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

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| In the Matter of | ) | |
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| Promoting Telehealth in Rural America | ) | WC Docket No. 17-310 |
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# REPLY COMMENTS OF YUKON-KUSKOKWIM HEALTH CORPORATION

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Dan Winkelman
President and CEO
YUKON-KUSKOKWIM HEALTH CORPORATION
Box 528
Bethel, Alaska 99559
(907) 543-6000

Matt DelNero
Michael Beder
COVINGTON & BURLING LLP
One CityCenter
850 Tenth Street, NW
Washington, DC 20001-4956
(202) 662-6000

*Counsel for Yukon-Kuskokwim Health Corporation*

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## REPLY COMMENTS OF YUKON-KUSKOKWIM HEALTH CORPORATION

Yukon-Kuskokwim Health Corporation ("YKHC") filed these reply comments in response to the Notice of Proposed Rulemaking ("NPRM") adopted in the above-captioned proceeding, which appropriately recognizes that "a well-designed Rural Health Care (RHC) Program is more vital than ever" to giving rural communities access to high-quality health care despite "the obstacles to healthcare delivery faced in isolated communities."[1]

## I. INTRODUCTION AND SUMMARY

For YKHC's patients in remote areas of southwest Alaska, the telemedicine services that the RHC Program makes possible often make the difference between life and death. As explained in YKHC's initial comments,[2] YKHC provides a wide range of health care services to approximately 30,000 people living in more than 50 rural and remote communities in southwest Alaska, across a region the size of the state of Washington. In almost all cases, YKHC facilities provide the only regionally available health care services to the individuals living in these rural communities. YKHC depends on telemedicine capabilities to serve these far-flung communities

[1] *Promoting Telehealth in Rural America*, Notice of Proposed Rulemaking, 32 FCC Rcd 10631, 10632-33 ¶¶ 1-2 (2017) ("NPRM").

[2] Comments of Yukon-Kuskokwim Health Corporation, WC Docket No. 17-310, at 1-2 (filed Feb. 2, 2018) ("YKHC Comments").

effectively. YKHC accordingly relies heavily on the RHC Program to secure, at affordable rates, the telecommunications services on which these capabilities depend.

YKHC supports the position adopted by the vast majority of commenters that the RHC Program's funding cap should be increased or eliminated. The language of the Communications Act provides that health care providers are "entitled" to purchase telecommunications services at rates reasonably comparable to urban rates. The statute therefore does not support any imposition of a funding cap that would limit this right. If, however, the Commission determines to set a funding cap, YKHC agrees with commenters proposing that the cap at a minimum be doubled to $800 million to reflect inflation over the previous two decades and to allow for expected and necessary growth of the RHC Program.

By contrast, YKHC opposes proposals that would punish health care providers serving the most remote and hard-to-connect areas by subjecting so-called "outlier" providers to "enhanced review" burdens or by artificially increasing these providers' out-of-pocket costs (whether through benchmark-based caps or requiring minimum payments higher than the reasonably comparable urban rate). Such proposals would undermine the tenets on which the RHC Program was established by penalizing those the statute was designed to protect and promote. Any such cost controls would only serve to deter health care providers from providing adequate health care to rural communities.

Finally, YKHC encourages the Commission to adopt its proposal to streamline the administrative processes to reduce burdens on rural health care providers. Specifically, the Commission should harmonize forms between the Telecom and HCF Programs, thereby easing the application process and minimizing unnecessary bureaucratic expenditures. Additionally, the

competitive bidding standards between these programs should be harmonized to reduce confusion and enhance transparency.

## II. THE RHC PROGRAM MUST BE FULLY FUNDED TO SERVE THE MISSION CONGRESS SET.

Commenters broadly agree that the RHC Program funding cap should be increased to reflect both the expansion of the program and inflation in the 20 years since the $400 million cap was established. YKHC agrees that the cap should either be eliminated entirely, or increased to at least $800 million. Further, if the Commission is determined to impose a cap, the funding level should be tied to inflation to ensure that support remains level in real terms. The Commission should, in addition, roll over any unused funding into subsequent years and prioritize funding for highly rural areas.

