Alaska Native Health Board

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February 2, 2018

Ajit Pai, Chairman
Mignon Clyburn, Commissioner
Michael O'Rielly, Commissioner
Brendan Carr, Commissioner
Jessica Rosenworcel, Commissioner
Federal Communications Commission
445 12th Street, SW
Washington, DC 20554
Submitted via: http://www.regulations.gov
http://apps.fcc.gov/ecfs/

RE: Comments on WC Docket No. 17-310 Notice of Proposed Rulemaking (NPRM) and Order

Dear Chairman Pai,

On January 3, 2018, the Federal Communications Commission (FCC) published the above captioned NPRM in the Federal Register. The purpose of the NPRM is to solicit comment on a variety of issues related to the administration of the FCC's Rural Health Care (RHC) Program, which is critical to supporting Alaska Native rural health care services. In 2016, the demand for RHC Program resources for the first time exceeded the $400 million cap that the FCC established.

These comments are submitted on behalf of the Alaska Native Health Board (ANHB). ANHB is pleased that the FCC is investigating approaches to provide the RHC Program a more sustainable foundation on which to operate and grow with increased funding. As explained in greater detail below, the RHC Program is an important tool with which the federal government fulfills its trust responsibility to American Indians and Alaska Natives. The $400 million cap on the RHC Program is not authorized by statute and threatens to severely undercut the provision of health care services to Alaska Natives, who live in the most remote parts of the United States and whose health care depends on connectivity.

ANHB was established in 1968 with the purpose of promoting the spiritual, physical, mental, social, and cultural well-being and pride of Alaska Native people. ANHB is the statewide voice on Alaska Native health issues and is the advocacy organization for the Alaska Tribal Health System (ATHS), which is comprised of tribal health programs that serve all of the 229 tribes. As the statewide tribal health advocacy organization, ANHB assists tribal partners, state and federal agencies with achieving effective communication and consultation with tribes and their tribal health programs. The ATHS is a truly comprehensive statewide system of health care. It is a voluntary affiliation of over 30 Alaska Tribes and Tribal Health Organizations (THOs) providing health services to over 166,000 Alaska Native and American Indian (AN/AI) people. Each Tribe and THO is autonomous and serves a specific geographical area; and, many are the only health provider in their respective community. This fact makes the ATHS an integral part

of the Alaska Public Health System serving tens of thousands additional non-AN/AI community members and Veterans. It is a finely-tuned network that provides services through:

- 180 small community primary care centers spanning over 660,000 square miles
- 25 sub-regional mid-level care centers
- 4 multi-physician health centers
- 6 regional hospitals
- Alaska Native Medical Center tertiary care

Tribal Health and the Federal Trust Responsibility

Unlike other non-tribal rural health care providers (HCPs), the ATHS is not merely a community entity striving to provide health care to people loosely connected by a rural geography. Instead, the ATHS is a part of the federal–tribal health care system, which rests on the foundation of the underlying federal trust responsibility to tribes and Alaska Natives.

Inherent tribal sovereignty predates the formation of the federal government of the United States as well as, in the State of Alaska, the onset of statehood in the territory. In the early days of America, the Supreme Court ruled on several aspects of what is known as the federal trust responsibility to tribes. In *Worchester v. Georgia*, the Court established that the federal government, not states, has the authority over and responsibility for matters relating to members of Indian tribes. 31 U.S. 515 (1832). The Court also ruled that this federal relationship is special in nature, requiring the federal government to treat Indian Tribes as "domestic dependent nations," and that the relationship between Indians and the federal government was like that "of a ward to his guardian." *Cherokee Nation v. Georgia*, 30 U.S. 1 (1831).

This broad concept of the federal "trust responsibility" has taken different forms and doctrines over the years and in different contexts, but it has remained a bedrock principle of federal law. In the area of health care, Congress passed the Snyder Act in 1921, providing explicit federal authorization supporting health programs for Indians and Alaska Natives by mandating the expenditure of funds for "[t]he relief of distress and conservation of health … [and] for the employment of … physicians … [for Indian tribes]." 25 U.S.C. § 13.

