Before the
Federal Communications Commission
Washington, DC 20554

In the Matter of	)	
	)	
Wireline Competition Bureau	)	CC Docket No. 02-60
Invites Comments on Petition	)	
for Rulemaking Filed by	)	
Schools, Health & Libraries	)	
Broadband Coalition, et al.,	)	
Seeking Further	)	
Modernization of the Rural	)	
Health Care Program	)	

COMMENTS OF NTCA–THE RURAL BROADBAND ASSOCIATION

January 14, 2016

TABLE OF CONTENTS

Page

Before the
Federal Communications Commission
Washington, DC 20554

In the Matter of	)	
	)	
Wireline Competition Bureau	)	CC Docket No. 02-60
Invites Comments on Petition	)	
for Rulemaking Filed by	)	
Schools, Health & Libraries	)	
Broadband Coalition, et al.,	)	
Seeking Further	)	
Modernization of the Rural	)	
Health Care Program	)	

COMMENTS OF NTCA–THE RURAL BROADBAND ASSOCIATION

I. INTRODUCTION AND SUMMARY

NTCA–The Rural Broadband Association[1] ("NTCA") hereby submits these comments in response to the Schools, Health, Libraries Coalition ("SHLB") et al. joint Petition for Rulemaking ("Petition"),[2] which seeks to further modernize the Rural Health Care Program ("RHC Program"). As a matter of initial procedure, many aspects of the Petition should be dismissed as they represent untimely Petitions for Reconsideration of carefully balanced policy

[1] NTCA is the premier industry association representing rural telecommunications providers. Established in 1954 by eight rural telephone companies, today NTCA represents nearly 900 rural rate-of-return regulated telecommunications providers. All of NTCA's members are full service rural local exchange carriers (" RLECs") and many of its members provide wireless, cable, Internet, satellite, and long-distance services to their communities. Each member is a "rural telephone company" as defined in the Communications Act of 1934, as amended ("the Act"). NTCA's members are dedicated to providing competitive modern telecommunications services and ensuring the economic future of their rural communities.

[2] *Wireline Competition Bureau Invites Comments on Petition for Rulemaking Filed by Schools, Health & Libraries Broadband Coalition, et al., Seeking Further Modernization of the Rural Health Care Program*, CC Docket No. 02-60, DA 15-1424 (rel. Dec. 15, 2015), ("Petition").

decisions made in the Commission's extensive Report and Order released on December 12, 2012.[3]

Nevertheless, to the extent that the Commission determines that it has cause to proceed forward and re-evaluate the mechanics of the RHC Program, it should start by taking a step back, and reviewing the RHC Program within the context of the totality of the of the universal service programs. Each universal service program is complementary; each serves a purpose in furthering the statutory mission of universal service as a whole. The goal of universal service is undermined, however, to the extent that these programs are not coordinated with, or worse still compete with, one another. In rural areas in particular, the High Cost Program can provide foundational support for the other three universal service programs, ensuring that robust, modern networks are in place *throughout* communities for *all* users, including but not limited to low-income consumers, schools, libraries, and health care providers ("HCPs"). For this reason, the Commission can and should ensure that any reforms with respect to any one program help, rather than hinder or undermine, the goal of universal service generally or the workings of any other program.

In regard to reform of the RHC Program specifically, to the extent that any new reforms might be considered, the Commission should adopt a methodological, data-driven, analytical approach, starting with a clear analysis of the "problem" at hand before proceeding forward with "solutions" in the form of changes to the program mechanics. NTCA asserts that proceeding as noted requires distinguishing between the challenges of "availability" and "affordability." The Commission should leverage rural broadband providers' successes, and target limited RHC Program resources where needed the most.

[3] *Rural Health Care Support Mechanism*, Report and Order, WC Docket No. 02-60, (rel. Dec. 21, 2012), ("Report and Order").

Then, in regard to additional, specific changes to the mechanics of the RHC Program suggested by the Petition, the Commission should continue to ensure that HCPs make efficient and effective use of existing resources, and preserve safeguards that are in place to protect public investments.

Consistent with the theme of coordination among universal service programs, NTCA tentatively supports joint applications for E-rate and RHC Program support, provided the Commission employs safeguards to protect existing public investment from inefficient consortium purchases – in other words, coordination among universal service programs requires more than *just* coordination between E-rate and RHC programs; it requires an assessment of the impacts of proposed reforms on *all* of the universal service programs.

Finally, as suggested by the Petition, the Commission should support the broadband component of remote patient monitoring—including both wireless and wireline services. Remote Patient Monitoring promises increased care in a more efficient and effective manner, and, as such, this is the type of technological enhancement that merits additional evaluation by the Commission.

