

Table of Contents

I.	Introduction	3
II.	The Commission Should Eliminate the Rates Database Approach.....	3
III.	The Commission Should Adopt a New Definition of Rurality Using Census Bureau Definitions and Census Blocks.	6
A.	Summary of Rurality Recommendations.....	6
B.	A Few Examples of Rurality Classification Problems Illustrate the Need to Change the Rurality Definition.	7
C.	The Commission Should Change the Rurality Classifications	9
1.	Utilize Standard US Census Designations of Metropolitan and Micropolitan	9
2.	Utilize USDA RUCA Codes as a Second Option for HCPs	11
IV.	The Commission Should Suspend the Funding Prioritization Until It Reviews the Classification of Shared Costs and to Avoid Harm to Rural HCPs Participating in Consortia.	13
V.	The Commission Should Eliminate or Reform the Internal Cap	14
VI.	The Commission Should Substantially Increase the Overall Cap to \$2 Billion Annually Due to the Surge in Telemedicine	17
VII.	Instead of Revising the Telecom Program Invoicing Rules, USAC Should Reform its Invoicing Procedures.....	20
VIII.	The Commission and USAC Should Improve their Application Processing, Funding Decisions, and Appeals of Decisions.	23
A.	Deficiencies in Current Practice.....	29
B.	MSAs Should Be Eligible for Evergreen Status.....	30

I. Introduction

The Schools, Health & Libraries Broadband (SHLB) Coalition appreciates the opportunity to submit these comments on the Further Notice of Proposed Rulemaking (*Further Notice*) to improve the operation and reach of the Rural Health Care (RHC) Program. The SHLB Coalition is a public interest organization whose mission is to promote open, affordable, high-quality broadband for anchor institutions and their communities.¹ High-capacity broadband is the key infrastructure that health care providers, libraries, K-12 schools, community colleges, colleges and universities, public housing and other anchor institutions need for the 21st century. Enhancing the broadband capabilities of rural healthcare providers is especially important to the most vulnerable segments of our population – those in rural areas, low-income consumers, disabled veterans, elderly persons, students, minorities, and other disadvantaged members of our society.

II. The Commission Should Eliminate the Rates Database Approach.

In the *Further Notice*, the Commission seeks comment on ways to improve the Rural Health Care Telecom Program, including asking whether it should adopt an alternative method of setting rates other than the Rates Database approach that was adopted in 2019.² SHLB encourages the Commission to eliminate the Rates Database approach as it does not work as the Commission intended and fails to achieve the goals of the program.

When the Commission adopted the Rates Database in 2019, it understandably sought to increase transparency and predictability into Telecom Program rates, as well as reduce burdens

¹ The SHLB Coalition has grown to over 300 members and includes representatives of health care providers and telehealth networks, schools, libraries, state broadband offices, private sector companies, state and national research and education networks, consulting firms and consumer organizations. See www.shlb.org for a current list of SHLB Coalition members.

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

on program participants.³ As the Commission acknowledges, “At the time the Commission adopted these rules, it did not know what the urban and rural rates generated by the Rates Database would be.”⁴ And in fact, after the Rates Database was implemented, issues with the rates became apparent.⁵

Although in general the cost to provide services is likely to be greater in more rural areas, the rates promulgated in the Rates Database did not reflect this. In many states, the Rates Database listed rates in more rural areas that were lower than the rates in less rural areas of the state.⁶ And while it can be expected that rates will increase as the speed of the service increases, the Rates Database included higher rates for slower speed services in many instances.⁷

Finally, although the Commission has focused on the many issues with the rural rates in the Rates Database,⁸ the urban rates contain significant errors as well. In 31 states the Rates Database included a median urban rate that exceeded one or more of the rural tier rates in that state, often by significant amounts.⁹ In areas where urban rates exceed rural rates in the Rates Database, rural health care providers would be unable to receive any support under the Telecom

³ *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Report and Order, 34 FCC Rcd 7335, 7373-74, ¶¶ 79-81 (2019) (*Rates Database Order*).

⁴ *Further Notice*, FCC 22-15, ¶ 9.

⁵ *Id.* ¶¶ 10-14.

⁶ Letter to Chairwoman Rosenworcel and Commissioners Carr, Starks, and Simington, Federal Communications Commission, from John Windhausen, Jr., Schools, Health & Libraries Broadband (SHLB) Coalition, WC Docket No. 17-310, at 5 (Jan. 25, 2021) (SHLB January 25th *Ex Parte* Letter); *see also* Letter to Marlene H. Dortch, Federal Communications Commission, from Gina Spade, Counsel for SHLB, WC Docket No. 17-310, Attachment (Mar. 31, 2021) (SHLB March 31st *Ex Parte* Letter).

⁷ SHLB January 25th *Ex Parte* Letter at 4; SHLB March 31st *Ex Parte* Letter at Attach.

⁸ *Further Notice*, FCC 22-15, ¶ 10 (“After conducting an examination of the initial median rural rate calculations in the Rates Database, the Bureau found anomalies that could result in inadequate or inconsistent Telecom Program support, such as lower median rural rates in more rural areas of the state or lower median rural rates for higher bandwidth services.”).

⁹ SHLB January 25th *Ex Parte* Letter at 4; SHLB March 31st *Ex Parte* Letter at Attach.

Program. In some cases, it appears that the Rates Database promulgated erroneous urban rates due to the inclusion of rates that are offered in rural areas.¹⁰ And as the Commission's charts in the *Further Notice* demonstrate, the Rates Database includes urban rates in Alaska – presumably in Anchorage – that are \$240 for 10 Mbps, \$309 for 20 Mbps and \$538 for 50 Mbps, but the urban rates in California – presumably in cities such as Los Angeles, San Diego and San Francisco – are \$1,128 for 10 Mbps, \$1,268 for 20 Mbps and \$1,579 for 50 Mbps.¹¹ The fact that the Rates Database includes rates in urban areas of California that are three to five times higher than urban rates for the same services in urban areas of Alaska clearly shows that there is a problem with the database's rates.

