

September 30, 2026

The Honorable Brendan Carr
Chairman
Federal Communications Commission
45 L Street NE

Submitted electronically via regulations.gov

RE: Promoting Telehealth in Rural America

Dear Chairman Carr,

On behalf of the American Academy of Family Physicians (AAFP) and the Council of Academic Family Medicine (CAFM), including the Society of Teachers of Family Medicine, Association of Departments of Family Medicine, Association of Family Medicine Residency Directors, and NAPCRG, we appreciate the opportunity to submit comments on the Federal Communications Commission's (FCC) [proposed rule](#), Promoting Telehealth in Rural America, published in the August 31, 2026, issue of the Federal Register.

Our organizations have long [supported](#) telehealth as it advances appropriate standards of care, continuity, and the patient-physician relationship, particularly in rural settings. Reliable connectivity enables rural practices to access electronic health records, prescribe medications, exchange clinical information, coordinate care, consult specialists, provide telehealth services, support remote patient monitoring, protect patient information, and participate in continuing medical education. Connectivity also enables family physicians to maintain continuity with established patients while facilitating access to specialty expertise and services that may not otherwise be available locally.

Accessible telecommunications and telehealth services have become increasingly important as rural communities confront a shrinking primary care workforce. Between 2017 and 2023, rural communities experienced an 11% loss of family physicians, while only 1% of new physicians entering primary care between 2016 and 2022 chose rural practice.ⁱ Many rural physicians practice in small or independent settings, making the decline of independent practice especially consequential for communities that already have few alternatives for care.

The strength of the rural physician workforce also depends on the stability of rural clinical training sites. Rural residency programs, rural training tracks, Teaching Health Center Graduate Medical Education programs, and longitudinal rural rotations rely on local clinics and hospitals to provide continuity experiences, faculty supervision, specialist consultation, and broad-scope clinical training. And substantial evidence continues to show that physicians who train in rural settings are more likely to practice in rural communities.^{ii,iii}



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The effects of this proposed rule therefore ripple beyond present-day patient care, to impacting the capacity of rural communities to train and retain their future physician workforce.

Thus, our organizations offer the following recommendations to strengthen Telehealth in Rural America:

- **Align rurality determinations with existing federal definitions whenever possible to reduce complexity and improve consistency across agencies;**
- **Protect access for the most remote and underserved communities by ensuring funding calculations reflect the realities of highly rural, Tribal, frontier, and geographically isolated areas;**
- **Recognize backup connectivity as essential healthcare infrastructure that supports patient safety, continuity of care, telehealth, and physician training;**
- **Avoid shifting compliance risk onto rural providers if evergreen contract requirements are revised; and**
- **Maintain sufficient program data to evaluate access, participation, and equity outcomes before eliminating Healthcare Connect Fund reporting requirements.**

A. Improving Support Calculations in the Telecom Program

1. Redefining Similar Services and Rural Area Comparability

The FCC seeks comment on how to define "similar services" and "comparable rural areas" for purposes of determining rural rates under the Telecommunications Program. Specifically, the proposed rule asks whether the FCC should retain the existing 30% bandwidth threshold, whether it should continue to use a technology-neutral approach, whether it should broaden the pool of comparable services and rural areas, and how to ensure that rate determinations accurately reflect the costs of serving rural locations.

Comments on Redefining Similar Services and Rural Area Comparability

While we do not take a position on the specific mathematical methodologies that should be used to normalize bandwidth differences or project rates across service tiers, we strongly urge the FCC to evaluate any changes through the lens of access to care, administrative feasibility, and impact to rural physicians. A methodology that is technically precise but operationally burdensome may ultimately reduce telehealth access in rural America if it discourages carrier participation or delays support for rural clinicians.

We support retaining a technology-neutral approach that evaluates services based on their functionality and ability to support health care delivery. Rural providers often rely on different technologies depending upon geography, infrastructure availability, weather conditions, and carrier networks.



