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 UNITED STATES TELECOM ASSOCIATION

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I. Introduction and Summary.

USTelecom is pleased to file these comments in response to the Commission's proposed rulemaking on its Rural Health Care (RHC) Program.[1] Since its inception, this program has facilitated rural healthcare provider access to vital communications services thereby enabling these providers to deliver essential healthcare services to persons living in rural areas. The *NPRM* details the benefits of telemedicine, how it improves lives, as well as the savings that it generates. USTelecom supports the program and agrees that "a well-designed [RHC] Program is more vital than ever."[2]

The Commission has identified a number of challenges with the design and operation of a component of its RHC Program – the Telecom Program – and has sought comment, in particular, on reforms to that program. USTelecom shares some of the Commission's concerns with how the Telecom Program has been operating outside of Alaska. Based on its members' experience with the Telecom Program, we believe that, in the Lower 48 states, rural rates are often already "reasonably comparable" to non-mileage-based urban rates for telecommunications services

[1] *Promoting Telehealth in Rural America*, Notice of Proposed Rulemaking and Order, 32 FCC Rcd 10631, ¶ 6 (2017) ("*NPRM*" and "*Order*").

[2] *Id.* at ¶ 1.

purchased by healthcare providers. Cases of waste, fraud, or abuse that have come to light recently may have had their genesis in consultants' efforts to extract support for their healthcare provider clients from the Telecom Program where that statutory premise was already satisfied. As a result, Telecom Program reforms in the Lower 48 states should center on enhancing USAC's ability to detect and reject applications where federal universal service support is not needed to meet the statutory purpose of the Telecom Program.

To be clear, USTelecom and its members believe that the circumstances that gave rise to the waste, fraud, and abuse of the Telecom Program do not exist in Alaska, which is why many of these proposals exclude healthcare providers operating in Alaska. In Alaska, the Telecom Program has transformed rural health care, saving lives by raising the standard of care, accelerating diagnosis, expanding treatment options, improving patient experiences, enabling statewide access to the expertise of specialist doctors and services, all while reducing costs. As Commissioner O'Rielly has testified before the U.S. Senate, "In terms of telehealth, what they are able to do with very small dollars in remote parts of [Alaska is] very impressive . . . . Other places using telehealth and telemedicine are really eating up some significant dollars, whereas Alaska has been very efficient and addressed the issue very thoughtfully."[3]

[3] *See* U.S. Senate, Committee on Commerce, Science, and Transportation, Hearing: "Oversight of the Federal Communications Commission," Testimony of Commissioner O'Rielly (March 8, 2017) (responding to questions from Senator Dan Sullivan, at time 2:38:28 in the archived video webcast, available at: https://www.commerce.senate.gov/public/index.cfm/hearings?ID=B9D3B299-E3CC-480A-B09B-1DEF0512A57C) (visited February 1, 2018); see also Commissioner Michael O'Rielly, Blog Entry, "Alaska: Lessons Learned," Sept. 5, 2014 ("Alaska is a pioneer when it comes to the adoption and use of communications technology to deliver health care services, especially in the more remote areas where transportation is costly. Alaska's health care providers in these remote areas integrate what I refer to as 'technology triage' to diagnose and treat patients. Instead of traditional in-person doctor-patient visits, community health aides use medical carts ('AFHCAN carts') that utilize the telecom portion of the FCC's Rural Health Care Program to 'store and forward' health information to doctors located many miles away. For more complex cases or

In short, USTelecom and its members urge the Commission, as this proceeding unfolds, to recognize the critical, literally vital role of the Telecom Program in sustaining access to efficient health care services in Alaska, and to tailor its policies accordingly. While these comments advocate certain reforms for the Lower 48 states, conditions in Alaska differ greatly. The steep urban/rural price gradient in Alaska means that the program has unique value and importance in that state, while there is no need to resort to fraud to establish the statutory basis for funding.

By the Commission's own acknowledgement, its Telecom Program has not had any "significant changes . . . in the two decades since it was first established."[4] While the Commission has aggressively sought to modernize all of its other universal service support mechanisms over the past decade, the Telecom Program remains stuck in the '90s. Under Section 254(h)(1)(A) of the Communications Act, 47 U.S.C. § 254(h)(1)(A), the Telecom Program must ensure that rural healthcare providers have access to telecommunications services that are necessary for the provision of health care services at rates that are "reasonably comparable" to those available in urban areas. As created in 1997, the program is premised on the notion that rates for non-mileage-based telecommunications services, including voice service, in rural America are significantly higher than they are in urban areas. While that premise remains true in Alaska today, it no longer holds in much of the rest of the country. Moreover, the Commission's reforms aimed at increasing transparency in its USF programs have not yet

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situations, such as behavioral services, they can use more bandwidth-intensive video teleconferencing services . . . By using technology effectively, providers in Alaska are able to diagnose symptoms and problems early, and treat minor ailments locally, thereby minimizing expensive and unnecessary health care services and transportation.") (available at: https://www.fcc.gov/news-events/blog/2014/09/05/alaska-lessons-learned) (February 1, 2018).

