Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

In the Matter of	)	
	)	
Emergency Petition for Waiver	)	
of 47 C.F.R. § 54.675(a)	)	
	)	
Promoting Telehealth in Rural America	)	WC Docket No. 17-310
	)	
Rural Health Care Universal Service	)	CC Docket No. 02-60
Support Mechanism	)	

EMERGENCY PETITION FOR WAIVER OF THE RURAL HEALTH CARE PROGRAM FUNDING CAP PENDING CONCLUSION OF THE OPEN RULEMAKING

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The Schools, Health & Libraries Broadband (SHLB) Coalition, by its attorney and pursuant to § 1.3 of the Commission's Rules ("Rules"), hereby petitions the Federal Communications Commission ("FCC" or "Commission") to immediately waive Section 54.675(a) of its Rules and fully fund qualified applications for Rural Health Care funding for Funding Year ("FY") 2017 and until the Commission concludes the open rulemaking in WC Docket No. 17-310.[1] The Rural Health Care program funding cuts required by Section 54.675(a) for FY 2017 were much larger than anticipated and are effectively retroactive because they were not announced by USAC until more than eight months after the start of the funding year, much later than was reasonable or reasonably expected. As a result, health care providers across the nation that entered into contracts for eligible services effective at the start of FY 2017 (July 1, 2017) in reasonable reliance on a

[1] *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Notice of Proposed Rulemaking and Order, FCC 17-164 (Dec. 18, 2017) (*NPRM & Order*).

predictable and sufficient source of universal service funding[2] face immediate and significant financial hardship, including downgraded bandwidth and service quality (with potential impacts on network security), staff layoffs, poorer quality health care for rural patients, or even bankruptcy. Moreover, the uncertainty over program funding will potentially impact carrier investment decisions, hindering broadband deployment in rural areas. The events of FY 2017 will likely recur in FY 2018 unless the Commission takes steps to complete reforms of the program under consideration in the current rulemaking.

The Commission itself waived the $400 million cap on the Rural Health Care program just four months ago because of concern about the impact on rural health care providers. Those same concerns, and the same rationale, support the emergency waiver requested by this Petition. There is thus precedent and good cause for the relief requested, and a waiver of the $400 million cap to fully fund qualified applicants until the current Rural Health Care program rulemaking is concluded will be in the public interest.

In support thereof, the following is respectfully submitted:

I. BACKGROUND

A. Basis for the $400 Million Rural Health Care Program Cap

When Congress mandated a universal service program for Rural Health Care in the Telecommunications Act of 1996, it did not mandate a spending cap for the program. In fact, the statutory language says the FCC "shall" make funding available, suggesting there should not be

[2] *See* 47 U.S.C. § 254(b) (Requiring the establishment of universal services policies to reflect principles that include, among other things, "specific, predictable and sufficient Federal and State mechanisms to preserve and advance universal service.").

any cap at all.[3] The current $400 million cap on annual Rural Health Care program expenditures was established by the Commission in 1997 based on assumptions that the maximum circuit every health care provider eligible to participate in the program would need was a T1 (1.5 Mbps).[4] The cap was also based on Commission estimates of the number of potentially eligible program participants at that time.[5] These assumptions are now more than 20 years old and predate the Commission's establishment of the Healthcare Connect Fund and Congress' inclusion of an estimated 4,675 not-for-profit skilled nursing facilities (SNFs) as eligible program participants in 2016.[6] The SHLB Coalition has previously estimated that the number of eligible health care providers eligible to participate in the program has more than doubled since 1997,[7] but until the current *NPRM & Order* the Commission had not formally reconsidered the basis for the $400 million cap.

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[3] *Cf. NPRM & Order* at ¶ 32 (*citing, e.g.*, Letter from Geoff Strommer, Counsel to Tribal Organizations in Alaska, to Chairman Ajit Pai and Commissioners, FCC, WC Docket No. 02-60, at 1 (filed Aug. 15, 2017) (arguing that Section 254(h)(1)(A) of the Telecommunications Act of 1996 is an entitlement mandate and that a cap is not authorized by Congress)); *see also* SHLB RHC NPRM Comments at 14-15; SHLB RHC NPRM Reply Comments at 4-5.

