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

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

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

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SUMMARY

Congress established the Rural Health Care (RHC) program in 1996 to help rural consumers gain better access to telemedicine services. The statute guarantees telecommunications price parity between urban and rural not-for-profit health care providers and promotes the availability of advanced telecommunications services (broadband) to all not-for-profit health care providers, both urban and rural. But this program has fallen short of its goals. For this reason, the SHLB Coalition filed a Petition for Rulemaking in December 2015 asking the FCC to upgrade the program and ensure that its statutory purposes are met. We are thus extremely pleased that the Commission opened the "Promoting Telehealth in Rural America" proceeding to ensure RHC programs are meeting those statutory directives: the Telecommunications Program (Telecom Program) to support pricing parity, and the Healthcare Connect Fund (HCF) to support the availability of broadband for health care providers nationwide.

To ensure those statutory directives are met, we urge the Commission to increase the annual RHC spending cap from $400 to $800 million to reflect that the number of health care providers potentially eligible for the RHC program has more than doubled since 1997 when the $400 million cap was promulgated. The $150 million HCF "sub-cap" should also be increased proportionally. Alternatively, we support removing the Telecom Program from the existing $400 million cap – because the rural/urban price parity is statutorily mandated and thus should be uncapped – and maintaining the $400 million level of funding exclusively for the HCF. In either case, the RHC cap should be indexed to inflation, and we respectfully request USAC administrative expenses not be counted against the cap, as is the case with the High Cost program. We support further measures to guard against waste, fraud and abuse – such as harmonizing RHC program rules on gifts and consultants with the E-rate program – however we believe these steps should be taken simultaneously with a cap increase as the demand for greater broadband connectivity will continue

to expand due to changes in the healthcare marketplace and federal mandates regarding electronic health records. We observe that a cap increase would increase the current universal service fund (USF) contribution factor by at most by 1%, which is small compared to the three-point increase in USF contribution factor over the last two years attributable to the declining contribution base. We caution against using the declining USF contribution base to drive policy decisions about how much funding is needed to meet Congressional objectives for the RHC program – especially as here where Congress has not mandated spending caps for meeting those objectives.

We believe the program rules should be tweaked to target funding to rural markets. For instance, we support protecting program participants with the highest connection costs from unlimited pro rata funding reductions in the event the cap is reached. We also support creating different discount categories in the HCF program as the best method to target support to those with higher connection costs – such as those in frontier or extremely rural areas (however the Commission chooses to define this). We do not support exempting any class of program participants from pro rata reductions, or de-prioritizing certain types of applicants such as non-rural health care providers, certain types of applicants that are part of consortia, or certain types of eligible services, such as equipment. We note that Consortia bring significant cost-benefits to the HCF program, not just through bulk-buying and administrative efficiencies, but through more efficient network designs which have been shown to lower connectivity costs. The Commission should therefore not take steps that could dis-incentivize participation in consortiums.

Finally, we ask the Commission to consider changes to the program funding calendar to allow USAC to make funding decisions faster and sooner in the funding cycle. In addition, administrative efficiency should be measured with greater transparency and increased responsiveness to stakeholders. We caution against measuring efficiency simply by how little

USAC spends on program administration relative to disbursements. To increase responsiveness, we believe deadlines for funding decisions and administrative appeal decisions should be mandated and/or codified. To increase transparency, USAC should be directed to make basic program data available on par with what has been long available in the E-rate program.

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

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 (HCPs), libraries, K-12 schools, community colleges, colleges and universities, public media and other 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.

[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 http://shlb.org/about/coalition-members for a current list of SHLB Coalition members.

I. INTRODUCTION

The Commission rightly recognizes that technology and telemedicine play a growing, increasingly critical role in the delivery of health care across the country, and that rural communities, with aging populations and struggling economies, are falling behind and need access to telemedicine, telehealth, and cloud-based services more than ever.[2] Because rural access to medical technologies, and the financial resources and broadband access needed to enable them, continues to be uneven as compared to urban areas, the RHC programs continue to be critically important. This was presciently recognized by Congress in 1996 when it codified universal service commitments to (1) telecommunications cost parity between urban and not-for-profit rural HCPs, and (2) enhanced access to advanced services for not-for-profit HCPs nationwide – making clear that Congress intended this to be a national program available to the entire country, with a focus on rural markets.

As discussed below, SHLB and its members participating in the RHC programs ("SHLB health care participants") favor increasing the overall size of the program to ensure those Congressional objectives are fulfilled. There are at least two ways to do this. First, the Commission could increase the funding for the RHC program up to a cap (indexed for inflation) that is based on the expected costs of providing sufficient broadband to support telemedicine, telehealth, and supporting cloud-based services to the increasing number of non-profit HCPs across the country (a "ground up" approach). We believe that, because the number of eligible entities has more than

[2] *Promoting Telehealth in Rural America, Notice of Proposed Rulemaking and Order*, WC Docket No. 17-310, FCC 17-164, ¶ 1 (Dec. 18, 2017) (*NPRM and Order*) (citing Anna Gorman, *Healthcare's New Rural Frontier*, Politico (Apr. 12, 2017) ("[Telemedicine] projects [at rural hospitals] often depend on grants or government awards, because rural hospitals' operating margins are slim. And some of the telemedicine and remote monitoring technologies require high-speed internet, which isn't always reliable or cost-effective in rural areas."), https://www.politico.com/agenda/story/2017/04/rural-healthcare-idaho-lost-rivers-000394 (last visited Jan. 18, 2017)).

doubled since 1996, doubling the $400 million cap to $800 million is justified. Second, the Commission could exclude the Telecom Program from the cap – as we argue the statute requires – and maintain the current $400 million cap (indexed for inflation) for the HCF portion of the RHC program. Raising the cap for funding the RHC program is especially urgent now considering that demand for the program has surged above the cap for the past two years.

Even after the cap is raised and more funding is made available, it may be possible that demand for program funds will exceed the cap in future years. We encourage the Commission to make decisions in this proceeding to decide how funding will be allocated to provide applicants and providers with greater certainty. In doing so, the Commission should consider what allocation will be most effective in providing high-quality telemedicine, telehealth and supporting cloud-based services to those most in need. For instance, HCPs with the highest costs need some protection from *pro rata* reductions that could be disruptive to operations. Ultimately, we favor establishing different discount tiers for HCF participants based on rurality as a better method for ensuring limited RHC funding is distributed where it is needed most.

Finally, we support substantial improvements in how USAC administers the RHC programs, including greater transparency of program data and program guidance provided by USAC, and a greater emphasis on USAC's responsiveness and transparency to applicants as a critical measure of administrative efficiency. To ensure this shift, the Commission should codify requirements and establish deadlines for USAC's processing of funding applications and for rendering administrative appeal decisions.

II. THE COMMISSION SHOULD INCREASE THE SIZE OF THE RHC PROGRAM TO ENSURE ITS STATUTORY PURPOSES ARE FULLFILLED, WHILE ADOPTING ADDITIONAL MEASURES TO ENSURE PROGRAM INTEGRITY

The Commission asks what is driving growing demand in the RHC programs, how to ensure limited program funds are being used effectively, and whether and how much to increase the $400 million RHC program cap, and the $150 million "sub-cap" for HCF upfront costs and multiyear funding commitments.[3] The Commission asks commenters to consider the impacts of increased programmatic spending on the universal service fund (USF) contribution factor and thus, on consumers.[4]

There are at least four reasons for increasing the funding available for the RHC program above the $400 million cap set in by the Commission in 1997:

1. The changes in health care delivery and technologies that make telemedicine and telehealth more accessible and valuable, and cloud-based disaster recovery solutions more available and necessary;
2. The continuing closure crisis for rural hospitals;[5]
3. Congress' addition in 2016 of Skilled Nursing Facilities (SNFs) to the list of eligible entities;
4. Federal government mandates on health providers, such as the implementation of electronic medical records.

