



February 2, 2018

Chairman Ajit Pai
Commissioner Mignon Clyburn
Commissioner Michael O’Rielly
Commissioner Brendan Carr
Commissioner Jessica Rosenworcel
Federal Communications Commission
445 12th Street, SW Washington, DC 20554

Re: Notice of Proposed Rulemaking on the Rural Health Care Program – WC Docket No. 17-310

Dear Chairman Pai and FCC Commissioners:

The National Organization of State Offices of Rural Health appreciates the opportunity to respond to the FCC’s Notice of Proposed Rulemaking on the Rural Health Care Program, WC Docket No. 17-310. This is an important effort to identify solutions to improve access to telehealth in rural communities across the nation.

NOSORH is the national, non-profit membership organization of the fifty State Offices of Rural Health (SORH). Our mission is to promote the capacity of State Offices of Rural Health and their partners to improve health care in rural America through leadership development, education, and partnerships. The SORH are anchors of information, expert and neutral conveners and trusted resources for technical assistance. SORH have a long track record of supporting telehealth initiatives, helping states to address policy issues and ensuring providers understand funding and infrastructure resources.

The comments attached address the RHC program funding cap, funding prioritization and rate calculation. For clarification, additional comment or questions, please don’t hesitate to contact me by email at any time teryle@nosorh.org.

Sincerely,

Teryl E. Eisinger, MA
Executive Director

FCC Notice of Proposed Rulemaking Promoting Telehealth in Rural America NOSORH Draft Comments

Overview

The National Organization of State Offices of Rural Health (NOSORH) provides these comments to the Federal Communications Commission in response to its request for information outlined in the January 3, 2018 Notice of Proposed Rulemaking - 47 CFR Part 54 -WC Docket No. 17-310 -FCC 17-164 - Promoting Telehealth in Rural America.

Since the inception of the Rural Health Care (RHC) Program, NOSORH member Offices have worked with rural healthcare providers in their states to assure their active participation. These comments reflect the insights gained from these efforts.

Comments on RHC Program Funding Cap

NOSORH makes the following comments related to the NPRM questions on the RHC Program funding cap:

- **Increase RHC Program Funding Cap**: NOSORH recommends that the RHC Program funding cap be raised in the near term to reflect the needs of rural health providers. The aim would be to establish a budget cap that realistically reflects inflation, changes in technology and expansions of eligibility. NOSORH recommends that budget cap receive a one-time adjustment that reflects where that cap would have reached if annual adjustments had been made since the program's inception. In addition, NOSORH recommends that the RHC Program receive annual increases to the cap which reflects the factors cited above. This will make the RHC program similar to other FCC programs with an annual increase in funding. As part of the adjustment to the budget cap NOSORH recommends that unused funds in any year be allowed to roll over into subsequent program years.
- **Study Long-Term Program Need**: Linked to this near-term funding cap increase NOSORH recommends that the FCC conduct a study to assess the long-term needs of different categories of rural health providers, looking both at estimated infrastructure needs as well as needs for ongoing operational support.

The study should include an inventory of rural healthcare provider sites, including all categories of rural healthcare providers – such as hospitals, Rural Health Clinics, Federally Qualified Health Centers, public health offices, private practices, and long term care providers. The study should differentiate service sites from organizational providers – often a given provider may have multiple satellite locations. Partners in this effort could include the DHHS Health Services

and Resources Administration as well as the Centers for Medicare and Medicaid Services.

This study should also include examination of the categories of telecommunications support needed by different types of providers. It should go beyond consideration of bandwidth buckets and look at the details of how different telehealth services are used by different healthcare providers. The study should emphasize health care provider *needs* and not wants – for example a primary care provider might want a 100 MBPS with rapid imaging transfer, but might only need a 25-50 MBPS connection and a slower imaging transfer.

Finally, NOSORH believes that the special circumstances of telehealth in Alaska merit a unique approach. NOSORH recommends the FCC study the long term telehealth needs of Alaska and assure that the RHC Program priorities and procedures appropriately consider Alaska's special needs.

