December 9, 2022

SUBMITTED ELECTRONICALLY VIA ECFS

Ms. Marlene H. Dortch
Secretary
Federal Communications Commission
45 L Street NE
Washington, DC 20554

<u>Re: Ex Parte Filing</u>
Promoting Telehealth in Rural America, WC Docket No. 17-310

Dear Madam Secretary:

Pursuant to Federal Communications Commission's ex parte rules, I hereby submit the following summary of our December 7, 2022, conversation with members of the Wireline Competition Bureau (WCB) to discuss the current Further Notice of Proposed Rulemaking in the above-listed docket,[1] as well as certain points made in the Comments and Reply Comments of the Schools, Health & Libraries Broadband (SHLB) Coalition filed in this proceeding.[2]

The following individuals participated in the call along with the undersigned:

- Adam Copeland, Associate Bureau Chief, WCB;
- Bryan Boyle, Deputy Division Chief, Telecommunications Access Policy Division, WCB;
- Jodie Griffin, Division Chief, Telecommunications Access Policy Division, WCB;
- Kiara Ortiz, Honors Attorney, WCB;
- John Windhausen, Jr., Executive Director, SHLB Coalition;
- Gina Spade, Principal, Broadband Legal Strategies, LLC; and
- Jeffrey Mitchell, Principal, Mitchell Law, PLLC.

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[1] *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Further Notice of Proposed Rulemaking, FCC 22-15 (Feb. 22, 2022) (*Further Notice*).
[2] *See* Comments of the Schools, Health & Libraries Broadband Coalition, WC Docket No. 17-310 (Apr. 14, 2022) https://www.fcc.gov/ecfs/search/search-filings/filing/104150125127386 (*SHLB Comments*) and Reply Comments of the Schools, Health & Libraries Broadband Coalition, WC Docket No. 17-310 (May 16, 2022) https://www.fcc.gov/ecfs/search/search-filings/filing/10516257736972 (*SHLB Reply Comments*).

The participants in the call made the following points:

SHLB is encouraged by the launch of the *Further Notice* and the questions raised by the Commission. While SHLB addressed many topics in its Comments and Reply Comments, it highlighted certain ideas in this conversation that the Commission could implement in the short term and without political controversy. Those issues include the following five items:

Eliminate or Reform the Internal Funding Cap for Healthcare Connect Fund.

We noted the original purpose of the internal funding cap (subcap) was to ensure equipment, upfront and self-construction costs, and multi-year contract costs would not overwhelm the fund. USAC data released in April 2022 suggests these original concerns have not been realized.[3] Most notably, the demand for self-construction costs was zero in funding years 2016 and 2017 and has averaged $6.5 million over the last five years (2016 to 2021). Accordingly, we believe that the entire subcap could be eliminated.

If the Commission is not ready to eliminate the subcap entirely, we suggest reforming it, such as applying it only to network equipment and upfront and self-construction costs.

We recognize that at least one commenter raised the issue of a spike in demand if multi-year funding requests are removed from the subcap (or the subcap is eliminated).[4] While SHLB believes the many multi-year requests that are currently approved each year under the current system should minimize any surge, we note that New England Telehealth Consortium (NETC) offered the following suggestion to address the issue:

> "to avoid a surge of multi-year requests in the first year they are removed from the internal cap (or the internal cap is eliminated), the Commission could temporarily implement its proposal to truncate multi-year requests [if] the [overall] cap is exceeded. For example, if the [overall] cap is exceeded in any of the first three years following elimination of the internal cap, the Commission could eliminate the third year of funding in multi-year requests to bring demand below the cap. If that was insufficient, it could eliminate the second year. This step should significantly stagger demand over the initial three-year period after the rule change and avoid demand spikes."[5]

We think this proposal would address the issue, but we would also support any temporary measure the Bureau might devise as a transition.

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[3] *See* Letter from Mark Sweeney, Vice President, Rural Health Care Division, USAC, to Jodie Griffin and Bryan Boyle, Wireline Competition Bureau, FCC (April 1, 2022), at Table 5.
[4] *See* Comments of Alaska Communications Systems, Inc. at 33-34.
[5] Reply Comments of NETC at 4.

Continue Postponement of the Rates Database in the Telecom Program.

SHLB thanks the Bureau for the thought that was put into the rates database, and we recognize that the Commission is operating within the statutory language regarding how discounts are supposed to be applied. However, the record does not show support for these suggested proposals, and it appears that many proposals suffer from similar issues as the database that was released.

SHLB asks that, in the short term, the Bureau should continue to postpone the rates database for at least another couple of years. We anticipate that future broadband funding and investment will provide more competition and suggest that the Commission can reevaluate the Telecom Program in the coming years.

