, a brief description of the current state of the healthcare market and technologies, as well as an overview of changes in HCP network design and security. After providing this background

[1] *See generally* FRANCISCAN HEALTH, https://www.franciscanhealth.org/about-us (last visited Feb. 2, 2018).

[2] *See generally* PARKVIEW HEALTH, http://www.parkview.com (last visited Feb. 2, 2018).

[3] Promoting Telehealth in Rural America, Notice of Proposed Rulemaking and Order, FCC 17-164 (Dec. 18, 2017) ("NPRM").

information, the Commenters will then outline their thoughts on some of the FCC's proposals in the NPRM, as well as a few additional proposals of the Commenters' origination for changes to the RHC Program. These thoughts and proposals generally fall into three categories: first, comments on the FCC's proposed changes to funding levels and funding allocation; second, proposals that are intended to better align the RHC Program with advances in healthcare delivery models and technology; and finally, proposals with respect to the administration of the HCF Program, which are intended to improve efficiencies in the application process, reduce the administrative challenges associated with seeking funding, and improve the efficiency and effectiveness of the limited funds for RHC Program participants.

BACKGROUND AND CONTEXTUAL INFORMATION

Overview of Commenters.

Each of the Commenters is a regional health system that maintains a network of hospitals, clinics, physician offices, ambulatory care centers, home health services and telehealth services, all of which together serve the needs rural patient populations. Franciscan Alliance is a nonprofit Catholic healthcare system with twenty (20) acute care sites and a network of two-hundred seventy (270) ambulatory care locations throughout central Indiana and Illinois. In 2017, Franciscan Alliance had 1,799,368 patient encounters, more than half of which were with patients living in rural census tracts.[4] Parkview Health is a not-for profit health system with nine (9) community based hospitals and a network of ambulatory care locations throughout northeast Indiana and northwestern Ohio. Of the patients served by Parkview Health in 2017, fifty-seven percent (57%)

[4] Franciscan Alliance conducted a per census tract analysis based on patient address. The data processing for this analysis required extensive resources and significant time and effort. In sum, it took seven (7) data analysts a total of ninety-four (94) hours over the course of several weeks to prepare this data. Because of the difficulties in conducting this analysis, and challenges in converting a patient address to a rural census tract (as more fully described in *infra* note 19, the Commenters advise that further data collection by the FCC on this element is not practical. For additional information on the method used to prepare this data, *see infra* note 19.

resided in rural areas.[5]

Furthermore, each Commenter is a past and current participant in the HCF Program, using HCF-allocated funds to make substantial and transformational investments in their network, that extend the reach of their healthcare services to serve rural patients in Indiana, Ohio, Michigan, and Illinois.

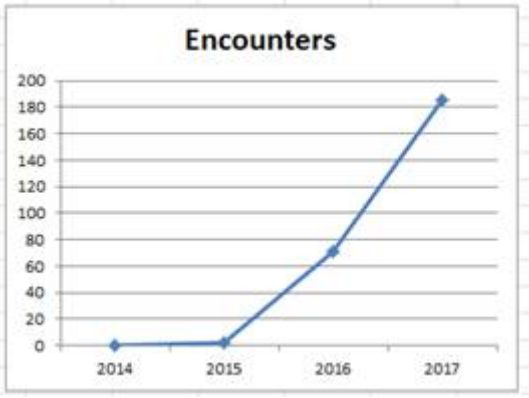
Franciscan Alliance has participated in the HCF Program as a Consortium of health care providers since 2015. Through the HCF Program, Franciscan has secured funding commitments to maintain its current network while developing and building a new robust fiber wide area network to connect it rural physician care sites and rural patient population to its urban hospitals and data centers. In addition, Franciscan has secured funding commitments for security and firewall equipment for its wide area network as well as other network hardware necessary to implement the wide area network.

