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

John Windhausen, Jr.
Executive Director
SCHOOLS, HEALTH & LIBRARIES BROADBAND (SHLB) COALITION
jwindhausen@shlb.org
(202) 256-9616

Jeffrey A. Mitchell
LUKAS, LAFURIA, GUTIERREZ & SACHS, LLP
8300 Greensboro Drive, Suite 1200
Tysons, VA 22102
(703) 584-8678

Counsel for Schools, Health & Libraries Broadband (SHLB) Coalition

March 5, 2018

TABLE OF CONTENTS

SUMMARY

Several commenters in this proceeding – especially health care related organizations – supported the SHLB Coalition's recommendation to increase the RHC funding cap to reflect changes in the health care and broadband marketplaces, in addition to the rate of inflation since 1997. In fact, several parties endorsed the idea of doubling the cap to $800 Million per year. Several parties also agreed with the SHLB Coalition that the statutory language requires the Commission to provide sufficient funding for the Telecom Program without any cap.

USTelecom's suggestion to hold off on increasing the cap until the Commission takes steps to eliminate waste, fraud and abuse is unnecessary. The Commission can take steps now to root out any problems – such as increasing transparency in the program, publishing urban rates, and enhancing competition in the bidding process – and simultaneously increase the funding cap to address the urgent need for increased funding.

The SHLB Coalition disagrees with USTelecom's claim that urban and rural rates are similar in the Lower 48 states. One SHLB member provided a specific example showing that the rates in rural Utah are several times more expensive than the rates in Salt Lake City. The SHLB Coalition recently published a study of the costs of deploying fiber that found significant cost differences in six different geographic typologies. For instance, the costs of deploying fiber vary from $34,000 per anchor in urban markets to $151,000 per anchor in desert areas (excluding Alaska).

Permitting urban health care providers (HCPs) to participate in consortia offers significant benefits to rural HCPs, and urban HCPs should not be down-graded to second-class status. Those who oppose including urban sites in the RHC program offer no evidence to support the claim that urban sites should be excluded. Further, urban HCPs make up a small portion of total HCPs that participate in the program. Similarly, while some commenters propose eliminating support for administrative centers and data centers, SHLB maintains that these centers enable greater rural health care provisioning and constitute a tiny portion of all HCPs receiving funding.

The SHLB Coalition notes that the time frame for applicants to submit RFPs, negotiate contracts and file the necessary application forms is extremely condensed and should be expanded to allow applicants greater opportunity to obtain better contract terms. SHLB agrees with USTelecom that applications should be reviewed and approved on a rolling basis. Applications could be approved pending a determination of the exact amount of funding that is awarded. The SHLB Coalition offers a number of other suggestions for improving the process of applying for funding, such as making more forms and instructions available.

The SHLB Coalition also suggests using Rural-Urban Commuting Codes (RUCA) as an additional mechanism to determine if an HCP is rural (without replacing the existing rural definition). Finally, we encourage the Commission to adopt rules to promote greater transparency in the RHC program, similar to the E-rate program.

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, whose members include many participants in the Rural Health Care (RHC) programs – the Healthcare Connect Fund (HCF) and the Telecommunications Program (Telecom Program) – by its attorney hereby submits these reply comments in the above-captioned proceeding.

I. THE COMMENTS DEMONSTRATE WIDESPREAD SUPPORT FOR INCREASING THE CAP ON THE RHC PROGRAM, ESPECIALLY AMONG HEALTH ORGANIZATIONS

A. Comments from Health Organizations Strongly Supported Increasing the Cap By More than General Inflation to Reflect Growing Healthcare Needs.

In the Notice of Proposed Rulemaking that launched this proceeding,[1] the Commission not only asked commenters whether the cap should be increased, but also asked what the revised cap should be.[2] There was widespread support among the commenters for raising the cap, especially among healthcare and healthcare-related organizations. The perspectives of healthcare organizations should be given special weight in this proceeding given the importance of telemedicine to rural areas of the country facing a shortage of doctors and higher incidence of

[1] *Promoting Telehealth in Rural America, Notice of Proposed Rulemaking and Order*, WC Docket No. 17-310, FCC 17-164, (Dec. 18, 2017) (*NPRM and Order*)

[2] "We seek comment on increasing the cap for the RHC Program and whether we should retroactively increase the cap for FY 2017. Looking ahead, beyond FY 2017, by how much should we increase the cap?" (para. 15)

health-related problems. The following healthcare or healthcare-related organizations all supported increasing the cap:

