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

The Schools, Health & Libraries Broadband (SHLB) Coalition[1] welcomes the opportunity to file these comments responding to the Federal Communications Commission's January 2023 Second Further Notice of Proposed Rulemaking in the Rural Health Care (RHC) Program.[2] Through its comments, SHLB aims to provide thoughtful insight into actions that could improve not only the operation of the program but also help to extend its reach to serve rural communities in need.

Regarding the proposed Telecom Program rules, SHLB applauds the Commission's decision to eliminate the Rates Database as the basis for determining rates under the RHC Telecom Program but asks the Commission to avoid implementing future requirements that could reduce competition or disincentivize new investment when reforming the Rural Rate Rules. Additionally, to calculate urban rates under the Telecom Program, SHLB supports basing urban rate calculations on rates provided in a city and also recommends that the Commission examine different ways to expand the definition of an urban area to increase the number of areas

---

[1] The SHLB Coalition is a broad-based public interest coalition of more than 330 organizations that share the goal of promoting open, affordable, high-quality broadband for anchor institutions and their communities. SHLB Coalition members include 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. SHLB health care members make up well over half of the funding provided in the RHC Program. *See* http://shlb.org/about/coalition-members for a current list of SHLB Coalition members.

[2] *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*).

that qualify for determining urban rates. The Commission should also refrain from relying upon urban rates from the Rates Database. Finally, SHLB cautions the Commission to consider certain concerns when revising the FCC Form 466 to collect more information about services purchased by providers, especially if it could deter participation in the Telecom Program. If the Commission adopts reforms to FCC Form 466, it should make clear that the additional information is to be used only for informational purposes.

Regarding proposed reforms to the RHC Program, SHLB supports the Commission's proposal for soon-to-be-eligible HCPs to receive a "conditional approval of eligibility" to enable them to apply for RHC support ahead of their formal opening. Additionally, SHLB supports the proposed corrective and operational SPIN change deadline extension to 120 days after the service delivery deadline and asks that the Commission grant i) any pending SPIN change waiver requests that were the result of failure to comply with the old deadline, and ii) any pending invoice deadline waiver requests that are connected to an unapproved or untimely submitted SPIN change request. Further, SHLB supports allowing health care providers to request changes to their Evergreen Contract dates under a purely administrative process which does not require a rule change. Finally, SHLB supports amending the Healthcare Connect Fund program rules to make eligible network equipment necessary to make functional an eligible service supported under the Telecom Program.

I. PROPOSED TELECOMMUNICATIONS PROGRAM RULES

SHLB applauds the Commission's decision to eliminate the Rates Database as the basis for determining rates under the RHC Telecom Program.[3] As the Commission correctly noted, "[R]ates generated by the Rates Database could result in inadequate or inconsistent Telecom Program support for rural health care providers that undermines the goals of the Telecom

[3] *Id.* at ¶¶ 8-9.

Program."[4] The record supported reversion to the prior method of calculating rates on an interim basis, although the Commission noted that "improvements to these methods may be necessary for the long term given the issues that the Commission has previously cited with respect to these rate calculation methodologies."[5] Unfortunately, the changes proposed in the *Further Notice* do not adequately resolve the issues surrounding the complexity of the current Telecom Program rate calculation rules, and are unlikely to eliminate the review process delays experienced by program participants.[6]

A. The Commission Should Proceed Cautiously in Reforming the Rural Rate Rules and Avoid Requirements that Could Reduce Competition or Disincentivize New Rural Investment.

For determining rural rates under the Telecom Program, the Commission proposes to essentially maintain the current three-tiered methodology with some minor changes – the same methodology that the Commission and most commenters agreed was no longer appropriate given the current state of the telecommunications industry.[7] Rural rates are currently determined through one of three methods: Method 1 – the average of rates that a service provider charges to non-health care provider (HCP) commercial customers for the same or similar services provided in the rural area where the HCP is located; Method 2 – if the service provider does not have any commercial customers in the HCP's rural area, the average of publicly available rates charged by other service providers for the same or similar services in that area; or Method 3 – if there are no rates under Methods 1 or 2 or the service provider reasonably determines that those rates are unfair, a cost-based rate that is approved by the Commission or a state commission.

---

[4] *Id.* at ¶ 11.

[5] *Id.* at ¶ 72.

