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

In the Matter of	)	
	)	
Promoting Telehealth for Low-Income Consumers	)	WC Docket 18-213
	)	
COVID-19 Telehealth Program	)	WC Docket No. 20-89
	)	

COMMENTS OF THE

SCHOOLS, HEALTH & LIBRARIES BROADBAND (SHLB) COALITION

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I. Background

The Schools, Health & Libraries Broadband ("SHLB") Coalition, whose members include many participants in the Rural Health Care (RHC) program (both the Healthcare Connect Fund ("HCF") and the Telecommunications Program ("Telecom Program")), appreciates the opportunity to submit these comments to the Federal Communications Commission ("Commission") in the above-captioned proceeding. The SHLB Coalition is a broad-based coalition of organizations that share the goal of promoting open, affordable, high-quality broadband for anchor institutions and their communities.[1]

The Commission first established the COVID-19 Telehealth Program ("Program") in April 2020 as directed by Congress in the CARES Act.[2] According to the Commission, "[t]he Program was established to help health care providers provide telehealth and connected care services to patients at their homes or mobile locations in response to the COVID-19 pandemic."[3] The Commission completed its award of funding on July 8, 2020. Congress subsequently provided a second round of funding in the amount of $249.95 million in the Consolidated Appropriations Act, signed into law on December 27, 2020. In a Public Notice released on January 6, 2021, the Commission requested comment on the implementation of the second round of funding for the Program. As required by the Consolidated Appropriations Act, the FCC sought comment on "the metrics [to be used] to evaluate applications for funding" and "how the Commission should treat applications filed during the funding rounds for awards from the

[1] SHLB Coalition members include representatives of health care providers and networks, schools, libraries, state broadband offices, private sector companies, state and national research and education networks, and consumer organizations. See http://shlb.org/about/coalition-members for a current list of SHLB Coalition members.

[2] https://www.congress.gov/116/bills/hr748/BILLS-116hr748enr.pdf.

[3] Public Notice, para. 3.

COVID-19 Telehealth Program using amounts appropriated under the CARES Act." The Commission also seeks comment on "other improvements to the application, review, and invoicing process."[4]

II. The Commission Should Act Quickly.

The Commission did an admirable job in the first round of funding, opening the Program to applications in April and completing its award of all first round funding by July 8, 2020. Because the COVID-19 pandemic continues to wreak havoc across the country, causing an extraordinary number of hospitalizations and deaths, the distribution of this second round of funding should also be expedited. The SHLB Coalition urges the Commission to issue a final order, begin accepting applications, and complete its awards as soon as possible. The SHLB Coalition offers the following suggestions based on the questions raised in the Public Notice to help the Commission move quickly to award funding to healthcare providers (HCPs) as fairly and efficiently as possible.

1. Should the FCC continue to target funding to HCP's in areas "hardest hit" by COVID19 at the time of the funding decision? How should the FCC define areas "hardest hit"? ¶7 of PN

The SHLB Coalition believes every area of the country should be eligible for funding because the virus is everywhere. It is hard to define a "hard hit" area. The virus continues to spread indiscriminately, and some areas that have relatively mild levels of infection today may become "hot spots" by the time the funding is available. The new mutant form of the virus (which started spreading rapidly in the UK last month and is more contagious than previous strains) is already becoming widespread across the U.S. Furthermore, states and localities that

[4] Public Notice, para. 2.

have done a better job of limiting the spread of the virus should not be punished by restricting their eligibility for funding.

Having said that, the Commission may wish to give greater weight to applications from medically underserved areas. Medically underserved areas have fewer doctors and other medical resources available, so funding from the Commission for these areas may be especially impactful. These areas can be found easily at https://data.hrsa.gov/tools/shortage-area/mua-find.

2. What weight should be given to pre-existing strain and should the FCC distinguish between pre-pandemic strain and pandemic-related strain? ¶8 of PN

As the Commission knows, rural areas tend to face doctor shortages and a lower standard of living. As such, the SHLB Coalition suggests that the Commission give particular attention to the needs of medically underserved areas as mentioned above. Many of these medically underserved areas are in rural markets, but using the medically underserved areas allows the Commission to target resources to those areas that have a particularly strong need.

