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Federal Communications Commission
Office of the Secretary

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**The Department of Health and Human Services Recommendations for the Federal
Communication Commission's Rural Health Care Support Mechanism**

Purpose

To provide additional contextual information to the Federal Communications Commission (FCC) regarding the Department of Health and Human Services' (HHS) comments to FCC's Notice of Proposed Rulemaking on the Rural Health Care Support Mechanism. Specifically, this document elaborates on the following three key recommendations for FCC to:

1. Align FCC's eligibility criteria with the definition of health care provider expressed by Congress in 2009,
2. Align FCC's performance goals with key HHS requirements without overburdening rural health care providers, and
3. Increase the level of capital support provided to certain participants in FCC's program.

Background

As a result of an August 2, 2010 meeting that included the HHS Secretary and the FCC Chairman, and with encouragement from Chairman Genachowski, HHS provided comments on FCC's Notice of Proposed Rulemaking on the Rural Health Care Support Mechanism, which was issued on July 15, 2010. HHS's objective in commenting was to support FCC's efforts to address serious broadband capacity and connection issues facing rural health care providers and to align FCC's program with Congress's and the Administration's health information technology (IT) agenda as well as the HHS meaningful use incentives. On October 29, 2010, HHS and FCC met to discuss HHS's comments to the proposed regulation. HHS agreed to provide additional contextual information regarding three of its key recommendations. This information is provided in the Recommendations section below.

Meaningful Use and Rural America: The American Recovery and Reinvestment Act of 2009 (ARRA) was enacted to foster national and regional economic growth. ARRA's Health Information Technology for Economic and Clinical Health (HITECH) Act provisions authorized an unprecedented investment in health IT. Specifically, the HITECH Act authorized HHS to establish programs to improve health care quality, safety, and efficiency through the promotion of certified health IT, including certified electronic health records (EHRs) and private and secure electronic health information exchange. For example, the Centers for Medicare and Medicaid (CMS) EHR Incentive Programs (i.e., meaningful use incentive programs) provide incentive payments to eligible health care providers participating in these programs when they adopt certified EHR technology and use it to achieve meaningful use. Through ARRA, Congress charged the HHS Office of the National Coordinator for Health IT (ONC) with coordinating the Federal Government's efforts to realize the implementation of nationwide health IT infrastructure within a legislatively mandated timeline.

The Administration's goal is for all Americans to benefit from access to EHR technology. In February 2010, the White House convened a task force to coordinate efforts and investments to meet this health IT agenda. Access to a sufficient level of broadband services is a key element of the Administration's larger efforts to ensure that all health care providers become meaningful users of certified EHRs.

Lacking access to the same resources as their urban and sub-urban counterparts, rural health care providers face challenges adopting EHR technology. Without targeted support, rural communities could be set back by ARRA and the meaningful use requirements, rather than assisted by them. Rural health

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care providers could incur penalties for not achieving meaningful use in time without ever having had a reasonable chance at getting the incentives.

In response, on August 2, 2010, the Secretary of HHS convened a meeting with the FCC Chairman, the Secretaries of the US Department of Agriculture (USDA) and US Department Commerce, as well as a Veterans Affairs representative to discuss interagency collaborations to ensure widespread rural adoption of certified health IT and address key challenges for rural health providers, chief among them being access to affordable broadband connectivity sufficient to transmit relevant patient data in a reliable way. As a result of these meetings, HHS has continued to collaborate with FCC to align resources and objectives with the Administration's overall health IT objectives and, specifically, to ensure that rural health care providers have access to broadband services.

FCC's Rural Health Care Support Mechanism: Within FCC's Universal Service Fund programs, the Rural Health Care Support Mechanism was established to improve the quality of health care available to patients in rural communities by ensuring that eligible health care providers have access to affordable telecommunications services. The Telecommunications Program and the Internet Access Program (i.e., operational program) may provide funding to eligible health care providers for telecommunications services, including broadband, necessary for the provision of health care. In addition, the Rural Health Care Pilot Program (i.e., infrastructure program), provides broadband networks in rural areas where service is lacking. Funding for this mechanism is capped at \$400 million annually.