[4] *See Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776, ¶ 707 (1997) (Universal Service First Report and Order) (subsequent history omitted) ("we estimate that the maximum cost of providing services eligible for support under [the statute] is $366 million, if all eligible health care providers obtain the maximum amount of supported services to which they are entitled. That is, we assume that each rural health care provider will request support for a service of 1.544 Mbps.") (*First Report & Order*); *NPRM & Order* at ¶ 15 ("The current cap on the RHC Program has remained at $400 million since its inception in 1997."). In establishing the cap, the Commission acted *sua sponte* as the Joint Board had not recommended the adoption of a funding cap. *See First Report & Order* at ¶ 704.

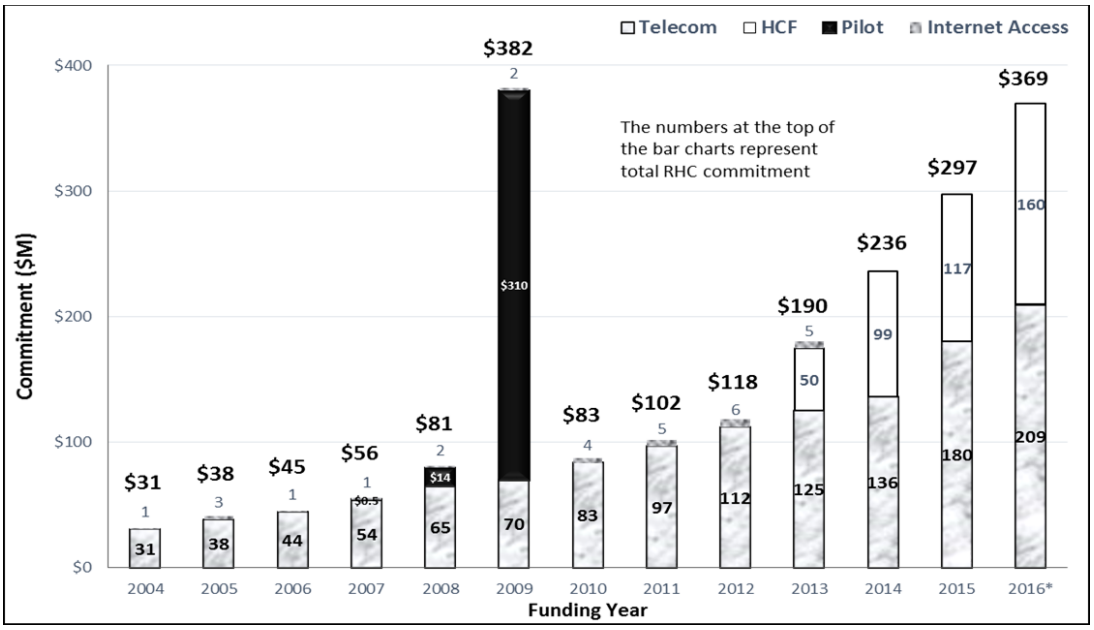
[5] *See id.* at ¶ 706 (estimating 12,000 eligible program participants while acknowledging there "is no list of public and non-profit health care providers that fit the definition of 'health care provider' in section 254(h)(5)(B) and are located in rural areas").

[6] *See* Frank R. Lautenberg Chemical Safety for the 21st Century Act, Title II – Rural Healthcare Connectivity, Pub. L. No. 114-182 (2016) (Rural Healthcare Connectivity Act of 2016) (amending the Act to include SNFs (as defined in section 1819(a) of the Social Security Act) as an eligible health care provider type) (codified at 47 U.S.C. § 254(h)(7)(B)); SHLB RHC NPRM Comments at 13, n.33 (linking to public data supporting a reasonable estimate of the number of eligible SNFs).

[7] *See* SHLB RHC NPRM Comments at 12-14.

B. Funding Requests, Funding Decisions, and Available Funding

Before FY 2016, Rural Health Care program funding commitments generally remained well below the $400 million cap:[8]



In August 2016 (toward the beginning of FY 2016 which started July 1, 2016), in anticipation of possibly hitting the funding cap in FY 2016, the FCC's Wireline Competition Bureau for the first time established filing windows in the Rural Health Care program.[9]

The second filing window for FY 2016 closed on November 30, 2016, after which it was announced that the total funding requests submitted in the second window had exceeded available funding. FY 2016 funding commitments were released by USAC in April 2017, approximately five months after the close of the second and final filing window. For FY 2017, the first and only filing window closed on June 30, 2017, after which it was announced that funding requests filed

[8] *See NPRM & Order* at ¶ 8-9

[9] *See Wireline Competition Bureau Provides a Filing Window Period Schedule For Funding Requests Under the Telecommunications Program and the Healthcare Connect Fund*, Public Notice, 31 FCC Rcd 9588, WC Docket No. 02-60 (Wireline Comp. Bur. 2016).

in this first window exceeded available funding.[10] USAC began releasing FY 2017 funding commitments on or about March 16, 2018, *over eight months after the close of the final (and only) filing window*.