Parkview Health System, Inc. has participated in the HCF Program as a Consortium of health care providers since the Program's inception in 2014. Through the HCF Program, Parkview has secured funding commitments to develop a new robust fiber wide area network to connect its rural critical access hospitals and rural physician patient care sites to its urban hospitals and data center, thereby allowing for the delivery of sophisticated health care to the rural population throughout northeastern Indiana and northwestern Ohio. Specifically, it has secured funding for broadband services delivered over Ethernet connections, service provider deployment costs in the building of its fiber network, and network equipment necessary to implement the wide area network.

Finally, each of the Commenters has made significant investments in the use of advanced

[5] Parkview's analysis of rurality of patients is based on county of residence.

technology in order to provide telehealth services to their rural populations. For example, Parkview, recently recognized by the American Hospital Association's Health Forum as a 2017 "Most Wired" hospital,[6] uses its telemedicine capabilities to extend the expertise of its stroke team to all of its community hospitals.[7] Similarly, Franciscan Alliance has made telemedicine one of its key, long term investments and, as demonstrated by the following table, has seen significant increases in the number of patient encounters through such telemedicine capabilities.



In 2018, Franciscan Alliance anticipates seeing even more significant increases in telemedicine patient encounters, as it extends Franciscan's expert cardiology services to patients in two rural Indiana counties through the development of a telemedicine outreach program. The Commenters' ability to provide such advanced telemedicine services is a direct result of the robust networks each Commenter developed (or anticipates developing based on pending funding requests) using funds received from the Universal Service Fund.

Overview of the Healthcare Market and Healthcare Technologies.

The healthcare market is rapidly evolving. As a result of advancements in technology, pharmaceuticals, medical devices, and surgical techniques, traditional hospital services are often

[6] *See generally 2017 Most Wired Award Honorees and Demographics*, H&HN, https://www.hhnmag.com/mostwired/results/AwardAndDemographics (last visited Feb. 2, 2018).

[7] *See* PARKVIEW HEALTH EMERGENCY, http://www.parkview.com/en/health-services/emergency/Pages/default.aspx

replaced with less invasive services that require less recovery time and a shorter hospital stay. Advances in home health care, remote medical device monitoring, and telemedicine now allow patients to return to their homes sooner, receiving care remotely that would have historically required the patient remain in the hospital.[8] Health systems are responding to this trend by building networks of care centers in rural and semi-urban locations closer to where their patients reside.

Overview of Changes in Network Design and Security.

In order to keep up with these rapid advancements, and to further the connectivity between healthcare providers ("HCPs"), other HCPs, and their patients, healthcare systems are also changing their network infrastructure, migrating from architectures reliant on self-hosting solutions to cloud-based models delivering Software as a Service (SaaS) solutions. The net of these factors is that health systems, clinically-integrated networks, and other forms of consortiums are migrating from traditional, point-to-point private networks to advanced point-to-cloud networks that utilize virtual private network technology to establish network functionality.

With advancement in technology also comes the corresponding need for advancement in network security, especially given the increasing number, and cost of, data breaches. For example, according to the Ponemon Institute's Cost of Data Breach Study (the "Data Breach Study"), in 2017, the average total cost of a data breach was $7.35M, a 5% increase from 2016.[9] For the healthcare industry in particular, the average cost per lost or stolen record in 2017 was $380, substantially above the overall mean of $255 per record.[10] Healthcare networks are increasingly under attack by even more sophisticated criminal organizations. Fifty-two percent (52%) of the

[8] *See, e.g.*, Melanie Evans, *Hospitals Face Closure as 'a New Day in Healthcare' Dawns*, MODERN HEALTHCARE (Feb. 21, 2015), http://www.modernhealthcare.com/article/20150221/MAGAZINE/302219988.

[9] PONEMON INSTITUTE, 2017 COST OF DATA BREACH STUDY (2017), *available at* https://www.ibm.com/security/data-breach#393716.

[10] *Id.*

data breaches reported in the Data Breach Study resulted from a malicious or criminal attack.[11] In addition, according to Solutionary, a NTT Group security company, the health care industry is the victim of 88% of all ransomware attacks in the United States.[12] Thus, network security is of ever-increasing concern—and cost—for HCPs. In fact, organizations spend an average of 5.6% of their overall IT budget on IT security and risk management.[13] Worldwide spending on information security products and services in 2018 is expected to grow to roughly $93 billion, an increase of 7.64% over 2017.[14]

Overview of Commenter Proposals.

