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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The Schools, Health & Libraries Broadband (SHLB) Coalition, whose members include many participants in both of the Rural Health Care (RHC) programs—the Healthcare Connect Fund (HCF) and the Telecommunications Program (Telecom Program)—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-quality 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] SHLB Coalition members include representatives of health care providers and networks, schools, libraries, state broadband offices, private sector companies, state and national research and education networks, and consumer organizations. See http://shlb.org/about/coalition-members for a current list of SHLB Coalition members.

The Commission has requested additional comment on determining the urban and rural rates in the Telecom Program.[2] Generally speaking, the points SHLB made in its comments on last year's NPRM still apply, so in these comments SHLB highlights what it believes are the most important matters the Commission should consider as it moves forward with this rulemaking.

Currently, there are two components that determine the amount of subsidy HCPs receive in the Telecom Program: the urban rate and the rural rate. The Wireline Competition Bureau seeks further comment on its proposal to determine what rural rates may be charged by carriers by using an average of all "publicly available" rates. Further, the Commission seeks comment on whether urban rates should be similarly averaged using all "publicly available" rates.

SHLB appreciates the Commission's desire to improve the RHC program and agrees that the Commission's current rules are outdated in a competitive marketplace. While using an average of "publicly available" rates may sound appealing at first blush, the reality is that it is not easy to gather and analyze these rates, especially in rural areas. Trying to calculate the "average rate" introduces a great amount of uncertainty and arbitrariness into the process as rates may vary based on technology and location. Further, limiting the calculation to the "publicly available" rates may exclude rates that are actually made available to customers in the marketplace.

SHLB is concerned that the complexity and unpredictable effects of the proposed rules will force rural health care providers (HCPs) currently participating in the Telecom Program to either leave the RHC program altogether or move to the HCF program. Either way, the rural

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[2] *The Wireline Competition Bureau Seeks Additional Comment on Determining Urban and Rural Rates in the Rural Health Care Program*, WC Docket No. 17-310, DA 18-1226 (rel. Dec. 4, 2018) (*Public Notice*).

HCPs that are most in need will not be able to afford the telecommunications services that they need to provide quality health care to residents of rural areas. SHLB is already aware of several rural health care providers that will not be participating in the Telecom Program in FY2019 because of the uncertainty of the past few years. It should be emphasized that HCPs are not in control of the rates that are provided to them – that is the role of the service providers. If the FCC and USAC raise questions about the rates, proving the reasonableness of the rates should be the responsibility of the service provider, not the HCP.

The Commission's proposal to average the "publicly available" rural rates would also discourage service providers from bidding on rural HCP requests for proposals, given that the prices service providers quote in their bids may end up being higher than the prices that the FCC and USAC will support.

Determining rates based on an average of publicly available rates may not be consistent with Congress' intent in creating the RHC program. Congress intended rural HCPs—and by extension, the patients they serve—to be able to access telecommunications services at prices that are "reasonably comparable" to their urban counterparts. This is even more important given that rural residents already do not have access to the same health care services as urban residents. Most importantly, the HCPs that need the most funding are the ones who stand to lose the most if changes to the program do not compensate them fully for their costs.

I. Urban Rates Should Be Established by the Commission in a Transparent Process.

The Commission has proposed establishing urban rates using an average of all publicly available rates. SHLB believes, however, that the urban rate should be determined only after a proceeding at the Commission, with a notice and comment period. SHLB agrees that the

Commission should establish bandwidth ranges that are reasonable in today's marketplace.[3] The Commission should identify the basis for the proposed urban rates and allow parties to provide additional rates they are aware of via a challenge process. Urban rates should not be limited to "publicly available" rates as those rates may not reflect rates that are being charged in the marketplace. Further, averaging urban rates would ensure that HCPs would definitely pay higher rates than some of their urban counterparts, contrary to what Congress intended.[4] Another uncertainty is whether the Commission would use a weighted average of the rates, and how information regarding the number of services or customers at each different rate would be identified and collected. Instead, the Commission should review all rates it has access to, and should select the lowest market rate in the relevant urban area as the urban rate.[5]

