

**Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554**

In the Matter of)	
)	
Amendment of Part 54 of the Commission's Rules)	RM No.
to Further Modernize the Rural Health Care)	CC Docket No. 02-60
Program)	

PETITION FOR RULEMAKING

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SUMMARY

The Rural Health Care program continues to be critically important to health care providers and their patients across the country, but especially in the most remote and rural communities. The ability to obtain emergency treatment from a specialist via a robust broadband connection, for example, is increasingly important to the health outcomes for rural patients. While the Commission in 2012 took significant steps to modernize the Rural Health Care program by creating the Healthcare Connect Fund, those improvements are being overwhelmed by a host of demographic, economic, and social trends that disproportionately affect rural communities. These trends include aging populations, increasing poverty, and changes in the health care industry driven by rapid technological and regulatory shifts. There is wide agreement that increased adoption of broadband-enabled care models by all health care providers is essential to meeting and overcoming these challenges.

In order to address disparities in health availability and health outcomes between rural and non-rural areas, Petitioners urge the Commission to further modernize the Rural Health Care program to increase the availability of affordable, modern, quality broadband capable of meeting the needs of health care in the 21st Century. These changes include increasing the discount percentage in the Healthcare Connect Fund to ensure rural health care providers have access to, and can afford, the quality broadband necessary to support broadband-enabled care. Petitioners also propose changes to support the deployment of remote patient monitoring and to further spur the formation of consortia capable of ensuring all safety-net health care providers participate in the unfolding broadband revolution.

To ensure the Rural Health Care program remains on sound financial footing, Petitioners urge the Commission to update its analysis of eligible health care providers, to consider minimum

levels of connectivity needed by those providers, and to recalibrate the Rural Health Care program cap based on such an analysis. We suggest ways the Commission can ensure the cap is not exceeded in the next few years as the Rural Health Care program continues to grow. Petitioners also ask the Commission to ensure efficient program administration by clarifying existing rules and ensuring USAC is deploying the resources necessary to support program reforms and program growth. Petitioners seek changes to the Commission’s definition of “rural” and the establishment of a limited waiver process for entities that serve rural but don’t meet the definition of rural. The Commission should also clarify the HCP eligibility categories and issue guidance to ensure potential program beneficiaries can reasonably determine their eligibility status in advance. Finally, in order to encourage skilled nursing facilities and other presently ineligible health care providers to participate in consortia networks, Petitioners ask the Commission to expand the scope of what constitutes an “eligible connection” for consortia participating in the Healthcare Connect Fund.

Health care, after many years of slow evolution is undergoing increasingly rapid change. Petitioners urge the Commission to take this opportunity and build on past reform efforts. In this rapidly evolving environment, it is vital for the Commission to ensure universal service for rural health care continues to efficiently and cost effectively promote access to affordable modern broadband.

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The Schools, Health & Libraries Broadband (“SHLB”) Coalition, the California Telehealth Network (“CTN”), the New England Telehealth Consortium (“NETC”), the Health Information Exchange of Montana (“HIEM”), the Utah Telehealth Network (“UTN”), the Colorado Telehealth Network (“CoTN”), and the Southwest Telehealth Access Grid (“SWTAG”), who together facilitate broadband connectivity and support telemedicine adoption for health care providers (“HCPs”) across eleven states (“Petitioners”), by their attorney and pursuant to § 1.401(a) of the Commission’s Rules (“Rules”), hereby petition the Commission to initiate a rulemaking to amend Part 54 of the Rules to further modernize the Rural Health Care (“RHC”) program. (Rules are found at Part 54 Subpart A (section 54.5) and Subpart G (sections 54.600 to 54.649).) In support thereof, the following is respectfully submitted:

I. INTRODUCTION

The SHLB Coalition is a broad-based coalition of organizations that share the goal of promoting open, affordable, high-capacity broadband for anchor institutions and their communities.¹ High capacity broadband is the key infrastructure that health care providers, libraries, K-12 schools, community colleges, colleges and universities, public media and other

¹ Our SHLB Coalition members include representatives of health care providers and networks, schools, libraries, state broadband mapping organizations, private sector companies, state and national research and education networks, foundations, and consumer organizations. See www.shlb.org for a current list of SHLB Coalition members.

anchor institutions need for the 21st century. Enhancing the broadband capabilities of these community anchor institutions is especially important to the most vulnerable segments of our population – those in rural areas, low-income consumers, disabled and elderly persons, students, minorities, and many other disadvantaged members of our society.

Each petitioner other than the SHLB Coalition is a consortium of health care providers (“HCPs”) participating in the RHC programs (the Healthcare Connect Fund (“HCF”) and the Rural Health Care Pilot Program (“Pilot Program”). CTN is a consortium of rural and urban HCPs across California. Formed and developed by a broad-based group of public and private stakeholder organizations (www.caltelehealth.org), CTN directly facilitates connections to over 251 California HCPs including direct or networked connections to California’s academic medical centers, tribal health facilities, Critical Access Hospitals (“CAHs”), Federally Qualified Health Centers (“FQHCs”), and county and municipal health facilities. As a nonprofit corporation, CTN also operates the California Telehealth Resource Center with funding from the Health Resource and Services Administration (“HRSA”) at the Department of Health and Human Services (“HHS”) to provide technical and programmatic assistance and training to healthcare providers in California. CTN is today fostering access to advanced telecommunications infrastructure across California that allows rural and urban communities access to a broad range of technology-enhanced services to improve the quality of healthcare. CTN’s goal is to bridge the growing divide between urban and rural, and between served and underserved, by connecting over 1,000 California healthcare providers over the next three years to a state- and nation-wide broadband network dedicated to healthcare.

NETC is a regional non-profit healthcare consortium formed in 2007 in response to the creation of the Pilot Program. NETC was the recipient of the largest single Pilot Program funding

award (approximately \$24.6 million). Using Pilot Program and now HCF funding, NETC operates a 120 Gbps network with dual, redundant core sites in Maine and New Hampshire, managing connectivity for 318 healthcare providers in Maine, New Hampshire, and Vermont. NETC facilitates the provision of private network and commodity Internet services, as well as access to the Internet2 backbone, for its participating members over a high-speed, scalable, quality-of-service network.

HIEM is a not-for-profit collaboration of HCPs in communities across northwest and north central Montana that was established to develop and share electronic health information and to improve patient care throughout a shared service area. HIEM successfully utilized one-time disbursements through the Pilot Program to deploy 425 miles of fiber backbone to non-profit HCPs across a shared service area that reaches the Blackfeet Indian Reservation and features difficult terrain, harsh and unpredictable weather, sparse population, and spans territory on both sides of the Continental Divide. HIEM's partnerships with local private carriers have supported broadband improvements in local communities and enabled HIEM participants to have scalable access to a future-proofed 10 Gbps fiber backbone.

UTN is a network established by the University of Utah to link patients to HCPs throughout Utah and into Wyoming and Idaho using leading edge telecommunications technology. Its members and partners include non-profit rural hospitals, community health centers, HCPs on the Navajo reservation in southeast Utah, the majority of local health departments in the state, Intermountain Healthcare, a large integrated hospital network, and University of Utah Health Sciences Center, the only academic medical center in the Intermountain West. Utah's rugged geography and long distances contribute to a marked disparity in the availability of specialty-care between rural and urban populations in the state. Through participation in the RHC

Telecommunications Program starting in 1999, the Pilot Program, and soon the HCF, UTN has increased the availability of broadband connectivity dedicated for the adoption of telehealth services, use of health information technology, and in support of the mission and operations of its HCPs across the state. In 2014, UTN merged operations with the Utah Education Network, which connects all public education and libraries throughout Utah, to form the Utah Education and Telehealth Network, with the goal of a single state-wide network for healthcare and education.

CoTN was formed in 2008 in order to utilize Pilot Program funding to establish a dedicated health care network in Colorado. CoTN became fully operational during the Pilot Program and was the first consortium in the nation to migrate to the HCF in 2013. CoTN presently facilitates subsidized broadband connectivity to 210 behavioral and physical health care sites in urban and rural communities throughout Colorado. CoTN works in partnership with health information technology entities and advances policy goals and health outcomes to rural and underserved communities throughout the state. CoTN has also launched a statewide image exchange service, the Colorado Imaging Exchange, providing a vender-neutral archive for storage and retrieval of clinical and diagnostic images. CoTN's goal is to further maximize access to health care services through the statewide adoption of telehealth services as an integral component of the Colorado health care delivery system.

SWTAG is a decentralized consortium of HCP broadband networks intended to create an infrastructural platform to effectively coordinate clinical services, patient and provider education, and workforce development/training programs among participating healthcare entities in the network. SWTAG is a Pilot Program awardee with the goal of enhancing access to advanced telecommunications and information services for all healthcare providers. Through their participation in the SWTAG, eight health systems across New Mexico and into Arizona have

received expanded access through upgraded equipment and services. SWTAG serves as the administrative coordinator for health care entities/stakeholders and as the intermediary between participating HCPs and the Universal Services Administrative Company (“USAC”).

II. THERE IS AN UNDENIABLE PUBLIC NEED FOR BROADBAND ENABLED HEALTH CARE TO LEVERAGE LIMITED HEALTH CARE RESOURCES TO MEET RISING DEMAND FOR CARE ESPECIALLY IN RURAL AMERICA

When it enacted the Telecommunications Act of 1996, Congress gave the Commission broad authority to address the health disparities that exist between the nation’s rural and urban areas.² First, Congress mandated that telecommunications carriers provide telecommunications services for health care purposes to rural HCPs at rates that are “reasonably comparable” to rates in urban areas.³ In doing so, Congress intended to diminish the rural-urban health disparity by facilitating increased use of telemedicine.⁴ In addition, in Section 254(h)(2)(A), Congress directed the Commission to develop rules to enhance access to “advanced telecommunications and information services” to health care providers. This directive gives the Commission additional authority to expand health care providers’ access to broadband-enabled services and allows the Commission to take additional measures to improve telemedicine services in both rural and urban areas.⁵

The Commission under this authority has attempted to promote health equality by

² According the National Institutes of Health (“NIH”), health disparities refer to the “differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups [in the United States].” NIH TRANS WORKING GROUP ON HEALTH DISPARITIES. NIH HEALTH DISPARITIES STRATEGIC PLAN AND BUDGET, FISCAL YEARS 2009-2013 (2010), <http://www.nimhd.nih.gov/documents/NIH%20Health%20Disparities%20Strategic%20Plan%20and%20Budget%202009-2013.pdf>.

³ 47 U.S.C. § 254(h)(1)(A).

⁴ See H.R. REP. NO. 104-458, at 133 (1996).