[6] *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Report and Order, 34 FCC Rcd 7335, ¶¶ 55-56, 58 (2019).

[7] *Id.* at ¶¶ 53-55.

In the *Further Notice*, the Commission proposes to reverse the order in which Methods 1 and 2 are applied, to rename them Methods A (rates based on other providers' rates) and Method B (rates based on the service provider's own rates), and to rely on the median rather than the average of applicable rates.[8] These proposals, however, do not seem likely to improve the efficiency of the Telecom Program. In fact, requiring service providers to rely on other providers' rates in the first instance, and using median rates that do not adequately account for rate disparities are likely to deter service provider participation in the program. This will eliminate competitive options for HCPs. Service providers are no more likely to be able to find rural rates charged by other carriers than they were in 2019, when the Commission acknowledged it was extremely difficult.

Most important to SHLB and its members is that the program fulfills its statutory duty to ensure that rural HCPs are paying a rate comparable to that of an urban health care provider. Using the median rate of the very few available rates will harm the rural HCPs that are the most expensive to serve and therefore the most in need of universal service funding. By definition, using a median rate will mean that service providers that serve the most rural HCPs will be charging less than it will likely cost to serve them. No carrier will want to make an investment in facilities to increase the bandwidths that are available; Chairwoman Rosenworcel has noted this as an issue in rural areas.[9] For the reasons below, the proposed cost-based method will not address this problem.

---

[8] *Further Notice* at ¶¶ 76-77.

[9] *Chairwoman Rosenworcel Proposes to Increase Minimum Broadband Speeds and Set Gigabit Future Goal*, FCC News Release, https://docs.fcc.gov/public/attachments/DOC-385322A1.pdf (July 15, 2022) ("low-income neighborhoods and rural communities are being left behind and left offline" due to low broadband speeds).

Nor should the Commission adopt the proposal to create an automated process to generate the rural rate.[10] Similar to the Rates Database, developing such a process will expend resources that are unlikely to result in useable rates. The Open Data information is available for use by program participants; there is no benefit to mandating that USAC again attempt to manipulate it for this purpose. Instead, the Commission should direct USAC to continue improving the Open Data information so that entire application forms are available instead of partial data as is the case now.

The Commission also proposes to maintain the Method 3 cost-based rate approval process but seeks to impose certain evidentiary requirements on providers seeking to use this option that could be burdensome. The Commission recognized that when these requirements were proposed as part of a waiver process alternative to the Rates Database, stakeholders overwhelmingly opposed them due to "the burdensome nature of the information requested, the possibility that the cost-based method would not provide sufficient support for those that could not calculate their rates using the Rates Database and the fact that these evidentiary requirements go far beyond the evidentiary requirements for Method 3."[11] Furthermore, these increased evidentiary requirements will only serve to complicate the review process. It currently takes a long time to review cost-based submissions, with some service providers waiting multiple years for a decision. Increasing the amount of information to be provided will only serve to exacerbate this process. For all of these reasons, the Commission should refrain from imposing them on the cost-based rural rate calculation option in the Telecom Program going forward.

---

[10] *Id.* at ¶ 79.

[11] *Id.* at ¶ 86.

B. Reforms to the Urban Rate Rules Should Focus on Maximizing Availability and Administrative Simplicity.

For calculating urban rates under the Telecom Program, SHLB supports the Commission's proposal to eliminate the standard urban distance distinction in the prior urban rate rules and to instead base urban rate calculations on rates provided in a city.[12] We agree with the Commission that this change will simplify the urban rate determination process and should be adopted.

The Commission also should consider expanding the definition of an urban area to increase the number of areas that qualify for determining urban rates. In particular, the Commission should examine different ways to determine urban areas in locations, e.g., West Virginia, where few or no cities exist under the current definition. In these areas, the Commission should instead use rates from the largest three to five cities in the state. The Commission should also consider allowing health care providers to use Metropolitan Statistical Areas (MSAs) to determine their urban rates when the population in those areas together total more than 50,000, even though individual cities within the MSA do not meet that threshold. These expansions would increase the number of publicly available urban rates for HCPs to identify.

Finally, the Commission should refrain from relying upon urban rates from the Rates Database. The suggestion in the *Further Notice* that there were "relatively few" complaints about the urban rates in the Rates Database is simply incorrect.[13] As SHLB and other commenters pointed out, there were numerous instances where the urban rates in the Rates Database exceeded the rural rates, which would result in Telecom Program support being

[12] *Id.* at ¶ 88.