II. CERTAIN ASPECTS OF THE JOINT PETITION FOR RULEMAKING ARE EFFECTIVELY UNTIMELY PETITIONS FOR RECONSIDERATION AND SHOULD BE DISMISSED

The Petition at hand, which sets a goal of modernizing the RHC Program, is in certain respects effectively an untimely Petition for Reconsideration of the Commission's Report and Order, and those aspects of the Petition should be dismissed, including: changes to the RHC Program annual funding cap and/or reimbursement percentage afforded to HCPs; support for short-term funding relief in the event the RHC Program exceeds the cap; expansion of the definition of "rural"; revising HCP eligibility categories; re-examining support provided to

consortia which include ineligible HCPs; revisiting support for consortia administrative expenses; and a review of the Commission's stated prohibition on the entity constructing HCP-owned facilities from also leasing excess capacity.

In these parts of the Petition, the petitioners are asking the Commission to revisit carefully crafted decisions made just a few short years prior to this new filing. The Report and Order was based upon hundreds of filings from various stakeholders, a substantial and comprehensive record. The Order struck a delicate balance of policy objectives, ultimately meeting the needs of rural patients, while addressing the institutional concerns of healthcare and telecommunications stakeholders alike and Petitioners, while disappointed with the current rules, present no evidence that the Commission's rules are not operating as intended

Further, the petitioners have not demonstrated that these specific issues should be re-litigated. Many of the arguments made in the Petition were initially introduced, discussed, and then ultimately ruled upon by the Commission in its Report and Order. For instance, prior to the Report and Order, health care stakeholders argued to significantly increase the reimbursement percentage,[4] while others recommended a reimbursement level lower than the 50% proposed by the Commission for the Broadband Services Program.[5] The Commission ultimately concluded

[4] *See, e.g.*, Comments of the United States Department of Health and Human Services at 7-8, 9-10 (urging the Commission to raise the discount level to 90% under the Broadband Services Program for rural HCPs that qualify for meaningful use incentive program and further urging the Commission to provide up to 100% discount for infrastructure) filed Sept. 8, 2010; Comments of the New England Telehealth Consortium at 2-3 (arguing for 85% discount rate for the Broadband Services Program) filed Sept. 9, 2010; Comments of the Oregon Health Network Comments at 9 (explaining that "rural HCPs will struggle to come up with even a proposed 15% match") filed May 25, 2012; Comments of ATC Broadband at 44 (suggesting that a discount level of more than 80% is needed to impact broadband deployment) filed Sept. 8, 2010; Comments of Internet2 Ad Hoc Health Group at 19 (suggesting an 85% discount for non-recurring and recurring charges associated with "[v]erified core infrastructure") filed Sept. 23, 2010; Comments of Eastern Montana Telemedicine Network at 2 (arguing for 85% discount) filed Sept. 8, 2010; Comments of the Fort Drum Regional Health Planning Organization at 6 (suggesting a 70% baseline discount rate) filed Sept. 8, 2010.

[5] Report and Order, ¶90.

that "requiring a 35% HCP contribution appropriately balances the objectives of enhancing access to advanced telecommunications and information services with ensuring fiscal responsibility and maximizing the efficiency of the program."[6]

The Commission also received targeted comments, and subsequently evaluated and then ruled upon the definition of "rural"[7]; eligibility to participate in a consortia[8]; and support for consortia administrative expenses[9]—subject areas which are each re-visited in the Petition. Further, the Petition requests that the FCC revisit its stated prohibition on the entity constructing HCP-owned facilities from also leasing excess capacity. However, the Commission installed this limitation to ensure an "arm's length transaction" between the vendor that installed the excess capacity, its affiliate, and the participant in the Program.[10] This criteria was intended to " help safeguard against program manipulation and to help prevent conflicts of interest or influence from vendors and for-profit entities that may lead to waste, fraud and abuse."[11] In this instance, the Petitioner is attempting to re-litigate program mechanics and undermine existing safeguards.

Following the release of the Report and Order, only one timely Petition for Reconsideration was filed, and this was by United States Telecommunications Association on behalf of its member telecommunications service providers.[12] Healthcare stakeholders—including the joint petitioners—did not object to the new rules-of-the-road.

---

[6] *Id*., ¶91.

[7] *Id*., ¶68.

[8] Id., ¶57.

[9] *Id*., ¶171.¶

[10] *Id*., ¶103.

[11] *Id*., ¶100.