In the experience of SHLB health care participants – which include large statewide and regional consortia networks with thousands of rural HCP participants – growing demand for RHC funding is driven primarily by economic factors, including fundamental shifts in the healthcare marketplace driven by technological advancements. These changes have manifested in part with a

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[3] *NPRM and Order*, at ¶¶ 4, 16-17.

[4] *Id.* at ¶ 16.

[5] *See* North Carolina Rural Health Research Program, University of North Carolina, *83 Rural Hospital Closures: January 2010 – Present* (Jan 5. 2018), http://www.shepscenter.unc.edu/download/11619/ (last visited Feb. 1, 2018).

pronounced merger trend as struggling rural providers often must either merge or close.[6] Federal government policies and mandates have also contributed to the pace and direction of change, as has awareness of the critical impact broadband for health care has on disaster recovery efforts.[7] Over the last five years in particular, these forces have transformed high-bandwidth broadband for healthcare – for telemedicine, telehealth, and management and operations – from a "nice-to-have" capability to an absolute necessity. While we support efforts to address wasteful use of program funds and to limit opportunities for fraud and abuse, changes in the healthcare marketplace combined with the clear statutory purposes of the RHC programs warrant a substantial increase in programmatic funding. Going forward, any programmatic caps should be indexed to inflation. In addition, USAC RHC-specific administrative expenses should not be deducted from the cap.[8]

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[6] *See* Brian Alexander, *America's Rural Hospitals Are Dangerously Fragile: Consolidation in the health-care industry is threatening small and independent hospitals and the communities they're in*, THE ATLANTIC (Jan. 9, 2018), ("[S]tand-alone nonprofit hospitals have been auctioning off their real estate to investors, selling themselves to for-profit chains or private-equity firms, or, like Berger, folding themselves into regional health systems."), https://www.theatlantic.com/business/archive/2018/01/rural-hospitals/549050/ (last visited Feb. 2, 2018); *see also, e.g.*, Elizabeth Fite, *Done deal: Erlanger acquires Murphy Medical Center in North Carolina*, TIMES FREE PRESS (Jan. 26, 2018) ("Like many small, rural hospitals across the country, Murphy faced the growing challenges of limited resources, high costs, federal regulations and isolation."), http://www.timesfreepress.com/news/local/story/2018/jan/26/done-deal-erlanger-acquires-murphy-medical-ce/462184/ (last visited Feb. 2, 2018); *see generally* American Hospital Association (AHA), TRENDWATCH CHARTBOOK 2016, Chart 2.9: Announced Hospital Mergers and Acquisitions, 1998 – 2015, https://www.aha.org/system/files/research/reports/tw/chartbook/2016/chart2-9.pdf.

[7] *See, e.g.*, John Brandon, *How to Use the Cloud as a Disaster Recovery Strategy*, INC. (2011) ("Galanti says the perspective on disaster planning for how to access cloud services has changed because most of the cloud computing they do in their business is not run locally. Even though some of the local applications, such as Microsoft Outlook, run within Windows, the actual e-mail is housed off-site, not on a local server. The business does not even store documents locally - everything is scanned and stored online."), https://www.inc.com/guides/201106/how-to-use-the-cloud-as-a-disaster-recovery-strategy.html. (last visited Feb. 2, 2018); *cf. Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 21 FCC Rcd 11111, ¶ 4 (2006) ("increasing broadband connectivity among health care providers at the national, state and local levels would also provide vital links for disaster preparedness and emergency response").

[8] The Commission has elected not to deduct program-specific administrative costs from available funding in the High Cost program. *See Connect America Fund*, WC Docket No. 10-90, Report and Order and Further Notice of Proposed Rulemaking, FCC 11-161, 26 FCC Rcd 17663, ¶ 126 (2011) (maintaining $4.5 billion budget for Connect America Fund "plus administrative expenses"); *but see* 47 C.F.R. § 54.715(c).

With respect to the USF contribution factor, recent increases in that factor reflect a concerning erosion of the contribution base rather than USF programmatic growth, with the base declining by almost 14% (from $14.9 billion to $12.9 billion) in the last two years alone. This is an alarming trend the Commission must address irrespective of any changes to the RHC programs. Moreover, because the RHC program is small compared to the other USF programs, even doubling RHC program spending would increase the annual overall USF spending (which is now over $9 billion) by less than 5%.[9] Thus, a dramatically larger RHC program would have an enormously beneficial impact on rural health care and an extremely minor impact on consumer's telephone bills. Even if raising the cap on the RHC program affects the contribution factor by about one percentage point, this impact is much smaller than the effect of the declining contribution base. Because USF spending is statutorily mandated while USF spending caps are not, the Commission's first priority should be to ensure that Congressional directives are fulfilled. While programmatic caps are appropriate as a mechanism to ensure fiscal discipline, they should only be implemented after the Commission establishes that statutory objectives and requirements are met.

A. RHC Demand is Being Driven Primarily by Growing Reliance of Rural Health Care Providers on Broadband

With respect to the kinds of telehealth services that are being used by program participants, we note that for consortia in the HCF, this information is reported annually to USAC.[10] SHLB health consortia participants report that every possible category of telehealth applications tracked by USAC is in regular use. A recent survey of over 100 rural hospitals nationwide performed by HIMSS Analytics validates the experience of SHLB health care participants based on the

[9] We note that the FCC has recently proposed to increase funding for the Connect America Fund by $500 million. *See Chairman Pai Proposes Over $500 Million In Funding To Promote Rural Broadband Deployment*¸ FCC Press Release (Jan. 16, 2018), https://transition.fcc.gov/Daily_Releases/Daily_Business/2018/db0116/DOC-348723A1.pdf.

[10] *See Rural Health Care Support Mechanism*, 27 FCC Rcd 16678, 16808-09 (2012) (*HCF Order*).

thousands of HCPs they serve: that care delivery and reliance on the cloud for administrative operations, including disaster preparedness, are the primary drivers. The HIMSS Analytic survey specifically shows:

- Telehealth is a principal driver of bandwidth demand;
- "Cost and availability continue to be hurdles in obtaining necessary network connectivity";
- "'Network reliability' and the 'Availability of fiber-based services' were top consideration in enhancing healthcare delivery methods."
- Disaster recovery preparation is dependent upon network redundancy, storage, and cloud-based services.[11]

While broadband-enabled care is the major driving demand for high-speed bandwidth, healthcare operations and management and disaster recovery are also dependent on cloud-based applications and services, including electronic health records (EHRs).[12] Indeed, with health operations dependent on high-speed access to the cloud, when network services are down it now disrupts local care delivery, not just remote care delivery. For example, many rural HCPs no longer maintain their own servers to run healthcare applications locally and are fully dependent upon network connectivity for basic operations. "Cloud-based" services include private network and internet-based services such as EHR systems, picture archiving and communication systems (PACs), and telemedicine systems, which are all essential to operations and patient care.

Evidence that growth in RHC program demand is being driven by greater reliance and dependence on high-speed broadband is easily seen in the HCF. The New England Telehealth Consortium (NETC) is one of the largest HCF consortia in the country, with 890 participating

[11] *See* THE IMPACT OF CONNECTIVITY ON RURAL HOSPITALS & THE PROMISE IT HOLDS, Bryan Fiekers, HIMSS Analytics (Dec. 7, 2017), http://www.himsslearn.org/impact-connectivity-rural-hospitals-promise-it-holds.

[12] *Id.*

sites, 750 of which are rural. NETC's data set on bandwidth demand now spans six New England states and goes back to 2008 when, as part of the RHC Pilot Program, NETC surveyed over 400 sites in three states as part of the design phase for the network. NETC sites currently utilize 50 of the 51 categories of telemedicine applications tracked by USAC. Since 2010, NETC has seen a dramatic increase in bandwidth requirements due to the growing use among participating sites of telemedicine and telehealth applications, including EHRs, PACs, and other cloud-based services. For example, the original 320 NETC sites have seen a seven-fold growth in installed bandwidth across the NETC network over the past seven years, from 6 Gbps to 45 Gbps. Bandwidth demand has been increasing on average 33% annually over this period, which NETC estimates will continue over the next seven years. Current bandwidth for the entire NETC network is 232 Gbps, projected to increase to 1700 Gbps by 2024.

