Center for Telemedicine Law
1050 Connecticut Avenue, NW
Washington, DC 20036-5339
Phone 202/857-6000
Fax 202/857-6395
E-mail telemedlaw@ctl.org

July 1, 2002

Ms. Marlene H. Dortch
Office of the Secretary
Federal Communications Commission
445 12th Street, S.W.
Washington, D.C. 20554

Re: WC Docket No. 02-60
Notice of Proposed Rulemaking Regarding the Universal Service Support Mechanism for Rural Healthcare
Response to Comments

Dear Ms. Dortch:

We are writing to express our agreement with and support for the Comments submitted to the Federal Communications Commission (FCC) on the above captioned Notice of Proposed Rulemaking (NPRM) by Joseph Tracy, Karen Rheuban, M.D., Rob Sprang, Sam Burgiss, Ph.D., Mary DeVany, Jana Katz, Eugene Sullivan and Nina Antoniotti, Ph.D. A copy of those Comments (hereinafter referred to as "the Comments") is attached to this letter.

The Center for Telemedicine Law (CTL) is an organization devoted to exploring the legal and regulatory aspects of telemedicine. Founded by a number of leading healthcare organizations (including the Mayo Foundation, the Midwest Rural Telemedicine Consortium, the Cleveland Clinic Foundation and Texas Children's Hospital), CTL seeks to identify and clarify the legal and regulatory barriers to the use of telemedicine and to offer solutions for overcoming those barriers.

While CTL endorses all of the proposals advanced in the Comments, we particularly wish to emphasize the need for expanding the definition of "eligible health care providers." The definition currently being utilized does not allow participation in the Universal Service Support Mechanism (USSM) by many healthcare service providers in rural areas, notably nursing homes and other long term care facilities. These organizations simply are not able to pay the full cost of telecommunication services for telehealth without financial support from the USSM. Furthermore, the definition should be expanded to allow participation in the USSM by a for-profit hospital when that hospitals is the only hospital serving a county and/or accepts Medicare or Medicaid patients at a level of more than 50% of its gross revenues.

In addition to supporting the Comments with regard to their recommendation concerning expansion of the definition of "eligible healthcare provider," CTL also subscribes to the

suggestion in the Comments that the application and administrative processes be streamlined. This could be accomplished in part by developing a single application form, whereby an applicant organization would provide the Rural Health Care Division (RHCD) with the six items of information outlined on page 8 of the Comments.

We believe adoption of the proposals advanced by the authors of the Comments will serve as a catalyst to encourage more widespread participation in the USSM for telehealth applications by rural healthcare organizations. The benefits will include a better quality of healthcare for America's rural citizens, as well as the laying of a groundwork for more connectivity between urban and rural public health agencies, which may in turn have beneficial effects on the country's preparedness for any possible bioterrorism event.

For these and other reasons advanced in the Comments themselves, CTL urges the FCC to give serious consideration to all of the proposals made therein.

Sincerely,

Yadin David, Ph.D., PE, CCE
Chair, CTL Board of Directors

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

In the Matter of:

Notice of Proposed Rulemaking (NPRM)	)
Regarding the Universal Service Support Mechanism	)WC Docket No. 02-60
for Rural Healthcare.	)

Comments of:

Joseph Tracy, Executive Director, Missouri Telehealth Network, Columbia, MO

Karen Rheuban, MD, Medical Dir., Univ. of Virginia Office of Telemedicine, Charlottesville, VA

Rob Sprang, Director, Kentucky Telecare, Lexington, KY

Sam Burgiss, PhD, Director, University of Tennessee Telehealth Network, Knoxville, TN

Mary DeVany, Director, Avera McKennan Telehealth, Sioux Falls, SD

Jana Katz, Chief Admin. Officer, UC Davis Center for Health and Technology, Sacramento, CA

Eugene Sullivan, Director, University of Virginia Office of Telemedicine, Charlottesville, VA