Congress revisited the trust responsibility for tribal and Alaska Native health care with the Indian Health Care Improvement Act, finding that "[f]ederal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people." 25 U.S.C. § 1601(1). Congress also found that it is a "[m]ajor national goal . . . to provide the resources, processes, and structure that will enable Indian tribes and tribal members to obtain the quantity and quality of health care services and opportunities that will eradicate the health disparities between Indians and the general population of the United States." 25 U.S.C. § 1601(2).

The FCC took up the matter of its own relationship with American Indians and Alaska Natives in June 2000 with its Policy Statement "In the Matter of Statement of Policy on Establishing a Government-to-Government Relationship with Indian Tribes" [hereinafter *FCC Policy Statement*]. In that Policy Statement, the FCC recognized that "[t]he federal government has a federal trust relationship with Indian Tribes, and this historic trust relationship requires the federal government to adhere to certain fiduciary standards in its dealings with Indian Tribes." *FCC Policy Statement* at 3.

The Policy Statement further outlines some of the specific ways that the FCC has committed itself to implementing the federal trust responsibility. For instance, the Policy Statement provides that the FCC will "[w]ork with Indian Tribes on a government-to-government basis consistent with the principles of Tribal self-governance to ensure, through its regulations and policy initiatives … that Indian Tribes have

adequate access to communications services." *Id*. at 4. The FCC also, "[i]n accordance with the federal government's trust responsibility, and to the extent practicable, will consult with Tribal governments prior to implementing any regulatory action or policy that will significantly or uniquely affect Tribal governments, their land and resources." *Id.* In addition, the FCC "[w]ill endeavor to streamline its administrative process and procedures to remove undue burdens that its decisions and actions place on Indian Tribes." *Id.* at 5.

It is against this backdrop of the federal trust responsibility that the FCC's approach to rural health care must be understood. The RHC Program has been a major success in Alaska, and it is one very important way that the FCC fulfills the federal trust responsibility. In fact, the RHC Program is mission critical to tribal HCPs. However, if the FCC adopts policies that result in diminished RHC funding, or policies that require an increase in tribal HCP contribution rates, the trust responsibility would be undermined and the viability of tribal HCPs threatened. That is because such policies would ultimately require the reallocation of already scarce federal Indian Health Service money that would otherwise be used to pay for the provision of health care in order to pay for necessary telecommunications services. Tribal HCPs, unlike other rural HCPs, do not have the capacity to simply pass added costs on to patients. Additionally, the Indian Health Service (IHS) is desperately underfunded at around 60% of need. The federal government has a trust responsibility to the individual American Indian and Alaska Native patients as well. Any further reduction of IHS dollars, including through reallocation to fund connectivity, is a serious threat to the health status of American Indians and Alaska Natives.

For the federal trust responsibility to have meaning, the FCC must adopt rules that reflect the FCC's understanding that tribal HCPs are fundamentally different than other HCPs. FCC rulemaking is less effective if it essentially simply robs one federal agency of funding to contribute to some other federal program, all while individual patients' access to health care suffers as a result.

The Telecommunications Act Does Not Authorize Capping the RHC Program

The FCC lacks the statutory authority to impose a cap on the RHC Program. Section 254(h)(l)(A) of the Telecommunications Act of 1997 is written unambiguously as a mandatory program that includes funding as an entitlement associated with that mandate. Under Section 254(h)(l)(A), Congress instructed the FCC to make payments to telecommunications providers (telcos) on behalf of rural health care providers and a "[t]elecommunications carrier providing service under this paragraph **shall be entitled** to have an amount equal to the difference, if any, between the rates for services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in comparable rural areas in that State treated as a service **obligation** as a part of its obligation to participate in the mechanisms to preserve and advance universal service. " 47 U.S.C. § 254(h)(l)(A) (emphasis added). The $400 million cap is contrary to this statutory mandate, which entitles telcos to the full amount of the difference in rates, without qualification.