[13] *Id.* at ¶ 90.

unavailable to HCPs in those areas.[14] The Commission recognized these serious flaws when it waived its rules requiring use of the urban rates in the Rates Database twice and ultimately rescinded the requirement altogether.[15] These unreliable and potentially harmful rates should not be used in the Telecom Program going forward. The Commission should continue to allow program participants to use publicly available urban rates from USAC's Open Database, including rates from the E-rate Program.

C. Proposed Form 466 Revisions Could Hamper Participation in the Telecom Program.

In the *Further Notice* the Commission proposes to revise the FCC Form 466 to "collect more granular information about the services purchased by health care providers."[16] Although HCPs are required to file the Form 466, the Commission proposes to include a minimum of nearly 30 additional data requests on the form to be collected from service providers.[17] As discussed above in the context of additional cost-based evidence for rural rates, SHLB is concerned that imposing significant new burdens on service providers will hamper participation in the Telecom Program.[18] This is detrimental to rural HCPs, which would be afforded fewer options for their telecommunication service needs, particularly in areas where such options may already be limited.

---

[14] *See, e.g.,* Letter from Gina Spade, Counsel for SHLB, to Marlene Dortch, Secretary, FCC, WC Docket No. 17-310, https://www.fcc.gov/ecfs/document/1033167030920/1 (Mar. 31, 2021) (citing nearly 100 examples in 31 states where the urban rates exceeded the rural rates in the Rates Database).

[15] *Rural Health Care Support Mechanism; Promoting Telehealth in Rural America*, WC Docket Nos. 02-60 and 17-310, Order, 36 FCC Rcd 7051(Wireline Comp. Bur. 2021); *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); *Further Notice* at ¶ 8-9.

[16] *Further Notice* at ¶ 109.

[17] *Id.* at ¶¶ 109-110.

[18] *Cf. Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 18 FCC Rcd 24546, ¶ 53 & n.176 (2003) (noting elimination of FCC Form 468 completed by carriers in order to streamline the RHC application process) (*2003 RHC Order*).

Furthermore, it is unclear whether the large amount of additional data requested will be useful in achieving the Commission's stated goals of increasing the accuracy of rural rates. Specifically, the Commission identifies five primary areas affecting rural rate accuracy: "(1) services reported by healthcare providers are not defined by a single factor such as technology or speed; (2) some reported rates are based on distance whereas others are not; (3) value-added services beyond data transmission are not reported; (4) bundled prices offered by service providers make 'apples-to-apples' rate comparisons difficult; and (5) the form does not measure the impact of SLAs on the rates offered."[19] Rather than requiring the collection of significant amounts of additional data, the Commission should first consider whether clarifying and improving targeting the information currently requested on the Form 466, with minimal targeted additions, could better address the Commission's concerns.

If the Commission does decide to adopt its proposals to require this additional information from service providers, it should make clear that the information is to be used only for informational purposes. HCPs should not be penalized if a submitted data point changes. For example, if during the installation process a service provider determines that the original technology reported on the Form 466 must be changed but the same speed and type of service is delivered to the HCP, there should be no adverse effect on the HCP's receipt of funding.

II. PROPOSED REFORMS TO THE BROADER RHC PROGRAM

A. Conditional Eligibility for New Health Care Providers

SHLB supports the Commission's proposal to establish a procedure for soon-to-be-eligible HCPs to receive a "conditional approval of eligibility" that will enable them to apply for RHC support ahead of their formal opening.[20] This will ensure these HCPs can obtain support as soon as they open, instead of having to wait until the next funding year.

---

[19] *Id.* at ¶ 108.

[20] *Further Notice* at ¶¶ 97-99.

As the Commission noted in the *Further Notice*,[21] the Wireline Competition Bureau's *Hope Community Order*[22] was adopted before the RHC program cap eliminated the rolling application process that had been standard in the RHC for many years. In addition, the *Hope Community Order* involved a community mental health center which, unlike other HCP-types, has its own fact-dependent eligibility check[23] that can be difficult to fully complete ahead of formal opening. The Commission's proposed conditional eligibility process, which would require an HCP to "update[] its eligibility request by providing documentation showing that it is an eligible [HCP]" in advance of an eligibility determination by USAC,[24] presumably will allow HCPs to submit a *CMHC Checklist* or other necessary documentation once it is ready to open.

