

**Before the
Federal Communications Commission
Washington, D.C. 20554**

In the Matter of)	
)	
Rural Health Care Support Mechanism)	WC Docket No. 02-60
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)	

COMMENTS OF GENERAL COMMUNICATION, INC.

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SUMMARY

General Communication, Inc. (GCI) supports the Commission's continuing efforts to streamline and improve the rural health care universal service support mechanism. Many of the Commission's tentative proposals have a great deal of merit, and GCI believes that this proceeding has the potential to more fully realize Congress' intent by enabling rural Americans to use advanced telecommunications to benefit from the latest medical advances and the best possible medical care.

GCI proposes that the Commission modify its approach to rural health care support in the following ways. First, the Commission should clarify that the term "rural health clinic" encompasses rural centers that provide various medically necessary health services ranging from prenatal care to substance abuse treatment, as well as hospices in remote areas where rural health care universal service support is the crucial link in bringing physicians to non-ambulatory patients.

Second, the Commission should follow through on its tentative proposal to provide universal service support for Internet access for rural health care providers; such access is of great value to rural health care providers, is fully consistent with Section 254 of the Act, and is particularly important in remote areas such as the Alaskan bush, where GCI's satellite service provides the only telecommunications link to many villages.

Third, GCI urges the Commission to look to functional equivalents when calculating discount services, so that rural health care providers in the Alaskan bush can receive discounts for satellite service in communities that often have no terrestrial service whatsoever, and seldom have "reasonably priced" terrestrial alternatives.

Finally, the Commission can streamline the funding process by combining Forms 466 and 468, and by adopting a clear policy of funding priorities based on the Schools and Libraries Division (SLD) model, where telecommunications funding is favored over Internet funding and applications that are received before a date certain are favored over late-filed applications.

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General Communication, Inc. (GCI) commends the Commission for having issued the *Notice* that began this proceeding¹ and thereby undertaking to streamline and improve the support mechanism administered by the Rural Health Care Division (RHCD) of the Universal Service Administrative Company (USAC). GCI supports the Commission’s effort to improve the support program for rural health care providers, and offers the following comments on specific areas where the program can be improved. Specifically, GCI believes that the Commission should:

- Explain that the statutory definition of “rural health clinic” includes a wide range of rural centers that provide health counseling and other health-related services, as well as to include points of community treatment for non-ambulatory patients;
- Support Internet access for rural health care providers;
- Look to functional equivalents, including satellite services, when setting discount rates;
- Streamline the application process by combining and minimizing paperwork to reduce delays and dropout applicants; and
- Prioritize funding in the event the annual cap is exceeded, setting clear filing windows for priority and also ensuring that basic telecommunications services receive higher priority than Internet access funding requests.

¹ Notice of Proposed Rulemaking, *Rural Health Care Support Mechanism*, WC Docket No. 02-60, rel. Apr. 19, 2002, FCC 02-122, 2002 FCC LEXIS 1958 (“*NPRM*”).

I. ALASKA DEMONSTRATES THE TREMENDOUS PUBLIC BENEFITS OF RURAL HEALTH CARE SUPPORT.

Deployment of telecommunications services to rural health care providers in Alaska is one of the Telecommunications Act of 1996's true success stories. GCI – a diversified communications carrier that offers facilities-based interexchange service, facilities-based competitive local-exchange service, ISP, cable, and other services – is the largest provider of telecommunications services to rural schools, libraries, and health care providers in Alaska. GCI provides C-band, Ku-band, or leased microwave communications service to more than 160 remote villages in the Alaskan bush, and its services include providing “TeleHealth” broadband access to nine regional health organizations and 70 rural health clinics. In total, approximately twenty rural health care providers in Alaska are receiving telecommunications services supported by federal universal service.

This support has led to a dramatic transformation of health care delivery in rural Alaska. Rural Alaska – known as the “bush” – is characterized by small villages, usually of only a few hundred in population, that are separated by great distances with no interconnecting roads. Literally, the only way to reach these villages is by airplane, by boat, or by snow machine over frozen winter trails. In these villages, usually the only health care provider is a community health aide (CHA) with no more training than an EMT. Doctors arrive only periodically, if at all. Even today, when advanced emergency services are necessary, the patient must be airlifted to Anchorage – a substantial expense. Until very recently, for emergency triage, or for routine or more minor care, prior to rural health care provider support, the CHA's or a family member's only recourse was to describe the patient's condition and symptoms over the phone to a physician who then had to make medical decisions without any opportunity to actually observe her patient.