Due to the many rate anomalies and inconsistencies in the Rates Database, the Wireline Competition Bureau waived the requirement to use rates from the Rates Database before it took effect.¹² The Bureau recently extended the Rates Database waiver for health care providers and service providers in Alaska through Funding Year 2023.¹³ For Telecom Program participants in areas other than Alaska, however, the waiver applies only through Funding Year 2022.¹⁴ This means that beginning in Funding Year 2023, which begins on July 1, 2022, participants in the Telecom Program will be forced to use the faulty Rates Database. Given the extremely short time period before the beginning of Funding Year 2023 and the well-recognized problems with the Rates Database, the further waiver granted to Alaska should be extended to apply on a nationwide basis as soon as possible.

¹⁰ SHLB January 25th *Ex Parte* Letter at 4-5.

¹¹ *Further Notice*, FCC 22-15, ¶ 11, Tables 1 and 2.

¹² *Id.* ¶¶ 12-14.

¹³ *Rural Health Care Support Mechanism; Promoting Telehealth in Rural America*, WC Docket Nos. 02-60 and 17-310, Order, DA 22-401 (Wireline Comp. Bur., Apr. 12, 2022).

¹⁴ *Further Notice*, FCC 22-15, ¶ 14.

The Rates Database was a well-intentioned but failed experiment that the Commission should now set aside. It did not achieve the objectives the Commission was seeking.¹⁵ The rates in the database were not derived in a transparent manner, causing confusion for program participants, and hindering their ability to address anomalous or counter-intuitive results. Furthermore, the Rates Database resulted in significant increases in the amounts that health care providers would have to pay to receive the same services. SHLB found that use of the Rates Database would more than triple the monthly recurring charges paid by non-Alaskan rural health care providers.¹⁶ These providers can ill afford to take on such significant cost increases, particularly in light of the extra burden placed on rural health care systems by the COVID-19 pandemic. Such an outcome directly contradicts the intent of the Rural Health Care program.

In addition to the issues with the rates contained in the Rates Database, the process of relying on predetermined rates eliminates competition, as service providers will have no reason to offer rates below those listed in the database. The Commission should therefore eliminate the use of the Rates Database for the Telecom Program altogether.

III. The Commission Should Adopt a New Definition of Rurality Using Census Bureau Definitions and Census Blocks.

A. Summary of Rurality Recommendations

The current FCC definitions of rurality result in HCP classifications that run contrary to the intent of the RHC program. The existing criteria, unique among Federal agencies:

- Treats isolated rural towns the same as urban towns adjoining large metropolitan areas,
- Relies on a population threshold of 25,000 without consideration of other factors such as proximity to a metropolitan area, and

¹⁵ *Id.* at 60, Statement of Chairwoman Rosenworcel (noting that the Rates Database “had problems” and compiled rates that didn’t “make sense”).

¹⁶ SHLB January 25th *Ex Parte* Letter at 3.

- Disqualifies large geographic areas in rural communities due to reliance on Census tracts rather than a smaller unit of measure.

Proposed modifications to the rurality definitions described herein would:

- Harmonize FCC definitions with long-standing definitions from the US Census Bureau (Census) and the United States Department of Agriculture (USDA),
- Better classify healthcare providers located in isolated towns that serve large surrounding rural areas, and
- Provide administrative efficiencies aiding applicants, USAC and the FCC.

B. A Few Examples of Rurality Classification Problems Illustrate the Need to Change the Rurality Definition.

We offer three examples from Ohio that are typical across the country.

City: Upper Arlington, Ohio, is an affluent community adjacent to the Columbus metropolitan area (with a population that exceeds 1.4 million). Visual inspection alone as provided in Figure 1 demonstrates that Upper Arlington is urban, matching the FCC classification.

Figure 1: Upper Arlington, Ohio



Town: Zanesville is an impoverished town in Appalachian Ohio that is geographically isolated from any metropolitan area. The health care providers in Zanesville deliver services to the surrounding rural expanse as seen in Figure 2, yet this town is rated as “urban” by the FCC.

Figure 2: Zanesville, Ohio



Village: Dresden is an impoverished village in Appalachian Ohio that is geographically isolated from any metropolitan area as illustrated in Figure 3. The current FCC criteria classify this village as “urban.”

Figure 3: Dresden, Ohio



Under the existing FCC definitions of rurality, there is no differentiation between these three communities of VERY different circumstances – all three are designated as “urban.” The only remaining priority differentiation under current HCF rules is based on whether the community has been designated as medically underserved.

Zanesville and thousands of similar towns across the country qualify as “urban” because they exceed the FCC’s unique-among-all-agencies population cap of 25,000. Villages such as Dresden fall into the lowest priority “urban” classification because the Census tract surrounding the Village, spanning 48 square miles, touches the “Zanesville urban cluster.”

The only differentiation among these three communities under current RHC prioritization is based on whether the area is designated as medically underserved.

C. The Commission Should Change the Rurality Classifications

We propose the Commission adopt two methods for determining the rurality of health care provider sites under the HCF.

1. Utilize Standard US Census Designations of Metropolitan and Micropolitan

We suggest the FCC utilize well-established US Census Bureau (Census) designations for the classification of rurality for health care sites. In 2003 the Census defined “Metropolitan Statistical Areas” and “Micropolitan Statistical Areas” as the primary method for distinguishing among Core-Based Statistical Areas.¹⁷

“Metropolitan Statistical Areas have at least one urbanized area of 50,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties.”

“Micropolitan Statistical Areas have at least one urban cluster of at least 10,000 but less than 50,000 population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties.”

The “metropolitan” and “micropolitan” designations offer a clearer definition of rurality than the current method employed by the FCC, which is not recognized by the Census. The switch will allow applicants and USAC to utilize existing Census designations to pre-qualify sites, demonstrate rurality assertions and determine the funding priority each site will receive.

¹⁷ <https://www.census.gov/topics/housing/housing-patterns/about/core-based-statistical-areas.html>.

At present, FCC utilizes Census tracts to classify sites. If even a tiny corner of a tract touches an “urban cluster” such as the example of Dresden, Ohio, then any HCPs located in that tract are classified as “urban.” Switching to Census blocks for HCF rurality designations will avoid disqualification of large rural geographic areas due to a slight overlap with an urban cluster.