### A. The funding cap should be either eliminated or increased.

YKHC supports the nearly unanimous position adopted by commenters that the RHC Program's funding cap should be increased or eliminated altogether. As explained by commenters such as Southcentral Foundation and the Alaska Native Tribal Health Consortium, the language of the Communications Act does not support imposing any cap on funding for the RHC program.[3] The funding cap therefore should be eliminated in its entirety. Section 254 of the Act entitles public and nonprofit rural health care providers to purchase telecommunications services "at rates that are reasonably comparable to rates charged for similar services in urban

[3] *See* Comments of Southcentral Foundation, WC Docket No. 17-310, at 3 (filed Jan. 31, 2018) ("Southcentral Comments"); Comments of Alaska Native Tribal Health Consortium, WC Docket No. 17-310, at 4 (filed Feb. 1, 2019) ("ANTHC Comments"). *See also* Comments of Schools, Health & Libraries Broadband Coalition, WC Docket No. 17-310, at 14-15 (filed Feb. 2, 2019) ("SHLB Comments").

areas in that State," and the difference between these rates constitutes part of the telecommunications carrier's "service obligation to participate in the mechanisms to preserve and advance universal service."[4] Reimbursements to carriers under the RHC Program are the mechanism by which the Commission enables rural health care providers to purchase telecommunications services at reasonably comparable rates. The statute imposes no cap on the right of health care providers — individually or in the aggregate — to purchase such services as "necessary for the provision of health care services in a State."[5] The Commission therefore lacks the statutory authority to impose any cap on RHC Program funding.

Capping funding levels for the RHC Program also is contrary to congressional intent. As explained by the Alaska Native Tribal Health Consortium, the "Act makes clear that Congress understood that programmatic health care successes were expected to come from a fully funded RHC Program" and that Congress did not ask the Commission to create this program "only to then pull the rug out from under those programs through insufficient future funding."[6] The RHC Program was designed to recognize the increasing dependence that rural health care providers have on telecommunications services, the obstacles faced by these providers in gaining access to such services in remote areas, and the resulting gulf in costs that rural health care providers face as opposed to their urban counterparts. Arbitrary limitations on funding levels that are

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[4] 47 U.S.C. § 254(h)(1)(A).

[5] *Id*.

[6] ANTHC Comments at 4; *see also* Comments of the Bristol Bay Area Health Corporation, WC Docket No. 17-310, at 4 (filed Feb. 2, 2018) ("Bristol Bay Comments"); Comments of Council of Athabascan Tribal Governments, WC Docket No. 17-310, at 4 (filed Feb. 1, 2018) ("Athabascan Tribal Government Comments"); Comments of Norton Sound Health Cooperation, WC Docket No. 17-310, at 4 (filed Feb. 2, 2018) ("Norton Sound Comments"); Comments of Alaska Native Health Board, WC Docket No. 17-310, at 3 (filed Feb. 1, 2018) ("ANHB Comments"); Comments of Maniilaq Association, WC Docket No. 17-310, at 3 (filed Feb. 2, 2018) ("Maniilaq Comments").

disconnected from this design, and that fail to reflect the needs of rural communities in an increasingly technological economy, cannot be supported by the plain language of the statute and undermine the statute's effectiveness in serving the purposes set by Congress.

If the Commission nonetheless imposes a funding cap, the cap should be raised to at least $800 million.[7] As the Commission recognized in the NPRM, "advances in technology have improved telehealth and telemedicine capabilities and with it a need for expanded bandwidth."[8] Therefore, to the extent the Commission imposes an artificial limitation on funding levels, the limit at a minimum must "reflect the current bandwidth needs of, and purchase decisions by, healthcare providers in rural areas."[9] The Alaska Communications comments emphasize that, in light of technological advances that have had a dramatic impact on demand, even "a budget of $900 to $999 million would not be unreasonable for the RHC program in FY 2018."[10] Increasing the funding cap to $800 million not only would account for the over 20 years of inflation since the initial $400 million cap was imposed but also would provide space for the expected and necessary growth in the RHC Program as telemedicine capabilities continue to advance.[11]

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[7] *See, e.g.,* ANTHC Comments at 7; Bristol Bay Comments at 7; Athabascan Tribal Government Comments at 5; Norton Sound Comments at 7; ANHB Comments at 6; Maniilaq Comments at 5; Comments of Franciscan Alliance, Inc. and Parkview Health System, Inc., WC Docket No. 17-310, at 6-8 (filed Feb. 2, 2018) ("Franciscan Alliance Comments"); Comments of Kellogg & Sovereign Consulting, LLC, WC Docket No. 17-310, at 6 (filed Feb. 2, 2018) ("Kellogg Comments").

[8] NPRM, 32 FCC Rcd at 10639 ¶ 15.

[9] Comments of General Communication, Inc., WC Docket No. 17-310, at 2 (filed Feb. 2, 2018) ("GCI Comments").

[10] Comments of Alaska Communications, WC Docket No. 17-310, at 13 (filed Feb. 2, 2018).

[11] *See, e.g.,* ANTHC Comments at 7; Bristol Bay Comments at 7; Athabascan Tribal Government Comments at 5; Norton Sound Comments at 7; ANHB Comments at 6; Maniilaq Comments at 5.