B. Extending the SPIN Change Deadline

SHLB has previously noted that applicants have no control when their service provider is involved in a merger or acquisition, or when a service provider with multiple Service Provider Identification Numbers (SPINs) makes internal SPIN reassignments – each of which requires the applicant to request a corrective SPIN change from USAC. Because applicants must request these corrective SPIN changes prior to expiration of the service delivery deadline (typically June 30),[25] they are forced to seek a rule waiver from the Commission when service providers fail to timely notify them of the need for a SPIN correction. SHLB is thus pleased the Commission "tentatively agree[s]" with SHLB that the SPIN change deadline should be

---

[21] *Id.* at ¶ 97 n.256.

[22] *See Hope Community Resources, Inc.– Barrow MH, Rural Health Care Universal Service Support Mechanism*, WC Docket No. 02-60, Order, 31 FCC Rcd 7883 (WCB 2016) (*Hope Community Order*).

[23] *See* Rural Health Care Universal Service, Community Mental Health Center Checklist, https://www.usac.org/wp-content/uploads/rural-health-care/documents/FCC-Forms/CMHC-Certification-Checklist.pdf (*CMHC Checklist*).

[24] *Further Notice* at ¶ 98.

[25] *See* 47 C.F.R. §§ 54.625(c), 54.626(a).

extended.[26] SHLB supports the proposed extension to 120 days after the service delivery deadline (typically October 28 each year) and agrees the deadline for both corrective and operational SPIN changes should remain the same and thus both should be extended.[27]

Because the current invoicing deadline is also 120 days after the service delivery deadline, the Commission asks whether extending the SPIN change deadline by 120 days will disadvantage HCPs that cannot invoice due to USAC still processing a SPIN change.[28] Although current rules allow USAC to extend the invoicing deadline by another 120 days when timely requested,[29] to fully address the concern that delayed processing of SPIN changes could impact invoicing[30] (and trigger invoice waiver requests), we suggest the Commission modify Section 54.627(a) of its rules in the following manner:

> *Invoice filing deadline. Invoices must be submitted to the Administrator within 120 days after the later of:*
>
> *(1) The service delivery deadline, as defined in § 54.626; or*
>
> *(2) The date of an approved SPIN change or site and service substitution request, a revised funding commitment letter issued pursuant to an approved post-commitment request made by the applicant or service provider, or a successful appeal of a previously denied or reduced funding request. Before the Administrator may process and pay an invoice, it must receive a completed invoice from the service provider.*[31]

---

[26] *Further Notice* at ¶ 103.

[27] *Id.*

[28] *Id.*

[29] 47 C.F.R. § 54.627(b).

[30] *Further Notice* at ¶ 103 ("If the SPIN change deadline is moved to the invoice deadline and the [HCP] files a SPIN change request so close to the deadline that [USAC] cannot process the request before the invoice deadline, the [HCP] will not be able to submit invoices. Does the flexibility this change would offer to [HCPs] justify the disadvantage to health care providers who are unable to invoice because they filed a SPIN change request too close to the deadline?").

[31] This minor change would be within the scope of the Further Notice because the Commission has asked how to mitigate the impact of the proposed extension of the SPIN change deadline on invoicing. Our intention is to capture any change or modification after the original funding commitment that may impact a healthcare provider's ability to comply with § 54.627(a).

Finally, if the Commission makes this proposed change to the SPIN change deadline, we ask that it simultaneously grant any pending SPIN change waiver requests that were the result of failure to comply with the old deadline. Similarly, we ask the Commission to grant any pending invoice deadline waiver requests that are connected to an unapproved or untimely submitted SPIN change request.