Federal policies continue to recognize the economic and clinical value of broadband and telemedicine, and to promote telemedicine usage. This is reflected in the latest round of United States Department of Agriculture Distance (USDA) Learning and Telemedicine (DLT) grants awarding over $24 million in funding for projects in 28 states.[13] Some of these projects are intended to address the opioid epidemic, and all are recognized as supporting economic growth and job development in rural America.[14]

The Commission considers trends in the Telecom Program, such as declining numbers of HCPs receiving more support for costlier connections, and asks the degree to which wasteful

[13] *See* USDA Invests in e-Connectivity to Restore Rural Prosperity by Providing Training and Health Care Services, USDA Press Release (Jan 19, 2018), https://www.usda.gov/media/press-releases/2018/01/19/usda-invests-e-connectivity-restore-rural-prosperity-providing.

[14] *See id.* ("'Connecting rural Americans to quality education and health care services is an innovative and important tool in our efforts to facilitate economic growth, job creation and quality of life in rural America,' Anne Hazlett, the USDA's Assistant to the Secretary for Rural Development, said in a press release.").

purchasing decisions by HCPs may be to blame.[15] We do not believe that wasteful purchasing is widespread. We generally support mechanisms that require some amount of "skin-in-the-game" as an effective and simple way to ensure applicants procure only the services they need.[16] We are concerned, however, that additional heightened scrutiny in the application process would slow down an already unreasonably lengthy process. (We address this further below.) In the experience of SHLB health participants, program demand is being driven (1) by growing bandwidth demands that routinely outpace declines in pricing, and (2) by greater numbers of HCPs procuring the high-speed broadband they increasingly need to meet their business needs and the healthcare needs of their rural patients.

B. Funding Levels Should Be Increased So They Are Sufficient To Meet the Statutory Purposes of the RHC Programs

The RHC program mandated by Congress in 1997 was ahead of its time. Sluggish growth in demand for funding over the years likely reflected this fact as much as potential issues with program design, administration, or outreach and education. With medical technologies having sufficiently advanced, and rural areas now facing unprecedented economic and demographic challenges, the record shows the principal driver of demand for funding in this program is the growing need for the very services envisioned by Congress in 1996. Therefore, while we fully support efforts to ensure efficient and carefully targeted support, the size of the RHC program – which is manifestly not limited by the statute – should be recalibrated to meet Congressional objectives in light of the demonstrably growing need for this funding.

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[15] *NPRM and Order* at ¶ 16.

[16] *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 18 FCC Rcd 24546, ¶ 58 (2003) (*2003 Order and Further Notice*) (recognizing that "the requirement that health care providers remain responsible for a significant portion of service costs" helps protect the RHC program from waste).

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.[17] 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.[18] In doing so, Congress effectively mandated price parity between urban and rural HCPs to facilitate the increased use of telemedicine.[19] 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 *everywhere*.[20] This further directive provides the Commission authority to expand health care providers' access to broadband-enabled services – including promoting infrastructure deployment if that is necessary to enhance access to advanced telecommunications and information services.[21]

The Commission under this authority has long fostered greater equality of health access by

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[17] 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.

[18] *See* 47 U.S.C. § 254(h)(1)(A) (providing that telecommunications carriers "shall" provide discounted telecommunications services to nonprofit HCPs "that serve[] persons who reside in rural areas".).

[19] *See* H.R. REP. NO. 104-458, at 133 (1996) ("It is intended that the rural health care provider receive an affordable rate for the services necessary for the purposes of telemedicine and instruction relating to such services.").

[20] *See id.* at 132 ("New subsection (h) of section 254 is intended to ensure that health care providers for rural areas, elementary and secondary school classrooms, and libraries have affordable access to modern telecommunications services *that will enable them to provide medical and educational services to all parts of the Nation*.") (emphasis added); *see also HCF Order*, 27 FCC Rcd at 16705 ("As the Fifth Circuit has found, 'the language in section 254(h)(2)(A) demonstrates Congress's intent to authorize expanding support of 'advanced services,' when possible, for non-rural health providers.'") (*citing Texas Office of Public Utility Counsel v. FCC*, 183 F.3d 393, 446 (5th Cir. 1999) (subsequent history omitted)).

[21] *See Fed.-State Joint Bd. on Universal Serv.*, Report and Order, 12 FCC Rcd 8776 ¶ 634 (1997) (*First Report and Order*) (concluding that Section 245(h)(2)(A) provides the Commission with "the authority to establish rules to implement a program of universal service support for infrastructure development as a method to enhance access to advanced telecommunications and information services under section 254(h)(2)(A) . . .".).

supporting the increased adoption and use of telemedicine and telehealth: establishing the Telecommunications Program in 1997 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"[22]; establishing the RHC Pilot Program in 2006 for healthcare networks 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"[23]; and creating the HCF in 2012 to improve broadband connectivity to HCPs, especially in rural areas, and to foster the development of state and regional healthcare consortia.[24]

Notwithstanding these and other critical governmental programs, rural Americans continue to experience significant health disparities – and the need for access to health care via broadband-enabled technologies is greater and more critical today than ever before. Indeed, as the Administration and this Commission have both recognized, 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. [25] Telemedicine and telehealth are universally recognized

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[22] *HCF Order*, 27 FCC Rcd at 16684 (citing *Federal-State Bd. on Universal Service*, 12 FCC Rcd 8776, 9093 (1997)).

[23] *Id.*

[24] *Id.* at 16680.

[25] *See* REPORT TO THE PRESIDENT OF THE UNITED STATES FROM THE TASK FORCE ON AGRICULTURAL AND RURAL PROSPERITY 23 (Jan. 2018) (*Rural Prosperity Report*) (noting "increased mortality among working-age adults, and an aging population [as] health factors that are driving numerous other aspects of rural social and economic life."), https://www.usda.gov/sites/default/files/documents/rural-prosperity-report.pdf.; *NPRM and Order* at ¶ 1 (citing American Hospital Association Connect2Health Comments at 4-5); *see also* Rural Assistance Center, *Rural Heath Disparities, Introduction* 1, https://www.ruralhealthinfo.org/topics/rural-health-disparities (last visited Jan. 9, 2018); 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 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, https://www.ers.usda.gov/webdocs/publications/44424/9371_eib57_1_.pdf?v=41136; *cf. FCC Seeks Comment and*

as essential tools for cost-effectively addressing and reducing these disparities.

1. The Commission Should Promulgate an Annual Funding Cap on the Basis of an Accurate Determination of the Number of Potentially Eligible HCPs

As we stated in our 2015 Petition, the Commission should "determine the aggregate potential demand for the funds on a record that includes the best available factual data. . . .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. The Commission arrived at its $400 million cap based on its 'generous' estimate that there were approximately 12,000 potentially-eligible rural HCPs."[26]

We offer the following good faith estimate of the number of HCPs that are potentially eligible under the program today and propose them as a proxy for considering the reasonableness of the current $400 million cap considering the statutory objectives set forth above. Our data updates the categories utilized by the Commission in the 2012 *HCF Order* and shows the total number of eligible entities today is more than double the number of entities that the Commission estimated in 1997, when the current $400 million cap was established.

Data on Actions to Accelerate Adoption and Accessibility of Broadband-enabled Health Care Solutions and Advanced Technologies, GN Docket No. 16-46, Public Notice, 32 FCC Rcd 3660, 3664, n.19 (2017) (*Connect2Health PN*).

[26] *SHLB, et. al Petition for Rulemaking to Further Modernize the Rural Health Care program*, WC Docket 02-60, at 24 (Dec. 7, 2015) (*SHLB Petition*).