Alaska Native Health Board (ANHB)
American Hospital Association (AHA)
American Telemedicine Association (ATA)
Healthcare Information and Management Systems Society (HIMSS)
National Association of Community Health Centers (NACHC)
National Organization of State Offices of Rural Health (NOSORH)

Most of the commenters suggested that it was not enough to raise the cap by inflation alone; most suggested that the cap should be raised to reflect the changes in the healthcare marketplace and the broadband needs of eligible health care institutions. Following are quotes from some of the health care organizations who submitted comments supporting raising the cap to a level greater than the rate of inflation since 1997:

National Organization of State Offices of Rural Health (NOSORH):

> NOSORH recommends that the RHC Program funding cap be raised in the near term to reflect the needs of rural health providers. The aim would be to establish a budget cap that realistically reflects inflation, changes in technology and expansions of eligibility. (P.2)

Healthcare Information and Management Systems Society (HIMSS) and Personal Connected Health Alliance (PCHAlliance):

> HIMSS and PCHAlliance recommend that funds be increased at a rate that accounts for inflation and the rising costs of care since its inception in 1997 . . .. The $400 million cap simply does not extend as far as it did when the fund was first established. Funds should be increased at rates that reflect the integral role of broadband connectivity to an increasing number of healthcare delivery functions. (P. 4)

American Hospital Association (AHA):

> The RHC Program is thus essential to providing affordable broadband access to rural health care providers ("HCPs") and supporting telehealth services that improve health outcomes in rural communities. However, the Program's full potential is limited by a spending cap that is insufficient to

> meet the costs associated with delivering high-capacity broadband-enabled telehealth services. (P. 5)[3]

Alaska Native Health Board (ANHB):

> ANHB suggests that, if the FCC keeps any cap in place, the base level of funding for the RHC Program be doubled to $800 million at a minimum. Additionally, the RHC Program should be adjusted in the future to account for inflation, which is, for instance, how the E-Rate Program operates. More importantly, the RHC program also needs to be adjusted in the future for growth in connectivity demand for health care: modern applications such as videoconferencing continue to drive the need for higher bandwidth and lower latency, and the mission-critical nature of telecommunications is driving the need for redundant and more fault tolerant systems. (P. 6)

Kodiak Area Native Association (KANA):

> We believe that the FCC should increase the budget for the rural health care support mechanisms to reflect inflation over the past two decades and increases in the level of support available from those mechanisms, as well as increased technology and telecommunications demands due to our HIPAA legal obligations, advances in telemedicine capabilities, changes in patient expectations and standards of care, and new demands from skilled nursing facilities. (P. 1)

Numerous other healthcare and healthcare-related organizations also supported an increase in the $400 million RHC cap. These included the National Rural Health Association (NRHA),[4] the Alaska Native Tribal Health Consortium (ANTHC),[5] CHRISTUS Health,[6] Community Hospital Corporation (CHC),[7] the American Association of Nurse Practitioners (AANP),[8] the

[3] *See also* AHA Comments at 8-9.

[4] *See* NRHA Comments at 4 (supporting raising cap, among other things, "to reflect the changes in technology and its use in health care that drive the need for the support of the RHC program.").

[5] *See* ANTHC Comments at 7-8 (supporting $800 million program with future adjustments for inflation and program cost increases).

[6] *See* CHRISTUS Health Comments at 3.

[7] *See* CHC Comments at 2-3.

[8] *See* Comments of AANP at 1-2 (supporting cap increase to reflect increased demand for telehealth services; "particularly important for small rural practices to utilize telehealth since the costs of implementing telehealth for those practices can often be a barrier to entry.").

American Academy of Family Physicians (AAFP),[9] Florida Association of Community Health Centers (FACHC),[10] the Alaska Primary Care Association (APCA),[11] Norton Sound Health Corporation (NSHC),[12] and the College of Healthcare Information Management Executives (CHIME).[13]

Notably, Franciscan Health Alliance and Parkview Health System (FHA/PHS) suggested applying the average medical care inflation rate (CPI-Medical) over the last 20 years, as tracked by the U.S. Bureau of Labor Statistics, as the appropriate measure of program growth. According to FHA/PHS, applying CPI-Medical retroactively results in an inflation-adjusted RHC cap of $810 million.[14] This is consistent with SHLB's call to double the size of the current cap based on the apparent doubling of the number of eligible entities (including the recent addition by Congress of skilled nursing facilities). If the Commission relies solely on an inflation adjustment mechanism to update the RHC cap (and going forward), SHLB agrees with FHA/PHS that CPI-Medical is the logical and appropriate inflation factor to use.

