Before the
Federal Communications Commission
Washington, D.C. 20554

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

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

The Schools, Health & Libraries Broadband (SHLB) Coalition submits these reply responses to the Federal Communications Commission's Second Further Notice of Proposed Rulemaking in the Rural Health Care (RHC) Program.[1] SHLB takes this opportunity to reply to other comments initially submitted in this proceeding and to continue to encourage the Commission to develop and implement proposals that would streamline the administration and enhance the overall reach of the RHC Program. Regarding suggested proposals for setting future rural rates in the Telecom Program, SHLB supports reforms that will maximize and improve the services available to healthcare providers (HCPs) in rural areas and the communities they serve. To do this, the Telecom Program rural rate methodologies should be simplified where possible by relying on rates set through the competitive bidding process in areas where competition exists. The Commission also should consider funding last-mile special construction in the Telecom Program to increase competition in rural areas. Additionally, SHLB agrees with other initial commenters that the Commission should not reinstate the funding cap on satellite services in the Telecom Program. This change could negatively impact provider participation and marketplace competition, especially in areas that rely on satellite services for connectivity. We

[1] *See Promoting Telehealth in Rural America*, Order on Reconsideration, Second Report and Order, Order, and Second Further Notice of Proposed Rulemaking, WC Docket No. 17-310, FCC 23-6 (rel. Jan. 26, 2023) (*Further Notice*).

also continue to suggest that the Commission's proposed additions to FCC Form 466 could significantly burden service providers, resulting in inadvertent negative impacts on participation in the Telecom Program and harm to HCPs relying on it. Further, SHLB is pleased that initial commenters did not oppose certain SHLB recommended proposals set forth in the *Further Notice*, such as allowing soon-to-be HCPs to receive a conditional approval of eligibility and RHC Program funding, extending the corrective and operational SPIN change deadline, and establishing a process to allow HCPs to request changes to their Evergreen Contract dates following a funding commitment. Our members are mindful of the potential impacts that these issues can create on the administration of the RHC Program, and we thus continue to support solutions that streamline the funding process. SHLB is also pleased that other commenters support revising the Healthcare Connect Fund (HCF) rules to make eligible network equipment necessary to make functional an eligible service supported under the Telecom Program and urges the Commission to move forward on this proposal. Finally, regarding the Commission's query regarding diversity, equity, inclusion, and accessibility, SHLB suggests that the Commission take into consideration that future policies – such as those regarding rural rates and allowances for innovative equipment and service offerings – can significantly impact healthcare accessibility for communities in rural areas.

I. TELECOM PROGRAM RULE CHANGES SHOULD ENHANCE COMPETITION AND MAXIMIZE CHOICE FOR HCPS.

SHLB believes that rural HCPs and the Telecom Program are best served when competitive choices are available. Competition encourages service providers to offer more innovative and faster speed services for lower prices, allowing Telecom Program funding to reach more rural HCPs and allowing those HCPs to provide better healthcare services to

Americans. Any reform to the Telecom Program rules should be undertaken with this objective in mind.

SHLB agrees with GCI Communication Corp. (GCI) that competitive bidding should be used to establish the Telecom Program rural rates in areas where competition exists.[2] The Telecom Program already requires HCPs to conduct competitive bidding prior to applying for support, just as applicants are required to do in the HCF Program and the E-rate Program. Rather than imposing additional complicated rate-setting methods that service providers must use to establish the rates submitted in Telecom Program bid responses, in competitive areas the Commission should move to mirror the approach taken in the HCF or E-rate Programs. In an area where multiple service providers respond to HCPs' requests for service on posted Forms 465, competition will constrain the rates offered by service providers and there is no need to impose additional rural rate restrictions. Eliminating the burdensome and confusing requirements under Methods 1, 2 and 3, or the proposed Methods A, B, or cost studies approach in competitive areas will encourage service provider participation in the Telecom Program, leading to more choices and lower rates. Eliminating the rate-setting methods will also reduce the costs to administer the program, which is important when the program is near or exceeding the cap each year.