[4] *NPRM* at ¶ 6.

been applied to the Telecom Program. Basic information about applicant funding requests and how support amounts are calculated are hidden from public view. These issues, and others described in the *NPRM*, have caused the Telecom Program to balloon in size over the past several years. Consequently, the RHC Program hit its annual $400 million funding cap in funding year 2016 and is on track to do the same for funding year 2017.[5]

The Commission requests comment on whether to increase the annual $400 million cap. Certainly, transformative changes in the healthcare industry and the program itself since 1997 have increased demand for rural telehealth and telemedicine services. Since 1997, technology has exponentially increased the range of medical services that can be delivered remotely; portable and electronic health records have become a focus of national public policy; and the Commission has increased the scale and scope of the RHC Program to include skilled nursing facility applicants, support for a greater range of equipment, facilities, and increased support for broadband Internet access services from 25 percent to 65 percent of the retail rate of services under the Healthcare Connect Fund (HCF) Program.

At the same time, outside of Alaska, the urban/rural price gradient has flattened, reducing the need for Telecom Program support to achieve its statutory purpose in the Lower 48 states. Thus, while USTelecom believes that the Commission should ensure sufficient Telecom Program funding for Alaska to achieve the statutory mandate of reasonably comparable urban and rural healthcare provider rates, changes to the Telecom Program budget should await a fuller but speedy review and overhaul of that program. In the Lower 48 states, real questions exist as to how much Telecom Program demand is driven by aggressive attempts to create a perception that urban and rural telecommunications service rates diverge far more greatly than they do. The

[5] *Id.* at ¶ 4.

Commission first should adopt rules designed to curb such waste before determining whether any increase in the cap is necessary. Failure to do so will send the wrong signal to the market and would only encourage greater waste, fraud, and abuse.

USTelecom suggests a number of fundamental reforms to the Telecom Program. If adopted, we believe such reforms will free up funding in the Lower 48 states necessary to meet the legitimate need for Telecom Program support in Alaska. These proposed reforms include: establishing a rebuttable presumption that non-mileage-based rates for telecommunications services outside Alaska are reasonably comparable between rural and urban areas; directing USAC to publish additional rate and service information to provide data to support (or rebut) that presumption; and capping Telecom Program support everywhere based on the lower of the rural rate for terrestrial or functionally similar satellite services. USTelecom also urges the Commission to extend HCF and E-rate best practices to the RHC Program.

The Commission has suggested several rate regulation proposals designed to rein in the exceptionally high "rural" rates and exceedingly low "urban" rates that have found their way into too many applicants' funding requests. USTelecom appreciates that the overall intent of these proposals is to inject some pricing rigor into the Telecom Program, thus ameliorating or altogether eliminating the current practice of giving applicants' consultants complete discretion over the alleged "rural" and "urban" rates associated with the services subsidized by the Telecom Program. While the intent is reasonable, USTelecom recommends caution for several reasons as undue price regulation in this market segment could disrupt competitive outcomes without necessarily addressing the fraud and abuse such rules intended to tackle.

First, it is important to note that competition exists across large swaths of this market, including many rural areas in the country. Where competition exists, price regulation – whether

rate regulation or based on ad hoc and intractable pricing benchmarks – will distort market outcomes which could unwittingly result in competitive service providers exiting this market segment, thus hurting – not helping – the intended beneficiaries of the program. Second, having USAC staff oversee such complex price regulations, which are far outside their field of expertise or authority, will generate uncertainty, complexity and risk for both Telecom Program beneficiaries and their service providers. Rather than stopping fraud and abuse, such complexity could enable continued gamesmanship from applicants, service providers or consultants under the cover of complex regulations.

II. Discussion

A. Ensure Sufficient Telecom Program Funding for Alaska Until the Commission Completes its Review of the Telecom Program.