Each year the total amount of approved (or held) funding requests ("Net Demand") is lower than the total amount of funding requests submitted at the close of the final filing window ("Gross Demand").[11]

	FY 2013	FY 2014	FY 2015	FY 2016	FY 2017
Gross Demand (Amount requested)[12]	$ 250,609,669	$ 278,640,545	$ 377,642,768	$ 556,242,179	$ 567,260,000
Year-over-year increase		$ 28,030,876	$ 99,002,223	$ 178,599,411	$ 11,017,821
Net Demand[13]	$ 190,000,000	$ 236,000,000	$ 297,000,000	$ 405,748,507	$ 521,330,000
Year-over-year increase		$ 46,000,000	$ 61,000,000	$ 108,748,507	$ 115,581,493
Denial rate (denied/requested)	**24%**	**15%**	**21%**	**27%**	**8%**
Funding shortfall[14]	$0	$0	$0	$ 20,470,232	$ 133,110,000
Pro rata reduction (cut)	n/a	n/a	n/a	7.5%	15.5% (individ.) 25.5% (consortia)

[10] *See* USAC RHC CIRCUIT – FIRST QUARTER 2017, https://www.usac.org/rhc/telecommunications/outreach/newsletters/2017/q1.aspx.

[11] *See* USAC Glossary of Terms, https://www.usac.org/rhc/tools/funding-commitments/glossary-terms.aspx. For FY 2017, a significant number of funding requests apparently have been neither approved nor denied and so remain on hold.

[12] For FY 2013-2015, see USAC historical funding commitments data available at https://www.usac.org/rhc/tools/funding-commitments/archive/funding-commitments-archive.aspx; for FY 2016 requested funding, see USAC FY 2016 funding information available at https://www.usac.org/rhc/tools/funding-commitments/archive/default.aspx; for FY 2017 requested funding, see USAC FY 2017 funding information available at https://www.usac.org/rhc/tools/funding-commitments/prorata-factors.aspx. *See also* USAC RURAL HEALTH CARE COMMITTEE BRIEFING BOOK at 22 (July 24, 2017) (reporting total gross programmatic demand for FY 2017at the close of the filing window of $567,276,742), https://www.usac.org/_res/documents/about/pdf/bod/materials/2017-07-24-rhc-briefing-book.pdf.

[13] For FY 2013-2015 approved requests, see commitments referenced in the preceding table; for FY 2016 approved requests, for FY 2016 requested funding, see USAC FY 2016 funding information available at https://www.usac.org/rhc/tools/funding-commitments/archive/default.aspx; for FY 2017 approved requests, see USAC FY 2017 funding information available at https://www.usac.org/rhc/tools/funding-commitments/prorata-factors.aspx.

[14] Shortfall = Program Funding Available (the $400 million cap less USAC administrative expenses) - Net Demand.

The table above includes all funding years since implementation of the Healthcare Connect Fund. For FY 2017, the year-over-year growth in Gross Demand was much lower than any recent funding year, while the apparent denial rate – which can help project what the eventual *pro rata* reductions might be – turned out to be much lower than in any recent funding year.[15]

Finally, the Commission in December 2017 waived the $400 million cap so that unused Rural Health Care program funding from prior years would be available for FY 2017 (with priority given to individual applicants as compared to applicants that applied as part of consortia).[16] Ultimately only $31 million in unused funding from prior years was available in FY 2017 to offset funding cuts.[17] With this $31 million in additional funding for FY 2017 and the scant $11 million increase in year-over-year funding requests for FY 2017, it was reasonable for applicants to expect that the funding shortfall for FY 2017 would have been *lower* than in FY 2016 or eliminated altogether. Instead, it appears that because more funding requests were deemed potentially eligible (as reflected in a denial rate that was far lower than in the past), the funding shortfall *increased* from $20 to $133 million in FY 2017.