In areas without competition, SHLB supports GCI's request to allow service providers to rely on any publicly available rate under Method 2/Method A.[3] Under this method, a service provider's rural rate is based on rates charged by other providers for the same or similar services

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[2] GCI Comments at 20.

[3] *Id.* at 36-37. If only one provider bid in the competitive bidding process, the Commission could require that provider to use the rate it bid in the competitive bidding process if that rate was lower than a rate that would be established using the rate methodology. That would ensure that the program would have the benefit of competition even if only one provider submitted a bid.

in the area. There is no reason to limit rates under this approach to those listed in USAC's Open Data. Rates available from other public sources should be acceptable as well. Allowing service providers to rely on a broader range of publicly available rural rates will reduce the number of rates required to undergo a burdensome and time-consuming cost justification process that would discourage providers from bidding.

If the Commission moves from an average to a median rate under Method 1/B and Method 2/A, SHLB agrees with GCI that the rates should be weighted for volume.[4] In implementing the Rates Database, the Commission instructed USAC to count each rate only once, regardless of how many times it appeared in the data. Eliminating multiple rates of the same value distorts the result in a manner that does not accurately reflect real-world marketplace conduct. To calculate a median rural rate, all valid rural rates should be included regardless of whether they are the same as other rates in the data. In addition, where very few rural rates exist, e.g., fewer than five, USAC should use the average of the rates rather than the median.

To further increase competition, the Commission could consider funding last-mile special construction in the Telecom Program. Special construction is funded under both the HCF and E-rate Programs and has led to significantly increased competition, ultimately reducing the prices that applicants and the programs pay.[5] As GCI demonstrates in its comments, increased infrastructure deployment in Alaska has led to related increases in competition.[6] Allowing rural HCPs to obtain funding for last-mile special construction through the Telecom Program similarly

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[4] *Id.* at 40-42.

[5] *See, e.g., Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 27 FCC Rcd 16678, 16748, ¶ 153 (2012) (agreeing with commenters that HCF support for one-time service provider build-out charges "will result in cost-effective pricing . . . which in turn reduces the cost to the Fund.")

[6] *Id.* at 10-11.

could increase the number of providers willing and able to provide service in rural areas that are lacking last-mile facilities due to the high cost of deployment.[7] It would also likely improve the type and speed of available services to rural HCPs and the communities they serve.

We disagree with GCI's suggestion to include a copayment requirement in the Telecom Program.[8] For HCPs in the most remote, costly to serve areas, even a minimal copayment could prove to be unaffordable. And as GCI recognizes, imposing a copayment on Telecom Program participants is inconsistent with the statutory requirement that rural HCPs pay "rates that are reasonably comparable to rates charged for similar services in urban areas."[9] Therefore, the Commission should not adopt a copayment requirement or eliminate the Telecom Program by merging it with the HCF Program as GCI suggests.[10]

Instead, as SHLB has previously commented, the Commission should consider revising the HCF Program to include varying copayment tiers corresponding to an HCP's rurality. For example, HCPs in non-rural areas could continue to receive the current 65 percent discount; those in less rural areas could receive a 75 percent discount; HCPs in rural areas could receive an 85 percent discount; those in extremely rural areas could receive a 95 percent discount; and HCPs in the most difficult to serve areas that are inaccessible by roads, the "Frontier" tier, could receive a larger discount percentage such as 99 percent.[11] The Commission could establish

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[7] Although rural HCPs can obtain special construction funding through the HCF, that program funds only 65 percent of special construction costs. Rural HCPs in extremely high-cost areas may not be able to afford to pay 35 percent of a special construction project.

[8] GCI Comments at 24-25.

[9] *Id.* at 25 (noting that forbearance from section 254's urban rate requirement would be necessary to impose copayments in the Telecom Program); 47 U.S.C. § 254(h)(1)(A).

[10] *Id.* at 24.

[11] Reply Comments of the Schools, Health & Libraries Broadband (SHLB) Coalition, WC Docket No. 17-310, at 8-9 (May 16, 2022). As SHLB noted in those reply comments, any additional HCF discount tiers should be implemented in conjunction with an increase in the overall RHC cap to ensure that any

copayment tiers within the HCF Program without conflicting with the statutory urban rates requirement applicable to the Telecom Program.[12] Additional copayment tiers in HCF would encourage HCPs in more rural areas to move to the HCF Program, where the copay amounts would create additional incentives for rural HCPs to carefully consider pricing.

