

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

In the Matter of

California Telehealth Network
Request for Review of Decision
of the Universal Service Administrator

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CC Docket No. 02-60

**REQUEST FOR REVIEW OF DECISION OF THE
UNIVERSAL SERVICE ADMINISTRATOR**

Jeffrey A. Mitchell
LUKAS, NACE, GUTIERREZ & SACHS, LLP
8300 Greensboro Drive
Suite 1200
McLean, VA 22102
(703) 584-8678

Counsel for California Telehealth Network

December 20, 2013

Table of Contents

SUMMARY i

I. STATEMENT OF INTEREST..... 2

II. STATEMENT OF FACTS..... 3

 A. Funding Application Process in the RHC Pilot 3

 B. Health Clinics in the RHC Pilot Program 6

 C. Enter the Healthcare Connect Fund 6

 D. CTN, the RHC Pilot, and the Transition to HCF 8

III. ARGUMENT..... 10

 A. Health Clinics Should Not Be Considered Ineligible Solely Because They Are
 Non-Rural 11

 1. USAC Erred in Changing Prior Practice Regarding Non-Rural Health
 Clinics 11

 2. HCPs Providing Clinical Care in a Consortium that is Majority Rural
 Should Be Considered Eligible..... 11

 3. The Commission Has Rejected Formalistic Definitions of the HCP Types
 Listed in the Act..... 13

 B. A Substantive Change in Policies Regarding HCP Eligibility Criteria Is Improper
 Absent Notice and an Opportunity for Public Comment..... 15

 C. If the Commission Concludes that a Change in HCP Eligibility Criteria Was
 Proper, the Effective Date Should Be the Date New Programmatic Forms Were
 Approved 16

IV. REQUEST FOR RELIEF...... 17

V. CONCLUSION 18

SUMMARY

California Telehealth Network asks the Commission to reverse a decision of the universal service administrator (USAC) denying eligibility in the Rural Health Care (“RHC”) program to 29 non-rural health clinics. While USAC has long considered such clinics eligible, USAC claims the recent Healthcare Connect Fund (“HCF”) Order changed the rules regarding health care provider (“HCP”) eligibility. But USAC does not identify any language in the HCF Order that can be construed to make such a change. Instead, USAC contends that a change in back-end processes for inputting HCF application data into its systems signaled this major policy shift.

The Commission should not allow policy changes of this magnitude to be implemented in such a fashion. Non-rural clinics are vital to the sustainability of large statewide consortia such as CTN – the very consortia the Commission through implementation of the HCF seeks to encourage. There was no conceivable notice from either USAC or the Commission that such a change in policy was imminent. As result CTN, individual clinics, and large health systems with clinics that participate in CTN, have all been surprised. USAC’s decision introduces considerable uncertainty which is reducing the attractiveness and viability of the HCF itself. At a minimum, the Commission should reverse the USAC decision pending notice to all RHC stakeholders and an opportunity to comment.

Finally, if the Commission upholds the USAC decision, it should change the effective date to September 9, 2012 – the day the new HCF programmatic forms were approved for use. The Commission should also grandfather any non-rural clinic that was previously determined to be eligible by USAC in the RHC pilot program. Finally, to avoid future confusion on the scope of the seven statutory eligibility categories for HCPs, the Commission should direct USAC to publish the administrative criteria it uses to determine HCP eligibility.

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California Telehealth Network (“CTN”), by its attorney and pursuant to sections 54.719(c), 54.720, 54.721, and 54.722 of the rules of the Federal Communications Commission’s (“FCC” or “Commission”), files this Request for Review (“Request”) of a decision by the Rural Health Care Division (“RHCD”) of the Universal Service Administrative Company (“USAC”) dated October 22, 2013 (“Decision”).¹ The Decision denies eligibility to 29 non-profit health care providers in the universal service program for Rural Health Care (“RHC”) because they are “Urban Health Clinics.” Since as early as 2008 USAC had considered such entities eligible for Rural Health Care program subsidies when part of a consortium of HCPs that met certain other requirements. However USAC appears to have concluded that a minor change in the way RHCD processes applications for the newly enacted RHC Healthcare Connect Fund (“HCF”) represented a significant change in FCC policy regarding the eligibility of such entities.

The policy change in HCP eligibility reflected in the Decision will undermine CTN as well as the Commission’s ambitious goals for the HCF. Accordingly, CTN respectfully requests the

¹ Letter from RHCD to Eric Brown, California Telehealth Network (Oct. 22, 2013). (Attached as Exhibit 1.)