In establishing urban rates, the Commission should compare rates that are apples to apples. The Commission should compare services that use the same technology and offer the same service level (quality of transmission). Getting the urban rate correct is especially important as this reflects the amount that rural HCPs will be paying.[6] To implement this approach, the Commission may consider contracting with a team of advisors outside of the

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[3] SHLB would also suggest that the Commission allow for revisions to the bandwidth tiers by the Wireline Competition Bureau on delegated authority.

[4] There is especially a danger that rates that have effectively been replaced by a different product may still be included in a tariff. The tariffed rate is often the ceiling, and the parties often negotiate a lower rate. The Commission should not rely on the posted rates because they are often significantly higher than actual rates, unless they have evidence that customers are actually paying those rates. Avoiding the use of tariffed rates would help the Commission ensure that the average rate is not set too high because of a posted rate that no customer may actually be paying.

[5] Some carriers may object to their rates being identified in a public proceeding. The Commission can either keep some of the information confidential or use rates from E-rate or state master contracts that are already in the public domain. It is our HCP members' understanding that carriers are responsible for calculating and documenting the rural rate.

[6] *See* below for SHLB's suggestion that HCPs pay an additional 5% on top of the urban rate.

Commission to review rates and make recommendations. Former state utility commission staff with experience in rate reviews might be good candidates for such a team.[7]

II. Rural Rates Should Be Determined Primarily by the Market, as Long as the HCP Contributes Five Percent of the Urban Rate-Rural Rate Difference.

SHLB believes that the Commission should primarily rely on the competitive bidding process to establish the rural rates for HCPs. The Commission's proposed rule reverts to rate regulation—disfavored in every other instance—instead of promoting competition. SHLB understands that, under the current rules, HCPs have no requirement to select a carrier that is the most "cost-effective" for the program, so SHLB proposes an alternative approach that will require some price sensitivity for rural HCPs.

The Commission's proposed new rule requiring an averaging of all publicly available rates in the HCP's rural area most likely will harm the Telecom Program and HCPs. If tariffed rates are used as a formula to establish rural rates, the RHC program will not get the benefit of a competitive market. Averaging only publicly available rates will mean, by definition, the program is not receiving the lowest rate possible. SHLB members are concerned about this possible effect, especially given that RHC program dollars need to go even further with the recent demand on the cap.

Further, because of deregulation, many services, such as Ethernet, are not tariffed or published publicly, or are only tariffed by one carrier. Those "publicly available" rates may not reflect all of the rates available in a market. In addition, a reseller may be able to combine the

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[7] It would also be extremely helpful if USAC could update the safe harbor urban rates by state posted on its website to reflect more current technologies such as Ethernet services. *See 2003 RHC Order*, 18 FCC Rcd at 24563, para. 33; Promoting Telehealth in Rural America, WC Docket No. 17-310, Notice of Proposed Rulemaking and Order, 32 FCC Rcd 10631 at ¶¶ 73-76 (2017) (*Notice*). The Commission has not updated the bandwidth tiers since 2003. *Id.*

services of multiple carriers to offer a better rate. The program therefore will not receive the benefit of the competitive market for these services that the Commission has correctly encouraged, and instead will pay more for services than the rates charged by the service providers in a competitive market.[8]

The proposed rule averaging publicly available rates would also not be predictable. The rural rate would be extremely difficult, if not impossible for HCPs and service providers to determine. Given the variables in the proposed rule—that the rate must include "all" "publicly available" rates—it is likely that rural rates would be second-guessed after the fact.[9] The program would not be predictable: carriers could not be sure that the rates they bid would be accepted by USAC, possibly until months after the competitive bidding process ended. If the program established rural rates that were not reflective of market realities, carriers would likely stop offering RHC-supported services to HCPs, reducing their choices, or worse, eliminating their options for broadband altogether.[10] Such an outcome is not good for the rural HCPs—the anchor institutions—that can drive broadband access for entire communities.

