

grandfathering or permanent waiver. Without such relief, these health care providers would lose support on which they heavily rely when providing essential telehealth and telemedicine services in rural communities, many of which are served by Windstream.³ Given the Commission’s broader efforts to promote the use of broadband to enhance rural health care,⁴ and its strong interest in increasing utilization of the Rural Health Care Support (“RHCS”) mechanism,⁵ a permanent solution ensuring continued support to these well-established rural health care providers—many of whom have used this funding to institute robust broadband telehealth services—would serve the public interest and be consistent with the Commission’s goals.

As the Virginia Telehealth Network (“VTN”) emphasizes in its comments, the reasoning that underpinned the Commission’s prior grandfathering decisions continues to apply.⁶ Most

analysis of the Pilot Program and its progress under the current definition of “rural.” Comments of the California Public Utilities Commission and the People of the State of California, WC Docket No. 02-60, at 5 (August 30, 2010) (California PUC Comments).

³ Windstream is one of the nation’s largest providers of telephone and broadband service to rural America, operating in 23 states, including Nebraska. Windstream is committed to serving primarily rural areas, and its coverage areas average 18 subscribers per square mile, compared to about 100 subscribers per square mile for the largest wireline carriers.

⁴ See, e.g., Health Care Broadband In America, Early Analysis and a Path Forward (OBI Technical Paper No. 5), at 4 (August 2010).

⁵ Federal Communications Commission, Connecting America: The National Broadband Plan at 214-15 (rel. March 16, 2010) (National Broadband Plan) (highlighting the under-utilization of the current support mechanism and recommending changes to the Internet access program, including subsidy support levels higher than the current 25 percent).

⁶ VTN Comments at 11 (citing *Rural Health Care Support Mechanism*, Order on Reconsideration, 23 FCC Rcd 2539 ¶ 6 (2008) (*Order on Reconsideration*) (noting that petitioner and commenters “proffered specific, uncontested evidence” of future harm; “additional time is necessary for the Commission to evaluate the effect of the new definition on health care providers”; and the presence of surplus RHCS funding means that no entities would be disadvantaged by continued support); *Rural Health Care Support Mechanism*, Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 19 FCC Rcd 24613 ¶ 23 (2004) (acknowledging that some rural providers would no longer be eligible for

significantly, the Commission in 2008 held that discontinuing support “would serve only to endanger the continued availability of telemedicine and telehealth services” in areas that are essentially rural, and cited concrete evidence of specific harms that would result if support is discontinued.⁷ As the petitioner and numerous commenters demonstrate with specific examples, withdrawing RHCS funding from grandfathered providers now, just as then, would threaten the provision of telemedicine and telehealth services in rural Nebraska and beyond—services upon which many rural consumers have come to depend.⁸ Furthermore, as the American Telemedicine Association asserts, this rationale is “even more important today as the nation implements health reform, the [Commission] focuses on broadband deployment, the aging of the population provides a growing need to expand care and reduce costs and the downturn of the economy presents even greater pressure on these communities.”⁹

Permitting these health care providers to continue to receive RHCS funding would also be wholly consistent with Congress’s and the Commission’s goals with respect to the Universal Service Fund and the National Broadband Plan. One of the chief aims of universal service is “to enhance . . . access to advanced telecommunications and information services for . . . health care providers.”¹⁰ The National Broadband Plan recommends reforming the RHCS so that it more

support “simply because we revised our definition [of ‘rural area’]” and would require a transition period).

⁷ See *Order on Reconsideration* at ¶¶ 6-7.

⁸ See, e.g., Letter from Anne Boyle, Commissioner, Nebraska Public Service Commission, to Federal Communications Commission, WC Docket No. 02-60, at 2 (July 26, 2010); VTN Comments at 5-9; Tri Valley Comments at 1; NSTN Comments at 2-3; UVA Comments at 7-9; Valley County Comments at 1; Rock County Comments at 1; Good Samaritan Comments at 2.

⁹ ATA Comments at 1.

¹⁰ See 47 U.S.C. § 254(h)(2)(A).

effectively subsidizes network deployment to enhance health care delivery.¹¹ And in its recent *Notice of Proposed Rulemaking* concerning reforms of the RHCS, the Commission proposes to expand the definition of eligible health care providers¹² and make other changes designed to increase the utilization of the program.¹³ In this context, it is entirely appropriate to continue granting a relatively small amount of funding¹⁴ to providers that already are offering critical telemedicine and telehealth services to rural patients and their families and doctors—individuals that have come to rely upon these services for receipt and delivery of rural health care.

Finally, as multiple commenters note, a continuation of funding would permit the Commission to maintain and improve its assessment of ongoing initiatives in connection with the RHCS mechanism,¹⁵ and a permanent solution would ensure stability and certainty, maximizing providers’ ability to respond to patients’ needs, take advantage of new innovations, and enter into long-term, cost-saving contracts and arrangements.¹⁶

¹¹ National Broadband Plan at 215-16 (recommending establishment of a Health Care Broadband Infrastructure Fund and performance measures to ensure that providers are using networks “in a way that improves the country’s health delivery system”).

¹² *Rural Health Care Support Mechanism*, Notice of Proposed Rulemaking, WC Docket No. 02-60, at ¶¶ 114-15 (July 15, 2010).

¹³ *Id.* at ¶ 3 (referencing, for example, a proposal to create a health infrastructure program that would support up to 85 percent of the construction costs of new networks in unserved and underserved areas).

¹⁴ For example, the \$223,000 in support that would be lost by the Norfolk, Kearney and Grand Island hub hospitals and Fremont endpoint in Nebraska, while crucial to the survival of the NSTN, amounts to less than 0.1 percent of the total \$400 million RHCS program.

¹⁵ See VTN Comments at 13. See also California PUC Comments at 5 (agreeing that a “time extension is reasonable” so the FCC has time to evaluate the Pilot Program and the progress under the current definition of ‘rural’).

¹⁶ VTN Comments at 14.

For all these reasons, the Commission should revise its definition of “rural health care provider” to include, on a permanent basis, those health care providers eligible for support under the RHCS mechanism (and who had funding commitments) prior to July 1, 2005. As VTN notes, administrative precedent exists for the permanent grandfathering of rural providers and, in particular, telemedicine sites.¹⁷ In the alternative, the Commission should waive permanently the “rural” eligibility requirement as to entities participating in the RHCS program that were classified as rural before the Commission’s current definition took effect. The Commission may waive its rules for “good cause shown,”¹⁸ and as discussed above, enabling the continued provision of essential telemedicine and telehealth services to rural communities relying upon these services is a good cause and unquestionably in the public interest.

Respectfully submitted,

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¹⁷ *See id.* at 16, fn.36.

¹⁸ 47 C.F.R. § 1.3.