Commission clarify that no change in policy regarding the status of clinic HCPs in non-rural areas has occurred, and direct USAC to continue its previous practice – particularly given this issue was *never* considered as part of the RHC rulemaking that led to the HCF.² If the Commission determines that a policy change regarding the classification of non-rural health clinics is warranted, it should implement such a change only after proper notice to CTN and other program stakeholders, and to make such a change on a prospective basis only. Finally, if the Commission upholds the Decision, it should find that the effective date for the change in policy is September 9, 2013, the date notice appeared in the Federal Register of Office of Management and Budget (“OMB”) approval of the information collections required for the new HCF application forms.³

I. STATEMENT OF INTEREST

CTN is a consortia of rural and urban HCPs across California who are participating in the Commission’s federal universal service program for Rural Health Care. CTN is also the lead entity for the CTN consortium, responsible for submitting and certifying applications to RHCD for RHC support on behalf of its eligible HCP participants. Formed and developed by a broad based group of public, private and stakeholder organizations (www.caltelehealth.org), CTN directly serves over 270 California HCPs including direct or networked connections to California’s academic medical centers, tribal health facilities, Critical Access Hospitals, Federally Qualified Health Centers, and county and municipal health facilities. As a nonprofit corporation, CTN also operates the California Telehealth Resource Center, which receives funding from the Health Resource and

² See *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Notice of Proposed Rulemaking, 25 FCC Rcd 9371 (2010) (*NPRM*); *Wireline Competition Bureau Seeks Further Comment on Issues in the Rural Health Care Reform Proceeding*, WC Docket No. 02-60, Public Notice, 27 FCC Rcd 8185 (Wireline Comp. Bur. 2012) (*WCB Public Notice*); *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 27 FCC Rcd 16678 (2012) (*Healthcare Connect Fund Order* or *HCF Order*).

³ See 78 Fed. Reg. 54,967 (Sept. 9 2013).

Services Administration (“HRSA”) at the Department of Health and Human Services (“HHS”) to provide technical and programmatic assistance and training to healthcare providers in California.

CTN was founded as a participant in the Rural Health Care pilot program (“RHC Pilot”) which provided CTN with a \$22.1 million funding award, the largest single-state award of its kind. Additional funding for CTN was provided by the California Emerging Technology Fund, the California Health Care Foundation, the California Teleconnect Fund, the National Coalition for Health Integration, United HealthCare, and the University of California. CTN is today fostering access to advanced telecommunications infrastructure across California that allows rural and urban communities access to a broad range of technology-enhanced services to improve the quality of healthcare. CTN’s goal is to bridge the growing divide between urban and rural, and between served and underserved, by connecting over 800 California healthcare providers to a state- and nation-wide broadband network dedicated to healthcare.

II. STATEMENT OF FACTS

CTN is a 501(c)(3) that serves as the lead entity for a consortium of HCPs that has been participating in the Commission’s RHC Pilot since November 2007. Eligible HCPs participating in CTN began receiving supported eligible services through the RHC Pilot in May 2011. CTN is now participating in the FCC’s new Healthcare Connect Fund (“HCF”).

A. Funding Application Process in the RHC Pilot

CTN was one of 69 projects across the country selected by the FCC for the RHC Pilot. Each project was given a funding “award” which represented a “maximum support amount” set by the FCC, based on the approved scope and design of their RHC Pilot proposal.⁴ To receive

⁴ See *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 22 FCC Rcd 20360, 20374, ¶35 (2007) (*Pilot Selection Order*); *id.* at 20429, Appendix B.

funding, however, USAC had to approve funding commitments in response to specific funding requests submitted by each project. These funding request were submitted on FCC forms previously approved for use in the regular or “primary” RHC program.⁵

RHC Pilot projects submitted the FCC Form 465 to request supported services from vendors and to certify to USAC which HCPs participating in the consortium were eligible for RHC support; and the FCC Form 466-A to request support for specific eligible services for specific eligible HCPs. These application forms had been designed for the primary RHC program which, among other differences from the RHC Pilot, awarded support only on an individual HCP basis. To address the need to support networks through a single funding commitment, the *Pilot Selection Order* included several spreadsheet-like “attachments” that could be submitted with each form as part of the application process.⁶ This allowed the lead entity to submit a single form on behalf of the many HCPs participating in the network consortium – with entity-specific information reflected in the respective attachment.⁷

However, the use of form “attachments” did not fully address the mismatch between using FCC forms designed for the primary RHC program in the RHC Pilot. For example, one innovation of the RHC Pilot was, for the first time, providing universal service support for non-rural HCPs, provided they were part of a network that included HCPs serving rural areas.⁸ Yet the FCC Form

⁵ *Id.* at 20403, ¶ 83.

⁶ *Id.* at 20435-45, Appendices E, F, G. The various attachments were the “FCC Form 465 Attachment”, the “FCC Form 466-A Attachment”, and the “FCC Form 466-A Network Cost Worksheet”.

⁷ *See id.* at 20405, ¶ 86 (“[F]or purposes of administrative efficiency, selected participants may submit one master FCC Form 465, provided the information contained in the FCC Form 465 identifies each eligible health care provider participating in the Pilot Program and is included in an attached Excel or Excel compatible spreadsheet.”).

⁸ *See id.* at 20367, ¶ 16.