The statutory purpose of the Telecom Program is to ensure that rural healthcare providers can obtain access to telecommunications services necessary for the delivery of health care at rates that are reasonably comparable to those available in urban areas. Although the statute makes no mention of a budget, the Commission established the annual funding cap on the RHC Program at its inception in 1997. Twenty years later, USTelecom has no objection to revisiting the size of this cap with an eye toward increasing it. As summarized above, transformative changes in the healthcare industry have thrust telehealth and telemedicine to the fore. A persistent scarcity of doctors, specialists, and other medical resources in rural areas have made broadband telecommunications connectivity into one of the most fundamental necessities of modern rural medical care.

The Commission should take the steps necessary to ensure that sufficient Telecom Program funding is available to fully fund Telecom Program demand in Alaska, in order to meet the requirements of Section 254(h)(1)(A). In Alaska, the steep gradient between rates for

telecommunications services between urban and rural areas points to great need for Telecom Program support. This need is reflected in today's distribution of Telecom Program support, with a significant portion of funding used to support healthcare providers in that state.

The state of Alaska is approximately one-sixth of the entire land area of the nation, yet is home to just 0.2 percent of the U.S. population.[6] Alaska is dotted with hundreds of largely native Alaskan villages that are not connected to the state's road system, power grid, or other basic infrastructure, or even the continental mainland. Often separated from the state's population centers of Anchorage, Fairbanks, and Juneau, and from each other, by hundreds of miles of wilderness or open ocean, or both, these villages constitute some of the very most remote and difficult-to-reach points in the nation. They very often lack local access to doctors and nurses, and for much of the year, poor weather may preclude travel for extended periods.

In these conditions, access to telemedicine makes the difference truly between life and death in the Alaskan Bush. Using telecommunications services supported by the Telecom Program, a community health aide with basic training can administer basic tests, and connect the patient to doctors and specialists located in Anchorage or other distant points. The Alaska native Tribal Health Consortium has calculated that, by 2017, with support from the Commission's RHC Program, 115,000 patients in the Alaska Tribal Health System have received care by telehealth and 30 different specialty care services offer visits by live video. The program has generated $82 million cumulative travel-related savings since 2001, a figure that is growing by some $10 million in additional savings annually.

[6] *See, e.g.*, World Population Review, "U.S. States Ranked by Population 2018" (*available at:* http://worldpopulationreview.com/states/) (visited February 1, 2018).

Elsewhere, the need for Telecom Program support is more muted. In the Lower 48 states, USTelecom members show far smaller differences between their urban and rural rates, including those available to healthcare providers. Thus, we question whether all of the Telecom Program support flowing to the rest of the nation is truly necessary to meet the requirements of Section 254(h)(1)(A). Thus, USTelecom opposes any increase in Telecom Program support for healthcare providers outside of Alaska until after the Commission has evaluated reforms, including the extent to which the urban/rural rate telecommunications rate disparities continue to exist, and whether support available for telecommunications services under the HCF Program also fulfills the statutory mandate of Section 254(h)(1)(A).

Last year, pursuant to the Commission's rules, USAC prorated some RHC Program beneficiaries' funding, reducing expected support by 7.5 percent for those healthcare providers.[7] Proration may be an equitable means to address unanticipated demand for RHC Program support that exceeds available funding among beneficiaries, but it is no long-term solution. The Commission's RHC support mechanism is required by statute to be "specific" and "predictable."[8] Having support recipients' funding amounts vary by funding year is inconsistent with these statutory directives. Moreover, as the Commission notes, it creates real hardship for these beneficiaries because they will have to pay their service providers more than they had originally budgeted.[9] And, of course, this problem is exacerbated for many Telecom Program participants that benefit from extraordinarily high discounts. Beneficiaries receiving discounts

[7] *NPRM* at ¶ 4 & n. 11.

[8] 47 U.S.C. § 254(b)(5).

[9] *NPRM* at ¶¶ 108, 111.

well north of 90 percent are not price sensitive so having to pay even a small percentage of the cost of the service as a result of proration can be a real financial shock.

The Commission sought to mitigate this hardship, first for Alaska beneficiaries during funding year 2016 and, more recently for all RHC Program beneficiaries in funding year 2017, by permitting service providers to voluntarily reduce their rates for service to these customers.[10] USTelecom previously explained why this, too, cannot be a long-term solution.[11] In fact, USTelecom urged to Commission to make clear that the funding year 2017 waivers will be one-time only. The obvious concern is that healthcare providers will inappropriately factor a service provider's prior willingness to "voluntarily" reduce its rates into its bid selection process for future funding years. Rather than reducing waste, fraud, and abuse in the RHC Program, placing service providers in the position of being asked repeatedly to reduce their rates will only add to it by undermining the integrity of the competitive bidding process.