Nina Antoniotti, PhD, Marshfield Clinic Telehealth, Marshfield, WI

ABOUT THE AUTHORS

Each of the authors is a leader in telehealth and each is an active telehealth provider. In 2001, the telehealth programs directed by the authors provided 48,505 patient encounters using telehealth technology in 170 hospitals and clinics, and in 65 homes. The group has over 59 years of cumulative telehealth experience. All eight of the authors are members of the American Telemedicine Association (ATA), five are members of the ATA Policy Committee, and two are members of the ATA Board of Directors, one of which is the Treasurer of the ATA (http://www.americantelemed.org). All eight of the authors are members of the Center for Telemedicine Law (CTL), and four are members of the CTL Board of Directors, one of which is the Treasurer of the CTL (http://www.ctl.org). Three of the authors were appointed by their respective governors to serve on the Southern Governors' Association Task Force on Medical Technology focusing on telehealth issues (1999). One of the authors was appointed by his senator to serve on the FCC Health Care Advisory Board reporting to the Chairman of the FCC (1997). All of the authors have contributed to telehealth by publishing numerous papers and by making presentations for many professional organizations. The authors have testified before the FCC and Congress a total of eight times concerning the Universal Service Support Mechanism for Rural Healthcare and reimbursement for telehealth.

June 26, 2002

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Executive Summary

The Telecommunications Act of 1996 had two themes with a potential to impact the delivery of healthcare services. First, the Act was intended to create competition among telecommunications providers, in an effort to facilitate the deployment of new and various services at competitive rates. Second, Congress intended for the Universal Service support mechanism to provide discounted telecommunications services to healthcare providers in rural communities, so as to reduce the financial disparities inherent in the provision of such services to rural constituents.

For the most part, the Act has only delivered upon one of its promises to rural areas of the United States – the creation of a program that provides, in a limited fashion, discounted telecommunication rates to healthcare providers engaged in telehealth activities. However, the Act has done little to create a competitive environment or to help with the development of additional telecommunications infrastructure in rural areas.

The authors would like the FCC to recognize that an informal assessment of 26 telehealth programs conducted by the University of Missouri in 2002, found that 12 programs considered the cost of telecommunication services to be the single biggest barrier to sustaining their telehealth program and 4 considered the costs to be near the top of the barrier list. This suggests that the high cost of telecommunications services is clearly a barrier to the sustainability of many telehealth programs. The authors also recognize that over the past decade, the Federal government has invested hundreds of millions of dollars in telehealth programs. The inability to sustain this investment, attributable to unaffordable telecommunication costs, defeats the well intentioned efforts of Congress and those seeking to enhance access to healthcare services, especially as may be needed for purposes of national security and/or rural preparedness.

While there are many issues to deal with, there are four main issues that the Federal Communications Commission (FCC) must address if the Universal Service Mechanism (USM) is to meet its full potential for helping deliver necessary healthcare services to individuals living in underserved rural areas. These issues include:

- **Eligible health care providers should be expanded!** The current definitions arbitrarily deny the ability of some healthcare providers (e.g., nursing homes, other long term care facilities) to provide

necessary healthcare services because they cannot afford the full cost of telecommunication services for telehealth. The expansion should also include certain for-profit hospitals when such a hospital is the only hospital in a county and/or provides services to Medicare or Medicaid patients at a level of more than 50% of their gross revenues. We believe the FCC has the latitude to expand the program to cover additional providers in an effort to meet the objectives of the USM for healthcare.

- **Both the Maximum Allowable Distance (MAD) and the requirement of comparing rates to the closest city of 50,000 population should be eliminated.** The calculation and administration of the MAD is time and labor intensive and is not adequate for purposes of creating a comprehensive telehealth network. Additionally, the Act did not mandate a rate comparison to the nearest city of 50,000 and as the FCC has pointed out - in many cases a larger city than the nearest city of 50,000 will have available both a greater variety of telecommunications services and services at a lower rate attributable to competition.

- **Comparison of rates should be based on comparable bandwidth, not type of service.** Clinicians and patients do not care what service (e.g., T1, SDSL, ATM) provides the telehealth connection, they merely care about the quality of the connection. In the case of telehealth, quality is defined by the amount of bandwidth that is available for the transmission. As such, comparisons of rates need to be made on bandwidth, not the type of service. Especially when one considers that some less expensive urban services (e.g., SDSL) are unavailable at any price in a rural area.

