



January 31, 2018

Secretary Marlene H. Dortch  
FCC Reference Center, Room CY-A257  
445 12th Street SW  
Washington, DC 20554

Re: Promoting Telehealth in Rural America, WC Docket No. 17-310

Dear Secretary Dortch:

On behalf of the American Academy of Family Physicians (AAFP), which represents 129,000 family physicians and medical students across the country, I write in response to the [proposed rule](#) titled, "Promoting Telehealth in Rural America" as published by the Federal Communications Commission (FCC) in the January 3, 2018 *Federal Register*.

The AAFP appreciates that in this proposed rule, the FCC suggests several steps to ensure that rural physicians and clinicians get the support they need while guarding against waste, fraud, and abuse. We offer the following comments to improve the FCC's consideration of rural healthcare and telehealth issues.

In this proposed rule, the FCC asks for comments regarding whether the Commission should adjust the \$400 million cap annually. The FCC provides an example, noting if indeed the Commission had adjusted the \$400 million cap annually for inflation each year from 1997 forward, and had based adjustment for inflation "on the GDP-CPI (which the E-rate Program uses to adjust its cap)," then the Rural Health Care (RHC) program cap would have been approximately \$571 million for FY 2017. The AAFP urges the FCC to adjust for inflation and to also consider the price fluctuation in technology.

The Commission also seeks comment on whether to roll over unused funds committed in one funding year into a subsequent funding year. The AAFP supports this approach.

The Commission seeks comment on the types of unused funds from a given funding year to be rolled over to a subsequent funding year. We remind the FCC that technology projects often become delayed by issues beyond the control of the medical practice. We encourage the FCC to consider policy establishing that a one-year roll-over is "automatic" but a second-year roll-over would require justification by the medical practice to the FCC which would undergo an approval process within FCC.

The FCC also seeks comment on whether to modify its current definition of the term "rural area" or adopt a new definition entirely. The AAFP encourages consistency in the definition of "rural" in the federal government, unless there is an explicit and demonstrable reason why one use of "rural" would mean something different.

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The Commission seeks comment on whether the RHC Program should take into consideration the economic need of the population served by the physician and clinician when prioritizing disbursements. If so, the FCC asks if Medicaid eligibility would be an appropriate measure of economic need. The AAFP reminds the FCC that Medicaid eligibility varies by state. Perhaps the modified adjusted gross income (MAGI) or other economic indicators would lead to less variability across states.

The FCC also asks whether funding should be prioritized based on economic need of the population served by the physician or clinician. The AAFP wholeheartedly agrees with the suggestion that funding should be prioritized in this way.

As the FCC contemplates changes for rural physicians and clinicians, we urge the FCC to reference the AAFP's [policy](#) on access to rural health care. We support the position that inequities of payments to rural hospitals should be abolished, and that the AAFP and other stakeholders make reasonable efforts to ensure that these inequities be discontinued to eliminate these disparities in access to quality care for all populations.

It is the [policy](#) of the AAFP to support expanded use of telehealth and telemedicine as an appropriate and efficient means of improving health when conducted within the context of appropriate standards of care. The appropriateness of a telemedicine service should be dictated by the standard of care and not by arbitrary policies. Available technology capabilities as well as an existing physician-patient relationship impact whether the standard of care can be achieved for a specific patient encounter type.

Telehealth is different from telemedicine in that it refers to a broader scope of remote healthcare services than telemedicine. While telemedicine refers specifically to remote clinical services, telehealth can refer to remote non-clinical services such as physician or clinician training, continuing medical education or public health education, administrative meetings, and electronic information sharing to facilitate and support assessment, diagnosis, consultation, treatment, education, and care management.

Telehealth technologies can enhance patient-physician collaborations, increase access to care, improve health outcomes by enabling timely care interventions, and decrease costs when utilized as a component of, and coordinated with, longitudinal care. Responsible care coordination is necessary to ensure patient safety and continuity of care for the immediate condition being treated, and it is necessary for effective longitudinal care (for clarification, forwarding documentation by electronic means, including fax, is not acceptable for coordination of care with the primary care physician or medical home).

We believe the FCC's RHC program has an important role to play to ensure disparities are not widened for those in rural areas, including disparities tied to lack of timely access to quality health care which telemedicine and telehealth may help alleviate *if* conducted in a manner supportive of longitudinal care. For example, policy which supports incorporating telemedicine and telehealth capabilities within rural physician/providers' practices and enables the primary care physician providing longitudinal care to reach out via technology to secure an e-consult with a specialist in a timely manner, which could otherwise take weeks or months for the patient to access, would support provision of cost-effective, responsible longitudinal care. On the contrary, policy which only supports

the continuance or expansion of direct-to-consumer telehealth services would lead to care provided in silos, which can fracture care and increase total cost of care.

Finally, it is the [policy](#) of the AAFP that access to high quality health care services for rural Americans continues to be dependent upon an adequate supply of rural physicians. While efforts to meet physician shortages in rural areas have improved the situation, there continues to be a shortage of physicians for rural areas. Although current data is not always available to assess the magnitude of the problem, and variation exists based on differing definitions of "rural," studies based on the demand to hire physicians by hospitals/physician groups, or based on the number of individuals per physician in a rural area, continue to indicate a need for additional physicians in rural areas. A balanced and cooperative effort among those involved in medical education is needed to promote rural practice. This includes increased recruitment of medical students from rural backgrounds; active teaching, both at the academic medical center and the community level, of skills needed in rural settings; as well as providing necessary funding for rural medical education on the federal, state and private level. All need to work together to provide support for the training of future rural physicians.

We appreciate the opportunity to provide these comments. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or [rbennett@aafp.org](mailto:rbennett@aafp.org) with any questions or concerns.

Sincerely,

A handwritten signature in black ink, appearing to read "John Meigs, Jr.", with a stylized flourish and the initials "MS" at the end.

John Meigs, Jr., MD, FAFBP  
Board Chair

### **About Family Medicine**

Family physicians conduct approximately one in five of the total medical office visits in the United States per year – more than any other specialty. Family physicians provide comprehensive, evidence-based, and cost-effective care dedicated to improving the health of patients, families and communities. Family medicine's cornerstone is an ongoing and personal patient-physician relationship where the family physician serves as the hub of each patient's integrated care team. More Americans depend on family physicians than on any other medical specialty.