In its discussion of the annual funding cap, the Commission requests comment on whether it should roll over unused RHC funds committed in one funding year into a subsequent funding year, as is done in the Commission's E-rate program.[12] USTelecom supports this proposal and urges the Commission to adopt it. The Commission suggests numerous other approaches to addressing the cap issue (e.g., prioritizing funding based on rurality of area served by the healthcare provider).[13] USTelecom appreciates the thoughtful suggestions but submits that, after the Commission implements needed reforms to the Telecom Program in the Lower 48,

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[10] *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 32 FCC Rcd 5463 (2017); *Order* at ¶¶ 111-17.

[11] Letter from Kevin G. Rupy, USTelecom, to Marlene Dortch, FCC, WC Docket No. 17-310 (filed Dec. 7, 2017).

[12] *NPRM* at ¶ 19.

[13] *Id.* at ¶¶ 24-34.

there may be no need for any increase in Telecom Program funding outside of Alaska in the foreseeable future.

B. USTelecom Urges the Commission to Make Certain Essential Telecommunications Program Reforms

1. Establish a Rebuttable Presumption for Non-Mileage-Based Telecommunications Services.

While the unique geography, costs of service, and market characteristics of Alaska cause large urban/rural rate differences to persist in that state, USTelecom believes that, elsewhere in the nation, USAC is awarding funding to Telecom Program applicants to account for the alleged difference between rural and urban rates in cases where there is no legitimate difference. In today's telecommunications services market in the Lower 48 states, the standard rate for many, if not most, non-mileage-based telecommunications services is the same in rural and urban areas.[14] Yet, service providers are being compelled by USAC to provide discounts for those services. When the Congress directed the Commission in 1996 to ensure reasonable comparability of rates between what a rural healthcare provider had to pay for telecommunications services and what a similarly situated customer had to pay in an urban area, there may have been a basis for that presumption of more widespread and substantial rural / urban price differentials. However, USTelecom posits that, by and large, this is no longer the case.[15]

[14] Indeed, a provider of interexchange telecommunications services is statutorily prohibited from charging subscribers in rural and high-cost areas rates that are higher than the rates it charges its subscribers in urban areas. *See* 47 U.S.C. § 254(g). USTelecom's members are currently reviewing which telecommunications services they have been directed by USAC to discount and which of those services are priced exactly the same in rural and urban areas. USTelecom's members hope to have this information available by the reply comment deadline.

[15] For example, the Commission found last year that the market for business data services is subject to "intense competition," with almost 500 facilities-based providers competing in this space. *See Business Data Services in an Internet Protocol Environment et al.*, WC Docket No. 16-143 et al., 32 FCC Rcd 3459, ¶¶ 1-2 (2017) (*BDS Order*). Cable providers, which have a

Among other reforms, USTelecom therefore recommends that the Commission establish a rebuttable presumption that non-mileage-based rates for telecommunications services outside Alaska are reasonably comparable between rural and urban areas. In the more than twenty years since the Commission established its Telecom Program, the small-to-medium sized business (SMB) telecommunications services marketplace – which characterizes the rural healthcare provider market – has rapidly evolved. For example, services from the 90s like **c**ircuit-based DS1s and DS3s, which "once dominated the business data services market" are "becoming obsolete" and are being replaced by packet-based services.[16] In addition, cable operators and other competitors have been aggressively rolling out Ethernet and other services across the country. Indeed, "[s]mall and midsized businesses have been the bread and butter business target for cable operators from the start."[17] Technological and competitive changes since the 90s have led to very substantial changes to the pricing and product structures in SMB services, making it all the more important for the Commission to revisit the Program.[18]

Such a rebuttable presumption not only gives meaning to the statutory requirement in Section 254(h)(1)(A), it also ensures that the Commission's program complies with Section 254(b). Section 254(b)(5), for example, requires the Commission's support mechanisms to be "sufficient." As the Commission and the courts have found, "excessive funding may itself

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ubiquitous presence in rural America, are "formidable competitors," whose business data services are growing at about 20 percent each year. *Id.* at ¶ 2.

[16] *Id.* at ¶ 3.

[17] Sean Buckley, "Comcast, Charter lead cable's challenge to telcos in the business sector," Fierce Telecom (Dec. 15, 2016), https://www.fiercetelecom.com/telecom/comcast-charter-lead-cable-s-challenge-to-telcos-business-services-sector (also describing other services cable is offering to the SMB market, including fiber-based Ethernet and next-gen IP voice services like SIP trunking, and how its prices continue to drop).