3. Should the FCC maintain a $1M limit and how should it handle applications by statewide entities, large HCP's, or HCP's with multiple sites? ¶9 of PN

We do not believe that the FCC should cap the award of funding at $1 million per applicant. Some applicants may represent consortia that serve multiple states and multiple health care providers, including many health care providers in medically underserved areas that need funding. Also, limiting the amount to $1 million may encourage consortia applicants to divide up their applications into smaller segments, which may extend the decision-making timeline. It may be more efficient to have a smaller number of total applications filed. Also, smaller

applicants may not have the resources to apply individually, but allowing a consortium to file on behalf of multiple small entities may result in more funding availability to smaller providers.

It is also unclear how a cap would work with the statutory directive to fund one application from each state (i.e., if the only application from a state is over $1 million). The Commission should take care that, if a cap is utilized, it does not encourage applicants to "game" the process.

In addition to considering medically underserved areas, we suggest that the Commission consider a proportional allocation of funds based on state and territory population as a rough guideline. (While the statute requires the Commission to award at least one application for each state and the District of Columbia, it did not prohibit applications from territories. SHLB believes the territories should receive consideration for funding equivalent to states.) For example, the state of Ohio has a population of 11.7 million people, approximately 3.5 percent of the U.S. population. Therefore, the Commission should try to award about 3.5 percent of the $250 million -- $8.75 million -- to recipients located in Ohio. The amount should not be a hard and fast rule, and the Commission and USAC should have some flexibility to depart from these guidelines in their best judgment. Nonetheless, laying out these criteria in advance would help guide the Commission and USAC in allocating funding fairly throughout the nation. The Commission should also consider that some states did not receive any funding in the first round and should ensure that those states receive adequate funding in Round 2.

4. Are there other equitable limitations that will help spread funding to a greater number of HCPs without sacrificing the needs of larger HCPs? ¶10 of PN

Giving a slight preference to Round 2 applicants who did not receive funding in Round 1would promote fairness and would allow health care practitioners to acquire necessary

equipment and facilities that could extend beyond the funding program. For this reason, we suggest that second round applications that did not receive funding in the first round be given extra weight when the Commission makes second round funding decisions.

This is not to say that HCPs that received funding in Round 1should be disqualified from receiving funding in Round 2. Some first round applicants - such as Indian tribes - may be particularly vulnerable to the spread of the virus and should be eligible for Round 2 funding even if they received funding in Round 1. For instance, the Navajo Nation has been in lockdown for much of the time since the coronavirus hit and the latest lockdown order runs until January 25, 2021.[5] The Nation may need additional funds to support wireless connections to allow its medical personnel greater access to remote locations and patients. To ensure a fair distribution of resources, the Commission could limit funding for additional payments to recurring services for Round 1 recipients.[6] The Commission should consider the ongoing needs of the applicants as opposed to a blanket prohibition on Round 1 recipients receiving funds for Round 2.

5. What metrics should be used to prioritize funding? ¶11 of PN a. HCP's serving a large % of COVID-19 patients? b. Specific types of telehealth and connected services? c. HCP's treating at-risk populations; d. Tribal, low-income, or rural?

It is difficult to prioritize given the widespread of the disease. Perhaps the most important metric to examine is the depth of experience and proven success of the healthcare provider in serving its community. We also note that mental health providers and community

[5] https://www.ndoh.navajo-nsn.gov/covid-19.

[6] Because of the rolling nature of the applications, Round 1 recipients did not have much time to prepare their applications and some of the funds from Round 1 may not have been able to be used in the time frame allowed. If so, the Commission should allow Round 1 recipients to use their funds beyond the Round 1 deadline.

health centers encounter special difficulties and are in great need of assistance because of the psychological impact of the virus.

6. Should the FCC continue accepting applications on a rolling basis but set aside a portion of funding for each state and D.C.? ¶12-13 of PN

The SHLB Coalition prefers that the Commission establish an application window with a specific deadline (such as March 15). Establishing a filing window gives all applicants the same amount of time to compile and submit applications. With the rolling application process in Round 1, many larger applicants with more resources and personnel were able to apply right away. The rolling window may have unintentionally given larger applicants a preference.