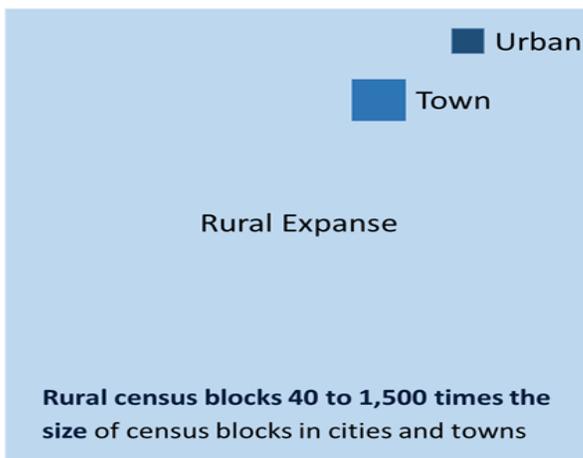
Census blocks or block-groups are a better unit of measure in rural areas given the relative size of Census blocks in rural areas compared to urban areas as illustrated in Figure 4.

§ In metropolitan areas, a census block = 2 acres on average

§ In micropolitan areas, a census block = 6 acres on average

§ In the rural areas, a census block = 250 to 3,500 acres (750 acres in Figure 4), 40 to 1,500 times larger than in metropolitan areas.

Figure 4: Census Block Size Differences



The Census tract 39119911100 in which Dresden, Ohio, resides encompasses a total area of 48 square miles (30,720 acres) and population of 6,115. This Census tract overlaps slightly with the Zanesville urban cluster relegating Dresden to a classification of “urban.”

2. Utilize USDA RUCA Codes as a Second Option for HCPs

The USDA offers another strong solution for determining rurality utilizing the Rural-Urban Commuting Area (RUCA) codes.¹⁸ We recommend that the FCC allow applicants to utilize RUCA codes as a second way to qualify as rural. The proposed metropolitan/micropolitan classification works well in most of the country. Yet the RUCA codes offer a better solution in the most remote areas such as Alaska. The RUCA codes are Census tract-based thus somewhat less effective in rural areas east of the Mississippi, thus we recommend that the Commission alter its rules to allow both RUCA and Metropolitan/Micropolitan classification options to applicants.

Figure 5 explains the proposed classifications and criteria. The revised designations could also be used to apply a differential subsidy level based on the rurality classification.

Classification	Metropolitan/Micropolitan Census Based Definitions	USDA RUCA Code Based Definitions	Differential Subsidy
Urban	Within a Metropolitan Statistical Area that contains part of an urban cluster	Codes 1-3	65%
Rural	Within a Micropolitan Statistical Area that contains part of an urban cluster + Metropolitan Statistical Areas that does not contain part of an urban cluster	Codes 4-6	75%
Remote	Within a Micropolitan Statistical Area that does not contain part of an urban cluster	Codes 7-9	85%
Frontier	Neither in a Micropolitan or Metropolitan Statistical Area	Code 10	95%

Figure 5: Proposed Classifications of Rurality and Differential Subsidy

The proposed designations better align with the intent of the program. Consider the examples of how the proposed change would affect rurality designations for our three example communities in Ohio as illustrated in Figure 6.

¹⁸ <https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx>

Community	Upper Arlington, OH	Zanesville, OH	Dresden, OH
Population	35,000	26,000	1,810
Location	Adjoins metropolitan area of Columbus, Ohio, with population of 1.4 million	Surrounded by rural expanse, 50 miles from closest metropolitan area	Surrounded by rural expanse, 50 miles from closest metropolitan area, census tract slightly overlaps with Zanesville urban cluster
Median Income	\$102,000	\$26,000	\$22,000
Current FCC Classification	Urban	Urban	Urban
Proposed Census Based Classification	Urban	Rural	Remote
Proposed RUCA Based Classification	Urban	Rural	Rural

Figure 6: Classification Outcomes

Such a shift will keep rural-focused facilities from being swept into the lowest priority funding tier. These modified rurality designations could be used for both:

- a. Funding prioritization, and
- b. Calculation of rurality percentage for consortia.

We do anticipate a significant increase in the potential demand under this revised classification approach. But the potential increase in demand would be appropriate because these small, rural HCPs are exactly the kind of institution that the RHC program was created to assist. Thus, we suggest that the proposed streamlining efforts proposed herein would result in better overall utilization of the HCF funding.

IV. The Commission Should Suspend the Funding Prioritization Until It Reviews the Classification of Shared Costs and to Avoid Harm to Rural HCPs Participating in Consortia.

The Commission's current funding prioritization scheme is designed to make pro-rata reductions to funding for non-rural HCPs before funding is reduced for rural HCPs.¹⁹ While well-intended, SHLB urges the Commission to consider suspending implementation of this scheme until it investigates how the data are calculated and analyzed for shared costs. SHLB submits that there are well-founded concerns reducing funding for consortia will reduce funding directly attributable to, and directly benefiting, hundreds of rural HCPs.

This is because certain RHC program expenditures for HCF consortia are inaccurately classified as non-rural when they include expenditures for network services shared with rural HCPs. For example, HCF consortia often purchase services or equipment that provide network services to both rural and non-rural HCPs – however those shared costs are reported as “non-rural” (*i.e.*, the services or equipment are physically located at, or associated with, a non-rural HCP number). Failure to address this issue means that pro-ration of funding for consortia that include rural and non-rural HCPs will reduce funding for some shared network costs that, for all intents and purposes, are 100% attributable to rural HCPs.²⁰ USAC is not able to separate these shared costs and does not currently provide HCF consortia the ability to report them – something the Commission recognized in 2012 in reference to an analogous issue with RHC Pilot Program

¹⁹ See 47 C.F.R. § 54.621(b); see also *2019 Rates Database Order*, 34 FCC Rcd at 7396-97, ¶ 129, Table 3 (“The table . . . highlights that in funding year 2017, a significant amount of funding went to sites in non-rural areas as part of consortia in the Healthcare Connect Fund Program. These sites will now be deprioritized and could receive less funding than sites in rural areas if demand exceeds available funds.”). We explain below why the data in Table 3 likely substantially overstates the amount of funding attributable to non-rural HCPs.