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[8] SHLB notes that, if the Commission adopts this type of rate regulation, then it should eliminate the requirement for competitive bidding for HCPs. If the rates must be established using a formula based on rates that are "publicly available," then there is no reason HCPs would have to compare bids. Every carrier that bids would be required to offer the same price, as best they can determine what that price should be. The downside, of course, is that the program will not receive the benefit of market rates.

[9] Furthermore, reliance on 'tariffed rates' does not take into account the rates charged by non-traditional carriers that may not file tariffs. Not even carriers holding state-level CPCN certifications or Section 214 FCC approvals are required to post tariffs in most cases, so using tariffed rates as the gold standard eliminates entire classes of operators that may offer lower-cost/better quality providers. Business Data Services offerings such as Ethernet are non-tariffed services that are widely available.

[10] If HCPs paid only their share (*i.e.*, the urban rate), instead of the amount they had contracted for, HCPs would be no more price sensitive than they are today, and the service provider will be left to endure the reduction. Potential service providers would be reluctant to bid if they knew the price they offered may not end up as the actual rate for which they will be reimbursed—an outcome that will reduce competition. A reduction in competition will not help reduce costs to the program.

Instead, the Commission should consider changing the amount of the subsidy in the Telecom Program from 100 percent of the difference between the urban and rural rate to 95 percent of the difference between the urban and rural rate.[11] This could be called the "rural subsidy" or the "rural discount." With this approach, HCPs also would have to pay 5 percent of the difference between the urban and rural rates (plus the urban rate). Today, because HCPs only pay the urban rate, if they have a choice between carriers, price may not be a factor in their selection at all. Requiring HCPs to pay 5% of the urban-rural rate difference would ensure that HCPs are price sensitive to the total cost of the services. Further, this approach would be consistent with the statutory directive that rural HCPs pay rates "that are reasonably comparable" to the urban rate.[12] SHLB would support a transition period so that HCPs can plan for this additional expense.

III. The Commission Must Also Address Several Open Issues in the RHC Program and the Healthcare Connect Fund.

The Public Notice asks for comment on the rural rate for the Telecom Program. Nonetheless, the SHLB Coalition respectfully submits that there are also several open issues regarding the Rural Health Care program as a whole, and with the Healthcare Connect Fund in particular, that are extremely important for the Commission to address. The resolution of these issues is critical if the RHC program is to accomplish the congressional directive to bring the benefits of telemedicine to rural consumers. Accordingly, in addition to its comments on the

[11] SHLB understands the unique challenges faced by HCPs in Alaska and recommends that the Commission continue to allow Alaskan providers to receive 100% of the difference between the urban and rural rates. We recognize that 5% of a larger subsidy will be a larger dollar amount that the HCP would be expected to shoulder. The Commission should consider a cap on the dollar amount that an HCP would pay so that the neediest HCPs do not end up paying the most co-pay.

[12] 47 U.S.C. § 254(h)(1)A). Congress did not say that rural HCPs must not pay more than the urban rate or the same as the rural rate.

Telecom Program, the SHLB Coalition urges the Commission to promptly address the following issues.

A. The Commission should set deadlines for the processing of all applications.

As of this writing, more than six months after the close of the application filing window for FY2018, a sizable number of applicants still do not know whether or not they will be funded. This is especially true for consortia applicants, who have not seen any FY2018 applications approved to date. This delay stands in stark contrast to how the program operated prior to FY2016, when applications were approved within a few months after being filed. This delay also stands in contrast to the E-rate program, where the Commission has claimed that most of the FY2018 applications were resolved by September 1, within six months after the close of the filing window. The SHLB Coalition appreciates that the RHC program has faced some unique challenges in the past few years due to the growth in demand. Nonetheless, the growth in demand is even more reason for the Commission and USAC to put greater effort into resolving the open issues and reviewing pending applications. We suggest that the Commission adopt a goal that USAC will complete its review of all applications within four months of the close of the filing window. The Commission should track and issue public reports on USAC's success in meeting this goal.