In addition to a cap being contrary to the express language of the Telecommunications Act, the cap is contrary to congressional intent. The Act makes clear that Congress understood that programmatic health care successes were expected to come from a fully funded RHC Program. Congress did not create a $400 million cap. Congress did not ask the FCC to create a successful program that builds health care solutions for rural Alaska communities only to then pull the rug out from under those programs through insufficient current and future funding.

ANHB recommends that the proposed rules reflect that the unambiguous statutory language of the Telecommunications Act requires full funding of the RHC Program as intended by Congress to create universal service for HCPs such as embodied in the ATHS.

Program Growth in Alaska

ANHB appreciates the NPRM's acknowledgement of the importance of the RHC Program. While the RHC program has grown in utilization of funding, the FCC has not increased the funding cap for the RHC Program since 1998. Meanwhile, telehealth and telemedicine solutions and services have grown exponentially, as has the concomitant need for bandwidth. Additionally, reliance on electronic health records has dramatically expanded, in accordance with requirements of federal quality incentive programs.

It is important for the FCC to understand that connectivity is mission crucial to Alaska THOs delivering health care to some of our country's most remote communities. In Alaska, patients are not where the doctors are. Without connectivity, patients are more portable than their data. For decades, Alaskans needing health care travelled large distances while their data stayed behind. Now the data is more portable than the patient, in large part thanks to the success of FCC funding and the RHC program. As evidence of this - the ATHS has now relied on telehealth programs for more than 20 years to deliver care to more than 200 facilities throughout Alaska. The system has been used by 4,500 providers for more than 300,000 clinical cases, has generated almost 70,000 EKGs of heart patients, 200,000 images of ear disease alone, and another half million images of trauma, wounds, and rashes.

Annually approximately 20% of all Alaska Natives receive care through telehealth. This level of adoption, and dependence on communications, may be unmatched anywhere else in the Unites States. For example, the Alaska Native Medical Center (ANMC) now offers 30 different specialties by video conferencing. More than 70% of all consultations using these tools prevent the patient from having to travel to see a specialist – resulting in statewide savings estimated at $10 million annually in avoided patient travel costs. Our organization has achieved many of the same cost savings through use of telehealth in addition to those at ANMC. Because of the federal nature of the health care program, these are then cost savings that result in greater impact from the limited federal funding.

New care models have been developed and refined in Alaska to maximize access to rural area. For the first time, it is possible to provide better access to our most remote regions than can be delivered in a major metropolitan area. Most specialty consultations at ANMC are completed within 4 hours - regardless of where the patient lives. One clinical specialty (ENT) that provides virtual care to more than 4,000 patients per year now has a median turnaround time of 70 minutes. A recently published 16-year retrospective analysis of one rural clinic documented patients would wait 5 months or longer to obtain an in-person appointment, which then dropped to 8% of all patients in the first three years with telehealth, then less than 3% of all patients in next three years using telehealth Providers at ANMC have documented the ability and accuracy for telehealth to be used in a multitude of care models – from surgical planning and expert triage to post-surgical follow up and empowerment of travelling providers.

The value of telecommunications in health care stretches far beyond telehealth. An important example is the effort within the Alaska Tribal Health System to adopt a single patient record for all Alaska Natives. While federal regulations have provided both incentives and penalties related to the adoption of modern health record systems, the Indian Health Service has failed repeatedly to provide an electronic health record system that complies with federal regulations and supports organizations in their desire to maximize patient care. The Alaska Tribal Health System is a birth-to-death health care system, and patients are often seen in multiple locations managed by different organizations. For this reason, many Alaska tribal health organizations have been working aggressively and investing many millions of their own health care dollars to adopt a single shared Electronic Health Record (EHR). Currently, 19 organizations have adopted this shared EHR and more than 66% of all health care in the ATHS is documented in this system. Because the EHR technology is remotely hosted in Kansas City, the majority of all patient encounters in rural Alaska now depend on subsidized connectivity to reach the patient record

and for providers to enter their notes, for coders and billers to operate in the revenue cycle, and for organizations to manage and measure quality of care. In other words – the ATHS cannot provide care in rural Alaska without telecommunications. It is critical to almost every patient visit.