B. Several Commenters Agreed with SHLB that the Telecom Program is Mandatory and Should Not Be Subject to Any Cap.

In our initial comments, we noted that, because the statutory language uses the term "shall", Congress intended that the Telecom Program not be subject to any cap at all. The SHLB Coalition

---

[9] *See* Comments of AAFP at 1 (urging cap adjustment to reflect inflation and technology); ANTHC Comments at 4.

[10] *See* Comments of FACHC at 2 ("[the size of] the funding cap should . . . reflect inflation, eligibility expansions, and changes in costs resulting from advances in technology.").

[11] *See* APCA Comments at 1-2.

[12] *See* NSHC Comments at 6-7.

[13] *See* Comments of CHIME at 2 (supporting doubling of cap to support SNFs and to help address public health emergency associated with opioid crisis which is worse in rural areas).

[14] *See* Joint Comments of FHA/PHS at 7-8 ("The cost of providing healthcare has outpaced general inflation. In the last 20 years, the cost of medical care has grown at an average rate of 3.5% in contrast to the Consumer Price Index which has displayed an annual growth rate of 2.2%").

thus proposed removing the Telecom Program from the $400 million RHC cap altogether (and leaving the current $400 million cap in place for the HCF – inflation adjusted – going forward). Several other commenters noted the mandatory nature of the Congressional language.[15]

C. There Was Hardly Any Opposition To Raising the Cap.

Based on our review of the initial comments, only USTelecom expressed any hesitation about raising the RHC cap.[16] USTelecom appears not to object to raising the cap so long as measures are undertaken to prevent waste (discussed further below). NTCA – the Rural Broadband Association cited the many benefits of rural telemedicine and suggested that determining the proper funding should be "data-driven."[17] NCTA – the Internet and Television Association (NCTA) said only that program funds should be used "efficiently".[18]

Even USTelecom acknowledged that substantial changes in the healthcare marketplace have increased demand, noting that "transformative changes in the healthcare industry and the program itself since 1997 have increased demand for rural telehealth and telemedicine services."[19] USTelecom says the Commission "should ensure sufficient Telecom Program funding for Alaska"

---

[15] *See, e.g.*, NSHC Comments at 3-4; ANTHC Comments at 1-7; ANHB Comments at 1-6; Comments of Southcentral Foundation at 3-4; Comments of Maniilaq Association at 3-5; Comments of Council of Athabascan Tribal Governments at 1-5; *see also* Comments of Space Exploration Technologies Corp. Comments at 6-7 (arguing that both the Telecom Program and HCF reflect a "shall" directive from Congress).

[16] AT&T did not file initial comments but submitted an *ex parte*. *See* AT&T January 25, 2018 *ex parte* (recommending that RHC program reforms be adopted before "any consideration is given to increasing the cap on the program.").

[17] "NTCA supports the Commission's overarching goal to facilitate greater provision of telehealth in rural America. NTCA urges the Commission to pursue this goal, including funding and distribution methodologies, on the bases of evidentiary data with a principal focus on defined needs and desired outcomes. Accordingly, resources that are to be allocated to these purposes should be based upon a realistic, data-driven expectation of fulfilling public policy, rather than an arbitrarily drawn process that is not correlated to the task at hand." (NTCA Comments p. 1)

[18] "In considering reforms to the rural health care support programs, the Commission should make sure that funding is being used as efficiently as possible to achieve the objectives of the statute." (NCTA Comments, p.1)

[19] *See* USTelecom Comments at 6.

and expresses concern only about operation of the Telecommunications Program (not the HCF) in the lower 48 states. As USTelecom explained:

> In the Lower 48 states, real questions exist as to how much Telecom Program demand is driven by aggressive attempts to create a perception that urban and rural telecommunications service rates diverge far more greatly than they do. The Commission first should adopt rules designed to curb such waste before determining whether any increase in the cap is necessary.[20]

We disagree with USTelecom about the alleged "waste" in the Telecom Program based on its claim that there is little if any difference between urban and rural rates in the lower 48 states. As we discuss below, significant differences between urban and rural rates remain today. (USTelecom does not provide evidence of the rate congruity and suggests it will submit such evidence in its reply comments. The SHLB Coalition will respond to such evidence if and when it is filed.)

