National Rural Health Association

April 14, 2022

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

RE: [WC Docket No. 17-310; FCC 22-15; FR ID 75595] Promoting Telehealth in Rural America

The National Rural Health Association (NRHA) appreciates the emphasis the Federal Communications Commission (FCC) has placed on improving the Rural Health Care (RHC) program. As you know, this program is invaluable for rural health care providers to establish telecommunications and broadband services necessary for providing health care in our rural communities. NRHA appreciates the FCC's attention to the RHC program through this further notice of proposed rulemaking (FNPRM). 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 that provides national leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, doctors, nurses, and patients. We work to improve rural America's health needs through 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.

Defining "rural area" for the purpose of program participation

Background: NRHA is particularly interested in the evaluation of the definition of "rural area" for the purpose of program participation and encourage revisions of the definition in a manner that will be most beneficial to under resourced rural communities. Currently, the RHC program employs a definition of "rural area" that relies upon a health care provider's location relative to the Census Bureau's Core Based Statistical Area designation. Until 2004, however, the FCC employed the definition used by the Federal Office of Rural Health Policy (FORHP), located within the Department of Health and Human Services (HHS), which is largely a combination of the Office of Management and Budget (OMB) non-metropolitan counties plus all metropolitan census tracts with Rural-Urban Community Area (RUCA) codes 4-10.

As you know, the current RHC program definition of "rural area" includes four tiers. Those four tiers are then divided into two buckets: health care providers in a medically underserved area/population (MUA/P) and health care providers not in a MUA/P. Currently, the four tiers, which become eight when the MUA/P distinction is applied, are as follows: an extremely rural tier (counties entirely outside of a

Core Based Statistical Area with populations up to 9,999); rural tier (census tracts within a Core Based Statistical Area that does not have an urban area or cluster with a population equal to or greater than 25,000); less rural tier (census tracts with a Core Based Statistical Area with an urban area or cluster with a population equal to or greater than 25,000, but where the census tract does not contain any part of an urban area or cluster with population equal to or greater than 25,000), and a non-rural tier (all other non-rural areas). Within an MUA/P, the extremely rural tier is priority one, the rural tier is priority two, less rural tier is priority three, and the non-rural tier is priority seven. Outside an MUA/P, the extremely rural tier is priority four, the rural tier is priority five, the less rural tier is priority six, and the non-rural tier is priority eight.

TABLE 1 TO PARAGRAPH (B) - PRIORITIZATION SCHEDULE

Health care provider site is located in:	In a medically underserved area/population (MUA/P)	Not in MUA/P
Extremely Rural Tier (counties entirely outside of a Core Based Statistical Area)	Priority 1	Priority 4.
Rural Tier (census tracts within a Core Based Statistical Area that does not have an urban area or urban cluster with a population equal to or greater than 25,000)	Priority 2	Priority 5.
Less Rural Tier (census tracts within a Core Based Statistical Area with an urban area or urban cluster with a population equal to or greater than 25,000, but where the census tract does not contain any part of an urban area or urban cluster with population equal to or greater than 25,000)	Priority 3	Priority 6.
Non-Rural Tier (all other non-rural areas)	Priority 7	Priority 8.

Analysis: NRHA understands the aim of the FCC implementation of rural in this context: priority is for providers outside of a metropolitan or micropolitan statistical area, with focus being put on underserved areas. The reality is that these tiers are imperfect when implemented. Because of the way FCC has classified these tiers, communities in micropolitan counties, that would typically be considered rural in other capacities or under other definitions, may be considered less rural or non-rural. The current definition places a larger emphasis on tier one, extremely rural communities, and disadvantage other rural communities. This is concerning as areas that are typically considered rural in other program participation are considered non-rural for FCC purposes. As a result, upon implementation frontier states, such as Alaska, have disproportionate representation in the program. Our analysis using public USAC data for the RHC program shows Alaskan providers accounting for nearly 80% of Telecom program funding (with 12% of applicants). The next five states make up 25% of applications and 12% of funds, followed by 10 more states being 40% of applications and 5% of funds. The last 25 states have 23% of applicants and 3% of funding.

Recommendation: NRHA recognizes that definitions of rural is an incredibly difficult topic and no one definition can meet all programmatic needs. **However, NRHA encourages the FCC to work to develop a definition that is more consistent with existing Federal definitions of rural. Further, we recommend that FCC error on the side of being more inclusive when defining rural** as we have heard from many members who meet all criteria but are not funded due to current imbalances in funding scoring. NRHA appreciates the focus on extremely rural and underserved communities but believes it should allow other rural communities who struggle for broadband connectivity to receive valuable funding.