An example of the transformation brought about by rural health care universal service support is in the Kotzebue region, a collection of twelve villages more than five hundred air miles from Anchorage. In eleven of these villages, the local CHA can connect to a family practice physician at a regional hospital in the town of Kotzebue. With real-time, two-way streaming videoconferencing capability, these physicians are actually able to observe and communicate with their patients. They no longer have to try to diagnose the cause of a rash by relying on an oral description over a radio or a telephone. Electronic transmission of files, images, and document scans make it possible for a radiologist in the lower 48 to read x-rays instantaneously, for an obstetrician in Juneau to assist in childbirth, for a dermatologist in Anchorage to examine a suspicious rash, and for a trauma specialist in Fairbanks to triage emergency situations and make immediate, informed decisions about medical evacuation needs.

Rural health care support has worked. But as the *Notice* reflects, it can be improved still further. GCI's specific recommendations for reform of the rural health care universal service support program are laid out in the following sections.

II. THE COMMISSION SHOULD CLARIFY THE MEANING OF "RURAL HEALTH CLINIC."

In discussing the scope of the term "health care provider," the Commission has always relied on the seven specifically enumerated categories of health care providers listed in Section 254(h)(7)(B). Those seven categories are:

- i. post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools;
- ii. community health centers or health centers providing health care to migrants;
- iii. local health departments or agencies;
- iv. community mental health centers;
- v. not-for-profit hospitals;
- vi. rural health clinics; and

vii. consortia of health care providers consisting of one or more entities described in clauses (i) through (vi).²

In its first implementation of the health care provider support scheme five years ago, the Commission concluded that these seven categories are “unambiguously described” in the Act and, therefore, adopted the Joint Board’s “recommendation that the Commission attempt no further clarification of the term”³ The Commission, therefore, has never defined any of these terms. Respectfully, GCI believes that it has become necessary for the Commission to at least clarify the meaning of “rural health clinic” and ensure that legitimate rural health care providers are not turned away by the RHCD.

The term “rural health clinic” is sometimes interpreted in the field as encompassing only locations with physician-based services. This definition is too narrow, and does not capture the full range of health care services necessary to a modern, holistic approach to medical care. In the villages to which GCI provides service, for example, there are several rural centers that provide health services relating to prenatal care, dietary assistance, substance abuse, family planning, wellness, and similar health services, but which are not affiliated with organizations providing physician-based services.

Nothing in the words “health clinic” requires that the organization be physician-based. The Commission has previously found, for example, that the Act permits support for “non-clinical, public health services.”⁴ Clinics that provide these related, medically necessary, non-

² See Sixth Order on Reconsideration in CC Docket No. 97-21; Fifteenth Order on Reconsideration in CC Docket No. 96-45, *Changes to the Board of Directors of the National Exchange Carrier Association, Inc.; Federal-State Joint Board on Universal Service*, 14 FCC Rcd 18756, 18786 (¶¶ 48- 49) (1999) (“*Fifteenth Order on Reconsideration*”).

³ See Report & Order, *In re Federal-State Joint Board on Universal Service*, 12 FCC Rcd 8776, 9118 (¶655) (1997) (“*Universal Service Order*”).

⁴ See *id.*, 12 FCC Rcd at 9100 n.1596 (1997).

physician-based services to the public on a not-for-profit basis should be eligible for support, so long as they are state certified or are independent departments of state-certified rural health care providers. Centers of this type are clearly within the meaning of the term “rural health clinic” in Section 254(h)(7)(B)(vi). But without an explicit Commission statement that such rural health clinics are eligible for RHCD funding, they are at the mercy of RHCD’s sometimes arbitrary eligibility determinations.⁵

In addition, the Commission should recognize that organizations such as hospices in these tiny communities without physicians are important points of care for those in the community who are no longer ambulatory and therefore cannot make it across the village to the health clinic. Excluding these points of care for the non-ambulatory population imposes an urban perspective on rural health care delivery. Thus, the Commission’s previous decision to exclude hospices or long-term care facilities for lack of a “convincing justification”⁶ was unduly narrow, especially as applied to the unique circumstances of these remote Alaska villages. It must be remembered that the physician cannot physically drop by on rounds, as would be the case at an urban nursing facility. In this case, it is crucial to bring the physician to the patient through telecommunications. Although the statute’s use of the word “clinic” precludes individual home uses, there is no reason why the natural meaning of the word “clinic” cannot include a group setting that is potentially available to all members of the very small village community.