YKHC also agrees with the overwhelming majority of commenters in supporting adjusting the funding level annually hereafter to account for inflation[12] and in encouraging the FCC to roll-over unused or released RHC Program funds to meet the needs of subsequent funding years.[13] The necessity of providing connectivity to rural health care providers is only increasing as telemedicine capabilities advance. A funding cap that fails even to match inflation, in contrast, amounts to a perpetual series of automatic funding cuts in real terms, which would fundamentally undermine the RHC Program's ability to serve its mission. Similarly, even if the program does not spend all of its available funds in a particular year, that is no justification for permanently removing those funds from the program rather than rolling them over to meet the program's ongoing needs.

**B. Highly rural areas should be prioritized.**

As numerous commenters have explained, if program funds must be prioritized, highly rural areas should receive highest priority.[14] As suggested by the Alaska Native Tribal Health Consortium, this would "reflect the real costs associated with connectivity, as rurality is clearly

[12] *See*, *e.g.*, ANTHC Comments at 7; Kellogg Comments at 6; GCI Comments at 18; Community Hospital Corporation, WC Docket No. 17-310, at 1 (filed Jan. 29, 2018) ("CHC Comments"); Critical Access Health Coalition, WC Docket No. 17-310, at 2 (filed Feb. 2, 2018) ("CAH Coalition"); National Association of Community Health Centers, WC Docket No. 17-310, at 13 (filed Feb. 2, 2018) ("NACHC Comments"); Florida Association of Community Health Centers WC Docket No. 17-310, at 2 (filed Feb. 2, 2018) ("FACHC"); TeleQuality Communications, LLC, WC Docket No. 17-310, at 4 (filed Feb. 2, 2018) ("TeleQuality Comments").

[13] *See e.g.*, ANTHC Comments at 7-8;," Advanced Data Services, WC Docket No. 17-310, at 1 (filed Feb. 2, 2018) ("ADS Comments"); Alaska Primary Care Association, WC Docket No. 17-310, at 2 (filed Feb. 2, 2018) ("ACPA Comments"); American Telemedicine Association, WC Docket No. 17-310, at 2 (filed Feb. 2, 2018) ("ATA Comments"); US Telecom, WC Docket No. 17-310, at 11 (filed Feb. 2, 2018) ("US Telecom Comments"); CHC Comments at 1; Franciscan Alliance Comments at 8; Southcentral Comments at 4.

[14] *See*, *e.g.*, National Health Law Program, WC Docket No. 17-310, at 5 (filed Feb. 2, 2018); SHLB Comments at 15; ACPA Comments at 2.

one of, if not the absolute, driving factor."[15] Remoteness and cost factors, for example are exactly why Alaska was an early adopter of telehealth and telemedicine program opportunities. The widespread adoption of these programs in rural areas of Alaska makes federal investment in such programs disproportionately efficient and effective.[16] Further, as the Bristol Bay Area Health Corporation emphasizes, in the most rural areas connectivity in health care "is not a luxury—it is a lifeblood."[17] For instance, many of the communities YKHC serves can only be reached by airplane, boat, or snow machine, and more than a dozen of these communities are more than an hour away (greater than 100 miles) from the YKHC Regional Hospital in Bethel by air — when the weather permits air travel at all. To serve its patients effectively, YKHC must be able to reliably transmit and receive on a 24/7 basis, among other items, patient electronic medical records, high-resolution medical images (such as CT scans), and real-time two-way communications used for telemedicine consultations and telepsychiatry services — all of which depend on telecommunications services that become more expensive, and more critical, the more remote a community is.

Accordingly, if the Commission must prioritize funding, the highest priority should go to the highly rural and isolated communities that most depend on this funding and the capabilities it enables.

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[15] ANTHC Comments at 8.

[16] *See e.g.,* ANTHC Comments at 6; Bristol Bay Comments at 7; Athabascan Tribal Government Comments at 4; Norton Sound Comments at 6; ANHB Comments at 5; Maniilaq Comments at 5.

[17] Bristol Bay Comments at 7.

## III. THE RHC PROGRAM MUST NOT PENALIZE SO-CALLED "OUTLIERS" FOR SERVING THE MOST REMOTE, HARD-TO-CONNECT AREAS.

The underlying purpose of the RHC program is "to ensure that Americans in rural areas have access to telehealth services, including advanced services, that are reasonably comparable to those services provided in urban areas and that are available at rates that are reasonably comparable to rates charged for similar services in urban areas."[18] As the comments of Alaska-based commenters make clear, the limited infrastructure, extreme geographic isolation, limited historic investment in utilities and communications systems, and very high travel, fuel, and health care costs, make Alaska stand out as a unique example of the rural-urban divide the RHC was intended to address.[19] There accordingly is no justification for penalizing providers who serve these most isolated areas by subjecting them to "enhanced review" burdens or by artificially increasing these providers' out-of-pocket costs, whether through benchmark-based caps or requiring minimum payments higher than the reasonably comparable urban rate.

