



PUBLIC NOTICE

Federal Communications Commission
445 12th St., S.W.
Washington, D.C. 20554

News Media Information 202 / 418-0500
Fax-On-Demand 202 / 418-2830
TTY 202 / 418-2555
Internet: <http://www.fcc.gov>

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WIRELINER COMPETITION BUREAU SEEKS FURTHER COMMENT ON ISSUES IN THE RURAL HEALTH CARE REFORM PROCEEDING

WC Docket No. 02-60

Comment Date: August 23, 2012
Reply Comment Date: September 7, 2012

1. In this Public Notice, the Wireline Competition Bureau seeks to develop a more robust record in the pending Rural Health Care reform rulemaking proceeding, particularly with regard to the proposed Broadband Services Program.¹ The Commission's Rural Health Care Pilot Program has helped foster the creation and growth of numerous state and regional broadband networks of health care providers (HCPs) throughout the country.² These Pilot project networks have enabled health care providers in rural areas to tap into the medical and technical expertise of other health care providers on their networks, using telemedicine and other telehealth applications to improve the quality and lower the cost of health care for their patients in rural areas.³ As the Commission moves forward with reform of the Rural Health Care (RHC) program, it can benefit greatly from the experience of the Pilot projects and the lessons learned in the Pilot Program. A more focused and comprehensive record will help the Commission craft an efficient permanent program that will help health care providers exploit the potential of broadband to make health care better, more widely available, and less expensive for patients in rural areas.

2. In its March 16, 2010, Joint Statement on Broadband, the Commission said that "ubiquitous and affordable broadband can unlock vast new opportunities for Americans, in communities large and small, with respect to . . . health care delivery."⁴ The *National Broadband Plan* issued that same day

¹ *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Notice of Proposed Rulemaking, 25 FCC Rcd 9371, 9407-9415, paras. 90-113 (2010) (*NPRM*).

² See *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 21 FCC Rcd 1111 (2006) (*2006 Pilot Program Order*); *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 22 FCC Rcd 20360 (2007) (*2007 Pilot Program Selection Order*).

³ See, e.g., USAC Apr. 27 Site Visit Reports; USAC Mar. 16 Site Visit Reports. A list of recent *ex parte* filings and associated short cites used throughout this Public Notice is attached in the Appendix.

⁴ *Joint Statement on Broadband*, GN Docket No. 10-66, FCC 10-42, para. 3 (rel. Mar. 16, 2010).

recommended, among other things, that the Commission reform its Rural Health Care program in two ways: (1) by replacing the existing Internet Access Fund with a Health Care Broadband Access Fund, and (2) by establishing a Health Care Broadband Infrastructure Fund to subsidize network deployment for HCPs where existing networks are insufficient.⁵ Later that year, the Commission issued a Notice of Proposed Rulemaking in this docket proposing, consistent with the National Broadband Plan recommendations, both a Health Infrastructure Program, which would support the construction of new broadband HCP networks in areas of the country where broadband is unavailable or insufficient, and a Health Broadband Services Program, which would support the monthly recurring costs of broadband services for rural HCPs.⁶

3. Since the Commission issued the *NPRM* in 2010, the rural health care Pilot projects have made additional progress toward full implementation of their health care broadband networks.⁷ Although the Commission allowed Pilot projects to receive support to construct and own broadband network facilities, many Pilot projects chose to lease broadband services from commercial service providers as a way to implement broadband networks connecting HCPs.⁸ Projects chose to lease services instead of building networks because HCPs did not want to own or manage the networks and could more easily obtain needed broadband without owning the facilities or incurring administrative and other costs associated with network ownership. In light of the number of successful projects that elected to lease services instead of constructing networks, this Public Notice focuses on deepening the record regarding the Commission's proposed Broadband Services Program and the participation by consortia, including Pilot projects, in such a program.

4. In recent months, Commission staff has engaged in outreach calls and meetings with many Pilot projects, as well as with other entities knowledgeable about rural health care, telemedicine, and Health IT.⁹ Based on what we have learned from the Pilot projects, and in light of the comments and other information filed in this Docket, we have identified several areas relating to the Broadband Services Program proposed in the *NPRM* that would benefit from further development of the record: (1) use of consortium applications; (2) inclusion of urban health care providers in funded consortia; (3) services and equipment to be supported; (4) use of competitive bidding processes and multi-year contracts; and (5) broadband needs of rural health care providers. We are especially interested in obtaining input that reflects the experience of participants in the Commission's current Rural Health Care programs, particularly that of the Pilot Program participants. To the extent possible, parties should identify

⁵ Federal Communications Commission, *Connecting America: The National Broadband Plan*, at 215-16 (rel. March 16, 2010) (*National Broadband Plan*).

⁶ See *NPRM*, 25 FCC Rcd at 9373, para. 3.

⁷ The Commission recently issued an order maintaining support on a transitional basis for those Pilot project health care provider sites that will exhaust their Pilot funds before the end of the coming funding year (before June 30, 2013), while the Commission considers potential reforms that would enable Pilot recipients to transition to a permanent support mechanism. *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, FCC 12-74 (rel. July 6, 2012).

⁸ See *infra* para. 9 and note 32.

⁹ See Appendix. As defined in the *National Broadband Plan*, Health IT includes "information-driven health practices and the technologies that enable them" such as "billing and scheduling systems, e-care, EHRs [electronic health records], telehealth and mobile health." *National Broadband Plan* at 200.

throughout their comments the particular Public Notice questions to which they are responding, by using the relevant section numbers and letters (for example, “Section I.a. -- Consortium application process”).

I. CONSORTIA

5. Section 254(h)(7)(B)(vii) of the Communications Act specifically authorizes funding for consortia of eligible health care providers.¹⁰ Commenters suggest that the consortium approach has many benefits, especially for rural HCPs that have limited administrative, financial, and technical resources.¹¹ Although a health care provider may apply for funding under the existing Rural Health Care telecommunications program or Internet access program (collectively, “Primary Program”) as a member of a consortium, in practice consortium applicants in the Primary Program must still file a separate form for every HCP site, and thus the consortium process has not been as widely used in that program as it has in the Pilot Program.¹²

6. In the *NPRM*, the Commission recognized that many Pilot projects, which are consortia of HCPs, may wish to transition to the permanent Broadband Services Program, if adopted, and sought

¹⁰ 47 U.S.C. § 254(h)(7)(B)(vii).

¹¹ See USAC Observations Letter at 2-4 (discussing benefits of the consortium approach); Comments of Virginia Telehealth Network, WC Docket No. 02-60, at 34-35 (filed Sept. 8, 2010) (VTN Comments) (recommending that the Commission consider the use of a consortium application, by which a single party could apply for and receive funding on behalf of a group of eligible entities and then administer that funding for their benefit); Comments of Internet2 Ad Hoc Health Group, WC Docket No. 02-60, at 20 (filed Sept. 8, 2010) (Internet2 Comments) (stating that Pilot program participants, including consortia, should be allowed to transition to the Broadband Services Program); PSPN Feb. 23 *Ex Parte* Letter at 2 (stating that individual HCPs often do not have the capacity to negotiate the processes of the RHC program and that the ability to bill as a consortium is more efficient than requiring hundreds of members to submit invoices each month); Colorado Feb. 28 *Ex Parte* Letter at 1-2 (stating that the joint purchasing power of a consortium has led to a cost-effective contract and financial benefits to member HCPs, and that the consortium mechanism has increased Colorado’s participation in the RHC program from 10 to 15 participants in the Primary Program to over 200 participants in the Pilot Program); Pilot Conference Call Mar. 13 *Ex Parte* Letter (PMHA *et al.*) at 3 (noting the view of five Pilot projects that a reformed RHC program should provide opportunities for networks to file as consortia, which takes the administrative burden off of small HCPs that do not have the time or personnel to apply for funds through the RHC program, and that the ability to bill service providers as a consortium in the Pilot Program was very helpful); Pilot Conference Call Mar. 26 *Ex Parte* Letter (AEN *et al.*) at 4 (noting the view of six Pilot projects that the consortium-based approach in the Pilot Program is much easier than the process in the Primary Program).