[12] *See* United States Telecommunications Association, Petition for Reconsideration and Clarification, *Rural Health Care Support Mechanism*, WC Docket No. 02-60 (field April 1, 2013).

Given the substantive lack of objections filed by stakeholders, one can infer that the Commission reached sound policy decisions that do not need to be re-visited. However, to the extent the Commission decides to re-open the proceeding and allow re-litigation of the specifics of these aspects of the RHC Program, initial positions to the contrary and alternate proposals should likewise be considered for potential adoption.

For instance, NTCA, in its previous filings leading up to the Report and Order, requested additional, concerted protections to guard against overbuilding existing infrastructure and assets, especially those constructed leveraging other universal service programs or resources.[13] NTCA detailed the need for a comprehensive process that goes beyond a simple competitive-bidding mechanism. To summarily avoid overbuilding, such a carefully crafted process should "include both publicly posted notice of applications, and a sufficient and reasonable opportunity for interested parties to provide relevant data that would indicate whether existing networks in the vicinity could satisfy the needs of the applicant in lieu of self-provisioning infrastructure."[14] In addition, NTCA noted that any evaluation of the "cost-effectiveness" associated with deployment of telecommunications infrastructure in connection with the RHC Program must involve a long-term view of the "total cost of ownership."[15]

Unfortunately, the Commission declined to place these restrictions into practice; rather, a health care consortium that seeks support to embark on greenfield construction via HCP-owned

[13] National Telecommunications Cooperative Association, Ex Parte Notice, *Rural Health Care Support Mechanism*, WC Docket No. 02-60 (filed Dec. 5, 2012); Initial Comments of National Telecommunications Cooperative Association , *Rural Health Care Support Mechanism*, WC Docket No. 02-60, (filed Sept. 8, 2010) at 4-6; Comments of the National Telecommunications Cooperative Association, *Wireline Competition Bureau Seeks Further Comment on Issues in the Rural Health Care Reform Proceeding*, WC Docket No. 02-60, (filed Aug. 23, 2012).

[14] National Telecommunications Cooperative Association, Ex Parte Notice, *Rural Health Care Support Mechanism*, WC Docket No. 02-60 (filed Dec. 5, 2012).

[15] *Id.*

facilities and services, is only required to submit Form 461 and a Request for Proposals to the Universal Service Administrative Company ("USAC")[16]—in essence, the HCP is instructed to enter into a straight-forward competitive bidding process, which, as a result, ignores the risk of overbuilding assets due to a lack of a comprehensive notice-and-disclosure process in addition to inadequate review and oversight. Further, the HCP is instructed to evaluate and self-select the winning telecommunications service provider based upon the most "cost-effective method of providing service"—criteria which is widely open to interpretation.[17] HCPs' core competencies do not include owning and managing communications networks. As NTCA has noted in its past filings, a HCP's self-analysis associated with a network infrastructure "build vs. buy" decision likely will not include realistic and validated costs associated with equipment procurement, and the ongoing expense associated with maintaining and upgrading network infrastructure over its decades-long life.[18] And without clear and unambiguous guidance with respect to evaluation criteria, HCPs can and may opt to self-construct duplicative network infrastructure.

[16] Report and Order, ¶236.

[17] Report and Order, ¶221: "The Commission has defined 'cost-effective' for purposes of the existing RHC support mechanism as 'the method that costs the least after consideration of the features, quality of transmission, reliability, and other factors that the HCP deems relevant to . . . choosing a method of providing the required health care services.'[17] The Commission does not require HCPs to use the lowest-cost technology because factors other than cost, such as reliability and quality, may be relevant to fulfill their health care needs.[17] Furthermore, initially higher cost options may prove to be lower in the long-run, by providing useful benefits to telemedicine in terms of future medical and technological developments and maintenance.[17] Therefore, unlike the E-rate program, the RHC program does not require participants to consider price as *the* primary factor in selecting a service provider.[17] Instead, applicants identify the factors relevant for health care purposes, and then select the lowest price bid that satisfies those considerations."

[18] National Telecommunications Cooperative Association, Ex Parte Notice, *Rural Health Care Support Mechanism*, WC Docket No. 02-60 (filed Dec. 5, 2012).

Overbuilding concerns are warranted.[19] If the Commission deems it necessary to revisit the mechanics of the RHC Program as sought in the Petition, it should likewise re-examine the specifics of how a "build vs. buy" decision is determined, ensuring that adequate protections are in place to prevent overbuilding telecommunications assets.

