

September 30, 2026

Marlene H. Dortch
Office of the Secretary
Federal Communications Commission
45 L Street NE
Washington, D.C. 20554

RE: WC Docket No. 17-310; Promoting Telehealth in Rural America

Submitted electronically via <https://www.fcc.gov/ecfs/>.

Dear Secretary Dortch,

The National Rural Health Association (NRHA) appreciates Federal Communications Commission (FCC) efforts to improve the Rural Health Care (RHC) program. The RHC program is an invaluable resource for rural health care providers to establish telecommunications and broadband services necessary for providing health care in rural communities. NRHA appreciates the FCC's attention to the RHC program through its third further notice of proposed rulemaking. With the advancement of telehealth flexibilities in recent years increasing bandwidth needs of rural health providers, NRHA is encouraged to see a renewed focus on this critical program.

NRHA is a non-profit membership organization with more than 21,000 members nationwide that provides leadership on rural health issues. Our membership includes nearly every component of rural America's health care, including rural community hospitals, critical access hospitals, long-term care providers, doctors, nurses, and patients. We work to improve rural America's health needs through government advocacy, communications, education, and research.

The FCC's RHC program is a key asset for rural health care providers across the country seeking to establish and expand broadband and telecommunications services that might otherwise be unaffordable. Changes are necessary, however, to ensure the program's long-term viability and resource allocation to the areas of greatest need. Reliable, high-speed broadband connectivity is critical for providers serving rural communities with limited resources, fewer clinicians, and significant barriers to care. Telehealth is no longer solely an emergency response tool as rural providers increasingly depend on it for behavioral health services, specialty consultations, remote patient monitoring, stroke care, chronic disease management, and care coordination. NRHA appreciates FCC's acknowledgement that expanding telehealth and digital health services have increased bandwidth requirements for rural health providers. Affordable and reliable connectivity is essential to maintaining access to care amid persistent workforce shortages, limited specialty access, long travel distances, and continuing provider shortages faced by rural residents.

I.A.1. Redefining Similar Services and Rural Area Comparability

Defining Rural Areas.

NRHA encourages the FCC to align RHC Program eligibility with federal health policy definitions of rurality, in particular the definition used by the Federal Office of Rural Health Policy.¹ This definition combines rural definitions from the United States Census Bureau, the Office of Management and Budget, and the United States Department of Agriculture Economic Research Service and is inclusive

¹ <https://www.hrsa.gov/rural-health/about-us/what-is-rural>

of non-metropolitan counties, outlying metropolitan counties with no population from an urban area of 50,000 or more people, and census tracts with RUCA codes 4-10 in metropolitan counties. The Commission should also recognize that micropolitan and frontier communities may experience the same telecommunications limitations and health care access challenges as communities currently classified as rural. A definition that meets these standards would prevent otherwise eligible providers from being excluded solely because different federal programs apply different geographic standards.

Rural Rates.

NRHA appreciates the FCCs' efforts to address problematic components of Methods 1 and 2 through the $\pm 30\%$ threshold. However, this threshold does not address the availability of comparable commercial rates that providers may use to calculate the rural rate, nor the potential for inflated rates for rural healthcare providers.

Regarding rural rate calculations, NRHA is primarily concerned with the availability of comparable commercial rates and the potential for service providers to select higher rates. If providers can select commercial services that are substantially different from rural healthcare providers, this opportunity would produce less accurate estimates and potentially increase the financial burden on rural providers and the RHC program. For example, a service provider could use the median of its rates in the Telecom Program in the same rural area and determine a higher rural rate than is warranted. This is why NRHA would encourage a different rate calculation.

The FCC's current proposal to reconsider the $\pm 30\%$ threshold presents an opportunity to address these concerns. While expanding the definition of similar services may increase the availability of comparable commercial rates, NRHA is concerned that doing so without appropriate safeguards could result in comparisons between services with substantially different bandwidth capabilities and costs.²

NRHA encourages the FCC to consider safeguards to prevent service providers from selectively using higher commercial rates to inflate rural rates. We encourage the FCC to consider a cost-based rate calculation for applications exceeding a specified threshold, such as \$100,000. This approach would require service providers to justify their requested rural rate through an itemization of the costs associated with providing the requested service. For applications below that threshold, Methods 1 and 2 would remain appropriate, provided that comparable rates are available, and appropriate safeguards are maintained.