II. THE COMMISSION SHOULD NOT REINSTATE THE FUNDING CAP ON SATELLITE SERVICES.

In the *Further Notice*, the Commission sought comment on whether it should reinstate the funding cap on support for satellite services in the Telecom Program. The proposed cap would be set at the amount an HCP would have received for similar terrestrial-based services. SHLB agrees with GCI that the Commission should *not* reimpose the funding cap on satellite services.[13] GCI states that, rather than operating satellite facilities, Telecom Program service providers "must purchase the capacity at wholesale rates, which are themselves not subject to any rate regulation. Because they have no control over the wholesale rates, satellite resellers cannot lower prices to or below that rate in response to the cap; the only possible responses are to provide service at a loss or to not offer the satellite service at all."[14] SHLB likewise believes that reimposing the cap could reduce marketplace competition (such as through the ways offered by GCI) and ultimately harm the HCP's choice of providers and services, especially in areas that are less traditionally served by terrestrial-based offerings.

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potential increase in HCF demand does not take funding away from HCPs that continue to rely on the Telecom Program for support.

[12] As implementation of rurality-based discount tiers is likely to increase participation in the HCF Program, the Commission should eliminate or modify the internal HCF cap. *Id.* at 4-6.

[13] *See* GCI Comments at 25-36.

[14] *Id*. at 34.

III. THE COMMISSION SHOULD CLARIFY EXISTING QUESTIONS ON FCC FORM 466 RATHER THAN REQUIRING ADDITIONAL INFORMATION AS PROPOSED.

In our initial comments, we expressed concern about the Commission's proposal to collect additional data about services purchased by HCPs on FCC Form 466. Although other initial commenters did not generally oppose the proposal, SHLB continues to suggest that this change could significantly burden service providers, impact their participation in the Telecom Program, and inadvertently harm HCPs that lose access to service offerings. For example, the Commission proposes to collect nearly 30 *additional* data points on Form 466. While we are aware of the potential benefits associated with collecting more granular information, we encourage the Commission to strive for policies that streamline the application process. Due to the sheer amount of information the proposal requires for submission, however, we believe that the proposed change could result in the opposite effect. Carriers and service providers may decide not to participate in an elongated application process, decreasing their participation in the Telecom Program and hindering the number of competitive rates and services available to participating HCPs. SHLB thus reiterates its initial position and suggests that the Commission instead target ways to clarify questions and information already requested on Form 466.

Additionally, if the burden to provide this additional information shifts completely to the service provider without oversight by the HCP, there is potential for an increased amount of (potentially complicated) appeals if any data point is input incorrectly or changes after submission, through no fault of the HCP. If the Commission moves forward with its proposal and integrates the full scope of proposed data fields into Form 466, SHLB reiterates that it should clarify that the additional requirements are for information purposes only and would not adversely affect an HCP's funding.

IV. INITIAL COMMENTERS DO NOT OPPOSE PROPOSALS ALLOWING CONDITIONAL HCP ELIGIBILITY, SPIN CHANGE DEADLINE EXTENSION, AND A PROCESS TO CHANGE EVERGREEN CONTRACT DATES.

SHLB is pleased that initial commenters did not oppose certain proposals in the *Further Notice* that SHLB supported in its initial comments to improve the administration of the RHC Program. Namely, the initial comments did not oppose ideas that would i) allow HCPs to apply for RHC support ahead of opening by receiving a conditional approval of eligibility; ii) extend the corrective and operational SPIN change deadline to 120 days after the service delivery deadline; and iii) create a process to allow HCPs to request changes to their Evergreen Contract dates following a funding commitment. Regarding the Commission's proposal to create a conditional approval for participants that will soon be eligible HCPs, we fully agree with The American Association of Nurse Practitioners that this change "will improve flexibility for providers"[15] and believe that this flexibility will, in turn, maximize the RHC Program's ability to provide much-needed funding for rural providers at a time when the need is high. Likewise, the Commission's proposed SPIN change deadline extension and inquiry regarding the implementation of a process to allow an HCP to make changes to Evergreen Contract dates following a funding commitment directly respond to issues voiced by many SHLB members that currently impact the efficiency of the RHC Program's administration. Accordingly, the *Further Notice* provides the opportunity to correct such issues and better streamline the program. SHLB thus continues to support these proposals and, given the lack of opposition to them, urges the Commission to take the necessary steps to implement these changes going forward.

