THE EVANGELICAL LUTHERAN Good Samaritan Society®
In Christ's Love, Everyone Is Someone.

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Testimony of The Evangelical Lutheran Good Samaritan Society re. H.R. 4111, the Rural Health Care Connectivity Act of 2015

Good Morning.

Chairman Walden, Ranking Member Eshoo and other members of the Subcommittee. It is my honor to appear before you today in support of H.R. 4111, the Rural Health Care Connectivity Act of 2015 sponsored by Subcommittee Members Rep. Leonard Lance (R-NJ), Rep. Dave Loebsack (D-IA) and Rep. Kevin Cramer (R-ND).

My name is Dan Holdhusen, and I am the Director of Government Relations for The Evangelical Lutheran Good Samaritan Society (The Society). The Society is the nation's largest not-for-profit, faith-based senior care and services organization. The Society was founded in 1922, and is headquartered in Sioux Falls, South Dakota. We offer a broad spectrum of senior services ranging from home health, respite care, assisted living, post-acute care, senior apartments and affordable housing to skilled nursing care and hospice care. Currently, the Society serves more than 240 locations in 24 states caring daily for more than 30,000 people and employing more than 23,000 staff members.

On behalf of the Society and the American Health Care Association (AHCA), the nation's largest association of long-term and post-acute care providers, I would like to express our strong support for the Rural Health Care Connectivity Act of 2015. If enacted, this bill would offer substantial and critical support for not-for-profit and public providers of skilled nursing care that operate in rural and frontier areas and across the country.

The Society currently operates 168 skilled nursing facilities (SNFs), of which 122 (73%) are in the Universal Service Administrative Company (USAC)-defined rural areas. These SNFs play a critically important role in the delivery of care in rural and frontier areas of our country, and are significant and growing pioneers in telehealth services.

By amending the Communications Act of 1934 to include SNFs among the types of health care providers who may request support from a telecommunications carrier under the Universal Service Fund, the bill would provide the necessary telecommunications and information services to serve persons who reside in rural areas at rates that are reasonably comparable to rates charged for similar services in urban areas.

It has been our long-held belief that Congress fully intended to make rural, non-profit, long-term care SNFs as eligible health care providers under section 254(h)(5)(B) of the 1996 Telecom Act.

In fact, on several occasions we provided informal and formal comments to the Federal Communications Commission (FCC) expressing these strong-held views.

With the passage of this bill, the FCC will have the direction it needs to continue to develop the Health Care Connect Fund, and implement the Healthcare Broadband Experiment program such that SNF's can benefit along with other covered health care providers.

As the Committee explores the ways in which telehealth and telemedicine will be applied in the care of our nation's aging, we would like to share our views and experience in this area. The Society strongly believes in the importance of recognizing rural, not-for-profit SNFs as a vital part of the healthcare spectrum. Further, the Society believes that it is critically important for providers providing long-term care in SNFs to utilize and advance the use of new technologies to better deliver healthcare services to their patients and – like other providers in the healthcare continuum – have access to affordable broadband connectivity.

Unfortunately, we have seen SNFs overlooked in terms of resources available for access to affordable broadband services in a number of federal policies. But, this bill gives us hope that SNFs will no longer be treated as second-class providers of senior care.

For nearly a century, operations in rural populated states like South Dakota, North Dakota, Iowa, Kansas, Nebraska and Minnesota have enabled the Society to develop an expertise in providing senior care in rural settings.

The Society as an Innovator

The Society has been forward-thinking in the comprehensive provision of care for seniors, and has invested significantly in developing innovative services and technologies designed to improve the quality of care and lower the overall costs of care. For example:

- The Society has developed, implemented and is advancing eLongTermCare telehealth technology designed to connect patients in rural SNFs to hospitals and their doctors without having to physically transport patients on a regular basis.
- The Society has also developed and is advancing the LivingWell@Home (LW@H) program, which offers a suite of technologies designed to help seniors live more independently and remain longer in the place they choose to call home. Use of this patient remote-sensing technology suite began in the Society's assisted living and home care communities in July 2012. The LW@H program is designed to enhance care and service delivery through the use of sensor technology, telehealth and a central data monitoring system, all developed and managed by the Society.
- The Society has undertaken a pilot project that deploys tablet-style computers to patients in some of its facilities and provided training that enabled seniors to "connect"

to family, caregivers, and doctors online. The intent of this program is to demonstrate how Internet usage by seniors can decrease depression and isolationism – a chronic problem among the elderly of this country that often leads to collateral physical and emotional healthcare concerns – and increase communication between senior patients, their family members and their communities.

