Before the
Federal Communications Commission
Washington, D.C. 20554

In the Matter Of	)	
	)	
Promoting Telehealth in Rural America	)	WC Docket No. 17-310
	)	

REPLY COMMENTS OF THE SCHOOLS, HEALTH & LIBRARIES BROADBAND (SHLB) COALITION

The Schools, Health & Libraries Broadband (SHLB) Coalition[1] welcomes the opportunity to file these reply comments, especially because so many of the initial commenters supported the SHLB Coalition's ideas submitted in our initial comments. SHLB urges the Commission to take this opportunity to ensure that the Rural Health Care (RHC) Program can effectively meet the demand for greater broadband connectivity needed to provide the increased use of telemedicine services throughout the country. To do this, the Commission should raise the overall cap of the RHC Program and should eliminate or reform the internal cap on the Healthcare Connect Fund. The Commission also should heed the calls in the initial comments to revise and expand the definition of rurality in the program and should eliminate the requirement to use the flawed Rates Database.

I. THE COMMISION SHOULD UPDATE THE RHC PROGRAM TO ACCOMMODATE INCREASED RELIANCE ON TELEMEDICINE

A. The RHC Program Cap Should Be Increased Significantly

The Commission should not be pennywise and pound foolish. The Commission should seize the opportunity in the current proceeding to increase the amount of funding available in the

[1] The SHLB Coalition is a broad-based public interest coalition of more than 300 organizations that share the goal of promoting open, affordable, high-quality broadband for anchor institutions and their communities. SHLB Coalition members include representatives of health care providers and telehealth networks, schools, libraries, state broadband offices, private sector companies, state and national research and education networks, consulting firms and consumer organizations. *See* http://shlb.org/about/coalition-members for a current list of SHLB Coalition members.

RHC Program to accommodate the increased need for broadband to facilitate telemedicine.[2] Commenters agree the Commission should take this step to ensure that healthcare connectivity needs in rural areas can be fully met.[3] The highest priority should be to drive investments in broadband to support telemedicine, which is an urgent and growing national need. No party submitting a sound and qualified proposal for funding should be denied funding due to an arbitrary administrative cap. It is not an exaggeration to say that RHC funding is essential for providing high-quality healthcare and will save lives. The high demand for COVID-19 Telehealth and Connected Care dollars demonstrates an enormous need for greater funding. The Commission should respond to this national crisis of a shortage of broadband for rural health care providers and make substantial reforms to increase the funding and to accelerate approval of RHC applications. The Commission's speedy treatment of Covid-19 Telehealth funding shows that it can be done without jeopardizing accountability and integrity of the program. The Commission should use this opportunity to fundamentally refocus the RHC program to prioritize getting funding out the door as quickly as possible.

In addition to this need for greater rural healthcare funding, there are several specific dynamics that make increasing the RHC program cap necessary:

- Broadening the definition of rural (as discussed below) to allow more healthcare entities to be eligible for funding will require more funding;

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[2] *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Further Notice of Proposed Rulemaking, FCC 22-15, ¶ 15 (Feb. 22, 2022) (*Further Notice*).

[3] ADS Comments at 5 ("The Commission should consider an increase in the overall cap to reflect the unprecedented increases in the use of telemedicine during the COVID-19 pandemic to levels that are expected to sustain if not continue to increase."); Alaska Native Health Board Comments at 4 ("Since 2017-18, the FCC's rulemaking efforts appear to not treat the RHC program as requiring mandatory payments, as written in the Act, but instead to be an ongoing effort to implement funding caps, either through de facto and arbitrary amounts (previously capped at $400 million for example) or through limiting disbursements through complex rules, rather than advocating for increased funding to simply expand the program to continue to meet rural health objectives.").

- The Connected Care pilot should be made permanent and would mean greater demand;
- The Healthcare Connect Fund should be revised to include larger discounts available to health care providers in more rural areas;
- Delays in USAC processing applications for RHC funding have artificially depressed demand for funding. Once the program is operating more smoothly, more health care providers are likely to apply. In addition, delays in processing site and service substitutions and delays in reimbursements are also hindering program growth.

Recently released USAC data show large gaps between funding requested (gross demand), funding committed, and funding disbursed. Delays in USAC funding approval for new funding and site and service substitution requests are a significant factor in committed funds not being fully disbursed. (See table in the next paragraph.) For example, the NC Telehealth Network Consortium has an option that allows healthcare providers to cancel service for a new site if funding is delayed. Rural healthcare providers with extremely tight budgets appreciate this option so they can closely manage their budgets and cash-flow. In other cases, healthcare providers may also choose not to renew their service contracts due to funding uncertainty. They may even be forced to select a lower-quality service due to funding uncertainty. Funding uncertainty is caused by approval delay, the possibility of a pro-rata reduction due to reaching the funding cap, and the inability of health care providers to receive multi-year funding commitments due to the internal cap in the Healthcare Connect Fund.

