July 1, 2021

Senator Brian Schatz
U.S. Senate
Washington, DC 20510

Dear Senator Schatz,

The Schools, Health & Libraries Broadband (SHLB) Coalition[1] very much appreciates your interest in upgrading telehealth networks so that all Americans can benefit from telemedicine. Even though the COVID-19 pandemic is nearing an end in this country, the changes to telemedicine are widespread and permanent. According to one report, only 11% of Americans used telemedicine before the pandemic, but over three-quarters of people are interested in using telemedicine going forward.[2]

As you recognized last year,[3] the surge and long-lasting demand for telemedicine places enormous strain on the telecommunications and broadband capacity available to healthcare providers. In many cases, healthcare providers report that they cannot send electronic medical records and operate video visits with patients simultaneously because of the lack of broadband capacity. As states provide greater telehealth flexibility to promote telemedicine, HCPs will need even greater bandwidth in the future to handle the increase in traffic.[4]

The principal federal program providing funding for telehealth networks is the Rural Health Care (RHC) program created by Congress in the Telecommunications Act of 1996. The program is administered by the Federal Communications Commission and by the Universal Service Administrative Company (USAC). Unfortunately, the RHC program needs a significant upgrade to address the post-COVID changes in the telehealth market. In short, the RHC program is underfunded and suffers from administrative delays that inhibit its effectiveness.

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[1] The SHLB Coalition is a non-profit public interest organization that promotes open affordable, high-quality broadband for anchor institutions and their surrounding communities. We have over 280 members from across the U.S. More information is available at www.shlb.org.

[2] "Only 11 percent of U.S. consumers used telehealth services in 2019, according to an analysis by the consulting firm McKinsey. Only months into the pandemic, however, the figure rose to 46 percent, with more than three-quarters of Americans expressing interest in using telehealth services going forward. McKinsey estimated that $250 billion in health care costs could be virtualized." https://www.rollcall.com/2021/03/09/one-year-in-broadband-access-and-telehealth-are-two-big-winners-under-covid-19/.

[3] https://www.schatz.senate.gov/news/press-releases/schatz-markey-bennet-lead-bipartisan-group-of-senators-in-urging-federal-government-to-expand-access-to-telehealth-services-for-rural-communities-.

[4] https://www.hhs.gov/coronavirus/telehealth/index.html.

To improve the program, the SHLB Coalition recommends legislation that would provide immediate additional funding and streamline the application process to bring telemedicine to all. The SHLB Coalition worked with its members to estimate the costs of providing 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 important to promoting 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.

Second, we calculated their 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). This average cost estimate was derived based on our members' examination of the costs of several hundred health care sites across the country. The total annual broadband spend for these sites will be approximately $3.09 billion ($42,324 x 72,990).[5] According to the FCC's rules, the RHC program would cover approximately 88% of these costs for a subtotal of approximately $2.72 billion. The FCC is already planning to make approximately $612 million[6] available for 2021 applicants, which means the total unmet need (funding shortfall) for broadband service is approximately $2.11 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 legislation should 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 x 72,990).

Taken together, we estimate that the need for annual funding to upgrade HCPs' broadband service and internal connections to be about $3.91 billion per year ($2.11 b + $1.8 b) over and above the amount of funding the FCC is currently planning to make available. Over 5 years, the total amount of funding needed would be $19.55 billion.

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[5] If Congress chooses to permit for-profit health care providers to participate in the program in addition to nonprofit health care providers, we estimate that the total number of sites would increase to about 150,000 and their broadband and telecommunications spend would total about $5 Billion per year.

[6] https://docs.fcc.gov/public/attachments/DA-21-332A1.pdf.

This cost estimate does not include the costs of cybersecurity or devices for individuals who wish to engage in telemedince from home or other locations outside the healthcare provider's premises.

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.

In order to put the RHC program on the right track, we respectfully ask you and your Congressional colleagues to appropriate funding of $2 billion for the FCC's Rural Health Care program as a down payment on the future of telemedicine. Combined with accompanying administrative reforms to improve the processing of RHC applications, this legislation would 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 upgrade their telehealth networks and services so that we are better prepared for the future.