¹² The Commission’s traditional rural health care programs (the telecommunications program and the Internet access program) are together commonly referred to as the “Primary Program.” The telecommunications program ensures that rural HCPs pay no more than their urban counterparts for their telecommunications needs in the provision of health care services. See 47 U.S.C. § 254(h)(1)(A); *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776, 9093-9161, paras. 608-749 (1997) (*Universal Service First Report and Order*); 47 C.F.R. Part 54, Subpart G. The Internet access program provides a 25 percent discount off the cost of monthly Internet access for eligible rural HCPs. See 47 C.F.R. § 54.621; *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, 24557, para. 22 (2003) (*2003 Order and Further Notice*).

comment on that transition.¹³ We now seek to further develop the record on issues relating to the use of consortium applications in the proposed Broadband Services Program:

- a. Consortium application process. We seek comment on specific procedures for the application process for consortia in the proposed Broadband Services Program and ask commenters to focus on how to streamline the application process while protecting against waste, fraud and abuse. What specific information should the Commission require from the consortium leader regarding each consortium member on the application forms? Should letters of authorization (LOAs) from participating members of the consortium be required? If so, should LOAs be submitted at the request-for-funding-commitment stage (with the filing of the Form 466-A), rather than at the request-for-services stage (with the filing of the Form 465), as is now the case under the Pilot Program? Submitting the LOAs later in the process, with the Form 466-A, would appear to be more administratively efficient for the consortium, because the consortium could wait until it had completed competitive bidding and knew the pricing before soliciting the LOAs. Before they know the pricing, health care providers are likely to be less certain about whether they will want to participate. This approach also would be administratively simpler for USAC, as USAC would only have to confirm eligibility for that smaller group of HCPs that already know the pricing and are therefore more sure that they want to participate. We also seek comment on the alternative of requiring HCP LOAs to be submitted at the earlier (Form 465) stage, as in the Pilot Program. Should the Commission require consortium applicants to provide details in the consortium's request for services (the Form 465) regarding the services to be purchased, such as the desired bandwidth, sites to be served, and general type of service, as is currently required in the Pilot Program? Should the Commission require the lead entity and selected vendor to certify that the support provided will be used only for eligible purposes, as it does in the Pilot Program in connection with Form 466-A? Should the Commission require applicants to submit a "declaration of assistance," as is required with the Form 465 in the Pilot Program? We encourage commenters to draw on their experience with the Pilot and Primary programs in supporting any recommendations for streamlined application procedures.
- b. Post-award reporting requirements. What is the least burdensome way to collect information necessary to evaluate compliance with the statute and other relevant regulations, and to monitor how funding is being used? Should the Commission require consortium applicants to submit Quarterly Reports, as in the Pilot Program?¹⁴ Would the same information that is required for single HCP applicants be required for each HCP in a consortium application, or should the Commission permit consortium applicants to submit a reduced amount of information for each HCP, as it did in the Pilot Program? We encourage commenters to draw on their experience with the Pilot and Primary Program in supporting any recommendations for streamlined reporting procedures.
- c. Site and service substitution. The Pilot Program permits site and service substitutions within a project in certain specified circumstances, in order to provide some amount of flexibility to project participants. Under the Pilot Program, a site or service substitution

¹³ *NPRM*, 25 FCC Rcd at 9415, para. 113.

¹⁴ *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20423-24, paras. 126-127.

may be approved if (i) the substitution is determined to be provided for in the contract, be within the change clause, or constitute a minor modification, (ii) the site is an eligible health care provider or the service is an eligible service under the Pilot Program, (iii) the substitution does not violate any contract provision or state or local procurement laws, and (iv) the requested change is within the scope of the controlling FCC Form 465, including any applicable Request for Proposal.¹⁵ Should the Commission adopt a similar policy for consortia that participate in the Broadband Services Program, if adopted? Would any modifications to that policy be warranted for the Broadband Services Program?

II. INCLUSION OF URBAN SITES IN CONSORTIA

7. One of the benefits of facilitating the establishment and operation of health care networks that serve providers in rural America is improved access to specialized care that typically is more available in urban areas. Historically, support under the Primary Program has only been provided to health care providers that meet the rural health care mechanism's definition of "rural."¹⁶ In the Pilot Program, however, the Commission permitted non-rural health care providers to participate as part of consortia that include health care providers serving rural areas.¹⁷

8. In response to the *NPRM*, a number of commenters and USAC identify many benefits from including public and not-for-profit urban (or "non-rural") health care providers in rural broadband health care networks.¹⁸ Urban providers have taken the lead in many of the Pilot projects, and commenters note

¹⁵ USAC Site and Service Substitution Policy, at 1, 3, *available at* <http://www.universalservice.org/res/documents/rhc-pilot-program/pdf/Site-and-Service-Substitution.pdf> (last visited June 29, 2012); *see also* *Federal-State Joint Board on Universal Service; Access Charge Reform, Price Cap Performance Review for Local Exchange Carriers, Transport Rate Structure and Pricing, End User Common Line Charge*, CC Docket No. 96-45 *et al.*, Fourth Order on Reconsideration & Report and Order, 13 FCC Rcd 5318, 5448-51, paras. 224-229 (1997) (*Universal Service Fourth Order on Reconsideration*) (outlining the circumstances under which rural health care program participants can make modifications to a contract that USAC has previously approved for funding without completing an additional competitive bidding process).

¹⁶ Whether an HCP is "rural" depends on where it is located in relationship to any Core Based Statistical Area (CBSA). An area located outside of any CBSA is rural. However, an area within a CBSA can be rural, depending on the characteristics of the particular census tract. *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 19 FCC Rcd 24613, 24619, para. 9 (2004) (*Second Report and Order and Further Notice*).

¹⁷ *2006 Pilot Program Order*, 21 FCC Rcd at 11111, 11114, paras. 3, 10. The Pilot Program was established under section 254(h)(2)(A) of the Act, which provides the Commission broad discretionary authority to provide universal service support for "advanced services" for all health care providers. *See* 47 U.S.C. § 254(h)(2)(A) ("The Commission shall establish competitively neutral rules to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for all public and nonprofit . . . health care providers . . ."); *Texas Office of Public Utility Counsel v. FCC*, 18 F.3d 393, 446 (5th Cir. 1999) (concluding that "the language in § 254(h)(2)(A) demonstrates Congress's intent to authorize expanding support to 'advanced services,' when possible, for non-rural health providers").

¹⁸ USAC Observations Letter at 4-5 (stating that urban participation in Pilot projects was beneficial from a network design perspective, provided necessary leadership to bring disparate stakeholders together, provided IT expertise and (continued...)

that many urban HCPs also provide technical, financial, and administrative support that otherwise might be unavailable to rural HCPs.¹⁹ Commenters have also noted that urban locations typically have medical specialists and other resources that rural HCPs need to access, through telemedicine and other telehealth applications.²⁰ To further develop the record in the rulemaking docket, we now seek more focused comment on issues relating to the participation of urban HCPs in consortia that serve rural health care needs as part of the Broadband Services Program, if adopted.

- a. Proportion of urban or rural sites in consortia. The *2007 Pilot Program Selection Order* allowed urban HCPs to receive support under the Pilot Program as long as they were part of networks that had more than a *de minimis* number of rural HCPs on the network.²¹ If the Commission were to provide support for broadband services to urban HCPs that are members of consortia that serve rural areas, should it adopt specific rules to ensure that the major benefit of the program flows to rural HCPs and/or to rural patients? For example, should the Commission require that more than a *de minimis* number of rural HCPs be included in such consortia, as in the Pilot program, and if so, what specific metrics should be used to determine whether a sufficient number of rural

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technology to rural HCPs, and facilitated access for rural patients to health care specialists in urban areas); Comments of the Nebraska Statewide Telehealth Network, WC Docket No. 02-60, at 5 (filed Sept. 8, 2010) (stating that specialty urban providers serve not only as rural health safety nets through provision of health care, but also provide leadership in collaborative ventures, education, training, and information technology support to small rural health facilities and practitioners) (NSTN Comments); Colorado Feb. 28 *Ex Parte* Letter at 2 (stating that Colorado has created a 60 percent rural, 40 percent urban statewide health care network that “undergirds, complements, and strengthens the existing and necessary urban/rural interdependencies,” and stating that supporting only rural sites fails to recognize the reality of urban/rural interdependencies). Consistent with previous uses, we use the term “urban” to mean “non-rural.” See *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20421, para. 120.