- The Society has implemented an electronic point-of-care documentation system in all of its facilities, and has deployed electronic billing systems built to interact with payers and insurance providers.
- The Society is continuously working to improve its ability to utilize remote sensing technologies using telehealth technology in independent senior housing settings to transmit and convey clinical information to doctors and clinics, thereby producing timelier, convenient, cost effective and better quality outcomes for its patients.

Access to broadband connectivity at robust speeds and affordable prices is essential in the provision of the Society's wide range of services. If the Society is to continue to develop innovative technologies designed to lower costs and improve care for seniors in its long term care facilities like SNFs – particularly those in rural or frontier areas – focus must be given to the SNFs ability to obtain robust and affordable broadband connectivity.

SNFs Need Robust and Affordable Broadband Connectivity to Provide Vital Services to Senior Citizens in Rural America

SNFs need access to advanced broadband connectivity in order to provide necessary healthcare related services to seniors. It is important to make clear that the need for broadband technology, telehealth and other advanced technologies are no different for a SNF than those of an acute care setting (i.e. a hospital or urgent care clinic). The Federal Communications Commission (FCC) itself recognized that "There is evidence that skilled nursing facilities are particularly well-suited to improve patient outcomes through greater use of broadband." (Report and Order in WC Docket No. 02-06, *In the Matter of Rural Health Care Support Mechanism*, Released December 12, 2012, FCC No. 12-150.) Yet, because SNFs fall somewhere between not-for-profit hospitals (47 U.S.C. Sec. 254(h)(7)(b)(v)) and rural health care clinics (47 U.S.C. Sec. 254(h)(7)(b)(vi), SNFs lack access to the federal financial assistance that acute care settings and other healthcare providers have enjoyed, in part through the various programs under the federal Universal Service Fund (USF) program.

In spite of these obstacles – and without access to USF funding – the Society has implemented Electronic Medical Records, telehealth and other technologies into its care system that allows facilities to connect with its brethren in the acute healthcare community. We do this for a simply, yet profound, reason: we believe it is critical and essential to work with providers of acute care services as we care for our elderly populations.

We believe these efforts are critical because in many rural communities, a SNF is often the only healthcare provider available for 100 or more miles. With telehealth capabilities, for example, the Society can extend ambulatory and emergency health care services into rural communities.

However, advancing the Society's technology capabilities is becoming more and more difficult as the healthcare environment evolves in more complicated directions, and SNF providers operate with slim and progressively decreasing operating margins. The cost of broadband connectivity is extraordinary in rural areas, and often the robust speeds necessary to advance the most state-of-the-art health technology services are out of reach to SNFs due to cost and availability. For example, in the 168 SNFs operated by the Society, the breakdown of the bandwidth currently installed is as follows:

- 98 sites have single T1 circuits which is 1.5Mbit/second
- 52 sites have two T1 circuits which is 3.0Mbit/second
- 16 sites have three T1 circuits which is 4.5Mbit/second
- 2 sites have 5Mb ethernet circuits

The local access – which is the largest portion of the Society's monthly technology costs – is based on mileage and therefore tends to be more expensive for the rural sites. The average access cost for rural locations is $497 for each T1 circuit installed, compared with $256 for urban sites. Therefore, rural sites cost $240 more per month than urban locations. Obtaining more robust broadband connectivity (which is greatly needed) would result in an even greater price disparity between rural and urban prices.

Furthermore, it is important to note that upgrading circuits at the SNFs is an ongoing and constant concern and effort, which puts even further financial pressure on the rural sites. Indeed, SNFs require affordable, sustainable access to broadband if they are to continue to advance the use of technologies for other related and critical functions, such as remote training initiatives, maintenance and dissemination of electronic medical files, further the integration with online pharmacies, and enable rural healthcare providers and caregivers to obtain continuing education.