C. Impact of the FY 2017 Cuts on Program Participants

Participants in both components of the Rural Health Care program (the Healthcare Connect Fund and the Telecommunications Program) will be imminently and irreparably harmed by the FY 2017 funding cuts. For example, The Evangelical Lutheran Good Samaritan Society

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[15] Because some FY 2017 funding requests remain on hold, the denial rate for FY 2017 could change.

[16] *See NPRM & Order*, ¶¶ 109-110. Universal service funding is collected and held in reserve for commitments and appealed funding denials (among other things). Unused funding occurs when funding commitments from previous years are not fully utilized, or when funding reserved for appeals is no longer needed.

[17] *See* USAC FY 2017 funding information, available at https://www.usac.org/rhc/tools/funding-commitments/prorata-factors.aspx.

(one of the largest providers of skilled nursing facilities in the country) has recently filed a letter in this docket explaining the harm caused by these funding cutbacks.[18]

In addition (as shown in the attached Declaration), forty-four participants in the North Carolina Telehealth Network ("NCTN") will see their share of the costs associated with their broadband subscription rates go from 35% of the cost to 52%, retroactive to July 1, 2017. This increase in costs affects local health departments, critical access hospitals, and federally qualified health centers ("FQHCs"). Because of the timing of the cuts, most of these entities have already submitted their 2017-18 fiscal budgets and in some cases will now have to cut other programs to meet these unexpected costs, potentially impacting network security, service quality, and patient care. The smaller the health care organization, the greater the potential impact.[19]

A connection to NCTN provides security and a high degree of network performance and reliability that is necessary for important telehealth applications such as Telestroke, which requires rapid transmission of very large CT images for emergency remote diagnosis. For example, Eastern North Carolina critical access hospitals use their NCTN connections to participate in the Telestroke network supported by experts at Wake Forest Baptist Hospital in Winston-Salem, N.C. Rural Health Care universal service subsidies help ensure that NCTN network connections capable of supporting this Telestroke program are affordable for these small rural providers. Because of the FY 2017 funding cuts, some of these health care providers will be unable to continue to obtain NCTN connections – or may decide that it is not worth the financial uncertainty to participate in NCTN.[20]

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[18] Letter from Dan Holdhusen, Director of Government Relations, The Evangelical Lutheran Good Samaritan Society, to Chairman Ajit Pai, FCC, WC Docket Nos. 17-310, 02-60 (filed Apr. 1, 2018).

[19] *See* Declaration of Dave Kirby, Project Manager, NCTN, at 1.

[20] *Id.* at 2.

In the Telecommunications Program there will be similar impacts, with greater severity in Alaska. Examples of these immediate and severe impacts are illustrated below. Mark Marlow, Chief Operations Officer for Alaskan behavioral health care provider, Akeela Incorporated (http://www.akeela.us), provided the following statement to SHLB:

> After fulfilling the Federal mandate of utilizing an Electronic Health Record database it became obvious that our existing statewide network infrastructure was outdated and unable to accommodate the new larger data flow across our narrow bandwidth. Faced with a growing need for a reliable high-speed, wide bandwidth network, we knew going out to bid to find answers to our increasing needs was paramount. Also because of our increased remote program needs for the use of a Tele-med system bringing psychiatric professionals across our network for children's behavioral mental health programs we had to expand our networks capabilities. These needs in Alaska are absolute and ever increasing. Because of the vast size of the state and the difficulty of its terrain the best connectivity with statewide services is through our provider's network infrastructure. Any reduction in RHC funding will severely affect our ability to provide program services to our many locations because of already limited funding by the state over the past several years. Our percentage of contribution for this usage is calculated and budgeted for annually and frankly, at this point any changes in the Federal funding will result in limited services or cutting of behavioral mental health services programs. The communities in all of Alaska are better served because of continued funding and especially in remote areas as well as central and South-central areas of greater population base.