Potentially Eligible HCPs	**Current**	***HCF Order***	**1997**
Post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools[27]	810	625	625
FQHC care delivery sites[28]	9,754	2,612	1,200
Local health departments[29]	2,533	2,136	3,526
Community mental health centers[30]	263	263	1,500
Community non-profit hospitals[31]	3,805	1,674	2,049
Rural health clinics[32]	4,177	2,741	3,329
Not-for-profit skilled nursing facilities[33]	4,675	N/A	N/A
Total	26,017	10,051	12,229

NOTE: This does not include other health care entities that may be eligible, such as school-based health clinics and prison health clinics.[34]

The Commission reported in the *NPRM and Order* that the average per-HCP annual

[27] This number includes schools of nursing but excludes teaching hospitals which are captured elsewhere. *See* American Association of Colleges of Nursing, AACN in Brief http://www.aacnnursing.org/Portals/42/News/AACN-FactSheet-2017.pdf (last visited Jan. 31, 2018).

[28] *See* COMMUNITY HEALTH CENTER NATIONAL CHARTBOOK, National Association of Community Health Centers, at 22 (Fig. 2.1) (2017), http://www.nachc.org/wp-content/uploads/2017/06/Chartbook2017.pdf (last visited Jan. 31, 2018). Previous counts of FQHCs appear limited to FQHC grantee organizations rather than care delivery locations.

[29] *See* National Profile of Local Health Departments, National Association of County & City Health Officials, (2017) http://nacchoprofilestudy.org/wp-content/uploads/2017/01/Figure1-2.jpg (last visited Jan. 31, 2018).

[30] We use the number here provided by the FCC in 2012.

[31] *See* American Hospital Association, Fast Facts on U.S. Hospitals (2018), https://www.aha.org/statistics/fast-facts-us-hospitals (last visited Jan. 31, 2018). This number includes both non-profit community hospitals and non-federal state and local government community hospitals. About 47% of total hospitals are rural (2,244/4,711). *See* NC Rural Health Research Program, Rural and Urban Hospitals in the United States, August 2017, http://www.shepscenter.unc.edu/download/15316/ (last visited Jan. 31, 2018).

[32] The number of rural health clinics reflects a manual count by state based on the following CMS data set: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/rhclistbyprovidername.pdf#page=16 (last visited Feb. 2, 2018).

[33] The total current number of SNFs is 15,583 with about 30% (4675) of those estimated to be not-for-profit. *See* NURSING HOME DATA COMPENDIUM 2015 EDITION, Department of Health & Human Services, Centers for Medicare and Medicaid Services, at 17 (2015), https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/Downloads/nursinghomedatacompendium_508-2015.pdf (last visited Jan. 31, 2018). We understand that not-for-profit SNFs are often stand-alone entities which tend to be more rural than urban.

[34] We do not distinguish in all cases between rural and non-rural sites because under current rules non-rural sites (except Rural health clinics) may participate in the program if they are part of a majority rural consortium. As we explained in the *SHLB Petition*, however, where site addresses are available in the source data, it is possible to make an individualized determination of rurality using USAC's RHC rurality tool. *See SHLB Petition* at 29-30 (noting for example that, at that time, 28 out of 65 of local health departments in New Mexico were rural and 100% of the CMS-designated rural health clinics in Maine, New York, and New Mexico were rural).

commitment in the Telecom Program was $32,000 in funding year (FY) 2013.[35] If all 26,017 sites received support at that level today, the total RHC funding would be $833 million, more than double the current cap. While many sites will not need that much support (and some will need much more), this is a reasonable basis for sizing the cap today, *i.e.*, doubling the current cap to reflect more than double the number of potentially eligible sites when the program cap was first set. (We recognize that the $32K average Telecom Program includes Alaska, but unless the Telecom Program is excluded from the cap, the cap must be sufficient to meet the needs of Alaskan providers.) Moreover, a program size of $800 million (indexed to inflation) would be comparable to the Lifeline program and would be substantially smaller than either the E-rate program or the Connect America Fund program. This figure would be well within the bounds of reasonableness considering the statutory purposes of the program, the changes in the rural economy and medical technology, and the overall $9 billion size of the USF.

2. The Commission Could Give Priority to the Telecommunications Program by Placing the Program Outside of any Cap Calculations

Although we address the question of priority more fully below, in this section we consider potential reforms to the Telecom Program and how these might achieve the objective of ensuring sufficient and predictable support for those areas "in greatest need of access to health care."[36] First, as proposed above, a substantial increase in program funding would, at least initially, eliminate the need for any prioritization scheme. But the Commission also asks whether the statutory language establishing the Telecom Program in fact gives it priority over the HCF.[37]

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[35] *NPRM and Order* at ¶ 10.

[36] *NPRM and Order* at ¶ 27.

[37] *NPRM and Order* at ¶ 32 (citing, *e.g.*, Letter from Geoff Strommer, Counsel to Tribal Organizations in Alaska, to Chairman Ajit Pai and Commissioners, FCC, WC Docket No. 02-60, at 1 (filed Aug. 15, 2017) (arguing that section

We have already observed that the RHC statutory language does not *require* the Commission to establish a funding cap. However, the term "shall" in Section 254(h)(1)(A) authorizing the Telecom Program represents a statutory directive that appears to preclude a hard cap – at least for that program.[38] If the Commission so concludes, it could maintain a cap for the HCF but place the Telecom Program outside of this cap. This would effectively give the Telecom Program priority and ensure sufficiency and predictability for the beneficiaries of that program. Placing the Telecom Program outside of the RHC cap would also resolve the issue of *pro rata* reductions having a disproportionate impact on those Telecom Program applicants with very high monthly-bandwidth costs.[39] SHLB and its health care participants would support this type of approach if the current $400 million cap is not reduced (and thus is fully available for HCF applicants), and is then indexed to inflation.

3. HCF Support Should Be Targeted with Variable Discount Levels Rather Than Exempting Any Service or Entity Type from *Pro-Rata* Reductions

To better target HCF support to more remote areas that in most cases are "in greatest need of access to health care",[40] the Commission could adopt more categories of rural, such as "frontier rural", "extremely rural", and "rural", akin to the breakdown the Commission provided in the NPRM.[41] Below is an illustration:

254(h)(1)(A) of the Telecommunications Act of 1996 is an entitlement mandate and that a cap is not authorized by Congress).

[38] To the best of our knowledge, the FCC has never ruled on whether the Telecom program funding is mandatory and not subject to a cap. Even though the Commission adopted a cap of $400 million in 1997, the demand for the program was so far below the cap for so many years that the issue has not arisen until now.

[39] *See NPRM and Order* at ¶ 21; *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 32 FCC Rcd 5463, 5464, ¶ 5 (2017).

[40] *NPRM and Order* at 27.

[41] *See NPRM and Order* at ¶ 26. We understand in the NPRM the Commission used the following criteria to define these categories:

Current			Proposed		
	Telecom Program	**HCF**		**Telecom Program**	**HCF**
Extremely Rural	Eligible under the current definition of "rural"	65% discount	Frontier	Eligible	95% discount
Rural		65% discount	Extremely Rural		85% discount
Less Rural		65% discount	Rural		65% discount
Non-rural (in mostly rural consortium)	Ineligible	65% discount	Urban (in mostly rural consortium)	Ineligible	60% discount
	$400 Million Cap			No cap	Indexed $400 Million Cap

In addition, while the current RHC definition of "rural" based on census categories is well-established, there are other federal definitions of rural the Commission could easily adopt that are more granular and more reflective of rurality as it is lived by rural residents. Greater granularity would avoid not-uncommon situations where HCPs that appear rural and that clearly serve rural residents[42] are considered non-rural because of their proximity to a town (or an aggregation of smaller towns) of 25,000 or greater.[43] Many experts recognize significant problems with the Census Bureau definitions.[44] More granular alternative measurements for rurality include the

- Extremely Rural: In an area that is entirely outside of a Core Based Statistical Area;
- Rural: In an area within a Core Based Statistical Area that does not have any Urban Area with a population of 25,000 or greater;
- Less Rural: In a Core Based Statistical Area that contains an Urban Area with a population of 25,000 or greater, but is within a specific census tract that itself does not contain any part of a Place or Urban Area with a population of greater than 25,000.

We do not necessarily favor continued use of CBSAs, however, and we use these categories simply to illustrate the general structure of our proposed approach.