⁵ The Commission has also recognized the broad scope of authority granted by section 254(h)(2)(A) in the E-rate context. See, e.g., *Modernizing the E-rate Program for Schools and Libraries, Connect America Fund*, 29 FCC Rcd 15538, 15555-56 (2014) (“*Second E-rate Modernization Order*”).

supporting the increased adoption and use of telemedicine and telehealth. In 1997, the Commission established the RHC Telecommunications Program to ensure rural HCPs pay no more for their telecommunications services than their urban counterparts by mandating that telecommunications providers offer discounted rates to rural HCPs in the amount of the “rural-urban differential.”⁶ In 2006, the Commission established the Pilot Program to bring the benefits of “innovative telehealth and telemedicine services” to the nation’s rural areas where the need for those benefits is “most acute.”⁷ Finally, in 2012, it created the HCF to improve broadband connectivity to HCPs, especially in rural areas.⁸

Despite these and other critical governmental programs, rural Americans continue to experience significant health disparities.⁹ Rural residents have higher incidence of disease and disability, increased mortality rates, lower life expectancies, and higher rates of pain and suffering than those in urban areas.¹⁰ Rural risk factors for health disparities include geographic isolation, lower socio-economic status, higher rates of health risk behaviors, and limited job opportunities.¹¹ Studies have shown that rural residents are older, poorer, have fewer physicians to care for them, and have greater transportation difficulties reaching physicians and HCPs.¹² Some of these factors,

⁶ *Rural Health Care Support Mechanism*, 27 FCC Rcd 16678, 16684 (2012) (“*HCF Order*”) (citing *Federal-State Bd. on Universal Service*, 12 FCC Rcd 8776, 9093 (1997)).

⁷ *HCF Order*, 27 FCC Rcd at 16684.

⁸ *See id.* at 16680.

⁹ *See, e.g.*, MICHAEL MEIT ET AL., RURAL HEALTH REFORM POLICY RESEARCH CENTER, THE 2014 UPDATE OF THE RURAL-URBAN CHARTBOOK (Rural Health Reform Policy Research Center), Oct. 2014, at 1-5, <https://ruralhealth.und.edu/projects/health-reform-policy-research-center/pdf/2014-rural-urban-chartbook-update.pdf>.

¹⁰ *See* Rural Assistance Center, *Rural Health Disparities, Introduction 1*, <https://www.ruralhealthinfo.org/topics/rural-health-disparities> (last visited Nov. 29, 2015); CAROL ADAIRE ET AL., HEALTH STATUS AND HEALTH CARE ACCESS OF FARM AND RURAL POPULATIONS (USDA Economic Research Service Bulletin No. 57), Aug. 2009, at i, http://www.ers.usda.gov/media/155453/eib57_1_.pdf.

¹¹ *See* Rural Assistance Center, *supra* note 10, at 1.

¹² *See id.*

and their effects in rural America, are listed below.

- Rural areas are home to a higher proportion of the elderly. Individuals 65 years and over constitute approximately 14.5% of the American population. In rural areas, the percentage of the population 65 years and over is 20%.
- Rural Americans make up nearly 25% of the nation's population, but only 10% of the nation's physicians practice in rural America.¹³
- Rural residents are less likely to have employer-provided health care coverage or prescription drug coverage, and the rural poor are less likely to be covered by Medicaid benefits than their urban counterparts.¹⁴
- Death and serious injury accidents account for 60% of total rural motor vehicle accidents versus only 48% of urban accidents.¹⁵
- Although only one-third of all motor vehicle accidents occur in rural areas, two-thirds of the deaths attributed to these accidents occur on rural roads.¹⁶
- Rural residents are nearly two times more likely to die from unintentional injuries other than motor vehicle accidents than are urban residents. Rural residents are also at a significantly higher risk of death by gunshot than urban residents.¹⁷
- Rural residents tend to be poorer. On the average, rural per capita income is \$7,417 lower than in urban areas, and rural Americans are more likely to live below the poverty level.¹⁸
- Rural residents are more likely to be unemployed, have lower rates of post-secondary education, and have lower median household incomes than urban residents.¹⁹
- Healthcare services available in rural areas are less likely to include specialized and highly sophisticated or high-intensity care.²⁰

¹³ See THE TEXAS A&M UNIVERSITY SYSTEM HEALTH SCIENCE CENTER, SCHOOL OF RURAL PUBLIC HEALTH, SOUTHWEST RURAL HEALTH RESEARCH CENTER, RURAL HEALTHY PEOPLE 2010: A COMPANION DOCUMENT TO HEALTHY PEOPLE 2010, VOLUME 1 45 (Larry Gamm et al, eds. 2003), <https://sph.tamhsc.edu/srhc/docs/rhp-2010-volume1.pdf>.

¹⁴ See *id.* at 19.

¹⁵ See National Rural Health Association, *What's Different about Rural Health Care?* 2, <http://ruralhealthweb.org/go/left/about-rural-health>.

¹⁶ See THE TEXAS A&M UNIVERSITY SYSTEM HEALTH SCIENCE CENTER, *supra* note 13, at 77.

¹⁷ See National Rural Health Association, *supra* note 15, at 1.

¹⁸ See *id.* at 1.

¹⁹ See *id.* at 5.

²⁰ See *id.* at 4.

- There are 2,157 Health Professional Shortage Areas in rural areas compared to 910 in urban areas.²¹
- Abuse of alcohol is a significant problem among rural youth.²²
- Occurrence rates for cerebrovascular disease and hypertension are higher in rural than urban areas.²³
- The suicide rate among rural men is significantly higher than in urban areas.²⁴
- Medicare payments to rural hospitals and physicians are dramatically less than those to their urban counterparts for equivalent services. This correlates closely with the fact that more than 470 rural hospitals have closed in the past 25 years.²⁵
- Medicare patients with acute myocardial infarction (“AMI”) who were treated in rural hospitals were less likely than those treated in urban hospitals to receive recommended treatments and had significantly higher adjusted 30-day post AMI death rates from all causes than those in urban hospitals.²⁶
- Rural residents are more dependent on public transportation. However, transportation options are fewer, as only 60% of rural counties have public transportation available.²⁷
- Rural residents have greater transportation difficulties reaching health care providers, often travelling great distances to reach a doctor or hospital.²⁸

As these statistics show, the Commission’s efforts at bridging the rural-urban health divide are being overwhelmed by demographic, regulatory, and economic pressures. In addition, small rural hospitals in America are in crisis, facing a combination of challenges that threaten their

²¹ See National Rural Health Association, *supra* note 15, at 1.

²² See *id.*

²³ See *id.*

²⁴ See THE TEXAS A&M UNIVERSITY SYSTEM HEALTH SCIENCE CENTER, *supra* note 13, at 165.

²⁵ See National Rural Health Association, *supra* note 15, at 2.

²⁶ See *id.* at 2.

²⁷ See Rural Assistance Center, *supra* note 10, at 5.

²⁸ See National Rural Health Association, *supra* note 15, at 2.

continued viability.²⁹ Nationwide, 59 rural hospitals have closed since 2010.³⁰ The number of annual closures has increased each year during that period, with 13 rural hospitals shutting down so far in 2015 alone.³¹ The National Rural Health Association has identified 283 more rural hospitals as being on the brink of closure.³² More than a third of rural hospitals were found to have operated at a deficit in 2013.³³

Some of the challenges rural hospitals face are inherent in being rural. Because they are smaller facilities, they typically cannot take advantage of economies of scale that can reduce costs.³⁴ In addition, attracting top talent is challenging in rural communities, which means that rural hospitals must pay more to land healthcare professionals.³⁵ Rural hospitals also serve “some

²⁹ See Jayne O'Donnell and Laura Ungar, *Rural Hospitals in Critical Condition*, USA TODAY, Nov. 12, 2014, <http://www.usatoday.com/story/news/nation/2014/11/12/rural-hospital-closings-federal-reimbursement-medicaid-aca/18532471/>; see also Guy Gugliotta, *Rural hospitals, beset by financial problems, struggle to survive*, WASH. POST, Mar. 15, 2015, <http://wapo.st/1BHy5re> (“[R]ural hospitals . . . suffer from multiple endemic disadvantages that drive down profit margins and make it virtually impossible to achieve economies of scale. These include declining populations; disproportionate numbers of elderly and uninsured patients; the frequent need to pay doctors better than top dollar to get them to work in the hinterlands; the cost of expensive equipment that is necessary but frequently underused; the inability to provide lucrative specialty services and treatments; and an emphasis on emergency and urgent care, chronic money-losers.”).

³⁰ See North Carolina Rural Health Research Program, University of North Carolina, *59 Rural Hospital Closures: January 2010 – Present* 1, <https://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/> (last visited Nov. 29, 2015).

³¹ See *id.*; see also O'Donnell and Unger, *supra* note 29, at 1 (“Since the beginning of 2010, 43 rural hospitals — with a total of more than 1,500 beds — have closed, according to data from the North Carolina Rural Health Research Program. The pace of closures has quickened: from 3 in 2010 to 13 in 2013, and 12 already this year. Georgia alone has lost five rural hospitals since 2012, and at least six more are teetering on the brink of collapse”); Coshandra Dillard, *Dying rural hospitals affect most vulnerable*, TYLER MORNING HERALD, Feb. 14, 2015, <http://www.tylerpaper.com/TP-News+Local/213794/dying-rural-hospitals-affect-most-vulnerable> (profiling closing of East Texas Medical Center in Gilmer, TX); Alex Smith, *Facing Layoffs And Closures, Rural Hospitals Push For Medicaid Expansion*, KCUR Kansas City Public Radio, Feb 11, 2015, <http://hereandnow.wbur.org/2015/02/24/rural-hospitals-medicaid> (profiling closing of Sac-Osage Hospital in Osceola, Missouri).

³² See Paul Demko, *As rural hospitals struggle, solutions sought to preserve healthcare access*, MODERN HEALTHCARE MAGAZINE, May 16, 2015, at 2, <http://www.modernhealthcare.com/article/20150516/MAGAZINE/305169959>.

³³ See *id.*

³⁴ See *id.* at 4.

³⁵ See *id.*

of the sickest and poorest” patient populations in the nation and these closings are reducing the availability of emergency and other care to these populations, resulting in avoidable deaths and medical complications.³⁶ Managing care for these “sickest and poorest” is a particular challenge for rural hospitals, and readmission penalties associated with their care are one factor in the perfect storm these hospitals are facing.³⁷ Moreover, all rural health care providers – and many other safety net providers³⁸ – face the same kinds of pressures being faced by hospitals.

The Commission must continue to find ways to help health care providers serving rural residents, including rural hospitals, many of which are the intended beneficiaries of the RHC program. Indeed, if the crisis among rural hospitals demonstrates anything, the apparent underutilization of the RHC program³⁹ cannot be attributed to a lack of need for RHC support among intended program beneficiaries. The following sections of this petition suggest ways the Commission could work within its authorization from Congress to continue to address urban/rural

³⁶ See O’Donnell and Unger, *supra* note 29, at 1.

³⁷ See Dillard, *supra* note 31 (“The Affordable Care Act was designed to provide more access to health care, helping rural hospitals stay afloat. However, new penalties for performance-based measures, such as re-admission rates, stifled already strapped hospitals.”).