As NCTA notes,[21] the rules for determining the differences in rates are quite unclear. Current Telecom Program rules defining the urban and rural rate seem to assume the existence of regulated, publicly available rates, but prices in the broadband marketplace are largely deregulated and are not set this way today. These rules should be clarified to prevent confusion and uncertainty in how the Telcom Program is administered. For instance, the FCC could publish and maintain a nationwide urban rate, or series of urban rates, as a safe harbor to remove one source of uncertainty and prevent gamesmanship.[22]

---

[20] *Id.* at 6-7.

[21] *See* NCTA Comments at 2.

[22] NRHA Comments at 5 ("Urban and rural rate standards were historically done by USAC but it became expensive (so in a cost cutting move this was delegated in 2001 to health care providers) – this has led to more of a role for consultants (who can search out the best rates for their clients – searching for best urban rate not best rural rate which ultimately means the FCC is paying the most) – health care providers are not equip[ped] to do this.").

Rural rates, in contrast, should be set by the market, and any new rules should not create uncertainty about whether support will be approved or otherwise discourage carriers from submitting bids. If the Commission attempts to set rural rates in advance, or if applicants and carriers must guess whether Telecom Program support requests will ultimately be approved by USAC, applicants and carriers may forego participating in the program. Indeed, if carriers decline to even bid, the "rural rate" becomes a meaningless concept and rural health care providers will not receive the services they need.

SHLB in its initial comments suggested certain steps that can ensure that as much competition as possible is taking place – by implementing a bid registry for example for carriers that may be concerned their bids are not being fairly considered.[23] The Commission could also adopt other ideas to promote competition, such as requiring applicants to provide greater information about the scope of the services that they request, requiring that HCP RFPs not favor any type of providers, promoting greater transparency in the program equivalent to the transparency in the E-rate program, and requiring that HCPs certify that they have evaluated all bids.[24] With measures such as these, the Commission can clarify the urban and rural rate calculations so that there is no reason to wait to increase the funding cap. Clarifying the rules and increasing the cap can be done simultaneously in this proceeding.

D. Increasing the Investment in the Rural Health Care Program is an Investment that Will Generate Significant Cost Savings.

As the Kodiak Area Native Association explained:

> Growing evidence indicates that access to telehealth services also lowers health care costs in rural communities, saving money at the local, state, and national levels. As one example, the [ANTHC] estimates that access to telehealth services saves rural Alaskans $10 million annually in travel

[23] *See* SHLB Comments at 21.

[24] *See* Comments of TeleQuality, pp. 23-25.

> costs [alone]. At the national level, the Veterans Health Administration (VHA) estimates that the annual cost in 2012 to deploy its telehealth program was $1,600 per patient per year, compared to over $13,000 for traditional home-based care and $77,000 for nursing home care. Telehealth was also associated with a 25 percent reduction in the number of bed days of care, and a 19 percent reduction in hospital admissions, across all VHA patients utilizing telehealth services.[25]

In considering the costs and benefits of a larger RHC program, the Commission must recognize that RHC universal service expenditures – which the Commission was directed by Congress to ensure are predictable and sufficient – result in cost savings to individuals, communities, and to other federal programs such as Medicaid (which covers travel costs).[26]

II. DESPITE CLAIMS TO THE CONTRARY BY USTELECOM, THERE ARE SUBSTANTIAL DIFFERENCES BETWEEN URBAN AND RURAL RATES IN THE LOWER 48 STATES

USTelecom makes the highly questionable assertion that there is little need for the Telecom Program in the lower 48 states because urban and rural rates have "flattened".[27] USTelecom provides no evidence to support its claim that there are no significant differences between urban and rural rates, but it claims it will submit such evidence in its reply comments. The SHLB Coalition will respond more fully if and when such information is submitted.

In the meantime, USTelecom claims the Telecom Program "is premised on the notion that rates for non-mileage-based telecommunications services . . . in rural America are significantly higher than they are in urban areas."[28] But the concept of "mileage-based" rates does not appear

---

[25] *See* Comments of Kodiak Area Native Association at 2.