- **The application and administrative process should be streamlined.** The application and administrative efforts to access the program keep many rural healthcare providers from applying for universal service discounts. The Rural Health Care Division (RHCD) has done a good job in refining the program, but it needs to be further simplified. This would include, but is not limited to, developing a less imposing application process; encouraging telecommunication providers to respond in a timely manner; requiring telecommunications providers to bill the customer only for the discounted amount of the service; and to account for multi-year contracts through the development of "EZ" (e.g., IRS 1040EZ) forms.

The remainder of the document deals with these four critical issues and others as requested by the FCC. Recommendations for change are provided.

COMMENTS SPECIFIC TO THE NPRM SECTIONS

1. **The list of Eligible Healthcare Providers must be expanded.** In order for the USM to successfully meet its objectives, we recommend the FCC expand the definition of eligible healthcare provider to include any rural, not-for-profit healthcare entity with a certified Medicare and/or Medicaid provider number. Furthermore, we recommend that the FCC also include ANY for-profit hospital, when that hospital is the ONLY hospital in a rural county **and/or** provides services to Medicare and Medicaid patients at a level of more than 50% of their gross revenues accrued in services to these patients.

   We ask for these changes because the current definitions arbitrarily deny the ability of some healthcare providers (e.g., nursing homes, other long term care facilities) to provide necessary healthcare services simply because they cannot afford the full cost of telecommunication services for telehealth connections.

   In the case of for-profit facilities, it could be argued that these hospitals are public in character by virtue of the beneficiaries they serve. As an example, in two medically underserved counties in Southwest Virginia, bankruptcy of two not-for-profit hospitals has resulted in their purchase by national for-profit corporations. In those counties, these hospitals remain the ONLY local provider of inpatient and emergency care, yet these hospitals are no more able to support the cost of T1 connectivity to the University of Virginia Telehealth Network than they were prior to their acquisition by the corporate entity. Indeed, connectivity of these hospitals to the telemedicine network becomes less feasible, because of the incremental increase in telecommunications costs ($320/mo to $1000/mo) borne by the hospital once RHCD funded discounts are no longer available.

   For purposes of simplicity, we respectfully ask the FCC to define rural areas as any area not designated as a metropolitan statistical area (MSA) and include any area falling under the Goldsmith Modification within an MSA or a "non-urbanized area" as defined by the Bureau of the Census.

   Expanding the definition as suggested would mean the USM will be more widely used and meet its potential. Not to mention the importance of having all healthcare providers connected for homeland security purposes. Nuclear, chemical or bioterrorist events are as likely to impact rural communities

as well as urban centers. These rural communities historically have been least prepared to respond, by virtue of their geographic isolation from tertiary or quaternary medical expertise. Yet, our rural hospitals, regardless of their for-profit or not-for-profit status will be called upon to provide services in coordination with our public health agencies. If unconnected and untrained, our nation's rural healthcare providers cannot be expected to provide appropriate diagnostic care in service of homeland security. In short, the benefits of affordable and enhanced connectivity to our rural hospitals cannot be understated.

2. **Both the Maximum Allowable Distance (MAD) and the requirement of comparing rates to the closest city of 50,000 population need to be eliminated.** In place of these two items, we simply recommend that the FCC allow comparisons based on rural telecommunications costs/rates to any urban area in a state and that the RHCD post those rates on its website.

   The authors concur with the FCC "that limiting rural healthcare providers to discounts for connections to the nearest city of 50,000 or more may not be adequate for purposes of creating a comprehensive telemedicine network." In fact, in many cases, a larger city than the nearest city of 50,000 will have available both a greater variety of telecommunications services and services at lower rates. Not to mention that since patient referrals frequently bypass the nearest city of 50,000, we believe this selection of "nearest" urban area also artificially places undue constraints/restraints on referring physician trade practices within a state.

   The Act did not mandate a rate comparison to the nearest city of 50,000. As such, there is no basis in law for continuing with the MAD or the requirement to compare rates to the closest city of 50,000.

   As stated earlier, calculating the MAD is labor intensive, costly and makes the USM less efficient. Eliminating the MAD will have little impact on the fund.

3. **Comparison of rates should be based on comparable bandwidth, not type of service.** Support should be provided based on functionality of the end-user, so 1.5mb of bandwidth connectivity provided by a dedicated T-1 to a rural hospital (where DSL is not available) should be comparably priced as a DSL circuit providing the same bandwidth to an urban hospital. Basing the discount

rates on this type of methodology should result in more applications being filed under the USM, because it will make broadband communication services in the rural areas more affordable.