Program participants apply for FCC funding through the Universal Service Administrative Company (USAC), which administers the Universal Services funds.

HHS and FCC Definitions of Health Care Provider: Most recently, in 2009, Congress defined "health care provider" for the purposes of the HITECH Act to include,

"a hospital, skilled nursing facility, nursing facility, home health entity or other long term care facility, health care clinic, community mental health center (as defined in section 1913(b)(1)), renal dialysis facility, blood center, ambulatory surgical center described in section 1833(i) of the Social Security Act, emergency medical services provider, Federally qualified health center, group practice, a pharmacist, a pharmacy, a laboratory, a physician (as defined in section 1861(r) of the Social Security Act), a practitioner (as described in section 1842(b)(18)(C) of the Social Security Act), a provider operated by, or under contract with, the Indian Health Service or by an Indian tribe (as defined in the Indian Self-Determination and Education Assistance Act), tribal organization, or urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act), a rural health clinic, a covered entity under section 340B, an ambulatory surgical center described in section 1833(i) of the Social Security Act, a therapist (as defined in section 1848(k)(3)(B)(iii) of the Social Security Act), and any other category of health care facility, entity, practitioner, or clinician determined appropriate by the Secretary."

However, in administering its programs, FCC applies a narrower 1996 definition of health care provider. That is, for the purposes of the Universal Service Fund, the term "health care provider" means: 1) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; 2) community health centers or health centers providing health care to migrants; 3) local health departments or agencies; 4) community mental health centers; 5) not-for-profit hospitals; 6) rural health clinics; and 7) consortia of the above entities.¹

HHS and FCC Health Care Providers Eligibility Criteria: A health care provider eligible for meaningful use incentive programs includes, for example, a physician, nurse practitioner, certified nurse-midwife,

¹ Communications Act of 1934, as amended by the Telecommunications Act of 1996

dentist, physician assistant who furnishes services in a Federally Qualified Health Center or Rural Health Clinic that is led by a physician assistant, and Critical Access Hospital.²

However, only an entity that is either a public or non-profit rural health care provider shall be eligible to receive supported services from FCC.³ Accordingly, non-eligible institutions include, for example, 1) private physician offices or clinics; 2) emergency medical service facilities; 3) and for-profit hospitals. These eligibility criteria are not in line with HHS criteria, which do not distinguish between for-profit, not-for-profit, and public health care providers.

Recommendations

I. Align the eligibility criteria with the definition of health care provider expressed by Congress in 2009 in the HITECH Act

In 2009, Congress stated that HHS shall support “[i]nfrastructure and tools for the promotion of telemedicine, including coordination among Federal agencies in the promotion of telemedicine.”⁴ This reference in the HITECH Act calls into question FCC’s adherence to earlier definitions of “health care provider.” Accordingly, HHS recommends that FCC define eligible “health care provider” in accordance with Congress’s and the Administration’s health IT goals. To this end, HHS offers the following two options:

1. Apply Congress’s 2009 definition of health care provider and expand eligibility to include for profit health care providers, in accordance with HHS meaningful use incentive programs.
2. Maintain, for now, use of the 1996 definition of health care provider, but expand eligibility to include for-profit health care providers, in alignment with HHS meaningful use incentive programs.

Rationale: The health care industry provides services that are necessary to all Americans. The quality of care is regulated by the Government regardless of the tax status of a health care provider. Further, health care providers that are unable to meet a set of stringent requirements may lose their tax-exempt status. It would be unfortunate for a hospital’s loss of tax-exempt status to result in a diminished ability to obtain sufficient and reliable broadband connectivity, which would ultimately impact the quality of service and potentially the well-being of these rural communities. FCC’s exclusion of private health care providers may arbitrarily limit access to the benefits of EHRs by rural Americans. This would be contradictory to FCC’s overall objective to make available to all Americans, without discrimination, a rapid, efficient, nationwide communications service with adequate facilities at reasonable charges, for the purpose of promoting, among other things, safety of life.

