

September 8, 2010

Honorable Julius Genachowski
Chairman
Federal Communications Commission
445 12th Street, SW
Washington, DC 20554

RE: Rural Health Care Support Mechanism, WC Docket No. 02-60

Dear Chairman Genachowski:

On behalf of our more than 5,000 member hospitals, health systems and other health care organizations, and our 40,000 individual members, the American Hospital Association (AHA) appreciates the opportunity to comment on the Notice of Proposed Rulemaking (NPRM) on the Federal Communications Commission's (FCC) *Rural Health Care Support Mechanism* issued July 15. The Commission is proposing several reforms to its existing universal service health care support mechanism in order to expand the reach and use of broadband connectivity for and by eligible public and non-profit health care providers, including:

- a Health Infrastructure Program to support the construction of new networks connecting health care providers; and
- the Health Broadband Services Program to subsidize a significant portion of recurring costs for access to broadband services for eligible health care providers.

SUMMARY AND STATEMENT OF INTEREST

The AHA has participated in proceedings designed to enhance the availability of Internet access and other broadband facilities to health care providers. We have long endorsed the Commission's efforts to offer financial support for telecommunications services necessary to expand health care services into rural areas. The AHA also has provided the Commission with proposals to improve the use of universal service support mechanisms for rural health care delivery and to enhance program participation. Finally, we have worked with the FCC to promote the existing Rural Health Care Pilot Program, which serves as an important source of lessons learned to inform the proposed changes.



The AHA supports the FCC's goals to increase the availability of broadband facilities and services for health care providers through proposed changes to the rural health care support mechanism. However, we urge the Commission to further streamline the eligibility and application processes used to award the available funds. We are concerned that a program that is too administratively burdensome will be unable to provide support where it is most needed. Previous experience with the Rural Health Care Pilot Program and the current Rural Health Care Internet Access Program provides ample evidence that heavy administrative burdens limit participation. For example, in 2009 only \$60.7 million was spent, out of the \$400 million available.

Broadband connectivity can play a vital and expanding role in our nation's health care delivery system, and it is critical in improving the level of health care service in rural America. Making available the necessary bandwidth to support telemedicine in rural and other underserved communities is a major objective of the FCC's proposed programs. Broadband investment for telehealth purposes will generate significant efficiencies in our health care delivery system, as well as improving access to clinical expertise and health care information in more remote medical facilities.

Expanded access to telemedicine using broadband technologies serves important public health goals by promoting opportunities to remotely monitor patients, facilitate collaboration among medical professionals, and exchange medical data such as mammograms, MRI and CT scans. Telemedicine also reduces the need for patients to travel to specialized facilities for treatment or routine check-ups. As technologies advance and telemedicine expands to more areas of the country, the therapeutic benefits to patients will increase while the costs and burdens of patients traveling are substantially reduced.

The FCC's proposed changes to the rural health care support mechanism are a step in the right direction to achieve those goals. However, problems identified during the Rural Health Care Pilot Program should be addressed in structuring a more permanent program, especially the pilot program's administrative complexity, which discouraged many potential health care providers from initiating the application process. Therefore, the AHA urges the FCC to simplify both proposed programs so that they will be attractive and available to a much wider group of eligible entities, thereby increasing their ability to achieve the lofty goals for which they are being created.

In structuring any program for the development of broadband infrastructure and use of broadband services, the Commission should keep in mind the following key factors:

- The structuring and management of communications services are not primary disciplines for health care facilities. Funding programs must, therefore, avoid complex application processes and provide support for administrative, consulting and legal expenses incurred in the management of the supported projects.
- The health care system in which eligible public and non-profit hospitals operate will also generally encompass for-profit health care facilities, including hospitals,

physician offices, skilled nursing facilities and medical clinics as elements in the provision of quality medical services. The ability to include, and provide access to, those for-profit providers as part of any health care information/communications network will be critical to eligible entities' ability to achieve significant efficiencies and improvements in their own provision of health care services. Restrictions on the ability of eligible entities to leverage for-profit entities' participation in broadband health care networks may significantly decrease the attractiveness of such networks for the non-profit and public entities for which the rural health care support mechanisms are designed.