³⁸ “Safety net providers” are generally considered health care providers that “offer care to patients regardless of their ability to pay for services; and a substantial share of their patient mix are uninsured, Medicaid, and other vulnerable patients. Certain types of health care providers such as public hospitals, community health centers, rural clinics, and local health departments are generally viewed as ‘core’ safety net providers. Specialized programs, such as AIDS and school-based clinics, are also considered to be core providers.” See Laura Summer, M.P.H., *The Impact of the Affordable Care Act on the Safety Net*, Washington, Academy Health (2011), at 1 (citations omitted), https://www.academyhealth.org/files/FileDownloads/AHPolicybrief_Safetynet.pdf.

³⁹ The \$279 million in funding requests for FY 2014 (as of June 30, 2015) remains well below the \$400 million programmatic cap for the RHC program. See 47 C.F.R. § 54.675(a). FY 2014 requests (as of June 30, 2015) represented an 11% year-over-year rate of growth from FY 2013’s \$250 million in requests (as of June 30, 2014). See USAC Rural Health Care Funding Information Archive, <http://usac.org/rhc/healthcare-connect/funding-information/funding-information-archive.aspx>. The 11% year-over-year rate of growth is consistent with growth rate in previous years. See, e.g., *USAC 2014 Annual Report*, at 10 (RHC program actual *disbursements* grew from \$86 million in CY 2010 to \$137 million in CY 2014, an average \$12.6 million per year increase), <http://www.usac.org/res/documents/about/pdf/annual-reports/usac-annual-report-2014.pdf>. Note also that funding requests as of June 30 each year significantly exceed actual funding commitments for that year, which in turn exceed actual program disbursements.

health disparities by supporting universal deployment of advanced telecommunications and information services to health care providers.

III. THE COMMISSION SHOULD FURTHER MODERNIZE THE RURAL HEALTH CARE PROGRAM TO FACILITATE MORE FULLY THE BROADBAND-ENABLED TRANSFORMATION OF THE HEALTHCARE SECTOR

Through the Pilot Program and the HCF, the Commission has taken major steps to ensure the RHC program kept pace with the rapid changes underway in the healthcare and telecommunications industries, reshaping the RHC programs to try to keep rural residents from being further left behind. Petitioners have all witnessed first-hand the benefits and impacts of these policy changes in the communities we serve – in lives saved, transportation and care costs reduced, and health outcomes and quality of life improved. The Commission deserves much praise for these efforts. But the work addressing disparities of access to care is far from done, especially in the face of the accelerating demographic and economic trends noted above.

In this section, we focus on the ways the HCF program is falling short of meeting the needs of rural HCPs – particularly the limits of the 65% HCF subsidy. Petitioners (other than the SHLB Coalition) are consortia that participated in the Pilot Program. As the Pilot Program has ended, each has migrated (or is migrating) their HCP participants to the HCF – with a resulting reduction in the subsidy from 85% to 65%. First-hand experience shows this reduction has caused rural HCPs to delay needed broadband upgrades, reduce bandwidth orders, or forego program participation altogether. We discuss these impacts below. However, in considering how the RHC program can continue to address the disparities of affordability and access in rural areas, the subsidy level is only one of several components of the HCF and larger RHC program that needs improvement. We consider specific proposed changes to the both the HCF and the larger RHC program in Sections IV and V, respectively.

A. Rural Health Care Providers Face the Highest Costs for Connectivity and Are Least Able to Afford the Level of Connectivity They Need

Rural HCPs tend to have the most expensive last-mile connectivity and tend to be least able to afford that connectivity – they are thus the most affected by the HCF’s 35% match requirement. HCPs that cannot afford the 35% match have three options: leave the consortium (and the HCF) and seek a higher subsidy for a point-to-point connection through the Telecommunications Program (HCF consortium participants are not permitted to receive the Telecommunications Program’s urban-rural difference discount⁴⁰); seek match funding from public sources; or forego the levels of connectivity they need. Unfortunately, in Petitioners’ experience, this last option is the most common.

The high cost of rural connectivity is reflected in both higher monthly recurring costs and substantially higher one-time costs (special construction). HCPs that are the most rural struggle meeting the 35% match with both monthly recurring and one-time costs.⁴¹ The inability to afford the one-time costs associated with needed service upgrades is a continuing challenge for rural HCPs that lack access to quality broadband.⁴² Rural HCPs may also simply decline to obtain

⁴⁰ See *HCF Order*, 27 FCC Rcd at 16717 n.236 (“Although we adopt a flat-rate discount approach here due to the substantial benefits of that approach, we continue the availability of support based on an urban/rural differential . . . under the existing Telecommunications Program for those health care providers that choose to remain in that program.”).

⁴¹ In Colorado for example, Telluride Medical Center (rural San Miguel County) is the only 24-hour emergency, Level 5 Trauma Care Center in this very mountainous region. Telluride Medical Center was not able to upgrade facilities during the Pilot Program and so had access only to copper facilities offering 4.5 Mbps service. After the HCF program was launched, the 35% match requirement made initiating any significant service upgrade cost prohibitive. A service upgrade required an 80 foot trench dug to bring fiber to the building at a one-time cost of over \$12K. Under the HCF, the 35% required match was more than \$4K, exceeding funding available that year. Telluride Medical Center could have afforded a 15% match payment. To avoid a year delay installing this critical connection, CoTN was able to locate third-party funding to help Telluride. The Memorial Hospital Clinic in Craig Colorado (rural Moffat County) faced a similar problem, needing a 35-foot trench to receive a 40 Mbps fiber connection. The clinic could have afforded a 15% match for the one-time cost of over \$10K but could not afford 35%.

⁴² For example, in Utah, Utah Navajo Health Systems, Inc. (“UNHS”) operates four RHC eligible Community Health Centers near and in the southeastern portion of the Utah strip of the Navajo Reservation in San Juan County: Montezuma Creek, Monument Valley, Navajo Mountain, and Blanding. Comprehensive services provided by the clinics include medical, dental, behavioral health and radiology. A variety of telehealth services, a medication

needed connectivity, even in cases where the costs may seem relatively modest.⁴³ Petitioners strongly believe – and the Commission’s own policy pronouncements suggests – that the HCF should be helping ensure rural HCPs obtain needed upgrades to their connectivity.

dispensing system that reduces medication errors, an electronic medical record and other critical clinical and operations processes are utilized by using UTN’s microwave network on the Navajo Reservation.

Covering 7,933 square miles, Utah’s San Juan County is 24th largest county geographically in all 50 states, and the largest with a population of less than 2 persons per square mile. Many homes lack access to the Internet. The UNHS clinics are spread out over a large portion of the county and are more than 300 miles from Salt Lake City, a 6+ hour drive each way. Although the RHC program helps support the substantial monthly costs for point-to-point microwave connectivity to these locations, because these connections are point-to-point, there are fewer opportunities for other health care facilities to share connections and costs.

In exploring the possibility of bringing fiber to this area, fiber placement costs have been estimated at \$3.4 million to connect Monument Valley and Montezuma Creek to Blanding, Utah, home to the nearest hospital. This estimate excludes multiple associated costs such as engineering, environmental studies, construction challenges, permit fees, easements, right-of-way fees, terminating equipment, last mile, and other costs. The costs and limitations faced by health care providers in this remote county are incomparable to affordable access available to their urban counterparts.

Another example in Utah is the Manila Clinic in rural Daggett County. Uintah Basin Healthcare serves patients throughout a three county area in eastern Utah (Daggett, Duchesne and Uintah Counties) covering 8,478 square miles. Uintah Basin Medical Center and four offsite clinics (Altamont, Duchesne, Vernal and Tabiona) connect into UTN’s network. A fifth clinic, Manila Clinic, does not.

The Manila Clinic, the only health care facility in Daggett County (population 1,127), *was included in UTN’s Pilot Program RFPs but failed to elicit any bids from service providers*. It currently limps by on a DSL circuit providing 3-4 Mbps down/768 Kbps up. The clinic is 60 miles or a 1½ hour drive over a mountain pass to the nearest town (Vernal), 90 miles to Uintah Basin Medical Center, and 169 miles (3 hours) to Salt Lake City. It is staffed by a sole Physician Assistant who has great need but severely limited capacity to access or transmit pertinent medical information. As part of Uintah Basin Healthcare, he uses their remote-hosted cloud-based state-of-the-art EMR. However, it requires bi-directional bandwidth to refresh so bogs down every time he enters data. X-rays taken at the clinic can be digitized but not successfully transmitted. Uintah Basin services available to their other remote clinics include access to a CDC Analyzer for labs, an interface to pharmacy services, and the opportunity to receive specialty services via telehealth. The Manila Clinic has a telemedicine cart in anticipation of improved bandwidth but hasn’t been able to use it to date.

Bringing fiber infrastructure to Manila over a mountain pass and difficult terrain has been estimated to cost more than \$4 million. This is a rough estimate of fiber placement only and excludes multiple associated costs such as engineering, environmental studies, construction challenges, permit fees, easements, right-of-way fees, terminating equipment, last mile, monthly recurring charges and other costs. The costs and challenges to bring fiber to Daggett County are incomparable to similar options readily available to urban areas.

⁴³ For example, in California Community Health Centers of the Central Coast includes a network of small clinics and hospitals in both rural and non-rural settings. Of the fifteen sites participating in CTN during the Pilot Program with an 85% subsidy, ten dropped out of the HCF program because of affordability concerns. This included one rural location that could not justify the modest monthly cost of a T1 (1.5 Mbps) connection, \$150/month after the HCF subsidy.

Over five years ago, the *National Broadband Plan* recommended minimum bandwidth for HCPs of 10 Mbps.⁴⁴ Those minimum bandwidth requirements have increased since that time. Indeed, Goal No. 4 of the *National Broadband Plan* was for “affordable access to at least 1 gigabit per second broadband service to anchor institutions such as schools, hospitals and government buildings.”⁴⁵ The Commission in 2015 redefined its 2010 definition of “advanced telecommunications capability” for *residential* subscribers to at least 25 Mbps down/3 Mbps up (a substantial increase from the previous standard of 4 Mbps down/1 Mbps up).⁴⁶ In Petitioners’ experience, symmetric 20 Mbps (20 Mbps down/20 Mbps up) is the minimum required bandwidth today for a small health care provider with more than one practicing physician.⁴⁷ Larger health care providers with a higher number of practicing physicians need even greater levels of connectivity. Yet a significant number of our rural participants have connections of 5 Mbps or less, with many still using legacy copper rather than modern broadband.⁴⁸ Many HCPs either do not have access to modern broadband or cannot afford the costs (recurring or non-recurring) to

⁴⁴ See Federal Communications Commission, *Connecting America: The National Broadband Plan* 210-211 (rel. Mar. 16, 2010) available at <https://www.fcc.gov/national-broadband-plan>. (recommending at least 10 Mbps for any health care provider with more than one practicing physician) (“*National Broadband Plan*”).

⁴⁵ See *id.* at XIV.

⁴⁶ See *Inquiry Concerning the Deployment of Advanced Telecommunications Capability to All Americans in a Reasonable and Timely Fashion, and Possible Steps to Accelerate Such Deployment Pursuant to Section 706 of the Telecommunications Act of 1996, as Amended by the Broadband Data Improvement Act*, 30 FCC Rcd 1375, 1377 (2015).