People living in rural and frontier locations - such as Alaska villages - squeeze more out of every bit of connectivity than anyone else in the world. The partnership between the FCC and Tribes has done much to address disparities not only in connectivity but in the delivery of health care. The FCC's subsidy programs (the Telecommunications Program and USAC funding) are the only reason Alaska is able to do this. Otherwise connectivity is too expensive - costing between $10,000 and $20,000 per month for a T1 line in many places. The 2016 RHC cap forced pro-rating of USAC subsidies and had a dramatically unfair effect on Alaska tribes - raising Alaska's "out of pocket" costs for connectivity by more than 1,000% and creating a real risk of staffing cuts, reductions in care, and potentially dismantling the program gains discussed above.

Alaska THOs have continued to expand our telecommunications infrastructure in a cost effective manner, but the FCC's proposed rule does not discuss all these gains as successes, rather treating Alaska as a costly outlier. Alaska THOs do not control the urban and rural rates or costs, nor do they control the investment in telecommunications infrastructure outside health facilities. If the FCC has issues with those decisions and costs, its focus should then be on the telecommunications providers, rather than punishing THOs with limited funding now that the THOs are fully bought into telemedicine usage, EHR usage, and telehealth more broadly.

Because of limited infrastructure, extreme geographic isolation, limited historic investment in utilities and communications systems, and very high travel, fuel, and health care costs, Alaska stands out as a unique example of the rural–urban divide the RHC was intended to address. Even the most urbanized areas of Alaska, such as Anchorage, Fairbanks, and Juneau lag far behind their urban counterparts in the lower 48 for telecommunications access and affordability. Once outside these urban areas, Alaska telecommunications issues are categorically different than other parts of the United States.

All of these remoteness and cost factors are exactly why Alaska was an early adopter of telehealth and telemedicine program opportunities. These capabilities can literally mean the difference between having health care and not having health care in many areas, particularly where visits to health professionals would otherwise require one or more flights for even the simplest consult. With the use of telehealth, along with the successes of the Alaskan Tribal Health Compact and the full roll out of the ISDEAA in Alaska, health care for Alaska Native communities has undergone a renaissance of change that has produced a wide range of successes. Thus, not only are federal investments in these programs disproportionately efficient and effective but, simply put, connectivity in Alaska health care is not a luxury—it is a lifeblood. Without it, lives are at risk unnecessarily and the federal government cannot meet its trust responsibilities to ensure even a minimum level of health care for Alaska Natives throughout the state.

As Commissioner Michael O'Reilly stated in the FCC's December 14, 2017 meeting at which the FCC voted to adopt the NPRM, Alaska is an example of how the RHC Program should work, and funding should not be taken away from a region that is unlike any other in the country. Thus, ANHB believes that evaluation and prioritization of RHC funding should include consideration of the positive health outcomes achieved by providing access to care in the most cost effective, and least personally disruptive, means possible. ANHB encourages the FCC to consider the enormous successes the RHC Program has had in Alaska as the FCC engages in its rulemaking process.

Funding Levels

In the NPRM, the FCC requests comment on proposed funding level increases for the RHC Program. As we have stated above, the cap on RHC Program funds is contrary to the express language of the Telecommunications Act. We understand, however, that the FCC initially set the $400 million cap in order to "be specific, predictable, and sufficient." FCC Report and Order "In the Matter of Federal–State Joint Board on Universal Service," Dkt. No. 96-45 at 365 (May 8, 1997). Thus, the $400 million cap was not intended to result in a shortfall in the RHC Program, and it did not create a conflict with the Telecommunications Act so long as the cap was not reached. ANHB suggests that, if the FCC keeps any cap in place, the base level of funding for the RHC Program be doubled to $800 million at a minimum. Additionally, the RHC Program should be adjusted in the future to account for inflation, which is, for instance, how the E-Rate Program operates. More importantly, the RHC program also needs to be adjusted in the future for growth in connectivity demand for health care: modern applications such as videoconferencing continue to drive the need for higher bandwidth and lower latency, and the mission-critical nature of telecommunications is driving the need for redundant and more fault tolerant systems.