[18] *Id. See also BDS Order* at n. 9.

violate the sufficiency requirements of the Act" by "detract[ing] from universal service by causing rates unnecessarily to rise, thereby pricing some consumers out of the market;"[19] and "excessive subsidization arguably may affect the affordability of telecommunications services, thus violating the [affordability] principle in § 254(b)(1)."[20] By awarding discounts to certain healthcare providers to account for an alleged disparity in rates between rural and urban areas where none exists, "it is hard to imagine how the Commission could achieve the overall goal of §254 – the 'preservation and advancement of universal service,' 47 U.S.C. § 254(b) – if the USF is 'sufficient' for purposes of § 254(b)(5), yet so large it actually makes telecommunications services less 'affordable,' in contravention of § 254(b)(1)."[21] Just as the Commission took action to cap funding received by competitive eligible telecommunications carriers in 2008 after finding that these providers were receiving subsidies in excess of what was needed for them to remain in the market, so too should the Commission move to eliminate discounts for non-mileage-based telecommunications services where such rates are already reasonably comparable between rural and urban areas.

We recognize that some healthcare providers in the Lower 48 are located in extremely remote areas where there is still a significant difference between urban rates and the rates available in these extremely remote areas. For those entities, even the 65 percent discount from the HCF Program may be inadequate to ensure that its rates for service are reasonably comparable to urban rates. It is for this reason that we suggest making the presumption of reasonable comparability rebuttable under the Telecom Program. Such requests would be

[19] *Alenco Communications v. FCC*, 201 F.3d 608, 620 (5th Cir. 2000).

[20] *Qwest Commc'ns Int'l Inc. v. FCC*, 398 F.3d 1222, 1234 (10th Cir. 2005).

[21] *Rural Cellular Ass'n v. FCC*, 588 F.3d 1095, 1103 (D.C. Cir. 2009).

subject to enhanced review by USAC and, among other things, that review would include an analysis of whether the healthcare provider received other bids and, if so, what were the proposed prices for service. By providing rural healthcare providers the ability to show that a deeper discount is necessary to ensure reasonably comparable rates as paid in urban areas, the Commission satisfies the requirement in Section 254(h)(1)(A).

2. Make All Funding Requests Public and Searchable.

To permit meaningful review of applicants' funding requests that seek to rebut this presumption of reasonable comparability, the Commission should direct USAC to make all funding requests public and searchable. Already, FCC Forms 462 and 466 alert users on their face that, "Information requested by this form will be available for public inspection." Today, USAC has not implemented that commitment. Rather, USAC publishes only the total amount of each funding commitment, but no information on the specific services the applicant purchased, the urban rate the applicant will pay, or the competing bids that were rejected. USAC's actions are inconsistent with the representations regarding public inspection contained in FCC Forms 462 and 466.

The Commission should extend to the RHC Program its determination in the *E-rate Modernization Order* that the need for pricing transparency of subsidized services would be best served by making information regarding the specific services and equipment purchased by schools and libraries, as well as associated retail pricing, publicly available on USAC's website for funding year 2015 and beyond.[22] Thus, pursuant to that order, in the E-rate program, all applicants' funding requests (FCC Form 471) are posted on USAC's website in an open data

[22] *See Modernizing the E-rate Program for Schools and Libraries*, WC Docket No. 13-184, Report and Order and Further Notice of Proposed Rulemaking, 29 FCC Rcd 8870, 80 FR 167, FCC 14-99, ¶¶ 158-66 (2014).

platform that can be searched by the general public, including other applicants, service providers, academics and third parties at large. The decision to make this information publicly available injected transparency into the E-rate program as a catalyst for increased competition, and, among other things, enhanced review of the cost-effectiveness of purchased supported services.

Thanks to this Commission directive and the open data platform that USAC has developed, today, the public is armed with robust, searchable data tools that include essential data provided by applicants to USAC contained in FCC Form 470 (outlining the services sought) and FCC Form 471 (requesting funds for eligible E-rate services), including the types of services rendered at a given location, associated prices and service providers delivering the service. Importantly, USAC's E-rate open data platform includes effective export data tools that allow third parties to evaluate the data. The RHC Program requires at least this level of transparency, particularly in light of the extraordinary waste, fraud, and abuse in the Telecom Program. Making RHC funding requests publicly available and readily searchable will allow interested parties (the selected service provider, competitors, other healthcare providers, academics, government watchdogs, consultants) to analyze the reasonableness of the request and will promote increased competition in this program.

USTelecom urges the Commission to direct USAC to undertake similar efforts to create an open data platform for the RHC Program. In recognition of the challenges the E-rate community underwent during the funding year 2016 season (some of which remain today) due, in part, to USAC developing the E-rate Productivity Center (EPC) in a vacuum without consulting user stakeholders, the Commission should require USAC to consult with stakeholders as it develops plans for an open data platform for the RHC Program.

