Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, DC 20554

Promoting Telehealth in Rural America	**)**	**Docket No. 17-310**

Comments of

NTCA–THE RURAL BROADBAND ASSOCIATION

To the Commission:

I. INTRODUCTION

NTCA–The Rural Broadband Association (NTCA) hereby submits comments in the above-captioned proceeding.[1] NTCA supports the Commission's effort to ensure that rural healthcare providers receive funding necessary to access broadband and other telecommunications services that are critical inputs for telehealth and other services. Establishing the proper definition of "rural" in these regards is a crucial aspect of ensuring that funding is directed to the areas where it is needed most, and NTCA is encouraged by the Commission's studied attention to this issue. At the same time, however, NTCA suggests that the relative benefits of certain definitions of "rural" must be weighed against the overall efficiencies of evaluating and then categorizing the relevant service areas. Overall, NTCA urges the Commission to maintain consistency within its own regulations and to utilize in the Rural Healthcare Program (RHC) the same definition for "rural" as is used for E-rate.

[1] *Promoting Telehealth in Rural America: Further Notice of Proposed Rulemaking,* Docket No. 17-310, FCC 22-15 (2022) (FNPRM).

II. DISCUSSION

A. RURAL AREAS FACE UNIQUE HEALTHCARE NEEDS

The Commission's inquiry into ensuring more accurate targeting of telehealth resources comes at an important time. Broadband providers, healthcare services, and end-users are at a confluence of experiences that are driving increased interest in and use of telehealth services. The COVID-19 pandemic marked an inflection point in public policy and public responsiveness. The Commission's COVID-19 Telehealth Program, funded through dedicated Congressional appropriations, recognized the usefulness of telehealth for treating not only the novel coronavirus but also various acute and chronic conditions that do not require patients to travel to a facility.[2] Data indicate positive public response to telehealth availability. The Department of Health and Human Services reported that 43.5% of Medicare primary care visits in April 2020 were conducted via telehealth, a remarkable increase from the previous February in which only 0.1% of primary care visits were via telehealth. During the initial phases of the COVID-19 pandemic, 33% increases in telehealth usage were documented in Iowa, South Dakota, and Oklahoma.[3] Older populations, generally viewed as being a smaller proportion of "early adopters" of technology, were represented strongly among telehealth users.[4]

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[2] *See, Promoting Telehealth for Low-Income Consumers, COVID-19 Telehealth Program: Report and Order,* Docket Nos. 18-213, 20-89, FCC 20-44, at para. 4 (2020).

[3] "HHS Issues New Report Highlighting Dramatic Trends in Medicare Beneficiary Telehealth Utilization Amid COVID-19," US Department of Health and Human Services (Jul. 28, 2020) (https://www.hhs.gov/about/news/2020/07/28/hhs-issues-new-report-highlighting-dramatic-trends-in-medicare-beneficiary-telehealth-utilization-amid-covid-19.html) (viewed Aug. 26, 2020).

[4] *See, e.g.,* Greenwald, P., Stern, ME, Clark, S., Sharma, R., "Older Adults and Technology: In Telehealth, They May Not Be Who You Think They Are," International Journal of Emergency Medicine (2018) (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5752645/) (viewed Sep. 14, 2020).

These telehealth strides impart great promise for rural America. Rural areas face unique healthcare needs. On average, rural residents are older and face higher rates of chronic and acute conditions than their urban counterparts. According to the Centers for Disease Control and Prevention (CDC), rural Americans are at a greater risk of death from heart disease, cancer, unintentional injury, chronic lower respiratory disease, and stroke than their urban counterparts.[5] When combined with distance from specialists and other socioeconomic factors, rural residents may be less able or less likely to obtain regular treatment for chronic conditions. By way of example, the CDC reports that COPD (chronic obstructive pulmonary disease) is more common in rural areas than urban areas.[6] Significant disparities are also seen among chronic conditions such as diabetes and hypertension/hypertension control.[7] For example, the CDC explains that higher rural COPD rates are due, in part, to "less access to smoking cessation programs" and the fact that "[r]ural residents are also likely to be uninsured and have higher poverty levels, which may lead to less access to early diagnosis and treatment."[8] Broadband access has also been cited as a tool in combatting substance abuse and the opioid crisis.[9] And the effectiveness of mental

[5] *See, About Rural Health*, Centers for Disease Control and Prevention (Aug. 2, 2017) (https://www.cdc.gov/ruralhealth/about.html) (visited Jul. 27, 2021).