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Requiring technological similarity may unnecessarily narrow the pool of comparators and likely increase reliance on more burdensome rate-determination methods. We support reasonable flexibility in identifying comparable services where doing so expands access to commercial-rate methodologies and reduces unnecessary reliance on more burdensome cost-study processes. Rural communities frequently have limited telecommunications markets, and rigid comparator requirements may inadvertently make support more difficult to obtain for telecommunication providers serving the most isolated communities. Thus, we support allowing rural comparators from adjoining states when those locations share relevant geographic, infrastructure, and market characteristics. Rural care delivery and telecommunications networks do not conform neatly to state borders. A location across a state line may be more comparable than a location hundreds of miles away in the same state. Further, we strongly encourage the FCC to implement protections within their comparator framework that prevents highly remote communities from being compared with rural locations that are substantially less isolated and less costly to serve.

We are also concerned that broad or vague definitions of rurality may obscure significant differences across rural communities. **We [reiterate](#) our previous recommendation that the FCC maintain consistency with existing federal definitions of rural unless a different definition is supported by a clear and demonstrable programmatic need.** Rural areas are not interchangeable. Geographic isolation, infrastructure access, workforce shortages, telecommunications competition, and economic conditions vary considerably across rural areas. A community located near a metropolitan area may technically qualify as rural while having significantly different telecommunications options than a frontier community, Tribal community, or geographically isolated area.

Rather than creating a new FCC-specific framework for measuring rurality, we encourage the FCC to align with established federal definitions and classifications whenever possible.

Family physicians and rural health care organizations already navigate numerous federal definitions of rurality used by agencies such as HRSA, CMS, USDA, and the Office of Management and Budget. A separate FCC-specific framework adds complexity and increases the likelihood of inconsistent treatment across federal programs. At the same time, alignment with existing rural definitions should not lead to the conclusion that all rural communities are comparable. When determining whether rural areas are truly comparable, the Commission should continue to consider all factors that affect the cost and feasibility of delivering telecommunication services.

We also encourage the FCC to explicitly recognize that facilities operated by the Indian Health Service, Tribal health programs, and Urban Indian health programs often serve some of the most isolated communities in the country. Comparing these facilities to rural communities with substantially greater infrastructure, provider availability, and telecommunications competition risks understating the true cost of service and exacerbating differences in health experiences. Finally, we strongly urge the FCC to place primary responsibility for rate-specific documentation on the telecommunications service provider that possesses the relevant pricing and cost information.



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This proposed rule should not shift that burden to a rural physician practice that lacks access to the carrier's proprietary data.

2. Improving or Replacing Cost Studies

The Rural Health Care (RHC) Program includes two support mechanisms. The Telecommunications Program provides support equal to the difference between the cost of eligible telecommunications services in a rural area and the cost of comparable services in an urban area within the same state. By contrast, the Healthcare Connect Fund (HCF) Program provides a 65% discount on eligible broadband and advanced telecommunications services and supports consortia that may include rural and urban health care providers. Under the Telecommunications Program, support calculations require both an urban rate and a rural rate. The rural rate is determined through three sequential methods. Methods 1 and 2 use commercial-rate comparisons; Method 3 applies when sufficient comparable rates are unavailable and permits the service provider to support its proposed rural rate with a cost study documenting the costs attributable to the requested service. The FCC seeks comment on potential revisions to Method 3 that would reduce administrative burden while preserving transparent, accurate, and adequately supported rural-rate determinations.

Comments on Improving or Replacing Cost Studies

We support retaining Method 3, as many of the communities facing the greatest connectivity challenges are also the communities least likely to have sufficient commercial-rate comparisons available. Eliminating Method 3 without dependable alternatives may cause telecommunications carriers to decline to bid or leave remote rural health care providers without an administratively feasible way to obtain support.