In addition, Rhoda Jensen, Executive Health Director with the Yakutat Tlingit Tribe, provided the following statement on behalf of the Yakutat Community Health Center (https://www.yakutathealth.org):

> The Yakutat Community Health Clinic currently receives 10 Mbps on a Satellite link. This is insufficient with our electronic health records system and the 17-20 staff members we employ. Unfortunately, we have been unable to increase our bandwidth due to financial constraints, even though this limitation has had a negative impact on our business operations. Our ability to continue to provide quality healthcare services is now also being threatened even more by the proposed [FY 2017 funding] cuts. We currently pay $400 a month with the subsidy, but with the proposed increases, our costs will surge to $3,900 a month. This is an additional $42,000 we cannot afford, nor did we budget for in 2017. We are also alarmed at the prospect of costs increasing even more in 2018.

> Our organization, the Yakutat Community Health Center, recently invested in an electronic health record system (as is required by federal mandate) and have paid high costs to be on the same platform with other Tribal Health Organizations and regional hospitals. Using this system requires that we have internet access tor every patient encounter. Being on the same platform as other hospitals greatly improves our continuity of care for our patients, however our organization is going to have to make the hard choice of whether we can afford to continue to use this system if we can't afford to purchase internet access.
>
> It is interesting to me that rural healthcare clinics function much like the human body. Without the proper nutrition (or financial resources) the body (or health clinic) will cease to function properly. When federal agencies mandate laws and requirements of healthcare centers, but do not provide the financial resources to implement them, the clinics will fail and patients will suffer the consequences in the same manner as malnutrition affects the human body.

The following additional statements from Alaskan tribal health care providers were provided to A. Stewart Ferguson, Chief Information Officer, of the Alaskan Native Tribal Health Consortium (https://anthc.org), who shared them with SHLB:

> **Chugachmiut** (https://www.chugachmiut.org)
>
> The impact from cuts to the Rural Health Care Program are far reaching and will be devastating to Chugachmiut and the people we serve.
>
> Telemedicine has allowed us to dramatically improve access to care, accelerate diagnosis and treatment, avoid unnecessary medivacs, and expand local treatment options.
>
> It has also helped reduce Medicaid costs. Telemedicine services are used daily to provide care to the people we serve in 5 rural Alaska communities.
>
> A cut to these services would be catastrophic, and in turn, lead to cuts in other areas of healthcare services that we provide.
>
> **Yukon-Kuskokwim Health Corporation** (https://www.ykhc.org)
>
> We have been discussing how we can reduce the bandwidth [of] our circuits to help alleviate some of the costs going forward (assuming no fixes are made for the cap). The only way we could significantly reduce our bandwidth with our villages is to eliminate telehealth. As you know, telehealth is a critical tool for our care in the communities throughout our region, allowing face to face interaction, especially for our Behavioral Health patients. It would severely hamper treatment and counselling efforts in the region if we were [to] have to do this.

> As for how the shortfall will affect us this year, we need to refresh a large amount of equipment in our data center as well as around Bethel. This unbudgeted cost will prevent us from doing it this fiscal year. Much of our equipment is end of life/end of support and we could be dead in the water if any equipment goes on us. Additionally, we were planning on expanding our Cisco ISE system to further protect our network and [Protected Health Information] but may not be able to do so.

II. LEGAL STANDARD

The Commission may waive any of its rules where good cause is shown.[21] Waiver is appropriate where (i) special circumstances warrant deviation from the general rule, and (ii) such deviation serves the public interest.[22] As the Commission explained in the *Report & Order*:

> The Commission may exercise its discretion to waive a rule where (a) the particular facts make strict compliance inconsistent with the public interest, (b) special circumstances warrant a deviation from the general rule, and (c) such deviation will serve the public interest. In making these determinations, the Commission may consider evidence of hardship, equity, and more effective implementation of overall policy on an individual basis.[23]

The Commission has previously used its authority to waive the $400 million funding cap. In the December 2017 *Report & Order*, the Commission waived Section 54.675(a) only to allow unused funding from prior years to be committed above the $400 million funding cap for FY 2017. In finding good cause for such a waiver, the Commission found:

> If there is a proration in FY 2017, most RHC Program participants will have faced back to back cuts in their funding requests. Being mindful of the vital services RHC Program healthcare providers make available in their communities, we seek in this Order to bring some immediate relief in the event of a proration in FY 2017. . . .

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[21] 47 C.F.R. § 1.3.

[22] *See NE Cellular Tel. Co. v. FCC*, 897 F.2d 1164, 1166 (DC Cir. 1969).

[23] *NPRM & Order* at ¶ 108 (citing *Northeast Cellular*, 897 F.2d at 1166; *WAIT Radio v. FCC*, 418 F.2d 1153, 1159 (D.C. Cir. 1969)).