III. NEVERTHELESS, IF THE COMMISSION DECIDES TO PROCEED FORWARD, ANY MODIFICATIONS TO THE RURAL HEALTH CARE PROGRAM MUST BE BASED UPON A SYSTEMATIC, DATA-DRIVEN APPROACH TO REFORM

Assuming *arguendo* the Commission considers this Petition despite the procedural and substantive issues raised above, NTCA urges the Commission to employ a methodical process to its analysis before it makes any decisions in regard to the mechanics of RHC Program.

Within the E-rate reform proceeding, NTCA asserted that the Commission should embark upon a data-driven, analytical approach to reform of the universal service program designed to

[19] Once again, NTCA observes that the record in this proceeding demonstrates that overbuilding is more than a hypothetical risk. *See, e.g.*, Comments of the Montana Telecommunication Association, WC Docket No. 02-60 (filed Sept. 8, 2010) at 12-13.

In addition, overbuilding has occurred in various other Federal grant and loan programs, such as the unfortunate consequences associated with EAGLE-Net, a broadband stimulus-funded project that overbuilt existing fiber runs in rural portions of Colorado. (*See, e.g.*, June 20, 2013, press release from the House Energy & Commerce Committee:https://energycommerce.house.gov/press-release/energy-and-commerce-committee-leaders-continue-inquiry-100mcolorado-broadband-stimulus-grant.)

The Commission would be wise to head the lessons-learned in Montana and Colorado, and consequently install carefully designed notice-and comment procedures to ensure overbuilding does not occur again. NTCA recognizes that overbuilding is not rampant within the RHC Program; rather, these two examples are discrete instances, but the threat is real -- and the consequences for the affected rural telecommunications provider and its customers can be devastating.

In addition, as mentioned earlier, the United Sates Telecommunications Association filed a Petition for Reconsideration of the Report and Order on Apr. 1, 2013. This was, once again, the only Petition for Reconsideration that was filed – and the association had similar concerns to NTCA, noting that the Commission should reconsider permitting and encouraging the speculative installation and resale of excess capacity, as well as permitting dark fiber to be deemed an eligible "service." Given these shared concerns, if the Commission decides to proceed forward with reform of the RHC Program, it should promptly re-evaluate the protections around the construction of greenfield projects and the resultant sale of excess capacity.

assist schools and libraries with obtaining affordable access to broadband connectivity.[20] Likewise, in the health care context, the "solution" to modernization of the RHC Program must depend, in the first instance, upon isolation and clear definition of the "problem" at hand. The Commission must gather data that can be used to assess and validate the unique needs that each individual HCP – including the unique requirements associated with availability, affordability, quality of service, and capacity requirements. The Commission should employ an analytical framework that leverages rural broadband providers' successes, and targets limited RHC Program resources where needed the most. NTCA asserts that proceeding as noted "requires distinguishing between the challenges of 'availability' and affordability,' as follows"[21]:

1. Affordability – The HCP in question has a robust connection in place today that supports broadband speeds that are reasonably likely to be used by the HCP in the foreseeable future (or such connections are in the process of being constructed in the area). The problem to be solved then is not how to connect the HCP, but how to ensure that the HCP can obtain a reasonable level of broadband for its mission at a reasonable price on an ongoing basis.

2. Availability –

    a. Partial Availability – The HCP in question has some level of broadband access today (or facilities to enable such broadband access are in the process of being constructed in the area), but the last-mile connection to that HCP does not support broadband speeds that are reasonably likely to be used by the HCP in the foreseeable future. The problem to be solved then is how to upgrade the last-mile connection to the HCP to enable higher-speed broadband access, but there is no need to rebuild an entire network from scratch.

    b. Total Unavailability – The HCP in question has no broadband access today and there is no construction planned or underway to deploy facilities to enable

[20] *See* Comments of NTCA, *Modernizing the E-rate Program for Schools and Libraries,* WC Docket No. 03-184, (filed April 7, 2014) at 4. *Also see* Reply Comments of NTCA, *Modernizing the E-rate Program for Schools and Libraries,* WC Docket No. 03-184, (filed April 21, 2014) at 4-5. *Also see* Reply Comments of NTCA, *Modernizing the E-rate Program for Schools and Libraries,* WC Docket No. 03-184, (filed Sept. 30, 2014) at 1.

[21] Comments of NTCA, *Modernizing the E-rate Program for Schools and Libraries,* WC Docket No. 03-184, (filed April 7, 2014), at 4-5.