In light of the foregoing background and context, in the following sections of these Comments, the Commenters propose changes to the RHC Program that fall into three main categories: (1) Changes to RHC Program funding levels and funding allocation between RHC Programs; (2) Changes to better align the RHC Program with the current realities of the healthcare industry; and (3) Changes to improve RHC Program efficiency – both for the FCC, and for those HCPs participating in the RHC Program.

CATEGORY ONE:
CHANGES TO RHC PROGRAM FUNDING LEVELS AND FUNDING ALLOCATION BETWEEN RHC PROGRAMS

Given the ever-increasing costs facing the healthcare industry, the Commenters propose that the FCC: (1) establish an increased annual cap for the HCF Program of $800 million that is

[11] *Id.*

[12] Ana Mulero, *Charts: Must-know Healthcare Cybersecurity Statistics*, HEALTHCAREDIVE (Feb. 27, 2017) https://www.healthcaredive.com/news/must-know-healthcare-cybersecurity-statistics/435983/.

[13] Press Release, Gartner, Inc., Gartner Says Many Organizations Falsely Equate IT Security Spending With Maturity (Dec. 9, 2016), available at https://www.gartner.com/newsroom/id/3539117.

[14] Press Release, Gartner, Inc., Gartner Says Worldwide Information Security Spending Will Grow 7 Percent to Reach $86.4 Billion in 2017 (Aug. 16, 2017), available at https://www.gartner.com/newsroom/id/3784965.

annually adjusted to CPI – Medical; and (2) reallocate funds among the various Universal Service Fund Programs.

A. *The RHC Program Funding Cap Needs to be Increased.*

The RHC Program has seen a consistent increasing demand for Program funding as healthcare delivery and care coordination models increasingly look towards technology to more effectively and efficiently share patient information and provide better care, and as consumers seek the convenience of telemedicine and other telehealth services. For this reason, the Commenters support an increase in RHC Program cap ("RHC Cap") in order to better align the available funds with market growth and the objectives of the Universal Service Fund. In increasing the RHC Cap, the Commenters propose the following steps be taken by the FCC.

First, the Commenters propose that the FCC apply an annual adjustment for inflation to the RHC Cap that tracks the cost of medical care as published by the U.S. Bureau of Labor Statistics (CPI-Medical).[15] The cost of providing healthcare has outpaced general inflation. In the last 20 years, the cost of medical care has grown at an average rate of 3.5% in contrast to the Consumer Price Index which has displayed an annual growth rate of 2.2%.[16] Thus, applying a standard inflationary CPI-U adjustment to the $400 million RHC Cap, since the RHC Program's inception

[15] U.S. Dep't of Labor, Bureau of Labor Statistics, *Databases, Tables & Calculators by Subject, CPI-All Urban Consumers*, BUREAU OF LABOR STATISTICS, https://data.bls.gov/timeseries/CUUR0000SAM?output_view=pct_12mths (last visited Feb. 2, 2018).

[16] *Healthy Inflation? Inflation in the Healthcare Industry vs. General CPI* (Jul. 13, 2017), https://fredblog.stlouisfed.org/2017/07/healthy-inflation/.

in 1997, results in an RHC Cap of $619.8 million.[17] Applying the CPI-Medical adjustment to the $400 million RHC Cap for the same period, would result in an RHC Cap of $810.27 million.[18]

Second, the Commenters propose that the FCC roll over unused funds committed in single funding year to subsequent funding years. The Commenters agree with the FCC that the roll-over mechanism should include: (i) funds previously held in reserve for appeals; and (ii) funds committed to an HCP but not used by an HCP. The Commenters propose that all unused funds from each year be rolled over to multiple subsequent funding years until such funds are ultimately disbursed. These unused funds represent dollars already paid by consumers into the Universal Service Fund, rather than new dollars requiring collection and would be an easy mechanism through which to increase the RHC Cap.