Furthermore, because it will be difficult for applicants to simultaneously apply for both the RHC program and the COVID-19 program, we also respectfully suggest that the Commission extend the deadline for applications for the Rural Health Care (RHC) Program for two months until June 1, 2021 in order to give applicants the opportunity to apply for both programs. An established filing window for the Program and an extension of the RHC Program deadline will also allow the administrative burden of processing applications to be spread out over time.

7. How should the Commission treat applications filed during Round 1? ¶14-16 of PN

The Commission asks whether Round 1 applicants that did not receive funding should be allowed to re-submit or amend their applications for Round 2. This is not advisable. The virus is affecting different populations today than last April and May, and the rollout of the vaccine means the situation on the ground may be quite different than last year. We also understand that

the Commission's application portal may not be designed to allow Round 1 applicants to submit an update to their applications. Round 1 applicants who just re-submit their Round 1 applications or amend them are less likely to be granted. For all these reasons, it seems reasonable for all applicants to submit new applications for this second round of funding.

8. Should USAC be responsible for administering all remaining work to complete Round 1 and Round 2, including, but not limited to portal updates, initial review of invoices, and application guidance and outreach? ¶18 of PN

USAC needs additional resources and staffing if it is going to be tasked with working on the COVID-19 Telehealth Program in addition to its existing responsibilities to administer the RHC program. The RHC program is already operating behind schedule and requiring USAC to add to its workload without additional resources will cause delays in both programs.

In addition, if USAC is responsible for analyzing the applications, the Commission will need to establish specific criteria for USAC's review and prioritization. Stating that Commission staff will make the final determinations is not sufficient when some applications will never be seen by Commission staff. We note that USAC is not allowed to interpret the statute or Commission rules, so providing guidance to USAC is of paramount importance. While we understand the Commission staff's desire for assistance in reviewing the applications, it should not sacrifice agency expertise and guidance.

9. Should eligibility be determined by filing an FCC Form 460; by USAC as part of the application review (no 460); or are there other means of identifying HCP's and determining eligibility? ¶19 of PN

We support the idea that applicants should not have to obtain 460 approval before filing an application for the COVID-19 Telehealth Program. USAC often takes a month to approve Forms 460, which may delay the application and review process. Applicants could instead demonstrate their eligibility as part of their application. This will reduce the burden on USAC and will also expedite the filing of Telehealth Program applications.

**10. Are there additional improvements we should consider making to the application, review and invoicing process? ¶20, 21 **

First, we agree that applicants should be allowed to substitute vendors, eligible services, and/or eligible connected devices as long as the substituted items are eligible and the total amount sought for reimbursement does not exceed the commitment amount.

Second, we recommend one improvement from Round 1 with respect to invoicing. In Round 1, applicants had to receive service and pay for the services before submitting an invoice to the Commission for payment. Specifically, the Commission required awardees to "first pay the vendor or service provider for the costs of the eligible services and/or connected devices received before requesting reimbursement for those costs from the COVID-19 Telehealth Program."[7] That upfront payment can cause significant hardship for cash-strapped awardees, especially those that need the funding the most. The Commission should allow awardees to invoice the Commission or USAC when they receive their bills, instead of after they have paid

[7] https://www.fcc.gov/covid-19-telehealth-program-invoice-frequently-asked-questions at Question 1.

for the services, or allow for the direct payment of vendors that already have an account with USAC.

11. Should applicants only be required to demonstrate eligibility of connected devices and services in Round 2 during the invoicing process? ¶21

The Round 1 process was not particularly burdensome with respect to applicant support for the eligibility of devices and services. Some documentation of eligibility at the beginning of the process should help ensure that funds are awarded appropriately.

Finally, as noted above, applicants should not be required to pay their invoice before receiving reimbursement from this Program. Many health care providers, especially smaller HCPs and those in hard hit areas, do not have the cash on hand to pay these bills and cannot afford to put their health care services on hold while waiting for reimbursement from USAC.

Respectfully submitted,

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