PRAIRIE
HEALTH VENTURES

April 7, 2020

Nebraska Public Service Commission
P.O. Box 94927
300 The Atrium, 1200 N Street
Lincoln, NE 68509

To Whom It May Concern,

Prairie Health Ventures, LLC (PHV), is a regional health alliance owned and directed by 55 not-for-profit hospital members. PHV is based in Lincoln, Nebraska, and works with rural hospitals and providers to bring business and clinical solutions through a collaborative model. Currently, PHV provides support in supply chain, virtual services, pharmacy services, grant writing, USAC consulting and population health. PHV also has more than 500 affiliate non-acute healthcare members. These members include pharmacies, physician practices, labs, surgery centers, home-health services and long-term care centers.

PHV manages the Independent Health Network, Inc. (IHN). The IHN is a not-for-profit corporation that was created in 2015. The primary reason for the creation of the IHN was to support standing up a private medical fiber network that connects 20 critical access hospitals and qualified regional/urban hospitals and medical education organizations in Nebraska, and 1 critical access hospital in northern Kansas. IHN currently files and receives funding support from USAC's Healthcare Connect Fund (HCF), under the consortium model.

In addition, PHV operates a USAC Consulting Services business that serves over 150 individual sites (rural hospitals, clinics, public health departments, etc.), of which a high majority are located in Nebraska. We also serve consortiums with members located in Nebraska and 17 other states, making total sites served over 750. We help these entities maximize their use of the USAC Rural Health Care Program.

We feel that, through support from the Nebraska Universal Service Fund, the Nebraska Telehealth Program can offer solutions to improve access, quality and business performance for rural Nebraska healthcare. Updating the support NTP provides healthcare providers to mirror the FCC's goals/procedures and supplementing federal funding will only add value to the benefits Nebraska healthcare already receives from NTP.

Sincerely,

Rodney Triplett
CEO

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1. Should the Commission restructure its funding mechanism to account for changes made by the FCC in its 2012 Healthcare Connect Fund Order? Yes
    a. Specifically, should the Commission restructure funding to support the health care providers under the model created by the FCC through the HCF? Yes
    b. If so, should the Commission continue to provide funding under the RHC Telecom program funding model as well? Why or why not? No. From our experience, other than in Alaska, no one is using the Telecommunications Program for circuits anymore and all Internet access subsidies are now funded through the Healthcare Connect Fund (HCF) Program. In addition, the HCF program has a broader scope to include network equipment and management.
    c. If the Commission provides funding to health care providers receiving support under either federal model, should the Commission consider phasing out funding under the RHC Telecom program? No. If so, how should that transition be structured and how long should the transitional period last? There should be no transition period, due to lack of use in Nebraska.

2. Should the Commission consider the goals of these two programs and prioritize one over the other? Why or why not? The HCF Program is the program that's currently being used by providers. It is in wide-use and is much broader in scope than the Telecommunications Program. The HCF Program should be the priority.

3. With a limited amount of funding available how should the Commission structure the provision of funding? If support is provided under both the RHC Telecom program and HCF program, how should the Commission prioritize funding of the two programs? Support should only be provided under the HCF Program. That program should be the priority.

4. Federal support can be provided to consortia with member hospitals that cross state lines. Should the Commission consider a proration of funding for consortia applications with health care providers that are not located in Nebraska? How should the proration be calculated? No, the Commission should not consider funding outside of state lines.

5. Should a deadline for applications be established and available funding be awarded on a competitive set of standards? Why or why not? We feel this program should mirror the USAC program for commonality and fiscal years. The deadline for applications should mirror the existing USAC model.

6. Should funding be allocated on a first come first served basis? No.

7. What timing for a state filing window would enable health care providers to properly marry their funding plans with federal filing windows? The program should match the federal USAC filing window going forward.

8. Should funding be provided via a tiered support approach based on rurality? Yes. Should the Commission adopt the same rurality test being employed on the federal level? Yes, it should mirror the federal level.