3. Where Functionally Similar Terrestrial and Satellite Services Are Both Available, the Commission Should Cap Telecom Program Support based on the Lower of the Two Rates

Under Section 54.609(d) of the Commission's rules, Telecom Program support for satellite service is capped based on the rate for functionally similar terrestrial-based service, where both are available. The Commission seeks comment on whether to retain this rule, in light of other reforms it has proposed. USTelecom believes that this rule not only remains necessary, but that the Commission should expand it to make clear that the Telecom Program support is limited to the *lower of* the rural rate for functionally similar satellite or terrestrial service, where both are available. There is significant evidence in the record that, in western Alaska, there is an unregulated monopoly provider of terrestrial broadband telecommunications service that has achieved virtually a 100 percent market share of rural healthcare providers and support, and is charging inflated rates for terrestrial services that are far in excess of those prevailing for functionally similar satellite substitutes.[23] By capping rates for these services based on the cost of functionally similar satellite alternatives, the Commission could eliminate tens of millions of dollars annually in wasteful spending under the Telecom Program with this one change alone.

C. Extend E-rate "Best Practices" to the RHC Program.

In its *NPRM*, the Commission proposes to adopt rules in its RHC Program similar to those currently applicable to its E-rate program. USTelecom supports this and encourages the Commission to go beyond gift restrictions and consultants.[24] We discuss these proposals below.

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[23] *See Ex Parte* Letter from Richard R. Cameron, Cameron Law & Policy LLC for Alaska Communications, to Marlene H. Dortch, Secretary, FCC, WC Docket No. 02-60 (filed Nov. 13, 2017).

[24] *See NPRM* at ¶¶ 87-88, 89-93.

1. Bid Evaluation and Cost-Effectiveness Standard.

USTelecom agrees with the Commission that the RHC bid evaluation and cost-effectiveness standards merit revision. In doing so, USTelecom recommends that the Commission consider applying to the RHC Program principles for bid evaluation and cost-effectiveness that apply today to the E-rate program.

Specifically, USTelecom recommends the Commission consider mandating RHC Program applicants to conduct open, transparent procurement processes similar to those that apply to E-rate applicants today, by providing additional information, either in the FCC Form 465 or in a publicly available Requests for Proposals (RFPs) regarding the services they require, as well as their anticipated usage demands. Typically, today, the applicant may specify only that it requires telecommunications services for, by way of illustration, "sending and receiving medical billing info, files and/or images to and from remote locations, patient videoconferencing, medical administration, and telemedicine." Even though the FCC Form 465 now includes a matrix of applications and usage level ("light/moderate/heavy") categories, additional detail would enable service providers and applicants alike to assess their service needs more accurately. USTelecom suggests that it would help ensure meaningful bid evaluation and cost effectiveness review for the applicant to include additional information in the FCC Form 465, such as the desired resolution for video-conferencing, the number of patients to be monitored simultaneously, the volume of files to be transmitted at peak hours, the types of equipment it intends to use with the service, recent utilization data for its current services, any planned upgrades to its telemedicine capabilities or usage needs over the term of the new contract it seeks (*e.g.*, 3-5 years), and any other relevant background information or details.

USTelecom also suggests that the Commission align the competitive bidding standards for the Telecom Program with those applicable to HCF, including the obligation to conduct a fair

and open competitive bidding process.[25] Additionally, USTelecom recommends that the Commission adopt for the RHC Telecom Program the HCF mandate that price be a primary factor in bid evaluations and that the bid selected be the most cost-effective service offering.[26]

2. Codify Gift Restrictions.

Since 2010, the Commission has prohibited E-rate applicants' from soliciting or accepting any "gift, gratuity, favor, entertainment, loan, or any other thing of value from a service provider participating in or seeking to participate" in the E-rate program.[27] The Commission's rules similarly prohibit service providers from offering or providing E-rate applicants with such gifts.[28] The Commission indicates that "[a]lthough there is no specific rule in the RHC Program, a gift from a service provider to an RHC applicant is nonetheless considered to be a violation of the Commission's competitive bidding rules. . . ."[29] Because this is not codified, as it is for E-rate, USTelecom is concerned that not all RHC applicants, consultants or service providers are even aware of this gift restriction, let alone have complied with it. Codifying this rule, as the Commission proposes, is a necessary step to eliminate fraud and abuse in the RHC Program.

We support extending the E-rate rule, as is, to the RHC Program. Indeed, a number of USTelecom members that participate in both the E-rate and RHC programs already apply the E-rate gift restriction rule to their RHC activities as well. However, USTelecom urges the

[25] *See* 47 C.F.R. § 54.642(b).