One possible definition of rural is a return to the FORHP definition which includes both county-wide and subcounty locations. Another would be a modified version that uses just RUCA codes to categorize and

differentiate rurality. If the goal is to be able to make distinctions within rural areas, the FCC could use rural subcategories within this type of definition to target priority areas, populations, or categories.

Determining Accurate Rates in the Telecom Program

Background: As shown in table 1 above, the RHC program uses both geography and medical underservice in determining the prioritization schedule. The identified categories of rurality are appropriate, upon modification of definition as discussed above. However, the use of Medically Underserve Areas/Populations (MUA/Ps) is extremely problematic.

Analysis: The MUA/P designation has several drawbacks to prioritize need, including having a limited scope of measurement specific to subpopulations or provision of services that do not accurately capture a complete rural healthcare perspective. Further, most MUA/P designations are significantly out of date and are not routinely updated by HHS. For example, nearly 68% of designations have not been updated in more than 20 years and do not reflect current shortage needs. *See below for additional data on both the MUA and MUP designations.*

Medically Underserved Areas (MUAs) -- Last Update

Category	Number of MUAs	PCT of MUAs
MUAs More than 10 Years	3,070	85.7%
MUAs More than 20 Years	2,586	72.2%
MUAs More than 25 Years	2,402	67.0%
MUAs More than 30 Years	813	22.7%
All MUAs	3,584	100.0%

Medically Underserved Populations (MUPs) -- Last Update

Category	Number of Rural MUPs	PCT of Rural MUPs
MUPs More than 10 Years	366	65.6%
MUPs More than 20 Years	152	27.2%
MUPs More than 25 Years	92	16.5%
MUPs More than 30 Years	2	0.4%
All MUPs	558	100.0%

Recommendation: NRHA recommends FCC broaden the medical underserved criteria including use of indicators such as essential community provider status, population density, readiness for telemedicine, existing infrastructure, etc. We have heard from many members who have attempted FCC applications without receiving funding solely related to scoring, despite being from rural, underserved areas. If the FCC decides that medical underservice is the ideal indicator, we recommend using the Health Professional Shortage Area (HPSA) designation, rather than MUA/P, as it is more

inclusive and regularly updated. As the FCC considers use of indicators such as essential community provider status, NRHA encourages the agency to expand the category of providers eligible to use funds including emergency medical services (EMS), community paramedicine, community mental health centers, etc. given the need for these services in rural areas.

Application processing, funding decisions, and appeals of decisions

Background: NRHA appreciates the FCC's attention on the RHC program's application processing, funding decisions, and appeals decisions. We regularly hear significant feedback from our members that the application is overly burdensome and the time from application to award is of substantial concern. The COVID-19 pandemic placed incredible stress on already fragile rural hospitals and communities, making concerns about burden and resource allocation even more important.

Recommendation: NRHA encourages the FCC to streamline the application and decision-making processes to ensure the funding that is needed in rural communities is received in a timely manner. Further, we recommend the FCC **consider all opportunities to decrease the administrative burden required for application processing, decision making, and the appeals process.** Small or rural hospitals have limited administrative staff to complete such paperwork, which can be a deterrent for applying for programs such as the RHC, that expands telehealth in rural communities.

Digital equity and inclusion.

Recommendation: Research shows that expanding access to telehealth and telemedicine increases the availability and quality of care for patients living in rural areas. Inequitable access to broadband and telehealth services impacts access to care and can subsequently broaden health disparities. **NRHA encourages the FCC to increase funding necessary to access the broadband telecommunications services required to provide vital healthcare services and expand the funding cap to engage in the Rural Health Care Healthcare Connect Fund Program and the Telecom Program.** Further, we encourage the FCC to include rural experts in the development of new RHC program guidelines, relying on the significant expertise that exists with Federal programs, including FORHP located in HHS.

NRHA appreciates the FCC's attention to improving the RHC program. These resources are critical to rural providers building out broadband services in their communities. NRHA looks forward to working with the FCC to ensure rural providers can access this program across the board. For more questions on NRHA's comments, please contact Josh Jorgensen (jjorgensen@ruralhealth.us).

Sincerely,

Alan Morgan
Chief Executive Officer
National Rural Health Association