If FCC is unable, at this time, to align its definition of health care provider with Congress’s 2009 definition, FCC should, at a minimum, expand eligibility criteria to include private rural healthcare providers that are eligible for meaningful use incentive programs but do not have adequate broadband connectivity either because there is none in their area or because they require very costly solutions (i.e., dedicated internet access). Data from the FCC payment model shows that expanding the eligibility to include private rural health care providers that are eligible for HHS meaningful use incentive programs would not compromise FCC’s ability to stay within its budget cap.

² 42 CFR Parts 412, 413, 422, and 495.

³ 47 CFR § 54.601.

⁴ The American Recovery and Reinvestment Act of 2009, Health Information Technology Act, Public Law 111-5, Section 3011 (a)(4).

II. Align performance goals with meaningful use incentive programs without overburdening rural providers

FCC's health care broadband subsidies are intended to support health care providers in achieving HHS health IT objectives, which are focused on supporting health care providers achieve meaningful use of certified health IT. HHS meaningful use incentive programs and other initiatives launched by HITECH are intended to support these HHS health IT objectives. Therefore, FCC's performance goals should be aligned with HHS meaningful use incentive programs. However, applicants cannot achieve meaningful use without access to a sufficient level of broadband connectivity, and eligibility for FCC's program should not be contingent on the applicants already meeting meaningful use. HHS recommends the following performance metrics for FCC's Rural Health Care Support Network. These performance goals apply to FCC program participants that are required to work towards meaningful use and that are eligible for meaningful use incentive programs.⁵

As appropriate, applicants must identify a health care provider that will work to achieve meaningful use. That is, every applicant to FCC's Rural Health Care Program that employs at least one health care provider eligible for a meaningful use incentive program, must identify on the USAC application at least one provider in its health care institution that will work towards meaningful use.

FCC's Infrastructure program – FCC should work with CMS to monitor the following milestones:

1. Within the first year of participation in FCC's program, the provider must be registered with CMS for the Medicare or Medicaid EHR Incentive Program.
2. Within the first three years of participation in FCC's program, providers enrolled in the Medicaid EHR Incentive Program must demonstrate to Medicaid that they have adopted, implemented, or upgraded certified EHR technology.
3. Within the first eight years of participation in FCC's program, providers enrolled in a meaningful use incentive program must demonstrate that they have made progress towards achieving meaningful use. For example, providers enrolled in the Medicare EHR Incentive Program should demonstrate to Medicare that they have achieved meaningful use of certified health IT for at least one year of participation in the Medicare EHR Incentive Program.

FCC's Operational program – FCC should work with CMS to monitor the following milestones:

1. As a condition for the second year of funding, the provider must be registered with CMS for the Medicare or Medicaid EHR Incentive Program.
2. As a condition for the fourth year of funding, providers enrolled in the Medicaid EHR Incentive Program must demonstrate to Medicaid that they have adopted, implemented, or upgraded certified EHR technology.
3. As a condition for the ninth year of funding, providers enrolled in a meaningful use incentive program must demonstrate that they have made progress towards achieving meaningful use. For example, providers enrolled in the Medicare EHR Incentive Program should demonstrate to Medicare that they have achieved meaningful use of certified health IT for at least one year of participation in the Medicare EHR Incentive Program.

⁵ That is, health care providers that are not eligible for CMS EHR Incentive Programs should not be held to these goals. Rural health clinics, for example, are not eligible for the Medicare EHR Incentive Program and may not meet the Medicaid patient volume threshold to be eligible for the Medicaid EHR Incentive Program. Such rural health clinics should not be held to these performance goals

Rationale: These performance goals ensure that FCC and HHS programs are consistent and that similar health care providers are working towards the same goals. In addition, these milestones are feasible for rural health care providers that face significant challenges in meeting meaningful use requirements. Further, this process creates minimal additional burden on both FCC and its applicants because it relies on an existing infrastructure within CMS, including internal control processes implemented by CMS. Therefore, applicants have minimal additional requirements over those imposed by CMS, and FCC can rely on CMS to track complex health care information. With these metrics, the Federal Government would be minimizing the burden on health care providers and coordinating key Administration programs and objectives.