As previously mentioned, the quality of a video connection is related to the amount of bandwidth being provided by that connection. In the case of Internet Protocol (IP) based video, a 384k-bandwidth connection is the same whether it runs over T1, ATM, Frame Relay, DSL, etc. Thus, the service selected to deliver such a connection is insignificant, as long as the proper amount of bandwidth can be delivered.

4. **The application and administrative process should be streamlined.** The RHCD application and administrative process has improved over the years, but completing the application, obtaining timely cooperation from some telecommunication providers, receiving timely payments from the fund and prorating discounts still has room for improvement. These issues are discussed below:

   a. **The application process should be streamlined.** The University of Virginia Telemedicine Network was advised that more than 30% of healthcare facilities fail to renew requests for discounts because of administrative complexity. To make the application process more appealing and easier to work with we recommend the following:

      i. **Develop "EZ" forms (e.g., IRS Form 1040EZ).** In cases where a multi-year contract has been signed after a competitive bid process, we request that RHCD develop "EZ" forms that the applicant and telecommunication provider can simply sign indicating that no change in service has occurred and that the service is still in place and eligible for the Universal Service discounts. This would simplify the process for all involved.

      ii. **Post the lowest available urban rates on the RHCD website.** The authors recommend posting, on an annual basis, the lowest benchmarked rates offered by the telecommunications providers on the RHCD website so, that healthcare providers can easily calculate their discounts for budgeting purposes.

iii. **Develop a single application form.** To simplify the general application process, we recommend a single application in which the healthcare provider provides RHCD with documentation of:

1. Status of healthcare provider (hospital, community health center, for-profit status, sole hospital in rural county) with Tax ID number;
2. In cases of for-profit hospitals, documentation of revenues for Medicare and Medicaid patients exceeding 50% of total revenues and/or proof that the facility is the only hospital in the rural county;
3. Location defined as a non-MSA, an area defined by the Goldsmith Modification within an MSA, or a "non-urbansized area" as defined by the Bureau of the Census;
4. Type of telecommunications service requested;
5. Benchmarked rate based on postings of available rates in any urban area/city in the state (it must be mandated that every provider of telecommunications and information services list the price of their service); and
6. Local telecommunications provider selected to provide service and rate based on postings.

b. <u>Telecommunication providers should only bill the discounted amount to the customer after a 90 day application process.</u> Currently, the eligible healthcare provider must pay the full cost of the eligible service and receive a rebate only after all of the telecommunication company forms have been completed. Simply stated, most small rural healthcare providers cannot afford such financial outlays. Additionally, due to delays in the administration of the mechanism and in a telecommunication company's response to completing the necessary RHCD forms, rebates may not appear in the same fiscal year as the expense. This creates major accounting problems for individuals whose yearly funding comes from federal grant sources, and for others who must also develop accurate fiscal year budgets. Therefore, we recommend a process in which telecommunications providers respond to RHCD forms within 90 days. This process is described immediately below.

c. <u>Telecommunication providers should be required to file all forms with RHCD within 90 days.</u> The USM does not specify the time in which a telecommunications company must respond to the completion of the Rural Health Care Division's (RHCD) forms and this creates

the huge budget and cash flow problems just described. In order to deal with those problems, we recommend:

(1) Telecommunication companies be required to complete all RHCD forms within 90 days.
(2) During that 90-day period, the telecommunication carrier may bill the customer for all applicable charges.
(3) After that 90-day period, the telecommunication carrier may only bill the customer for the discounted amount and must rebate the difference for the first 90 days of service, within 45 days of completion of the RHCD forms.
(4) If the telecommunications carrier fails to respond in 90 days, they must continue the telecommunications service and refrain from billing the customer, until such time the forms have been finalized.

While the above process may seem extreme, it may be the only way to get the telecommunication provider to deal with the mechanism in a timely manner, without creating budget and major cash flow problems for the eligible healthcare provider.

d. <u>Prorating of telecommunication services is unnecessary, if the telecommunications network is private and dedicated, the telehealth program stipulates that telehealth interactive video activities occur on the network, the program maintains records to that effect, does not resell time, and does not connect the network to voice switching equipment that would attach to the public phone network.</u> If an expansion of providers included all rural, not-for-profit entities with Medicare and Medicaid provider numbers, and certain for-profit facilities as previously described, there would be no need to prorate services as long as the above criteria were met. Not having to prorate services in this situation alleviates the administrative burden and cost of having to calculate the prorated amounts.