²⁰ For example, if a consortium has 100 HCP participants and 60 of them are rural HCPs, then as much as 60% of shared network costs are 100% attributable to those 60 rural HCPs. (This is a simplified example and there are other reasonable ways of performing such an allocation.)

consortia (many of whom migrated into the HCF).²¹ Indeed, any prioritization scheme that intends to de-prioritize consortia that include non-rural sites must avoid proration of costs that are demonstrably attributable to serving rural HCPs.²²

V. The Commission Should Eliminate or Reform the Internal Cap

SHLB generally supports reforming the internal cap as set forth below. However, we believe that the Commission should eliminate the internal cap altogether. *See FNPRM* at ¶ 71 (asking whether “[it] would [] be better to simply eliminate the internal cap on upfront costs and multi-year commitments”) SHLB suggests that the original rationale for adopting the internal cap has dissipated. The original concern (dating from 2012) was that upfront construction costs and multi-year contract costs would overwhelm the limited availability of funding, leaving little funding remaining to cover ongoing costs. Experience has shown that this concern has not materialized. The data shows that the amount of funding requested for upfront costs and multi-year contracts has been close to the internal cap and has not significantly impacted ongoing support for other HCPs. Furthermore, network construction of more advanced, future-proof technologies often leads to lower ongoing costs, thus saving money for both the program and for individual HCPs. (There is no comparable cap in the E-rate program; in fact, the Commission’s E-rate reforms in 2014 to promote fiber deployment have helped to lower schools and libraries ongoing costs.) Congress has recently created new funding opportunities to close the digital divide by *increasing* capital construction in rural markets. The internal cap on RHC construction

²¹ *See HCF Order*, 27 FCC Rcd at 16704, n.148 (“funding attributed to non-rural locations likely is overstated because shared equipment and services often are attributed to non-rural locations even though they are used by all the network sites.”).

²² Every consortium knows the number and bandwidth of all rural and non-rural HCPs participating in their networks and could provide an allocation of shared network costs if requested.

discourages investment and is out of step with the need to invest in greater broadband capacity all across the U.S. and especially in rural areas.

If the Commission nevertheless feels it is important to retain some sort of internal cap, the FCC should modify the cap to apply only to network equipment and upfront costs such as network construction (not to multi-year contracts). Because of the danger that demand would exceed the internal cap, many applicants have shifted from multi-year commitments to single-year applications, which is less efficient. Removing multi-year commitments from the cap will mean fewer single-year applications and thus fewer overall applications to process in each funding cycle. The offsetting reduction in single-year applications means that increased multi-year applications should have little effect on overall program demand.

Moreover, a close read of the 2012 HCF order suggests the primary purpose for establishing the HCF internal cap in the first instance was to protect the RHC program from funding too much new network construction. This objective would still be accomplished if multi-year commitments were removed from the internal cap.²³

The Commission's decision in the HCF Order to allow HCPs for the first time to self-construct their own broadband networks represented an important new option for RHC program participants that was strongly opposed by some groups.²⁴ Although the Commission determined

²³ See *Rural Health Care Support Mechanism*, WC Docket No. 02-60, *Report and Order*, 27 FCC Rcd 16678, 16764, ¶ 190 (2012) (*HCF Order*) (“we anticipate that the \$150 million should be sufficient to meet *demand for upfront payments*”) (emphasis added).

²⁴ See USTelecom Association Petition for Reconsideration and Clarification, WC Docket No. 02-60 (filed Apr. 1, 2013) (Petition); Petition for Reconsideration of Action in a Rulemaking Proceeding, 78 Fed. Reg. 24147 (2013) (arguing among other things that the HCF HCP network self-construction rules violated the Act); see also *Reply Comments of the United States Telecom Association*, WC Docket No. 02-60 (filed May 10, 2013) (summarizing opposition to the just-adopted HCF network self-construction rules).

a self-construction option would “plac[e] downward pressure on bids for services”²⁵ it nonetheless implemented three “safeguards” intended “to ensure that the self-construction option will be exercised only where it is absolutely necessary.”²⁶ One of those three safeguards was the \$150 million HCF internal cap, which the Commission explained would “help ensure that the Fund does not devote an excessive amount of support to large up-front payments for HCP self-construction, which could potentially foreclose HCPs’ ability to use the Fund for monthly recurring charges for broadband services.”²⁷

The decision in 2012 to allow network equipment to be funded through the HCF (also for the first time) was part of the “Hybrid Infrastructure and Service Approach” the Commission adopted and was included in the internal cap for essentially the same reason as network construction.²⁸ We recognize that the Commission in 2012 rejected adopting a \$100 million cap solely for HCP-self construction.²⁹ In doing so, however, the Commission explained that the internal cap should also include commercial carrier costs “need[ed] to deploy facilities to serve the HCP.”³⁰

Lastly, when it established the original size of the internal cap, the Commission recognized that “if it appears a significant number of [Telecom] Program participants are moving

²⁵ See *HCF Order*, 27 FCC Rcd at 16712, ¶ 72.

²⁶ See *id.* at ¶ 73.

²⁷ 27 FCC Rcd at 17713, ¶ 75.

²⁸ *Id.* at 17711, ¶ 70 (“In addition to funding HCP-owned network facilities, we also include as an essential component of this hybrid approach the provision of funding for equipment needed to support networks of HCPs and the provision of support for upgrades that enable HCPs to obtain higher bandwidth connections.”).

²⁹ *Id.* at 17802, ¶ 298.

³⁰ *Id.*

to the Healthcare Connect Fund”, it might be appropriate to consider increasing its size.³¹

Accordingly, if the Commission declines to remove multi-year funding commitments from being subject to the internal cap, then we respectfully request the Commission increase the internal cap to reflect the number of applicants that have migrated from the Telecom Program to the HCF since 2012.³² (While the Commission has adjusted the internal cap for inflation in the past few years, the cap increases have not kept up with the migration of HCPs from the Telecom program into the HCF.)