III. Increase the level of capital support provided to FCC's program participants

In order for FCC's Rural Health Care Program to succeed, it must help eligible health care providers gain access to broadband connectivity comparable to their urban and suburban counterparts. Such connectivity will enable these rural providers to work toward achieving meaningful use, qualify for meaningful use incentive payments, and improve health care quality and outcomes in their communities. However, rural health care providers may not participate in FCC's programs if they cannot afford to do so, given an insufficient level of support. Many rural health care providers are already operating under very thin margins and may not even have sufficient funds to cover their payroll expenses.

With the 15% match imposed by FCC's infrastructure program, a pilot program, FCC only funded 20 of the 69 original awardees, with the vast majority needing extensions outside of the original three-year preparation period to meet the match requirement. Participants who were able to meet the match requirements tended to be affiliated with large university systems. Maintaining the 15% match without permitting in-kind contributions could recreate the challenges faced by the applicants who took part in the pilot program.

Similarly, data from ONC's Regional Extension Center (REC) Program shows that the matching requirement affected the success of the program and the level of provider enrollment in the program. For example, the Indiana REC only had 81 providers enrolled in its program; when it lowered the matching requirement, it enrolled 471 providers in one month. A California REC that had recruited less than 400 providers in six months was able to enroll 972 providers in two months when it temporarily lowered the matching requirements. To address this issue, ONC will provide additional funds to support Critical Access Hospitals that cannot meet the matching requirement.

Further, HHS has recently decided to decrease the burden of the matching requirement imposed on RECs because of the difficulties the RECs experienced. For example, in order to meet the matching requirement, many RECs charged health care providers for the RECs' technical assistance services. Health care providers did not avail themselves of the RECs' services because they could not afford to pay for these services.

Infrastructure program – FCC should decrease the level of capital funding that certain providers must contribute in order to meet the match requirement. For example, FCC should allow in-kind contributions (e.g., administrative costs, man-hours devoted toward achieving meaningful use) to go toward providers' matching requirement. Tracking these in-kind contributions will provide FCC a level of assurance against fraud, abuse, and waste that cannot be achieved simply by requiring dollar payment. As noted above, this has been a successful strategy in the HHS Regional Extension Center program.

In addition, HHS recommends no or low dollar (5% match at most) contribution requirements for the following types of applicants: 1) those in underserved areas, or in high poverty counties; key Federal safety-net providers such as Federally Qualified Health Centers, Rural Health Clinics, Critical Access

Hospitals, Medicare Dependent Hospitals, Sole Community Hospitals, and Tribal and/or Federal Indian Health Service sites; and 2) providers eligible for meaningful use incentive programs.

Operating program – FCC should increase the subsidy levels for certain rural health care providers. HHS recommends increasing the subsidy level to 90%, through 2017, for the following types of applicants: 1) those in underserved areas, or in high poverty counties; key Federal safety-net providers such as Federally Qualified Health Centers, Rural Health Clinics, Critical Access Hospitals, Medicare Dependent Hospitals, Sole Community Hospitals, and Tribal and/or Federal Indian Health Service sites; and 2) providers eligible for meaningful use incentive programs.

Rationale: This increased support will allow eligible providers that have limited access to capital funding to benefit from FCC's programs. Further, allowing in-kind contributions to be counted toward the match for certain key health care providers will ensure that 1) FCC's programs are successful in underserved, rural communities and 2) eligible health care providers are afforded the broadband connectivity necessary to enable them to qualify for CMS meaningful use incentive payments. Finally, tracking in-kind contributions (e.g., activities directed toward achieving meaningful use) will provide FCC a level of assurance against fraud, waste, and abuse that cannot be achieved simply by requiring dollar payments.