465 required each to make the following certification (among others) under penalty of perjury: “I certify that the health care provider is located in a rural area.”⁹

USAC, in implementing the RHC Pilot application process, ultimately developed its own versions of the attachments which differed somewhat from what the FCC included in the *Pilot Selection Order*, and which USAC required each RHC Pilot project to use. USAC’s spreadsheet versions of the attachments included certain automated features such as fields with drop-down menus in which the applicant could select from pre-defined categories. These changes were presumably intended to help with administrative efficiency, but they also served to address some of the confusion caused by use of primary RHC program forms – including confusion caused by the FCC Form 465 requiring projects to certify rurality under penalty of perjury even though the RHC Pilot expressly allowed non-rural HCPs.¹⁰

Of relevance here, “Column 27(b)” of the USAC Form 465 attachment spreadsheet corresponded to the “Eligible Entity Type” column of the Form 465 attachment included by the FCC in Appendix E of the *Pilot Selection Order*. USAC’s Column 27(b) provided a drop-down Excel field containing a pre-defined list of eligible-entity categories that included “10: Urban Health Clinic.”¹¹ USAC recognized such entities as eligible for support under the RHC Pilot.

⁹ See FCC Form 465, Line 35 (2008).

¹⁰ In addition, the wording of the FCC Form 465 certification addressed a single HCP even though a single-form’s certification was assumed to apply to the attachment which could contain hundreds of HCPs – both eligible and ineligible (or partially eligible), and rural and non-rural.

¹¹ Other Column 27(b) categories included:

- 11: Other (ineligible) entity
- 2: Community health center or health center providing health to migrants
- 4: Community mental health center
- 5: Not-for-profit hospital
- 6: Rural health clinic

B. Health Clinics in the RHC Pilot Program

The Commission in the *Pilot Selection Order* strongly suggested that a variety of entities could qualify as “clinics” that were eligible HCPs. For example, in approving various RHC Pilot awards, the Commission made positive reference to “correctional facilities’ clinics”¹² and “local hospitals and their associated clinics” that would be served.¹³ Similarly, in accepting one RHC Pilot application, the Commission noted approvingly: “The [applicant’s] goal is to connect all 50 rural hospitals and 76 rural clinics to the state network. . . .”¹⁴ The term “clinic” was thus used generically and functionally, to designate a health care location in which clinical care was provided.

This functional use of the term “clinic” was in keeping with earlier precedent in which the Commission held that “dedicated emergency departments in *for profit* rural hospitals constitute [eligible] ‘rural health clinics.’”¹⁵ The Commission has thus long recognized as eligible HCPs clinics that were not, strictly speaking, “rural health clinics” as that term may be narrowly defined in other statutes and implementing regulations.¹⁶

C. Enter the Healthcare Connect Fund

On December 12, 2012, the FCC issued the *HCF Order*. The *HCF Order* adopted many policies first introduced as part of the RHC Pilot. For example, the HCF continued the practice of allowing non-rural HCPs to receive support when participating in a consortium containing rural

¹² See *Pilot Selection Order* at 20388, ¶ 53.

¹³ *Id.*

¹⁴ See *id.* at 20377, ¶ 40

¹⁵ See *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 18 FCC Rcd 24546, 24553-55, ¶ 14 (emphasis added) (2003) (*2003 Report and Order*); see also *id.* ¶¶ 13-16.

¹⁶ See 42 C.F.R. § 405.2401 (defining “rural health clinic” for purposes of Medicare reimbursement under the Social Security Act, 42 U.S.C. sections 1302 and 1395hh).

HCPs. The HCF continued this policy with some changes including: whereas the RHC Pilot required the number of eligible rural HCPs in a consortium network to be non-*de minimus*, the HCF required a majority of eligible HCPs in the consortium to be rural.¹⁷ Notably, in fashioning the HCF rule regarding the percentage rural, the Commission took careful note of the percent of HCPs in each RHC Pilot that were non-rural.¹⁸

The Commission also took the welcome step of “grandfathering” RHC Pilot projects – such as CTN – that met the old *de minimus* standard but that would not meet the new majority-rural standard:

For purposes of the majority rural requirement, we “grandfather” non-rural HCP sites that have received a funding commitment through a Pilot project that has 50 percent or more non-rural HCP sites with funding commitments as of the adoption date of this Order.¹⁹

Nowhere in the *HCF Order* does the Commission address the issue of certain non-rural HCPs no longer being eligible under the HCF, or suggest that the definition of what constituted a “rural health clinic” was changing.

The *HCF Order* also authorized RHC Pilot participants such as CTN to qualify for HCF funding beginning July 1, 2013 (versus January 1, 2014, for new HCF participants).²⁰ The FCC anticipated, however, that new HCF program forms needed by RHC Pilot projects would not be approved by OMB in time. Accordingly, the Commission allowed RHC Pilot participants such as CTN to apply for HCF support using RHC Pilot forms – *i.e.*, the FCC Forms 465, 466-A and

¹⁷ See *HCF Order*, 27 FCC Rcd, at 16707, ¶ 61.

¹⁸ *Id.* at 16704, ¶ 57 (noting that approximately 34 percent of the 3,822 Pilot project sites consisted of non-rural eligible HCPs). USAC’s change in the definition of eligible non-rural HCP presumably affects these percentages.