- The needs of providers for broadband support vary over time. Therefore, the FCC should retain flexibility in setting allocations across programs and per project.
- Health care providers are at varying places with regard to meaningful use of electronic health records. Tying broadband support to meaningful use is unnecessary and could further the existing digital divide between urban and rural providers.
- Institutions that are already involved in the Rural Health Care Pilot Program need guidance on how the FCC plans to transition from its current activities to the proposed programs. Some of those programs may require additional support for infrastructure development, while others may want to transition to ongoing support for broadband services. In either case, current participants need a clear path forward that minimizes duplicative application processes.

THE FCC SHOULD SIMPLIFY THE RULES THAT WILL GOVERN BOTH THE HEALTH INFRASTRUCTURE AND BROADBAND SERVICES PROGRAMS

The Commission proposes an application and selection process for the broadband infrastructure program that consists of an initial application phase, a project selection phase, and a project commitment phase. Under the proposal, even at the initial application phase an applicant would be required, among other things, to verify that the available broadband infrastructure in its area is insufficient for health care delivery. At the project commitment phase, the applicant would face an additional 12 application components and reporting requirements, including a competitive bidding requirement.

The AHA urges the Commission to use a lighter touch in establishing criteria for projects that may be eligible for funding under the broadband infrastructure program and in establishing the application requirements for such projects. Three specific areas of concern are:

- the proposed requirement that applicants conduct detailed studies to show that broadband infrastructure is not available;
- the proposed extensive requirements for contracting and reporting; and
- the proposed requirements on minimum connectivity speeds for funded projects.

Assessment of Broadband Availability

The AHA recommends that the application process for the broadband infrastructure program minimize applicants' obligations to demonstrate that existing broadband resources are insufficient for health information technology (IT) needed for health care delivery. The Commission rightly seeks to focus the Health Infrastructure Program on those areas of the country where the existing broadband infrastructure is inadequate for health care purposes. However, the existence of commercially available facilities in an area may not be determinative of their adequacy for health care purposes, and thus of eligibility for funding under the Health Infrastructure Program. Health care providers choosing to undertake the construction of facilities under the Health Infrastructure Program will have given great weight to any existing broadband alternatives available. Even where some facilities do exist, they may be insufficient for health care purposes, including factors of reliability and quality of services from existing providers.

Further, the types of dedicated facilities that may be constructed using the Health Infrastructure Program will not be competing with existing commercial networks, so the need for a detailed showing of need will pose considerable administrative cost and burden on smaller applicants with minimal benefit for protecting the fund as a whole. While the Commission may choose to give priority to requests for funding in those areas where the applicant has demonstrated that no broadband facilities exist (if aggregate funding available is insufficient to satisfy all applicants in any given year), adding the substantial administrative burdens related to a showing of availability in the application process may not improve the process, but only discourage eligible applicants from requesting funding.

Contracting and Reporting Requirements

In the NPRM, the FCC also proposes detailed mandatory contracting provisions that would be imposed on all construction contracts, indefeasible rights of use (IRU) or eligible capital leases, as well as numerous reporting obligations associated with projects for which funding has been approved, including sustainability reporting, reporting compliance with various project milestones, vendor cost requirements and other quarterly reporting obligations. Given member experience with prior programs, where the burden of reporting could overwhelm project managers, the AHA believes that the FCC should seek to reduce the burden of contracting and reporting requirements associated with the Health Infrastructure Program. Given the plethora of commercial contracts for infrastructure that exist in the very competitive broadband industry today, there is no need for the Commission to dictate contract terms for any infrastructure project.