Sincerely,

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July 1, 2021

Draft Legislation to Reform the Rural Health Care Program Administered by the Federal Communications Commission

The national COVID-19 pandemic highlighted the critical importance of improving our broadband infrastructure to facilitate telemedicine for all Americans. Unfortunately, the legislation creating the Rural Health Care (RHC) program (administered by the Federal Communications Commission) was drafted over 25 years ago and needs permanent and long-term improvements to ensure that all healthcare providers have sufficient and affordable access to broadband connections and telehealth services for the future.

To address this need, the SHLB Coalition[1] has put together the attached legislative language that will reform and update the RHC program to support remotely provided care beyond the COVID-19 pandemic.

Summary:

Similar to the E-rate program, the FCC's Rural Health Care program provides a subsidy to certain health care providers to lower their cost of broadband connectivity. The attached legislation would update the RHC program to 1) expand the number of entities eligible for the program, 2) codify the current Healthcare Connect Fund, 3) authorize universal service support for devices needed to provide telehealth and internal connectivity within healthcare providers, 4) clarify the definition of a rural healthcare provider, 5) expedite decisions on RHC funding applications, 6) increase the cap on spending for the program, and 7) provide a one-time appropriation of $2 billion to the program to reflect the surge in telemedicine demand that will persist after the pandemic.

In particular, the attached language would:

- Amend the Telecommunications Act of 1996 to:
  - Modify the definition of a "health care provider" in Section 254(h)(7) to add new eligible entity types (non-rural health clinics and temporary, mobile, or satellite health care delivery sites);
  - Add a new clause to 254(h)(1)(A) to codify the Commission's existing Healthcare Connect Fund;
  - Authorize the FCC to enhance access to "devices necessary to enable the provision of telehealth services"[2] in Section 254(h)(2)(A).

[1] The Schools, Health & Libraries Broadband (SHLB) Coalition is a non-profit public interest group with over 280 members from around the US. We support open, affordable, high-quality broadband for anchor institutions and their surrounding communities. More information is available at www.shlb.org.

[2] *See* Coronavirus Aid, Relief, and Economic Security (CARES) Act, Pub. L. No. 116-136, 134 Stat. 281 (2020); *Promoting Telehealth for Low-Income Consumers; COVID-19 Telehealth Program*, WC Docket

- Direct the Commission to:
    - Broaden the definition of "rural" (using U.S. Census criteria) for purposes of determining which healthcare providers can participate in the program, and for determining how to prioritize funding within the program.
    - Create multiple higher flat-rate subsidy levels for some rural healthcare providers that participate in the program, depending on how rural they are.
    - Mandate timely funding decisions in years where gross demand is below the funding cap.
    - Raise the program's annual funding cap from $612 million to $2.8 billion (less than 2/3 the size of the current E-rate cap) to ensure the program will accommodate the massive shift to remote care that will continue post-pandemic.
    - Provide a one-time appropriation of $2 billion to augment (through 2026) the universal service contributions that fund the RHC program, while the FCC develops rules to implement this legislation.
    - Preserve the existing sub-cap in the Healthcare Connect Fund ("HCF") but clarify that it applies only to upfront costs for self-construction.
    - Allow RHC Telecommunications Program participants to fund equipment (such as routers) through the HCF when that equipment is needed to make an eligible service in either program functional.

<u>What the proposed language WILL NOT do</u>:

- Alter the existing RHC Telecommunications Program
- Alter the rural funding prioritization system recently implemented by the FCC.

For Further information or questions, please contact John Windhausen, SHLB Coalition Executive Director, at jwindhausen@shlb.org. (www.shlb.org)

Nos. 18-213, 20-89, Report and Order, 35 FCC Rcd 3366, 3379, ¶ 24 (2020).

Subtitle D—Healthcare Broadband Expansion.

SECTION __01. SHORT TITLE.

This Subtitle may be cited as the "Telehealth Connectivity Act of 2021".

SEC. __02. TELECOMMUNICATIONS AND BROADBAND SERVICES FOR NON-PROFIT HEALTH CLINICS AND TEMPORARY, MOBILE, AND SATELITE LOCATIONS.

(a) IN GENERAL.—Section 254(h)(7)(B) of the Communications Act of 1934 (47 U.S.C. 254(h)(7)(B)) is amended—

(1) in clause (vi), by striking "rural";

(2) in clause (vii), by striking "and" at the end;

(3) by redesignating clause (viii) as clause (ix);

(4) by inserting after clause (vii) the following:

(A) "(viii) temporary, mobile, or satellite health care delivery site";

(5) in clause (ix), as redesignated, by striking "clauses (i) through (vii)" and inserting "clauses (i) through (viii)".