[6] *Rural Health, COPD*, Centers for Disease Control and Prevention (https://www.cdc.gov/ruralhealth/copd/index.html) (visited Aug. 26, 2020).

[7] *Fact Sheet: CDC Health Disparities and Inequalities Report*, Centers for Disease Control, at 3 (2011) (https://www.cdc.gov/minorityhealth/chdir/2011/factsheets/CHDStroke.pdf) (visited Aug. 3, 2021).

[8] *Urban-Rural Differences in COPD Burden*, Chronic Obstructive Pulmonary Disease (COPD), Centers for Disease Control and Prevention (https://www.cdc.gov/copd/features/copd-urban-rural-differences.html#:~:text=Rural%20populations%20may%20have%20more,living%20in%20more%20urban%20areas) (visited Sep. 14, 2020) *citing 2016 County Health Rankings: Key Findings Report*, Population Health Institute, University of Wisconsin (2016) (https://www.countyhealthrankings.org/sites/default/files/media/document/key_measures_report/2016CHR_KeyFindingsReport_0.pdf) (visited Sep. 14, 2020).

[9] *Rural Community Action Guide,* U.S. Office of National Drug Control Policy, U.S. Department of Agriculture at 30-34 (2019) (https://www.usda.gov/sites/default/files/documents/rural-community-action-guide.pdf) (visited Aug. 18, 2021).

health services via telehealth warrants consideration for rural spaces that lack sufficient access to mental health professionals.[10] Ensuring affordable broadband and telecommunications access for rural healthcare providers is an important element in ensuring improved healthcare outcomes in rural spaces.

Telehealth growth both *before* and during the COVID-19 pandemic occurred in rural areas served by NTCA members. During the COVID-19 pandemic, West River Telecom (Hazen, North Dakota) worked with area hospitals and clinics to plan for overflow locations and ensure connectivity. Ben Lomand Connect (McMinnville, Tennessee) provided resources for customers via social media including livestreaming experts on mental health. In pre-pandemic achievements, Dakota Central Telecommunications (Carrington, North Dakota) worked with health care systems to leverage its fiber optic network to support robotic home health devices that can administer tests and medications and report patient information to health care providers. Broadband deployed by Home Telecom (Moncks Corner, South Carolina) supports telepsychiatry using high-definition cameras and symmetrical broadband to reduce average patient stays from 36 hours to just four hours. Federal telehealth responses, rural needs, and NTCA member participation in telehealth inform NTCA positions on Commission inquiries aimed at refining and improving the delivery of important telehealth resources to rural spaces.

[10] Current literature indicates that additional investigations will be necessary before the most effective protocols for mental health via telehealth are evaluated. Moreover, questions regarding appropriate training, licensure, and reimbursement must be addressed. Nevertheless, it is reasonable to anticipate that teletherapy will offer an additional avenue for patient treatment. For an overview of this issue, *see,* Michael L. Barnett, Haiden A. Huskamp, *Telemedicine for Mental Health: Making Progress, Still a Long Way to Go,* Psychiatry Online (Dec. 18, 2019) (https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201900555) (visited Aug. 24, 2021).

B. A PROPER DEFINITION OF RURAL IS NECESSARY TO ENSURE THE DIRECTION OF FUNDING TO AREAS IN NEED

The "Telecom Program" component of RHC subsidizes the difference between rural and urban rates for telecommunications services. A proper definition of "rural" is essential to ensuring that RHC funding is directed to the correct regions. As the Commission considers the definition of "rural," NTCA is guided by two overarching interests:

1. To ensure that programs aimed at benefitting rural healthcare providers direct the necessary resources to providers in rural areas, and that definitions of "rural" do not inadvertently capture larger, more metro-like places that could quickly consume program resources while neglecting areas most in need.

2. To ensure efficiency by maintaining consistency among various regulatory paradigms, thereby avoiding confusion and unnecessary administrative burdens that may be created as telecom and healthcare providers reconcile potentially competing programmatic definitions.