Indeed, the recently released USAC data illustrate this uncertainty.[4] By dividing commitments by gross demand for each funding year, we can measure the "success" rate for RHC applications over the last 10 years:

[4] Letter from Mark Sweeney, USAC, to Jodie Griffin and Bryan Boyle, FCC, WC Docket No. 17-310 (Apr. 1, 2022).

Rural Health Care Summary Derived from USAC Letter to FCC of 1 April 2022									
	Demand		Commitments			Disbursements			
Funding Year	Total Demand	Change in $ from Previous FY	Total Commitments	As Percentage of Demand	Change in $ from Previous FY	Total Disbursements	As Percentage of Commitments	As Percentage of Demand	Change in $ from Previous FY
FY12	$130,910,189		$117,867,268	90%		$116,607,832	99%	89%	
FY13	$201,747,022	54%	$181,185,416	90%	54%	$179,628,100	99%	89%	54%
FY14	$300,686,249	49%	$224,935,336	75%	24%	$223,983,672	100%	74%	25%
FY15	$419,670,452	40%	$276,280,768	66%	23%	$268,539,277	97%	64%	20%
FY16	$533,495,514	27%	$315,451,592	59%	14%	$306,537,808	97%	57%	14%
FY17	$567,238,396	6%	$346,893,960	61%	10%	$339,652,716	98%	60%	11%
FY18	$666,956,868	18%	$309,568,177	46%	-11%	$298,647,528	96%	45%	-12%
FY19	$765,953,897	15%	$453,494,666	59%	46%	$399,720,213	88%	52%	34%
FY20	$648,239,376	-15%	$448,714,180	69%	-1%	$320,516,953	71%	49%	-20%
FY21	$645,332,954	0%	$477,405,657	74%	6%	$102,746,267	22%	16%	-68%

The plummeting application success rate in recent years paints an alarming picture suggesting a variety of causes that could include unclear program rules, changing application processing standards, and poor applicant training and outreach. The fact that demand for RHC support actually decreased in FY20 and did not rebound in FY21 shows that there are significant problems with the program. The demand for telehealth services was skyrocketing during the pandemic, yet applicants chose not to seek RHC support despite the clear need for broadband services for healthcare. The level of funding uncertainty RHC Program applicants face has had severe negative impacts on program demand.

B. The Commission Should Eliminate or Reform the Internal Cap

As the SHLB Coalition stated in its initial comments, the Commission should eliminate the internal funding cap for the Healthcare Connect Fund.[5] SHLB agrees with the Commission

[5] SHLB Comments at 14-15.

that, at a minimum, the internal cap should not apply in funding years in which the total demand does not exceed the total remaining support available.[6] The Commission adopted the internal funding cap to ensure that upfront construction costs and multi-year contract costs would not overwhelm the fund. That has not proven to be the case. In fact, network construction of more advanced, future-proof technologies often leads to lower ongoing costs, thus saving money for both the program and for individual HCPs. Moreover, the increased use of multi-year commitments reduces the number of single-year commitments and are therefore considerably more efficient administratively for both USAC and for applicants. Therefore, the cap should be eliminated.

If, however, the Commission does retain the internal cap, it should be revised to apply only to network equipment and upfront costs such as network construction and should no longer apply to multi-year contracts.[7] This revision would comport with the Commission's original intent in adopting the internal cap, which was to protect the RHC program from excessive costs of funding new network construction. This objective would still be accomplished if multi-year commitments were removed from the internal cap.

To the extent eliminating or modifying the internal cap causes a temporary initial increase in the number of multi-year funding requests that cause the program demand to exceed the overall cap, the Commission will likely have carry-forward funding to use to provide commitments. While there may be a one-time spike in demand, the offsetting reduction in single-year funding requests partly addresses that possibility. The next year, demand would decrease because the applicants with multi-year commitments would not need to apply for funding in subsequent years.

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[6] *Further Notice*, FCC 22-15, ¶ 65.

[7] *Id.* ¶ 68.

Alternatively, if demand for multi-year commitments implicates the overall cap, the Commission could, only for an initial three-year period, adopt its proposal to first commit a single year of funding to each of those applicants before using the prioritization tiers to commit subsequent years.[8] The Commission could also monitor the demand in this category and make additional changes as warranted.