[42] *Cf.* Section 254(h)(1)(A) (applying to HCPs that "serve[] persons who reside in rural areas [of a] State").

[43] *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order and Notice of Proposed Rulemaking, 26 FCC Rcd 9145, 9149-50, ¶¶ 13-15 (2011) (*Rural Grandfathering Order and NPRM*) ("The record demonstrates that grandfathered facilities, while not located themselves in a "rural area" under current Commission definitions, play a key role in providing health care services to 'fundamentally rural' areas. These providers are not located in large urbanized areas.") (footnotes omitted); *see also, e.g., Petition for Waiver on behalf of Tuolumne MeWuk Indian Health Center*, WC Docket 02-60 (Aug. 2, 2016) (clinic at foot of Sierra Nevada Mountains no longer rural after census bureau aggregated small cities in the area into a larger micropolitan entity that exceeded 25,0000, despite county population declining in 2015 to below 2000 levels), *denied,* Streamlined Resolution of Requests Related to Actions by the Universal Service Administrative Company, Public Notice, WC Docket Nos. 02-60, at 14 (Dec. 29, 2016).

[44] For example, the Federal Office of Rural Health Policy (FORHP), Health Resources and Services Administration (HRSA) provides a helpful overview of the two principal federal definitions of rural, acknowledging these limitations:

USDA, Economic Research Service's (ERS) Frontier and Remote (FAR) Methodology, which is based on driving distances to the edges of nearby urban areas,[45] and the FORHP rurality criteria which utilize Rural-Urban Commuting Area (RUCA) codes.[46]

While SHLB and its health care participants would welcome an opportunity to consider in detail the potential effects of different definitions of rural and frontier on the RHC programs, ready access to current USAC RHC data sets would be needed. Notwithstanding, we generally support establishing "extremely rural" and "frontier rural" categories, however defined, that would provide 85% and 95% discounts, respectively, in the HCF program.

C. Increased Spending in the RHC Programs will be Economically Beneficial to Rural Communities and Rural Residents

Rural hospitals are typically anchor institutions for their rural communities, providing jobs and economic stability, not just health care. National Rural Health Association (NRHA) reports that as many as 20% of the employment and income in rural communities can be associated with the local hospital.[47] While rural hospitals face many different challenges today, Congress through

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"There are measurement challenges with both the Census and OMB definitions. Some policy experts note that the Census definition classifies quite a bit of suburban area as rural. The OMB definition includes rural areas in Metropolitan counties including, for example, the Grand Canyon which is located in a Metro county. Consequently, one could argue that the Census Bureau standard includes an overcount of the rural population whereas the OMB standard represents an undercount."), https://www.hrsa.gov/rural-health/about-us/definition/index.html (last visited Feb. 2, 2018). *See also* National Rural Health Association Policy Brief, *Definition of Frontier* (outlining a variety of governmental definitions used to define highly rural or frontier), https://www.ruralhealthweb.org/getattachment/Advocate/Policy-Documents/NRHAFrontierDefPolicyPaperFeb2016.pdf.aspx?lang=en-US (last visited Feb. 2, 2018).

[45] *See* USDA, Economic Research Service, https://www.ers.usda.gov/data-products/frontier-and-remote-area-codes.aspx; *id.* at https://www.ers.usda.gov/webdocs/DataFiles/ 51020/52626_farcodesmaps.pdf?v=42109.

[46] *See* n.44, above. We recognize that the Commission previously declined to utilize RUCA codes when it last changed the definition of rural in 2004. *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 19 FCC Rcd 24613, ¶ 19-20 (2004). We believe experience with the current definition over the last 14 years warrants reconsideration of a rural definition that is more granular such as one using RUCA codes.

[47] *See* https://www.ruralhealthweb.org/NRHA/media/Emerge_NRHA/Advocacy/Government%20affairs/2017/SRH-Act-Talking-Points-Economic-Impact-(2017).docx.

the rural health care provisions of the Telecommunications Act of 1996 clearly intended the FCC to play a role ensuring these institutions have access to affordable telecommunications and advanced services. For the many reasons we have shown, the statutory purposes of these programs have never been more important.

Access to telehealth in rural communities also brings economic benefits. NTCA—The Rural Broadband Association recently identified the following economic benefits of rural telehealth, both quantifiable and nonquantifiable.[48] Quantifiable economic benefits included:

- Avoided transportation costs;
- Avoided lost wages due to avoided travel;
- Allowing rural hospitals to provide and more efficiently share expensive specialist resources that reside in distant urban hospitals;
- Keeping lab/pharmacy revenues in local communities.

Nonquantifiable benefits included:

- Access to medical specialists;
- Timelier diagnoses – which can improve health outcomes and save lives;
- Increased comfort as rural patients can remain in their communities to receive care;
- Transportation (or lack thereof);
- Providers getting to work with distant specialists;
- Improved outcomes associated with greater access to care.

The report goes on to include summaries of case studies in Arkansas, Kansas, Oklahoma, and Texas, quantifying annual cost savings for rural facilities due to telehealth – with lost wages

[48] *See* Rick Schadelbauer, *Anticipating Economic Returns of Rural Telehealth*, NTCA—The Rural Broadband Association, 7-8 (March 2017), https://www.ntca.org/sites/default/files/documents/2017-12/SRC_whitepaper_anticipatingeconomicreturns.pdf

avoided (for example) ranging from $4,188 to $68,269 and travel expenses avoided ranging from $2,303 to $109,080.[49]

These findings are echoed in the recent report by the President's Task Force on Agricultural and Rural Prosperity:

> High-speed internet access can also address the gap in health services in rural communities. Telehealth and telemedicine allow rural residents to connect to distant healthcare professionals, conduct remote monitoring of chronic medical conditions, and access specialists that may not work in their local health facilities. Remote healthcare through telehealth and telemedicine also reduces the cost of care, improves patient outcomes, and reduces the burden on patients.[50]

Finally, USDA has acknowledged the economic benefits of telemedicine through its telemedicine and distance learning grant awards.[51] As Assistant to the Secretary for Rural Development Anne Hazlett explained: "Under Secretary Perdue's leadership, USDA is committed to being a strong partner in creating rural prosperity . . . Connecting rural Americans to quality education and health care services is an innovative and important tool in our efforts to facilitate economic growth, job creation and quality of life in rural America."[52]

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[49] *Id.* at 9-10; *see also, e.g.*, Karen S. Rheuban, MD and Director of the University of Virginia Center for Telehealth, *Testimony before the Committee on Small Business Subcommittee on Health and Technology, United States House of Representatives*, at 5 (Jul. 31, 2014) ("Telehealth should be viewed as integral to rural development. More than 90% of patients seen through our UVA telemedicine program remain within their community healthcare environment, resulting in a reduction of unnecessary transfers, and thereby contributes to the economic viability of community hospitals.), https://smallbusiness.house.gov/uploadedfiles/7-31-2014_rheuban_testimony_final.pdf.

[50] *See Rural Prosperity Report* at 19, https://www.usda.gov/sites/default/files/documents/rural-prosperity-report.pdf.

[51] *See* USDA Invests in e-Connectivity to Restore Rural Prosperity by Providing Training and Health Care Services, USDA Press Release (Jan 19, 2018), https://www.usda.gov/media/press-releases/2018/01/19/usda-invests-e-connectivity-restore-rural-prosperity-providing.

[52] *Id.*

D. The Commission Should Adopt Measures Against Waste, Fraud, or Abuse that Bring Parity between the Telecom Program, HCF, and E-rate Rules

SHLB and its health care participants support the Commission's proposals to adopt rules in the Telecom Program and the HCF that establish a relatively uniform set of standards applicable to competitive bidding, including gift rules, and rules pertaining to outside consultants. There are good reasons to have clarity and uniformity of rules in these areas. We support the Commission's recent enforcement activity and observe that such activity may be more efficient in protecting the program from waste, fraud, and abuse than imposing burdensome new rules.[53] In addition, we generally see competition as the best and most efficient method to promote responsible purchasing decisions in the RHC programs, thereby ensuring that funding is used efficiently.