[26] *See id.* ("Medicaid costs through avoided patient travel.").

[27] *See* USTelecom Comments at 5-6 ("[O]utside of Alaska, the urban/rural price gradient has flattened, reducing the need for Telecom Program support to achieve its statutory purpose in the Lower 48 states. . . . In the Lower 48 states, real questions exist as to how much Telecom Program demand is driven by aggressive attempts to create a perception that urban and rural telecommunications service rates diverge far more greatly than they do.").

[28] *See* USTelecom Comments at 5.

in the statutory language authorizing the Telecom Program.[29] Moreover, SHLB members believe that there are many examples of rural healthcare providers facing much higher charges than for equivalent services in urban areas. For instance, rural rates for telecommunication services in Utah for health care facilities are significantly higher than urban rates. In Utah, urban Salt Lake City (SLC) is home to the state's only children's hospital, academic medical center, and cancer institute. Contract rates for 1 Gbps service for the Utah Education and Telehealth Network (UETN) can range from $500/month in urban hospitals and clinics, to $2,975/month for a hospital 159 miles from SLC (RUCA 7) and $2,200/month for a critical access hospital 312 miles from SLC (RUCA 10). Rural rates for 100 Mbps service also vary widely depending on rurality: $470/month for a local health department 119 miles from SLC (RUCA 4), $800/month for a community health center 182 miles from SLC (RUCA 10), $1,800/month for a rural clinic 205 miles from SLC (RUCA 10), and $2,999 for a community health center 483 miles from SLC (RUCA 10).

Rural rates are often much higher than urban rates due to the higher cost of deploying broadband facilities in rural markets. The SHLB Coalition recently issued a report prepared by CTC Technology and Energy, an engineering firm that has substantial experience in deploying fiber to different markets around the country. CTC developed a cost model that reflects the cost differential among six types of geographic regions in the U.S. The report finds that the costs of deploying fiber vary from $34,000 per anchor in urban markets to $151,000 per anchor in desert areas (excluding Alaska).[30]

---

[29] While basic long-distance telephone service may no longer exhibit significant differences between urban and rural rates, telephone service represents a tiny portion of all RHC funding.

[30] "The average cost to connect Anchors with last-mile fiber—including constructing the last-mile fiber, bringing the fiber into the building, and acquiring and activating the network electronics— ranges across typologies, from $34,000 per Anchor for connecting a large number of Anchors in a metropolitan area to $151,000 per Anchor for connecting a large number of Anchors in a desert area." See, "A Model for Understanding the Cost to Connect Anchor Institutions

III. CONSORTIA APPLICATIONS PROVIDE GREAT BENEFITS TO RURAL HCPS AND REQUESTS TO REDUCE URBAN PARTICIPATION RATES OR OTHERWISE DOWN-GRADE CONSORTIA APPLICATIONS TO SECOND-CLASS STATUS SHOULD BE REJECTED

While most commenters addressing the HCF supported the SHLB Coalition's position that consortia applications provide great benefits for rural HCPs and that including urban HCPs in these consortia benefit the rural HCPs,[31] some commenters suggested otherwise. NRHA, for instance, says that urban providers connect to the cloud (not directly to a rural HCP), and that urban HCPs can pay for their broadband costs through reimbursements from their telemedicine services. Even NRHA, however, does not propose a complete bar to urban participation; it just suggests that funding "must be demonstrated to be purely for the benefit of the rural participants in the consortia."[32]

The SHLB Coalition disagrees with NRHA regarding the benefit of urban sites to rural HCPs. The benefits of including urban sites in consortia were outlined in the FCC's Staff Report evaluation of the 2007 Pilot program.[33] The staff report explained: "Leaders of Pilot projects often come from large medical institutions and universities, which frequently are located in urban areas.

---

with Fiber Optics, " pp 2-3, available at http://shlb.org/uploads/Policy/Infrastructure/SHLB_ConnectingAnchors_CostEstimate.pdf.

[31] *See, e.g.*, NETC Comments at 3-4 (noting, among other things, design efficiencies of consortium networks); Illinois Rural HealthNet Comments at 3 (noting success of FCC investing through the RHC Pilot Program in its successful statewide broadband network now offering Gigabit speeds when only T1 (or less) levels of service were previously available); Rural Nebraska Healthcare Network Comments at 2 (challenging assumption that consortia automatically enjoy economies of scale with service providers in rural areas with little to no competition); *cf.* Joint Comments of FHA/PHS at 13-14 (noting antiquation of point-to-point network configurations).