II. COMMENTERS SUPPORT CHANGING AND EXPANDING THE DEFINITION OF RURALITY

The initial comments demonstrate widespread support for changing the definition of "rural" in the RHC Program. SHLB recommends that the Commission harmonize its rural classification with methods used by the Census Bureau (Metropolitan and Micropolitan Statistical Areas) and the Department of Agriculture (Rural-Urban Commuting Area (RUCA) codes). We agree with ADS that "the Commission could keep its current definition of Rural Area as one way to qualify as 'rural' under the RHC program, but then include one or more other federally recognized methods as alternatives to establish rurality."[9] Alaska Communications echoes this approach, stating, "Any change to the definition of 'rural' should add to the eligibility criteria and should not replace the current definition. Clearly, any change that caused an area to lose rural status could not be based on a considered determination that those affected have gained better access to health resources. To the extent that the Commission determines that any change to the definition of 'rural' has merit, it should become an additional way for HCPs to qualify as rural, but not exclude any HCP that qualifies under the current definition."[10] The

[8] *Id.* ¶ 68. As noted below, SHLB believes the Commission should revise its use of the prioritization tiers.

[9] ADS Comments at 4-5.

[10] Alaska Communications Comments at 7.

Commission should implement these changes to its classification of rural areas for the RHC Program.

III. THERE IS NO SUPPORT FOR RETAINING THE RATES DATABASE IN THE TELECOM PROGRAM

Commenters universally agree that the Commission should not use the flawed Rates Database.[11] As GCI noted, "The Rates Database failed because it sacrificed accuracy and fairness in a chase for simplicity, and the Commission should move on to a different framework."[12]

Instead, the record indicates support for retaining the current mechanism in place under the Telecom Program. Specifically, under the orders waiving the requirement to use the Rates Database,[13] Telecom Program participants may use previously approved rural and urban rates or may use methods in place prior to the Rates Database to demonstrate rural and urban rates.[14]

Alaska Communications advocates the permanent adoption of this approach with some modifications for determining rates going forward.[15] GCI supports use of the existing methodology on an interim basis.[16] And ENA Healthcare urges the Commission to maintain the

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[11] Alaska Native Tribal Health Consortium Comments at 3 ("ANTHC recommends removing the Rates Database, and maintaining the subsidy as currently done."); Community Health Corporation Comments at 1 ("CHC supports an alternative solution and the elimination of the rates database.").

[12] GCI Comments at 42; *see also* Alaska Communications Comments at 27-28 ("[T]he Commission should not devote any additional time or resources to making the rural rate database suitable for use in Alaska.").

[13] *Rural Health Care Support Mechanism; Promoting Telehealth in Rural America*, WC Docket Nos. 02-60 and 17-310, Order, 36 FCC Rcd 7051, 7056-57, 7059-60, ¶¶ 12-15, 20-22 (Wireline Comp. Bur. 2021) (*Rates Database Waiver Order*); *Rural Health Care Support Mechanism; Promoting Telehealth in Rural America*, WC Docket Nos. 02-60 and 17-310, Order, DA 22-401 (Wireline Comp. Bur., Apr. 12, 2022) (*Alaska Further Waiver Order*).

[14] For urban rates, applicants can use recently approved rates, rates approved by state commissions such as those in Alaska, and other validly documented rates. Any approved urban rate should be available to all HCPs within the state for that funding year. ADS Comments at 4.

[15] Alaska Communications Comments at 22-24,

[16] GCI Comments at 6.

use of the current methodology for two additional funding years and then reexamine whether a new methodology is even necessary for the Telecom Program.[17]

SHLB agrees with these providers that the Commission should retain the current mechanism in place for the Telecom Program at this time. The Rates Database has proven to be an unworkable and ineffective method for determining rates. Maintaining the current methodology is a better solution while the Commission determines whether further changes are necessary given the changes to the program.

For instance, many HCPs have chosen to switch from the Telecom Program to the HCF, in part due to the uncertainty and funding delays associated with the Telecom Program in recent years. Given this, the Commission should consider revisions to the HCF that would provide additional support to HCPs in rural areas. Specifically, the Commission could establish differing discount percentages correlating to an HCP's rurality. For example, using an amended version of the rurality tiers the Commission has established, HCPs in non-rural areas would receive the current 65 percent discount, those in less rural areas would receive a 75 percent discount, HCPs in rural areas would receive an 85 percent discount, and those in extremely rural areas would receive a 95 percent discount.[18] The Commission could establish discount tiers within the HCF program without conflicting with the statutory requirement applicable to the Telecom Program that HCPs pay rates reasonably comparable to urban rates within a state.[19] Importantly, this proposal would ensure that HCPs are price sensitive when evaluating bids for services while still providing a significant subsidy for rural HCPs. The Commission should implement these

[17] ENA Healthcare Comments at 5-6.