¹⁹ *Id.* at 16707, ¶ 62.

²⁰ *Id.* at 16818, ¶ 353.

associated attachments.²¹ The new forms for HCF were approved for use by OMB on September 9, 2013.²²

Notably, under the HCF, there were no “attachments” for the corresponding new program forms that would have been equivalent to the attachments used in the RHC Pilot. Rather, the FCC and USAC apparently anticipated a fully paperless filing process for the HCF in which the “attachment” functionality would be designed into a web-based system that allows a single lead entity to upload information associated with the many HCPs that may be part of a single application.²³

D. CTN, the RHC Pilot, and the Transition to HCF

Between May 2011 and November 2012, USAC approved for funding in the RHC Pilot no fewer than 71 CTN HCPs that were classified as eligible under the “10: Urban Health Clinic” category. Between when the *HCF Order* was released and the Decision, there was no formal communication from USAC or the FCC suggesting that the *HCF Order* changed the status of these “urban health clinics.”²⁴ Accordingly, CTN continued to communicate with participants and prospective participants that included health systems with non-rural health clinics that such clinics remained eligible for RHC support under the HCF.

²¹ *Id.* at 16821, ¶ 361 (“We permit [RHC Pilot projects] to use the same forms they used in the Pilot Program to secure [transitional HCF] funding. . .”).

²² See 78 Fed. Reg. 54,967 (Sept. 9 2013) (approving new FCC Forms 460, 461, 462, 463).

²³ See generally, USAC HCF Training for Consortium Leaders, Consortia: Overview of FCC Forms, http://www.usac.org/res/documents/RHC/training/2013/2013-HCF-Fall-Training-Forms-Overview_Consortia.pdf (last checked Dec. 17, 2013) (Slide 17 indicates that information for consortium participants will be uploaded through web portal).

²⁴ For example, the FCC’s “Healthcare Connect Fund – Frequently Asked Questions” has a section addressing “Healthcare Provider Eligibility” which does not address the issue. See <http://www.fcc.gov/encyclopedia/healthcare-connect-fund-frequently-asked-questions> (last checked Dec. 16, 2013).

On August 9, 2013, CTN submitted an “FCC Form 465 Package” (pursuant to the *HCF Order*, using the “old” forms) seeking HCF funding for HCP participants, including those 29 HCPs that are the subject of this Request. Notably, many of these entities had been previously submitted to USAC as part of a previous Form 465 under the RHC Pilot – and had previously cleared USAC’s RHC Pilot eligibility check. However for various reasons a funding commitment had not been requested and now CTN was seeking services for these entities through the HCF.

On October 22, 2013, RHCD responded with a determination that the 29 HCPs were not eligible for RHC support through the HCF. USAC explained the following (footnotes omitted):

In the Rural Health Care Pilot Program . . . entities that are “Urban Health Clinics” were eligible to participate and receive funding. The Pilot Program FCC Form 465 Attachment in Column 27(b) contained a dropdown menu with “Urban Health Clinic” as one of the Eligible Entity Types. Please note however that “Urban Health Clinic” is not an eligible entity type for purposes of the Healthcare Connect Fund.

Entities that participated in the [RHC Pilot] as an “Urban Health Clinic” and received funding via the issuance of a Funding Commitment Letter as of the adoption date of the Healthcare Connect Fund Order are eligible for funding as a “grandfathered entity” in the Healthcare Connect Fund. Alternatively, an “Urban Health Clinic” that meets the requirements of Section 330 of the Public Health Service Act may be classified as a “Community Health Center” for purposes of participation in the Healthcare Connect Fund.²⁵

USAC then determined that the 29 HCPs were not “Community Health Centers” and that they were also not “grandfathered entities” because they were not the subject of an RHC Pilot funding commitment issued prior to December 12, 2012, the date of the *HCF Order*.

Finally, CTN’s model for sustaining its ongoing administrative costs relies heavily on annual fees paid by or on behalf of participating HCPs. These fees currently amount to \$1,500 per year per site. Health systems with many HCPs have elected to participate in CTN based upon the

²⁵ See Decision, at 2.

understanding of what constitutes an eligible HCP that was operative in the RHC Pilot. Thus, the loss of 29 participating sites equates to a loss of substantial sustaining contributions from members, but also undermines incentives for health systems to participate in CTN – thereby further eroding sustainability. For example, many of the 29 denied HCPs are part of the Children’s Hospital of Oakland (“CHO”) system which is a current CTN participant.

III. ARGUMENT

The FCC took no discernable action in either the *HCF Order* or in the Paperwork Reduction Act Notice that accompanied submission of the HCF Forms to OMB²⁶ that provides a basis for changing the well-established policy of classifying certain non-rural health clinics as eligible HCPs. If the Commission decides to reinterpret the HCP eligibility categories to exclude non-rural health clinics, it should undertake to do so transparently, prospectively, and only after adequate notice and an opportunity to comment. In order to avoid a similar issue in the future – with numerous appeals signaling widespread disruption of other RHC Pilot networks²⁷ – the Commission should direct USAC to make public the criteria it uses to determine whether specific entities fall into the various HCP categories set forth in Section 254(h)(5)(B) of the Telecommunications Act²⁸ and 47 C.F.R. section 54.600(a).