¹⁹ See *supra* note 18; see also Pilot Conference Call Mar. 13 *Ex Parte* Letter (PMHA *et al.*) at 2-3 (group of five Pilot projects stating that urban HCP participation is “the key to the networks’ success;” that rural HCPs value their connection to urban hospitals and their instant access to specialized care; that urban HCPs have provided technical support to rural HCPs and trained some of their IT staff, which has led to an improved rural HCP workforce; and that many rural HCPs rely on urban sites in their network to pay for their networks’ administrative expenses).

²⁰ See *supra* note 18; see also Comments of the New England Telehealth Consortium, WC Docket No. 02-60, at 3 (filed Sept. 7, 2010) (stating that the majority of its sites are rural, but need to be connected to urban hospitals for access to telemedicine, clinical specialists, and PACS systems) (NETC Comments); Internet2 Comments at 18 (noting that in North Carolina, many non-rural sites serve rural populations and tertiary facilities in metropolitan areas often provide critical specialty services to rural populations); OHN Feb. 28 *Ex Parte* Letter at 6-7 (stating that the subsidy for urban providers is critical to supporting integrated health care delivery, that rural/frontier providers are looking for improved access to urban specialists and resources to augment their dwindling clinical and operational resources, and that without the urban centers of excellence being on and actively using the network connection, there would be no value to the rural/frontier providers in connecting); Pilot Conference Call Mar. 26 *Ex Parte* Letter (AEN *et al.*) at 1 (explaining that the inclusion of urban sites in the Pilot Program was critical to providing specialty care, because of the shortage of specialists in rural areas).

²¹ *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20834-5, para. 50.

HCPs are participating in the consortia?²² For instance, should the Commission specify a maximum percentage of urban sites within a consortium? USAC states that urban sites make up approximately 35 percent of all HCP Pilot Program sites that received funding commitments as of January 2012.²³ Should the Commission adopt this or a different percentage as an upper limit on the proportion of urban HCP sites within the rural health care program overall or within a consortium?

- b. Limiting percentage of funding available to urban sites. In the alternative, should the Commission specify a maximum amount of funding that can be provided to urban sites within a consortium? USAC estimates that about 35 percent of committed funds have gone to urban HCPs in the Pilot Program (while noting that this figure probably overstates the true urban share).²⁴ Given that the Commission has sought comment on how to transition Pilot Program participants into a reformed program, would adopting a requirement that urban sites receive no greater than 35 percent of total funds per funding year be a workable and appropriate restriction? How would the existence of such limits on urban site funding or inclusion of urban sites affect the consortium planning process and the development and growth of consortia over time?
- c. Impact on Fund. To the extent commenters support a particular approach to limiting the participation of urban sites in consortia serving rural areas, they also should estimate the likely impact on the RHC funding mechanism if the Commission were to adopt their recommended approach. Commenters should provide data to support their estimates. We welcome detailed analysis on the impact on the Fund of any limits (or lack thereof) on urban HCP participation that the Commission may adopt or that parties may propose.
- d. Impact on network design. USAC notes that in the hub-and-spoke configuration common to Pilot projects, where a centralized or primary HCP serves as the main provider and is surrounded by several subsidiary providers, the hub is often an urban HCP.²⁵ What impact would including (or excluding) urban sites from funding under the Broadband Services Program have on network design and efficiency, from both a cost perspective and a technological perspective? Would it be possible to limit funding for urban sites to recurring and non-recurring charges associated with equipment necessary to create hubs at urban HCP sites? Would such a limitation unnecessarily restrict participation by urban HCPs or otherwise limit the effectiveness of the program?
- e. Role of urban health care providers if not funded. There may be significant benefits to Pilot projects from having a project leader that handles administrative and other

²² See Comments of Rural Wisconsin Health Cooperative, WC Docket No. 02-60, at 3 (filed Sept. 8, 2010) (stating that non-rural providers should be funded, but Commission should include language that safeguards the program from turning into something that loses its rural provider focus).

²³ See USAC June 27 Data Letter at 1.

²⁴ See USAC May 30 Data Letter at 2-3; USAC May 4 Data Letter at 3.

²⁵ USAC Observations Letter at 5; see also NOSORH Mar. 28 *Ex Parte* Letter at 1 (stating that in Minnesota, urban hospitals are typically the hubs of health care networks, and more and more rural hospitals are joining as spoke sites to those hubs).

necessary tasks on behalf of the other project participants.²⁶ If the Commission were to exclude urban sites that are part of consortia serving rural communities from receiving funding under the Broadband Services Program, would there be administrative benefits to allowing such urban providers still to serve as project leaders even though they do not receive any support? In response to the *NPRM*, some commenters and Pilot projects contend that without support from the RHC program, urban sites may be reluctant to participate in broadband networks with rural HCPs, which could undermine the ability of rural HCPs to interconnect with those urban sites and to draw on their technical and medical expertise.²⁷ What incentives would urban providers have to participate as a project leader if they are unable to receive any support?

- f. Grandfathering of urban sites already participating in Pilot projects. If the Commission chooses not to provide funding to urban sites under the Broadband Services Program, or sets limits on such funding as discussed in paragraph (b) above, should the Commission nevertheless provide funding to urban sites that have received funding under existing Pilot projects?²⁸ Should the Commission limit the funding to existing Pilot project urban sites only for so long as the urban site is a member of a consortium with rural HCPs?

III. ELIGIBLE SERVICES AND EQUIPMENT

9. In the Pilot Program, the Commission allows health care providers to use “any currently available technology” in order to create networks.²⁹ The Pilot Program funds both recurring costs and non-recurring costs (NRCs) for dedicated broadband networks connecting HCPs in a state or region, including the cost of subscribing to commercial service providers’ services.³⁰ As noted above, although

²⁶ See USAC Observations Letter at 1, 4-5.

²⁷ See, e.g., NETC Comments at 3 (arguing that it is very important that urban hospitals receive a subsidy so that they are incented to be part of a network that is connected to rural sites); Pilot Conference Call Mar. 13 *Ex Parte* Letter (PMHA *et al.*) at 3 (summarizing call with five Pilot project representatives, who stated in relevant part that due to the current economic environment, budgets are tight for urban HCPs, and it may be difficult for urban HCPs to continue to provide support to rural HCPs in their networks if they are ineligible to receive RHC program funding themselves); PSPN Feb. 23 *Ex Parte* Letter at 1 (stating that urban hospitals, which serve as “consulting” sites for rural hospitals in telemedicine, are often as hard-pressed for available funding as the rural hospitals and cannot bear the non-discounted costs of participation in the networks, and without their participation, vital links in the chain of health care are missing).

²⁸ Approximately 730 sites that have received funding commitments in the Pilot Program are urban, as of January 2012, out of a total of approximately 2,100. See USAC June 27 Data Letter at 1.

²⁹ 2007 *Pilot Program Selection Order*, 22 FCC Rcd at 20421, para. 119.

³⁰ Eligible expenses under the Pilot Program include: (1) costs for deploying transmission facilities and providing access to advanced telecommunications and information services (including costs for design, engineering, materials and construction of fiber facilities or other broadband infrastructure; engineering, furnishing (*i.e.*, as delivered from the manufacturer), and installing network equipment; and operating and maintaining the constructed network); (2) costs of subscribing to carrier-provided transmission services to the extent that a participant chose to subscribe to such services in lieu of deploying its own broadband network; and (3) costs of network equipment that terminates a carrier’s or other provider’s transmission facility, routers/switches directly connected to either the facility or the (continued...)

the Pilot Program permitted projects to construct and own broadband network facilities, many projects elected to lease broadband services (which mostly involve recurring costs) rather than constructing and owning the broadband facilities themselves. As of February 29, 2012, the Pilot Program had committed approximately \$35 million for construction, \$162 million for leased/tariffed facilities or services, and \$19 million for network equipment (including engineering and installation).³¹ The projects choosing to lease services cite several reasons for that choice, including that the HCPs' core competencies does not include owning or managing communications networks, that the HCPs can obtain the needed broadband without owning the facilities themselves, and that the administrative and other costs associated with broadband network ownership are too great.³²

10. For the Broadband Services Program, the *NPRM* proposed to fund “recurring monthly costs for any advanced telecommunications and information services that provide point-to-point connectivity, including Dedicated Internet Access.”³³ In light of the Pilot Program experience and the comments in the record, we seek more focused comment on questions related to this proposal.