> such broadband access in that unserved area. The problem to be solved then is one of true unavailability, where a "new build" might offer the only solution.[22]

NTCA's members have done a yeomen's job of delivering advanced connections to local rural HCPs, and given the data points obtained from NTCA's membership, in most RLEC service territories, the "problem" may be related to affordability vs. availability.[23] A failure to leverage this success and the availability of high-capacity, scalable networks already in place – and instead, treating each HCP as having an "availability" problem where that is not the case – will expend a significant amount of funds, and waste resources that could otherwise be directed to keeping services affordable or funding new construction in discrete areas that truly lack them. In direct contrast, tailoring solutions to the needs of each individual HCP and taking advantage of existing assets and facilities will enable the RHC Program to extend the benefits of broadband to as many HCPs and their patients as possible.

[22] *Id.*

[23] According to an internal NTCA member survey, respondents report that they serve, on average, more than 94% of CAIs with their service territories – defined as K-12 schools; public libraries; community colleges; (non - Veterans Administrative) hospitals and clinics; and Veterans Administrative facilities. Further, according to this same survey, respondents report that they serve, on average, more than 88% of hospitals and clinics with their service territories. For those who provide telecommunications services to HCPs, more than 65% offer service via fiber. Service providers report that can provide a mean speed of 393.8 Mbps; and a median speed of 50 Mbps; but HCPs only purchase a mean speed of 16.3 Mbps and a median speed of 10.0 Mbps.

IV. IN REGARD TO ADDITIONAL, SPECIFIC, PROPOSED CHANGES TO THE MECHANICS OF THE RURAL HEALTH CARE PROGRAM, THE COMMISSION SHOULD CONTINUE TO ENSURE THAT HEALTH CARE PROVIDERS MAKE EFFICIENT AND EFFECTIVE USE OF EXISTING RESOURCES, AND PRESERVE SAFEGUARDS THAT ARE IN PLACE TO PROTECT PUBLIC INVESTMENTS

The Petitioners have suggested several discrete changes to the RHC Program. Despite the compelling legal and procedural arguments noted above, if the Commission decides to re-visit the issues at hand, it should ensure that HCPs make efficient and effective use of the limited resources available. Likewise, given the complementary nature of the universal service programs and related Federal loan and grant programs, the Commission should ensure that any one program—for instance, the RHC Program—does not disrupt or undermine public investments that have and/or will be made via another mechanism—for example, the High Cost Program; E-rate Program; Rural Utilities Service ("RUS") grants and loans; and/or the National Telecommunications and Information Administration ("NTIA") funding.

A. The Commission Should Decline to Increase the Overall Size of the USF Rural Health Care Fund and/or the 65% Discount Provided to Health Care Providers

Under the current rules, the RHC Program matches two-for-one the cost of broadband services or facilities; HCPs are required to contribute 35% matching funds which can be used for financing new construction, or leasing facilities from existing, established service providers.[24] This was a reasoned Commission decision. As the Order asserted, "[a] two-for-one match will significantly lower the barriers to connectivity for HCPs nationwide, while also requiring all program participants to pay a sufficient share of their own costs to incent considered and prudent

[24] 47 C.F.R. §54.633

decisions and the choice of cost-effective broadband connectivity solutions."[25] Further, as the Commission declared, HCPs need a "sufficient financial stake" in the RHC Program, and a "35% contribution requirement is economically reasonable and fiscally responsible."[26]

As noted earlier, within its declaratory Report and Order, the Commission struck a careful balance of policy objectives. For instance, in regard to the overall budget for the RHC Program, the Notice of Proposed Rulemaking ("NPRM") had initially suggested a 50% reimbursement level for monthly recurring costs, and up to 85% reimbursement for HCP-owned new construction.[27] NTCA agreed with the former, but asserted that an 85% discount on new infrastructure was a "substantial funding opportunity that would encourage some applicants to file in areas with existing broadband network, thus creating an 'overbuild' scenario."[28] For their part, health care stakeholders argued for a substantial increase in the reimbursement percentage.[29] However, in the Report and Order, the Commission simplified the RHC Program with a flat 65% reimbursement that can be used for either "build or buy" scenarios, i.e. building new self-constructed infrastructure or leasing facilities from established, existing service providers. In the Report and Order, the Commission struck a delicate balance between stakeholder viewpoints, and the Petitioners have not established that the Commission's conclusions warrant re-evaluation and/or re-prescription of the reimbursement level afforded to rural HCPs.

[25] Report and Order, ¶5.

[26] Report and Order, ¶48.

[27] NPRM, ¶4.

[28] Comments of NTCA, *Rural Health Care Support Mechanism*, WC Docket No. 02-60, (filed Sept. 8, 2010) at 4.