⁴⁷ For example, since going live in November 2012, NETC has processed requests to upgrade the amount of initially requested bandwidth for 230 of its 318 sites (72%). NETC’s current mean bandwidth is 20 Mbps (current average is 105 Mbps.)

⁴⁸ For example, CoTN currently has 82 of 210 member sites under 10 Mbps (39%). Of those, 77 have 5 Mbps and 5 have 7.5 Mbps. NETC currently has 36 of 318 sites (11%) under 10 Mbps and 125 sites (40%) at 10 Mbps or under. CTN currently has 128 of 251 sites (51%) using T-1 connections (1.5 Mbps). Cf. Connect2HealthFCC Task Force, *Broadband-Health-Connectivity Snapshot (Phase 1)*, map of Virginia (noting, among other things, “approximately 20 of Virginia’s 95 counties (21%) have common download speeds of <9Mbps. Lower download speed areas are not confined to areas of lowest population (rural).”), <https://www.fcc.gov/maps/connect2health-va-map>. Petitioners applaud this type of analysis, however thus far the effort seems focused on consumer access to health data rather than on HCP access to affordable modern broadband.

upgrade to 20 Mbps, much less to obtain redundant connectivity necessary to protect against downtime for critical cloud-hosted services.

Indeed, physically diverse redundant broadband connectivity has never been more critical to health care. Hospital data including electronic medical records are increasingly hosted remotely. In such an environment, network outages quickly cripple a HCP's ability to provide patient care. This is an emerging reality the Commission must recognize in determining appropriate goals and objectives for the HCF. Again, the ability to afford physically diverse broadband disproportionately impacts rural providers with the most expensive connections and the smallest patient populations from which to recover costs.

Finally, in Petitioners' experience, the lower the HCF subsidy, the less likely sites are to participate in a consortium. Fewer consortium participants causes fees for remaining participants to be greater than they would otherwise be, making it more difficult to attract new participants. An increased subsidy would better reflect the reality of rural HCP needs and allow both individual participants and the consortia as a whole to devote more resources to telemedicine adoption and use, and ultimately, patient care.

B. The 65% HCF Subsidy Does Not Adequately Support Rural Broadband Deployment

The Commission has been rightly praised for adopting flexible policies intended to support the deployment of new network infrastructure to anchor institutions where it proves – through the competitive bidding process – to be more cost effective. As the Commission explained: “[W]hen [service] providers are unable to build a business case to construct fiber in rural areas, last-mile fiber self-construction may be the only option for a HCP to get the required connectivity.”⁴⁹

⁴⁹ See *HCF Order*, 27 FCC Rcd at 16712 (footnote omitted).

Recognizing that rural anchor institutions continue to fall behind the digital divide, E-rate Modernization⁵⁰ built on innovations first adopted in the Pilot Program and the HCF to support fiber deployment.⁵¹

Unfortunately, the HCF appears to have had limited success stimulating new broadband deployments – at least to date. HIEM’s experience may be reflective of the obstacles potential projects are facing. While HIEM was able to leverage the Pilot Program 85% subsidy to support deployment of over 400 miles of new fiber in a very rural and remote area of the country, given the average cost per mile for new rural fiber infrastructure, the 15% match under the Pilot Program represented a significant hurdle.

HIEM’s proposed network design for the Pilot Program was to create a fiber ring that would deliver full physical route redundancy. However, only the first part of the HIEM project was funded and completed through the Pilot Program. HIEM anticipated using the HCF to complete the ring and to finally establish physical redundancy. However, notwithstanding HIEM’s experience as a successful consortium and in constructing the first part of its network, the HCF’s 35% match requirement has proven too great a hurdle for HIEM and its participating rural hospitals. HIEM, therefore, has no plans to seek bids for further construction under current HCF rules.⁵²

To help determine how widespread these obstacles are, Petitioners respectfully request that the Commission direct USAC to report the number of fiber projects proposed (Form 461

⁵⁰ See *Second E-rate Modernization Order*, 29 FCC Rcd at 15549.

⁵¹ See 47 C.F.R. § 54.636 (allowing HCP constructed and owned network facilities), § 54.638 (allowing upfront payments for special construction charges in excess of \$5000).

⁵² In addition, CTN is considering several fiber builds in remote and unserved areas of California. In none of the cases being looked at are the rural HCPs that will be served a viable source for the 35% match requirement. CTN is looking at state funding sources and potential excess capacity as potential sources for the required match funding.

approved), funded (Form 462 approved), under construction, or completed in the HCF. Publication of this information by USAC would allow commenters an opportunity to describe the obstacles such projects face, including the difficulty of the match requirement and challenges partnering with carriers in making such projects successful. (We propose specific HCF rule changes below that we believe will help HCPs obtain fiber connectivity, whether self-constructed or provided by existing providers).

C. **The HCF Does Not Adequately Promote and Sustain Open Consortia Which Are Needed to Ensure Rural Safety Net Providers Can Benefit from Broadband Enabled Care Models**

The Commission has recognized the benefits of consortia to rural HCPs⁵³ and adopted rules in the HCF to encourage consortia formation. It is unclear, however whether the HCF has mostly stimulated formation of *closed consortia* consisting only of affiliated HCPs (*e.g.*, HCPs under common ownership). While Petitioners do not question the value of such closed consortia, regional or statewide consortia that are open to all HCPs (“open consortia”) offer significant additional public policy benefits. These benefits include ensuring small or unaffiliated safety-net providers have access to affordable broadband. In addition, by supporting the implementation and use of telehealth and telemedicine among their participants, large open consortia also support the adoption of broadband-enabled care models – which are crucial to realizing the actual benefits of broadband access. This support for adoption is critically valuable to small and unaffiliated safety-net providers, many of whom need help realizing the full value of their broadband connectivity. (Of course, consortia do not receive RHC support to provide these additional services.)

⁵³ See *HCF Order*, 27 FCC Rcd. at 16686 (“The Pilot Program [which consisted solely of consortia] helped participating HCPs create local, regional, and even state-wide health care broadband networks, resulting in improved quality and lower costs of health care in rural areas.”).

Large open consortia can also provide standardized or “postalized” broadband rates to participants, which specifically helps small and rural HCPs. Postalization provides a standard monthly recurring rate for each level of bandwidth offered throughout the consortium, regardless of geographic location. While one-time special construction costs may still be necessary in certain situations, bidders to large open consortia can propose rates that reflect some cross-subsidy where the price paid by large urban hubs with high-bandwidth needs can help lower the pre-subsidy price for small rural providers. Such a structure can only be sustained, however, where the combination of rates and subsidy are sufficiently attractive to ensure the participation of large urban hub hospitals.

Despite these unique and important public policy benefits, it appears that few new open consortia have been established under the HCF. Challenges faced by existing large, open consortia – including several Petitioners – may explain why. Large consortia have substantial administrative costs, which are typically funded by membership fees. These administrative costs are associated with competitive bidding, vendor evaluation and selection, contracting, interfacing with USAC and USAC systems, network management and operations, billing management, and outreach and support.

While the HCF does not currently support consortium administrative costs, the amount of HCF subsidy directly affects consortia by making it less attractive to join in comparison to available alternatives. HCPs that drop out of a consortium, because they cannot afford the 35% HCF match (plus the consortium participation fee), are no longer supporting the administrative costs of the consortium. Fewer participants means greater consortium fees for remaining participants – creating a potentially negatively cycle of higher costs and lower participation. Conversely, consortia sustainability is aided by growth in the number of participants. All

Petitioners have found the 65% HCF subsidy (down from the 85% subsidy in the Pilot Program) has impeded growth – with sites dropping off, declining to join, or reducing (or declining to increase) bandwidth.

The Commission should evaluate whether its policy goals for consortia are being met under current HCF rules.⁵⁴ In doing so, it should consider not just the number of consortia that have been formed under the HCF, but the different types of consortia and the unique public policy benefits open consortia offer to small and unaffiliated safety-net providers. Petitioners propose specific HCF and RHC program rule changes below that will better foster the development of consortia, but especially large open consortia.

IV. TO HELP REDUCE DISPARITIES IN THE AVAILABILITY AND AFFORDABILITY OF BROADBAND FOR RURAL HEALTH CARE, THE COMMISSION SHOULD CONSIDER CHANGES TO THE HEALTHCARE CONNECT FUND

The following discussion provides some specific recommendations of rule changes that the Commission should adopt to improve the HCF.

A. Increase the Discount Percentage in the Healthcare Connect Fund

The Commission should consider increasing the flat rate discount percentage in the HCF program, especially for rural⁵⁵ and perhaps frontier areas.⁵⁶ Recognizing the unique importance

⁵⁴ See *HCF Order*, 27 FCC Rcd. at 16697 (“We adopt as our second goal [for the HCF] fostering development and deployment of broadband health care networks, particularly networks that include HCPs that serve rural areas. This goal is consistent with the statutory objective of section 254(h), which is to enhance access to telecommunications and advanced services, especially for health care providers serving rural areas. As discussed above and in the Pilot Evaluation, broadband health care networks also improve the quality and lower the cost of health care and foster innovation in telehealth applications, particularly in rural areas.”) (footnotes omitted).

⁵⁵ For example, the E-rate program discount matrix provides an additional 10% subsidy in some cases for rural. See 47 C.F.R. § 54.505(c).

⁵⁶ The USDA Economic Research Center defines and tracks “Frontier and Remote Areas” that may be useful for this purpose. “The 2010 Frontier and Remote Area (FAR) codes provide a statistically-based, nationally-consistent, and adjustable definition of territory in the U.S. characterized by low population density and high geographic remoteness.” See <http://www.ers.usda.gov/data-products/frontier-and-remote-area-codes.aspx>. We do not propose replacing the

of consortia, the Commission should also consider an increase in the discount percentage for consortia only. Such an increase will:

- Help struggling rural HCPs including struggling rural hospitals afford the broadband connectivity at the bandwidth levels they need;
- Make new rural fiber deployment more likely in places where it is desperately needed;
- Help offset administrative and network management costs that remain a barrier to the robust development and growth of sustainable open consortia, which are positioned and committed to supporting small and unaffiliated safety-net providers.

Petitioners believe restoration of the 85% discount available in the Pilot Program is warranted given the challenges in establishing and sustaining open consortia, driving the investments in network infrastructure that are still needed, and ensuring the most rural and financially challenged HCPs can afford the minimum bandwidth levels they need to fully embrace broadband-enabled care. In addition, higher subsidies often available through the Telecommunications Program also may discourage participating in HCF consortia.⁵⁷

B. Make Public-Private Partnership Easier for Broadband Projects

As noted, the HCF appears to have spurred the development of few if any new broadband deployments. While increasing the HCF discount percentage from 65% will address part of the reason for this, the Commission should consider other rule changes to encourage cost effective broadband deployments. Petitioners recognize that broadband deployments where HCPs own the supported facilities will be infrequent, but experience has shown the option to own broadband

FCC's definition of rural with the USDA FAR criteria. Rather, sites that fall into the USDA FAR classification would qualify for an additional subsidy.