At the same time, we are concerned that increasingly complex documentation requirements may themselves become barriers to participation. As [stated](#) in the proposed rule, cost studies were intended to be used infrequently, but RHC Program applicants relied on previously approved rates nearly 500 times in funding years 2024 and 2025. While cost studies are generally prepared by telecommunications carriers rather than physicians, their consequences are experienced by rural clinicians and their patients. When documentation requirements become excessively burdensome, carriers may decline to bid on smaller projects; delay deployment while documentation is prepared and reviewed; or prioritize larger and less complicated service locations. Thus, even if a practice is not directly responsible for preparing a cost study, it experiences the consequences of these delays, uncertainties, and reduced competition. Accordingly, we support simplifying Method 3 to the greatest extent possible while maintaining appropriate safeguards against waste, fraud, and abuse.

Further, we strongly support the proposed provision to allow continued reliance on previously approved rates. This provision has the potential to reduce burden without sacrificing accountability.



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Where the FCC has already reviewed and approved a rate for a comparable service, requiring repeated submissions of substantially similar documentation may generate administrative burden without corresponding program value. Reducing repetitive documentation requirements would provide greater predictability for rural providers and allow limited administrative resources to be directed toward patient care rather than regulatory compliance.

B. Making Effective Use of RHC Program Supported Services

1. Promoting Lower-Cost Secondary Services

The RHC Program currently provides support for multiple services serving the same eligible health care provider, including services used to maintain connectivity if another supported service becomes unavailable. The FCC seeks comment in this proposed rule on whether they should formally distinguish a telecommunication carrier's primary service from a secondary service used for backup connectivity. It also seeks comment on whether secondary services should be subject to technology-specific or performance-based eligibility criteria; whether to codify a requirement that an applicant select the most cost-effective secondary service that satisfies its stated needs; and whether, if demand exceeds available program funding, funding requests for primary services should receive priority over requests for secondary services.

Comments on Promoting Lower-Cost Secondary Services

For rural primary care practices, secondary connectivity can support patient safety and continuity of operations by reducing the risk that a single service disruption will interrupt routine and time-sensitive care. A substantial body of evidence supports that access to telehealth and health information technology can improve the quality, safety, and effectiveness of rural health care by supporting clinical services, professional consultation, electronic exchange of health information, and communication across the health care systems.^{iv,v,vi} These capabilities are integral to primary care, where physicians use telecommunications infrastructure to access electronic health records, transmit prescriptions, review diagnostic results, conduct virtual visits, coordinate referrals and transitions of care, and obtain specialist input. A 2025 literature review by the National Rural Health Association further describes the use of telehealth to expand access to specialty services, reduce delays in diagnosis and treatment, and avoid transfers to distant facilities.^{vii}

Accordingly, a loss of connectivity may disrupt both the delivery of primary care and a rural practice's ability to connect patients with specialty care. The FCC therefore should not treat secondary connectivity as categorically discretionary. The least expensive service is not cost effective if it cannot maintain the provider's essential operations. **We therefore support maintaining technology neutrality for secondary services, and, recommend the FCC to evaluate secondary services based on whether they support continuity of care, patient safety, and operational resilience rather than solely on whether a lower-cost technology exists.**



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Further, we strongly recommend the FCC to account for the role of reliable connectivity in rural physician workforce development. Only 2% of residency training occurs in rural areas, even though physicians who train in rural settings are more likely to remain in rural practice.^{viii,ix} Rural residency programs, Rural Training Tracks, Teaching Health Center Graduate Medical Education programs, and community-based training sites rely on connectivity for supervision, specialist consultation, virtual instruction, health-record access, and collaboration with distant sponsoring institutions. An outage can therefore disrupt both patient care and the limited training capacity on which rural communities depend to recruit and retain physicians. In assessing the cost effectiveness of secondary service, the FCC should consider these workforce and training-continuity benefits rather than treating backup connectivity solely as duplicative capacity.