VI. The Commission Should Substantially Increase the Overall Cap to \$2 Billion Annually Due to the Surge in Telemedicine

The Commission should substantially increase the amount of funding available for the Rural Health Care program in order to ensure that rural healthcare providers have the resources needed to provide high-quality affordable telemedicine in all areas of the country. The gross demand for RHC funding has been higher than the Commission’s overall cap in each of the last four years.³³ Even this level of demand has been artificially suppressed over the past few years due to administrative delays in processing RHC applications and uncertainty concerning the availability of funding. The actual demand for telemedicine and broadband networks underlying it is much higher than the dollars requested in the RHC program. For instance, a report issued by

³¹ *See id.* (“we impose a \$150 million annual limitation on total commitments for upfront payments and multi-year commitments . . . in order to limit major fluctuations in Fund demand . . .”). The demand data recently submitted by USAC bears this out, showing large year-to-year fluctuations in funding commitments for self-construction (in particular). *See* Letter from Mark Sweeny, Vice-President of the Rural Health Care Division, USAC, to Jodie Griffin and Bryan Boyle, Wireline Competition Bureau, FCC, Table 6 (Apr. 1, 2022) <https://www.fcc.gov/ecfs/file/download/DOC-5ff98dfb4d800000-A.pdf>.

³² *See, e.g., Promoting Telehealth in Rural America*, WC Docket No. 17-310, Notice of Proposed Rulemaking and Order, 32 FCC Rcd 10631, 10637 (2017) (*2017 Promoting Telehealth Notice and Order*) (recognizing that “[b]etween FY 2013 and FY 2016, the number of healthcare providers in the Telecom Program declined by more than 36 percent. . .”).

³³ <https://www.fcc.gov/ecfs/search/search-filings/filing/10401063787196>.

Health and Human Services found that telemedicine visits were 63 times greater in 2020 due to the pandemic.³⁴ The combination of the COVID pandemic and the growing recognition of the need for universal broadband infrastructure and the success of the COVID-19 Telehealth program all demonstrate the urgent need to provide much greater resources to this valuable program.

The SHLB Coalition worked with its members to estimate the true costs of providing adequate broadband connectivity, devices, internal connections and cybersecurity for telehealth networks across the U.S. The estimates below are based on real-world numbers provided by our members who have experience using a variety of technologies to promote high-quality and affordable telemedicine. The methodology we used to estimate the necessary funding is as follows:

First, we started with the assumption that both rural and urban health care facilities will need to upgrade their broadband capabilities to address the post-COVID-19 environment. In other words, we believe eligibility should be open to all Federally Qualified Health Centers, public health facilities and non-profit providers, regardless of rurality. This need for telemedicine extends to all regions of the United States.

According to our calculations, there are approximately 91,238 public and non-profit health care providers across the U.S. (urban and rural). This number includes all FQHCs and public health facilities. We expect approximately 80% (72,990) of these sites would seek funding from the RHC program if it is properly funded and administered.

³⁴ <https://www.hhs.gov/about/news/2021/12/03/new-hhs-study-shows-63-fold-increase-in-medicare-telehealth-utilization-during-pandemic.html>. The report found that the share of Medicare visits conducted through telehealth in 2020 increased 63-fold, from approximately 840,000 in 2019 to 52.7 million.

Second, we calculated the costs of upgrading their telecommunications and broadband capacity. We estimate that, on average, each health care site will need to spend about \$42,324 per year for upgraded broadband service (including routers and firewalls). Our members derived this estimate based on their experience in providing service to several hundred health care sites across the country. The total annual broadband spend for these sites will be approximately \$3.09 billion ($\$42,324 \times 72,990$). According to the FCC's rules, the RHC program currently covers approximately 88% of these costs, for a subtotal of approximately \$2.72 billion. The FCC is already planning to make approximately \$637,721,108 available for 2022 applicants, which means the total unmet need (funding shortfall) for broadband service is approximately \$2.08 billion per year.

Third, we recommend an allotment of funding to cover a portion of the cost of ensuring that all eligible HCPs could upgrade their internal connections (inside the building) to handle the increase in broadband traffic. While the E-rate program covers internal connections costs for schools and libraries, the RHC program currently does not provide the same resources for connections inside the healthcare building. We recommend that the FCC explicitly permit HCPs to be able to obtain such funding, and we suggest an allotment of \$25,000 per site, at a total cost of \$1.8 billion per year ($\$25,000 \times 72,990$).

Taken together, we estimate that the need for annual funding to upgrade HCPs' broadband service and internal connections to be about \$3.88 billion per year ($\$2.08 \text{ b} + \1.8 b) over and above the amount of funding the FCC is currently planning to make available. (This cost estimate does not include the costs of cybersecurity or devices for individuals who wish to engage in telemedicine from home or other locations outside the healthcare provider's premises.) While this funding is certainly significant, it remains below the cap on the E-rate program.

These estimates demonstrate that the need for funding to bring our telehealth networks and technologies up to speed is enormous. It is also difficult to predict as the market is still adjusting to the sea change in telemedicine demand and resources that will continue long past the end of the COVID-19 pandemic.³⁵

Of course, raising the cap does not automatically mean that all of this funding would be sought or spent right away. It may take several years for HCPs to learn about the increased availability of this funding and increase their staff to fill out successful applications. Therefore we respectfully ask the Commission to adopt a graduated increase in the overall cap to \$2 billion per year over the next three years. Adopting this funding plan would give confidence to potential applicants that there will be sufficient funding available for worthy applications. Combined with accompanying administrative reforms to improve the processing of RHC applications, such an increase in the overall cap could significantly improve our telehealth delivery system across the country.

Currently, the RHC program distributes funding to every state in the country, and more than 1,000 broadband service providers participate in the program. The actions above will help the nation's healthcare providers and broadband providers upgrade their telehealth networks and services so that we are better prepared for the future.