Finally, the Commenters propose that all roll-over funds be placed in the general fund and applied to applicants as determined through the funding commitment process.

B. Universal Service Program Funds should be reallocated to the RHC Program, where feasible.

The Commenters propose that the FCC consider reallocating funding within the Universal Service Fund to preference RHC Program. In particular, the Commenters ask that the FCC review the various programs and consider whether a movement of funds from one program to another is warranted. For example, the High Cost program has a budget over $4.5 billion,[19] a budget that is substantially higher than the RHC Program's $400 million budget. Comparatively, a reallocation of $200 million from the High Cost program to the RHC Program would have marginal effect on

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[17] U.S. Dep't of Labor, Bureau of Labor Statistics, *Database, Tables & Calculators by Subject, CPI Inflation Calculator*, BUREAU OF LABOR STATISTICS, https://www.bls.gov/data/inflation_calculator.htm (last visited Feb. 2, 2018).

[18] *Tom's Inflation Calculator*, HALFHILL.COM, http://www.halfhill.com/inflation_js.html (last visited Feb. 2, 2018).

[19] UNIVERSAL SERV. ADMIN. CO., ANNUAL REPORT (2016), available at http://www.usac.org/about/tools/publications/annual-reports/default.aspx (last visited Feb. 2, 2018).

the High Cost program, but a considerable, beneficial impact on the RHC Program, which has seen a steady increase in funding requests. Furthermore, many of the underlying goals of some of the Universal Service programs, such as, for example, the E-Rate Program, have already been met, which may justify a shift in the Universal Service Fund focus. For example, ninety-four percent (94%) of school districts in the country now meet the minimum federal connectivity target."[20] By contrast, healthcare costs continue to increase. For example, in 2016, healthcare spending grew by 4.3%, equating to $10,348 person and 17.9 % of the GDP, with hospital care and physician and clinical services reflecting more than half of the spending.[21]

CATEGORY TWO:
CHANGES TO BETTER ALIGN THE RHC PROGRAM WITH THE CURRENT REALITIES OF THE HEALTHCARE INDUSTRY.

As detailed in the background section of these Comments, since the RHC Program's inception, there have been significant developments in healthcare market and technologies that have resulted in HCPs: (1) reaching rural patient populations in alternative ways; (2) moving away from traditional network infrastructures to more advanced options; and (3) increasing their investment in network security. The following sections proposes several changes to the RHC Program that are intended to better align the RHC Program with such developments.

A. Success of the RHC Program should be based on the number of rural patients receiving care per dollar of funding, rather than the "remoteness" of HCPs.

In association with the preparation of these Comments, the Commenters conducted an

[20] Benjamin Herold, *Analysis: 94 Percent of School Districts Nationwide Meet Federal High-Speed Interest Access Targets,* GT.COM (Sept. 19, 2017), http://www.govtech.com/network/Analysis-94-Percent-of-School-Districts-Nationwide-Meet-Federal-High-Speed-Internet-Access-Targets.html.

[21] Ctrs. for Medicare & Medicaid Serv., *Historical National Health Expenditure Data,* CMS.GOV, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html (last visited Feb. 2, 2018).

analysis of the location of their patients' residence as compared to the locations at which rural patients received care.[22] During the 2017 calendar year, Franciscan Alliance had nearly 1.8 million patient encounters, roughly half which were with individuals identifying a primary residence in a rural census tract.[23] Interestingly, although half of Franciscan Alliance's patient encounters were with patients identifying a rural residence, only sixteen percent (16%) of its patient encounters occurred at healthcare sites located in rural tracts. Parkview conducted a similar analysis and concluded that, although fifty-seven percent (57%) of its patient population resides in rural locations, only forty-eight percent (48%) of its patient encounters occurred at healthcare sites in rural locations.[24] This data demonstrates that a high number of rural residents travel to semi-urban and urban locations to receive healthcare services or otherwise obtain healthcare services (such as

[22] The following is a description of this analysis:

Franciscan started culling the data necessary for its analysis on January 3, 2017. By January 5, 2017, Franciscan's internal reporting group had assigned two data analysts to begin building a report that would retrieve the necessary "patient visit" data from the SQL database sources. Shortly thereafter, however, the data analysts ran into exporting difficulties, as the size of the dataset was causing problems with the query. The data analysts continued to work on the problem by doing things such as filter out null values, and then experienced a new query failure, which resulted in the reporting team having to huddle together to try and figure out a "plan B" using a different export tool. By January 17, 2017, the reporting team was still continuing research on how to successfully export the "patient visit" data.