[26] 47 C.F.R. § 54.642(c) – (d).

[27] 47 C.F.R. § 54.503(d).

[28] *Id.* (creating a *de minimis* exception for items worth less than $20 with an annual maximum of $50 per year per individual). *See also NPRM* at ¶ 90 (describing the *de minimis* gift exception).

[29] *NPRM* at ¶ 89.

Commission to require USAC to maintain a searchable list of all entities participating in the RHC Program and the locations receiving RHC support so that service providers will have no doubt as to which healthcare providers are covered by the gift rule. It is simple enough for E-rate service providers to avoid offering or providing gifts to schools and libraries. It is much harder – indeed, likely impossible – to identify potential RHC Program-participating healthcare providers. This is the case because of non-rural healthcare provider consortia members in the HCF Program, as well as the location-specific nature of the RHC Program. To address this, USAC would maintain, and update as frequently as it determines is necessary, a list of all covered RHC entities and supported locations on its website. Any entity on USAC's list would be covered by the gift restriction rule. If an entity is not on that list and a service provider provides something of value to that healthcare provider, there should be no violation of the gift restriction rule if the healthcare provider subsequently participates in the RHC Program and is added to USAC's list at some later time.

3. Establish a "Shot Clock" for USAC Decisions on Rural Health Care Funding Requests.

USAC application processing times today are woefully inadequate to meet the needs of healthcare providers, or to satisfy the requirements of Section 254. Under the statute, support must be "specific, predictable and sufficient" to preserve and advance the universal service goals of the statute.[30] After unexpectedly lengthy delays in issuing funding year 2016 commitments, new USAC leadership pledged improvements in both speed and transparency for Funding Year 2017. But, with over seven months of funding year 2017 behind us, USAC has issued no funding commitments whatsoever, and applicants are in the dark as to when (or whether) they

[30] 47 U.S.C. § 254(b)(5).

may receive decisions on their funding requests. In many cases, service providers have delivered contracted services in good faith for seven months, accumulating large accounts receivable balances, with little or no incoming revenue in return. In other cases, healthcare providers have asked to postpone their service start dates, while they wait to see what level of financial commitment they will eventually incur. The program is on the wrong track. These egregious delays themselves undermine the RHC Program's mission.

USTelecom urges the Commission to (1) establish a consistent year-to-year schedule of funding period windows, with the first closing sufficiently in advance of the July 1 beginning of the funding year so that USAC can issue all funding decisions before the new funding year starts; (2) eliminate current rules that limit applicant's submission of requests for service (FCC Form 461 and FCC Form 465) to a strict timeframe starting on January 1st and, instead, like in the E-rate and in line with normal market practices, allow applicants to conduct their RFP processes on a rolling timeframe (3) direct USAC to issue decisions on all funding requests filed in that first window on a rolling basis (even if exact dollar amounts need to await the results of *pro rata* calculations), with all such decisions released by June 1, shortly before the beginning of that funding year, to give healthcare providers and service providers time to install and activate telecommunications services before July 1; and (4) require USAC to provide periodic (*e.g.*, weekly) updates on its progress in processing funding requests during and after the filing windows as long as funding requests are pending.

The Commission should require USAC to obtain sufficient rural health care staff and other resources to meet these requirements so that healthcare providers and their patients will never again have to endure the lengthy delays and process breakdowns characterized in funding years 2016 and 2017.

4. Streamline the RHC Invoicing Process

The RHC Program invoicing procedures are ripe for reform. Today's HCF Program rules provide incentives for applicants to delay processing invoices with USAC resulting in vastly delayed cash flow payments to service providers. Such delays generate significant, needless costs and risks to service providers that have to finance at times the service rendered to RHC beneficiaries for up to 18 months beyond the first date of service delivery.

This situation is caused by several factors. First, unlike in E-rate, applicants have no choice but to administer RHC invoicing via the service provider. RHC applicants have no option to bypass the service provider and obtain their subsidies directly from USAC (a process that would be equivalent to the Beneficiary Entity Applicant Reimbursement, or BEAR invoicing process in E-rate). Moreover, unlike in the Service Provider Invoice method in E-rate, the service provider in the RHC Program does not initiate or administer the invoicing process to USAC. Instead, under the RHC program, to get paid, service providers are at the mercy of the applicant to take two steps: (i) pay its portion of the overall bill to the service provider and (ii) initiate the FCC Form 463 invoice process for service provider review and certification. Only then will USAC reimburse the service provider for having provided a 65 percent discount to the HCF beneficiary.