[32] *See* NRHA Comments at 3-4.

[33] *See* Wireline Competition Bureau Interim Evaluation of Rural Health Care Pilot Program Staff Report, WC Docket No. 02-60, Staff Report, 27 FCC Rcd 9387 (2012) (*Pilot Program Staff Report*).

The urban health care providers often serve as hubs for the network, and as such receive support for the equipment that enables the entire network to operate."[34] The Staff further explained:

> *Urban sites are key members of rural health care provider networks*. As the Western New York Pilot project put it, without its urban partners it would be "building a road to nowhere." Broadband networks often bring to patients in rural areas the additional medical expertise, creativity, technical know-how, and innovation available in large urban medical centers. The leadership, technical and medical expertise, and administrative resources provided by urban health care providers also have proved central to the success of many Pilot projects.[35]

In addition, funding only rural connections to the cloud fails to recognize middle mile costs that are necessary to maintain the networks that provide cloud access. Indeed, the "cloud" is not simply the public internet, for healthcare the cloud includes secure private networks dedicated to health care.[36] These networks also tend to be open, allowing all health care providers on the network to communicate privately (if they choose). Having urban and rural participation helps offset the expense of these middle mile networks which bring the cloud closer in proximity to rural providers and ensure overall network design is efficient.

Western New York Rural Area Health Education Center (WNY R-AHEC) also offered the following explanation for why the HCF should continue to support both urban and non-urban:

> [T]he urban/rural divide is decreasing as partnerships and consolidations increase. The HCF has facilitated these partnerships to a degree and improved rural health care as a result of this increased partnership. Further, if a circuit runs from a rural facility to an urban facility, is this circuit rural

---

[34] *Id.* at 3.

[35] *Id*. at 4.

[36] *See, e.g.*, Joint Comments of FHA/PHS at 5 ("In order to keep up with these rapid advancements, and to further the connectivity between [HCPs], other HCPs, and their patients, healthcare systems are also changing their network infrastructure, migrating from architectures reliant on self-hosting solutions to cloud-based models delivering Software as a Service (SaaS) solutions. The net of these factors is that health systems, clinically-integrated networks, and other forms of consortiums are migrating from traditional, point-to-point private networks to advanced point-to-cloud networks that utilize virtual private network technology to establish network functionality.").

> or urban? Strictly limiting funding for urban facilities would be a disservice to numerous rural facilities that have partnered with the urbans.
>
> The fact of the matter is the [HCF] program has favorably impacted the quality of rural health care. If the program is overly restrictive in rural versus urban subsidization, who will rural facilities connect to as the partnerships and consolidations increase?[37]

Those who oppose consortia do not offer any facts to support the idea that consortia are not achieving the objectives set by this Commission.[38] In fact, many FQHCs are participating in the program only because of consortia. Furthermore, urban HCPs are not dominating the RHC program, even with the existing consortia. According to the Briefing Book released by USAC over the summer of 2017, less than one-third (31.57%) of HCPs receiving support in HCF consortia in 2016 were urban. The large majority of HCF consortia funding is already going to rural HCPs.[39]

Similarly, some have called for RHC funds to go only to those entities that are providing direct services to rural patients and should exclude funding to administrative centers and data centers. But these administrative and data centers provide direct support to the rural clinics. Without these centers, the rural provider would not be able to serve patients. The Commission's rules already require the funds to be used to support the provision of rural health services. Furthermore, the 2017 Briefing Book found that, of the 2705 entities who received support in 2016, only 152 were administrative or data centers (about 5.5%).[40] Eliminating these entities from

---

[37] *See* WNY R-AHEC Comments at 2.

[38] *See* AHA Comments at 13 ("There is no evidence that the current rule [allowing non-rural participation in consortia] is problematic, and it is unclear what benefits will accrue to rural HCPs or patients by increasing the percentage of rural providers required to participate in a consortium.").

[39] *See* USAC RURAL HEALTH CARE COMMITTEE BRIEFING BOOK at 31 (July 24, 2017), https://www.usac.org/_res/documents/about/pdf/bod/materials/2017-07-24-rhc-briefing-book.pdf. Note that because 100% of Telecom Program funding and 100% of HCF funding not going to consortia is for rural HCPs, less than 10% of total RHC program support is associated with urban HCPs ($30 million out of $369 million committed in FY 2016). *See id.* ($30,049,769 committed to urban HCPs compared to total FY 2016 commitment amount cited in NPRM).