While the reporting team was working on the foregoing export, the application programming team, consisting of two software engineers and an enterprise data architect, started the task of taking the customer and facility address data and converting it into rural census tract, in order to evaluate patient "rurality." This task required the team to design a multi-threaded console application and use a complex stepwise algorithm to obtain the tract info. It involved making multiple web requests to third-party developer APIs to translate address to latitude/longitude coordinates and then tie this into county and census tract info. The team utilized the US Census Department's developer API.

The translation was difficult, as initial attempts resulted in sporadic and frequent failed matches. By January 16, 2017, 250,000 of the 1.8M patient records had been cross tabulated as to rural census track. The work continued through the following weekend so that on Saturday, January 20th, the output dataset was complete. The team next focused on verifying the data and creating pivot table reports to summarize the results and by Monday, January 22nd, the team had the final dataset and reports completed.

[23] Franciscan Alliance utilized a third party tool to determine the rurality of its patient encounters. The data processing required extensive resources and significant time and effort. Because of complications in the data analysis and challenges in converting a patient address to a rural census tract, Commenters advise that further data collection by the FCC on this element is not practical.

[24] Parkview conducted its analysis based on the county of residence.

telehealth) from providers located in the semi-urban or urban setting.[25]

The current RHC Program centers its "rurality" analysis on the location of the HCP. The data above, however, demonstrates that such an analysis does not necessarily ensure that the greatest *number* of *rural patients* will receive the benefits of RHC Program funding. In light of this, the Commenters propose that the FCC shift the "rurality" analysis of the RHC Program from the "rurality" of an HCP to the "rurality" of the patient bases. This shift is in line with the underlying principles of universal service, and is within the FCC's statutory authority. For example, Section 254(b)(2) provides:

> The Joint Board and the Commission shall base policies for the preservation and advancement of universal service on the following principles [. . .] *Consumers in all regions of the Nation, including low-income consumers and those in rural, insular, and high cost areas,* should have access to telecommunications and information services, including interexchange services and advanced telecommunications and information services, that are reasonably comparable to those services provided in urban areas that are available at rates that are reasonably comparable to rates charged for similar services in urban areas.

47 U.S.C. 254(b)(2) (emphasis added). Thus, as acknowledged by the FCC in their request for comments,[26] the underlying principles of universal service focus on the *location of consumers*. Likewise, the statutory authority for the RHC Program focuses on the rurality of the patients being served, not the HCPs. For example, Section 254(h)(1)(A) provides:

> A telecommunications carrier shall, upon receiving bona fide request, provide telecommunications services which are necessary for the provision of health care services in a State, including instruction related to such services, to any public or non-public healthcare provider *that serves persons who reside in rural areas* in that State at rates that are reasonable comparable to rates charged for similar areas in that State [. . .].

[25] Commenters analyzed patient record information for this data. Data used reflected location of service; i.e. location of the healthcare professional providing the service; not the location of the patient when receiving the service. As a result, all telehealth encounters would be attributed to urban locations.

[26] *See supra* note 3, at ¶ 4, stating, "Through the RHC Program, the [FCC] has sought to support eligible HCPs in their delivery of essential healthcare services to families and individuals living and working in rural and remote parts of the country."

47 U.S.C. 254(h)(1)(A) (emphasis added). Thus, it is appropriate for the FCC to allocate RHC Program funds based on the number of rural patients served instead of the number of rural HCPs impacted.