Similarly, the numerous proposed reporting requirements should be simplified. For example, requiring vendors to maintain books and records to support all cost allocations for infrastructure projects likely will drive up vendor costs. Even more burdensome is the proposal that Health Infrastructure Program participants provide quarterly reports in six areas. Health care providers already are subject to myriad reporting requirements, and smaller medical facilities simply will not have the resources to take on quarterly – or even semi-annual – reporting requirements. Commission assessments of grantees' performance should be sufficient if they are undertaken annually.

Minimum Connectivity Speeds

In the NRPM, the Commission asks whether it should set a minimum connectivity speed for infrastructure projects in order to assure that funds are being used efficiently. As a general matter, the AHA is concerned that setting the minimum at the proposed 10 Mbps may result in unnecessary expenditures and preclude the use of cost-effective technologies that could adequately serve the needs of rural facilities connecting to larger hub medical resources. Therefore, if the Commission determines that it must set a minimum connectivity speed for infrastructure projects, the AHA urges the Commission to set that minimum at a level consistent with current practice and as low as reasonably possible.

The requirements for the Health Broadband Services Program also should be simplified. As with the Infrastructure Program, the Commission has suggested that it will fund only projects with minimum throughput, although it acknowledges that different providers will require different capacity levels to meet their needs. The NPRM also proposes to require that all services be obtained through a competitive bidding process.

We urge the Commission to streamline its proposal that a Health Broadband Services Program recipient be required to employ competitive bidding. For smaller health care providers in areas where the number of capable providers is low, this requirement could become an unnecessary impediment to participation. Moreover, for many rural providers, price will not be the only acceptable criterion for choosing a vendor. Many health care providers may have organizational affiliations that warrant interconnection through a private network, or other specific technical needs that also must be considered in choosing a broadband service provider. If the Commission proceeds to adopt this requirement, we urge that well-defined exemptions be provided to allow fund recipients to contract based on organizational affiliations and to protect health care providers where the benefits of competitive bidding are likely to be small. The AHA also supports the proposal to allow providers to enter into multi-year contracts in order to avoid the yearly reporting and re-bidding obligations, particularly where no changes are likely to occur and the services continue to be eligible for funding support.

The AHA also does not believe that the Commission needs to set a high bar on the minimum level of broadband capability that will be supported under the Health Broadband Services Program. No "one size fits all" description can fit any particular health care provider in any given circumstance. Health care providers generally should be given wide latitude to choose the broadband services, including the level of redundancy and reliability, that they require for their individual needs. Further, as the Commission notes, since the support only covers 50 percent of health care providers' costs, their own financial incentives should be to remain cost-effective as well as technology-efficient.

The AHA supports the Commission's proposal to allow service providers to receive payment for discounted services directly from the fund rather than as an offset to the vendor/carrier's universal service contribution obligations. Just as this reimbursement mechanism will simplify the administration of the program, the Commission should seek other ways to further simplify these funding mechanisms in order to benefit health care providers and their vendors.

Reimbursable Costs Should Be Expanded

Under the Commission's current rural health care Internet access program, a 25 percent discount is provided to all eligible rural health care providers and a 50 percent discount is provided to eligible providers in states that are entirely rural. In the NPRM, the Commission recognizes the need to expand those entities that are eligible for the 50 percent discount and to broaden the eligibility criteria to include non-medical elements of a health care provider's practice.

The AHA supports the Commission's proposal under the Health Broadband Services Program to extend at least a 50 percent discount to all eligible providers, regardless of jurisdiction. In order to recognize, however, that even a 50 percent discount may not be sufficient for smaller, less advantaged health care providers, it also is important for the Commission to establish a mechanism by which eligible health care providers can reasonably and promptly qualify to obtain greater discounts upon a showing of need.

The AHA supports the expansion of eligible entities under the Health Broadband Services Program to include off-site administrative offices. As health care providers seek to maximize the use of health care campuses for their core expertise and minimize their real estate costs by moving certain administrative staff off-site, it would be unfair to penalize those providers who achieve those efficiencies by denying them subsidies for the cost of interconnecting these off-site locations with the rest of their broadband network.