This increase and inflation adjustment will both account for the lost value of the program for 20+ years of no adjustments for inflation, plus build in space for RHC Program growth. The FCC has built a successful program by all accounts. Expenditures in the RHC Program impact every aspect of a rural community's foundation of strength, including healthy people, economically efficient program delivery, and closing the rural-urban technological divide. The FCC should, as the NPRM appears to indicate, grow the RHC Program rather than contract it. An $800 million initial funding level, with built-in adjustment for program growth and cost increases, will allow for program stability, without moving funding out of the overall Universal Service Fund (USF) structure. With this amount of funding, many of the other questions posed by the FCC in the NPRM will become moot, such as rollover funds, prioritization of one geographic area over another, and/or prioritization of RHC Program over, or linkage with, other USF-funded programs.

The NPRM also asks whether the cap should be retroactively increased for FY 2017. ANHB strongly supports a retroactive increase in the cap to address FY 2017. On December 14, 2017, the FCC voted to adopt an Order that: (1) provides a one-time waiver allowing the RHC Program's cap to be lifted for 2017 to the extent any unused prior-year RHC program funds were available to roll over; and (2) provides a waiver allowing service providers to voluntarily reduce their rates for qualifying FY 2017 requests. ANHB supports the FCC Order but remains concerned that the Order does not fully resolve the expected FY 2017 subsidy shortfall, potentially leaving tribal HCPs with considerable costs. Service providers in Alaska have already stated that they will not reduce their rates again for FY 2017, as they did in FY 2016. These service providers are critically needed in Alaska as well, so program stability will allow them to continue to invest in infrastructure, eventually bringing costs down as connectivity expands. ANHB urges the FCC to address the expected FY 2017 shortfall by retroactively increasing the RHC Program cap to a level sufficient to fully meet program demand.

Roll Over Funding

The NPRM requests comment on whether to allow unused RHC Program funds to be rolled over to a subsequent funding year. ANHB supports rolling over unused or released RHC Program funds to meet the needs of subsequent funding years. As the NPRM notes, in the E-rate Program all unused funding from previous funding years is made available for subsequent funding years. ANHB urges that the use of roll over funds not be limited to use in the next funding year but rather that these funds be made available for all subsequent funding years until the roll over funds are ultimately disbursed.

The NPRM also asks how roll over funds should be prioritized. We recommend that if prioritization is necessary, roll over funds be prioritized in line with the principles described below, based on rurality, need, and the federal trust responsibility to provide health care to American Indians and Alaska Natives.

Prioritization

To the extent that a funding level sufficient to fulfill the needs of the RHC Program is not approved, ANHB suggests the use of "rurality" (a term used by FCC) to prioritize funding under a hard cap and more limited funding system. Suggestions by HCPs as well as telcos from Alaska have included the recommendation that the FCC look at the "highly rural" definition and designation used by the Department of Veterans Affairs as a means of creating a higher level of priority among rural HCPs. This would then reflect the real costs associated with connectivity, as rurality is clearly one of, if not the absolute, driving factor. ANHB, therefore, supports the GCI proposal mentioned in the NPRM that would create a highly rural prioritization. However, we cannot support GCI's proposal to, in the event of a shortfall, require highly rural HCPs to pay a minimum amount that increases each year over five years. Tribal HCPs in Alaska cannot absorb these costs and do not need any extra incentive or "skin in the game" because tribal HCPs in Alaska are already working diligently to ensure efficient use of all program resources in order to maximize patient care. Moreover, the GCI proposal is not a modest increase in the costs paid by HCPs, but would increase the costs for many rural HCPs in Alaska by 500% over 5 years, equivalent to paying 5 times the urban rate.

ANHB also recommends that the FCC consider the economic need and reliance on RHC Program funding for health care delivery in its prioritization. This could be a subjective measure, but it is imperative that the FCC get out into Indian Country, see the IHS-funded systems in place, better understand the attempts of tribal health systems to adopt new technologies, and reflect in its final RHC Program rule policies that further encourage and fund these efforts. ANHB supports the consideration of health care professional shortages if prioritization of RHC Program funding is needed.