We have thoughts, however, regarding the proposed redefinition of "cost effectiveness." First, we support having a uniform cost effectiveness standard in both the Telecom Program and HCF. We also support changes that would require requests for service to include greater specificity than is currently required.[54] However, we caution against adopting a new definition of cost effectiveness that could unnecessarily limit an HCP's discretion to procure the services they need. We are concerned that creating a new and vague "cost-effectiveness" standard could give too much discretion to USAC staff to substitute their own judgment over those of the applicant. The process of applying for and receiving approval of funding applications is already quite slow and adding an uncertain cost-effectiveness analysis could make these delays even worse. Moreover, this Commission has previously recognized that because of the unique demands of health care,

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[53] *See DataConnex, LLC*, Notice of Apparent Liability For Forfeiture And Order, FCC 18-19 (rel. Jan. 30, 2018) (*DataConnex NAL*); *Network Services Solutions, LLC, Scott Madison,* Amendment to Notice of Apparent Liability for Forfeiture and Order, 32 FCC Rcd 5169 (2017) (*NSS Amended NAL*).

[54] *NPRM and Order* at ¶ 83.

applicants should not be forced to purchase the lowest cost solution.[55] We believe this remains true today and so strongly support maintaining this element of the current cost effectiveness standard.

In addition, we have concerns about a cost effectiveness standard that would limit services only to those "essential" to satisfy the communications needs of the applicant.[56] Again, HCPs are always going to be in the best position to make the determination about what is essential based not only on their current needs, but on their reasonable expectations of growth in demand for services based on their knowledge and understanding of the needs of their service area. We are particularly concerned that the "essential to satisfy the communications needs of the applicant" standard would invite USAC to second-guess HCP purchasing decisions well after they have been made – thus denying funding at a late stage in the process.

SHLB health participants strongly support implementing potential mechanisms that could protect competition in both the Telecom Program and the HCF. This could include a tool that would provide an optional independent cross-check when multiple bidders respond to a request for services – such as a bid registry through the RHC portal or an opportunity for vendors to copy USAC (if they choose) when submitting a bid to an applicant. Such a mechanism could easily improve fairness and openness in the competitive bidding process.

E. Growth in the USF Contribution Factor Increasingly Reflects Erosion of the USF Contribution Base

The USF contribution factor represents the assessment against carrier interstate telecommunications revenues that is necessary to fully fund the four universal service programs, along with USAC's expenses to administer the four programs and the fund. If universal service

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[55] *See 2003 Order and Further Notice*, 18 FCC Rcd 24546, ¶ 58 ("[We agree] that applicants should not be required to use the lowest-cost technology because factors other than cost, such as reliability and quality, may be relevant to fulfill their telemedical needs.").

[56] *NPRM and Order* at ¶ 84.

programs grow, or if the contribution base decreases, the contribution factor will increase. The USF contribution factor is set each quarter by the Commission based on the contribution base and projected quarterly demand – with true-ups occurring periodically to reconcile actuals with the projections.

The USF contribution factor for 1Q 2018 stands at 19.5%, up almost three points from one year ago and representing a record high.[57] As noted previously, although multiple factors impact the contribution base, it is undeniable that the decline in the contribution base is having a substantial and alarming impact on contribution factor growth. As noted previously, since 1Q 2016 the contribution base has declined by $2 billion; since 1Q 2013, the decline has been over $3.5 billion, or over 21%.[58]

[57] *See* Contribution Factors, USAC, http://www.usac.org/cont/tools/contribution-factors.aspx.

[58] The table below shows the history of contribution factors and the contribution base since 1Q 2013.

Calendar Quarter	Contrib. Factor	Contribution Base
2018_Q1	19.5%	$ 12,871,991,125
2017_Q4	18.8%	$ 13,025,590,609
2017_Q3	17.1%	$ 13,110,461,173
2017_Q2	17.4%	$ 13,615,143,917
2017_Q1	16.7%	$ 13,971,514,032
2016_Q4	17.4%	$ 14,218,125,939
2016_Q3	17.9%	$ 14,556,193,831
2016_Q2	17.9%	$ 14,737,051,873
2016_Q1	18.2%	$ 14,928,528,139
2015_Q4	16.7%	$ 15,000,900,630
2015_Q3	17.1%	$ 15,046,095,311
2015_Q2	17.4%	$ 15,148,440,571
2015_Q1	16.8%	$ 15,305,298,526
2014_Q4	16.1%	$ 15,708,767,485
2014_Q3	15.7%	$ 16,024,105,838
2014_Q2	16.6%	$ 15,984,853,000
2014_Q1	16.4%	$ 16,175,085,355
2013_Q4	15.6%	$ 16,161,841,188
2013_Q3	15.1%	$ 16,101,000,121
2013_Q2	15.5%	$ 16,151,648,734
2013_Q1	16.1%	$ 16,436,870,626

As illustrated below, the impact of the contribution base decline on the USF contribution factor in just in the last two years far outstrips the impact that even a doubling of the RHC program – from $400 million to $800 million – would have.

	Contribution Base	Projected Quarterly Demand	Adjusted Base	Contribution Factor
Current (1Q 2018)[59]	$12.872 billion	$2.081 billion	$10.683 billion	19.5%
(1) Current demand with 1Q 2016 base	$14.929 billion	$2.081 billion	$12.719 billion	16.4%
(2) RHC quarterly demand plus $100 million with current base	$12.872 billion	$2.181 billion	$10.584 billion	20.6%
(3) RHC quarterly demand plus $100 million with 1Q 2016 base	$14.929 billion	$2.181 billion	$12.620 billion	17.3%

The table above compares the impact on the contribution factor of (1) current demand but using the contribution base from 24 months ago; (2) doubling quarterly RHC demand (from $100 million to $200 million) using the current contribution base; and (3) doubling the quarterly RHC demand and using the contribution base from 24 months ago. We can see from table that doubling the RHC program increase the quarterly contribution factor by about one percentage point, substantially less than the three percentage point impact of the shrinking contribution base.

This alarming trend of a decreasing USF contribution base could well continue. While the Commission has a responsibility to ensure wise and effective use of USF expenditures, USF spending should be tailored to achieve statutory objectives, not to accommodate a shrinking contribution base.

[59] *See Proposed First Quarter 2018 Universal Service Contribution Factor*, CC Docket No. 96-45, Public Notice, DA 17-1203 (Dec. 14, 2017).

III. THE COMMISSION SHOULD ADOPT REFORMS TO BETTER TARGET SUPPORT TO RURAL PROVIDERS WHILE ENCOURAGING THE FORMATION OF CONSORTIA IN THE HEALTHCARE CONNECT FUND

A. The Commission Should Carefully Consider Any Priority System where Certain Classes of HCPs (or Services) are Exempted from Any *Pro Rata* Reductions

The Commission rightly recognizes that limited RHC funding must be disbursed in a way that is fair, but consistent with the statutory purposes of the RHC programs. However, SHLB includes large regional statewide consortia that will be harmed by the limited prioritization scheme the Commission adopted for FY 2017 only – in which individual program applicants receive priority for any available rollover funding. If such a rule of priority were adopted for future funding years, it would harm the many safety net rural providers that join consortia because they lack the administrative resources to participate in the RHC programs as individual applicants. (Safety-net participation in consortia is discussed further in the next section.) It would also create a strong and lasting disincentive to participate in consortia, potentially creating a death spiral where consortium administrative expenses – which the record shows are significant – would be borne by a shrinking pool of HCP participants.

If certain classes of HCPs are given priority status, then HCPs without priority will bear greater uncertainty and financial hardship associated with funding shortfalls. And, if funding demand for the protected Priority 1 class continues to grow over time, then as with E-rate in the past, funding for the non-protected Priority 2 class would shrink each year, potentially reaching zero.

SHLB and its health care participants believe as a general principle that all program participants that are subject to the programmatic funding cap should share some of the pain if funding commitments exceed available funds. (This would not apply to a cap-exempted reformed Telecom Program consistent with the principles discussed above.) Notwithstanding the general

principle of all program participants sharing the pain of cap reductions, we recognize those HCPs with the higher-cost connections face greater relative financial hardship absorbing *pro rata* reductions.[60] For that reason, we would support capping *pro rata* reductions for the most rural HCPs. We discuss this further in the following section.