[40] *Id.*

support would have a negligible impact on the availability of funds to other HCPs but would cause significant harm to the specific rural HCPs that rely upon the services provided by those administrative and data centers.

IV. THE PROCESSING OF APPLICATIONS, ESPECIALLY FOR CONSORTIA, SHOULD BE IMPROVED.

Numerous commenters address the need for administrative improvements at USAC as critical to any effort to reform the RHC program. For example, several commenters urged the Commission to allow more time for HCF consortia competitive bidding processes,[41] and many commenters address the problem of funding commitments being issued many months after the start of the funding year.[42] (The FY 2017 window ended on June 30, 2017, and as of early March 2018, funding FY 2017 commitments have still not been issued).

Kellogg & Sovereign (K&S) noted how the HCF consortia application timeline for FY 2018 allows only 119 days for the following to occur: applicant submits Form 461 (Request for Services); USAC reviews and posts of Form 461 and accompanying RFP; applicant conducts a minimum 28-day review period, evaluates bids, negotiates contracts, secures internal approval (including legal review), and submits a certified Form 462 (Request for Funding).[43] In a typical process, this would leave only two weeks for negotiating a contract (such as a multi-year master services agreement) and only seven days to complete Form 462.[44] FHA/PHS explained that

---

[41] *See, e.g.*, Joint Comments of FHA/PHS at 17-18; Kellogg & Sovereign Consulting (K&S) December 2017 Comments at 2-4.

[42] *See* USTelecom Comments at 20-21; Alaska Communications Systems (ACS) Comments a 38-41; Joint Comments of FHA/PHS at 18-19; K&G December Comments at 5; NETC Comments at 6-7; *see generally* NCTA Comments at 8-9 (urging streamlining of application process).

[43] K&S December Comments at 2.

[44] *Id.*

consortium contract negotiations can take as much as six months.[45] This compressed HCF schedule contrasts with E-rate where competitive bidding can begin much earlier in the funding cycle, giving applicants much more time to complete similar steps. Allowing applicants more time to negotiate contracts could result in more favorable contract terms and lower prices.

For ensuring faster funding decisions, USTelecom offered a proposal similar to SHLB's that funding commitment decisions can and should be issued on a rolling basis, prior to the results of any *pro rata* calculations that may be applicable.[46] This would allow applicants to avoid having to go through an additional competitive bidding process if they know that their previous year's bidding process and application had been approved. Certainly SHLB and many program participants also agree with USTelecom that:

> The Commission should require USAC to obtain sufficient rural health care staff and other resources to meet these requirements so that healthcare providers and their patients will never again have to endure the lengthy delays and process breakdowns characterized in funding years 2016 and 2017.[47]

SHLB offers the following additional suggestions for improving the processing of consortia applications:

- Provide a completed sample of each FCC form with instructions (covering both programs).
    - This will help the many applicants who only occasionally must complete the forms. It is particularly helpful to see a completed form in its entirety to help understand in advance how each form section relates to the other form sections.

---

[45] Joint Comments of FHA/PHS at 18.

[46] *See* USTelecom Comments at 21 ("[The Commission should] direct USAC to issue decisions on all funding requests filed in that first window on a rolling basis (even if exact dollar amounts need to await the results of *pro rata* calculations), with all such decisions released by June 1, shortly before the beginning of that funding year, to give healthcare providers and service providers time to install and activate telecommunications services before July 1."); SHLB Comments at 33 ("the Commission should direct USAC to issue funding decisions on a rolling basis, with funding amounts ultimately contingent upon a to-be-determined pro rata factor if one becomes necessary.").

[47] *See* USTelecom Comments at 21.

- For the online Network Cost Worksheet, make sure all items in the "Category of Expense" and "Expense Type" dropdown menus are eligible for discounts. Make these dropdown lists available as printable samples (with definitions) for reference.
    - There is some question about whether the current Expense Type drop down includes that are ineligible. To avoid confusion, these lists should only include eligible items.

- Reinstate the use of USAC liaisons assigned to large consortia. In the past, this liaison increased efficiency due to their in-depth understanding of a consortium's particular characteristics, such as a pre-approved MSA or evergreen contract and business processes. This allows quicker resolution of both simple and complex questions and issues.