[29] Report and Order, ¶96.

The Petition requests that the Commission revisit the overall funding cap on the RHC Program.[30] However, it acknowledges that the RHC Program has been routinely underutilized and applications have not come close to exceeding the cap at any point in time.[31] However, the Commission observed in the Report and Order that even with the substantive changes it made in 2012, it did not expect funding requests to exceed supply for many years.[32] As such, any funding left on the table does not substantiate the Petition's request to re-evaluate the mechanics of the RHC Program. Further, there is no need to increase the supply when excess demand is not present.

Likewise, the Petition requests that the Commission establish a mechanism to provide short-term relief in the event the RHC Program demands exceeds the cap,[33] but logically it follows that, based upon real-world experience, a provision for short-term funding relief is not necessary.

Despite these compelling reasons to stay the course, should the Commission be swayed to revisit funding of the RHC Program, it should be noted that any discussion and subsequent modification to the universal service budget—including for individual programs—should be appropriately tied to universal service contribution reform. To this end, the Commission has requested recommendations from the Federal-State Joint Board on Universal Service regarding

[30] Petition at 19.

[31] Petition at 10.

[32] Report and Order, ¶98, estimating that demand would "[a] 65% discount rate will help keep demand for the overall health care universal service, including the Healthcare Connect Fun, below the $400 million cap for the foreseeable future, even as program participation expands."

[33] Petition at 30.

potential modifications to the USF contribution mechanism.[34] As the Commission noted, the Joint Board will look into how the mechanism affects the Commission's ability to meet the statutory principles of universal service in light of changes in technology and industry dynamics.[35] Further, as NTCA has noted in other venues, these joint board recommendations should contribute to an already substantial record on the need to stabilize and broaden the contribution mechanism to enable it to meet the Commission's broadband deployment and adoption goals, and to ensure that all components of the USF fabric—E-rate, High Cost, Low Income and the RHC Programs—can be "right-sized" for their respective missions.[36]

B. The Commission Should Expressly Prohibit the Sale of Excess Capacity on Health Care Provider-Owned Greenfield Builds Supported by the Rural Health Care Program

In the Report and Order, the Commission allowed HCPs to use RHC Program funds to finance construction of greenfield facilities, and then to lease excess capacity on the subsequent HCP-owned network to unaffiliated users. The Petitioners now request that the Commission should delete and/or substantially modify some of the accompanying provisions that are in place to limit the circumstances under which excess capacity can be leased, and how the profits can be used.[37] This is dangerous path; relaxing any of the safeguards that are currently in place could inadvertently jeopardize existing community networks that operate as Carriers of Last Resort ("COLR")—and, as a result, serve to undermine existing public investments made via

[34] Federal State Joint Board on Universal Service, WC Docket No. 96-45, Universal Service Contribution Methodology, WC Docket No. 06-122, A National Broadband Plan for Our Future, GN Docket No. 09-51, Order, FCC 14-116 (rel. August 14, 2014).

[35] *Id.*, ¶1.

[36] Reply Comments of NTCA, *Modernizing the E-rate Program for Schools and Libraries*, WC Docket No. 13-184, (filed September 30, 2014).

[37] Petition at 20-21.

complementary Federal grant and loan programs. In fact, should the Commission endeavor to re-evaluate the overall mechanics of the RHC Program, NTCA strongly re-asserts its position that the Commission should comprehensively prohibit the sale of excess capacity on HCP-owned greenfield builds supported by the RHC Program.

To fully understand the potential repercussions that stem from commercially monetizing excess capacity on a HCP-owned greenfield network supported via RHC Program funds, it is useful to discuss the central financial tenets of rural telecom deployment. Rural service providers operate in high-cost, low-density areas of the country through a combination of private capital, RUS financing, and High Cost Program support. However, many rural and remote areas of the country are home to limited residents and even fewer anchor tenants, ensuring that the business case will not support more than one telecommunications operator. A second commercial network offering could entice and thereby remove anchor tenants and other customers from rural carriers' customer bases. This is particularly true for a network that receives 65% of its financing from the RHC Program, and therefore, may be able to compete and offer its excess capacity to commercial users at below-market rates.