[18] HCPs in the most difficult to serve areas that are inaccessible by roads, the "Frontier" tier, could receive a larger discount percentage such as 99 percent.

[19] 47 U.S.C. S 254(h)(1)(A). To the extent the Commission believes that the *Further Notice* does not provide adequate notice of this proposal, SHLB recommends that the Commission expeditiously issue a public notice to solicit comments on it.

additional HCF discount tiers in conjunction with an increase in the overall RHC cap to ensure that any potential increase in HCF demand does not take funding away from HCPs that continue to rely on the Telecom Program for support..

IV. THE COMMISSION SHOULD ADDRESS SEVERAL ADMINISTRATIVE PROBLEMS AND SEEK TO STREAMLINE THE APPLICATION PROCESS

No other commenters addressed the issue of prioritization with respect to consortium shared network costs which, presently, are arbitrarily classified as non-rural simply because USAC has no network cost allocation mechanism in place.[20] Specifically, the existing system incorrectly categorizes shared network costs as 100 percent non-rural, ignoring the rural locations that use the shared network and discriminating against urban-rural consortia. SHLB reiterates that the Commission should not eliminate or pro-rate RHC funding for these consortium network shared costs until some type of cost-allocation methodology is put in place. Alternatively, the Commission could immediately establish a safe-harbor cost allocation mechanism that looks to each consortium's urban-rural percentage. For example, in a year where the cap is exceeded such that Priority 7 and 8 HCPs receive no support, an individual consortium that is 40 percent urban (i.e., Priority 7 and 8) and 60 percent rural would have 60 percent of their shared network costs exempt from a funding reduction (i.e., the rural percentage would be considered Priority 2). Failure to address this issue could have extremely damaging effects on HCF consortia that have shared network costs in any year in which the current prioritization scheme is activated.

[20] SHLB comments at 13-14; *see also Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 27 FCC Rcd 16678, 16704, n.148 (2012) (acknowledging that "funding attributed to non-rural locations [in consortium networks] likely is overstated because shared equipment and services often are attributed to non-rural locations even though they are used by all the network sites.")

In addition, SHLB reiterates its position and agrees with other commenters who advocate against applying the HCF invoicing process to the Telecom Program.[21] The Commission should direct USAC to reform its Invoicing Procedures within the Telecom Program as the proposed changes to the Telecom Program invoicing rules fail to recognize the increased administrative burden for rural HCPs that would result from adoption of the FCC Form 463 process for the Telecom Program. Implementing upgrades to USAC's My Portal system would help reduce administrative burden for all stakeholders.

In addition, SHLB believes USAC should implement a trouble-ticket system to help applicants and USAC manage the large and increasing number of USAC information requests. At the current time there is no specific identification number associated with these requests, which makes it very difficult for applicants and USAC to keep track of how many are outstanding, the status of the requests, and even which funding requests are at issue. As a result, miscommunications occur between USAC and applicants regarding whether an information request remains outstanding, has been withdrawn, or has been successfully answered. These miscommunications have resulted in delays and loss of funding. Implementing a system to catalog and update these information requests would substantially increase efficiency for all stakeholders and help reduce applicant response time to USAC requests.

Site and service substitutions have also become much more difficult due to approval delays. A new one-year funding request takes at least seven months for approval, which also subsequently delays site and service substitutions and then leaves very little time to complete the substitutions. Then, there may be a substantial delay in the USAC approval of the site and service substitution as well. This means that if a healthcare provider is unfortunate enough to

[21] *See* ENA Healthcare Comments at 8-11.

have a service that starts or changes after the funding window has closed, there is a substantial risk that they may not be able to secure funding for the first year of service. This was not the case when three-year funding requests were at less risk of pro-rata reductions due to the internal cap because the healthcare provider had the second and third year of the multi-year request to complete a site and service substitution to secure funding back to the first year of the request for that new or changed service.

Finally, SHLB notes that the Commission should allow HCPs that plan to open within a funding year to apply for funding. USAC does not currently allow HCPs to apply until they are already operating, which could mean a new eligible location or HCP could be denied funding for more than a year after it is serving patients.

V. CONCLUSION

The Commission should take this opportunity to revise the RHC Program to meet the current and future need to access robust telemedicine services everywhere in the country, including in remote and rural areas. To do this, the Commission should increase the amount of funding available, adopt an expanded definition of rurality, continue the status quo in determining the urban and rural rates for the Telecom program, and streamline program rules.

Respectfully submitted,

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May 16, 2022