- a. Point-to-point connectivity. Some commenters have raised concerns regarding the term “point-to-point” in the *NPRM*.³⁴ We seek to further develop the record on the types of connectivity that should be eligible for support under the proposed Broadband Services

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terminating equipment, and computers and related hardware used exclusively for network management. *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20397-8, paras. 74-75.

³¹ USAC Observations Letter at 7-8.

³² USAC Observations Letter at 7-8; OHN Feb. 28 *Ex Parte* Letter at 1 (stating that utilizing existing fiber infrastructure to create a leased line network imposed less administrative burden and overhead on Oregon Health Network versus owning the actual equipment and fiber connection); Pilot Conference Call Mar. 13 *Ex Parte* Letter (PMHA *et al.*) at 3 (group of Pilot projects stating that HCPs' core competencies do not include constructing and owning networks, and that they preferred to lease services, which allowed the projects to reach many more HCPs than the construction options); Pilot Conference Call Mar. 16 *Ex Parte* Letter (ARCHIE *et al.*) at 3 (stating that while the Pilot Program helped prompt the deployment of fiber or other high capacity facilities to many HCP sites where such facilities were not previously available, HCPs do not want to own the telecommunications network facilities); Pilot Conference Call Mar. 26 *Ex Parte* Letter (AEN *et al.*) at 2 (noting comment that most stakeholders prefer not to own the physical facilities comprising their network, but would rather defer to service providers that have experience and expertise in these matters to complete any build out, and stating that in cases where construction is necessary, the HCP may issue one RFP for construction and a second RFP for an experienced entity to manage the network on behalf of the HCP).

³³ *NPRM*, 25 FCC Rcd at 9408, para. 93.

³⁴ *See, e.g.*, Internet2 Comments at 17 (noting that the term “point-to-point” is often used to refer to a connection that is restricted to two endpoints and with no data or packet formatting, and stating that health care organizations seeking modern, cost-effective telecommunications services should aim to employ an IP network); NETC Comments at 7 (recommending deletion of the term “point-to-point,” noting that connecting the large number of sites in NETC back to a central location with point to point circuits is impractical, and stating that a cloud-based network is the more practical design); Comments of Alaska Communications Systems, WC Docket No. 02-60, at 2 (filed Sept. 8, 2010) (ACS Comments) (stating that RHC support should continue to be technologically neutral and not limited to conventional “dedicated” point-to-point network infrastructure, as cloud computing, Multi-Protocol Label Switching (MPLS) and Internet-based network designs can provide fast, secure, and reliable service to and among RHC providers at costs well below building separate terrestrial connections to each facility).

Program. Health care networks and other enterprise customers use a wide variety of connectivity solutions which allow a variety of topologies (ring, mesh, hub-and-spoke, line, etc.) and technologies (MetroE, MPLS, Virtual Private Network, etc.) to meet their requirements. These solutions are “point-to-point” in the sense that they allow a facility to send or receive data to or from another facility, but they also provide additional capabilities -- for example, the ability to connect to multiple facilities on the same network, and/or the ability to connect to another facility without needing a physically “dedicated” circuit to that facility. Should the definition of services to be funded under the Broadband Services Program omit the phrase “point-to-point”? We seek comment on whether the rules for the Broadband Services Program should enumerate a wide range of connectivity solutions such as those listed above, or should be more general, in recognition of the likely change and evolution of services utilized by health care providers that will occur over time. Should there be any distinction in the types of services that would be funded if the applicant is part of a consortium, as opposed to individual applicants?

- b. Eligible non-recurring costs (NRCs). For the Broadband Services Program, the Commission proposed in the *NPRM* to provide one-time support for 50 percent of reasonable and customary installation charges for broadband access and to provide support for the cost of leases of lit or dark fiber.³⁵ The American Telemedicine Association has recommended that the Commission, at a minimum, support the costs of routers and bridges associated with the installation of broadband services to an eligible health care provider, and that the Commission allow such providers to work together to purchase equipment through joint, cooperative bidding procedures in order to allow for more efficient purchasing of network equipment costs.³⁶ USAC notes that the availability of funding for certain types of equipment in the Pilot Program (“servers, routers, firewalls, and switches”) facilitates the ability of health care providers to upgrade circuits or create private networks.³⁷ We seek more focused comment on whether the NRCs eligible to receive support under the Broadband Services Program should include equipment to enable the formation of networks among consortium members, similar to the Pilot Program.³⁸
- c. Limited Funding for Construction of Facilities in Broadband Services Program. As noted above, many Pilot projects chose to lease services rather than to construct and own their own network facilities.³⁹ Some Pilot projects nevertheless argue that they need the option

³⁵ *NPRM*, 25 FCC Red at 9410-11, paras. 100-102.

³⁶ Comments of the American Telemedicine Association, WC Docket No. 02-60, at 6, n. 6 (filed Sept. 8, 2010) (ATA Comments). *See also* ACS Comments at 12-13 (recommending that the Commission support RHC providers’ one-time network design, customer premises equipment, and installation costs where necessary to maintain quality broadband service all the way to the rural delivery point of the data transmission).

³⁷ *See* USAC Observations Letter at 6-7 (noting that equipment leases and purchases are not eligible for funding in the Primary Program).

³⁸ For the Health Infrastructure Program, the Commission proposed to fund NRCs similar to those funded in the Pilot Program. *NPRM*, 25 FCC Red at 9386, para. 35.

³⁹ *See supra* note 32.

of constructing their own facilities when no service provider is willing to construct broadband facilities and lease them to project participants, or when the bids a project receives for leased services are higher than the cost of construction.⁴⁰ The *NPRM* proposed a Health Infrastructure Program that would fund the construction of dedicated broadband networks in areas where broadband is demonstrated to be unavailable, and would require HCPs to have an ownership interest in the network facilities funded by the program.⁴¹ The Broadband Services Program, in contrast, would provide funding only for broadband services and, as proposed, would not cover capital or infrastructure costs.⁴² We seek to further develop the record on whether it would be appropriate under the proposed Broadband Services Program, if adopted, to provide funding to recipients to construct and own network facilities under limited circumstances. Would it be appropriate, for instance, in a situation where the applicant could demonstrate that self-provisioning the last mile facility to connect to an existing health care network is more cost-effective than procuring that last mile connectivity from a commercial service provider? What requirements would need to be in place to ensure that construction and ownership is the most cost-effective option?⁴³ How would a health care provider or consortium make such a showing? Would it be necessary to wait until after the competitive bidding process is completed in order for an applicant to be able to make that showing?⁴⁴ Are there other more preliminary milestones during the competitive bidding

⁴⁰ See, e.g., Pilot Conference Call Mar. 26 *Ex Parte* Letter (WNYRAHEC *et al.*) at 1 (noting that having a private fiber network as part of the larger network helped St. Joseph’s to control costs and ensure long-term success, as it could be cost-prohibitive to buy from a carrier the 1 to 10 Gbps connections needed to move medical images); Letter from David LaFuria, Counsel for Health Information Exchange of Montana, to Marlene H. Dortch, Secretary, WC Docket No. 02-60, at 2 (filed Sept. 22, 2011) (stating that HIEM’s network would be a small fraction of what it is now if HIEM had simply leased facilities from the outset, and arguing that the Commission should retain the option for program participants to construct network facilities, as removing that option from competitive bidding will change how incumbent carriers approach the bid process); Pilot Conference Call Mar. 16 *Ex Parte* Letter (ARCHIE *et al.*) at 3 (stating that ownership of newly constructed facilities only makes economic sense where there are gaps in availability).

⁴¹ *NPRM*, 25 FCC Rcd at 9381-9383, 9395-9397, paras. 19-25, 55-59.

⁴² *Id.* at 9408, 9410-9411, paras. 93, 100-102.

⁴³ The Commission has defined “cost-effective” 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.” See 47 C.F.R. § 54.615(c)(7) (Primary Program); *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20400, para. 78 (Pilot Program). Unlike the Schools and Libraries universal service support mechanism (commonly referred to as the E-rate program), the RHC support mechanism does not require participants to consider price as the primary factor in selecting service providers. The Commission has explained that applicants to the RHC support mechanism are not be required to use the lowest-cost technology because factors other than cost, such a reliability and quality, may be relevant to fulfill their telemedicine needs. *2003 Order and Further Notice*, 18 FCC Rcd at 24575-76, para. 58; *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20401, para. 79.