B. *The FCC's definition of "not-for profit hospital" should better align with the current structure of healthcare systems.*

Clinically integrated networks ("CINs") increasingly provide care to rural patients in ambulatory care settings, instead of at traditional, "brick and mortar" hospitals. However, to date, USAC has refused to acknowledge ambulatory services locations owned by not-for-profit hospitals locations as eligible for HCF Program funding. The goals of the Patient Protection and Affordable Care Act ("ACA") include improving patient access to quality medical care in an appropriate setting at an appropriate price. In order to achieve this goal, it is essential for rural patients to be able to access quality health care in ambulatory care sites near their home. As an example, the ability to promptly and efficiently provide neurology care to a stroke victim has a significant and measurable impact in the patient's outcome. However, many rural hospitals do not have a neurologist available to promptly assess and treat a stroke victim. Using "Telestroke services," a patient in a rural hospital ER can be connected with a neurologist (generally in a physician office in an urban area) in order to allow that patient to receive sometimes life-saving advanced care. In order to ensure that a neurologist's office (i.e. the ambulatory care site) that is wholly owned and operated by a not-for-profit hospital has the necessary connectivity to provide Telestroke services, the FCC should ensure this type of location is eligible for HCF Program funding.

Congress has defined "not-for-profit hospitals," to include the ambulatory care sites of a not-for-profit entity that directly or indirectly operates a facility licensed as a "hospital". See 26 USC 170 (b)(1)(A)(iii). Thus the FCC, consistent with market developments, should adopt this statutory definition for purposes of HCF Program funding. In addition, the FCC should recognize

any entity which is exempt from the federal communication excise tax or obligated to file an IRS Form 990(h) as a "not-for-profit hospital" within the meaning of the HCF Program.

C. *The HCF Program should be revised to better reflect developments in network design.*

In developing the universal service principals, Congress recognized the need for the FCC to have flexibility to adapt to changing technologies, and in-fact specifically directs the FCC to consider such evolution: "'Universal Service' is an *evolving* level of telecommunications services that the FCC shall establish periodically under this section, taking into account advances in telecommunication and information services." 47 U.S.C. 254(c). "The Commission shall establish competitively neutral rules […] to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for all […] healthcare providers […]. 47 U.S.C. 254(h)(2)(A).

Healthcare Providers are currently migrating from point-to-point private networks and self-hosted solutions to software as a service ("SaaS") solutions provided over point-to-cloud connections. The HCF Program currently provides funding for a connection between members of a Consortium, so long as the origination point for the circuit is eligible. In a traditional hub and spoke network, this permitted a hospital to obtain funding for associated ambulatory care sites when the hospital was identified as the "origination site" for the connection. As HCPs are increasingly migrating network services to cloud-based solutions, the connection from hospital to ambulatory care site may now travel over a VPN connection (i.e. hospital to cloud to ambulatory care site, and vice versa), instead of from hospital to ambulatory care site. Although cloud-based solutions provide greater stability and reflect best practices in network design, the HCF Program does not currently provide funding for such advanced networks; thus, incentivizing HCPs to adopt antiquated designs in the interest of reducing network cost through HCF Program participation.

The FCC should consider funding mechanisms that would allow HCPs to move beyond traditional point-to-point connections.

D. *Security equipment should be excluded from the HCF Program's per-site cap.*

As was detailed previously, network security is an increasing concern for HCPs today. The current HCF Program rules require that applicants amortize all one-time costs, including those for network security, in excess of $50,000 per Consortium site ("Per Site Cap") over three (3) years. Thus, if an HCP seeks funding for network security equipment in the same year as other network services, the HCP may exceed the Per Site Cap. The Commenters have found that security equipment vendors (as compared to common carriers and vendors of other types of network equipment) are less willing to spread payment for security equipment over a three year term. As a result, HCPs are forced to pay 100% of the cost of security equipment at time of purchase and then seek reimbursement from the vendor as the HCF Program funds are released to the vendor. This places the HCP in a precarious position in the event of a dispute between the vendor and HCP (perhaps related to an unrelated matter), as the vendor may elect to off-set the HCF Program funds instead of returning them to the HCP. Thus, the FCC should consider excluding equipment, and specifically security equipment, from the Per Site Cap.