²⁶ See 78 Fed. Reg. 39,286 (Jul. 1, 2013). In its Public Notice seeking specific comment on the new HCF forms, the Wireline Bureau similarly made no reference to this issue. See *Wireline Competition Bureau Seeks Comment on Healthcare Connect Fund FCC Forms 460, 461, 462, and 463*, WC Docket No. 02-60, Public Notice, DA 13-590 (Wireline Comp. Bur., Apr. 1, 2013).

²⁷ See Letter from Roger L. Holloway, President/CEO, Illinois Rural HealthNet to Linda Oliver, Deputy Chief, Telecommunications Access Policy Division, FCC Wireline Competition Bureau, WC Docket No. 02-60 (filed Nov. 21, 2013); Letter from Robert Jenkins, Program Manager, Colorado Telehealth Network to Marlene H. Dortch, Secretary, FCC, WC Docket No. 02-60 (filed Nov. 22, 2013); Letter from Kim Klupenger, Project Coordinator, Oregon Health Network to Marlene H. Dortch, Secretary, FCC, WC Docket No. 02-60 (filed Nov. 27, 2013).

²⁸ 47 U.S.C. § 254(h)(5)(B).

A. Health Clinics Should Not Be Considered Ineligible Solely Because They Are Non-Rural

1. USAC Erred in Changing Prior Practice Regarding Non-Rural Health Clinics

USAC in its Decision suggests that the absence of a “dropdown” menu on the HCF forms replacing the FCC Form 465 represents a policy change in HCP eligibility by the FCC. Significantly, however, the old FCC Form 465 never had such a “dropdown” menu. Indeed, the old FCC Form 465 and the new FCC Form 460 are identical in relevant respects in that they both provide an equivalent set of check boxes listing the seven HCP eligibility categories.²⁹ All that has occurred is a change in USAC’s back-end system for processing RHC application forms – from the use of manually submitted spreadsheet “attachments,” to a new functionally equivalent web-based portal. A change in back-end systems is not a legitimate basis for implementing such a significant policy change.

It is also irrelevant that USAC’s Form 465 attachment for the RHC Pilot included a check box for “urban health clinics.” Indeed, if the existence of the urban clinic check box is what rendered these HCPs eligible, then the fact that the *HCF Order* required CTN to use the old RHC Pilot forms in applying for HCF support should be dispositive and alone provides grounds for the Commission to reverse the Decision.

2. HCPs Providing Clinical Care in a Consortium that is Majority Rural Should Be Considered Eligible

The Commission has held that while it lacks authority to designate new HCPs, it can “clarify the types of entities that fit within [the] seven [statutory] categories.”³⁰ It was on this basis

²⁹ Compare FCC Form 465, Line 27 (2008) with FCC Form 460, Line 43 (2013). For purposes of the analysis below and to avoid confusion, we also refer to the “seven” HCP categories, even though “consortia of the above” is not a distinct type like the others.

³⁰ See 2003 Report and Order, ¶ 16.

the Commission previously recognized that Emergency Departments in for-profit rural hospitals were “public” health providers eligible in the “rural health clinic” HCP category. Thus the Decision addresses the following question: do health clinics that are not rural fit in one of the seven HCP types set forth in the statute? After saying “yes” for the last five years, USAC now says “no.” Setting aside for a moment the procedural issue of changing that answer without advance notice (addressed below), this subsection addresses arguments for continuing to consider certain non-rural health clinics as eligible HCPs.

Section 254(h)(1)(A) of the Telecommunications Act, which provides the statutory basis for the legacy “Telecommunications Program,” authorizes universal support only for HCPs located in rural areas. Section 254(h)(2)(A), which provides the statutory basis for the RHC Pilot and the HCF, authorizes the Commission to fashion policies to foster access to “advanced telecommunications and information services” for *any* eligible HCP – whether rural or urban. Up until now, for those RHC programs implemented pursuant to Section 254(h)(2)(A) – RHC Pilot and the HCF – this has meant with respect to each of the seven HCP types, an entity can be either rural or non-rural and qualify for support.

Notwithstanding this prior practice, of the seven entity types, “rural health clinic” concededly raises a unique question with respect to being non-rural. For example, while a “not-for-profit hospital” may be either rural or non-rural; can a “rural health clinic” also be either rural or non-rural? In the RHC Pilot, with the use of an “Urban Health Clinic” in the Form 465 attachment, USAC (with the presumed knowledge and acquiescence of Commission staff), answered that question in the affirmative. For the following reasons, and given the uniqueness of the RHC Pilot (where for the first time non-rural HCPs were eligible for RHC support), this was not an unreasonable conclusion.