As GCI explains, "[t]he 'benchmark' method would both impermissibly impose an external limitation on the calculation of rates and unfairly impact only 'outlier' parties."[20] Commenters such as Alaska Communications, TeleQuality Communications, LLC, and the numerous Alaskan health care provider and native tribal associations highlight why imposing

[18] Alaska Communications Comments at ii (citing 47 U.S.C. §254(b)(3)).

[19] *See, e.g.*, ANTHC Comments at 6; Bristol Bay Comments at 10; Athabascan Tribal Government Comments at 7; Norton Sound Comments at 6; ANHB Comments at 5; Maniilaq Comments at 7.

[20] GCI Comments at 36.

"outlier" labels on providers serving high-cost areas is counterproductive.[21] As a large segment of these commenters note, "access to telehealth services . . . lowers costs in rural communities, saving money at the local, state, and national levels."[22] Discouraging health care providers in these communities from taking full advantage of telehealth capabilities — either by increasing their out-of-pocket costs or subjecting them to unnecessary administrative burdens and funding uncertainty — would reflect a misguided focus on short-term spending reductions over long-term savings. Moreover, GCI also notes that, in its experience "per Mbps service rates charged to healthcare providers and supported by the Telecommunications Program have consistently decreased over time," belying the assumption that existing rural rates are inflated.[23]

Nor should the Commission — contrary to Section 254 of the Act — require any rural health care providers to make minimum payments in excess of reasonably comparable urban rates. YKHC accordingly opposes GCI's proposal that minimum payments by highly rural providers should be increased to the greater of the urban rate or one percent of the rural rate (subject to further increases).[24] Rural providers, who often have very limited resources, already have strong incentives to be as cost-efficient as is feasible, even when paying the urban rate. The Alaska Native Tribal Consortium elaborates that this proposal "would increase the costs for

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[21] Alaska Communications Comments at 24; TeleQuality Comments at 12-13. *See , e.g.,* ANTHC Comments at 6; Bristol Bay Comments at 10; Athabascan Tribal Government Comments at 7; Norton Sound Comments at 6; ANHB Comments at 5; Maniilaq Comments at 7.

[22] Comments of Bartlett Regional Hospital, WC Docket No. 17-310, at 2 (filed Feb. 2, 2018) ("Bartlett Regional Comments").

[23] GCI Comments at 2.

[24] *See* GCI Comments at 45. Commenters representing Alaskan native groups and health care providers also oppose this proposal. *See, e.g.,* ANTHC Comments at 8; Bristol Bay Comments at 9; Athabascan Tribal Government Comments at 6; Norton Sound Comments at 8; ANHB Comments at 7; Maniilaq Comments at 6.

many rural HCPs in Alaska by 500 percent over five years, equivalent to paying five times the urban rate."[25] As explained above, highly rural providers are the participants the statute was designed explicitly to protect. Imposing such "minimum payments" would effectively serve as a punishment for providers exercising their statutory rights. The RHC Program cannot and should not adopt rules intended to require any rural provider to pay more than the reasonably comparable urban rate.

Instead, the Commission should rely on market mechanisms to determine appropriate urban and rural rates. YKHC supports defining the urban rate for a connectivity service based on the service provider's offerings to comparable clients in urban areas and, where the service provider has commercial clients in rural areas, using the same metric for the service's rural rate.[26] Commission micromanagement of rates — especially rural rates — could discourage service providers from maintaining or expanding broadband infrastructure in the areas that are most challenging — and thus most expensive — to serve. As the TeleQuality Communications, LLC comments explain, "promoting competition in the rural healthcare market is the most powerful way to address potential rate manipulation."[27] In contrast, a miscalculation of "acceptable" rates by the Commission, for example by averaging rates across disparate geographies and densities, could conflict with the RHC Program's ability to fulfill its statutory mandate of making services available to rural health care providers at rates reasonably comparable to those paid by urban providers.

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[25] ANTHC Comments at 8.

[26] *See, e.g.*, GCI Comments at 50-52; TeleQuality Comments at 18-19. For example, "[c]ompetition is driving rates down in the E-rate Program and it will do the same in the RHC Program." TeleQuality Comments at 2.

[27] TeleQuality Comments at 2.