By "cherry-picking" the most attractive, high-volume, lucrative customers for the HCP-owned network, it consequently leaves the most costly-to-serve remnants of the service area to the COLR. This scenario threatens continued infrastructure investment and *increases* the existing service provider's reliance upon high-cost support. In the worst-case scenario, the existing service provider may be unable to continue to meet its network investments and infrastructure loans—reminiscent of the unfortunate consequences that resulted from EAGLE

Net, a broadband stimulus-funded project that overbuilt existing fiber runs in rural portions of Colorado.[38]

Further, in regard to the limited use of RHC Program funds for greenfield construction, this RHC Program rule was intended to be a stop-gap measure to provide access to service for HCPs otherwise left behind by commercial network service providers. It was not policymakers' intent to create a new commercial network that undermines the financial health and continued existence of COLRs in rural and remote areas of the country that are supported via complementary Federal loan and grant programs.

NTCA understands that it is quite difficult to make a business case for deploying, maintaining, and evolving telecommunications service in rural areas, but this begets the need for community network providers, which can provide service holistically to the community and not to just one anchor institution. Indeed, sustainability is much harder to achieve when serving only one kind of customer. With this in mind, it almost begs the HCP to employ new greenfield networks for overbuilding, and thereby undermining the sustainability of *both* the High-Cost and RHC Program funded networks in the same area.

For this reasons, to protect public investment and limited program resources, the Commission should draw a bright-line and expressly prohibit the sale of excess capacity on HCP-owned greenfield builds supported by the RHC Program. If it declines to act in this manner, at a minimum, the Commission should stay the course with the current restrictions placed upon HCPs' leasing of potential excess capacity.

[38] *See, e.g.*, June 20, 2013, press release from the House Energy & Commerce Committee:https://energycommerce.house.gov/press-release/energy-and-commerce-committee-leaders-continue-inquiry-100mcolorado-broadband-stimulus-grant.

C. NTCA Tentatively Supports Joint Applications for E-and Rural Health Care Program Support, Provided the Commission Installs Safeguards to Protect Existing Investment

NTCA tentatively supports the concept of joint applications for E-rate and Rural Health Care financial support. As asserted above, and also separately in the E-rate proceeding, the four universal service programs are synergistic in nature. The High Cost Program supports community-wide networks, while the E-rate and RHC Programs provide discounts on acquiring services for appropriate anchor institutions—with limited support for new self-construction tied to areas without access to commercial broadband. Additional coordination of project criteria, funding levels, and joint application steps would help ensure efficient use of limited universal service funding, and consequently benefit high-cost rural areas and their residents. Ideally, a joint application could rely upon the High Cost Program and existing commercial network service providers and their facilities where available, and further employ support via the E-rate and/or RHC Programs in areas where existing facilities are not available, or are too expensive for a school, library, and/or HCP to acquire on its own. However, NTCA cautions that if the Commission decides to re-evaluate joint E-rate/RHC Program applications accordingly, it should install appropriate safeguards to protect existing public investment from inefficient consortium purchases.

The Petition requested that Commission provide "a path for joint E-rate and HCF consortia applications for funding in areas left behind by commercial providers."[39] NTCA asserts that support for *areas that are left behind* is a fundamental tenet of the individual E-rate and RHC universal service programs, and, likewise, should be the foundation of any joint

[39] Petition at 22.

universal service program application. It logically follows that joint E-rate and Health Care applications should not be used to undermine and overbuild existing networks.

With that in mind, consortium purchasing poses a unique risk under certain circumstances. Joint E-rate/RHC Program applications likely would be larger in geography than any single-program applicant. As the Commission acknowledges, the formation of large consortia could "unfairly disadvantage smaller providers that may be efficient local providers of high-capacity services."[40] A small provider likely would have sufficient facilities in place to provide local schools, libraries, and HCPs within its service area with a high-capacity broadband connection at an affordable rate—but it likely would be unable to meet the needs of a large consortium that spans large swaths of both urban and rural areas, especially if it crosses county lines or state borders. Nevertheless, the local network service provider's core competencies and offerings should be considered by the consortium in lieu of proceeding down another path, which may result in an overbuild scenario.

Unfortunately, under a "bulk-buying" consortium scenario, given the sheer size of the consortium request, a single supplier could present itself as the only available solution, with little incentive to pass on resource efficiencies to the consortium purchaser. For example, a consortium that is awarded E-rate and/or RHC Program funds to build fiber transport or last-mile facilities, or lease dark fiber to serve a large number of schools, libraries and/or HCPs in a particular area, when only a small number of those consortium participants actually lack connectivity options and suffer from a "total unavailability" problem, would likely consume an inordinate amount of universal service resources, and thereby deny the benefits of financial support to other program participants. Such a situation, while perhaps appearing cost-effective

[40] *Wireline Competition Bureau Seeks Focused Comment on E-Rate Modernization*, WC Docket No. 13-184, Public Notice, (rel. Mar. 6, 2014), ¶35.

from the standpoint of that particular consortium purchaser, would in fact needlessly deploy resources where they may not be needed, wasting valuable universal service funding.