VII. Instead of Revising the Telecom Program Invoicing Rules, USAC Should Reform its Invoicing Procedures.

SHLB applauds the Commission's efforts to increase efficiencies in the RHC Program as a whole and agrees with the need to ensure funds are distributed correctly and only for eligible services received. However, the changes proposed by the Commission to the Telecom

³⁵ [Telehealth Usage Jumped 10% Nationally in January \(mhealthintelligence.com\)](https://www.mhealthintelligence.com/news/telehealth-usage-jumped-10-nationally-in-january).

Program's invoicing rules³⁶ lack consideration of the increased administrative burden for health care providers (HCPs) with use of the FCC Form 463 for the Telecom Program. The Commission does not need to revise the Telecom Program invoicing rules. Rather, what is needed are USAC system improvements to allow a service provider to invoice USAC for amounts equal to, or less than, the amount on the Health Care Provider Support Schedule (HSS). If USAC's system cannot be updated to accommodate invoicing for less funding than determined on the HSS, we ask the Commission to keep the Telecom Program invoicing rules and processes as they are.

There are important differences in the RHC Program rules and processes, including the application process, which support efficiencies in the HCF program that would not carry over to the Telecom Program for invoicing purposes. For example, the HCF Program allows for consortia and multiple expense filings, whereas Telecom does not. Therefore, the ability to file one FCC Form 463 for multiple sites and services is not available in the Telecom Program. Telecom Program applicants must file individual funding requests, and therefore invoicing forms, for each site. Under current Telecom Program invoicing rules, an HCP only has to file one FCC Form 467 for each of its funding requests. After submission of a 467, an HSS is generated, and a service provider can invoice USAC for reimbursement. If the Commission changes the Telecom Program invoicing process to use the FCC Form 463, HCPs who previously filed only one form (FCC Form 467) for each FRN could potentially now have to file 12 forms (FCC Form 463), one each month, per FRN in order to receive credits and allow for timely service provider reimbursement.

³⁶ Promoting Telehealth in Rural America, WC Docket No. 17-310, Further Notice of Proposed Rulemaking, FCC 22-15 (2022) (Further Notice) ¶73.

Based on the decreasing participation levels in the Telecom Program and without public information to show that the Telecom Programs invoicing process is the direct cause of improper payments, our preference is for no changes to be made to the Telecom Program invoicing rules and processes. However, if the FCC and USAC feel changes are necessary to ensure USAC can effectively and efficiently administer the Telecom Program, USAC should be directed to make further system updates that allow for changes in the amount of funding to be invoiced as long as it is equal to or less than the commitment on the HSS.

In FY 2021, USAC updated its My Portal system to allow HCPs to file revised FCC Forms 467³⁷ after an initial HSS was generated, but only before a service provider invoices for any portion of the committed funds.³⁸ If USAC's systems were able to support date changes to the FCC Form 467 after a service provider invoice is submitted and paid, we assume USAC would have made those changes in FY 2021. In lieu of the ability to submit date corrections, for future service dates after invoices have been submitted for prior service periods, we ask that the FCC and USAC consider updating its system to allow invoicing for less than the approved amount on the HSS. Rather than the HSS restricting the exact amount to be invoiced per month, allow the HSS to set the maximum allowable funding to be invoiced and give service providers the ability to invoice for an amount less than what is set by the HSS.

While current HCF program participants do agree the invoicing process is simple, there is room for improvement. Currently, when the undiscounted cost of service(s) is less than the approved funding amount, meaning savings to HCP's and ultimately the RHC Program, USAC treats these submissions with additional scrutiny and elevated review. This elevated review is

³⁷ See USAC FY 2021 Update Webinar 9/23/2021 (slides 28 & 29).

³⁸ See Rural Health Care Program October 2021 RHC Monthly Newsletter, "Do You Need to Make Changes to a Commitment After Your Funding is Approved?"

completed by a separate USAC audit team, requires duplicate submission of all FCC Form 463 supporting documentation, and causes significant delays in payments that are very hard on HCPs. Billing for the exact amount of service, different from the commitment amount, is normal under the E-Rate program and does not generate significant additional scrutiny. The “perfect invoice” view of USAC for both the Telecom and HCF Programs does not account for the likelihood of changes in services during a funding year and creates substantial additional work for limited value. If there was a way for HCPs and service providers to confirm to USAC that the billing is accurate, including under invoicing and requesting payment for less than the committed amount, it may reduce the amount of additional time and resources for USAC review. In addition, streamlining the Form 463 submission process by allowing a batch upload of data, similar to the Form 462, would be extremely beneficial in reducing errors and reducing the administrative burden on HCPs.

VIII. The Commission and USAC Should Improve their Application Processing, Funding Decisions, and Appeals of Decisions.

SHLB supports substantial improvements to further enhance the efficiency of application processing. We have several suggestions for administrative and process related changes for both the Telecom and HCF Programs.

Information Requests. One such improvement is uniformity in how USAC issues information requests. Currently, USAC issues information requests one of three ways: via email, within My Portal for the Telecom participants, and via RHC Connect for HCF. Applicants participating in both the Telecom and HCF Programs for different sites and/or services can receive information requests via all three methods, which is extremely cumbersome to maintain. There is no consistency in how information requests are issued, and HCPs are required to respond via the method in which the request was issued. HCPs are forced to respond via email

and/or within My Portal and/or RHC Connect depending on how USAC issued the request. This inconsistency is inefficient and creates challenges for HCPs trying to track and monitor information requests and the progress of their funding request applications. It would be helpful to have one uniform method for issuing information requests.

Another challenge HCPs face with USAC information requests is the inability to easily track or identify information requests in my portal or via email. While the funding request number (FRN) is typically seen as a unique identifier, it is not unique enough when USAC issues multiple information requests for the same FRN. Or, in the case of the Telecom Program, HCPs are unable to determine which information request is for which FRN under a certain HCP # because in My Portal USAC only provides that information within the body of each request, requiring HCPs to open each request to see the FRN. To better assist applicants in identifying and distinguishing between information requests, USAC should issue a unique identification (ID) # with each information request, similar to a help desk ticket #. This unique information request ID # would allow applicants to more easily track information requests as they are received and readily check that responses are submitted without duplication or accidental oversight.