Finally, the Commission should reject proposals to attempt to control costs by hamstringing providers who seek to expand their capabilities. The Commission thus should not define "cost effectiveness" as the least expensive means of meeting the minimal requirements. As explained by a wide range of service providers, health care systems, and Alaskan native associations and health care providers, such an overly restrictive definition of cost effectiveness would undermine the basic purpose of the RHC Program: to improve the quality of rural health care.[28] As explained by Southcentral Foundation, "[i]n the delivery of health care, 'cheaper' and 'minimums' are not likely to improve the health status of our patients. Technology changes almost daily, as do treatment modalities. Thus, we must have the flexibility to adapt to these changing environments, and we fear that being left to choose the cheapest services that provide only the minimum necessary will impede our ability to adapt and provide the best care available."[29] The Community Hospital Corporation commenters likewise note that "[t]his language opens the door for service or bandwidth caps and will hamper forward momentum in telemedicine for rural Healthcare providers."[30] The RHC Program was intended to improve access to health care for rural communities, not to impose cost controls that would deter health care providers from providing adequate health care.

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[28] *See, e.g.*, Comments of New England Telehealth Consortium, WC Docket No. 17-310, at 7 (filed Feb. 2, 2018) ("NETC Comments"); ADS Comments at 3-4; Southcentral Comments at 5; TeleQuality Comments at 20; Franciscan Alliance Comments at 14-15; ANTHC Comments at 10.

[29] Southcentral Comments at 5-6.

[30] CHC Comments at 3. Fourteen other commenters submitted letters in support of the CHC Comments. *See, e.g.*, Comments of Baptist Hospitals of Southeast Texas, WC Docket No. 17-310 (filed Jan. 31, 2018); Comments of Bingham Memorial Hospital, WC Docket No. 17-310 (filed Jan. 31, 2018); Comments of Freestone Medical Center, WC Docket No. 17-310 (filed Jan. 31, 2018); Comments of Jellico Community Hospital, WC Docket No. 17-310 (filed Jan. 31, 2018); Comments of McLeod Health, WC Docket No. 17-310 (filed Jan. 31, 2018).

## IV. THE FUNDING APPLICATION AND COMPETITIVE BIDDING PROCESSES SHOULD BE STREAMLINED.

YKHC supports efforts to streamline the RHC Program application process, reduce confusion for applicants, and minimize unnecessary burdens on rural health care providers.[31] In particular, YKHC encourages the Commission to adopt its proposal to harmonize the applicable forms between the Telecom Program and HCF Program. As the Commission recognizes in the NPRM, "[t]he use of multiple online forms for the RHC Program can cause confusion on the part of applicants and reduces the administrative efficiency of the applications process."[32] The RHC Program should also adopt consistent standards with respect to bidding processes and documentation requirements. Aligning standards across the RHC Program would reduce administrative burdens on both the Commission and on already over-encumbered rural health care providers. Streamlining these processes would allow all involved-parties to better focus their efforts and time on the actual purpose of the RHC Program — providing rural communities with reliable health care services — rather than dispensing scarce resources navigating overly complicated administrative procedures.

[31] *See, e.g.*, Comments of the National Rural Health Association, WC Docket No. 17-310, at 5 (filed Feb. 2, 2018); Comments of the American Hospital Association, WC Docket No. 17-310, at 17-18 (filed Feb. 2, 2018); CAH Comments at 2; CHC Comments at 3-4; NCTA Comments at 8-9; Kellogg Comments at 14-15; Southcentral Comments at 6.

[32] NPRM, 32 FCC Rcd at 10662 ¶ 96.

## V. CONCLUSION

YKHC relies heavily on the RHC Program to secure, at affordable rates, the telecommunications services that are vital to its health care program. However, the Program's artificially low cap and other challenges are putting these services at risk. YKHC therefore continues to urge the Commission to take steps — widely supported by other commenters — to ensure the Program effectively meets the needs of rural communities. Specifically, YKHC supports raising or eliminating the funding cap to reflect inflation and increasing demand; opposes any penalties on so-called "outlier" providers for serving hard to reach communities; and encourages the streamlining of the application process to reduce confusion and burdens on rural health care providers.

Respectfully submitted,

/s/

Dan Winkelman
President and CEO
YUKON-KUSKOKWIM HEALTH CORPORATION
Box 528
Bethel, Alaska 99559
(907) 543-6000

Matthew S. DelNero
Michael Beder
COVINGTON & BURLING LLP
One CityCenter
850 Tenth Street, NW
Washington, DC 20001-4956
(202) 662-6000

*Counsel for Yukon-Kuskokwim Health Corporation*

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