Do not Pro-Rate "Urban" RHC Funding for Consortium Network Shared Costs Until Cost-Allocation Methodology is Put Into Place

HCF consortia network services are often classified as non-rural even when they represent services *shared* with rural HCPs. This is because the costs associated with equipment that consortia share are typically arbitrarily assigned to a healthcare provider in a non-rural area.

We want consortia to have the ability to prorate the costs between urban and rural areas. We are not suggesting that the Commission change the cap mechanics, but to allow cost allocation of these shared costs and/or establish a safe-harbor cost allocation mechanism that relies on each consortium's urban-rural percentage.

A question arose whether SHLB's above proposal regarding pro-ration of consortium network common costs requires a rule change or whether this would just be a process change for USAC. SHLB's proposal is that USAC allow network common costs to be cost-allocated between non-rural and rural – which is most easily done using each consortium's rural participation percentage. SHLB does not propose, however, that these rural common costs be further subdivided among the 6 possible rural prioritization tiers. *See* Section 54.621(b); *see also* 54.605(a)(1). For simplicity, SHLB suggests that all rural network common costs be considered Priority 1 by default. Implementing such a solution would probably require a clarification regarding application of Section 54.621(b) to this situation. We would suggest the following:

> "majority rural consortia in the Healthcare Connect Fund may cost allocate shared network costs based on their consortia rural percentage established pursuant to Section 54.607(b). For purposes of the prioritization schedule in Section 54.621(b), all non-rural shared costs should be considered Priority 7 and all rural shared costs should be considered Priority 1."

There is No Need to Revise the Telecom Program Invoicing Rules

The Commission proposed to change the Telecom Program's invoicing rules to mirror those within the HCF. Given that the application processes for these two programs differ, we do not believe making the invoicing rules the same is the best solution. For example, in the Telecom

Program, applicants must submit a new application for each circuit they purchase. When the applicant reaches the invoicing stage, the service provider can invoice as many times that it wants throughout the year. In HCF, a healthcare provider can include all services in one application if it wishes.

Instead, SHLB suggests that USAC revise its systems to allow changes to be made at the invoicing stage, especially now that USAC is updating its RHC systems. Specifically, USAC should allow service providers to change information on the support schedule, such as the service end date, to ensure the correct amounts are invoiced to USAC.

If USAC has already explored this recommendation and determines that it cannot change its systems, we suggest that USAC, at a minimum, allow service providers to invoice for an amount less than the amount on the support schedule.

Allow HCPs that Plan to Open Within a Funding Year to Apply for Funding (Rather Than After They are Already Operating).

Currently, there is no process allowing a rural healthcare provider to open within a funding year and apply for funding in that funding year. For example, if a hospital opens in August of 2023, it is unable to apply for funding until funding year 2024. In other words, USAC will not approve the facility as a healthcare provider until it has officially opened. SHLB assumes that, because of the Form 460 approval process, USAC believes that it can only approve a healthcare provider that already exists.

Instead, SHLB recommends that healthcare providers should be able to apply for funding within the funding year that it opens, rather than after they are already operating. We note that this is the commonplace procedure within the E-rate Program, as USAC confirms that the new school opened when anticipated.

SHLB also addressed the following two ideas. Acknowledging that these items may require additional time to implement, we suggested that the Commission could refresh the record and include these for additional comment:

Broaden the Definition of "Rural" in the RHC Program to Include One or More Other Federally-Recognized Definitions.

SHLB understands that there are healthcare providers currently classified as non-rural, when in fact they are rural. Due to the complexities of the current definition of "rural", we support adding additional criteria to what constitutes a rural provider. We also note that the Commission should add on to the current definition without taking away rural status to any currently eligible entities.

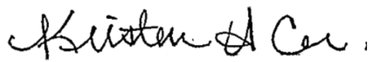
In its Comments and Reply Comments, SHLB suggested that the Commission could utilize US Census Bureau designations and USDA Rural-Urban Commuting Area codes.

Revise the Healthcare Connect Fund to Include Larger Discounts Based on the Rurality of Healthcare Providers

Rather than maintaining the flat 65% discount in the HCF, we suggest using discount tiers to recognize and correlate to the rurality of a healthcare provider's location. For example, in its Comments and Reply Comments, SHLB suggested the following discount tiers:

- HCPs in non-rural areas would receive a 65% discount;
- HCPs in less rural areas would receive a 75% discount;
- HCPs in rural areas would receive a 85% discount; and
- HCPs in extremely rural areas would receive a 95% discount

Sincerely,



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