> We find that the anticipated hardship that would be imposed on healthcare providers from proration in FY 2017 justifies good cause for waiver of certain rules to effectuate this relief.[24]

In finding it was in the public interest to effectuate the limited waiver of Section 54.675(a), the Commission explained:

> Due to the unique circumstances presented by the impact of proration on healthcare providers, we believe this limited waiver is appropriate and in the public interest. The need to prorate RHC Program support in FY 2016—for the first-time ever—placed an unexpected new payment obligation on healthcare providers. Prorating support again in FY 2017 could further exacerbate this impact on healthcare providers.[25]

The Commission concluded finally that "any potential cost to the RHC Program that could result from this Order will be minor and is outweighed by the benefits of our action."[26]

III. THE COMMISSION SHOULD IMMEDIATELY WAIVE THE $400 MILLION RURAL HEALTH CARE FUNDING CAP AND FULLY FUND APPLICANTS IN ORDER TO AVOID EXTREME FINANCIAL HARDSHIP TO HEALTH CARE PROVIDERS ACROSS THE NATION

For each and all the reasons set forth below, the Commission should promptly grant this emergency request to waive Section 54.675(a) of its rules and fully fund eligible funding requests until the current open rulemaking in the Rural Health Care program has concluded.

A. Special circumstances demonstrate good cause for a waiver in FY 2017 because of financial hardship to health care providers caused by the unexpected size and timing of the funding cuts.

The Commission has recognized the negative impact of Rural Health Care program funding cuts in FY 2016 on "the vital services RHC Program healthcare providers make available in their communities" – and further recognized that these impacts represented a hardship that

[24] *Id.* at ¶¶ 107-108.

[25] *Id.* at ¶ 110.

[26] *Id.* at ¶ 114.

would be made greater by "back to back cuts in their funding requests" if reductions occurred in FY 2017 also.[27] This was the Commission's justification for a limited waiver of Section 54.675(a) to allow rollover of unused funding for FY 2017, finding that the financial hardship of back-to-back Rural Health Care funding reductions on health care providers represented unique circumstances meeting the waiver standard.

The rationale for granting SHLB's request for a full waiver of Section 54.675(a) is almost identical to the unique circumstances identified by the Commission in December 2017, except that the size of the FY 2017 funding cuts, even after application of the rollover funding, were much larger than expected and an order of magnitude greater than the FY 2016 cuts, causing even greater financial hardship than what the Commission already has recognized. Section I.C. above provides examples in both the Healthcare Connect Fund and the Telecommunications Program, and in both the lower 48 and in Alaska, of rural health care providers that will be imminently and significantly harmed by the FY 2017 cuts, potentially impacting the availability of life-saving health services and the quality of patient care. Many more examples are available.

Finally, we believe it was the Commission's intention that the rollover funds provided in FY 2017 would eliminate the need for back-to-back cuts in program funding. For reasons outlined above, this did not occur. We strongly agree with the Commission, however, that back-to-back cuts remain a substantial and unwarranted hardship on program participants and must be avoided. We urge the Commission to avoid this hardship by promptly granting this waiver and fully funding Rural Health Care program applications for FY 2017.

[27] *Id.* at ¶ 107.

B. Waiving the cap until a revised cap is established with reasonable protections to reduce funding uncertainty will serve the public interest.

As harmful as the amount of the funding reductions will be on health care providers, announcing those reductions over eight months into the funding year undermines the universal service principles of sustainability and predictability and is otherwise not in the public interest. Put simply, it is not realistic to expect anyone to purchase a product or enter a long-term subscription for a service without knowing in advance the price for that product or service. Asking non-profit health care organizations, many serving impoverished rural communities and operating on razor-thin financial margins, to do this is not sound public policy and does not serve the public interest. Indeed, health care organization that need Rural Health Care funding the least are the ones most able to tolerate this type of uncertainty, with the most financially needy organizations more likely to simply give up and leave the program.[28]

We recognize that USAC might have released funding commitments sooner this year but for the Commission's December 2017 decision to allow unused rollover funding, but this does not mitigate the impact of this delay on health care providers. We also recognize that the Commission has allowed service providers to "forgive" some or all the 2017 funding shortfall.[29] However, service providers are unlikely to be able to afford to forgive such a drastic reduction in support from the program. Further, we remain concerned that this kind of temporary fix will discourage service providers from participating in the program. For example, the FY 2017 cuts now may mean carriers are being asked to provide services at a loss, creating a strong disincentive to participate in the program in future years. Subjecting applicants and service providers to the type

[28] *See Kirby Declaration* at 1-2 (noting greater price sensitivity of the smallest and more financially challenged program participants).