⁴⁴ See Reply Comments of the Brazos Valley Council of Governments, Health Information Exchange of Montana, New England Telehealth Consortium, Oregon Health Network, and Utah Telehealth Network, WC Docket No. 10-90 *et al.*, at 8-9 (filed May 23, 2011) (stating that “the best process for determining whether facilities capable of supporting medical broadband are, or are not available is a robust competitive bidding process through which HCPs (continued...)”).

process after which an applicant could make a showing? If the Commission were to make this option available, should there be specific caps on funding available to construct HCP-owned facilities?

- d. Ineligible sites and treatment of shared services/costs. Section 254(h)(3) of the Act and Section 54.671(a) of the Commission's rules restrict the resale of any services purchased pursuant to the rural health care support mechanism.⁴⁵ In the Pilot Program, the Commission determined that, under this resale restriction, a selected participant could not sell network capacity that was supported by Pilot Program funding, but could share excess network capacity with an ineligible entity as long as the ineligible entity paid its "fair share" of network costs attributable to the portion of the network capacity used.⁴⁶ In the Pilot Program, projects have allocated the cost of shared services and equipment among members (both eligible and ineligible HCPs) by taking into account a variety of healthcare-specific factors. We note that in the Pilot Program, projects submit information about sharing of services and costs among members with their requests for funding commitments, and that USAC reviews and approves those submissions.

We seek comment on whether there is a need to adopt specific rules in the Broadband Services Program (if adopted), regarding the participation of ineligible HCP sites (*e.g.*, for-profit rural health clinics or, if not included in the Broadband Services Program, urban HCPs) in consortia that receive funding for broadband services provided to eligible members. Even if not funded, there may be other health care and financial reasons why providers that are not funded through the program may wish to enter into cooperative arrangements with other providers that are funded, in order to create local and regional health care networks. By acting together, providers are more likely to receive lower pricing and a wider array of services to meet their health care needs. Should the Broadband Services Program have a "fair share" requirement comparable to the Pilot Program? In particular, should the Commission adopt a specific approach to shared services and costs for consortium applicants, or should the Commission just require that the allocation of the costs of shared services and equipment among consortia members be reasonable? We welcome further comment on whether the procedures utilized by USAC to implement the fair share requirement in the Pilot Program are workable or burdensome, and what measures would best address potential waste, fraud and abuse in a reformed program.

(Continued from previous page)

establish and post their required broadband service levels"); Letter from David LaFuria, Counsel for Health Information Exchange of Montana, to Marlene H. Dortch, Secretary, WC Docket No. 02-60, at 2, Att. at 13 (filed Mar. 29, 2011) (noting that HIEM's successful fiber deployments to date appear to have resulted in a greater number of competitively priced bids in subsequent deployments, and arguing that competitive bidding ensures that participants choose the most cost-effective bid, whether it be a lease or build option).

⁴⁵ 47 U.S.C. § 254(h)(3); 47 C.F.R. § 54.617(a).

⁴⁶ 2007 *Pilot Program Selection Order*, 22 FCC Rcd at 20416, para. 107.

IV. COMPETITIVE BIDDING PROCESS AND RELATED MATTERS

11. The Pilot Program requires projects to prepare Requests for Proposals (RFPs) and to use a competitive bidding process to select broadband infrastructure and service providers.⁴⁷ It appears that the competitive bidding process, in combination with bulk purchasing by a large number of health care providers using a single RFP, has led to lower prices, better service quality, and more broadband deployment than the individual HCPs might otherwise have obtained.⁴⁸ In the *NPRM*, the Commission proposed to extend the competitive bidding requirements currently applicable to the Primary Program's Internet access program to the Broadband Services Program, and sought comment on changes that could be made to make the competitive bidding mechanism more successful or efficient.⁴⁹ We now seek more focused comment on issues relating to the competitive bidding process.

- a. Competitive bidding process. Building on the experience gained from the Pilot Program, what specific requirements should be in place for competitive bidding in the Broadband Services Program, if adopted? Should the Commission require consortium applicants in the Broadband Services Program to prepare a Request for Proposal (RFP), as applicants in the Pilot Program were required to do? Should the Commission exempt consortia from the RFP requirement if they are applying for less than a specified amount of support (for example, if they are applying for less than \$100,000 in support)? Are there other elements of the competitive bidding process utilized in the Pilot Program that should be applied to the Broadband Services Program, either as is or with changes that the parties suggest to improve the process? Are there any competitive bidding requirements used in the Schools and Libraries Universal Service Support Mechanism that the Commission should apply to the Broadband Services Program, if adopted?⁵⁰
- b. Requirement to obtain competitive bids. Some commenters indicate individual rural HCPs may decide not to seek RHC support due to the added administrative burden associated with the competitive bidding process. The Virginia Telehealth Network (VTN) states that many rural HCPs are in areas served by a single broadband provider, where competitive options do not exist.⁵¹ Based on USAC's data, approximately 11 percent of RHC Primary Program applicants outside Alaska receive bids in the

⁴⁷ *2007 Pilot Program Selection Order*, 22 FCC Rcd at 29412-15, para. 100-104.

⁴⁸ See USAC Observations Letter at 3; Colorado Feb. 28 *Ex Parte* Letter at 1 (stating that financial benefits have accrued to member HCPs from the joint purchasing power that led to a cost-effective contract with the telecommunications service provider); OHN Feb. 28 *Ex Parte* Letter at 1 (stating that OHN's multi-vendor leased line network framework helped utilize the existing state fiber infrastructure while creating the highest level of competition possible, allowing smaller local carriers to compete directly and fairly with larger providers, which subsequently resulted in OHN's members receiving the most competitive bids (reduced costs) possible); Pilot Conference Call Mar. 13 *Ex Parte* Letter (PMHA *et al.*) at 2 (stating that the benefits of pilot funding include the ability to obtain Internet services as a group); Pilot Conference Call Mar. 26 *Ex Parte* Letter (WNYRAHEC *et al.*) at 2 (stating that WNYRAHEC has experienced a great deal of cost savings from being on a shared network).

⁴⁹ *NPRM*, 25 FCC Rcd at 9414, para. 110.

⁵⁰ See 47 C.F.R. § 54.503.

⁵¹ VTN Comments at 33.

competitive bidding process.⁵² In response to the *NPRM*, VTN recommends that the Commission consider a streamlined service provider selection process for HCPs that do not have multiple broadband service options, such as simply requiring an HCP to submit a simple certification of its efforts to identify all broadband providers and a description of the broadband service option selected.⁵³ In the Broadband Services Program, should competitive bidding only be required for consortium applicants, given the experience to date with the current competitive bidding requirement for individual HCPs in the Primary Program?⁵⁴ We particularly seek comment on this question from HCPs who have experience with competitive bidding as individual HCPs in the Primary Program. Should the Commission consider not applying a competitive bidding requirement to individual applicants who request only a limited amount of funding? Are there any other applicants that the Commission should exempt from competitive bidding requirements under a Broadband Services Program, if adopted?

- c. Multi-year contracts. Participants in the Primary Program must submit funding requests annually, but may obtain “evergreen” status for certain multi-year contracts. Participants with evergreen contracts are not required to go through the competitive bidding process annually.⁵⁵ In contrast, Pilot Program participants were awarded a set maximum award for a multiple-year period and permitted to carry over unused funds from year to year during the duration of the award,⁵⁶ which has reduced the paperwork they needed to file and may have allowed them to lock in stable prices for several years.⁵⁷ Notably, a significant number of Pilot participants opted to make use of long-term prepaid leases

⁵² In the Primary Program, requests for bids are posted for single HCP sites, even when the HCPs are part of a consortium application. On average, from 2006 through 2010, approximately 24 percent of Alaska Primary Program applicants received competitive bids in comparison to approximately 11 percent of non-Alaska applicants. *See* USAC June 27 Data Letter at 2. As of January 2012, Alaska HCPs have received over half of the Primary Program funding, although they make up a far smaller proportion of the number of HCPs receiving support in the Primary Program. *See* USAC May 4 Data Letter at 2-3.