E. *The FCC's current definition of "Cost-Effectiveness" appropriately allows HCPs to consider appropriate factors in selecting a service provider, and should be retained.*

The Commenters do not believe changing the definition of "Cost-Effectiveness" is the proper means by which to address the FCC's concern as to RHC Program waste. Doing so will inhibit the ability of HCPs to consider factors in selecting their service providers that are extremely important in the health care environment, such as continuity of care, data security, and a positive working relationship. For example, in addition to network security, one of the most important factors in selecting a service provider for the Commenters are the service providers' "Uptime

Guarantees;" commitments which ensure that there will be no delay or interruption of services. Nearly every step of the patient care process relies heavily on network connectivity. Thus, if the network fails or even slows down, patient care *will* be impacted. In light of the FCC's recent decision to repeal its net neutrality rules, HCPs will now have to pay more to obtain these necessary Uptime Guarantees. Thus, if the FCC limits HCPs ability to select a service provider to only those that are the "least expensive," it will be more difficult for HCPs to negotiate an adequate and necessary guarantee of uptime, speed and system security.

CATEGORY THREE:
CHANGES INTENDED TO IMPROVE RHC PROGRAM EFFICIENCY
CHANGES IN FUNDING LEVELS AND FUNDING ALLOCATION

As longtime participants in the RHC Programs, the Commenters have seen and experienced both the strengths and weaknesses of the current RHC Program application process, as well as the inefficiencies identified by the FCC in the NPRM. In the following sections of these Comments, the Commenters outline some potential changes to the RHC Program that are intended to address any such weaknesses and inefficiencies based on the Commenters' own experience.

A. The Telecommunications Program should be revised to better ensure efficient use of RHC Program funds, and reduce the risk of fraud and abuse.

The Commenters agree with the FCC that changes to Telecommunications Program ("Telecom Program") are necessary in order to ensure more efficient use of the RHC Program Funds. To that end, the Commenters propose that the FCC implement a "minimum cost share" requirement in the Telecom Program, similar to that found in the HCF Program. More specifically, the HCF Program currently obligates participating HCPs to pay 35% of the cost of the qualifying broadband infrastructure. Such an obligation ensures HCF program participants are efficient in their use of RHC Program funds. The FCC should implement a similar mechanism in the Telecom

Program, such as a requirement that funding for a connection not exceed 75% of the total cost of the connection (obligating HCPs to pay not less than 25% of the cost of the eligible services).

Additionally, the Commenters recommend that the FCC collect and maintain data to measure the cost of funding per rural resident (patient) served, to ensure the limited RHC Program dollars are efficiently used to make to make an impact for the greatest number of rural residents. Such data would allow the FCC to consider how many individuals are served per dollar of funding.

Finally, the Commenters agree with the FCC that a new rule in the Telecom Program requiring a "declaration of assistance" by applicants who engage consultants should be adopted. The FCC should also direct USAC to recognize the unique roll of attorneys.

B. The FCC should establish rules respecting consultant participation in the RHC Program.

The Commenters further agree with the FCC that both HCPs and service providers should be required to disclose the names of any consultants or third parties who helped them in any manner at any step of the application process of both the HCF and Telecom Programs. Applicants should also be required to describe their relationship with such consultants and third parties, specifically disclosing exclusivity obligations, rights of first refusal, tying arrangements, related or affiliated businesses and any contingent fee arrangements in place between the consultant and the applicant directly or indirectly related to telecommunication funding.

C. The RHC Program application process should be simplified for Consortia applicants.

The current Consortia application process places a large administrative burden on applicants. Currently, creating and populating a Consortium with the USAC portal is a three-step process. First, the Consortium must submit its own Form 460 to determine eligibility of the Consortium. Second, the Consortium must submit a Form 460 for *each and every participating entity* that intends to participate in the Consortium. Third, the Consortium must submit a Letter of

Agency and identify each participating entity covered by that Letter of Agency. For each of these three steps, both unique and duplicative information is requested by USAC. Consortia applications could be much more easily managed and processed, if Consortia were permitted to submit data in an Excel spreadsheet or other industry standard format. In addition, by combining steps two and three described above, allowing a Letter of Agency to be submitted along with the Form 460 eligibility request for each participating entity, the application process could be significantly streamlined.