Consequently, NTCA reiterates its position that "bulk buying" via a joint E-rate/RHC consortium should not translate to "bulk selling."[41] NTCA re-asserts that the Commission should therefore "make clear that consortia must not override local school [and library and/or HCP] purchasing decisions, must give full consideration to the procurement of services from multiple providers within a project footprint, and may not use 'packaged' proposals and creative definitions of project scope to circumvent prohibitions on using E-rate [and/or RHC Program] resources to overbuild existing facilities and network assets that are already capable of delivering robust broadband to a given school or library [or health care] location."[42]

D. The Commission Should Support the Broadband Component of Remote Patient Monitoring—Including Both Wireless and Wireline Services

Remote Patient Monitoring offers the opportunity to treat patients within their home and community to proactively address chronic conditions and other ailments before they become urgent. As the Petition noted, "remote patient monitoring (typically in the home) is critical for reducing costly hospital re-admissions, and necessary to cost-effectively manage population health using limited health resources."[43] Technology is readily available, but NTCA members and their customers' qualitatively report that the combined cost of the hardware, software, monitoring service, and the broadband connection is often too pricey for the rural patient.[44]

---

[41] Comments of NTCA, *Modernizing the E-rate Program for Schools and Libraries*, WC Docket No. 03-184, (filed April 7, 2014), at 6.

[42] *Id.*, at 7.

[43] Petition at 22.

[44] For instance, Gardonville Telephone Cooperative (www.gctel.com, based in Brandon, Minn.) offers an in-home technology pilot that connects hospice patients with their loved ones, caregivers, and medical team. Gardonville partnered with Knute Nelson, a non-profit organization that specializes in senior care,

As noted above, the Petition has re-hashed many old arguments that have been hotly debated, and then, subsequently, carefully weighed and ruled upon by the Commission. However, in juxtaposition, the Petition has also requested RHC Program support for the broadband component of remote patient monitoring. This is a true new technology enhancement based upon lessons learned that can and should be assessed by the Commission. NTCA urges the Commission to evaluate RHC Program support for the broadband component of the remote patient monitoring service—including both wireless and wireline services. In some rural areas, only one type of communications service may be readily available and provide the necessary quality of service and capacity parameters. As such, both wireline and wireless should be equally considered as reimbursed expenses.

V. CONCLUSION

As a matter of procedure, many portions of the Petition should be denied outright and dismissed. Nevertheless, if the Commission decides to proceed forward with modernizing the RHC Program, the Commission should take a step back and review the universal service programs from a macro level: the High Cost Program supports community-wide networks, while the E-rate and Rural Health Care Programs provide discounts on acquiring services for

---

to offer patients the GrandCare System, which enables in-home hospice patients to view pictures, receive incoming messages, watch medical videos, video chat with family and friends, and listen to music. The system also is connected to a variety of wireless activity sensors placed in the patient's home that can alert designated caregivers by phone, email, or text message if anything seems amiss; and it offers the capability for real-time biometric feedback. Knute Nelson obtained a grant from the Blandin Foundation, an organization that seeks to support vibrant, rural Minnesota communities, to support the service. Further, as part of this project, Gardonville provided customers with a low speed data service, at a discounted rate. As such, the service is a loss-leader for the telecommunications provider, but it serves an important community mission. Gardonville received a Smart Rural Community Special Recognition award in 2014 for its innovative use of health care technology and commitment to the needs of its local community. Subsequently, the company also received a Smart Rural Community Collaboration Challenge Award of $5,000. For more on the Smart Rural Community program: www.ntca.org/smart.

appropriate anchor institutions, with limited support for new self-construction tied to areas without access to commercial broadband. As such, the Commission first look to leverage existing community network providers that have a proven track record of meeting the communications needs of all users within the community, building upon policies which support their efforts.

In regard to the more limited RHC Program, the Commission should embark on a data-driven, analytical approach to reform, ensuring that HCPs make efficient and effective use of limited resources, and preserving safeguards that are in place to protect existing public investments.

Respectfully submitted,

By: /s/ Jill Canfield
Jill Canfield
Director – Legal & Industry

/s/ Jesse Ward
Jesse Ward
Industry & Policy Analysis Manager

4121 Wilson Boulevard, Suite 1000
Arlington, VA 22203
jcanfield@ntca.org
703-351-2000 (Tel)
703-351-2036 (Fax)

January 14, 2016