B. The Commission Should Prioritize HCF Funding Using Variable Discounts, and Otherwise Maintain the Current *Pro Rata* System but with Some Protections for the Most Rural HCPs

As an alternative to a priority system that would unfairly insulate certain program participants from the impact of funding limits, the Commission should instead rely on multiple discount tiers to ensure the program is delivering support where it is most needed. As we proposed in Section II.B.3. above, this would include reducing the discount percentage for non-rural HCPs (eligible as part of majority-rural consortia) from 65% to 60%, and increasing the discount levels for some of the most rural locations from 65% to 85% and 95%, respectively. To address the hardships faced by those applicants with extremely high service costs – in both the Telecom Program (if it is not excluded from the cap) and the HCF – SHLB and its health care participants would support implementing a maximum *pro rata* reduction such sites could face. This type of system, with different HCF discount tiers and limited protections for those with the highest connection costs, would more evenly distribute the hardship of cap reductions than a system that would create extreme winners and losers. Although the *pro rata* reduction system is inherently unpredictable, sharing such reductions more evenly is less unpredictable than a system where one class of non-prioritized HCPs faces dramatically greater reductions than the prioritized class.

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[60] *See Alaska Waiver Order*, 32 FCC Rcd at 5464, ¶ 5 (noting greater financial impact of *pro rata* reductions on Alaska HCPs because of their higher cost connections and the potential resulting public health impacts).

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C. Consortia Provide Substantial Benefits to Rural HCPs and Current Rules Governing Non-Rural Consortium Participants Should Be Maintained

Any policy that de-prioritizes consortia in the funding allocation process, or that makes it harder for consortia to form and flourish runs counter to prior Commission findings about the benefits and program cost savings created by consortia, and risks harming many HCPs that are most in need. The Commission recognized the specific and unique benefits of consortia as far back as 2006 when it created the Rural Health Care Pilot Program which was open to consortia applicants only.[61] In 2012, based on the experience with Pilot Program consortia, the Commission formally recognized the benefits of regional and statewide consortia to include:

- Providing greater rural access to medical specialists;
- Cost savings from bulk buying capability;
- Aggregation of administrative functions;
- More efficient network design; and
- The transfer of medical, technical, and financial resources from larger health systems to smaller HCPs.[62]

In addition to these benefits, SHLB and many health care consortia have previously explained how large, open consortia in the HCF offer safety-net HCPs[63] in rural areas, especially

[61] *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 22 FCC Rcd 20360, 20394, ¶ 69 (2007) (*Pilot Program Selection Order*). ("one of the purposes of the Pilot Program was to encourage health care providers to aggregate their connection needs to form a comprehensive statewide or regional dedicated health care network"); *Wireline Competition Bureau Interim Evaluation of Rural Health Care Pilot Program Staff Report*, WC Docket No. 02-60, Staff Report, 27 FCC Rcd 9387, ¶ 58 (2012) (*Pilot Evaluation*) ("the Pilot Program requires (and facilitates) consortium applications").

[62] *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 27 FCC Rcd 16678, 16699, ¶ 45 (2012) (*HCF Order*); *see also Pilot Evaluation*, at 4.

[63] The National Academy of Medicine defines "safety net providers" as follows:

those which are small and unaffiliated, the ability to participate in the RHC program.[64] Many of these small safety net providers do not have the administrative resources to participate in the RHC program without being part of a consortium.[65]

Considering these benefits, the Commission's decision in the *NPRM and Order* to prioritize individual applicants over consortium applicants to allocate rollover funding for funding year 2017 is not well-founded – with the benefits of consortia effectively used to justify their de-prioritization. This action penalizes consortium participants and dis-incentivizes consortia formation and growth. If similar policies are adopted that dis-incentivize consortia in future funding years, it will harm the RHC program by decreasing the very benefits provided by consortia the Commission has recognized, including lower pricing and more efficient network design. This makes little sense and ignores considerable evidence that large open consortia not only cater to the

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> Safety net providers are providers that deliver a significant level of health care to uninsured, Medicaid, and other vulnerable patients. In its report, the committee focuses on "core safety net providers." These providers have two distinguishing characteristics:
>
> 1. either by legal mandate or explicitly adopted mission, they offer care to patients regardless of their ability to pay for those services; and
> 2. a substantial share of their patient mix are uninsured, Medicaid, and other vulnerable patients.
>
> Core safety net providers typically include public hospitals, community health centers, and local health departments, as well as special service providers such as AIDS and school-based clinics. In some communities, teaching and community hospitals, private physicians, and ambulatory care sites fill the role of core safety net providers.

See AMERICA'S HEALTH CARE SAFETY NET: INTACT BUT ENDANGERED, The National Academies Press, at 1 (2000), *available at* http://www.academyhealth.org/files/Listen_Project_Full_Report_2016_Final.pdf (last viewed Jan. 28, 2018).

[64] *See SHLB Petition* at 17-19 (Dec. 7, 2015). "Open" consortia refer to consortia that are not limited to HCPs under common ownership and so are open to the smallest HCPs that lack administrative staff to even consider participating in the RHC program. Many of these unaffiliated HCPs are safety net HCPs. For example, the UETN network includes the following percentages of safety net providers:

Number of Safety Net HCPs/Total Sites	Rural Safety Net HCPs
57/82 (70%)	52/57 (91%)

[65] *Id.*

most financially challenged HCPs, but face significant operational challenges, including lack of administrative resources.[66]

For similar reasons, the Commission should be cautious before changing the "majority rural" requirement for consortia.[67] Understanding consortium network design helps illustrate why the Commission should be cautious about fixing something that is not necessarily broken. Consortium networks, particularly large open networks, are typically designed around a shared network ring. Network participants obtain a connection to the network ring which, in turn, provides access to all entities on the ring. With this design, last mile connection costs are minimized, while the middle-mile ring costs are shared. Allowing more entities to participate in such a network lowers the shared costs per participant. In this scenario, having non-rural HCPs share the ring costs provides a significant benefit to rural participants. Without this option, rural participants need a larger number of more expensive circuits to reach each of the hub hospitals where their specialists reside – effectively bearing both the middle- and last-mile costs for those connections.

While this is a simplified scenario, many existing large regional or statewide networks follow this basic design, including the Utah Education and Telehealth Network (UETN), NETC, North Carolina Telehealth Network (NCTN), Southern Ohio Health Care Network (SOHCN), Palmetto State Providers Network (PSPN), and the Health Information Exchange of Montana (HIEM). Lower connectivity costs for these networks reflect network design efficiencies, not just the benefits of bulk buying. As noted above, more efficient network design was one of the main

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[66] *See, e.g., SHLB Petition* at 20 ("administrative and network management costs that remain a barrier to the robust development and growth of sustainable open consortia").

[67] *See NPRM and Order* at ¶¶ 37-38; 47 C.F.R. § 54.630(b).

rationales for the Pilot Program and the HCF,[68] and the effect has been borne out in practice. The Commission offers no evidence to suggest there is anything problematic or inefficient about this approach that requires a significant change.

In the *HCF Order*, the Commission indicated that if rural participation rates remained substantially higher than 51%, there would be no reason to revisit this issue. Indeed, the Commission noted the Pilot Program (which required only non-*de minimis* participation of rural providers[69]), produced a 66% rural participation rate and suggested that if rural participation dropped below that level, it could signal a problem in the HCF.[70] With USAC reporting current rural participation rates around 80%, the current policy seems to be operating well and fully as intended. Funding availability seems the apparent rationale for considering a change rather than a finding of any negative impact on rural HCPs.