⁵⁷ Although in 2012 the average discount rate for the Telecommunications Program was around 69%, the Commission noted that in Alaska the discount rate was closer to 98% – reflective of the unique conditions there. *See HCF Order* 27 FCC Rcd 16719 n.251. While the average Telecommunications Program subsidy may be instructive, it is a somewhat arbitrary measure that does not reflect the specific conditions especially facing the most rural HCPs.

facilities keeps bids from existing providers low. Indeed, several HCP-owned projects have cost effectively delivered important investments in broadband capable of meeting the demands of health care. Experience has also shown that not only can HCP-owned broadband networks benefit – rather than undermine – local private service providers, partnerships with local providers are critical for the success of such projects. Such partnerships are made possible with HCP-owned excess capacity (pursuant to 47 C.F.R. § 54.633(d)) that can be leased to or swapped with existing providers.

Because successful public-private partnerships are critically important to the success and sustainability of quality broadband deployments for healthcare, HCF rules should be modified to encourage such partnerships. Specifically, the Commission should consider deleting or substantially modifying section 54.633(d)(5) which prohibits the entity constructing HCP-owned facilities from leasing excess capacity. Given the substantial cost to construct new facilities in remote and rural areas, revenue from excess capacity may be the only viable option for rural health consortia to obtain the match funding needed for a construction project. However, the entity most likely interested in purchasing Indefeasible Rights of Use (“IRU”) from the consortium may also be the entity best positioned to construct the new facilities. This is particularly so in remote areas where few entities may be available as potential partners.

To the extent section 54.633(d)(5) is intended to safeguard fund expenditures, the competitive bidding process will have already determined whether the construction bid is the most cost-effective way to deliver these facilities. Therefore, additional safeguards regarding the cost to construct are unneeded and may be counterproductive by removing the only possible private sector partner from participation. Because potential HCP-owned fiber projects may be the only

realistic solution to bring medical-grade broadband to HCPs in some communities, the Commission should seek comment on this proposal.

In addition, the Commission could better foster fiber deployment in unserved areas by providing a path for joint E-rate and HCF consortia applications for funding in areas left behind by commercial providers. CTN and UTN have each explored collaboration between HCPs, education, and library partners but have thus far been challenged by the lack of a clear process and lack of guidelines for allocating costs between the two programs. To help encourage such collaborations – which will help ensure efficient use of limited universal service funding – the Commission should consider closer alignment between the E-Rate and RHC programs, offering cost allocation guidelines (or safe-harbor allocation methods) and establishing application steps that parties interested in joint applications can follow.

C. Support for the Broadband Component of Remote Patient Monitoring

It is widely recognized that remote patient monitoring (typically in the home) is critical for reducing costly hospital readmissions, and necessary to cost-effectively manage population health using limited health resources.⁵⁸ To encourage continued adoption of remote patient monitoring, CHRISTUS Health (“CHRISTUS”) recently asked the Commission to allow rural HCPs to obtain a discount for the wireless broadband costs associated with providing remote monitoring.⁵⁹ CHRISTUS also noted the wide array of economic, demographic, and policy challenges facing

⁵⁸ See, e.g., *Just Around the Broadband Bend*, Posting of P. Michele Ellison, Chair, Connect2HealthFCC Task Force, Official FCC Blog, <http://www.fcc.gov/blog/just-around-broadband-bend> (Feb. 23, 2015) (noting accounts of rural Mississippians relying on remote monitoring to manage chronic conditions and avoid debilitating illness and effectiveness in reducing hospital readmissions in rural Ruleville, Mississippi).

⁵⁹ See Letter from George S. Conklin, Senior Vice President and CIO of CHRISTUS Health to Marlene H. Dortch, Secretary, FCC, CC Docket No. 02-60, Mar. 30, 2015 (“CHRISTUS Letter”).

rural hospitals (in particular) and urged the Commission to be proactive in continuing to find ways to support these important institutions.

Petitioners believe the CHRISTUS proposal has merit and urge the Commission to formally explore whether it will help rural HCPs if the broadband costs for remote patient monitoring were eligible, and what the likely demand for such funding will be. Petitioners agree with CHRISTUS that the statutory language in Section 254(h) of the Communications Act of 1934, as amended (“Act”), authorizes the FCC to subsidize broadband connectivity between an HCP and individual patients where such connectivity is exclusively utilized to provide remote patient monitoring.⁶⁰

D. Support for Consortia Administrative Expenses

As noted above, administrative expenses continue to be an obstacle to the formation and operation of consortia, particularly large open consortia that are tasked with bringing safety-net providers into the era of broadband enabled care. In the event the Commission declines to significantly increase the HCF subsidy, Petitioners respectfully request the Commission consider making a portion of consortium administrative expenses eligible costs.⁶¹ Among other things, certain assumptions the Commission made that HCF processes would be less burdensome than their Pilot Program counterparts do not appear to have been born out, particularly with respect to large open consortia. For that reason alone, the Commission should revisit the issue of consortium

⁶⁰ CHRISTUS explained that statutory language in Section 254(h)(1)(A) of the Act authorizes subsidies for those “telecommunications services . . . necessary [to provide] health care services,” while Section 254(h)(2)(A) authorizes rules that enhance HCP “access to advanced telecommunications and information services”, and argued that there is nothing in the text of either section that limits subsidies to broadband connections between entities rather than connectivity between eligible entity and patient. CHRISTUS Letter at 6-7.

⁶¹ See *Rural Health Care Support Mechanism*, 25 FCC Rcd 9371, 9386-87 (2010) (“Allowing a portion of [RHC] funding to be used for administrative expenses could enable [consortia] to explore more efficient, effective means of deploying broadband for the delivery of health care.”); but see *HCF Order*, 27 FCC Rcd at 16757 (need to support administrative expenses lessened due to streamlining application processes and expected small number of infrastructure projects).

administrative expenses. Moreover, with USAC expenditures to administer the RHC programs itself apparently capped, program inefficiencies are effectively being shifted to applicants, particularly large consortia. (We address USAC RHC administrative expenditures in Section V.C. below.)

V. CHANGES TO THE RHC PROGRAM NEEDED

A. Promulgate an Annual Funding Cap on the Basis of an Accurate Determination of the Number of Potentially-Eligible Rural HCPs

The purpose of rulemaking proceedings is to promulgate rules on the basis of adequate, accurate data. Thus, if a rulemaking is intended to formulate a funding cap, the Commission should determine the aggregate potential demand for the funds on a record that includes the best available factual data.⁶² Unfortunately, the rulemakings that promulgated and sustained the Commission's annual \$400 million funding cap on the RHC program do not include accurate record data and may grossly undercount the number of potentially-eligible rural HCPs.

When the Commission established its annual \$400 million funding cap in 1997, the Commission acted *sua sponte* inasmuch as the Joint Board had not recommended the adoption of a funding cap.⁶³ The Commission arrived at its \$400 million cap based on its "generous" estimate that there were approximately 12,000 potentially-eligible rural HCPs.⁶⁴ The estimate, which the Commission recognized was subject to error, was based on figures supplied by the HHS and four

⁶² This should include accurate data as to the number of potentially eligible participants as well as the estimated costs to reach minimum bandwidth targets reflecting the unique quality-of-service requirements for healthcare, including the need for physically diverse connectivity. *See Second E-rate Modernization Order* 29 FCC Rcd at 15569 (establishing new E-rate funding cap based in part on connectivity targets established in *First E-rate Modernization Order*). "Ensuring that schools and libraries will be able to meet the high-speed connectivity targets we have set for the E-rate program will require a combination of continued efforts to lower the prices paid for school and library broadband connectivity and an increase in E-rate support necessary to meet growing bandwidth demands of schools and libraries." *Id.*

⁶³ *See USF First R&O*, 12 FCC Rcd at 9140.

⁶⁴ *Id.* at 9141.

national associations.⁶⁵ Table 1 below sets forth the 1997 estimates of the potentially-eligible rural HCPs in each of the seven statutory categories.

TABLE 1

Post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools	625
Community health centers or health centers providing health care to migrants	1,200
Local health departments or agencies	3,526
Community mental health centers	1,500
Not-for-profit hospitals	2,049
Rural health clinics	3,329
Consortia of health care providers (accounted for in the first six categories)	--
Total	12,229

In March 2010 in its *National Broadband Plan*, the Commission’s staff estimated there were approximately 11,000 eligible HCPs.⁶⁶ The staff determined eligibility by matching the locations of non-public and public institutions with the Commission’s geographic definition of rural.⁶⁷ It estimated that there were 10,660 “unique locations” of eligible rural institutions.⁶⁸ Table 2 shows the total number of locations (both rural and non-rural) that the staff considered.⁶⁹

TABLE 2

Nonprofit hospitals	1,851
Federally qualified health centers (“FQHCs”)	2,612
Rural health clinics	3,349
Indian health services (“IHS”)	358
Veterans health affairs (“VHA”)	607
Federal prisons (“BOP”)	106
Public health departments	3,219
Total	12,102

⁶⁵ See *USF First R&O, 12 FCC Rcd* at 9141 n.1845. The Commission adopted the \$400 million cap on May 7, 1997. Its estimate of the number of rural HCPs was based in part on figures supplied in a telephone conversation on May 2, 1997, and a letter dated May 2, 1997. See *id.*

⁶⁶ See *National Broadband Plan*, at 214.

⁶⁷ See *id.* at 221 n.103.

⁶⁸ *Id.*

⁶⁹ See *id.*

For the purposes of the *National Broadband Plan*, the staff used the HHS' definition of a rural health clinic, assumed that the rural/urban split for BOP and VHA sites were in the same proportions to IHS and hospitals, respectively, and estimated that that there was one public health department per county that the Commission determined was totally rural.⁷⁰ The staff conceded:

These categories may be inconsistent with FCC terminology, since it has traditionally used its own definition of "hospital" and "rural health clinic." Also, 10,600 is likely an underestimate of eligible institutions because it does not count community mental health centers, post-secondary medical education, or state prisons.⁷¹

In July 2010, when the Commission proposed and sought comments on reforms to the RHC program, it saw "no need to revisit the overall funding cap."⁷² Just three months after the *National Broadband Plan* was released estimating that there were 11,000 eligible HCPs, the Commission stated that there were only 9,800 eligible HCPs⁷³ and it proposed to expand eligibility to 12,000 HCPs nationwide.⁷⁴ It did not reveal how it determined that there were 9,800 eligible HCPs, or why it rejected the *National Broadband Plan's* estimate of 11,000. Nor did it disclose how it estimated that proposed reforms (which were not adopted) would make an additional 2,200 HCPs eligible for funding. And the Commission did not solicit data on which to calculate the number of existing and potentially eligible HCPs – a failure the Wireline Competition Bureau ("WCB") repeated when it asked for further comments in July 2012.⁷⁵

⁷⁰ See *National Broadband Plan*, at 221 n.103.