In the NPRM, the Commission lists a number of non-recurring costs it will reimburse, expressing a concern that funds intended to expand broadband infrastructure should not be unduly dedicated to the management of an infrastructure project. While the AHA shares this objective, we believe that the Commission should nevertheless expand its list of non-recurring costs eligible for reimbursement from the infrastructure fund to include expenses similar to those that have been deemed eligible under the Broadband Technology Opportunities Program (BTOP) administered by the National Telecommunications and Information Administration and/or the Broadband Initiatives Program (BIP) administered by the Rural Utilities Service. Otherwise, the requirement could unduly burden many eligible entities who will be unable to shoulder those non-reimbursed costs.

For example, both BTOP and BIP will fund reasonable expenses in preparing an application as well as other administrative costs associated with network design, construction and contract administration. By contrast, while the Commission imposes a cap on administrative expenses of 10 percent of the award, it also limits annual expenditures to an artificially low \$100,000, regardless of the amount of the award. The Commission suggests this limit is based on paying for one full-time employee per project. However this level of funding may not be sufficient to cover all administrative activities. As noted above, some eligible health care facilities will rely on outside consultants to perform these functions. While a 10 percent cap may be justified, an arbitrary \$100,000 per year limit is not. Inadequate funding of administrative costs will discourage many applicants from participating.

Similarly, unlike the Commission's proposals in the NPRM, which would severely limit reimbursement of legal expenses, BTOP does not exclude relevant legal costs from

reimbursement. The FCC's program should not do so either. In the case of the Health Infrastructure Program, it is likely that smaller applicants may expend significant amounts for legal fees involved in forming a consortium, negotiating a long-term lease or IRU, and complying with the FCC's *National Environmental Policy Act* and *National Historic Preservation Act* requirements. Given the likely lack of any in-house legal resources available for such purposes, reimbursement of these costs under the Health Infrastructure Program will be critical to the applicant's ability to satisfy the program requirements.¹

THE FCC SHOULD RECOGNIZE THAT FOR-PROFIT ENTITIES ARE AN INTEGRAL PART OF THE RURAL HEALTH CARE SYSTEM

The AHA is pleased that the Commission intends to allow eligible entities to form consortia in order to pool resources in a more efficient applicant structure for the Health Infrastructure Program. The AHA also strongly supports the Commission's decision to continue the flexibility offered in the pilot program and allow health care providers to "join with state organizations, public sector (governmental) entities, and non-profit entities that are not eligible health care providers . . . to act as administrative agents for eligible health care providers within a consortium (para. 27)." Given the limited resources available to many smaller and most rural health care providers, the ability to join a larger group, administered by entities with greater expertise in such matters, will create an increased incentive for participation in the program. The AHA also supports the Commission's proposal to allow consortia leaders to obtain reimbursement of appropriate administrative expenses associated with the creation and participation of a consortium in the Health Infrastructure Program, and to hold title to any infrastructure/IRU/lease that may be created with the funds, for the beneficial interest of eligible health care providers.

The FCC's discussion of permissible consortium members in paragraphs 27-28 of the NPRM omits references to for-profit entities. However, it is unclear why consortia could not also include in their membership a for-profit private sector entity, including not only a for-profit entity which meets the eligibility requirements for a "health care provider,"² but other health care providers, such as a physician or other individual authorized under state or federal law to provide health care services, or any other health care facility operated by or employing individuals authorized under state or federal law to provide health care services. To the extent that such an entity would not qualify directly for funding under either the Health Infrastructure or Broadband Services Programs, but otherwise has a commonality of interest in the improvement of medical services in an area, there seems little policy rationale for excluding such entity's participation in eligible consortia. Indeed, in developing infrastructure and planning broadband network connections, providing access to for-profit health care providers is likely to be a key

¹ See BTOP Round 2 Grant Guidance, Comprehensive Community Infrastructure, Version 2.0, March 1, 2010, Section 18.8, page 87-88, 96 (listing legal costs as examples of eligible costs).