Section 254(h)(1)(A) of the Communications Act of 1934 (47 U.S.C. 254(h)(1)(A) is amended—

(1) by redesignating subsection (A), as subsection (A) clause (i);

(2) by inserting after clause (i), the following:

"(ii) A service provider shall, upon receiving a bona fide request, provide advanced telecommunications, information services, cybersecurity services, network capacity, and devices which are necessary for the provision of telehealth services in a State, including instruction relating to such services, to any public or nonprofit health care provider that serves persons who reside in that State at discounted rates. The discount shall be an amount that the Commission determines is appropriate and necessary to ensure affordable access to and use of such services, network capacity, and devices by such entities.

Section 254(h)(2)(A) of the Communications Act of 1934 (47 U.S.C.

254(h)(2)(A) is amended—

(1) by inserting "and to or within" between "classrooms," and "health care providers";

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply beginning on the date that is 180 days after the date of the enactment of this Act.

SEC. __03. DEFINITIONS.

In this subtitle:

(1) ELIGIBLE EQUIPMENT.—The term "eligible equipment" means the equipment described in section 54.613 of title 47, Code of Federal Regulations, or any successor regulation.

(2) FUNDING YEAR.—The term "funding year" has the meaning given the term in section 54.600(a) of title 47, Code of Federal Regulations, or any successor regulation.

(3) HEALTHCARE CONNECT FUND PROGRAM.— The term "Healthcare Connect Fund Program" means the program described in section 54.602(b) of title 47, Code of Federal Regulations, or any successor regulation.

(4) MULTI-YEAR COMMITMENTS.—The term "multi-year commitments" means the commitments described in section 54.620(c) of title 47, Code of Federal Regulations, or any successor regulation.

(5) RURAL HEALTH CARE PROGRAM.—The term "Rural Health Care Program" means the program described in subpart G of part 54 of title 47, Code of Federal Regulations, or any successor regulation.

(6) TELECOMMUNICATIONS PROGRAM.—The term "Telecommunications Program" has the meaning given the term in section 54.602(a) of title 47, Code of Federal Regulations, or any successor regulation.

(7) UPFRONT PAYMENTS.—The term "upfront payments" means the payments described in section 54.616 of title 47, Code of Federal Regulations, or any successor regulation.

SEC. __04. EXPANSION OF RURAL HEALTH CARE PROGRAM.

(a) PROMULGATION OF REGULATIONS REQUIRED.— Not later than 180 days after the date of enactment of this Act, the Commission shall promulgate regulations modifying the requirements in subpart G of part 54 of title 47, Code of Federal Regulations, in the following manner.

(1) Section 54.600(b) shall be revised to reflect amendments to Section 254(h)(7)(B) of the Communications Act of 1934.

(2) Regulations shall be promulgated to allow eligible recipients to receive universal service support through the Healthcare Connect Fund for "access to advanced telecommunications, information services, and devices necessary to enable the provision of telehealth services . . . to or within health care providers" as authorized by the amended language in Sections 254(h)(1)(A)(ii) and 254(h)(2)(A) of the Communications of 1934. An eligible recipient need not also receive universal service support for telecommunications or advanced services in order to obtain support for devices necessary to enable the provision of telehealth services.

(3) The definition of "rural area" in Section 54.600(e) shall reflect the standard US Census Bureau designations for the classification of rurality utilizing "Metropolitan Statistical Areas" and "Micropolitan Statistical Areas" as the primary method for distinguishing the relative rurality tier:

(A) **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.

(B) **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.

(C) Census block boundaries shall be used to rather than census tract boundaries.

(4) The following rurality tiers shall be delineated:

(A) **Extremely rural** – healthcare facilities located in counties entirely outside of both any Micropolitan Statistical Area or Metropolitan Statistical Area.

(B) **Rural** – healthcare facilities located in census blocks within a Micropolitan Statistical Area but the census block does not contain any part of an urban cluster.

(C) **Less Rural** – healthcare facilities located in census blocks within a Micropolitan Statistical Area, plus census blocks within a Metropolitan Statistical Area but the census block does not contain any part of an urban cluster.