- Require USAC to state a reason when it denies a form or application. One of our members offers the following illustration of how this would improve efficiency: An HCP was grandfathered as a pilot program participant for over 3 years. When the consortium updated the primary and site contact for this organization, USAC denied eligibility to the HCP. USAC would not provide a reason for this denial but simply directed the consortium to appeal the denial if they wished to do so. Understanding the reason behind the denial would have helped improve the consortium's business processes and enabled them to determine the best approach to take.

- Simplify the HCF application process so that it is comparable to the Telecom Program with respect to forms, processes, and USAC systems. Note that several consortia utilize both programs.

- Mechanisms for providing consistent USAC staff administrative guidance need to be improved. For example, does a competitive bidding exemption apply to a master services agreement? This is an example of a time-sensitive question where it is not unreasonable for USAC to provide a timely administrative response (*i.e.*, "yes" or "no" rather than a legal opinion). In addition, the RHC program should also offer greater online documentation and/or FAQs.

V. THE COMMISSION SHOULD USE RUCA CODES AS AN ADDITIONAL WAY TO IDENTIFY HCPS IN RURAL MARKETS.

The existing definitions of rurality cause some isolated locations to be treated as urban even though they are miles away from an urban center. While the current definition of rural does not always reflect the on-the-ground situation, we also understand that replacing the current definition of rural could cause confusion and could cause some currently eligible institutions to become ineligible. Rather than replacing the existing definition, we suggest that the Commission

adopt Rural-Urban Commuting Area (RUCA) codes as an additional way for health care providers to establish rurality. The use of RUCA codes based on commuting distance is an appropriate measure because telemedicine saves the costs of commuting. Under this proposal, everyone that is currently rural would stay rural, but additional entities that qualify as rural under the RUCA codes would become eligible as well. AHA also supported making the current definition of rural more inclusive.[48]

The Commission could, for instance, group the RUCA codes and discounts as follows: Area Codes 1-3 would be considered urban and would be entitled to a 50% discount under the HCF (if part of a majority rural consortia); Area codes 4-6 would be considered rural with a 65% HCF discount; Area Codes 7-9 would be considered "remote" with an 85% HCF discount, and Area Code 10 would be considered "frontier" with a 95% HCF discount.

VI. THE COMMISSION SHOULD IMPROVE TRANSPARENCY AND PUBLISH STANDARD RATES IN ORDER TO SIMPLIFY THE PROGRAM AND DETER WASTE, FRAUD AND ABUSE.

The Commission can improve the RHC program by allowing greater transparency of the data underlying the program. This would facilitate crowd-sourced data analysis for certain types of information such as where RHC funding is going. For example, the Commission should ensure the availability of Geographic Information Systems (GIS) locations of applicants and the maps of rural areas. As a general matter, the kinds of data that are freely available in the E-rate program should be available in the RHC program.

[48] AHA Comments at 17-16 ("The goal of the [RHC] program should be to support all health care providers that provide essential health care services to persons who reside in rural areas, notwithstanding their status according to the census.").

Lastly, publishing the rates charged to applicants in the Telecom Program (reported on FCC Form 466[49]) would also protect against waste and establish greater uniformity and reliability of the rate calculation.[50] The Commission, however, should be careful about using E-rate pricing data as a benchmark to determine rural health rates because many E-rate applicants rely on best efforts (or shared) service rather than the dedicated network connectivity health care providers often need (where lives are at stake).

VII. CONCLUSION

We urge the Commission to make changes above to satisfy Congressional intent and to improve the quality of health care across the United States.

Respectfully submitted,

John Windhausen, Jr.
Executive Director
SCHOOLS, HEALTH & LIBRARIES BROADBAND (SHLB) COALITION
jwindhausen@shlb.org
(202) 256-9616

Jeffrey A. Mitchell
LUKAS, LAFURIA, GUTIERREZ & SACHS, LLP
8300 Greensboro Drive, Suite 1200
Tysons, VA 22102
(703) 584-8678

Counsel for Schools, Health & Libraries Broadband (SHLB) Coalition

March 5, 2018

[49] *See* FCC Form 466, Lines 33 (service rate) and 40 (mileage-based costs); FCC Form 466 Instructions at 11 ("Information requested by this form will be available for public inspection.").

[50] *See also* NCTA Comments at 5.