USAC should also adopt a confirmation of receipt requirement for all information request responses within 48-hours of an HCP response submission, similar to what is currently done for all email communications to RHC-Assist and RHC-Appeals. As it stands today, without USAC acknowledgement of receipt, an HCP is left unsure if USAC has received their time-sensitive response. It is possible several weeks or months will go by without any communication from USAC. This is especially concerning for HCF information request responses submitted via email which may be prone to spam filters, file size restrictions, or other common email transmission failures. USAC's confirmation of receipt plus inclusion of the aforementioned

unique identifier would greatly assist HCPs in managing and monitoring the information request process to ensure timely responses are submitted and USAC can conduct its review effectively.

The Commission should also allow HCPs sufficient time to respond to information requests and allow them to continue working with USAC to respond in good faith to questions. HCPs now have 14 days to respond to an information request. USAC will sometimes allow for an extension but not always. For additional questions, USAC often only provides five or seven days for a response. The Commission should:

- (1) Require a 14-day response period for each information request, even if it is a follow-up to an earlier question. Often, the question is regarding a new topic and is not truly a follow-up. HCPs need sufficient time to respond.
- (2) Require USAC to continue working with applicants in good faith to respond to information requests. That means that USAC should grant extensions when HCPs need additional time to respond, and the extensions should be 14 days. Both of these directives exist in the E-rate program and they have not resulted in delays in funding commitments. These directives would help increase USAC's ability to resolve issues without HCPs having to appeal to the Commission.

The Commission should require USAC to include service providers in all communications related to funding requests, including the application, review questions, and decisions. The FNPRM at para. 43 suggests that the responsibility for submitting technical service data should transfer from Health Care Providers (HCPs) to service providers because HCPs may lack the technical expertise to submit this information. SHLB believes the applicant should retain the responsibility of responding to USAC and ensuring all information and documentation is accurate. Including the service provider would provide the service provider with real time information and the ability to better assist the applicant when service provider information or documentation is needed. USAC could use service provider contact information

provided on the funding request application (FCC Form 466³⁹) or the service provider contact information already available in its system from the FCC Form 498 for the Rural Health Care Program. Also, having USAC provide service providers access to funding request applications (FCC Forms 462 and 466), as it does in the E-rate Program, relieves the burden from the applicant of having to provide copies of every form and ensures consistent information and documentation for all parties bound by the Commissions RHC Program recordkeeping requirements.⁴⁰

We also note that the Commission currently requires USAC to request additional information from applicants within 21 calendar days of the submission of an application for funding.⁴¹ Based on the experience of our members, USAC is not currently in compliance with this requirement. The Commission should reevaluate this requirement. It might be prudent to adjust the amount of time USAC has to issue additional inquiries, while maintaining a set timeline, but it is unacceptable that some applicants do not receive any follow-up questions until more than six months after the beginning of the funding year.

Application Processing Metrics. The Commission should adopt metrics for the Rural Health Care program similar to those adopted for the E-rate program. The Commission should require USAC to submit a public quarterly report to WCB detailing the status of processing of applications and invoices. The data should be reported both by number of applications as well as by the amount of funding requests. USAC should have to report on data for both Telecom and HCF Program applicants, and have separate classifications for individual and consortia

³⁹ See Line 25, *Service Provider Contact Person Email*, of the FCC Form 466 Health Care Providers Universal Service *Funding Request and Certification Form*.

⁴⁰ 47 C.F.R. § 54.631 Audits and Recordkeeping.

⁴¹ *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, FCC 12-150 (2012) ¶300.

applicants. SHLB members have noted that consortia applications are typically among the last reviewed and committed, and we believe adding transparency to the process will help ensure this is not the case in future funding years.

Appeals Process Improvements. While USAC has made some improvements to its appeal process, RHC program participants continue to experience delays in USAC decisions on appeals. This has a huge impact on applicants who need definitive resolution when there is potential erroneous action by USAC. One illustrative example are several funding denials received by one SHLB health participant due to HCP ineligibility, where the eligibility of those participants are under an appeal pending with USAC for almost a year. Lack of a timely appeal decision has now created further appeals. Other applicants are waiting for decisions on appeals for FY 2020 funding requests where the entire funding request was denied because USAC did not determine an urban rate. We note, however, that USAC typically explains its decisions on appeal and the Commission should ensure that explanation continues when USAC denies funding or seeks to recover funding.⁴²

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 to issue decisions on appeals filed with the Commission.⁴³ USAC should not be permitted to unilaterally

⁴² USAC could adopt a process similar to that employed by the Wireline Competition Bureau, which issues a public notice monthly on decisions, for those decisions granting an appeal. Such a process should not be used for denials without an accompanying clear explanation.

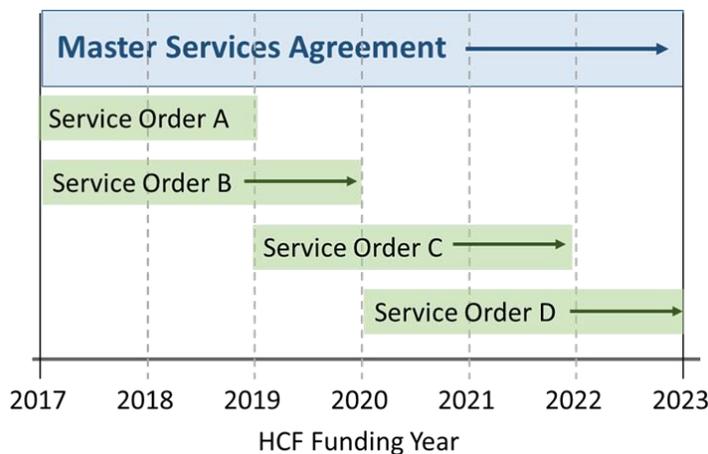
⁴³ See 47 C.F.R. § 54.724 (“The Wireline Competition Bureau [and the Commission] shall, within ninety (90) days, take action in response to a request for review of an Administrator decision that is properly before it.”).

extend that deadline. This is a reasonable measurement of USAC performance of its administrative duties.

