

April 24, 2023

Marlene H. Dortch
Office of the Secretary
Federal Communications Commission
45 L Street NE
Washington, D.C. 20554

RE: WC Docket No. 17-310; Promoting Telehealth in Rural America

Submitted electronically via <https://www.fcc.gov/ecfs/>.

Dear Secretary Dortch,

The National Rural Health Association (NRHA) appreciates the emphasis the Federal Communications Commission (FCC) has placed on improving the Rural Health Care (RHC) program. The RHC program is invaluable for rural health care providers to establish telecommunications and broadband services necessary for providing health care in rural communities. NRHA appreciates the FCC's attention to the RHC program through this second further notice of proposed rulemaking (SFNPRM). With the advancement of telehealth flexibilities in recent years increasing bandwidth needs of rural health providers, NRHA is encouraged to see a renewed focus on this critical program.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

The RHC program at the FCC is a key asset for rural providers across the country in building out broadband and telecommunications services. However, like any program, changes are necessary to ensure long-term viability for the program and to target resources to the areas of most need. As you recognize, reliable high speed broadband connectivity is critical for rural health care providers to serve patients in rural areas that often have limited resources, fewer clinicians, and higher rates of need for broadband and telecommunication services than urban areas.

Rural Rates.

NRHA appreciates FCC's efforts to implement a new methodology for determining rural rates in the Telecom Program. However, NRHA has several concerns about proposed Methods A and B.

Proposed Method A would use the median of all publicly available rates charged by other service providers for the same or similar services provided in the rural health care provider's area. We understand that proposed Method A uses other service providers' rates to better reflect market conditions and for other program integrity reasons. But rates charged by service providers are most often contractual and not publicly available. Proposed Method A would prove difficult or impossible to implement in many areas where rates are stated in contracts between commercial customers and service providers. Essentially, Method A would rarely be used, and parties would move to Method B.

NRHA also believes that proposed Method B would be problematic. Method B would determine the rural rate when there are no publicly available rates by using the median of the rates that the service provider actually charges to non-health care commercial customers for the same or similar services in the rural area. Using Method B could allow service providers to cherry pick their rates to use, potentially circumventing the protection that proposed Method A is meant to provide. The median of “same or similar services” may give service providers enough leeway to use a higher rate. For example, many service providers are participating in the Telecom Program along with the Healthcare Connect Fund (HCF) Program in the same area. Rates in the Telecom Program tend to be much higher than in HCF by nature of the programs. A service provider could use the median of its rates in the Telecom Program in the same rural area and determine a higher rural rate than is warranted.

NRHA believes that proposed Methods A and B may be difficult to implement because of the above concerns. Nonetheless, one supplement to the proposed rural rate methodology may mitigate against excess costs in the Telecom Program. NRHA proposes that the FCC use the cost-based rate method for any application that exceeds a threshold, such as \$100,000.¹ This method requires that service providers submit a justification of its requested rural rate, including an itemization of the costs of providing the service requested by the health care provider. NRHA contends that this method would help control the rate setting for large projects and ensure reasonable rural rates are used. When applications are lower than the threshold, proposed Methods A and B would be appropriate.

In addition, NRHA believes that this proposal would be appropriate for Alaska. Given that Alaska comprises a large proportion of the Telecom Program, and also comprises most of the highest cost commitments and disbursements,² using a cost-based determination could keep rates down. Whereas in other states competition may keep rates down, there is little competition in Alaska and service providers can charge higher rates.

Threshold for “Urban” Area.

NRHA supports maintaining the current urban area threshold of 50,000 or more. Across other agencies 50,000 or more threshold is used for urban or metropolitan areas and less than 50,000 is typically broken into smaller categories and considered rural. Retaining this threshold keeps consistency throughout other federal programs.

¹ NRHA used the Universal Service Administrative Company’s (USAC) “RHC Commitments and Disbursements Tool” to analyze the breakdown of participation in the Telecom Program by state and total committed funding amount. In 2020, 223 total funding commitments out of 2,711 were above \$100,000. In 2021, that number was 260. In 2022, this increased to 308. As the data shows more expensive funding commitments growing, NRHA believes this is a reasonable threshold for cost-based review by FCC. The commitments over \$100,000 are also a small proportion of the overall Telecom Program commitments. One contract could govern multiple funding commitments, so the overall number of applications to review could likely be smaller than the numbers referenced above.

² Again, NRHA used USAC’s “RHC Commitments and Disbursements Tool” to analyze the breakdown of participation in the Telecom Program by state and total committed funding amount. For example, in 2021, Alaska comprised all of the total committed funding amounts over \$150,000 except for 4, which were all in Arizona. In 2020, 8 out of 183 total committed funding amounts were in states other than Alaska. When the total committed funding is increased to \$500,000, in both 2020 and 2021, Arizona made up 2 funding commitments and Alaska made up the rest (62 in 2020 and 113 in 2021).

Cap and Prioritization in Healthcare Connect Fund Program.

FCC's final rule and order³ held that second and third years of multiyear contracts will be not fulfilled if the internal cap is met. In this scenario, the first year of multiyear contracts will be paid based on the prioritization schedule and then, if possible, further years on multiyear contracts would be paid. NRHA's concern is that urban health care providers would receive funding before rural health care providers have their multiyear contracts fully funded. NRHA believes that rural health care providers should be prioritized in this situation by having their multiyear contracts funded before urban health care providers have their first year funded. Multiyear contracts are simpler and relieve health care providers of administrative burden. Rural health care providers should have their full multiyear contracts honored to continue to incentive using such contracts. In addition, this program is meant to benefit rural health care providers so rural should be funded first and fully.

Further, because urban health care providers can apply to the HCF Program through a consortium, **NRHA urges FCC to release the data showing how much of the HCF funding is going to urban providers.**

NRHA also maintains that **FCC's internal cap on the RHC Program should be expanded.** FCC sets this cap internally and does not need congressional approval to expand it. When the cap was set the HCF Program did not exist and further urban participation in RHC Program was not contemplated because urban health care providers could not participate in the original Telecom Program. Now urban health care providers may participate in the HCF Program. Both the HCF Program and urban participation drive up costs so that the cap does not reflect the reality of the program. If the cap were expanded, the abovementioned concerns would likely be mitigated or solved.

NRHA appreciates the FCC's commitment to improving the RHC program. For more questions on NRHA's comments, please contact NRHA's Regulatory Affairs Manager, Alexa McKinley (amckinley@ruralhealth.us).

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association

³ Promoting Telehealth in Rural America, 88 Fed. Reg. 17,379 (Mar. 23, 2023) (to be codified at 47 C.F.R. pt. 54).