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Comment

Marlene H. Dortch
Secretary
Federal Communications Commission
445 12th Street SW
Washington, DC 20554

Re: WC Docket No. 02-60

Dear Secretary Dortch:

The Schools, Health & Libraries Broadband Coalition, California Telehealth Network, New England Telehealth Consortium, Health Information Exchange of Montana, Utah Telehealth Network, Colorado Telehealth Network, and Southwest Telehealth Access Grid filed a petition for rulemaking on December 7, 2015 seeking to amend Part 54 of the Commission's rules with a series of reforms to the Rural Health Care (RHC) program. Clarification of HCP eligibility categories was one component of the petition. We would like to provide comment on this petition as we feel strongly that simply providing clarification about the eligibility categories is insufficient in light of the changing landscape of rural health care delivery.

The health care delivery system depends on the availability of both health care providers and health care infrastructure to function effectively.

- Rural Health Care Workforce. Rural communities have a shortage of all levels of providers, including physicians, nurses, dentists, psychologists, and specialists. The loss of even a single health care provider (whether through retirement, relocation, illness or death), in a rural community can have devastating impacts.

  The lack of an adequate workforce is magnified in rural areas because the elderly population is growing more rapidly in rural than in urban areas. Individuals 65 years and over constitute approximately 14.5% of the American population. In rural areas, the percentage of the population 65 years and over is 20%. At the population level, overall health care utilization increases significantly with age.

- Rural Health Care Infrastructure. Sixty-seven rural hospitals have closed since 2010. Right now, 673 additional facilities are severely vulnerable and could close—this represents over 1/3 of rural hospitals in the U.S. In fact, the rate of closure has steadily increased since sequester and bad debt cuts began to hit rural hospitals; resulting in a rate six times higher in 2015 compared to 2010. Medical deserts are appearing across

rural America, leaving many of our nation's most vulnerable populations without timely access to care (National Rural Health Association).

Section 254(h)(7) of the Act specifically lists the types of health care entities eligible to receive universal service support through the FCC Rural Health Care Program (RHCP). This list includes entities traditionally known as the health care "safety net":

> (B) HEALTH CARE PROVIDER.—The term "health care provider" means—
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> (i) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools;
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> (ii) community health centers or health centers providing health care to migrants;
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> (iii) local health departments or agencies;
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> (iv) community mental health centers;
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> (v) not-for-profit hospitals;
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> (vi) rural health clinics; and
>
> (vii) consortia of health care providers consisting of one or more entities described in clauses (i) through (vi).

As a result of the above challenges, the rural health care "safety net" does not necessarily fit the profile of the same in suburban and urban communities. Rural communities have had to innovate in order to meet the health care needs of their populations. A variety of non-traditional health care providers have been integrated into healthcare delivery models (both existing and emerging) for rural populations. These providers serve the same functions as those listed as eligible providers, but may not be seen as eligible to receive universal service support through the FCC Rural Health Care Program (RHCP). We believe that there may be some flexibility in how eligible providers are defined, so as to allow their inclusion as eligible providers without undergoing statutory change. A few examples of these follow:

- **Emergency medical service providers.** Mobile integrated health care is a quickly evolving field in both rural and urban areas as Emergency Medical Services (EMS) providers look to reduce the use of EMS services for non-emergent 911 calls, overcrowding of emergency departments, and healthcare costs. In its simplest definition, Mobile Integrated Healthcare (MIH) is the provision of healthcare using patient-centered, mobile resources in the out-of-hospital environment. It may include, but is not limited to, services such as providing telephone advice to 9-1-1 callers instead of resource dispatch; providing community paramedicine care, chronic disease management, preventive care or post-discharge follow-up visits; or transport or referral to a broad spectrum of appropriate care, not limited to hospital emergency departments.

  In rural areas, Community Paramedics help fill gaps in the local delivery system due to shortages of primary care physicians and long travel times to the nearest hospital or clinic.

Community paramedicine is also viewed as a way of recruiting and retaining EMTs and paramedics. Rural EMS agencies are primarily volunteer since call volume is low. Many rural areas are having difficulty recruiting volunteers, since there is no career path within the existing volunteer system.

The role of both EMT- and paramedic-level Community Paramedics is to fill local healthcare gaps as a full participating member of a patient's medical home care team. To prepare them to participate in the medical home care team, they need additional education focused on understanding longer term care. A standard curriculum is available free of charge to colleges and universities. It consists of approximately 114 hours of didactic education (in the social determinants of health, public heath, and tailored learning about chronic diseases) and approximately 200 hours of lab and clinical experience.

Funding to start and sustain rural Community Paramedic programs is a significant issue. As of July 2014, most community paramedicine programs are funded either by the ambulance service itself, or through grants. There are currently three CMS Healthcare Innovation Grant awardees who receive Medicare fee-for-service for community paramedic services. In most states, community paramedicine services are not reimbursed by Medicaid, although Minnesota does allow reimbursement for certain services provided by Community Paramedics. Access to Broadband is vital to community paramedicine, both for access to training, transmission of health data/information and communication with other health care professionals, but adds to the cost of a program that is already struggling with funding.

- **Non-traditional "Clinic" sites.** Facilitated by telehealth, the practice site for health care services is no longer confined to a hospital or clinic setting. These non-traditional settings include workplaces, skilled nursing facilities, school/college/university campuses, retirement communities, housing developments and even retail stores. In many ways, this is a more cost-effective and less man-power intensive model of care. In rural areas, where resources are scarce, nontraditional "clinic" sites have been emerging. In some rural areas, nursing homes and skilled nursing facilities serve as a source for health care services for the community.

