

Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

In the Matter of)
Rural Health Care Support Mechanism) WC Docket No. 02-60
)
)
)

COMMENTS OF THE AMERICAN HOSPITAL ASSOCIATION

On behalf of our nearly 5,000 member hospitals, health systems and other health care organizations, and our 43,000 individual members, the American Hospital Association (“AHA”) appreciates the opportunity to respond to the Wireline Competition Bureau’s Public Notice seeking comment on the Schools Health and Libraries Broadband (“SHLB”) Coalition Petition for Rulemaking (“Petition”) requesting changes to the Federal Communications Commission’s (“FCC” or “Commission”) Rural Health Care (“RHC”) Program.¹

I. INTRODUCTION

Access to reliable, sufficient and affordable broadband is central to providing high-quality health care and has become an essential infrastructure need for hospitals and health systems. Growth in the use of electronic health records, technology-based patient engagement strategies, telehealth and remote-monitoring technologies all require access to robust broadband connections. Further, the move to more coordinated care requires ever greater exchange of health

¹ Petition for Rulemaking by 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 Seeking Amendment of Part 54 of the Commission’s Rules to Further Modernize the Rural Health Care Program, CC Docket No. 02-60 (filed Dec. 7, 2015).

information among providers. As one example of the growing reliance on broadband infrastructure, the AHA's most recent data, from 2014, indicate that 55 percent of hospitals have implemented telehealth, up from 35 percent in 2010. An additional 10 percent of hospitals are in process of implementing and another 7 percent will implement within a year.²

The FCC created the Healthcare Connect Fund ("HCF") as a part of the RHC Program in 2012 with the goal of increasing access to broadband for rural health care providers.³ While the changes to the program have been largely successful, experience under the program suggests that some additional modifications are needed to ensure full success. As noted in the Petition, many areas of the country continue to lack the broadband access needed to support modern forms of health care, highlighting the importance of the RHC Program.⁴ Furthermore, rural hospitals continue to face extraordinary challenges due to their remote locations, highly dispersed patient populations and limited finances.

These challenges can make participating in the HCF challenging, given the cost-sharing requirements and administrative complexity of the program. As a result, the funding levels for the program continue to lag behind the overall cap of \$400 million – commitments totaled \$239 million in fiscal year 2014, only \$60 million of which was for the HCF.⁵

Therefore, the AHA urges the FCC to make several changes to the HCF that will lead to greater participation and further expansion of broadband to support rural health care.

Specifically, the FCC should:

² AHA analysis of the AHA Annual Survey - Information Technology Supplement for 2014.

³ *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 27 FCC Rcd 16678, 16696, ¶ 34 (2012) ("2012 Rural Healthcare Order").

⁴ Petition at 5-11.

⁵ See <http://www.usac.org/rhc/healthcare-connect/funding-information/default.aspx>.

- Increase the HCF discount percentage from 65 percent to 85 percent;
- Allow some funding for consortium administrative expenses;
- Streamline program administration;
- Consider making remote patient monitoring an eligible expense; and
- Reconsider the definition of rural used by the FCC to be more inclusive.

II. THE HCF DISCOUNT PERCENTAGE SHOULD BE INCREASED

The AHA recommends that the FCC increase the HCF discount percentage from 65 percent to 85 percent. During the transition from the RHC pilot program to the HCF, the FCC decreased its level of support for broadband costs from 85 percent to 65 percent, which more than doubled the contribution required of health care providers (from 15 percent to 35 percent). In 2012, the AHA warned that this increased contribution requirement could result in a significant decrease in program participation.⁶ And, as noted above, while program outlays have increased somewhat, they remain well below the cap, suggesting that even with the 65 percent discount, broadband costs can be prohibitive for some rural health care providers.

Furthermore, an 85 percent support level is more in line with other broadband support programs administered by the FCC, such as the E-rate program, which supports up to 90 percent of costs for many schools' and libraries' broadband connectivity needs.⁷ At a minimum, the Commission should establish a mechanism by which eligible health care providers can reasonably and promptly qualify to obtain greater discounts upon a showing of need.

⁶ Letter from Timothy J. Cooney, Counsel for American Hospital Association, to Marlene H. Dortch, Secretary, FCC, at 2-3 (October 11, 2012); *see also* Letter from Bradley K. Gillen, Counsel for American Hospital Association, to Marlene H. Dortch, Secretary, FCC, at 2 (December 5, 2012).

⁷ 47 C.F.R. § 54.505.

III. THE RURAL HEALTH CARE PROGRAM SHOULD PAY FOR CONSORTIUM ADMINISTRATIVE EXPENSES

The AHA urges the Commission to include consortium administrative costs in its list of non-recurring costs eligible for reimbursement, including reasonable expenses in preparing applications and other administrative costs associated with network design, construction and contract administration.