B. The Commission should resolve the open question about how it will treat applications if the demand for funds exceeds the cap.

The demand for program funds has breached the cap in the last two years, yet the Commission has not settled on a policy to determine how to allocate funding when the cap is exceeded. In FY2016, all applicants endured a pro rata 7.5 percent reduction in funding. In early 2017, applicants were initially told that they would suffer either a 15 percent reduction (for individual applicants) or a 25 percent reduction (for consortia applicants). This discriminatory

treatment of consortia applicants has no basis in the Commission's rules, and it would have conflicted with several prior Commission statements recommending that applicants form consortia in order to improve service to rural America. Fortunately, the Commission later raised the cap for FY2017 and fully funded all FY2017 applicants. But the Commission's ad hoc approach to prior funding years leaves potential applicants wondering how the Commission will allocate funding if the cap is breached in the future. This uncertainty is also currently affecting FY2018 applicants (some of whom still have not received funding decisions for FY2017) in part because it appears that a program cap has been breached once again (the $150 million sub-cap).

Indeed, the Commission has not yet addressed the $150 million sub-cap in the HCF for those applications seeking funding for up-front, non-recurring expenses and multi-year funding requests. This sub-cap was supposedly adopted to prevent applicants from using up a large portion of the funding for build-out costs, thereby preventing HCPs from obtaining support for monthly recurring charges.[13] The logic for implementing a sub-cap was tenuous in the first place, since the Commission recognized that, as in the RHC pilot program, most HCF participants would choose to subscribe to carrier services rather than construct their own networks.[14] When the Commission raised the cap to $571 million in FY2017, it did not address the sub-cap, which remains stuck at $150 million. The Commission should consider eliminating the sub-cap altogether because it is inconsistent with the idea of promoting rural broadband deployment, or at a minimum should raise the sub-cap in proportion to increases in the overall cap.

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[13] *See HCF Order*, 27 FCC Rcd at 16700, ¶ 47.

[14] *Id.* at 16757, ¶ 73 ("we expect that most HCPs in the [HCF] program will choose to purchase services rather than construct and own facilities").

C. The Commission should clarify the definition of what constitutes a rural area.

The Commission's current rules regarding the definition of a rural market should be revisited. Hundreds of HCPs residing in and serving rural markets are considered to be urban due to the FCC's existing definition of rurality. Currently the rurality of a particular HCP location depends solely on the population of the "urban cluster" in which it resides as delineated by the U.S. Census Bureau. The FCC's population threshold of 25,000 results in designating many small-town HCPs as "urban" despite being located long distances from metropolitan areas. These small-town HCPs serve the surrounding rural areas and clearly fit the mission of the HCF.

Rather than adjusting the population threshold, we recommend adoption of USDA Rural-Urban Commuting Area (RUCA) Codes as an alternative method for determining rurality. The RUCA Codes classify U.S. census tracts using measures of population density, urbanization, and daily commuting – a well-established model and methodology. RUCA Codes provide much more accurate characterizations of the rurality of any geographic area compared to the current population threshold approach.[15]

The SHLB Coalition has previously proposed that the Commission use RUCA Codes as an additional indicator an HCPs' rural status, and we continue to support that recommendation.[16] We clarify that our proposal is to allow RUCA Codes (4-10) as an additional way an HCP can to qualify as rural, not as a replacement to the current system that relies on census data.[17]

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[15] See https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes.aspx.

[16] SHLB Comments at 15-16; SHLB Reply Comments at 15-16.