[29] *See NPRM & Order* at ¶¶ 111-113.

of annual uncertainty we have seen in both FYs 2016 and 2017 – with essentially retroactive funding cuts fluctuating from 7.5% to 25.5% – is not commercially tenable and is not sound public policy.

Lastly, we note that the fluctuation in the apparent "denial rate" has destroyed any illusion that the cuts could be predicted based on the gross demand numbers reported by USAC at the start of each funding year. As we noted above, the "gross" demand amounts for FY 2016 and FY 2017 were very similar. Had the denial rate remained somewhat constant with prior years, and had no rollover funding been made available, the 2017 funding cuts would have been smaller than the FY 2016 cuts (or even eliminated altogether). Obviously, this expectation did not materialize, further undermining statutory policies of sufficiency and predictability for universal service as well as the trust and faith in the program, including its administration by both the Commission and USAC.[30]

SHLB strongly believes the Rural Health Care program cap should be substantially increased to ensure the program is meeting statutory objectives (and bring better parity with its "sister" USF programs). A larger Rural Health Care program that avoids significant retroactive funding reductions such as those encountered in FY 2016 and FY 2017 would obviously avoid hardship and disruption to program participants in the future. Eliminating the funding uncertainty we saw in FY 2016 and FY 2017 and ensuring that sufficient funds are available for the program is in the public interest and essential to meeting Congressional objectives for universal service.

[30] 47 U.S.C. § 254(b)(5).

C. Strict application of the Rural Health Care program funding cap in FY 2017 is unreasonable and inconsistent with the public interest because the current cap has no reasonable factual basis.

Like many commenters in the current rulemaking, SHLB welcomed the Commission's willingness to consider raising the current $400 million programmatic cap. Even the two commenters who did not support an immediate cap increase recognized how much has changed since 1997 when the current cap was promulgated.[31] Indeed, there is no question that the current cap is based on factual assumptions – about bandwidth needs, bandwidth costs, and the number of eligible program participants – that are completely out-of-date. Although some, including SHLB, have questioned whether the statutory language for the RHC program permits a cap, at least for the Telecommunications part of the Rural Health Care program, there is no question Congress did not require or suggest the Commission adopt a cap for the Rural Health Care program, and the Joint Board on Universal Service did not recommend one.

Setting aside whether the statute authorizes (or does not preclude) some type of spending cap (or budget), the Commission still bears the burden of establishing a reasonable factual basis for any cap it imposes. The current $400 million cap, based as it is on factual assumptions made in 1997 and which are demonstrably outdated, does not meet that burden. Assumptions underlying the current cap also do not reflect changes to the program such as the creation of the Healthcare Connect Fund in 2012 and the addition of thousands of SNFs to the program by Congress in 2016.

Up until now, the arbitrariness of the current cap assumptions had not inflicted substantial hardship on rural health providers, but that has changed as of FY 2017. The way the program was implemented this year (discussed above), imposing draconian and retroactive funding cuts many

[31] *See* SHLB RHC NPRM Reply Comments at 5 (noting USTelecom recognized "transformative changes in the healthcare industry and the program itself since 1997 have increased demand for rural telehealth and telemedicine services.") (citing USTelecom RHC NPRM Comments at 6).

months after health care providers had budgeted costs and entered into binding contracts for products and services, cuts that were far beyond what could have been reasonably anticipated given publicly available information, do not satisfy any sort of public interest analysis. Many program participants are small non-profit health care providers serving rural populations facing disproportionate health and economic challenges and operating on razor-thin financial margins. Until the cap can be revised and procedures put in place to mitigate funding reductions and/or cause them to be disclosed earlier in the funding cycle, the current $400 million funding cap should be suspended, and applications should be fully funded.

IV. CONCLUSION

WHEREFORE, good cause having been shown, the Commission should immediately grant this petition, waive Section 54.675(a) and fully fund eligible applications for FY 2017 until the open rulemaking considering the appropriateness and size of the $400 million Rural Health Care Program funding cap is concluded and takes effect.