⁵ See generally Request for Review of Decision of the Universal Service Administrator, CC Docket Nos. 96-45 & 97-21, filed by Kawerak, Inc., Mar. 9, 2001 (appealing RHCD’s denial of “community mental health center” status to several centers operated by Alaskan Indian tribes because they lacked state certification, in spite of the fact that the centers had equivalent tribal certifications).

⁶ *Universal Service Order*, 12 FCC Rcd at 9118 (¶ 655); see also *Fifteenth Order on Reconsideration*, 14 FCC Rcd at 18786 (¶¶ 47-48).

Clarifying the eligibility of such health care centers will further multiple statutory directives. It will help effectuate the Commission's duty to make "available, so far as possible, to all the people of the United States ... a rapid, efficient, nationwide ... wire and radio communication service with adequate facilities at reasonable charges ... for the purpose of promoting safety of life"⁷ And it will give fuller effect to the Congressional purpose; Congress intended for the universal service support for rural health care providers to "provide the ability to ... find new information on the treatment of an illness, to Americans everywhere"⁸

III. THE COMMISSION SHOULD PROVIDE SUPPORT FOR INTERNET ACCESS FOR RURAL HEALTH CARE PROVIDERS.

GCI urges the Commission to follow through with its tentative proposal to provide universal service support for Internet access for rural health care providers.⁹ Much has changed since the Commission in 1997 first adopted proposals to support a limited amount of interexchange toll service to reach dial-up Internet access. The power of the Internet has continued to grow, with applications and resources that are more and more bandwidth intensive. The resources available on the web, and usage patterns have also changed. It is much more likely now that a physician would move among many different medical reference sites, rather than simply downloading from a single source.

What makes Internet access so valuable to teachers is the same thing that makes it so valuable to health care providers – easy access to relevant, useful information. Providing support for Internet access is also entirely consistent with Congress' purpose in passing Section 254; Congress intended for the provisions that provide support to health care providers to "open new

⁷ 47 U.S.C. § 151; *see also* NPRM ¶ 12.

⁸ H.R. REP. NO. 104-458, at 132 (1996).

⁹ NPRM ¶ 22.

worlds of knowledge, learning and education to all Americans – rich and poor, rural and urban.”¹⁰

Dial-up Internet access over toll facilities is wholly inadequate to serve these needs, especially in the type of rural conditions found in Alaska. For the most part, data rates for dial-up Internet access over toll facilities are far below urban dial-up Internet access speeds. In Alaska, these calls must be routed from the bush villages into Anchorage over satellite facilities. This drops the throughput rate down to a trickle.

More generally, any support that pushes the Internet “cloud” further into rural areas will increase points of presence (POPs) into the communities served by rural health care providers, leading to better service and bringing the benefits of the Internet more fully into that entire community. GCI’s experience with rural health care and schools and libraries support illustrates how this occurs. Today, GCI has begun to install unlicensed wireless equipment to offer high speed Internet access in villages at the same prices charged in Anchorage, Fairbanks and Juneau for GCI’s cable modem services. By 2004, GCI intends to roll out this service to all areas that it currently serves, other than those served by cable modem service.

Therefore, Internet access for rural health care providers should be supported by universal service funds just as such access is supported for schools. The mechanism for determining support could simply be the same as the mechanism that USAC already uses for existing non-mileage support calculations: the rate would be the rural Internet access data rate minus the equivalent closest standard urban area data rate. Alternatively, the Commission could adopt the method already in use for libraries: the discount percentage of the school district in which the facility is located, multiplied by the rural Internet access rate. Adding such support

¹⁰ H.R. REP. NO. 104-458, at 132 (1996).

would bring true Internet functionality to health care providers in rural areas that otherwise will not have service.