Comments on RHC Program Funding Prioritization

NOSORH recommends that priorities be established for both the HCF and the Telecom program components of the RHC. These priorities can be used for the prioritization of requests when the total exceeds the budget cap. They can also be used in determining the level of any support award, with higher priority requests getting higher percentages of award and lower priority requests receiving lower percentages of support. This approach would be similar to the process currently used in the E-rate program. It would eliminate across the board proration of support – which makes detrimental adjustments to awards equally to all requestors, regardless of requestor need and priority.

NOSORH makes the following additional comments related to the NPRM questions on the RHC Program prioritization:

- **Create Key RHC Program Priorities**: NOSORH recommends that the following three considerations be used in construction of RHC Program priority categories. The considerations can be combined to create a multifactor prioritization framework, similar to the factors used for the E-rate program.
 - **Degree of Rurality**: NOSORH recommends that the FCC make priorities to reflect, in part, the degree of rurality of the area where service is to be provided. In development of measures to be used for this priority, NOSORH recommends that the FCC consult with experts from the DHHS Federal Office of Rural Health Policy, the USDA-Economic Research Service and the Bureau of the Census
 - **Health Service / Health Professional Shortage**: NOSORH recommends that the FCC make priorities that reflect, in part, the degree of health service or health professional shortage in the area where service is to be provided. In development of measures to be used for this priority, NOSORH recommends that the FCC consult with experts from the DHHS Health Resources and Services Administration and the Centers for Medicare and Medicaid Services.

- **Study Other Possible Considerations for RHC Program Allocations:** In addition to the three considerations discussed above, NOSORH recommends that the FCC study whether the following two considerations might add to RHC Program effectiveness. These considerations could be used to create separate sub-funds for allocation in any program year.
 - **Type of Request:** NOSORH recommends that the FCC examine whether prioritizing the type of RHC support requested, i.e., infrastructure versus operating support, could be used to better achieve the RHC Program's goals.
 - **Level of Support:** NOSORH recommends that the FCC examine whether prioritizing the level of RHC support requested, i.e., low-cost versus high-cost, could be used to better achieve the RHC Program's goals. There is potential for greater impact if many low-cost requests are funded as opposed to one high-cost request. This prioritization could be linked to the Type of Request prioritization discussed above.

Comments on Rate Calculation Methodology

NOSORH has several suggestions for changes that would improve the rate calculation methodology:

- **Improve Assessment of Requests from Rural-Urban Consortia:** NOSORH recommends that the FCC examine how to better manage support requests from mixed rural-urban consortia. NOSORH believes it is important to recognize that the key factor in assessing these requests is the *level of telehealth service provided* to rural areas – not the number of rural health providers in a consortium.

Merely having a high percentage of rural healthcare provider members in a consortium does not guarantee that a high percentage of the financial benefit accrues to rural communities. There have been some cases where the larger part of financial support provided to rural-urban consortia has gone to its urban members. Nevertheless, NOSORH recommends a significant increase the minimum percentage of rural health care providers for eligible consortia. In addition, NOSORH recommends that the FCC consider adjustments to the capped maximum support for urban consortium partners to assure that the financial support to urban partners does not exceed the total support provided to the consortium's rural healthcare providers.

NOSORH feels that consortia applicants for RHC Programs should meet eligibility requirements before they receive financial support. This is particularly important for rural-urban criteria. In line with this view NOSORH recommends that the FCC eliminate grace period provisions for RHC Programs.

- **Develop Integrated Application Process for RHC Program Components:**
NOSORH recommends that the FCC examine ways to integrate the Telecom and HCF components of the RHC Program. A single simplified application from a requestor for appropriate support would be applicant friendly.

NOSORH has observed that, in previous years, some applicants with lower support percentages shifted their applications from the Telecom program to the HCF program, where they were guaranteed a higher percentage of support. An integrated application process which automatically awards the most advantageous support level would better coordinate the components of the RHC Program and eliminate this 'program shopping'.