⁵³ VTN Comments at 34; *see also* ATA Comments at 8-9 (stating that the current application process has proven to be onerous to some rural health providers, and suggesting that the Commission explore a streamlined process that does not require local bids); Comments of the American Hospital Association, WC Docket No. 02-60, at 5 (filed Sept. 8, 2010) (AHA Comments) (stating that the competitive bidding requirement could become an unnecessary impediment to participation for smaller HCP in areas where the number of capable providers is low, and urging the Commission to streamline the competitive bidding process).

⁵⁴ *See NPRM*, 25 FCC Rcd at 9414, para. 110 (proposing to apply the competitive bidding requirements of the Internet Access Program to the Broadband Services Program).

⁵⁵ 47 C.F.R. § 54.623(d); *see* USAC Rural Health Care, Evergreen Contracts, <http://www.usac.org/rhc/health-care-providers/evergreen-contracts.aspx> (last visited June 29, 2012). Evergreen status does not extend to situations where a participant seeks to add services, make cardinal changes, renew or extend the contract. *Id.*

⁵⁶ *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20374, para. 35 & 20429-30, App. B; Letter from Dana R. Shaffer, Chief, WCB, to Scott Barash, Acting Chief Executive Officer, USAC (Jan. 17, 2008), *available at* http://hraunfoss.fcc.gov/edocs_public/attachmatch/DOC-279603A1.pdf (instructing USAC to carry over any unused funds for a Pilot project in a funding year to the next funding year).

⁵⁷ USAC Observations Letter at 4.

and infeasible rights-of-use (IRU) arrangements.⁵⁸ For the Broadband Services Program, the Commission proposed to allow evergreen contracts, similar to those allowed in the Primary Program, and also to allow funding for the lease of lit or dark fiber, which is typically purchased under an IRU corresponding to the useful life of the fiber.⁵⁹

Commenters have suggested that the Commission could encourage high capacity broadband networks that would support health care providers' telemedicine and broadband needs by allowing HCPs to enter into long-term contracts for such networks with carriers or other telecommunications providers.⁶⁰ We seek comment on the benefits and drawbacks of providing funding for multi-year contracts, including long-term prepaid leases and IRUs, in the Broadband Services Program. The Nebraska Statewide Telehealth Network (NSTN) recommends that a "true" evergreen provision be applied to HCPs with multi-year contracts, which would allow for HCPs with multi-year contracts to apply only once for multiple years of funding.⁶¹

Would permitting evergreen contracts (as they are implemented today, with the annual filing requirement) be sufficient to allow consortia in the Broadband Services Program to reap the potential benefits of multi-year contracts, while minimizing administrative burdens? Or, would evergreen status need to be coupled with a multi-year award, and if so, would three years be sufficient for the term of the award, or would some other period be more appropriate?⁶² We note that long-term prepaid leases and IRUs generally involve a large, upfront payment. For example, the full cost for a dark fiber IRU is typically paid for in advance.⁶³ If the Commission permitted long-term prepaid leases and/or IRUs in the Broadband Services Program, how should it deal with upfront

⁵⁸ *Id.* at 7. An IRU is an infeasible right to use facilities for a certain period of time that is commensurate with the remaining useful life of the asset, generally 20 years. An IRU confers on the grantee the vestiges of ownership, and is customarily used in the telecommunications industry. It normally involves a substantial sum paid up front, generally priced as a certain amount (depending on market rates) per mile or per fiber mile. *See NPRM*, 25 FCC Rcd at 9395-96, para. 56.

⁵⁹ *Id.* at 9414-15, paras. 111-112; at 9411, para. 101; & at 9395 n. 116. For the Health Infrastructure Program, the Commission proposed to require participants to hold an ownership, IRU, or capital lease interest, and to prohibit short-term or operating leases in which the HCP has no ownership interest. *Id.* at 9395-96, paras. 55-58.

⁶⁰ *See, e.g.*, Comments of General Communication, Inc., WC Docket No. 02-60, at 15 (filed Sept. 8, 2010).

⁶¹ NSTN Comments at 6. *See also* AHA Comments at 5 (supporting proposal to allow providers to enter into multi-year contracts in order to avoid yearly reporting and re-bidding obligations).

⁶² ATA Comments at 9 (recommending "full" implementation of evergreen status, under which an HCP would only be required to re-file Form 467 (receipt of services) annually for a period of three years from the initial date of approval); NOSORH Mar. 28 *Ex Parte* Letter at 2 (noting National Organization of State Offices of Rural Health suggestion that the Commission consider a three-year period of eligibility for the Primary Program so that HCPs would not have to re-file each year, explaining that filing forms every year to receive support is burdensome for small HCPs and many recipients hire contractors to complete required paperwork).

⁶³ *NPRM*, 25 FCC Rcd at 9395 n. 116.

payments?⁶⁴ How would funding multi-year contracts impact the calculation and forecasting of demand for RHC support? What protections should be put in place to protect against waste, fraud and abuse? For instance, would the measures used in the Pilot Program for such arrangements be useful in the Broadband Services Program (such as sustainability plans, minimum contract length, and repayment requirements)? If so, should those same measures be used, or should they be modified in any respect?

- d. Existing Master Services Agreements (MSAs). MSAs permit applicants to opt into a contract for eligible services that have been negotiated by federal or state government entities without having to engage in negotiations with individual service providers. The U.S. Department of Health and Human Services has recommended that the Commission exempt from competitive bidding requirements federal health care providers (such as the Indian Health Service) that are required to use the General Services Administration Network contract for telecommunications services.⁶⁵ Should the Commission permit applicants for the Broadband Services Program to take services from an MSA, so long as the original master contract was awarded through a competitive process? What specific rules should be in place (*e.g.*, an exception to the competitive bidding requirement) in order for HCPs to take advantage of MSAs? Should Pilot program participants that have exhausted Pilot program funding be able to obtain support from the Broadband Services program for services pursuant to MSAs that were negotiated by the Pilot projects?
- e. Eligible service providers. The *NPRM* proposed that broadband services supported by the Broadband Services Program may be provided by “a telecommunications carrier or other qualified broadband access service provider.”⁶⁶ In response to the *NPRM*, some Pilot participants expressed concern that this definition would be too narrow, as it might exclude some vendors that responded to RFPs issued by project participants.⁶⁷ In the Pilot Program, a wide range of service providers responded to the RFPs issued by the project participants, including telecommunications carriers and companies in the fields of systems integration, optical networking, utilities, construction, electronics and equipment.⁶⁸ We seek more focused comment on the specific definition that should be

⁶⁴ For the Health Infrastructure Program, the Commission proposed to support IRUs and to permit capital leases, but proposed to prohibit lease payments in advance of the lease term and proposed to prohibit operating leases in which the lessee has no ownership interest. For the Broadband Services Program, the Commission proposed to limit upfront support for non-recurring charges to \$500,000, and to require non-recurring charges of more than \$500,000 to be part of a multi-year contract and prorated over a period of at least five years. *Id.* at 9398, para. 63, 9411, para. 102.

⁶⁵ *See* Comments of the U.S. Department of Health and Human Services (HHS), WC Docket No. 02-60, at 3 (filed Sept. 10, 2010) (HHS Comments).

⁶⁶ *NPRM*, 25 FCC Rcd at 9443, App. A, para. 23 (proposed Section 54.635); *see also id.* at 9410, para. 98.

⁶⁷ *See* NCTN Comments at 2; CTN Comments at 23; Comments of the Illinois Rural HealthNet, WC Docket No. 02-60, at 15-16 (filed Sept. 1, 2010).

⁶⁸ *See* USAC May 4 Data Letter at App. C. *See also 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20417, para. 110 (waiving section 54.601(c) of the Commission’s rules to enable Pilot participants to receive support for not only telecommunications services and Internet access, but also funding of infrastructure deployment and network design studies).

adopted in our rules for eligible providers under the Broadband Services Program, if adopted.

V. BROADBAND NEEDS OF RURAL HEALTH CARE PROVIDERS

12. Both the *National Broadband Plan* and the *GAO Report* emphasized the importance of determining the broadband needs of health care providers as part of the Commission's reform of its rural health care program.⁶⁹ A number of parties have commented on the broadband needs of health care providers, and USAC has filed an informal needs assessment.⁷⁰ In light of developments since the issuance of the *NPRM*, we seek to refresh the record on various questions relating to the broadband needs of rural HCPs, with particular attention to how the answers may vary based on the size and type of HCP, and how the broadband needs may change over time.