IV. THE COMMISSION SHOULD LOOK TO FUNCTIONAL EQUIVALENTS WHEN CALCULATING DISCOUNTED SERVICES.

GCI provides its rural services almost exclusively via satellite; many of the bush communities that receive GCI satellite service are accessible by plane or satellite only, and not by roads, much less terrestrial telecommunications services. Therefore, GCI strongly supports the Commission's proposal to look to the comparative functionality from the perspective of the end user, and not necessarily just to technical similarity, when determining the "similarity" of certain services for discount calculations.¹¹

As the Commission rightly notes, GCI and other providers of satellite service have been "particularly disadvantaged" by the current rules, which simply compare rural satellite rates to (identical) urban satellite rates, and offer no discount at all.¹² Of course, those rural health care providers that "have reasonably priced land-based alternatives"¹³ may not require support for satellite access, but much of the Alaskan population has no terrestrial service, the rural health care providers in the Alaskan bush communities served by GCI often have *no* alternative whatsoever to satellite service, and there is almost never a "reasonably priced" terrestrial alternative.¹⁴ Thus, GCI supports the Commission's move toward technology-neutral decision-making that is based on legitimate cost effectiveness and functional equivalence, rather than simply on distance.

¹¹ *NPRM* ¶¶ 32, 35, 38.

¹² *Id.* ¶ 38.

¹³ *Id.* ¶ 38.

¹⁴ *See generally* Notice of Proposed Rulemaking, *Extending Wireless Telecommunications Services to Tribal Lands*, 14 FCC Rcd 13679, 13686 (¶ 13) (1999).

V. GCI SUPPORTS STREAMLINING THE APPLICATION PROCESS.

In light of the Commission's request for suggestions on streamlining the application process,¹⁵ GCI suggests that FCC Forms 466 (Funding Request and Certification) and 468 (Telecommunications Carrier) be combined into a single form. A service provider could initiate this combined form by supplying contact data, service descriptions, and pricing information, and then forwarding it to the applicant for consideration and approval. The applicant could then complete their contact information and provide usage certifications.

In keeping with the Commission's goal of expanding participation in the rural health provider support program, such a combined form would eliminate delays and cut down on the number of rural health care providers who fail to complete the application process due to confusion or due to carrier unresponsiveness.¹⁶

VI. IF THE ANNUAL CAP IS EXCEEDED, THE COMMISSION SHOULD PRIORITIZE FUNDING BY TYPE OF REQUEST AND BY ORDER OF REQUEST.

The Commission has sought comment on its current rules, which provide for straight pro-rata allocation of funds if funding requests ever exceed the annual cap.¹⁷ GCI believes that RHCD funding should be prioritized just as Schools and Libraries Division (SLD) funding is prioritized; *i.e.*, telecommunications funding requests should be categorized as Priority One, and Internet access funding requests as Priority Two. The Commission should also use the SLD filing window rules to establish priority for RHCD funds. Thus, all applications filed in an initial window would be on equal footing, and if the annual cap is not sufficient to fund all of those applications, they would receive 100% funding for Priority One (telecommunications) requests

¹⁵ See *NPRM* ¶ 51.

¹⁶ See *id.* ¶ 52.

¹⁷ See *id.* ¶ 54.

and pro rata funding for Priority Two (Internet access) requests. Any later-filed applications (*i.e.*, after the close of the filing window) would be eligible, on a first-come, first-served basis, to receive whatever funds remain after the initial applications are processed. If the annual cap were exhausted in funding the initial applications, then late-filed applicants would receive nothing.

Such a prioritized system would have many public policy benefits, including a more predictable filing window, reduced time lags in the filing process (particularly if the Commission adopts a combined Form 466/468, as recommended above), better controls on the competitive bidding process due to better understanding of definitive application deadlines, and, eventually, reduced administrative costs due to the filing routine procedures that will be the eventual result of firm priority deadlines.

VII. CONCLUSION.

The FCC is to be commended for tackling the topics raised in this review. The Commission can ensure better access for rural health care providers by explaining the statutory definition of “health care provider,” by supporting Internet access for rural health care providers,

by looking to functional equivalents when setting discount rates, by streamlining the application process, and by prioritizing funding in the event the annual cap is exceeded.

Respectfully submitted,

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