⁷¹ *Id.*

⁷² *Rural Health Care Support Mechanism*, 25 FCC Rcd 9371, 9421 (2010).

⁷³ See *id.* at 9376.

⁷⁴ See *id.* at 9374.

⁷⁵ See *WCB Seeks Further Comment on Issues in the Rural Health Care Reform Proceeding*, 27 FCC 8185 (WCB 2012).

In December 2012, fifteen years after it established the RHC program, the Commission raised its “estimate” of eligible rural HCPs to 10,000, but left its \$400 million cap undisturbed.⁷⁶

Table 3 sets forth the figures the Commission used to come up with its estimate.⁷⁷

TABLE 3

Post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools	625
FQHCs	2,612
Rural local health departments	2,136
Rural community mental health centers	263
Rural non-profit hospitals	1,674
Rural health clinics	2,741
Total	10,051

The Commission’s latest estimate of eligible rural HCPs rests on shaky data. For the first statutory category, the Commission continued reliance on its 1997 finding that there were 625 institutions that offered a postsecondary medical education.⁷⁸ It made no attempt to determine, for example, the number of the nation’s 1,007 teaching hospitals⁷⁹ and 162 medical schools⁸⁰ that were eligible HCPs. In any event, it was unreasonable for the Commission to assume that there had been no change in the number of eligible institutions of higher medical education since 1997.

The Commission adopted the staff’s finding in the *National Broadband Plan* that there

⁷⁶ See *HCF Order*, 27 FCC Rcd at 16723.

⁷⁷ See *id.* at 16723 n.266.

⁷⁸ Compare *USF First R&O*, 12 FCC Rcd at 9141 n.1845 with *HCF Order*, 27 FCC Rcd at 16723 n.266.

⁷⁹ See Association of American Medical Colleges, *Key Facts about Teaching Hospitals 2* (Feb. 2009), <https://www.aamc.org/download/82452/data/keyfactsaboutth.pdf>.

⁸⁰ See Association of American Medical Colleges, *AAMC Organizational Directory Search Result*, <https://members.aamc.org/eweb/DynamicPage.aspx?site=AAMC&webcode=AAMCOrgSearchResult&orgtype=Medical%20School> (last visited Nov. 16, 2015).

were 2,612 FQHCs,⁸¹ the source of which was not disclosed.⁸² However, according to the National Association of Community Health Centers (“NACHC”), there were 1,202 FQHCs, *and 9,170 FQHC delivery sites*, in the United States (including U.S. territories) in 2013.⁸³ It is not known how many FQHCs and delivery sites are located in rural areas.

The Commission arrived at its estimate that there were 2,136 rural local health departments (“LHDs”) “by multiplying the percentage of rural counties in each state with the number of local health departments in the state.”⁸⁴ But there was no need for an estimate. The address of each one of the nation’s 2,533 LHDs⁸⁵ is available.⁸⁶ The Commission could have determined whether an LHD is at an FCC-approved rural location by using USAC’s eligible rural areas search tool⁸⁷ in conjunction with the Texas A&M geocode location tool.⁸⁸ For example, using these tools, the SHLB Coalition was able to identify 28 of the 64 LHDs in New Mexico as being rural LHDs.

⁸¹ See *HCF Order*, 27 FCC Rcd at 16723 n.266. FQHCs include all organizations receiving grants under § 330 of the Public Health Service Act (“PHSA”). FQHCs qualify for enhanced reimbursement from Medicare and Medicaid, as well as other benefits. FQHCs must serve an underserved area or population, offer a sliding fee scale, provide comprehensive services, have an ongoing quality assurance program, and have a governing board of directors. Certain tribal organizations and FQHC Look-Alikes (an organization that meets PHSA § 330 eligibility requirements, but does not receive grant funding) also may receive special Medicare and Medicaid reimbursement. See Health Resources and Services Administration, HHS, *What Are FQHCs?*, <http://www.hrsa.gov/healthit/toolbox/RuralHealthITtoolbox/Introduction/qualified.html>.

⁸² See *National Broadband Plan* at 221 n.103.

⁸³ See NACHC, *Key Health Center Data by State, 2013*, <http://www.nachc.com/client/2013%20Key%20facts%20by%20state%20data.pdf>. NACHC did not include approximately 100 FQHC Look-Alikes. See *id.*

⁸⁴ *HCF Order*, 27 FCC Rcd at 16723 n.266.

⁸⁵ See NATIONAL ASSOCIATION OF COUNTY & CITY HEALTH OFFICIALS, 2013 NATIONAL PROFILE OF LOCAL HEALTH DEPARTMENTS, Jan. 2014, at 4, <http://www.naccho.org/topics/infrastructure/profile/upload/2013-National-Profile-of-Local-Health-Departments-report.pdf>.

⁸⁶ See National Association of County & City Health Officials, *Directory of Local Health Departments (LHD Index)*, <http://naccho.org/about/lhd/> (last visited Dec. 7, 2015).

⁸⁷ See USAC, *Rural Health Care Program Step 2 Determine Eligibility*, <http://www.usac.org/rhc/healthcare-connect/individual/step02/> (last visited Dec. 7, 2015).

⁸⁸ See Texas A&M Geoservices, *Non-Parsed Postal Address Geocoding*, <http://geoservices.tamu.edu/Services/Geocode/Interactive/> (last visited Dec. 7, 2015).

Thus, the Commission can ascertain the exact number of rural LHDs that are eligible for funding.

The Commission estimated that there were 2,741 rural health clinics based solely on an oral *ex parte* presentation made by John Gale, a health services researcher, to the WCB on March 29, 2012.⁸⁹ Mr. Gale gave the WCB a “general overview” of the rural health clinic designation under the rules of the HHS’ Centers for Medicare & Medicaid Services (“CMS”), and he stated that in 2012 there were approximately 3,950 rural health clinics nationwide.⁹⁰ He estimated that “about” 51% of rural health clinics are independent, and “about” 30% to 40% of independent rural health clinics are public or not-for-profit.⁹¹ Mr. Gale also stated that “almost all” of the 49% of the rural health clinics that are provider-based are public or not-for-profit.⁹² Based on Mr. Gale’s approximations, the WCB calculated that there were 2,741 rural health clinics ((3,950 x .51 x .40 = 805.5) + (3,950 x .49 = 1,935.5)).

Once again, it was not necessary for the Commission to estimate based on expert approximations. The names and addresses of the 4,084 Medicare-certified rural health clinics⁹³ are publicly available.⁹⁴ Because the CMS treats non-urbanized areas as rural,⁹⁵ it is necessary to use USAC’s eligible rural areas search tool and Texas A&M’s geocode location tool to determine

⁸⁹ See *HCF Order*, 27 FCC Rcd at 16723 n.266; Letter from Linda L. Oliver to Marlene H. Dortch, WC Dkt. No. 02-60 (Mar. 29, 2012) (“WCB Letter”).

⁹⁰ WCB Letter at 1.

⁹¹ *Id.*

⁹² *Id.*

⁹³ See The Henry J. Kaiser Family Foundation, *Number of Medicare Certified RHCs 2*, <http://kff.org/other/state-indicator/total-rural-health-clinics/> (visited Nov. 17, 2015).

⁹⁴ See CMS, *Medicare Certified RHCs*, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/rhclistbyprovidername.pdf> (last visited Nov. 17, 2015).

⁹⁵ To qualify as a Medicare-certified RHC, a clinic must be located in a non-urbanized area, as defined by the Census Bureau, which has been designated (within the previous 4 years) by the Health Resources and Services Administration as a federally designated or certified shortage area. See CMS, *RHC Rural Health Fact Sheet 2*, <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/RuralHlthClinfctst.pdf>.

if a rural health clinic is at an FCC-approved rural location. The SHLB Coalition went through that exercise with respect to the 59 rural health clinics in Maine, New York and New Mexico, and it was able to determine that 100% of the rural health clinics in those three states would be classified as rural for the purposes of the RHC program.

The methodologies employed by the Commission to formulate its 2012 estimate of 10,000 eligible rural HCPs were inadequate or largely unexplained.⁹⁶ Moreover, by failing to consider a substantial number of FQHC delivery sites (almost 10,000), it appears to have grossly undercounted the number of potentially eligible HCPs.⁹⁷ Because the funding cap must be derived from an accurate accounting of the number of potentially-eligible rural HCPs, the Commission should specifically seek public comment concerning the facts and expert opinion relevant to the number of eligible rural HCPs in each of the statutory categories. Information about fiber availability to potentially eligible HCPs should also be sought.⁹⁸

B. Establish Mechanisms to Provide Short-Term Relief in the Event the Rural Health Care Program Demand Exceeds the Cap

With or without rule changes to the HCF program, it is possible the RHC program funding cap will be hit within the next few years. The Commission should therefore act now to establish mechanisms to address the cap on a temporary basis. This will provide a buffer period during which the Commission can consider a cap increase to avoid triggering automatic reductions in

⁹⁶ The Commission determined that there were 263 rural community mental health centers on the basis of an estimate of the Health Resources and Services Administration that was “adjusted” based on the Commission’s definition of a rural HCP. *HCF Order*, 27 FCC Rcd at 16723 n.266. It calculated that there were 1,674 rural non-profit hospitals “by multiplying the percentage of rural community hospitals by the total number of non-profit hospitals.” *Id.*

⁹⁷ See NACHC, *Key Health Center Data by State, 2013*, *supra* note 83.

⁹⁸ Any estimate of costs necessary to meet minimum bandwidth targets for healthcare should take into consideration the need for physically diverse redundant connectivity. (Under current rules in both the Telecommunications Program and the HCF, there is no limit to the number of subsidized connections an eligible HCP may obtain, provided each connection is used for an eligible purpose (*i.e.*, to provide health care or health care instruction). See 47 C.F.R. § 54.602(d) (only requiring supported connections to be used for “health care purposes”).

support among program participants in order to stay below the cap. Petitioners support consideration of the following mechanisms to address this issue:

- Use Collected but Uncommitted or Undisbursed Pilot Program Funding.

The Pilot Program was capped at \$417 million but ultimately committed less than \$365 million of that (in one-time funding).⁹⁹ In addition, Pilot Program projects face an invoicing deadline of six years from the date of their first funding commitment, meaning all Pilot Program disbursements will be completed by 2017.¹⁰⁰ Both uncommitted Pilot Program funding and committed but never-to-be disbursed Pilot Program funding should be made available to support temporary overruns for the RHC programs.

- Use De-committed RHC Funds from Prior Funding Years.

Similar to the E-rate program, each year a percentage of RHC program funding commitments (in both the HCF and Telecommunications Program) are never invoiced by applicants. This is a program feature because a funding commitment is simply a not-to-exceed amount based on contracts and rates available at the time the funding commitment is made. Actual services delivered will often differ from the commitment amount (disbursements are never made in excess of the funding commitment amount).