(D) **Urban** – healthcare facilities located in all other non-rural areas.

(5) The definition of "rural health care provider" in Section 54.600(f) shall include any eligible health care provider not in an Urban area.

(6) The discount rate for an eligible expense through the Healthcare Connect Fund Program (as described in section 54.611(a) or any successor regulation) shall be variable based on the rurality tier of the eligible location as follows:

(A) Extremely rural eligible sites shall be eligible to receive a 95% subsidy of eligible costs;

(B) Rural eligible sites shall be eligible to receive a 85% subsidy of eligible costs;

(C) Less Rural eligible sites shall be eligible to receive a 75% subsidy of eligible costs; and

(D) Urban eligible sites belonging to a consortium consisting of a majority of eligible rural health care providers shall be eligible to receive a 65% subsidy of eligible costs.

(E) Individual eligible sites that apply as part of an eligible consortium (as described in Section 54.600(b)(8) or any successor regulation) shall receive a subsidy of eligible costs in accordance with the rurality tier in which they are located, except that costs for services or equipment that are shared by a majority rural consortium shall be eligible for the Rural tier subsidy and shall be classified as Rural for purposes of any prioritization system, regardless of the location where such services are delivered or equipment is located.

(7) Rural Health Care Funding Cap Increase

(A) The aggregate annual cap for the Rural Health Care program shall be $2.8 billion to accommodate the estimated 92,000

eligible healthcare sites and shall remain indexed for inflation annually as per current provisions in Section 54.619(a)(1).

(B) The existing cap on multi-year applications, upfront costs and equipment in the Healthcare Connect Fund set forth in Section 54.619(a) shall apply only to upfront costs for self-construction.

(8) Rural eligible health care providers in the Telecommunications Program may receive support through the Healthcare Connect Fund for network equipment necessary to make functional an eligible service supported under the Telecommunications Program.

(9) In any year in which gross funding demand is below the annual cap, issuance of a decision on each application for funding not later than 60 days after the date on which the application is filed. Health care provider attestations and certifications regarding the eligibility of the healthcare sites shall be accepted as valid, subject to regular post-funding commitment audit verification.

(10) Release of funding not later than 30 days after the date on which an invoice is submitted with respect to an application that is approved, applicable services have been provided, and required invoices have been submitted as required under program rules.

(b) ADDITIONAL CHANGES TO RURAL HEALTH CARE PROGRAM.—

(1) RELEASE OF FUNDING FOR OUTSTANDING FUNDING REQUESTS.—

(A) IN GENERAL.—The Commission shall ensure the release of funding for all requests (outstanding as of the date of enactment of this Act) under the Rural Health Care Program not later than 60 days after the date of enactment of this Act, except that for outstanding funding requests that are subject to a review of the applicable urban and rural rates, the Commission shall ensure the release of interim funding not later than 60 days after the date of enactment of this Act, disbursed at a minimum of 65 percent of the funding request, subject to a true-up following the completion of such review.

(B) LIMITATION.—This paragraph shall not apply to any party or successor-in-interest to any party to which the Commission, during the period beginning on the date that is 1 year before the date of enactment of this Act and ending on January 31, 2022, has issued a Letter of Inquiry, Notice of Apparent Liability, or Forfeiture Order relating to the party's participation in the

Rural Health Care Program, pursuant to section 503(b) of the Communications Act of 1934 (47 U.S.C. 503(b)).

(C) REQUIRED REPAYMENT.—In the case of an eligible service provider that receives funding through the Rural Health Care Program pursuant to this paragraph to which the eligible service provider is not entitled, the Commission shall require the eligible service provider to repay such funds.

(c) EFFECTIVE DATE OF REGULATIONS.—The regulations required under subsection (1) shall take effect on the date on which the regulations are promulgated.

(d) TELEHEALTH CONNECTIVITY FUND.—

(1) ESTABLISHMENT.—There is established in the Treasury of the United States a fund to be known as the Telehealth Connectivity Fund.

(2) APPROPRIATION.—There is appropriated to the Telehealth Connectivity Fund, out of any money in the Treasury not otherwise appropriated, $2,000,000,000 for fiscal year 2022, to remain available through fiscal year 2026.