Many participants in the HCF are part of consortia that facilitate the process of program participation and contracting for broadband services. However, the program does not currently support any consortium administrative expenses, instead requiring consortium participants to cover the costs. Unfortunately, because organizing and running a consortium requires significant administrative and oversight costs, the Commission's decision not to cover these costs may be limiting participation in the HCF. Indeed, the Commission recognized the need to support up to \$100,000 in administrative costs associated with the proposed health infrastructure program in the *2010 RHC Program Reform NPRM*.⁸ While the Commission chose not to support administrative costs in the *2012 RHC Program Reform Order*,⁹ real-world experience with the HCF suggests that a lack of support for these expenses raises costs for potential consortia participants, which lead some health care providers to not participate, thereby increasing costs even more for those entities that remain in consortia. We note, however, that funding of consortium administrative costs may not be necessary if the overall discount rate is sufficiently raised.

⁸ *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Notice of Proposed Rulemaking, 25 FCC Rcd 9371, 9387, ¶ 38 (2010) (“*2010 RHC Program Reform NPRM*”).

⁹ *2012 Rural Healthcare Order*, 27 FCC Rcd at 16720-24, ¶¶ 90-98.

IV. ADMINISTRATION OF THE RHC PROGRAM MUST BE STREAMLINED

The AHA urges the Commission to streamline and upgrade the RHC Program for those who participate, so that the available funds can be fully deployed in support of a broadband-connected rural health care system.

As highlighted in the Petition, participation in the RHC Program can be hampered by a program management approach that lacks a robust information technology infrastructure and responsive system for application processing.¹⁰ As the AHA previously articulated, a program that is too administratively burdensome will discourage health care providers from participating.¹¹ The Commission should review the past several years of program applications to determine where improvements can be made to streamline the application and disbursement process.

V. THE COMMISSION SHOULD CONSIDER INCLUDING REMOTE PATIENT MONITORING AS AN ELIGIBLE EXPENSE

The Commission should consider changing the program rules to include costs necessary for remote patient monitoring as an eligible expense. Remote patient monitoring involves the collection of a patient's personal health and medical data via electronic communication technologies. Once collected, the data are transmitted to a health care provider at a different location, allowing the provider to continue tracking the patient's data once the patient has been released to his or her home or another care facility. Remote patient monitoring allows health care providers to better care for patients with chronic conditions, so they do not end up with acute

¹⁰ Petition at 33-34.

¹¹ Letter from Linda E. Fishman, Senior Vice President, Public Policy Analysis and Development, American Hospital Association, to Marlene H. Dortch, Secretary, FCC, at 2-3 (August 22, 2012).

episodes. Remote patient monitoring also can help manage the care of patients upon discharge from the hospital, reducing the likelihood of unnecessary readmissions.

As highlighted in a proposal by CHRISTUS Health,¹² the FCC does not currently support connectivity for remote patient monitoring. However, given the benefits of remote patient monitoring for care, the Commission should consider subsidizing the wireless broadband contracts between health care providers and the wireless carriers they use for remote monitoring as proposed in the Petition.¹³ This rule change would allow health care providers to obtain support for the cost of connectivity to individual patients, as well as to other health care providers, as permitted under current rules.

VI. THE DEFINITION OF “RURAL” SHOULD BE MORE INCLUSIVE

The AHA urges the Commission to reconsider the definition it uses to determine whether health care providers are rural and, therefore, eligible for support. As noted in the Petition, the definition of rural used by the FCC is fairly restrictive.¹⁴ As a result of the 2010 census and the most recent nationwide Core-Based Statistical Area designations, some areas that were previously considered rural are now considered non-rural.

Other federal agencies, such as the Office of Rural Health Policy with the Health Resources and Services Administration, have adopted alternative definitions of rural that may be

¹² Letter from George S. Conklin, Senior Vice President and CIO, CHRISTUS Health, and Jeffrey A. Mitchell, Counsel to CHRISTUS Health, to Marlene H. Dortch, Secretary, FCC at 4-5 (March 30, 2015).

¹³ Petition at 22-23.

¹⁴ Petition at 34-36; *See* 47 C.F.R § 54.5 (stating that for purposes of the rural healthcare universal service support mechanism, a “rural area” is limited to an area that is entirely outside of a Core-Based Statistical Area (CBSA); is within a CBSA that does not have any Urban Area with a population of 25,000 or greater; or is in a CBSA that contains an Urban Area with a population of 25,000 or greater, but is within a specific census tract that itself does not contain any part of a Place or Urban Area with a population of greater than 25,000).