At the outset, it is useful to note that "rural" is not a consistently defined term, even among various offices of the U.S. government. Previous Commission rules defined urban rates as no higher than "the highest tariffed or publicly available rate charged to a commercial customer for a functionally similar service in any city with a population of 50,000 or more in that state."[11] The U.S. Census Bureau defines "rural" as any area that is not "urban": an urban area is one with (a) an "urbanized area" with at least 50,000 people, or (b) an "urban cluster of at least 2,500 and fewer than 50,000 people.[12] In comparison, the Economic Research Service (ERS) of the USDA

[11] FNPRM at para. 5, citing 47 CFR 54.605(a) (2019). These "publicly available" rates were culled from, *inter alia,* websites, rate cards, publicly available contracts, and tariffs. This standard was subsequently amended to rely on a "rates database." Once implemented, however, the Commission found that anticipated rate trends did not comport to actual outcomes. For example, rates for *lower capability* services in rural areas were at times *higher* than a more robust offering. Or service rates in more densely populated areas were higher than rates in less densely populated areas where fewer users per square mile would be expected to result in higher rates. Taking note of these anomalies, the Commission deferred their implementation and now seeks comment on methods to determine support for the Telecom Program.

[12] United States Census Bureau website, "Urban and Rural Classification" (https://www.census.gov/geo/reference/urban-rural.html).

invokes population thresholds, but also considers whether "outlying counties" are "economically tied to the core counties as measured by labor-force commuting," among other criteria.[13] In contrast, the U.S. Office of Management and Budget (OMB) utilizes a separate set of definitions for urbanized areas that revolve around Metropolitan Statistical Areas and Micropolitan Statistical Areas. Like the USDA approach, OMB considers economic ties, such as those evidenced by commuting workers, between places. OMB notes, however, that its classifications "do not equate to an urban-rural classification."[14]

NTCA commends the Commission to promulgate an antidote to these confusing trends by conforming its definition of rural in the RHC program to the definition of the rural that the Commission adopted for the E-rate program. Specifically, 47 C.F.R. § 54.505(b)(3) provides that a school or library is "designated as 'urban' if located in an 'Urbanized Area' or an 'Urban Cluster' with a population equal to or greater than 25,000 . . . . Any individual school or library not designated as 'urban' will be designated as 'rural.'"[15] NTCA submits that this definition bridges two critical principles. First, it appropriately ensures that resources intended for rural spaces *stay* in rural spaces. This is not a bid for parochialism, but rather a logical extension of numerous Congressional and Commission actions that recognize the unique challenges posed by geographic remoteness and population sparsity. The limits imposed by the E-rate definition would ensure that RHC support is targeted to areas that are in fact more costly to serve than

[13] United States Department of Agriculture, Economic Research Services website, "What Is Rural?" (http://www.ers.usda.gov/topics/rural-economy-population/rural-classifications/what-is-rural).

[14] United States Office of Management and Budget, Bulletin No. 13-01, "Revised Delineations of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and Guidance on Uses of the Delineations of These Areas," at 3 (Feb. 28, 2013) (https://www.whitehouse.gov/sites/default/files/omb/bulletins/2013/b-13-01.pdf).

[15] *Modernizing the E-rate Program for Schools and Libraries; Connect American Fund: Second Report and Order and Order on Reconsideration,* Docket Nos. 13-184, 10-90, FCC 14-189, at para. 136 (2014).

urban regions, thereby extending the follow-on benefits to patients who can access telehealth services more effectively. Second, mirroring the E-rate definition promotes administrative efficiency. The numerous definitions among various Federal agencies, even if not in outright conflict with each other, set the stage for confusion as practitioners traverse from one regulatory paradigm to another. Moreover, it would test the bounds of logic were the Commission to incorporate different definitions for rural not simply within the broad corpus of Commission rules, generally, but within the single Universal Service Fund (USF) program. Federal policies promulgated by different agencies including the Commission have enabled significant strides forward to bring advanced communications services to rural and insular regions of our Nation. A proper definition of rural is necessary to ensure that these policies continue to inure to the benefit of regions that are truly rural. Even as the Commission recognizes the diversity among rural areas and factors such as population density and terrain that may affect service costs, it is important as well to strive for consistency within the rules and to, the extent practicable, avoid creating yet another definition.