(3) USE OF FUNDS.—Amounts in the Telehealth Connectivity Fund shall be available to the Commission to carry out the Rural Health Care Program, as modified by the regulations promulgated herein.

(4) RELATIONSHIP TO UNIVERSAL SERVICE CONTRIBUTIONS.—Support provided under the regulations required by paragraphs (1) through (3) of subsection (a) shall be—

(A) provided from amounts made available under paragraph (2) of this subsection and not from contributions under section 254(d) of the Communications Act of 1934 (47 U.S.C. 254(d)); and

(B) in addition to, and not in replacement of, funds authorized by the Commission for the Rural Health Care Program as of the date of enactment of this Act from contributions under section 254(d) of the Communications Act of 1934 (47 U.S.C. 254(d))

(C) Notwithstanding the above, the Telehealth Connectivity Fund shall only be used for Rural Health Care Program funding commitments (and resulting expenditures) each funding year above $612 million that are funded from contributions under section 254(d) of the Communications Act of 1934 (47 U.S.C.

254(d)).

254(h) Telecommunications services for certain providers

(1) In general

(A) Health care providers for rural areas

(i) A telecommunications carrier shall, upon receiving a bona fide request, provide telecommunications services which are necessary for the provision of health care services in a State, including instruction relating to such services, to any public or nonprofit health care provider that serves persons who reside in rural areas in that State at rates that are reasonably comparable to rates charged for similar services in urban areas in that State. A telecommunications carrier providing service under this paragraph shall be entitled to have an amount equal to the difference, if any, between the rates for services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in comparable rural areas in that State treated as a service obligation as a part of its obligation to participate in the mechanisms to preserve and advance universal service.

(ii) A service provider shall, upon receiving a bona fide request, provide advanced telecommunications, information services, cybersecurity services, network capacity, and devices which are necessary for the provision of telehealth services in a State, including instruction relating to such services, to any public or nonprofit health care provider that serves persons who reside in that State at discounted rates. The discount shall be an amount that the Commission determines is appropriate and necessary to ensure affordable access to and use of such services, network capacity, and devices by such entities.

* * * *

(2) Advanced services

The Commission shall establish competitively neutral rules—

(A) to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for all public and nonprofit elementary and secondary school classrooms, and to~~for~~ or within health care providers,~~,~~ and libraries; and

* * * *

(7) Definitions

For purposes of this subsection:

* * * *

(B)Health care provider

The term "health care provider" means—

(i) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools;

(ii) community health centers or health centers providing health care to migrants;

(iii) local health departments or agencies;

Commented [JM1]: This adds a new paragraph (ii) to section 254(h)(1)(A). The language is intended to codify the existing Healthcare Connect Fund (HCF), and to make clear the authorization extends to funding network capacity (which the HCF currently funds). The language authorizes the Commission to fund cybersecurity services as well as "devices necessary for the provision of telehealth services," which Congress previously funded through the CARES Act when it directed the FCC to establish the COVID-19 Telehealth Program. (Patients are currently not eligible to receive discounted devices through the HCF.) Health care providers could use these devices to provide care to patients in the home. Note "telehealth services in the State" is not intended to limit healthcare providers from providing telehealth services between states if such cross-state services are otherwise allowed by law. This new paragraph (ii) remains part of 254(h)(1)(A) under the heading "Health care providers for rural areas" and so is intended primarily to benefit persons residing in rural areas of a state. But the Commission retains its existing authority under Section 254(h)(2)(A) to "enhance access, to the extent technically feasible and economically reasonable" to services to *all* health care providers, whether rural or non-rural. The provision in (B)(ix) allows the FCC to provide HCF funding, including for equipment or devices, to non-rural providers that are part of a consortium containing more than a *de minimis* number of rural health care providers (as the FCC allowed as part of its 2007 Rural Health Care Pilot Program).

Commented [JM2]: The language "to or within" in the last line is intended to permit the FCC to now authorize internal connections funding for health care providers (to the extent technically feasible and economically reasonable).

(iv) community mental health centers;

(v) not-for-profit hospitals;

(vi) ~~rural~~ health clinics;

(vii) skilled nursing facilities (as defined in section 395i–3(a) of title 42); ~~and~~

(viii) temporary, mobile, or satellite health care delivery site; and

(~~viii~~ix) consortia of health care providers consisting of one or more entities described in clauses (i) through (vii).