ANHB recommends that the FCC consider the federal trust responsibility to provide health care to tribes and Alaska Natives as a factor for the FCC in determining funding priorities. All rural areas are important, but only American Indian and Alaska Native communities also have the underpinning of the federal government's preexisting and overarching trust responsibility to provide health care. The RHC Program, therefore, to be an accurate expression of the trust responsibility to tribes and Alaska Natives, must have a recognition of that program priority built in to any new rulemaking. ANHB appreciates that the NPRM specifically addresses the need to target support to rural tribal HPCs and requests information regarding the various proposals' effects on tribal populations.

NPRM Terminology, Benchmarks and Standards

ANHB strenuously suggests that the FCC's final rule adjust the way it discusses "Waste, Fraud and Abuse." The so-titled section of the NPRM seems to equate waste, fraud, and abuse with what the FCC terms "outlier" costs. As discussed above, Alaska has extremely high costs for connectivity due to a wide range of reasons that are well known and justified. Alaska is not an "outlier," but is rather simply Alaska. There is no need for "enhanced review" by the Universal Service Administrative Company (USAC) or additional scrutiny simply because Alaska telecommunications costs are high. If the FCC wants to create a national "benchmark" for cost-sharing (the NPRM discusses moving that rate to 90 percent), Alaska will suffer disproportionately because its costs are much higher to begin with and remote Alaska communities rely on connectivity to an even greater extent than even other rural locations in the United States.

Alaska should be left out of the "benchmark" contribution/discount rate discussion until the FCC studies the state in greater detail to understand what the specific impacts would be. For example, if any one or our THOs, Eastern Aleutian Tribes (EAT) for example, had to come up with an additional percent of its telecommunications budget, which in many forecasts would be a tenfold increase, due to a uniform RHC

Program rule change, the impact would be severe and result in EAT having to cut elsewhere, likely a provider or more, diminishing health care delivery to its communities. Some THOs would have to dismiss health care providers as a result. Alaska does not have "outlier" costs that indicate waste, fraud, or abuse. Alaska has high costs due to its unique and challenging landscape, but the benefits of RHC Program funding far outweigh those costs. Additionally, if a benchmark is established for Alaska, funding requests from tribal HCPs in Alaska should not be capped as an alternative to enhanced review. Tribal HCPs in Alaska cannot afford these costs, and such a cap would be inconsistent with the federal trust responsibility given the extent to which tribal HCPs in Alaska depend on the RHC Program to provide basic and life-saving care to Alaska Natives.

ANHB also questions of the use of the phrase "cost effectiveness" as a means of getting at some uniform standard that would include Alaska with the lower 48 states. Alaska HCPs put out for competitive bidding their requests for services consistent with the rules. "Cost effective" is a relative term and needs to consider the alternatives that, for rural Alaska communities, are often expensive or nonexistent. If the FCC wants to utilize "cost effectiveness" in its decision-making or prioritization, Alaska needs to be treated separately and with a deeper dive into the facts and background surrounding costs.

ANHB supports the NPRM's provisions on eliminating waste through having consistent rules related to consultants who work on the program as well as consistent and clear rules on what constitute "gifts."

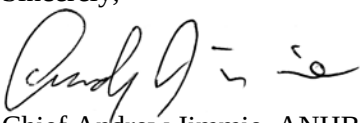
ANHB also supports any procedural improvements that will reduce the amount of time in which USAC funding levels are determined. This is a risk of each of our Members each year as it awaits USAC correspondence.

ANHB recommends that, prior to adopting a final rule, the FCC consult directly with tribes and Alaska Native organizations on the NPRM. This could occur through use of teleconference, direct meeting, and/or FCC reaching out specifically to tribes and tribal organizations.

Conclusion

ANHB thanks the FCC for its attention to the long-term needs and administration of the RHC Program. We look forward to working with the FCC as it carries out the federal trust responsibility to American Indians and Alaska Natives, with the unique circumstances of Alaska also in mind.

Sincerely,



Chief Andrew Jimmie, ANHB Chair