The Commission should establish a rule-based deadline after which all committed but un-invoiced funding is de-committed but remains available for future years. This rule could be similar to the Pilot Program – allowing invoicing to occur up to six years from the date of the relevant funding commitment.¹⁰¹ Such a rule would automatically create an available supply of de-

⁹⁹ See *HCF Order*, 27 FCC Rcd at 16685.

¹⁰⁰ See *Rural Health Care Support Mechanism*, 26 FCC Rcd 6619, 6628 (2011).

¹⁰¹ *But see* 47 C.F.R. § 54.645(b) (establishing a deadline for HCF invoices of six months from the last day of the funding commitment period).

committed funds each year. Similar to the E-rate program which rolls over de-committed funds to allow the program to exceed its annual cap,¹⁰² the Commission should hold de-committed RHC funds and allow them to accumulate in order to fund potential future cap overruns.

- Make Available Funds Not Committed In Prior Years

One final option the Commission could consider to address potential future cap overruns is to utilize undisbursed funds from prior years. Essentially this would mean allowing spending below the cap each year to accumulate on an absolute basis. If the Commission started in 2005 – the first year disbursements equaled approximately 10% of available funding – the approximate accumulations are reflected in the Table 4 below:

TABLE 4

	CAP	Disbursed ¹⁰³	Unspent	Available
2005	\$ 400,000,000	\$ 40,000,000	\$ 360,000,000	\$ 360,000,000
2006	\$ 400,000,000	\$ 45,300,000	\$ 354,700,000	\$ 714,700,000
2007	\$ 400,000,000	\$ 53,800,000	\$ 346,200,000	\$ 1,060,900,000
2008	\$ 400,000,000	\$ 49,500,000	\$ 350,500,000	\$ 1,411,400,000
2009	\$ 400,000,000	\$ 60,700,000	\$ 339,300,000	\$ 1,750,700,000
2010	\$ 400,000,000	\$ 86,000,000	\$ 314,000,000	\$ 2,064,700,000
2011	\$ 400,000,000	\$ 81,500,000	\$ 318,500,000	\$ 2,383,200,000
2012	\$ 400,000,000	\$ 106,000,000	\$ 294,000,000	\$ 2,677,200,000
2013	\$ 400,000,000	\$ 92,000,000	\$ 308,000,000	\$ 2,985,200,000

Even if the Commission made a percentage of undisbursed funds from prior years available, this would allow disbursements using unspent funds for a period of time, thereby

¹⁰² See 47 C.F.R. § 54.507(a)(6) (“All funds collected that are unused shall be carried forward into subsequent funding years for use in the schools and libraries support mechanism in accordance with the public interest and notwithstanding the annual cap.”); § 54.507(a)(5) (“On an annual basis . . . all funds that are collected and that are unused from prior years shall be available for use in the next full funding year of the schools and libraries mechanism in accordance with the public interest and notwithstanding the annual cap as described in this paragraph (a).”).

¹⁰³ Data source = USAC Annual Reports, <http://usac.org/about/tools/publications/annual-reports/default.aspx>.

allowing the Commission time to properly re-assess program objectives, establish appropriate targets, and estimate future demand.

C. Improve Incentives For USAC to Administer the RHC Programs Efficiently and Effectively

Petitioners applaud USAC and Commission staff for engaging openly with stakeholders to identify and address issues and problems in USAC systems and processes for administering the RHC programs. However, we remain concerned that RHC program participants continue to face processing delays and problems with systems functionality and that substantial progress remains to be made. We urge the Commission to review whether USAC is devoting the necessary human and technical resources to problem resolution and new systems development to consistently deliver responsive expert support, expeditious processing, and effective tools. In providing such oversight, the Commission should consider whether USAC is hamstrung by language in the *HCF Order* that appears to limit the resources USAC is permitted to devote to RHC program administration.

This language – contained in paragraph 42 of the *HCF Order* – measures “administrative efficiency” by looking at USAC’s costs to administer the program as a percent of funds disbursed (or possibly committed).¹⁰⁴ Petitioners certainly agree with the intent here: to ensure the RHC programs are efficiently administered by providing USAC with appropriate incentives to disburse funding.¹⁰⁵ However, many of the RHC Program process issues appear related to slow deployment

¹⁰⁴ See *HCF Order*, 27 FCC Rcd at 16698 (noting “USAC’s cost to administer the . . . RHC programs was nine percent of total funds disbursed in calendar year 2011, the highest of all four universal service programs.”).

¹⁰⁵ USAC administrative costs for the RHC program were \$12.3 million in 2014. This compares to 2014 USAC administrative costs of \$66.2 million for the E-rate program, \$21.8 million for High Cost, and \$18.8 million for Lifeline. See *USAC 2014 Annual Report* at 21, available at <http://www.usac.org/res/documents/about/pdf/annual-reports/usac-annual-report-2014.pdf>. Because RHC disbursements are low compared to the other USF programs, administrative costs *as a proportion of disbursements* are higher for RHC. Implementation of new programs such as

of new IT systems to run the program, and the lack of personnel with significant first-hand experience with the health care industry, with Health Information Technology, or in the telecommunications industry. Accordingly, we urge the Commission to eliminate this restriction on USAC – or at least suspend it for a period of several years. USAC should be encouraged to devote whatever resources are reasonably needed to hire qualified staff or contractors and to create a robust, state-of-the-art IT system to support the RHC application processes.

Petitioners believe these administrative challenges are an urgent matter. Moreover, given the issues Petitioners have raised relative to consortia administrative costs, it should be noted that USAC administrative deficiencies have the effect of shifting costs to applicants – in the form of delay and demands on staff that interface with USAC – further increasing administrative costs to both consortia and individual applicants.

D. Expand the Definition of “Rural”

The Commission has long recognized that certain HCPs which are not technically “rural” nonetheless “play a key role in providing health care services to rural and remote areas, and [that] discontinuing discounted services to these . . . providers could jeopardize their ability to continue offering essential health care services to rural areas.”¹⁰⁶ To address this issue, the FCC has deemed “rural” certain HCPs that were rural under the FCC’s pre-2005 definition, but that are not rural under the current definition.¹⁰⁷ (So-called “grandfathering”.)

the HCF, however, require significant upfront costs that can be expected to decrease over time (assuming successful implementation).

¹⁰⁶ See *Rural Health Care Support Mechanism*, 26 FCC Rcd 9145, 9149 (2011) (“*Rural Grandfathering Order*”); *HCF Order*, 27 FCC Rcd at 16710(permanently treating as “rural” those HCPs that were rural under the Commission’s pre-2005 definition of rural but are not rural under the current definition).

¹⁰⁷ *Rural Grandfathering Order*, 26 FCC Rcd at 9149.

As census data changes, the number of formerly rural HCPs will continue to grow.¹⁰⁸ In addition, in Petitioners’ experience, other HCPs besides those that were “rural” under the pre-2005 definition exhibit characteristics the Commission recognized as significant in its *Rural Grandfathering Order*.¹⁰⁹ That is, these HCPs do not technically meet the current definition of “rural” but provide essential health care services to rural and remote areas. Accordingly, Petitioners urge the Commission to revisit this issue and either (1) comprehensively expand the definition of “rural area,” and/or (2) establish a streamlined waiver process to allow the Bureau to designate as “providers of rural health care” HCPs that can demonstrate through objective criteria that they provide essential health care services to persons who reside in rural areas.

For example, in the *Rural Grandfathering Order*, in extending the rural status of the health care providers that happened to be at issue, the Commission recognized that some of the following factors were present in each case:

- “[N]ot located in large urbanized areas” and “play a key role in providing health care services to ‘fundamentally rural’ areas”;
- Offer “critical services” to their patients;
- “[L]ocated in regions experiencing specialty health care shortages, which these facilities are seeking to remedy via telemedicine”;
- Lack of access to affordable (“competitively priced”) broadband services compromises ability to provide telehealth services to rural areas;
- RHC eligibility would further other federal rural health policy objectives (such as entities in receipt of other federal funding to implement telemedicine programs).¹¹⁰

¹⁰⁸ See *Rural Health Care Support Mechanism*, Order, 29 FCC Rcd 8609, 8610 (Wireline Comp. Bur. 2014) (directing USAC to continually update “rural areas” based on most recently available census data and Core Base Statistical Area definitions); see also USAC Guidance on Rurality Change, <http://www.usac.org/rhc/rurality-change/>.

¹⁰⁹ See *Rural Grandfathering Order*, 26 FCC Rcd. at 9149-51.

¹¹⁰ See *id.*

The Commission should seek comment on whether the presence of one or more of these factors should provide a basis for otherwise eligible entities that do not meet its current definition of rural to nonetheless obtain a rural classification.¹¹¹

E. Clarify HCP Eligibility Categories

Section 254(h)(7) of the Act specifically lists the types of health care entities eligible to receive universal service support. These include the following:

- (i) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools;
- (ii) community health centers or health centers providing health care to migrants;
- (iii) local health departments or agencies;
- (iv) community mental health centers;
- (v) not-for-profit hospitals;
- (vi) rural health clinics; and
- (vii) consortia of HCPs consisting of one or more entities described in clauses (i) through (vi).¹¹²

¹¹¹ A good example of an HCP that is not rural under the current rule but that may meet these criteria is Hi-Desert Medical Center (“Hi-Desert”), located in Joshua Tree, California (San Bernardino County). Joshua Tree has a population of less than 7500 and lays in the Morongo Basin, on the southern edge of the Mohave desert, the northern edge of Joshua Tree National Park, and between the San Bernardino National Forest to the east and the 187,000 acre Sheephole Wilderness in the west. With bighorn sheep, mountain lions, black bears, and coyotes roaming the surrounding hills, it is far from urban. See Big Morongo Canyon Preserve, wildlife listing, <http://www.bigmorongo.org/a32Wildlife.htm>. San Bernardino County at 20,105 square miles is the largest county in the country, almost twice the size of the state of Massachusetts, but with a population density one-tenth that of Massachusetts – with most of that population concentrated in the San Bernardino Valley near to Los Angeles. Hi-Desert is the primary provider of healthcare services in the Morongo Basin area (which also includes the cities of Yucca Valley, Twenty-Nine Palms, and the Twenty-Nine Palms Naval Airbase). Hi-Desert is owned by the citizens of the communities it serves in the Morongo Basin and is the area’s third largest employer. In 2010, Hi-Desert provided charity and uncompensated care totaling \$3.3 million to those in need. See National Center for Rural Health Works, THE ECONOMIC IMPACT OF HI-DESERT MEDICAL CENTER ON THE ZIP CODE MEDICAL SERVICE AREA IN SAN BERNARDINO CO., CALIFORNIA 5 (2011), available at <http://www.hdmc.org/News%20Releases/2012economicImpact.pdf>.

¹¹² See 47 U.S.C. § 254(h)(7).

Despite the specificity of this list, program participants are not always able to determine on their own whether particular entities are eligible.