Respectfully submitted,

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April 3, 2018

DECLARATION OF DAVE KIRBY

My name is Dave Kirby. I am the Director of the North Carolina Telehealth Network (NCTN). NCTN was established in 2010 as part of the Rural Health Care Pilot Program. NCTN finished migrating all of its participating sites to the Healthcare Connect Fund in 2016. Over 58 percent of NCTN participating sites are rural. A predictable source of funding through the Healthcare Connect Fund remains vital to all of our participating sites, but especially those located in rural areas or that otherwise serve our rural residents. Below is an overview of how we anticipate the unexpectedly large funding year 2017 Rural Health Care program funding cuts will impact NCTN, cause financial harm to many of its participating sites, and potentially impact the availability of critically needed health services.

Forty-four NCTN healthcare provider organizations will see their broadband subscription rates increase by nearly 50% with this reduction in discounts. Over half of these providers are rural. Of these, almost all are either local health departments, critical access hospitals, or FQHC's. In other words, the providers which most need the discounts and are the highest priority for the Healthcare Connect program are being hit disproportionately by the reduction in discounts.

In addition, the timing of the discount falls after most of these organizations have submitted their budgets for the 2017-18 fiscal year. Particularly for the smaller providers with their slim operating margins, these organizations will inevitably struggle to adjust their budgets to accommodate the dramatic increase in subscription rates. In most cases, they will need to cut other programmatic priorities to accommodate this increase. The smaller the organization, the greater will be the challenge.

NCTN is a dedicated broadband network that enables its rural providers to communicate effectively across different sites within their organization and to connect to urban, tertiary care centers for intensive, expert acute care. In a number of cases, like the Telestroke network that links rural Eastern North Carolina critical access hospitals with Wake Forest Baptist's stroke experts, the performance and reliability of the network is a life-and-death matter. All these hospitals will be subject to the reduction in discounts.

Ultimately, this reduction in discounts will reduce the incentive that all NCTN subscribers have to join or continue with the Healthcare Connect program, but this disincentive is particularly important for the smaller, rural providers. These providers are very price-conscious, so they frequently opt for services with poorer performance at a lower price. Compounded by their limited technical support, less reliable services with less consistent performance will impact clinical operations since most providers now rely on distributed digital services to manage their operations and provide clinical services. Ultimately, lower quality and costlier clinical operations will be the result of the reduction in their discounts. Cutting the discount rates for the rural NC providers will negatively impact all other Federal and North Carolina programs intended to enhance access to and improve the quality of care for rural North Carolinians.

The healthcare providers served by the North Carolina Telehealth Network (NCTN), who will have to provide additional funds from their budgets to cover the reduction in Healthcare Connect discounts, includes:

Albemarle Regional Health Services
Alexander County Health Department
Appalachian District Health Department
Beaufort County Health Department
Black River Health Services, Inc.
Burke County Health Department
Caldwell County Health Department
CarolinaEast Health System

CaroMont Regional Medical Center

Carteret County General Hospital

Carteret County Health Department

Chatham County Public Health Department

Daymark Recovery Services, Inc.

Duplin County Health Department

Edgecombe County Health Department

FirstHealth of the Carolinas

Greene County Health Department

Halifax County Health Department

Henderson County Department of Public Health

Hertford County Public Health Authority

Iredell Memorial Hospital, Inc

J. Arthur Dosher Memorial Hospital

Jackson County Department of Health

Jones County Health Department

Lenoir Memorial Hospital

Lincoln County Health Department

Macon County Public Health Center (MCPHC)

Mission Health

Moore County Health Department

Moses H. Cone Memorial Hospital Operating Corporation

Nash General Hospital

NC Hospital Association

New Hanover Regional Medical Center

Northampton County Health Department

Pender Memorial Hospital, Inc.

Person County Health Department

Piedmont Health Services

Randolph Hospital, Inc.

Richmond County Health Department

Southeastern Regional Medical Center

UNC Rockingham Hospital (Morehead)

University of North Carolina Health Care System

Urban Ministries of Wake County (Open Door Clinic Program)

Vidant Health

WakeMed Health & Hospitals, Inc.

D. David Kirby — *April 2, 2018*

Dave Kirby — Date
Director of the North Carolina Telehealth Network