D. The Filing Window Periods should be revised to provide sufficient time for completion of the bidding period, vendor selection, contract negotiation, and preparation of funding request, and to ensure applicants are able to appropriately budget for the upcoming year.

The Commenters understand the need for filing window periods in managing the HCF Program applications, and agree that it is fair and equitable to applicants. However, the timing of the current filing window process places applicants in a difficult position with respect to the timing of contract negotiation and budget planning for the upcoming year. For example, in the Commenters experience, steps two (Form 461) and three (Form 462) of the current application process can take upwards of nine (9) to twelve (12) months.[27] The current filing window period requires that HCPs complete this process in five (5) months (January 1, 2018 through May 31, 2018), thereby making it difficult for applicants, particularly sophisticated Consortia applicants, to most effectively utilize the HCF Program. Thus, the Commenters propose that the period of time between step two (posting of an RFP/461) and the closing date of a filing window period be at least nine (9) months. Accordingly, Commenters propose that the Form 461 submission window open well before January 1 of a given calendar year.

[27] For Parkview Health System, Inc., the entire period of time between posting the 461/RFP to submission of complete 462 funding request took one year. For Franciscan Health Alliance, the entire period of time between posting the 461/RFP to submission of a complete 462 funding request took nine months.

In addition, because of the shortened filing window periods, the FCC should allow an applicants' Form 461 (and corresponding RFP) to be applied to subsequent funding years if such applicant was unable to complete the bid evaluation and contracting process prior to the close of the filing window period. For example, a Form 461/RFP submitted for FY2018 that did not result in a completed funding request (Form 462) should be available for use during the filing window period applied to FY2019. In the Commenters' experience, the contract negotiation process for a vendor selected through the competitive bidding process can take six (6) months or more, which may preclude the preparation and submission of a complete funding request by the end of a certain filing window period.[28]

Third, the Commenters request that filing window periods be fixed well in advance to enable applicants to most effectively manage their RHC Program participation. The fluid nature of the filing window periods in FY2016 and FY2017 caused confusion to many applicants. For filing window periods adopted by the FCC for all future funding years under the RHC Program, the Commenters propose that the filing window periods be fixed well in advance of any upcoming filing year so that applicants may plan their program participation accordingly.

Finally, the Commenters propose that the FCC consider a way to shorten the time between the close of a funding window period and the issuance of Funding Commitment Letters ("FCLs"). For FY2017, applicants have waited seven (7) months with no update as to when FCLs will be issued on funding requests submitted during the filing window period. This places hardship on HCPs who depend on these funds to offset their technology costs. Specifically, it creates difficulty in: (i) creating an accurate budget and financial plan, (ii) determining what technology the

[28] For both Parkview Health System, Inc. and Franciscan Alliance, Inc., the selection of the winning bidder and subsequent contract negotiation process took six months.

applicant can purchase, and (iii) following through with a planned technology project.[29] The timeframe for approval of FCLs needs to be shortened, and applicants need to be regularly updated as to the status of pending funding requests. In any event, the FCC must not adopt new rules that further extend the funding timeline.

CONCLUSION

Again, the Commenters would like to thank the FCC for the opportunity to describe their respective experiences as participants in the RHC Program, as well as to provide some thoughts on ways the FCC may be able to improve the RHC Program to better suit the current realities facing HCPs. Hopefully, these Comments provided the FCC with some proposals that will help the better align the RHC Program with advances in healthcare delivery models and technology, as well as to improve the efficiency and effectiveness of the Program. If the FCC has any follow-up questions, the Commenters would be happy to set up a time to further discuss the above proposals.

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[29] Franciscan Alliance, Inc. anticipated beginning its network redesign project in October, 2017. However, it is still awaiting approval (or amendment or denial) of its funding request which it submitted prior to June 30, 2017. The project has been delayed due to the uncertainty of USAC committed funds.