² 47 U.S.C. § 254(h)(7)(B) defines "health care provider" as: (1) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (2) community health centers or health centers providing health care to migrants; (3) local health departments or agencies; (4) community mental health centers; (5) not-for-profit hospitals; (6) rural health clinics; and (7) consortia of health care providers consisting of one or more entities described in clauses (1) through (6).

element in an eligible entity's ability to take full advantage of expanding broadband services and technologies. The Commission's rules have appropriately been designed to assure that non-eligible consortia members will not benefit from the federal resources that are intended for eligible members. As long as for-profit private sector entities are subject to the same restrictions, the AHA believes that the health care community as a whole will benefit by permitting them to be part of these consortia.

In the NPRM, the Commission proposes placing strict limitations on how an eligible entity can establish the availability of resources needed to satisfy the Commission's requirement that at least 15 percent of a project be funded from other sources. The AHA is concerned that the proposed restrictions on the allowed sources of support would eliminate many sources of matching funds, such as in-kind contributions from in-house personnel or volunteers, or in-kind or monetary contributions from carriers, contractors or other for-profit entities, making the match more difficult to achieve. The Commission acknowledges that some Pilot Program applicants have had difficulty meeting the matching requirement. The FCC's proposed restrictive approach would increase the burden on smaller entities that do not have the added capital to contribute to such a project. The AHA recommends that the FCC adopt a broader approach.

The FCC should consider allowing in-kind contributions (including in-house labor and volunteer labor) from applicants or consortium participants (including for-profit members), in-kind or cash contributions from third-party service providers, or cash contributions from for-profit participants, such as for-profit hospitals that may be willing to pay to be connected to an expanded broadband health network.³ The benefits of improved telehealth capabilities cannot be fully achieved if for-profit health care services providers are not part of the health care delivery network. Allowing their funds, as well as in-kind or cash contributions of third-party service providers, to support the eligible entities' participation will assure that the target eligible entities are able to access the critical broadband facilities that are being constructed using federal funding. The AHA also urges the Commission to establish in the final rule a reasonable path, including well-defined guidelines, by which eligible applicants may seek a waiver of the 15 percent matching requirement upon a showing of financial hardship and demonstrating that the project can be sustainable even in the absence of the requisite matching funds, just as in the BTOP program.⁴

The FCC also seeks comment on measures to adopt to prevent fraud, waste or abuse in funding infrastructure projects that will have excess capacity available for use by entities that are not eligible health care providers. Although the goals are worthy, the AHA is concerned that any restrictions adopted on shared use of funded infrastructure by for-profit entities – and the method of pricing any excess capacity that may be built into a particular project – should not discourage the ability to expand a funded infrastructure project to satisfy the needs of for-profit health care facilities. The delivery of high-quality health care services using advanced technology will not be limited to public and non-profit providers. The Commission should be wary of unduly restricting the ability of eligible entities to provide additional capacity in their projects to for-profit health care providers, such as by imposing the proposed fully distributed costing

³ See 2nd NOFA BTOP Guide Section 1.8, pages 5-6.

⁴ *Id.* Section 1.12.1, page 10.

methodology. Doing so could make use of excess capacity of funded facilities less than cost-effective to the detriment of fully achieving the public interest benefits of the Health Infrastructure Program.