Finally, it must be recognized that limiting RHC support to individual rural HCPs does not and will not prevent RHC funding from being used to fund connectivity to ineligible entities – whether urban or otherwise. Under longstanding rules for both the Telecom Program and the HCF, if a circuit is being used for eligible health care purposes, it is necessary only for one end of a point-to-point connection to be an eligible entity for the entire circuit to be supported in the program. For example, if a large ineligible urban hospital wants a connection to a rural location, so long as the entity at the rural end of the circuit is the applicant for funding purposes, the connection is eligible for support under program rules. There is nothing necessarily wrong with this, however, the Commission recognized this can create incentives for inefficient network design,

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[68] *See also HCF Order* at ¶ 54, n.137 (recognizing that "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.") (citation omitted).

[69] *Id.* at ¶ 57.

[70] *Id.* at ¶ 65.

which the consortium model can address. Thus, the RHC programs will always necessarily fund connections to urban locations – notwithstanding changes to the "majority rural" requirement for HCF consortia.

IV. THE COMMISSION SHOULD ADOPT CHANGES TO INCREASE ADMINISTRATIVE EFFICIENCY

A. HCF Requests for Services Should begin Before January 1, Allowing an Earlier Filing Window, and Earlier Funding Decisions

Prior to implementation of the funding windows, funding applications could be submitted at any time, with funding decisions issued on a rolling basis, sometimes within 30 days. For large networks especially, this allowed new sites to be added (or dropped), and bandwidth requests to be upgraded – which is part of the normal ebb and flow of any large network. Now however, there is only a single opportunity each year to apply for RHC discounts. This problem exacerbates the extreme delays in USAC issuing final funding decisions (discussed further below) and processing site and service substitutions. Currently, if a rural HCP's broadband funding need coincides with an open funding window, it may be able to obtain RHC discounts within 13 months. If the filing window has just closed, however, it could take as long as 18 months. The overview calendar is as follows:

Funding Period: July 1, 2018 thru June 30, 2019	
HCP seeks services prior to service request period (fall of 2017)	
January 1, 2018	HCF request for services window opens
February 1 – May 31, 2018	Funding requests may be submitted
December 2018 or later	Funding decisions issued
Period between funding need and issuance of funding decision = 13 months or more	
HCP seeks services after service request period (spring 2018)	
January 1, 2019	HCF request for services window opens

February 1 – May 31, 2019	funding requests may be submitted
December 2019 or later	funding decisions issued
Period between funding need and issuance of funding decision = 18 months or more	

It's important to consider this timeline through the eyes of rural HCPs. Initially they are pleased to learn that they may receive as much as a 65% discount through the HCF program. However, they then find out that the discount may be reduced by an undetermined amount due to the cap. And they will not even know the final amount of the discount for 13 to 18 months, depending upon when they started the HCF eligibility and funding process. The HCP's budget uncertainty continues each time the funding needs to be extended. These constraints are very limiting to the rural HCPs that the HCF program is attempting to serve.

This also results in a situation where funding decisions routinely come months after the start of the funding year, which means sites are either losing months of potential funding (if they delay starting services until after the funding request is approved), or proceeding at risk if services start prior to USAC issuing funding decisions. The Commission could partly mitigate this gap by allowing the HCF request for services period to commence in the fall rather than waiting until January each year. In the next section, we suggest some additional changes, such as returning to issuing funding decisions on a rolling basis, subject to a future determination of the *pro rata* reduction.

B. The Commission Should Improve Incentives for USAC to Administer the RHC Programs Effectively and Transparently

RHC program participants, particularly consortia, continue to face application processing delays and other issues associated with USAC systems functionality. As a result, we urge the Commission to consider whether USAC has the necessary human and technical resources to properly administer the program. While operation of the funding cap has been the justification for

unprecedented delays in issuing funding decisions – which, pre-cap, were issued on a rolling basis and are now being held until all funding decisions are final – SHLB health care participants are experiencing delays from USAC in administrative areas that are not related to cap operations, such as obtaining routine guidance and the issuance of appeals. We propose that USAC and the Commission increase focus on responsiveness, and transparency as appropriate measures of administrative efficiency and effectiveness.

Specifically, we propose the Commission codify deadlines for issuance of funding decisions and appeals, and that USAC be required to make public information related to RHC administration readily accessible through the USAC website. With respect to funding decision timeframes, even in a year in which funding requests are expected to exceed available funds, there is no reason to delay the issuance of in-window funding commitment decision letters (FCDL) until all decisions have been made and the *pro rata* factor determined. Instead, the Commission should direct USAC to issue funding decisions on a rolling basis, with funding amounts ultimately contingent upon a to-be-determined *pro rata* factor if one becomes necessary. In this way, applicants would have a funding decision including an evergreen contract determination (if applicable), which is critical to the funding application process for the subsequent funding year. For example, currently applicants are applying for FY 2018 support not having received funding decisions for FY 2017. In many cases, applicants must go through an RFP process they would not have to go through if the FY 2017 contract had already been determined to be evergreen. This is a waste of resources for applicants and for USAC, which now must unnecessarily review RFPs. The Commission should codify a hard deadline of 90 days for USAC to issue funding decisions from when they are received.

USAC decisions on appeals appear to be experiencing unprecedented backlogs. This has a huge impact on applicants who need definitive resolution when there is a potential erroneous action by USAC. To illustrate, one SHLB health participant received several funding denials due to HCP ineligibility, where the eligibility of those participants is under an appeal pending with USAC for almost a year. Lack of a timely appeal decision has now created further appeals – and likely the reservation of funds to potentially fund these sites, thereby unnecessarily tying up needed funding. To address this problem, the Commission should (1) require USAC to maintain a public list of all appeals received and when they are expected to be decided, and (2) extend to USAC the 90-day decision period that applies to the Wireline Bureau and the Commission considering appeals of USAC decisions.[71] USAC should not be permitted to unilaterally extend that deadline. This is a reasonable measurement of USAC performance of its administrative duties.

In assessing whether USAC is devoting necessary resources to RHC administration, the Commission should consider whether USAC may be constrained by language in the *HCF Order* that may be limiting the resources USAC is permitted to devote to RHC program administration. 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).[72] We agree USAC may benefit from incentives to timely process funding requests, however this provision may be preventing USAC from procuring and deploying the resources it needs to do so.[73]

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[71] *See* 47 C.F.R. § 54.724 ("The Wireline Competition Bureau [and the Commission] shall, within ninety (90) days, take action in response to a request for review of an Administrator decision that is properly before it.")

[72] *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.").

[73] USAC administrative costs for the RHC program were $10.5 million in 2016 (down from $12.3 million in 2014). *See USAC 2016 Annual Report* at 29, available at http://www.usac.org/_res/documents/about/pdf/annual-reports/usac-annual-report-interactive-2016.pdf; *USAC 2014 Annual Report* at 21, available at http://www.usac.org/_res/documents/about/pdf/annual-reports/usac-annual-report-2014.pdf. This compares to 2016 USAC E-rate administrative costs of $101.6 million for the E-rate program, $37.3 million for High Cost, and $20

We urge the Commission to eliminate any restrictions or disincentives for USAC to devote an appropriate level of resources to administering the RHC programs. 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. We also propose the Commission codify requirements for USAC to render funding and appeal decisions within a limited time frame. As suggested above, even in a cap-constrained environment when the final commitment amount cannot be known until all funding decisions have been finalized, it would be possible to notify applicants that their applications are approved, with only the *pro rata* calculation delayed until all decisions are final.

Finally, in addition to parity with E-rate on consultant and gift rules, the Commission should bring parity in the types of data that USAC routinely makes publicly available in the two programs. USAC should make data readily available on how RHC funds are used in both the Telecom Program and the HCF. This would include more granular information on how much HCF funding goes to one-time expenditures such as self-construction and special construction, and multi-year funding commitments. Notably all information submitted on the Forms 462 and 466 is public information and should be made available through the USAC website.[74]

million for Lifeline. Because RHC disbursements are so much lower than the other USF programs, administrative costs *as a proportion of disbursements* are higher for RHC.

[74] *See, e.g.*, FCC Form 466, Lines 33 and 40; FCC Form 466 Instructions at 11 ("Information requested by this form will be available for public inspection.").

V. CONCLUSION

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

Respectfully submitted,

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