Enabling SNFs to obtain robust and affordable broadband connectivity is critical. It will not only help lower overall healthcare costs; but also enhance the well-being of seniors by improving care, reducing hospital visits, and helping to keep them connected to their professional and family caregivers. Beyond the critical healthcare benefits described above, broadband access enhances the quality of life for seniors by enabling increased social interactions, limiting isolation concerns (particularly in rural areas), and providing economic benefits and access to healthcare-related services and information.

As the Committee continues its dialogue on modernizing the laws governing the technology sector and examines the universal service policy, the Society believes that it is vital that the critical needs of the rural, not-for-profit, long term care skilled nursing sector are included in these discussions.

Discussion on the FCC and SNF eligibility for Rural Healthcare Support Mechanism

Section 254(h) of the Telecommunications Act ensures that our nation's educational institutions and health care facilities have access to the USF for the purpose of deploying broadband to these facilities. At the time this provision was drafted, there was nothing in the Congressional Record indicating the intent to exclude SNFs from the benefits of Section 254. Indeed, SNFs fall somewhere between not-for-profit hospitals, 254(h)(5)(B)(v) and rural health care clinics, 254(h)(5)(B)(vi). The telecommunications needs of SNFs do not differ from those of acute care facilities, such as hospitals or urgent care centers. Logically, there would be no reason to exclude SNFs from rural health care universal service funding and ***yet the FCC has done just that*.**

When the FCC adopted the pilot program for skilled nursing facilities in 2012 in its *Rural Healthcare Support Mechanism* (WC Docket No. 02-60, Report and Order, 27 FCC Rcd 16678) (FCC 12-150), the FCC was unable to determine at the time whether or not SNFs fit under the definitions of eligible health care providers under section 254(h). Hence, the FCC created the SNF pilot program. In the 2014 *Technology Transitions Report and Order and Further Notice of Proposed Rulemaking (*FCC 14-05) the FCC eliminated the SNF pilot program and incorporated the SNF pilot funding into the general funding for rural healthcare broadband experiments.

- ***Eliminating the pilot program and keeping SNFs from applying for rural healthcare broadband experiments on their own (instead of as part of a consortium) seems to be a double blow to SNFs.***

SNFs play an important role in the delivery of care in communities across the country. SNFs provide care to over 3 million relatively high acuity patients each year, and a significant and growing site of service for telehealth. The inclusion of SNFs is necessary in any broad based, care coordination effort.

The aim of the FCC rural healthcare connect initiative is to:

- increase access to broadband for health care providers (HCPs), particularly those serving rural areas;
- foster the development and deployment of broadband health care networks; and
- maximize the cost-effectiveness of the program.

- ***Clearly, including SNF's in the rural healthcare connect initiatives at the FCC would be beneficial in lowering healthcare costs for seniors in rural settings.***

The Society submitted formal comments arguing that the FCC should implement the SNF Pilot Program. These comments were consistent with the Commission's critical and important rural healthcare goals in ensuring that there is "connectivity" for the patient population in SNFs, particularly in rural areas where costs of broadband connectivity are often not sustainable. The Society was joined in its pleading to reinstate the SNF Pilot Program funding by AHCA and Leading Age, the country's two largest professional associations. Together, the Society and the national associations advocated that the FCC provide important assistance to SNFs in obtaining access to broadband services. Unfortunately, the FCC Commissioners voted to indefinitely defer the SNF Pilot Program and SNFs have been denied access to critical resources ensuring broadband access in the rural areas they serve.

As the FCC pushes forward with rules and regulations on the Rural Healthcare Connect Fund and the Rural Broadband Healthcare Experiments, we are pleased to see Members of Congress acting to ensure that SNFs are classified as eligible for funding under Section 254(h). Allowing rural seniors to have the same access to telecommunications technology as the rest of the country is a good and fair policy and should have been embraced by the FCC.

In conclusion, we are extremely grateful for your leadership on this important issue that deeply impacts some of society's most vulnerable populations, our nation's seniors, and we strongly urge the Committee's adoption of this bill.

Again, I thank you for allowing me to testify in strong support of the Rural Health Care Connectivity Act of 2015, and I stand ready to respond to any questions you may have.

For further information, please contact me as follows:

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