In some cases eligibility can be reasonably assumed using governmental sources. For example, a list of the 4,084 CMS-certified rural health clinics by state is available online.¹¹³ In other cases, eligibility cannot be reasonably assumed – for example, a health clinic that is not certified by CMS (but that is public or non-profit) may nonetheless be an eligible “rural health clinic” for purposes of RHC support. For example emergency departments in for-profit rural hospitals,¹¹⁴ or health clinics located in rural schools or prisons may be eligible “rural health clinics.”

While USAC provides an “eligibility criteria checklist” for community mental health centers, it is not clear how this checklist is used by USAC and neither the Commission nor USAC provide guidance regarding the five other eligibility types.¹¹⁵ This creates uncertainty for both program participants and for policy makers who must understand the number of potential program participants to assess potential demand for program funding (addressed in Section V.A, *supra*). Indeed, in many cases, the only way to know for certain if a site is eligible is to submit a request for services (or in the case of HCF, a Form 460 Eligibility and Registration Form) to USAC and wait for a determination.

¹¹³ See *supra* note 88. See also 42 U.S.C. § 1395x(aa)(2) (defining “rural health clinic”). As noted earlier, a rural health clinic on the CMS list that is not “rural” using the Commission’s definition of rural may nonetheless be ineligible for RHC support.

¹¹⁴ See Rural Health Care Support Mechanism, 18 FCC Rcd 24546, 24553-55 (2003) (dedicated emergency rooms within rural for-profit hospitals that participate in Medicare eligible for support as “rural health clinics”) (“*2003 Report and Order*”).

¹¹⁵ Compare, for example, the USAC E-rate Program eligibility guidance <http://www.usac.org/sl/applicants/before-youbegin/definitions.aspx> to the RHC program <http://www.usac.org/rhc/telecommunications/health-care-providers/eligibility.aspx> which mostly restates 47 C.F.R. § 54.600, which itself simply restates Section 254(h)(7) of the Act.

At a minimum, in order to aid existing and potential program participants, the Commission should provide, or direct USAC to provide, “eligibility criteria checklists” for each statutory eligible entity type. To help USAC establish these eligibility checklists, the Commission could clarify whether the scope of the Section 254(h)(7) eligibility types can be determined by reference to statutory definitions provided in other federal statutes such as the Social Security Act.¹¹⁶ The Commission could further clarify whether certifications from other federal agencies that a particular entity falls within one of the relevant statutory definitions must be recognized by USAC. (This is would be similar to the E-rate program using National School Lunch Program data to determine eligibility for E-rate discounts.¹¹⁷)

The Commission should also clarify that the Section 254(h)(7)(B) health care provider types are more expansive than other federal statutes using the same or similar terms. For example, being certified by CMS as a “federal qualified health center” should translate into automatic classification as an eligible “community health center” – but an entity that provides functionally similar services should also be considered eligible. If this approach were clearly adopted, in cases where other agencies have certified a particular entity’s classification as an eligible entity type, USAC would not need to perform a functional analysis of eligibility – helping USAC streamline its eligibility determination processes.

In 2003, the Commission adopted such a “functional” definition of eligibility when it determined that certain emergency rooms function as rural health clinics, and that part-time providers of eligible services should be considered eligible entities on a pro rata basis:

¹¹⁶ See, e.g., 42 U.S.C. § 1395x(ff)(3)(B) (defining “community mental health center”); *id.* § 1395x(aa)(3) (defining “federally qualified health center”). The Commission should also clarify that non-profit consortium lead entities that are owned or controlled by eligible HCPs are eligible under Section 254(h)(7)(vii) (so-called “consortia of the above”).

¹¹⁷ See, e.g., 47 C.F.R. § 54.505(c).

[I]n most communities, emergency departments are the only ambulatory care entities that serve the public on a 24-hour a day, 7-day a week basis. In many instances, emergency departments of rural for-profit hospitals and critical access hospitals are the only health care providers in rural areas serving the medical needs of the community. Dedicated emergency departments typically provide the types of medical services often provided in traditional health clinics. Therefore, we find that dedicated emergency departments in rural for-profit hospitals should be eligible to receive prorated discounts as “public” “health providers,” and more specifically as “public” “rural health clinics.” It is necessary to clarify the definition of “rural health clinic” in this way to promote timely access to acute specialty healthcare services, chronic disease management programs and other preventive services essential to public health and safety. These entities are generally the initial point of entry into the healthcare system for any person suffering the consequences of a severe catastrophe or accident and constitute a vital segment of the health care community, particularly in the event of a national public health emergency. Additionally . . . given the realities of rural health care providers in offering quality health care services in rural areas, we clarify the entities listed in section 254(h)(7)(B) that qualify as rural “health care providers.” We conclude that entities listed in section 254(h)(7)(B) include non-profit entities that function as one of the listed entities on a part-time basis.¹¹⁸

The Commission should formally clarify that this functional approach extends to all public or non-profit HCPs, not simply those that provide eligible services on a part-time basis.

Finally, the Commission should consider expanding on its determination in 2003 that a HCP can be considered “public” if meets certain public interest obligations. In 2003, in clarifying that emergency rooms in for-profit rural hospitals are “public” HCPs, the Commission explained:

[T]his clarification is consistent with congressional intent and is necessary to give meaning to the term “public” health care provider under the rural health care program. Dedicated emergency departments in for-profit hospitals, including the emergency departments of critical access hospitals, are required, pursuant to the Emergency Medical Treatment and Labor Act (EMTALA), to provide medical screening examinations to all patients who present themselves and to stabilize or arrange for appropriate transfer of those patients with emergency conditions. Thus, such providers are “public” in nature by virtue of the persons they are required, pursuant to EMTALA, to examine and/or treat for emergency medical conditions.¹¹⁹

¹¹⁸ 2003 Report and Order, 18 FCC Rcd at 24554 (emphasis added; citations omitted)

¹¹⁹ *Id.* at 24553-54 (citations omitted).

The Commission should consider which HCPs are required by law to provide care, or that are otherwise meeting public health needs by, for example, serving a certain percentage of Medicare or Medicaid patients and/or providing substantial charity or uncompensated care. The Commission should also consider establishing a streamlined appeal process for entities that believe they qualify as “public HCPs” based on the services they provide to or within a community.

F. Consortium Connections to Ineligible HCPs Should be Supported Where More Than 50% of Consortium Participants are Eligible HCPs

The Commission in the *HCF Order* determined that connections to hospital administrative offices and data centers are eligible for support when such connections are part of a consortium.¹²⁰ The Commission recognized that supporting such connections “enables HCPs to use efficient network connections, rather than having to re-route traffic unnecessarily in order to obtain support.”¹²¹ Indeed, in adopting rules in the HCF to promote the development of consortia, the Commission explained how a “flexible consortium-based approach” promoted “efficiency of network design”:

Network design in many cases has been more efficient and less costly in the Pilot Program than in the Telecommunications Program, because the Pilot Program funds all public and not-for-profit HCPs, even those located in non-rural areas. Pilot projects were able to design their networks with maximum network efficiency in mind because funding is not negatively impacted by inclusion of non-rural sites in those networks.¹²²

An example of efficient network design might include a physical connection to a shared fiber ring that allows connections to any other HCP on that ring (and access to commodity Internet or Internet2). Costs might be reflected as a last-mile recurring charge for connection to the ring, and

¹²⁰ *HCF Order*, 27 FCC Rcd at 16741-46. The Commission also proposed, but never acted upon, a pilot program to consider the benefits of funding connections from eligible HCPs to skilled nursing facilities. *See id.* at 16815-18.

¹²¹ *Id.* at 16742 (footnote omitted).

¹²² *Id.* at 16702.

a recurring “fair share” charge associated with use of all shared network resources (*e.g.*, the fiber ring and network operations center (“NOC”) – with such costs sometimes recovered through a “port fee”). Ineligible entities would pay their own last-mile charge, plus an unsubsidized port fee.

As the Commission considers rules that affect consortia, efficient network design should continue to be a focus. For example, the Telecommunications Program has long supported network deployments but in doing so all circuits in the network must originate at an eligible rural location – which means there may be incentives to design networks around this requirement. As the Commission has noted:

Under the Telecommunications Program, circuits are only eligible for funding if one end of the circuit terminates at an eligible rural entity, which can create incentives for HCPs to maximize funding by ensuring that all connections within the network terminate at an eligible rural entity. As a technical and financial matter, this can lead to less efficient network design. For example, it may be more efficient to design the middle-mile component of a regional or statewide network by using connections between non-rural sites, rather than routing traffic through a rural site.¹²³

Under current rules in both the Telecommunication Program and the HCF, as long as the circuit originates at an eligible HCP and is used for eligible purposes (*i.e.*, to provide health care or healthcare instruction), the circuit can terminate at any type of health care location, regardless of whether it is rural or eligible. Thus, in either program, a rural eligible HCP can obtain funding for connections to a variety of non-rural or otherwise ineligible entities such as long-term care facilities or non-rural clinics. To the extent this rule is applied to HCF consortia (rather than just individual applicants), this rule tends to benefit health systems with affiliated ineligible HCPs. Such health systems can structure closed-consortia applications where the applicant for each connection to an ineligible health site is an eligible rural HCP. Ineligible HCPs that are not affiliated with a health system that has at least one rural eligible HCP cannot similarly benefit.

¹²³ *HCF Order*, 27 FCC Rcd at 16702 n.137.

To help level the playing field between individual HCPs and consortia (and if needed, between affiliated and unaffiliated HCPs and open and closed consortia), the Commission should consider broadening recognition of what constitutes an “eligible connection” for consortium networks. The rule would look at consortium network participants in their totality and ensure that at least 50% are eligible entities pursuant to Section 254(h)(7) of the Act. Sites that continue to be ineligible could continue to participate by paying the undiscounted cost for their connections (and a “fair share” of common network costs, if applicable).

Under this proposed rule, for example, an HCF consortium currently consisting of twenty-five Section 254(h)(7) eligible HCPs could receive HCF support to connect up to another twenty-four HCPs to its network that are not identified in Section 254(h)(7), provided those connections were being used for eligible purposes pursuant to Section 54.602(d) of the Rules. The rule could function similar to the current rule that allows non-rural eligible HCPs to receive HCF support if they are in a consortium that is majority rural.¹²⁴ The majority rural requirement would still apply and would count all HCPs with supported connections for the purposes of determining majority rural status.

VI. CONCLUSION

The broadband enabled transformation of the health care industry is necessary to address growing disparities of access to quality care between rural and non-rural patients. The Commission has done much to support broadband communications needed for rural health care, however further steps are needed. The reforms and improvements we ask the Commission to take will increase the availability and affordability of quality broadband to rural health care providers

¹²⁴ See 47 C.F.R. § 54.630(b) (“An eligible non-rural [HCP] site may receive universal service support only as part of a consortium that includes more than 50 percent eligible rural [HCP] sites.”)

and will help reduce growing rural health disparities. Attaining this goal is sufficient to justify initiating a rulemaking in which our ideas to further modernize the Rural Health Care programs can be vetted.

WHEREFORE, good cause having been shown, the Commission should grant this petition and issue an appropriate notice of proposed rulemaking. *See* 47 C.F.R. § 1.407.

Respectfully submitted,



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