NRHA supports the FCCs' efforts to reduce the administrative burden in Method 3. The Commission's continued reliance on temporary waivers allowing previously approved rural rates to be used in subsequent funding years demonstrates the need for a more permanent approach. Most recently, the FCC extended this flexibility to funding year (FY) 2027, allowing service providers to use previously approved rural rates from FY 2024 through FY 2026 that would otherwise require a new Method 3 cost-based justification.³

I.A.2. Improving or Replacing Cost Studies

Any revised rate-setting methodology should account for the limited administrative capacity of small rural hospitals, rural health clinics, Tribal facilities, and consortium participants. These providers may lack telecommunications consultants, legal staff, or other specialized expertise needed to

² Promoting Telehealth in Rural America, 88 Fed. Reg. 17,379 (Mar. 23, 2023) (to be codified at 47 C.F.R. pt. 54).
<https://docs.fcc.gov/public/attachments/FCC-26-54A1.pdf>

³ FCC Proposed Efficiency Reforms to the Rural Health Care Program. *Promoting Telehealth in Rural America*. (2026).
<https://www.fcc.gov/document/fcc-proposed-efficiency-reforms-rural-health-care-program-0>

complete complex cost studies. NRHA therefore encourages the FCC to pair the use of previously approved rates with simplified documentation requirements that reduce barriers to participation while preserving appropriate program safeguards.

Regarding wholesale rates, NRHA remains concerned that service providers could select higher rates or rates that reflect industries and services that are not applicable to healthcare. Relying on previously approved rates would reduce administrative burden for rural health care providers. However, we encourage the FCC to balance this with established safeguards to ensure that those rates reflect current market conditions and are periodically reviewed for fairness and applicability for rural healthcare providers.

Finally, NRHA concedes that allowing rate projections would be useful in a situation where commercial rates are not available, but we raise concerns about inflated projections. Given that telecommunications costs and bandwidth do not necessarily increase proportionally, NRHA encourages the FCC to permit interpolation between documented comparable rates rather than extrapolation beyond available rates when using rate projection. NRHA also encourages the FCC to ensure that any rates used to develop projections have been reviewed and determined to be reasonable and applicable to rural healthcare providers.

I.B.1. Promoting Lower Cost Secondary Services

NRHA also encourages the FCC to recognize the importance of redundant connectivity for rural health care providers. Many rural facilities have only one reliable terrestrial broadband option, yet uninterrupted connectivity is essential for many telehealth services including emergency capacity, tele-stroke programs, behavioral health care, cybersecurity resilience, and disaster response. Lower-cost technologies, including low-earth-orbit satellite service, may offer valuable secondary connections. However, program rules should not prioritize the lowest-cost option at the expense of reliability or prevent rural providers from obtaining support for necessary backup service.

I.B.2. Establishing an RHC Program Eligible Services List

NRHA supports greater clarity and predictability in RHC Program administration. A formal eligible-services list could make participation easier for small rural hospitals and clinics, reduce uncertainty during application review, and support adoption of emerging technologies, provided the list is updated regularly and remains sufficiently flexible to accommodate evolving telehealth needs.

I.C.1. Applying Performance Metrics

NRHA supports meaningful processing metrics and timely funding decisions because rural facilities often cannot front the cost of broadband upgrades, telehealth expansion, or network modernization while awaiting program approval. Predictable funding timelines are critical to successful implementation of connectivity investments in rural communities.

II. B. Regulatory Flexibility Act

Multiyear contracts are simpler and relieve health care providers of administrative burden and provide rural healthcare providers with greater financial predictability. NRHA maintains that rural health care providers should have their full multiyear contracts honored to continue to incentive using such contracts. In addition, given that the RHC program is intended to support rural healthcare delivery, rural providers should receive funding priority before resources are allocated to participating urban providers.

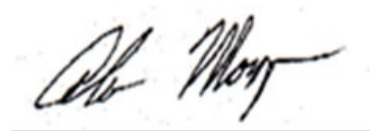
Further, because urban healthcare providers can participate in the Health Connect Fund (HCF) Program through a consortium, NRHA urges the FCC to release the data showing how much of the HCF funding is going to urban providers. Greater transparency regarding funding distribution would allow stakeholders to better understand whether program resources are appropriately supporting rural providers and identify potential improvements to existing prioritization policies.

II. C. Initial Regulatory Flexibility Analysis

NRHA also maintains that the FCC's internal cap on the RHC Program should be expanded. The FCC sets this cap internally and does not need congressional approval to expand it. When the cap was set, the HCF Program did not exist and further urban participation in RHC Program was not contemplated because urban health care providers could not participate in the original Telecom Program. Now urban health care providers may participate in the HCF Program. Both the HCF Program and urban participation drive up costs so that the cap does not reflect the reality of the program. If the cap were expanded, the abovementioned concerns would likely be mitigated or solved.

NRHA appreciates the FCC's commitment to improving the RHC program and ensuring that rural healthcare providers can access affordable telecommunications and broadband services. We encourage the Commission to prioritize rural providers, reduce unnecessary administrative burdens, and establish safeguards that ensure program funding is appropriately allocated. For more questions on these comments, please contact NRHA's Chief Policy Officer, Carrie Cochran-McClain at ccochran@ruralhealth.us.

Sincerely,



Alan Morgan
Chief Executive Officer
National Rural Health Association