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BI-STATE PRIMARY CARE ASSOCIATION
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Improving Access to Health Care for 30 Years
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February 8, 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:

Bi-State Primary Care Association (Bi-State) appreciates the opportunity to respond to the FCC's Notice of Proposed Rulemaking on the Rural Health Care Program, WC Docket No. 17-310.

Established in 1986, Bi-State is a nonpartisan, nonprofit 501(c)(3) charitable organization promoting access to effective and affordable primary care and preventive services for all, with special emphasis on underserved populations in Vermont and New Hampshire. Bi-State's combined Vermont and New Hampshire membership includes 28 Community Health Centers (CHCs), delivering primary care at over 120 locations for over 300,000 patients.[1]

Our CHCs are the backbone of the rural "health care safety net" and our comments come from the perspective of these rural providers. Congress explicitly indicated that rural providers are intended to benefit from the Rural Health Care Program (RHCP) and rural CHCs were named as one of the seven types of health care providers whom the program was designed to support. [2] In recent years, CHCs have become increasingly concerned that the RHCP has expanded beyond its original intent, to include providers who should not be eligible under a "plain reading" of the statute. As a result, CHCs have been subject to across-the-board funding reductions, and administrative complexities which have made it difficult for them to participate in the program that was designed for them. For this reason, we are pleased that the FCC is reexamining the program's structure, and offer the following comments:

<u>Funding cap:</u>

- The FCC should raise the $400 million cap for FY16-17 and FY17-18, to reflect recent expansions of the program, and to avoid penalizing rural CHCs.
- Whenever possible, the operational aspects of the RHCP should be aligned with the E-Rate program, including using GDP-CPI to update the funding cap annually.

[1] CHCs are community based and patient directed organizations that serve populations with limited access to health care. They are statutorily required to be located in or serve a high need community, governed by a community board composed of a majority of CHC patients, provide comprehensive health care and provide services regardless of a patient's ability to pay. *See generally* Section 330 of the Public Health Services Act.
[2] §254(h)(7)(B)(ii)

- In future years, the funding cap should be modified to reflect inflation, eligibility expansions, and changes in costs resulting from advances in technology.
- All unused RHCP funding from previous funding years should be made available in subsequent funding years until fully disbursed.

Prioritization of funding requests:

- The FCC's current across-the-board proration is unfair to rural CHCs who are plainly eligible under the statute because the proration implies that their requests are of equal merit to those received from providers whose eligibility is not explicitly identified in the statue and who seek a disproportionate share of the total RHCP funding.
- The most appropriate prioritization approach is to fully fund requests from individual providers who are clearly eligible under a plain reading of the statute – namely, "public or non-profit" providers who actually "serve(s) persons who reside in rural areas".
- If a second-tier prioritization approach is needed, the FCC should use scores for rural Health Professional Shortage Areas (HPSA), as calculated by the Federal Department of Health and Human Services.
- The definition of "rural" currently used in E-Rate should be applied to the RHCP.
- Bi-State strongly supports efforts to ensure that the vast majority of RHCP funds are directed to provider organizations actually treating patients who reside in rural areas. This will require the FCC to significantly tightening the administrative rules on urban-rural consortia.

Administrative Burden:

- The administrative burden of applying for and participating in the RHCP is becoming unsustainable for small rural CHCs. At this time, the application process is so complex that some CHCs hire consultants to navigate the process. This puts smaller CHCs who cannot afford consultants at a disadvantage and could force many to drop out of the program or not apply for funding at all.
- Bi-State strongly supports efforts to simplify the application and funding process so that it no longer disadvantages and discourages small providers from participating.

For further information on each of these recommendations, we refer you to the detailed comments submitted by our national association, the National Association of Community Health Centers.

In closing, Bi-State appreciates the opportunity to submit comments on this important issue, and both our staff and member CHCs would be happy to provide further information that would be helpful. Please do not hesitate to contact me at (603) 228-2830 extension 112 or via email at tkuenning@bistatepca.org if you would like additional information or require clarification on the comments presented above.

Sincerely,

Tess Stack Kuenning, CNS, MS, RN
President and Chief Executive Officer
Bi-State Primary Care Association