- a. Telemedicine. What bandwidth is needed for various types of telemedicine applications? In particular, how widespread is the use of teleradiology, and what bandwidth is required? How widespread is the use of videoconferencing in providing telemedicine, and what bandwidth is required? Will broadband needs associated with telemedicine likely change over time? What factors will cause the needs to grow? How important are connections between rural HCPs and urban HCPs?
- b. Electronic health records. How will the current trend toward adoption and exchange of electronic health records affect bandwidth needs? Congress has directed the Medicare and Medicaid programs to provide incentive payments for HCPs that have adopted electronic health records and have achieved "meaningful use" of those records, which includes some electronic exchange of those health records.⁷¹ Eventually, achieving "meaningful use" is expected to be mandatory for recipients of Medicare and Medicaid payments. What is the impact of "meaningful use" incentive payments and requirements on likely demand for broadband connectivity for rural HCPs? What is the likely impact of participation by rural HCPs in Health Information Exchanges?
- c. Other telehealth applications. What are the likely broadband needs for other telehealth applications (e.g., training and technical support for health care purposes and health IT applications)?
- d. Service quality requirements. We also seek comment on the needs of rural HCPs for such service quality features as dedicated connections, redundancy, low latency, and lack

⁶⁹ *National Broadband Plan* at 209, 213; U.S. Gov't Accountability Office, FCC's Performance Management Weaknesses Could Jeopardize Proposed Reforms of the Rural Health Care Program, GAO 11-27, at 21-27 (Nov. 2010), available at <http://www.gao.gov/products/GAO-11-27> (*GAO Report*). See also *NPRM*, 25 FCC Rcd at 9413, para. 106 (noting dearth of information on broadband needs of HCPs).

⁷⁰ See, e.g., USAC Needs Assessment; NRHA Dec. 21 *Ex Parte* Letter; NRHRC Dec. 27 *Ex Parte* Letter; ONC Jan. 6 *Ex Parte* Letter; ONC Jan. 17 *Ex Parte* Letter; John Gale Mar. 29 *Ex Parte* Letter.

⁷¹ See HHS Comments at 2; Centers for Medicare and Medicaid, "EHR Incentive Programs," <https://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms/> (last visited June 29, 2012).

of jitter. How much will these added levels of quality add to the cost of broadband services for HCPs? Will privacy and security requirements applicable to health care data exchange affect HCP broadband service quality needs?

- e. Cost savings from broadband connectivity. In the *NPRM*, the Commission recognized that the use of broadband by health care providers has the potential to enable them not just to provide higher quality health care but also to realize substantial savings in the cost of providing health care.⁷² Many of the Pilot projects report that the broadband connectivity made possible by the program helped to generate such cost savings.⁷³ We solicit specific information regarding the nature and magnitude of cost savings that HCPs have been able to achieve through use of broadband, as well as information and data regarding potential for cost savings through telemedicine and other telehealth applications.⁷⁴ Many of these cost savings are realized by the HCPs themselves, through reductions in the number of and length of hospital stays, through savings in patient transport costs, through savings in transportation costs and time for medical professionals, and through other Health IT applications (such as consolidation of billing and scheduling functions, transmission and remote storage of images and medical records, and video-based training of health care and health IT professionals).⁷⁵ Some

⁷² *NPRM*, 25 FCC Rcd at 9372-9373, para. 2.

⁷³ For example, Heartland Unified Broadband Network (HUBNet) estimates that over a thirty-month period, eight hospitals in its network have saved a total of \$1.2 million in transfer expenses following the implementation of e-ICU services. USAC Mar. 16 Site Visit Reports at 7. Similarly, Pennsylvania Mountains Healthcare Resource Development Pilot believes that its network has enabled the development of a revenue cycle management program that has the potential to increase an HCP's bottom line by 2-3 percent, as well as reduce operating costs. *Id.* at 15. One project noted that linking to urban centers and using telemedicine "bends the cost curve." Pilot Conference Call Mar. 26 *Ex Parte* Letter (WNYRAHEC *et al.*) at 2-3.

⁷⁴ Telehealth is defined as the "electronic exchange of information—data, images and video—to aid in the practice of medicine, advanced analytics" and non-clinical practices such as continuing medical education and nursing call centers. It "encompasses technologies that enable video consultation, remote monitoring and image transmission ("store-and-forward") over fixed or mobile devices. *National Broadband Plan* at 200. Although related to telehealth, telemedicine is usually more narrowly defined. The Centers for Medicare and Medicaid Services (CMS) defines "telemedicine" as "two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site to improve a patient's health." Centers for Medicare & Medicaid Services, <http://www.medicare.gov/Medicare-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html> (last visited June 29, 2012). The American Telemedicine Association defines "telemedicine" as "the use of medical information exchanged from one site to another via electronic communications to improve patients' health status." American Telemedicine Association, <http://www.americantelemed.org/i4a/pages/index.cfm?pageid=3333> (last visited June 5, 2012).

⁷⁵ *See, e.g.*, USAC Apr. 27 Site Visit Reports at 3 (noting that Satilla Regional Medical Center in Georgia has been able to reduce patient lengths of stay with no denigration of care through its eICU program); USAC Mar. 16 Site Visit Reports at 9 (describing how Palmetto State Providers Network (PSPN) allows patients to receive psychiatric consults "at any time, with minimal wait" instead of waiting days in hospital's emergency rooms); Quarterly Report of Missouri Telehealth Network, WC Docket No. 02-60, at 5 (filed Jan. 31, 2012) (estimating that since telehealth implementation began, 706 transport trips have been avoided, resulting in annual savings of approximately \$60,000 for Missouri taxpayers); USAC Mar. 16 Site Visit Reports at 10 (explaining that the adoption PSPN's tele-OBGYN service allows physicians to utilize the entire day seeing patients, instead of spending the day driving to rural areas and only being able to see each patient for a few minutes).

commenters note that telemedicine also creates the potential for rural HCPs to increase revenues, because telemedicine can enable rural providers to treat more of their patients locally.⁷⁶ Telemedicine also yields costs savings for patients and their families, who can avoid the cost of travel and loss of workdays by receiving treatment closer to home.⁷⁷ Some of the cost savings from telehealth applications accrue not directly to the HCP or the patients, but rather to other governmental entities (through savings in Medicare and Medicaid expenditures) and to other participants in the health care system (such as private insurers).⁷⁸ We solicit the submission of specific information on all these possible sources of cost savings, including cost data and any studies documenting cost savings.

VI. PROCEDURAL MATTERS

13. Interested parties may file comments and reply comments on or before the dates indicated on the first page of this document. Comments are to reference **WC Docket No. 02-60 and DA 12-1166** and may be filed using the Commission's Electronic Comment Filing System (ECFS). *See Electronic Filing of Documents in Rulemaking Proceedings*, 63 FR 24121 (1998).

- Electronic Filers: Comments may be filed electronically using the Internet by accessing the ECFS: <http://fjallfoss.fcc.gov/ecfs2/>.
- Paper Filers: Parties who choose to file by paper must file an original and one copy of each filing. If more than one docket or rulemaking number appears in the caption of this proceeding, filers must submit two additional copies for each additional docket or rulemaking number.
- Filings can be sent by hand or messenger delivery, by commercial overnight courier, or by first-class or overnight U.S. Postal Service mail. All filings must be addressed to the Commission's Secretary, Office of the Secretary, Federal Communications Commission.
- All hand-delivered or messenger-delivered paper filings for the Commission's Secretary must be delivered to FCC Headquarters at 445 12th St., SW, Room TW-A325, Washington, DC 20554. The filing hours are 8:00 a.m. to 7:00 p.m. All hand deliveries must be held together with

⁷⁶ *See, e.g.*, NRHRC Dec. 27 *Ex Parte* Letter at 2 (stating that keeping more patients locally helps rural hospitals to be successful); Pilot Conference Call Mar. 16 *Ex Parte* Letter at 1-2 (ARCHIE *et al.*) at 1-2 (explaining that keeping patients locally is "better for patients and helps rural hospitals financially"). *See also* NRHRC Dec. 27 *Ex Parte* Letter at 2 (explaining that many CAHs are experiencing negative margins and facing increasing difficulties in accessing capital).