Given today's RHC invoicing rules, applicants have up to 180 days after the end of the recurring service to initiate the process described above in (ii) (i.e., typically the end of the funding year – *e.g.*, June 30, 2017 for funding year 2016). This deadline typically falls on December 31st of the following funding year (i.e., December 31, 2017), or 18 months after the commencement of service to the HCF-eligible entity (in this example, July 1, 2016).

Because the applicant has no stake in when the service provider gets paid (indeed, it may have a disincentive to accelerate invoicing to USAC because it has to demonstrate payment of

the applicant's portion of the overall invoice at that time), the HCF Program – even more so than the E-rate program – is characterized by significant invoicing and payment lags, far beyond what normally occurs in the competitive market. Such delays are not conducive to the sustainability of the program because they serve as a disincentive to service provider participation and reduced competition ultimately hurts the beneficiaries of the HCF Program.

The Commission can and should eliminate these delays by reforming the HCF invoicing process as follows:

- Give applicants the option to administer their own invoices and payment directly from USAC in a similar fashion to the E-rate BEAR process.
- The Commission should require HCF beneficiaries to process invoices in a timely fashion. Specifically, the Commission should impose a requirement that participants pay their share of the overall cost of service within 90 days of being invoiced by the service provider, similar to the rules applicable to the E-rate program.
- The Commission should eliminate the requirement that the service provider certify the applicant's information on the FCC Form 463 to USAC. This requirement is burdensome and may discourage providers from participation due to this overly bureaucratic process.
- Additionally, if the Commission maintains the current service provider certification requirement, which it should not, the Commission should allow a reasonable timeframe for service providers to review and respond to applicant's filings related to invoices (currently, service providers must certify certain aspects of applicant's invoices on the same day these are filed at USAC). USTelecom recommends that the Commission establish a date the HCF beneficiary must submit the FCC Form 463 in the USAC tool and a separate deadline (10 business days as an example) for the Service Provider to review, certify and submit.

D. Reform the RHC Program Applicant Process to Reduce Bureaucratic Burden for Applicants, Service Providers and USAC.

Under current RHC procedures, some applicants submitting funding requests for support of services at multiple locations are compelled to submit separate applications for each location where the applicant is requesting discounts. This occurs despite the fact that service across

locations may be covered under one contract. The result of this practice is a great deal more bureaucracy for all stakeholders, including applicants, their service providers and USAC staff.

The Commission can and should mandate that USAC improve this process by implementing solutions similar to those developed in E-rate for so called "Parent-Child" entity relations. Using similar concepts and data tools as currently exist in E-rate, the RHC Program would greatly benefit from data regarding Parent-Child relationships being made publicly available and allowing interested parties to search and download data on beneficiary entity relationships.

E. Revise Rules for Consortia to Target Support to Rural and Tribal Lands

USTelecom supports the Commission's proposals to ensure that more HCF Program support targets rural healthcare providers, while still allowing for some non-rural healthcare providers to form part of an HCF consortium.[31]

Specifically, USTelecom recommends that the Commission increase the minimum percentage of rural healthcare providers in an HCF consortium. Currently, the HCF Program consortia "majority rural" rule requires that more than 50 percent rural healthcare providers be members of the consortium. This 50% plus 1 rule does not sufficiently ensure that the overall focus of the consortia targets rural healthcare providers. Indeed, the current rule only refers to the overall count of entities that form the consortia but does not consider the possibility that the amount of HCF support going to the non-rural consortia members is much greater than 50% of the overall subsidies received by the consortium. The Commission should consider revising the

[31] *NPRM* at ¶¶ 36 – 39.

minimum percentage of rural healthcare providers in a viable HCF consortium to more than 75%.

Additionally, the Commission should adopt its proposal to require a direct healthcare-service relationship between an HCF consortium's non-rural and rural healthcare providers that receive Program support. The original justification for introducing consortia applications in the HCF program was the recognition that telemedicine was evolving in such a way that patients of smaller, often rural, healthcare providers could be supported via telemedicine by medical personnel in larger, often non-rural, healthcare facilities. Allowing for such partnerships to be reflected in HCF consortia applications was a natural extension of these healthcare practices that HCF aimed to support.

These new models for delivering healthcare to patients located in remote areas are still under development. The Commission should encourage these partnerships by mandating, as it proposes, that the non-rural healthcare provider support be limited to those entities that are directly providing healthcare-related services to the rural members in the consortium. This means that consortium members will have to submit to USAC documentation indicating the nature and timeframe of the healthcare-related services being offered by non-rural members to rural members of the consortium.

Respectfully submitted,

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