FUNDING CAPS SHOULD BE FLEXIBLE

The Commission proposes to impose caps on individual awards and on the aggregate of all awards that it may make in any given fiscal year. Annual funding caps on either of the Rural Health Care Support programs is one way of ensuring that funds will be available for those who may be unable to obtain broadband services during the initial phases of the program. However, as with other elements of this program, the AHA urges the Commission to retain flexibility to increase the amount available, notwithstanding the annual cap, where obvious needs are demonstrated. It is important that the FCC not use artificial caps on program funds to delay the expansion of broadband services where health care providers are ready to implement facilities but cannot do so without the appropriate federal support. The AHA suggests the FCC allow the Universal Service Administrative Company (USAC) some flexibility to exceed the cap in any given year where demand for support exists.

MEANINGFUL USE CRITERIA SHOULD NOT BE EMPLOYED IN THE CONTEXT OF THE BROADBAND FUNDING MECHANISMS

In the NPRM, the Commission asks whether and how the agency could align its performance measures with the “meaningful use” criteria currently being developed by the U.S. Department of Health and Human Services (HHS) to measure the efficient use of health IT.⁵

The AHA strongly opposes any requirement tying eligibility for broadband funds to meaningful use criteria. The meaningful use criteria are intended to measure the use of electronic records, which is distinct from the use of telecommunications services to provide health services. In addition, access to broadband connections is likely to be a necessary precursor to meaningful use, since the meaningful use criteria include health information exchange measures, which by definition require access to broadband. We also are concerned that tying access to broadband funds to meaningful use could further the digital divide that currently separates many rural and urban communities. A recent study published in *Health Affairs* indicates that small/medium size, rural and public hospitals were among the least likely to have adopted a basic electronic health record system, and will face considerable challenges in getting to meaningful use.⁶ Adopting a meaningful use criterion, therefore, will have the unintended consequence of furthering the digital divide between urban and rural hospitals by depriving rural hospitals of access to the FCC’s funding programs. In addition, requiring eligible entities to maintain and provide the documentation related to any meaningful use criteria for telemedicine applications will place a significant burden on providers already faced with enormous documentation requirements.

⁵ NPRM at para. 142.

⁶ See “Tracking Hospital Use of Electronic Health Records,” August 26, 2010 issue of *Health Affairs* at www.healthaffairs.org.

Finally, as the Commission also recognizes, meaningful use is intended to be certified at the individual hospital or physician level, while the FCC's proposed programs are intended to support a variety of eligible entities and should not be designed to discourage eligible entities from forming or participating in a consortium application if the consortium could be penalized for the non-compliance of a single user.

THE COMMISSION SHOULD PROVIDE FOR AN ORDERLY TRANSITION FOR CURRENT PILOT PROGRAM PARTICIPANTS

The AHA recommends the Commission provide the current Rural Health Care Pilot Program participants clear guidance on the transition from their existing funding to the new permanent program being established. To the extent that the Commission adopts new eligibility requirements, reporting obligations or reimbursement restrictions, steps should be taken to assure that none of the pilot program participants are adversely impacted, while also ensuring that those same entities can obtain the benefits of any relaxation in program requirements that the FCC may adopt. In addition, pilot program participants should be permitted to choose whether to transition to the newly adopted rules without the need for re-applying.

CONCLUSION

A newly structured support mechanism for the expansion of broadband services to a broad base of health care services providers will provide a significant boost to the nation's health care delivery network. Broadband capabilities will be critical to the advancement of health care delivery in rural areas, but also in advancing medical services in all areas of the country. The NPRM, with our recommended changes to simplify and tailor the program, represents another significant step toward reaching the nation's health care objectives. The AHA looks forward to working with the Commission on this initiative and ensuring that broadband capabilities are advanced across America.

Thank you for the opportunity to submit these comments. If you have any questions, please contact me or Kristin Welsh, vice president, strategic initiatives and business group outreach, at kwelsh@aha.org or (202) 626-2322.

Sincerely,

_____/s/
Rick Pollack
Executive Vice President

Cc: The Honorable Meredith Attwell Baker The Honorable Michael J. Copps
The Honorable Mignon L. Clyburn The Honorable Robert M. McDowell
Sharon Gillett, Chief, Wireline Competition Bureau