9. Should the Commission entertain applications for funding that were not fully funded at the federal level due to federal caps? Why or why not? How would the timing of such applications work? Yes, the Commission should entertain applications for funding that were not fully funded at the federal level due to federal caps. In the current environment, there's a great deal of confusion regarding rurality levels, which we expect will take time to be reevaluated. Considering the impact and lessons learned from the current virus outbreak, we expect the federal program to expand to better support telemedicine efforts nationwide.

10. Should an application cap be established? If so, what should the cap be and how would it be administered? How should that application cap be set for health care providers seeking support individually versus as part of an established consortia of hospitals? Yes, an application cap should be established. The cap needs to be reviewed annually, relative to demand. A committee should be established for this. The application cap should be equal for individual applicants and consortiums, so there is no bias, as long as there is no urban site funding included for the consortiums.

11. Should there be any technology type or service which should not be considered eligible for funding? Should the Commission permit all projects deemed eligible for federal support to be eligible for state support? Eligibility for funding should mirror federal support for both individual and consortium applicants, with the exception of urban site support.

12. Under the federal support program, consortia arrangements can be supported if a consortium has more than 50 percent rural health care provider sites, with possible increases in the percentage when requests exceed the funding cap. Should the Commission set the required percentage to match the yearly established federal threshold? In the alternative, with a limited amount of funding, should the Commission consider a higher threshold or an increased amount of funding for consortium with higher percentages of rural health care provider sites? Either urban sites in consortiums should not be considered eligible, or rural sites should be give much higher consideration than urban sites. For all cases, we would advise that there be a strong bias for rural applicants for consortiums.

13. Under the HCF, costs are paid at a rate of 65 percent of eligible costs. What portion of the remaining 35 percent of costs should be eligible for supplemental support? Should the Commission deem some costs ineligible for funding? We would suggest a goal of 35% for all rural sites, and fund it at 100%. The Commission should mirror the federal program.

14. Should support be limited to providers serving non-profit hospitals? Should support for public health centers be considered? Yes, supporting non-profit entities mirrors the federal program. Yes, public health centers should be considered, as they provide a huge value to underserved communities (as long as they are non-profit). Non-profit hospitals, public health centers, community health centers, rural health clinics and rural VA clinics should be supported.

15. With the requirement that support must be provided to eligible telecommunications carriers (ETCs), how could the Commission consider funding for health care provider constructed and owned network facilities? Should these entities be required to obtain

certification as a Nebraska eligible telecommunications carrier (NETC)? If so, how should the Commission consider the entities' financial structure to determine which costs should be eligible? We suggest that the state uses the same model as the federal level, relative to carriers and other vendors obtaining service provider identification numbers (SPIN), assigned by the FCC. More clarification on the term "financial structure" would be helpful in order to answer the question properly.

16. Should the Commission consider funding only monthly recurring costs? If not, what type of non-recurring costs should be considered? If non-recurring costs are considered should a per site cap be employed? How should a cap be for non-recurring costs be calculated? No, the state should not consider funding only monthly recurring costs. One-time costs should also be included (e.g. equipment and install costs). Rules regarding non-recurring costs should mimic the federal USAC rules. Non-recurring costs should not be considered on per cap site, due to varying cost for last mile deployment. The cap should be based on the 35% that the federal program does not cover.

17. What type of reporting requirements should be placed on telecommunications companies that are bidding on and providing services? What about for health care providers receiving support for Telehealth services in Nebraska? We suggest implanting similar reporting requirements as USAC has for telecommunications companies. For health care providers, we suggest mimicking reporting requirements that the federal USAC system has. There are no utilization reporting requirements for individual applicants at the federal level at this time. We advise implementing a model that is similar to USAC's annual consortium report (annual report of what telehealth applications are being used).

18. Should it be mandatory that support be provided only as secondary to federal funding so the Commission can ensure that services were subject to established competitive bidding requirements? We recommend setting up a program that in almost all cases mimics the federal program. We do not suggest providing funding to entities that are not receiving funding from the national level. The Commission should be focused on supplementing the federal program.