2. Establishing an RHC Program Eligible Services List

The FCC proposes establishing a formal eligible services list modeled in part on the E-Rate program. Under the proposed rule, the Wireline Competition Bureau would seek public comment and publish the final list at least 60 days before the next application filing window. The proposed rule also seeks comment on whether to clarify the seven categories of eligible health care providers. Section 254(h)(7)(B) of the Communications Act identifies the following categories of eligible health care providers: post-secondary educational institutions offering health-care instruction, teaching hospitals, and medical schools; community health centers and health centers providing care to migrants; local health departments and agencies; community mental health centers; not-for-profit hospitals; rural health clinics; and consortia composed of eligible health care providers.

Comments on Establishing an RHC Program Eligible Services List

We extend cautious support for the creation of an Eligible Services List if it remains flexible, technology-neutral, annually updated, and reflective of evolving models of healthcare delivery. A well-designed list could improve transparency, predictability, and ease of participation, enabling telecommunications providers to reach more rural clinicians and patients. At the same time, we urge the FCC to ensure that the list is reviewed at least annually to ensure that the list accounts for the unique and evolving connectivity needs of rural providers, independent practices, and clinical training sites.

Further, we do not recommend narrowing or revisiting the underlying statutory categories of eligible health care providers. Instead, the FCC should clarify how modern rural healthcare organizations, physician-training sites, and collaborative care-delivery models fit within the categories already established by Congress. Any clarification should be interpreted broadly enough to preserve participation by existing eligible entities, including Rural Health Clinics, Tribal health facilities, community-based residency training sites, Rural Training Tracks, Teaching Health Center Graduate Medical Education sites, and eligible provider consortia.



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C. Evaluating and Improving Program Processes

2. Changing Evergreen Contract Approval Timing

Under the current RHC Program framework, a participant that enters into a multi-year contract through a compliant competitive-bidding process may avoid conducting a new competition in subsequent funding years only after Universal Services Administrative Company (USAC), which administers the Universal Service Fund under the direction of the FCC, designates the contract as “evergreen.” The Commission seeks comment on eliminating the requirement that USAC approve the evergreen designation before the participant may claim the competitive-bidding exemption. Under the contemplated approach, a participant could rely on the exemption before receiving USAC approval, subject to later review of whether the contract satisfies the applicable evergreen-contract criteria. The Commission also seeks comment on any safeguards needed to preserve compliance and program integrity under a post-filing review process.

Comments on Changing Evergreen Contract Approval Timing

While we appreciate the spirit of this proposed provision, we encourage the FCC to evaluate the tradeoff between reducing upfront review and increasing downstream compliance risk for rural clinicians. The current approval process provides applicants with a degree of certainty that a contract complies with program requirements. Eliminating that review could shift greater risk onto participating providers. Particularly if a compliance concern is identified years after a contract is executed, the resulting financial consequences may be manageable for a large health system but potentially significant for an independent physician practice, Rural Health Clinic, Tribal clinic, Critical Access Hospital, or community-based training site. Should the FCC proceed with changes to evergreen approval requirements, we strongly encourage the Commission to consider safeguards such as expedited review or safe-harbor protections that preserve certainty for applicants while reducing unnecessary administrative burden.

3. Eliminating HCF Annual Report Requirement

Section 54.618 currently requires each Healthcare Connect Fund (HCF) applicant to submit an annual report to USAC by September 30 for every funding year in which the applicant receives support. Adopted to assist the Commission in monitoring HCF performance, the requirement is separate from the program’s application, invoicing, audit, and record-retention obligations. The Commission now proposes to repeal section 54.618, tentatively concluding that the annual report no longer provides information necessary to assess program progress and instead imposes an additional administrative condition on receipt of support.

