June 2, 2022

SUBMITTED ELECTRONICALLY VIA ECFS

Ms. Marlene H. Dortch
Secretary
Federal Communications Commission
45 L Street NE
Washington, DC 20554

Re: Ex Parte Filing
Promoting Telehealth in Rural America, WC Docket No. 17-310

Dear Madam Secretary:

Pursuant to Federal Communications Commission's ex parte rules, I hereby submit the following summary of our May 27, 2022, conversation with Nagarajan in Chairwoman Rosenworcel's office to discuss generally the administrative process of the Rural Health Care Program as well as certain points made in the reply comments of the Schools, Health & Libraries Broadband (SHLB) Coalition filed in this proceeding (SHLB's Reply Comments). The following individuals participated in the call along with the undersigned: John Windhausen, Jr., Executive Director, SHLB Coalition; Gina Spade, Principal, Broadband Legal Strategies, LLC; and Jeffrey Mitchell, Principal, Mitchell Law, PLLC.

The participants in the call made the following points:

- The Commission should work with the Universal Service Administrative Company (USAC) to improve the Rural Health Care (RHC) Program application process. SHLB appreciates the concerted effort to clear backlog of past pending applications, but processing delays and program uncertainties appear to be driving participants from the program. The gross demand for the program declined in both 2020 and 2021, from a high of $765 million in 2019. That decline is counterintuitive given the unprecedented shift to telemedicine that occurred during the Covid-19 crisis.

- The Commission should raise the overall funding cap of the RHC Program. The current capped amount does not meet the true demand and, accordingly, creates uncertainty for applicants. Raising the funding cap can help manage any suspense and uncertainty for applicants that are worried the cap will be met prior to their application being processed. When the demand exceeds the cap, all applications must be reviewed before USAC makes funding decisions, rather than being approved on a rolling basis. If the cap was

raised, USAC could approve applications on a rolling basis without fear of exceeding the cap.

- The Commission should eliminate the internal funding cap for the Healthcare Connect Fund (HCF). When the Commission established the internal cap in 2012 it noted that significant migration from the Telecom program to HCF might warrant revisiting. This migration has since occurred. Further, equipment and construction costs have not exceeded the internal cap, and processing multi-year applications are more cost-effective over time. If the Commission does not eliminate this cap completely, it should at least remove multi-year funding commitments from the internal cap.

- SHLB recommends the following programmatic changes which will require a cap increase (and should not be implemented without such an increase):
    1. The Commission should broaden the definition of "rural" in the RHC Program. Because the statute does not define the term, the Commission has latitude to recognize and accept one or more other federal definitions.
    2. The Commission should make the Connected Care pilot a permanent program.

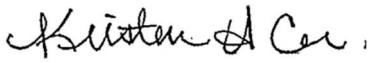
- The Rates Database does not accomplish what the Commission intended when it was created to ensure that the rural and urban rates for the RHC Program are reasonable, and all commenters have urged the Commission not to continue with the Rates Database. For the time being, the Commission should continue with the status quo. We also noted that competition is increasing in the RHC Program and will likely continue to increase as facilities and infrastructure continue to expand in rural areas.

  To recognize that many applicants have migrated from the Telecom program to the HCF, the HCF support levels should be revised to include discount levels greater than 65 percent for healthcare providers in "extremely rural," "rural," and "less rural" areas. For example, health care providers in non-rural areas would receive the current 65 percent discount, those in less rural areas would receive a 75 percent discount, those in rural areas would receive an 85 percent discount, and those in extremely rural areas would receive a 95 percent discount. This proposal has several advantages: (1) it would allow rural health care providers to switch to HCF to avoid the uncertainty of the Rates Database or similar alternative methodology in the Telecom program; (2) it would allow rural HCPs to apply for all of their funding (including equipment and Internet access) with one application instead of applying in both HCF and the Telecom program, which would increase efficiencies for both the HCPs and USAC; (3) it would ensure rural HCPs were price-sensitive when evaluating service providers; and (4) it would avoid statutory question regarding the Commission's similar proposal for the Telecom program.

The following point was included in SHLB's Reply Comments, but was not discussed on the call:

- USAC currently has no cost allocation mechanism in place with respect to consortium shared network costs. Accordingly, the existing Health Care Fund Program incorrectly categorizes shared network costs as 100 percent non-rural, ignoring rural locations that use the shared network. In the event non-rural costs are not funded under the current priority system, this discriminates against and will severely impact urban-rural consortia. As a solution, the Commission could establish a safe-harbor cost allocation mechanism to determine each consortium's urban-rural percentage for such shared costs.

Sincerely,



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