Evergreen Status of Master Services Agreements. Under the Healthcare Connect Fund, Master Services Agreements (MSAs) have been central to the operation of many consortia, as well as for large health care providers (HCPs) applying independently. After competitive bidding is completed, the MSA enables HCPs to purchase telecommunications services that tie back to the terms, conditions, and pricing of the MSA. The MSA approach offers many efficiencies to the consortia, the HCPs and USAC.

As an example, the Southern Ohio Health Care Network (SOHCN) selects carriers based on competitive bidding and then negotiates MSAs with the winning respondents. Member HCPs of the SOHCN can then purchase services from the carriers, executing connection contracts (also referred to as “service orders”) under the terms and conditions of the governing MSA as illustrated in Figure 7. The SOHCN MSAs generally operate under six- or seven-year terms, while the connection contracts by the member HCPs vary from twelve (12) months to sixty (60) months. During the term of any MSA, dozens of connection contracts of varying duration and originating at different times will be executed by the sixteen member HCPs.

Figure 7: Intent and Legal Basis of MSAs

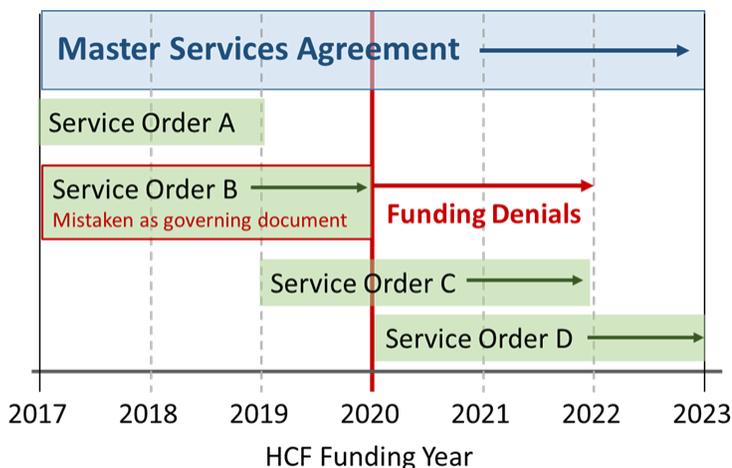


A. Deficiencies in Current Practice

Unfortunately, existing USAC processes do not take advantage of these benefits and, in many cases, create additional obstacles to the efficient operation of the Healthcare Connect Fund. For instance, as the result of a competitive bidding process in 2017, using an RFP approved by USAC, the SOHCN awarded Charter (dba Spectrum and TWC) as one of the two carriers to serve members of the consortium. SOHCN negotiated a Master Services Agreement, as described in the RFP, with a term extending through 2023.

Unfortunately, early in the life of the MSA, a USAC reviewer mistakenly interpreted one of the service orders as being the definitive governing document rather than the MSA. Since this point in time, unbeknownst to the SOHCN, USAC interpreted the end-date of the one particular service order as the end-date of the entire MSA as illustrated in Figure 8. This misunderstanding of MSAs has resulted in funding denials from USAC for two Funding Years (FY), both FY 2020 and FY 2021.

Figure 8: Impact of Mistaking the Term of a Service Order as the Term of the MSA



These denials – issued on the basis of an administrative mistake – have diminished funding to rural HCPs by \$1.2 million and generated unnecessary administrative burden for the SOHCN, USAC and ultimately the FCC.

As another example, USAC's FY 2020 denial based on this misinterpretation of the MSA term was received by the SOHCN on 17 June 2021, just two weeks prior to the end of FY 2020. The SOHCN prepared a lengthy appeal which was filed on 22 July 2021, an appeal USAC rejected on 31 March 2022, a full eight months after being filed. Now the SOHCN must prepare an appeal to the FCC.

USAC's actions related to SOHCN FY 2020 application occurred after the deadline for submitting applications for FY 2021 for which it subsequently received an identical "not evergreen" denial. The FY 2021 denial was received 3 March 2022, nine months into the funding year. The SOHCN is currently preparing its appeal to USAC.

We find this particularly frustrating because the SOHCN members are exactly the entities the Rural Healthcare Program was intended to benefit. The SOHCN has been involved with Rural Healthcare Programs through the FCC since 2007 when it won funding under Rural Health Care Pilot Program to extend fiber-optic based services across 13-counties in Appalachian Ohio. The SOHCN transitioned to the Healthcare Connect Fund in 2017 and represent sixteen HCPs operating 300+ sites across 40 counties. The consortium is currently 85% rural. Many other SHLB members have very similar stories as this SOHCN example.

B. MSAs Should Be Eligible for Evergreen Status

The existing USAC processes do not currently include review of MSAs for determination of evergreen status. Instead, the applicant must submit the results from the bidding process, the MSA and all Form 462s for the upcoming funding year before USAC will review the MSA itself. The applicant has no way to predict whether their MSA will be considered "evergreen" by USAC until receiving a funding commitment letter or a denial.

Thus, we request that the FCC specifically identify MSAs as a reasonable and efficient approach and direct USAC to:

- a. Extend the 461 process to encompass the review of:
 - o Competitive bidding results and scoring;
 - o Draft MSAs;
 - o The form of related connection contracts/service orders included as exhibits in the MSA.

- b. Approve the resulting MSA(s) as being “evergreen” or advise the consortium on changes necessary to the MSA to achieve “evergreen” designation. Allow the applicant to re-submit the renegotiated MSA for subsequent review and approval.

- c. Accept all subsequent connection contracts/service orders tied to the approved MSA as being “evergreen” without any change to the designation of the MSA as being evergreen for the entirety of its term.

We further request that such direction be retroactive to address pending appeals from the SOHCN and other applicants in similar circumstances.

We appreciate the Commission’s consideration of these comments. We expect to file additional thoughts in the reply comment round.

Sincerely,



John Windhausen, Jr.
Executive Director
Schools, Health & Libraries Broadband (SHLB) Coalition
1250 Connecticut Ave. NW Suite 700
Washington, DC 20036
jwindhausen@shlb.org
(202) 256-9616