The definition of rural and follow-on policies must avoid diffusing, and thereby diluting, attention to critical rural issues; "rural" must include areas that reflect the rural condition, as opposed to capturing areas that are more metro-like.[16] Policies intended to improve the "state of rural" could be undermined if resources were poured into areas that are not truly rural. This could happen if a population threshold has the effect of equating conditions in thriving metropolitan areas with a small town in Appalachia, a village in Nebraska, or a hamlet in Ohio.

[16] *See, i.e., Recommendation from the Metropolitan and Micropolitan Statistical Area Standards Review Committee to the Office of Management and Budget Concerning Changes to the 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas: Letter Comments of NTCA-The Rural Broadband Association,* 86 Fed. Reg. 5263 (Mar. 19, 2021).

The use of the E-rate definition for RHC focuses funding and will resolve "uncertainty and eligibility issues for program participants."[17]

This threshold E-rate based definition should not conflict with the Commission's consideration that various geographic cost factors that are not necessarily linked to population density may affect telecom service rates:[18] For example, the Commission notes that when program demand exceeds funding, priority is accorded to providers in Medically Underserved Areas, along with others on a sliding scale according to the current rurality tiers.[19] While this may be a logical *second* step, NTCA urges an approach that in its initial application is clear and measurable by existing and accessible metrics, such as those that inform the E-rate standard. In contrast, the Commission's proposal to replace defined rurality tiers with a dynamic, "threshold-free and unit-free" approach would be more complex than necessary for the task at hand.[20] Similarly, relying on Rural Urban Commuting Area (RUCA) codes may offer more focused granularity, and their source in Census Bureau data (as well as their formulation by, *inter alia,* the Federal Office of Rural Health Policy (FORHP) and USDA) may make certain of their elements familiar some rural telecom and healthcare providers.[21] But here, too, the potential gains in granularity may well be lost amidst the costs of complexity. NTCA does not suggest the Commission *per se* shy away from endeavors intended to sharpen funding focus, but rather to avoid implementing different definitions for a single qualitative term within the same program.

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[17] *See,* FNPRM at para. 17.

[18] *See, i.e.,* FNPRM at para. 22.

[19] FNPRM at para. 30.

[20] FNPRM at para. 25.

[21] FNPRM at para. 26.

In similar vein, the Commission seeks comment on whether rates should be based on census tract information. These data include population and business density; terrain and topography; distance from urban areas; "built-up" areas; and other information.[22] Here, too, NTCA supports recognition of the diversity of rural spaces, but commends the Commission to ensure that the RHC definition of "rural" align to the existing E-rate standard in order to enhance efficient administration by participating providers.

C. REASONABLY COMPARABLE SERVICES ARE MORE APPROPRIATELY GROUPED IN NARROWER CATEGORIES

Commission rules direct that reasonably comparable rates be charged for "similar services." The Commission seeks comment on how various services would be defined as similar, or not. The Commission explains that it currently relies on a standard that approaches the question "from the perspective of the end-user," and whether the services offer "functionally similar" capabilities.[23] NTCA supports the Commission's recommendation to continue this standard, as well as the Commission's recognition that other factors, including reliability and security, may be included alongside bandwidth as users determine whether a service is similar. NTCA notes, however, that the current +/-30% difference between advertised speed and the speed requested by the service provider is an unnecessary and inaccurate margin. A difference of one-third implicates a broad range of service capabilities and it is not clear that two services so far apart would in fact "reasonably comparable" service. NTCA commends the Commission to reconsider the 30% threshold and implement a smaller margin. This should include a fact-based analysis driven by health care provider participation to determine their use cases for various service types.

[22] NPRM at para. 28.

[23] NPRM at para. 33.

III. CONCLUSION

WHEREFORE the reasons stated above, NTCA commends the Commission to apply the E-rate definition for "rural" to the RHC program. This will ensure that targeted funding is directed to the proper regions and enable administrative efficiency by using common definitions within the USF programs.

Respectfully submitted,

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