[17] *Id.*

D. The Commission should increase the discount for rural HCPs in the HCF.

The Commission should consider increasing the discount for rural health care providers compared to urban providers in the HCF.[18] Currently the rules call for a flat 65 percent subsidy for all providers, which is significantly lower than the subsidy provided to many schools and libraries in the E-rate program. The Commission should consider returning to the 85 percent subsidy for remote rural HCPs (as in the RHC Pilot Program), with lower subsidy levels for urban sites (if participating as part of majority rural HCF consortium), and 95% for frontier locations (however the Commission chooses to define that term). If the Commission adopts SHLB's RUCA code proposal, we reiterate our suggestion that RUCA codes 1-3 be classified as urban, 4-6 as rural (with a 65 percent discount), 7-9 be considered remote rural (with an 85 percent discount), and RUCA code 10 as frontier with a 95 percent discount.[19]

E. The Commission should improve transparency in the RHC program as a whole, and especially in the HCF.

There are several changes the Commission should implement to make the RHC program data more transparent. For instance, it should publish the amount of funding requested for the Telecom Program and the HCF each year. The Commission should also publish the demand for funding for one-time special construction projects and multi-year funding requests that are subject to the $150 million sub-cap. In addition, the Commission should make the prices for RHC services more transparent. These data are collected on Forms 462/466 but they are not published. Making this pricing information publicly available could help health clinics compare and benchmark their rates with other, similarly situated customers.

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[18] *Id*.

[19] *Id.*

F. The Commission should address the backlog of consortia applications.

Many consortia applications have been in limbo for the past few years as USAC has not been processing these applications as quickly as individual applications. This is extremely unfortunate, as consortia often include hundreds of health care providers that are not receiving funding that they are due. The Commission encourages the filing of consortia applications, and it also said in 2012 that it planned to expedite consortia applications.[20] USAC's treatment of consortia applications is thus both disproportionately harmful and inconsistent with Commission precedent and policy.

G. The Commission should increase the RHC cap to $800 million, at least until it conducts a more detailed factual investigation of the actual costs.

SHLB continues to believe that the Rural Health Care program cap should be substantially increased to ensure the program is meeting statutory objectives (and to improve parity with its "sister" USF programs). We greatly appreciated and supported the 2018 decision to increase the cap to $571 million to reflect inflation since 1997, and the decision to fully fund all applicants in FY2018. This increase was vitally important to those HCPs and broadband providers that were faced with unexpected pro rata reductions.

Nonetheless, the uncertainty of future funding continues to plague the program and discourages HCPs from participating in the program. Neither USAC nor the FCC has published the demand for funding for FY2018, more than six months after the application window closed. This lack of information suggests that the demand for funding has either exceeded the cap or the sub-cap. Demand for RHC funding is likely to continue to grow because of the many changes in

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

the marketplace (*e.g.,* the growth of demand for electronic medical records, the closure of rural hospitals, the shortage of rural doctors, the aging rural population, and the addition of skilled nursing facilities as eligible entities) In our February 2018 comments, we suggested that the cap should be doubled to $800 million, and noted that this increase in funding is small compared to the overall size of the USF (the increase in the contribution factor would not be noticeable because it falls within the range of the quarterly fluctuations in the contribution factor).[21] We continue to believe that the cap increase adopted so far, which we appreciated, does not provide the certainty need for HCPs or for the broadband providers. A larger Rural Health Care program that avoids significant retroactive funding reductions such as those encountered in FY 2016 and FY 2017 would obviously avoid hardship and disruption to program participants in the future. Eliminating the funding uncertainty and ensuring that sufficient funds are available for the program is in the public interest and essential to meeting the Congressional directive.[22]

Respectfully submitted,

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[21] SHLB Comments at 13-14, 21-23.

[22] Ultimately, the amount of funding made available through the RHC program should be based on the current and projected broadband needs of rural healthcare providers. The exact amount of funding is not known at the present time, largely because of a lack of data. We encourage the Commission to begin to develop the data collection effort now so that it can make better decisions in the future regarding the needed level of funding going forward.