The Commission appeared to recognize in the *Pilot Selection Order* that clinics serving prisons were considered eligible as were clinics associated with hospitals.³¹ For example, the Commission did not clarify – notwithstanding this first-time funding for *non-rural* HCPs – that such clinics nevertheless had to always be rural. Put another way, if the Commission intended clinics alone to be eligible *only when rural*, then it was reasonable to expect it would have said so. Under these circumstances, it would not have been unreasonable for USAC to conclude that such clinics could be eligible HCPs whether located in rural or urban areas.

Moreover, the mismatch between the old RHC program Form 465 and the RHC Pilot certainly meant the form itself did not foreclose such an interpretation. As noted, those forms did not recognize – even expressly prohibited – funding for *any and all* non-rural HCPs. Thus, USAC and the RHC Pilot projects were effectively forced to routinely disregard aspects of the FCC Forms used to administer the RHC Pilot. At a minimum, this established that the eligibility categories listed on the forms designated by the FCC and used by USAC for the RHC Pilot were not necessarily dispositive on the question of non-rural clinic eligibility.

3. The Commission Has Rejected Formalistic Definitions of the HCP Types Listed in the Act

Although the non-rural clinics in the RHC Pilot were put into an “urban health clinic” category, these entities could alternatively classified as “community health centers.” RHCD’s reasoning in the Decision, however, suggests USAC has instead adopted a formalistic definition of the term “community health center” that is intended strictly follow the definition used in Section 330 of the Public Health Services Act.³²

³¹ See Section II.B., *supra*.

³² See *Decision*, at 2.

But the Commission has never taken such a formalistic approach to the definition of each HCP category and it should not allow USAC to do so now. The categorization of certain rural Emergency Departments as “rural health clinics” shows the Commission’s rejection of such an approach. Rather, the Commission should recognize that any statutory or regulatory definitions of the seven HCP types utilized by HHS (or by an equivalent state authority) can and should function as “safe harbors.” That is, any HCP that another state or federal agency recognizes as meeting one of the seven HCP definitions should be considered automatically eligible without further inquiry.³³ Any entity not so recognized, however, should be given an opportunity to establish that it fits functionally into the eligibility category.

USAC already engages in such a functional analysis with respect to “Community Mental Health Centers” for which USAC uses a questionnaire to establish that the HCP performs the functions necessary to be considered such an entity. A similar approach should be adopted for each of the eligible categories – with whatever criteria USAC uses to make its determinations made available to the public.

Alternatively or in addition, non-rural clinics that are owned or operated by an otherwise eligible not-for-profit hospital should be considered eligible under that HCP category. Such an approach need not conflict with the rule that requires “[e]ach separate site or location [to] be considered an individual health care provider for purposes of calculating and limiting support.”³⁴ That rule was promulgated for the legacy Telecommunications Program and is clearly intended to facilitate the calculation of support where the distance of a point-to-point connection is a relevant

³³ USAC or the FCC might even consider making public any lists of such entities maintained by HHS for this purpose.

³⁴ See 47 C.F.R. § 54.601(a)(2).

and necessary input.³⁵ Put simply, “calculating and limiting support” have nothing whatsoever to do with HCP eligibility or entity type.

B. A Substantive Change in Policies Regarding HCP Eligibility Criteria Is Improper Absent Notice and an Opportunity for Public Comment

The Decision states that “‘Urban Health Clinic’ is not an eligible entity type for purposes of the [HCF]” and cites 47 C.F.R. § 54.600(a).³⁶ However, there is no dispute that the list of seven eligible HCP types contained in the rules was unchanged by the *HCF Order*. Moreover, while the *NPRM* and the *WCB Public Notice* extensively addressed the matter of HCP eligibility, neither referenced nor addressed the specific issue of how non-rural health clinics were treated in the RHC Pilot and whether they would be treated differently in the HCF.³⁷

A change in the type of non-rural HCPs that are eligible for RHC support to exclude health clinics must be treated as a “rule” for purposes of the Administrative Procedure Act (“APA”) because it represents “an agency statement of general . . . applicability and future effect designed to implement . . . policy”³⁸ Adoption of a rule requires prior notice to the public, which the Commission failed to provide. Rather, the Decision implements an industry-wide rule with broad application without appropriate notice or an opportunity to comment, in violation of Section 553 of the APA.

³⁵ See *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776, ¶ 684 (1997) (internal citation omitted) (*First Report and Order*) (reflecting importance of the location where service is being provided in implementing bandwidth limitation in early RHC program in order to ensure support was predictable).

³⁶ Decision at 1.

³⁷ See, e.g., *NPRM*, 25 FCC Rcd at 9415-21, ¶¶ 114-127 (solely considering *expanding* the scope of the categories of HCPs to include, for example, renal dialysis centers); *WCB Public Notice*, 27 FCC Rcd at 8189-92 (considering whether to continue allow support for *any* non-rural HCPs, not any specific type of non-rural HCP).

³⁸ 5 U.S.C. § 551(4).