C. Allowing Evergreen Contract Date Changes

SHLB supports allowing HCPs to request changes to their Evergreen Contract dates; however this should be a purely administrative process which does not require a rule change.[32] As a general matter, in cases where a provided service start date is estimated, the actual service start date should always be considered relevant by USAC. In addition, when a contract starts or ends – *i.e.*, the term of the contract – is determined by the language in the contract. Contract language determines the length of the term and whether that term starts when the contract is signed, or when service commences (for example); whether a service agreement is a stand-alone contract, or is a service order pursuant to governing contract (*e.g.*, a Master Service Agreement); how multiple service orders with different start dates operate under a governing contract; *etc*. Indeed, if there is uncertainty or ambiguity about what a contract says, USAC should generally defer to the parties' interpretation. More specifically, we suggest the Commission clarify that, unless the parties' interpretation is obviously inconsistent with the language of the contract, USAC should defer to that interpretation.[33] Such a clarification will reduce uncertainty and create greater efficiency in the application process.

In addition, USAC should always allow the applicant to make corrections to the evergreen contract dates when the language of the contract supports those corrections. Thus, the

---

[32] *Further Notice* at 104 ("Would an alternative means require a change in our rules or could our current rules be interpreted to allow for evergreen contract date changes").

[33] Indeed, in the event there is a dispute between the parties about those terms, USAC's interpretation would have little to no weight.

Commission can and should make clear that evergreen contract date correction requests are always timely and are not precluded by expiration of the 60-day window for an appeal of the original Funding Commitment Letter. Indeed, the Commission recognizes that unknown service start dates are a common driver of the need for evergreen contract date changes and are often unknown at the time of the FCL is issued and sometimes for months after.[34] Imposing a 60-day appeal window when a service start date is unknown makes no sense and would be unfair. This clarification will also reduce uncertainty and increase administrative efficiency by avoiding unnecessary appeals.

D. HCF Program Eligible Equipment

SHLB supports amending the Healthcare Connect Fund (HCF) program rules to make eligible network equipment necessary to make functional an eligible service supported under the Telecom Program. Modernization and innovation in network design has made network equipment essential for both maintaining compliance with federal privacy laws and ensuring the secure transmission of patient data across network connections. Applicants working in the Telecom Program are no less bound to those compliance regulations than those working in HCF. Harmonizing the program would allow for applicants in both programs the ability to fund advanced network equipment. This equipment would facilitate the deployment of more secure networks while simultaneously allowing applicant HCPs the ability to realize greater long-term cost savings on connectivity by leveraging modernized equipment to connect the lowest cost internet service providers (ISPs) across their wide area network (WAN).

Advanced network equipment allows rural providers the ability to move away from single ISPs which often provide very high-cost connectivity in the most rural and remote

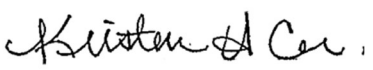
[34] *See Further Notice* at ¶ 104 ("services sometimes start after the estimated service start date, which means that the evergreen status of the contract expires before it would have if the evergreen designation period was based on the actual service start date.").

locations. New advances in networking technologies allow these providers to take advantage of lowest cost high bandwidth connectivity from local carriers while maintaining secured and private networks. One example, Mindsprings Health, a mental health provider in Western Colorado that covers 23,000 square miles across 10 counties between the Continental Divide and the Utah/Colorado state line, has used advanced network equipment to create a network topology that takes advantage of the best-priced local carriers. This diversification of carrier connectivity through its use of advanced networking equipment has subsequently improved network reliability and redundancy, reduced its monthly recurring costs by thousands of dollars annually, while increasing bandwidth exponentially. Similarly Peak Vista Health Centers, a federally qualified health center system in Colorado Springs that serves many of the rural communities in El Paso County was able to modernize their network utilizing advanced network equipment in the same way. In both cases, investment in advanced network equipment results in less long-term cost burden on the HCF program while allowing these HCPs to better serve their patient populations. While these are HCF examples, HCPs that rely on connections in the Telecom Program should be allowed to innovate to lower their costs and this proposed rule change will promote that outcome.

III. CONCLUSION

The RHC Program remains tremendously beneficial for increasing access to primary health care services for individuals in rural communities. Given the rise of telemedicine and other modernizations in the health care marketplace, providers need consistent financial support for reliable, robust, and secure broadband to continue to serve the evolving needs of these vulnerable populations. We appreciate the Commission's opportunity to provide comment on ways to enhance the program's functionality and meet this goal. We expect to file additional thoughts in the reply comment round.

Respectfully submitted,



Kristen Corra, Policy Counsel
Schools, Health & Libraries Broadband Coalition
1250 Connecticut Ave. NW, Suite 700
Washington, DC 20036

April 24, 2023