[15] American Association of Nurse Practitioners Comments at 3.

V. COMMENTERS SUPPORT MAKING ELIGIBLE HCF PROGRAM EQUIPMENT AVAILABLE FOR SERVICES SUPPORTED UNDER THE TELECOM PROGRAM.

As stated in our initial comments, SHLB supports revising the HCF program rules to make eligible network equipment necessary to make functional an eligible service supported under the Telecom Program. We are pleased to see that other commenters also support this proposal, such as the Alaska Primary Care Association (APCA). APCA suggests that allowing Telecom Program participants to purchase HCF network equipment when necessary to facilitate services supported under both programs will "foster innovation" and provide "lower-cost connectivity options" to Alaskan HCPs.[16] SHLB agrees, and likewise believes that allowing HCF-eligible equipment to support both HCF and Telecom Program services would allow for holistic programmatic support for modern, innovative network design. We additionally believe that such a change would provide a similar positive impact for HCPs outside of Alaska,[17] whereby HCPs nationwide could diversify their carrier options and realize potential cost-savings on those services. Such an option proves especially important for those rural HCPs where carrier competition is scarce.

VI. CONSIDERATIONS FOR DIVERSITY, EQUITY, INCLUSION, AND ACCESSIBILITY.

The *Further Notice* requests comment about how the Commission's suggested proposals may promote or inhibit advances in diversity, equity, inclusion, and accessibility. SHLB believes that future policies advanced by this proceeding, such as those intended on setting rural rates and fostering innovative equipment and service offerings for example, can significantly impact not

[16] Alaska Primary Care Association Comments at 1.

[17] *See* SHLB Comments at 13 for examples of HCPs in the State of Colorado who utilized advanced network equipment.

only an HCP's access to physical broadband, but can also affect its access to competitive, affordable, alternative resources that it often needs to serve rural (including tribal) communities. The pandemic emphasized how disconnected our nation's rural and tribal areas remain. We discovered that lacking broadband access presents problems not only for modern technology like remote learning and teleworking, but also for advanced healthcare services like telehealth – the lack of which can be life-threatening. Alaska Communications previously explained that many native Alaskans reside in remote Bush villages, and thus must rely on telemedicine services for general care and life-saving solutions.[18] Residents of rural areas, such as native Alaskans as mentioned above, thus benefit greatly from access to broadband and telehealth services. However, they are also the first ones to suffer if HCPs are unable to purchase competitively priced service offerings and/or their current infrastructure cannot support additional bandwidth or modern technological advances.

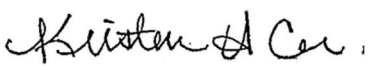
VII. CONCLUSION

SHLB is grateful for the opportunity to provide initial and reply comments to the many suggested proposals in this proceeding. We believe that the Commission should take this opportunity to not only focus on ways to streamline programmatic and administrative processes within the RHC Program, such as by implementing a conditional approval of eligibility for soon-to-be HCPs to help them receive program funding, extending the corrective and operational SPIN change deadline, and implementing a process to allow HCPs to request changes to their Evergreen Contract dates following a funding commitment, but to also consider suggestions for improving the longevity, applicability, and reach of the RHC Program generally. Maximizing

[18] *See* Comments of Alaska Communications on the Commission's Further Notice of Proposed Rulemaking, *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Further Notice of Proposed Rulemaking, at 35 (Apr. 14, 2022).

competition and improving access to like-saving equipment and services to HCPs and the rural communities they serve, allowing changes that foster innovative network design, and weaving digital equity concerns into future policies can better the program for today and future generations.

Respectfully submitted,



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