⁷⁷ USAC Mar. 16 Site Visit Reports at 7 (explaining that E-ICU allows patient to stay local, improving outcomes and decreasing stress and cost of travel for patients and families); Quarterly Report of Missouri Telehealth Network, DC Docket No. 02-60, at 6 (filed Jan. 31, 2012) (stating that telehealth utilization saved Missourians nearly 1,700 round trips to specialists' clinics in Columbia and Kirksville, resulting in saved fuel costs of over \$293,000).

⁷⁸ For example, PSPN estimates that it has saved Medicaid \$18 million over an 18-month period through use of telepsychiatry in the emergency departments of HCPs in its network. PSPN Feb. 23 *Ex Parte* Letter at 1; *see also* PSPN Mar. 27 *Ex Parte* Letter at 1.

rubber bands or fasteners. Any envelopes and boxes must be disposed of before entering the building.

- Commercial overnight mail (other than U.S. Postal Service Express Mail and Priority Mail) must be sent to 9300 East Hampton Drive, Capitol Heights, MD 20743.
- U.S. Postal Service first-class, Express, and Priority mail must be addressed to 445 12th Street, SW, Washington DC 20554.

People with Disabilities: To request materials in accessible formats for people with disabilities (braille, large print, electronic files, audio format), send an e-mail to fcc504@fcc.gov or call the Consumer & Governmental Affairs Bureau at 202-418-0530 (voice), 202-418-0432 (tty).

In addition, one copy of each pleading must be sent to each of the following:

- (1) Chin Yoo, Telecommunications Access Policy Division, Wireline Competition Bureau, 445 12th Street, S.W., Room 5-A441, Washington, D.C. 20554; e-mail: Chin.Yoo@fcc.gov;
- (2) Charles Tyler, Telecommunications Access Policy Division, Wireline Competition Bureau, 445 12th Street, S.W., Room 5-A452, Washington, D.C. 20554; e-mail: Charles.Tyler@fcc.gov.

14. This matter shall be treated as a “permit-but-disclose” proceeding in accordance with the Commission’s *ex parte* rules.⁷⁹ Persons making *ex parte* presentations must file a copy of any written presentation or a memorandum summarizing any oral presentation within two business days after the presentation (unless a different deadline applicable to the Sunshine period applies). Persons making oral *ex parte* presentations are reminded that memoranda summarizing the presentation must (1) list all persons attending or otherwise participating in the meeting at which the *ex parte* presentation was made, and (2) summarize all data presented and arguments made during the presentation. If the presentation consisted in whole or in part of the presentation of data or arguments already reflected in the presenter’s written comments, memoranda or other filings in the proceeding, the presenter may provide citations to such data or arguments in his or her prior comments, memoranda, or other filings (specifying the relevant page and/or paragraph numbers where such data or arguments can be found) in lieu of summarizing them in the memorandum. Documents shown or given to Commission staff during *ex parte* meetings are deemed to be written *ex parte* presentations and must be filed consistent with rule 1.1206(b). In proceedings governed by rule 1.49(f) or for which the Commission has made available a method of electronic filing, written *ex parte* presentations and memoranda summarizing oral *ex parte* presentations, and all attachments thereto, must be filed through the electronic comment filing system available for that proceeding, and must be filed in their native format (*e.g.*, .doc, .xml, .ppt, searchable .pdf). Participants in this proceeding should familiarize themselves with the Commission’s *ex parte* rules.

15. For further information, please contact Chin Yoo, Telecommunications Access Policy Division, Wireline Competition Bureau at (202) 418-0295 or TTY (202) 418-0484.

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⁷⁹ 47 C.F.R. §§ 1.1200 *et seq.*

APPENDIX

List of Ex Parte Filings and Short Cites

PARTY	ABBREVIATION	DATE OF FILING	SHORT CITE
John Gale, Maine Rural Health Research Center	John Gale	Mar. 29, 2012	John Gale Mar. 29 <i>Ex Parte</i> Letter
National Association of Rural Health Clinics	NARHC	Mar. 26, 2012	NARHC Mar. 26 <i>Ex Parte</i> Letter
National Rural Health Association	NRHA	Dec. 21, 2011	NRHA Dec. 21 <i>Ex Parte</i> Letter
National Rural Health Resources Center	NRHRC	Dec. 27, 2011	NRHRC Dec. 27 <i>Ex Parte</i> Letter
National State Offices of Rural Health	NOSORH	Mar. 28, 2012	NOSORH Mar. 28 <i>Ex Parte</i> Letter
Office of the National Coordinator for Health Information Technology in the U.S. Department of Health and Human Services	ONC	Jan. 6, 2012	ONC Jan.6 <i>Ex Parte</i> Letter
Office of the National Coordinator for Health Information Technology in the U.S. Department of Health and Human Services	ONC	Jan. 17, 2012	ONC Jan. 17 <i>Ex Parte</i> Letter
Oregon Health Network	OHN	Feb. 28, 2012	OHN Feb. 28 <i>Ex Parte</i> Letter
Palmetto State Providers Network	PSPN	Feb. 23, 2012	PSPN Feb. 23 <i>Ex Parte</i> Letter
Palmetto State Providers Network	PSPN	Mar. 27, 2012	PSPN Mar. 27 <i>Ex Parte</i> Letter
Pilot Project Group Call (Alaska eHealth Network, Southwest Telehealth Access Grid, Tennessee Telehealth Network, Virginia Acute Stroke Telehealth Project, Texas Health Information Network Collaborative)	AEN SWTAG TTN VAST THINC	Mar. 26, 2012	Pilot Conference Call Mar. 26 <i>Ex Parte</i> Letter (AEN <i>et al.</i>)

PARTY	ABBREVIATION	DATE OF FILING	SHORT CITE
Pilot Project Group Call (Arizona Rural Community Health Information Exchange, Erlanger Health System, Kentucky Behavioral Telehealth Network)	ARCHIE Erlanger KBTN	Mar. 16, 2012	Pilot Conference Call Mar. 16 <i>Ex Parte</i> Letter (ARCHIE <i>et al.</i>)
Pilot Project Group Call (Pennsylvania Mountains Health Care Alliance, Palmetto State Providers Network, North Carolina Telehealth Network, Colorado Health Care Connections, Rocky Mountain HealthNet)	PMHA PSPN NCTN CHCC RMHN	Mar. 13, 2012	Pilot Conference Call Mar. 13 <i>Ex Parte</i> Letter (PMHA <i>et al.</i>)
Pilot Project Group Call (Western New York Rural Area Health Education Center, St. Joseph's Hospital, Sanford Health Collaboration and Communication Channel, Oregon Health Network, Geisinger Health System, Bacon County Health Services, Inc.)	WNYRAHEC. St. Joseph's Sanford OHN Geisinger Bacon County	Mar. 26, 2012	Pilot Conference Call Mar. 26 <i>Ex Parte</i> Letter (WNYRAHEC <i>et al.</i>)
Rocky Mountain HealthNet Colorado Health Care Connections	RMHN CHCC	Feb. 28, 2012	Colorado Feb. 28 <i>Ex Parte</i> Letter
Universal Service Administrative Company	USAC	Mar. 14, 2012	USAC Observations Letter
Universal Service Administrative Company	USAC	Apr. 12, 2012	USAC Needs Assessment
Universal Service Administrative Company	USAC	May 4, 2012	USAC May 4 Data Letter
Universal Service Administrative Company	USAC	May 30, 2012	USAC May 30 Data Letter
Universal Service Administrative Company	USAC	June 27, 2012	USAC June 27 Data Letter
Universal Service Administrative Company Site Visit Summary (Northeast Ohio Regional Health Information Network, Heartland Unified Broadband Network, PSPN, Iowa Rural Health Telecommunications Program, PMHA)	USAC	Mar. 16, 2012	USAC Mar. 16 Site Visit Reports

PARTY	ABBREVIATION	DATE OF FILING	SHORT CITE
Universal Service Administrative Company Site Visit Summary (NCTN, Bacon County)	USAC	Apr. 27, 2012	USAC Apr. 27 Site Visit Reports