Comments on Eliminating HCF Annual Report Requirement

As [stated](#) in the proposed rule, the HCF Program accounted for 56.8% of all RHC Program funding commitments in funding year 2024. Eliminating the report requirement would therefore



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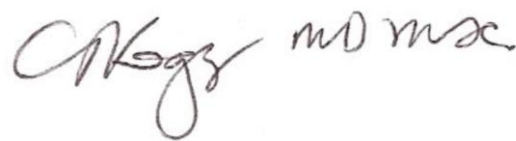
affect a substantial share of program-supported applicants while leaving other oversight requirements in place. Thus, our organizations appreciate the Commission's efforts to reduce unnecessary reporting burden. **However, we are concerned that eliminating the reporting requirement entirely may leave the Commission without sufficient information to evaluate whether the Healthcare Connect Fund is reaching the providers and communities it was designed to serve.** Broadband now supports core healthcare functions, including telehealth, care coordination, electronic health records, cybersecurity, and physician training. As these uses have expanded, the need to understand program participation and impact has only grown more important. In particular, prior to pursuing elimination, we encourage the FCC to ensure it can continue to assess participation by independent physician practices, Rural Health Clinics, Tribal health programs, community-based training sites, and other providers that often operate with fewer resources than larger health systems. Without that visibility, it may become more difficult to identify persistent connectivity gaps, participation barriers, or inequities in access across rural communities.

Thank you for the opportunity to provide comments on this important matter. For additional questions, please contact Sahana Chakravarti, Regulatory and Policy Strategist, at schakravarti@aafp.org or Nina DeJonghe, Director of Government Relations, at ndejonghe@stfm.org.

Sincerely,



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ⁱ Fogarty CT, Byun H, Huffstetler AN. Family Physician Workforce Trends: The Toll on Rural Communities. *Ann Fam Med*. 2025 Nov 24;23(6):535-538. doi: 10.1370/afm.240549. PMID: 41285597; PMCID: PMC12751282.

ⁱⁱ Patterson, D. G., Shipman, S. A., Pollack, S. W., Andrilla, C. H. A., Schmitz, D., Evans, D. V., Peterson, L. E., & Longenecker, R. (2024). Growing a rural family physician workforce: The contributions of rural background and rural place of residency training. *Health services research*, 59(1), e14168. <https://doi.org/10.1111/1475-6773.14168>

ⁱⁱⁱ Hu X, Patterson DG, Conrad SS, Luo Q, Dill MJ. Rural Background, Training Exposure, and Rural Practice Location Among US Physicians. *JAMA Netw Open*. 2026;9(8):e2625481. <https://doi:10.1001/jamanetworkopen.2026.25481>

^{iv} Centers for Disease Control and Prevention, National Center for Health Statistics. (2022, October 12). *Telemedicine use among adults: United States, 2021* (NCHS Data Brief No. 445). <https://www.cdc.gov/nchs/products/databriefs/db445.html>

^v Federal Communications Commission. (2021, January 19). *FCC annual broadband report shows digital divide is rapidly closing* (FCC 21-18). <https://www.fcc.gov/document/fcc-annual-broadband-report-shows-digital-divide-rapidly-closing>

^{vi} Office of the National Coordinator for Health Information Technology. (2026). *National trends in hospital and physician adoption of electronic health records* (Health IT Quick-Stat No. 61). <https://healthit.gov/data/quickstats/national-trends-hospital-and-physician-adoption-electronic-health-records/>

^{vii} National Rural Health Association. (2025, February). *Telehealth's impact on rural hospitals: A literature review*. <https://www.ruralhealth.us/blogs/2025/02/telehealth-s-impact-on-rural-hospitals-a-literature-review>

^{viii} U.S. Government Accountability Office. (2021, April). *Graduate medical education: Programs and residents increased during transition to single accreditor; distribution largely unchanged* (GAO-21-329). <https://www.gao.gov/products/gao-21-329>

^{ix} Patterson, D. G., Shipman, S. A., Pollack, S. W., Andrilla, C. H. A., Schmitz, D., Evans, D. V., Peterson, L. E., & Longenecker, R. (2024). Growing a rural family physician workforce: The contributions of rural background and rural place of residency training. *Health services research*, 59(1), e14168. <https://doi.org/10.1111/1475-6773.14168>



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