Section 553 requires that such notice shall include “either the terms or substance of the proposed rule or a description of the subjects and issues involved.”³⁹ Section 553 further provides that “[a]fter notice required by this section, the agency shall give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments”⁴⁰ These statutory provisions require the Commission to provide “sufficient notice” of a forthcoming rule that “affords interested parties a reasonable opportunity to participate in the rulemaking process.”⁴¹ Sufficient notice must, at a minimum, provide clear “notice of the scope of the regulations being proposed.”⁴²

C. If the Commission Concludes that a Change in HCP Eligibility Criteria Was Proper, the Effective Date Should Be the Date New Programmatic Forms Were Approved

Finally, in the event the Commission concludes that the phase-out of the USAC Form 465 attachment and its “urban health clinic” category did reflect or otherwise implement a change in the HCP eligibility criteria, then the only plausible effective date for such a change is the date the new programmatic forms became available for use. Therefore, the Commission should recognize that such a change did not occur until September 8, 2013, the date of OMB final approval of the new HCF programmatic forms. As such, the effective date of the new policy should be no earlier than this date.

In addition, CTN respectfully requests that any HCPs that were submitted to USAC as part of a Form 465 in the RHC Pilot and *which USAC previously approved as eligible* – whether or not a funding commitment was issued – be considered “grandfathered entities” under the HCF.

³⁹ 5 U.S.C. § 553(b)(3).

⁴⁰ 5 U.S.C. § 553(c).

⁴¹ *American Radio Relay League, Inc.*, 524 F.3d 227, 242 (D.C. Cir. 2008).

⁴² *Forester v. Cons. Prod. Safety Comm’n*, 559 F.2d 774, 788 (D.C. Cir. 1977).

Because CTN lacked any notice of an impending change in FCC policy on non-rural health clinics, such clinics (who had already been deemed eligible) were denied the opportunity to seek a funding commitment before issuance of the *HCF Order*. Accordingly, there is good cause for granting this request.

IV. REQUEST FOR RELIEF.

CTN respectfully requests, pursuant to 47 U.S.C. sections 254(h)(2)(A), (h)(5), and 47 C.F.R. sections 54.600-601, and 54.630, that the Commission grant this Request and instruct USAC to rescind the Decision and find the 29 affected CTN HCPs eligible for HCF support. In order to avoid confusion in the future regarding the statutory HCP categories, CTN requests the Commission direct USAC to make public the criteria RHCD uses to determine HCP eligibility.

V. CONCLUSION

Non-rural health clinics play a vital role in the health care system including serving underserved populations in both urban and semi-rural areas. Such clinics are important to the long term sustainability of state and regional consortia like CTN and which the Commission is seeking to encourage through the HCF. The Commission should thus reaffirm their eligibility. Alternatively, the Commission should not disrupt the reasonable expectations of RHC program stakeholders by implementing major policy changes through unnoticed changes in program forms, process, or other USAC administrative actions. If a change is needed, it should only come after a fair hearing from all sides of the issue.

Respectfully submitted,



Jeffrey A. Mitchell
LUKAS, NACE, GUTIERREZ & SACHS, LLP
8300 Greensboro Drive, Suite 1200
McLean, Virginia 22102
(703) 584-8678
jmitchell@fcclaw.com

Counsel for the California Telehealth Network

December 20, 2013

CERTIFICATE OF SERVICE

I certify that in accordance with § 54.721(c) I served a copy of this Request for Review on the USAC Administrator consistent with the requirement for service of documents set forth in § 1.47 on February 6, 2012.



Jeffrey A. Mitchell, Esq.

DECLARATION OF ERIC P. BROWN

I have read the foregoing Request, and I hereby declare under penalty of perjury that the facts set forth in the foregoing are true and correct to the best of my knowledge, information and belief, formed after reasonable inquiry.



Eric P. Brown
President and Chief Executive Officer
California Telehealth Network

EXHIBIT #1

Via Electronic Mail

October 22, 2013

Eric Brown
California Telehealth Network
2001 P Street
Suite 100
Sacramento, CA, 95811

RE: HCP 17211 Denial of Eligibility for 29 Entities [See Attachment A]

Dear Eric Brown:

The Rural Health Care (RHC) division of the Universal Service Administrative Company (USAC) received and initially reviewed the FCC Form 465 Package¹ submitted by HCP 17211, California Telehealth Network (CTN) on August 9th, 2013.² USAC has finalized processing the FCC Form 465 Package for eligibility determination and finds that several of the entities listed on the FCC Form 465 Attachment are not eligible to participate in the Healthcare Connect Fund.

In the Rural Health Care Pilot Program (RHCPP), entities that are “Urban Health Clinics” were eligible to participate and receive funding. The Pilot Program FCC Form 465 Attachment in Column 27(b) contained a dropdown menu with “Urban Health Clinic” as one of the Eligible Entity Types. Please note however that “Urban Health Clinic” is not an eligible entity type for purposes of the Healthcare Connect Fund.³

Entities that participated in the RHCPP as an “Urban Health Clinic” and received funding via the issuance of a Funding Commitment Letter as of the adoption date of the

¹ The FCC Form 465 Package includes the FCC Form 465 and all supporting documentation; including but not limited to, the Form, 465 Attachment, Network Plan, Scoping Document, Letters of Agency and Declaration of Assistance.