  As an example, Cathedral Square Corporation (CSC) is a nonprofit organization in Burlington, Vt. that owns and manages 24 affordable housing communities for seniors and individuals with special needs. The organization developed the Support And Services at Home (SASH) model, through which an interdisciplinary team of health professionals and service providers works at a housing site to help residents remain independent. The team is comprised of a full-time SASH coordinator and a wellness nurse, both of whom are employed or subcontracted by the housing development, as well as nurses, caseworkers, mental health professionals and service providers from community-based organizations. Using funds from the Vermont legislature, the Vermont Health Foundation and the MacArthur Foundation—as well as its own funds—CSC developed and piloted SASH at one of its apartment buildings from August 2009 to August 2010. Since July 2011, SASH has been integrated into the Blueprint for Health, Vermont's new health reform initiative. Organized

around a medical home model, the initiative involves the creation of interdisciplinary community health teams that provide coordinated care and support patients' primary care physicians. A Medicare-funded SASH program will extend the capacity of those community health teams in 112 housing developments throughout the state.

The organization's most ambitious technology initiative involves its efforts to connect SASH sites to Vermont's Health Information Exchange (HIE). Like many owners of older housing communities, SASH sites face a challenge as they attempt to upgrade their buildings to support technology innovations. Technology is virtually nonexistent in these buildings, but will become increasingly important in helping these sites share information with other practitioners and eventually institute more sophisticated methods of monitoring resident behavior and tracking health outcomes. CSC hopes to be included in the state's broadband initiative.

- **For-profit health care providers.** Rural health care facilities and practices are more than just sites for health care treatment. They are economic drivers in their communities — often a top-five employer with the greatest number of college-educated employees and one of the few places in a small town where people interested in health care can advance their careers. The National Rural Health Association estimates that 23 jobs — direct and indirect — are created for every physician recruited to work in a community health care facility. These facilities make up 20 percent of total economic development dollars in their communities. Hospitals and clinicians providing care to rural residents often see higher percentages of patients who are uninsured or have government-funded health plans. Such reliance on government-funded health plans makes rural hospitals and clinics, whether for-profit or non-profit especially vulnerable to budget cuts. Low patient volumes also create issues in rural areas. Some rural areas do not have the patient base to support multiple practices and more than one community hospital. Therefore, in some rural communities, many practices and hospitals that are for-profit are still functionally safety net providers. The loss of any one of these practices or hospitals due to financial viability would be devastating to the delivery of health care in these communities.

  The Sole Community Hospital (SCH) program was created by Congress to maintain access to needed health services for Medicare beneficiaries in isolated communities. Hospitals typically qualify for SCH status by demonstrating that because of distance between hospitals, they are the sole source of hospital services available in a wide geographic area. Both for-profit and nonprofit hospitals are eligible for the SCH classification as long as they can meet one of the following criteria:

  1. The hospital is located at least 35 miles from other like hospitals;
  2. The hospital is rural (located in a rural area), located between 25 and 35 miles from other like hospitals, **and** meets **one** of the following criteria:
     - No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals

located within a 35-mile radius of the hospital or, if larger, within its service area; or
    - The hospital has fewer than 50 beds and would meet the 25 percent criterion above if not for the fact that some beneficiaries or residents were forced to seek specialized care outside of the service area due to the unavailability of necessary specialty services at the hospital;
3. The hospital is rural and located between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each of 2 out of 3 years; or
4. The hospital is rural and because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

Although for-profit emergency departments are currently eligible to participate in the RHCP due to the requirements of the Emergency Medical Treatment and Labor Act (EMTALA), a similar case may be made for SCH hospitals that are for-profit. Additionally, one could also make that case for private practice clinics in rural areas if they have the same payor mix (high proportions of Medicare, Medicaid and self-pay) as non-profit "safety net" providers. In rural areas, we have seen some for-profit clinics that are geographically proximate to FQHC's and are very aggressive in their support of low-income patients, offering extended evening hours during the week as well as being open on weekends and holidays.

We are rapidly approaching a time when health care delivery will no longer be defined or confined by location. The Direct-To-Consumer virtual care evolution has already taken hold in urban and suburban areas where Broadband to the home is more ubiquitous than in rural areas. We are encouraged by the discussions of Lifeline Reform and Modernization that include healthcare as a consideration. Until such a time when policy pertaining to the FCC Rural Health Care Program catches up to the future direction of health care delivery, we would like to see if there may be some opportunities for greater latitude in the existing statute that would allow for a broader definition of eligible providers. These include:

1) Expand the definition of "rural health clinics" to include:
    a. Designating rural EMS agencies providing some of the same services of a rural health clinic as eligible providers.
    b. Designating rural skilled nursing facilities providing general community access to health services as eligible providers.
    c. Establishing a process for other types of non-traditional facilities who providing general community access to health services to be considered as eligible providers.
    d. Establishing a process for "for-profit" clinics and practices that are essentially "safety net" providers because they serve the same population and payor mix as

non-profit “safety net” clinics to be considered as eligible providers.

2) Expand the definition of “not-for-profit” hospital to include Sole Community Hospitals because they are the “safety net” as they serve the same population and payor mix as a non-profit hospital and are the only source of care within a geographic area.

The obstacles faced by health care providers and patients in rural areas are significant, but not insurmountable. However, rural communities will need to adapt and be creative to find solutions. Less restrictive interpretations of policies would better allow rural communities to innovate.

For questions or more information, please contact:

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