² As an existing Rural Health Care Pilot Program Pilot Project, Bacon County Health Services is allowed by the Healthcare Connect Fund Order to use existing Pilot Program forms to initiate competitive bidding for purposes of requesting funding through the Healthcare Connect Fund. *In the Matter of Rural Health Care Support Mechanism*, WC Docket 02-60, Report and Order, FCC 12-150, 22 FCC Rcd 16678 (2012) (*Healthcare Connect Fund Order*). “Existing Pilot Projects” refers to active Pilot Projects selected in the *2007 Pilot Program Selection Order*, including projects that have subsequently merged or otherwise restructured. See *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 22 FCC Rcd 20360 (2007) (*2007 Pilot Program Selection Order*).

³ [47 C.F.R. § 54.600\(a\)](#)

Healthcare Connect Fund Order⁴ are eligible for funding as a “grandfathered entity” in the Healthcare Connect Fund. Alternatively, an “Urban Health Clinic” that meets the requirements of Section 330 of the Public Health Service Act⁵ may be classified as a “Community Health Center” for purposes of participation in the Healthcare Connect Fund.

Upon review of the “Urban Health Clinics” and the services they provide (as listed on the FCC Form 465 Attachment submitted by California Telehealth Network), USAC finds that they do not meet the definition of a “Community Health Center” as defined by the Public Health Services Act, Section 330. USAC also determined that those entities did not previously receive a funding commitment through the RHCPP as of December 12, 2012 and are therefore not eligible for “grandfathered entity” status under the Healthcare Connect Fund.

Although the above mentioned entities are not eligible to receive funding, they may register as an “Ineligible entity” if they plan to participate as part of a consortium, thus receiving the benefits of membership of a consortium.

If you wish to appeal this decision, you may file an appeal with USAC, or directly to the FCC. The appeal **must be filed within 60 days of the date of this letter**. Detailed instructions for filing appeals are available at: <http://www.usac.org/rhc/about/program-integrity/appeals.aspx?pgm=telecom>

If you have questions or need assistance, or if you believe you have received this email in error, contact Rural Health Care at 1-800-453-1546, between 8:00 a.m. and 4:30 p.m. Eastern Time Monday through Friday, or by email at rhc-assist@usac.org.

Sincerely,

/s/ Rural Health Care Division

⁴ *Healthcare Connect Fund Order* was adopted by the FCC on December 12, 2012.

⁵ <http://bphc.hrsa.gov/policiesregulations/legislation/authorizing330.pdf>, last visited August 6, 2013.

Attachment A: Denied Entities

HCP#	HCP Name
33809	Axis Community Health, WIC Nutrition Program
22558	Children's Hospital & Research Center at Oakland, Brentwood Outpatient
22559	Children's Hospital & Research Center at Oakland, Castlemont High School Teen Clinic
22561	Children's Hospital & Research Center at Oakland, Ferritometry & Bone Density Clinic
22562	Children's Hospital & Research Center at Oakland, Fifty Second St Outpatient
22563	Children's Hospital & Research Center at Oakland, Larkspur Outpatient
22565	Children's Hospital & Research Center at Oakland, McClymonds High School
22566	Children's Hospital & Research Center at Oakland, Outpatient Subspecialty Clinic
22568	Children's Hospital & Research Center at Oakland, Pleasanton Subspecialty Clinic
22569	Children's Hospital & Research Center at Oakland, Psychiatry -53rd St. Clinic
27768	Coastal Health Alliance, Point Reyes Medical Clinic
22770	Hi-Desert Memorial Health Care District, Airway Surgical Center
33810	Hi-Desert Memorial Health Care District, Continuing Care Center
22773	Hi-Desert Memorial Health Care District, Hi-Desert Family Medical Clinic - Yucca Valley
33811	Hi-Desert Memorial Health Care District, Hi-Desert Homes Health Servoces
33812	Hi-Desert Memorial Health Care District, Hi-Desert Homes Health Servoces-Hospice
22774	Hi-Desert Memorial Health Care District, Outpatient Therapy
33814	Kids Come First Community Health Center
22884	Marshall Medical Center, Family and Internal Medicine - Placerville
22885	Marshall Medical Center, Family Medicine - El Dorado Hills
22889	Marshall Medical Center, Marshall OB/GYN - Placerville
22891	Marshall Medical Center, Pediatrics - Placerville
22917	Mountains Community Hospital, Mountains Community Hospital Rural Health Clinic
22918	Mountains Community Hospital, Running Springs Rural Health Clinic
23033	Saban Free Clinic - Beverly Blvd.
23034	Saban Free Clinic - Hollywood Blvd.
23035	Saban Free Clinic - Melrose
23155	St. Joseph Hospital, Outpatient Imaging
28476	Pediatric Group of Monterey