Dedicated circuits have fixed costs whether they are being used for healthcare or anything else. While the main focus for these types of connections is indeed telehealth, a site should not be penalized for using the dedicated circuit for non-health activities as long as the network time is not being resold and there is some benefit to the community. The FCC and Congress should easily recognize and understand that it would be a tremendous waste of a video network's

capabilities to leave it idle during periods when it was not being used for healthcare purposes. However, because of the current rules, not many are willing to utilize the untapped network time because it may result in the prorating of the discount received. Most small rural healthcare facilities cannot afford for such prorating to occur.

e. **Prorating of telecommunication services may be necessary for public and semi-private networks.** In these cases, prorating of services should be governed by the following principals and grouped into the proration table provided below.

i. Prorating network time that is **not** resold must occur on a per event basis and not on a time basis. This means that one dermatology event that takes 6 minutes counts the same as one educational event that takes 1 hour. As another example, if 250 dermatology encounters, 250 psychiatry encounters and 50 regional boy scout meetings occur in one year, the percentage of time in non-healthcare activities would be 9% (50/550) and according to the table below would not trigger any prorating of the service.

We recognize, that in the above case, the Commission will be very concerned with potential fraud and abuse issues related to those telehealth networks that pay per-minute charges for network connections. Recognizing this concern, we would simply state that given the current financial status of rural, not-for-profit hospitals, it would be unlikely that any hospital would allow any other not-for-profit or for-profit organization to use their network free of charge. These hospitals could not afford to pay the per-minute charges for another organization. Thus, these services would be resold and fall into "ii" below.

ii. Any amount obtained by the applicant through reselling the telecommunications portion of a video connection, regardless of the table below, must be refunded to USAC within 45 days of the end of the USAC funding year.

iii. The burden of record keeping for all health and non-health related events and the reselling of services shall be placed on the rural site receiving Universal Service support, even if the applicant of record filed as a consortium, or on behalf of the rural site.

iv. Any difference due to USAC, as a result of any other type of prorating activities, must be refunded to USAC within 45 days of the end of the USAC funding year.

v. Upon random audit by USAC, auditors will request records detailing utilization of network events.

Prorating Table

Estimated % of Telehealth Traffic	0-15%	16-35%	36-65%	66-85%	85-100%
% Proration for USF Funding	0%	25%	50%	75%	100%

Example: $1000/mo T-1 with approximately 60% of all traffic being healthcare related and 40% not healthcare related, AND is not re-sold to generate revenue for the program. The USF support would be 50%. Using the guidelines above, the rural site would be required to refund 50% of their support dollars to USAC within 45 days of the closing of the preceding funding year.

The authors recognize that this recommended change creates some additional work on the part of the healthcare provider. However, we want to protect against potential fraud and abuse while creating an accurate accounting of the prorated amount. There are too many variables to estimate what the prorated amount would be in advance of a funding year. Thus, we are suggesting the 45-day period after the close of a funding year to be the settlement period, where the Universal Service Fund receives any amount due from the prorating of services. Funding to the telecommunication provider in this arrangement is moot, because they have already been paid the correct amount. Only the Universal Service Fund would be reimbursed the prorated amounts due.

5. **Access to broadband Internet services for telehealth should be discounted.** In cases where telehealth networks are migrating to broadband Internet services, discounts should be based on the differential between the costs of a similar broadband Internet connections in any city within the State. In principal, the authors agree that the most efficient and cost-effective way to provide many telehealth services may be via the Internet in the future. Some networks are already beginning to use broadband Internet and Intranet services to provide quality video connections for the delivery of

interactive encounters between providers and patients, distance learning activities and teleradiology services. However, broadband Internet services are still limited in rural areas.

The authors also feel that support for Internet access provided under section 254(h)(2)(A) should include a rural-urban rate comparison of the sort required under section 254(h)(1)(A). For instance, if the cost of DSL service providing an upstream and downstream bandwidth of 384k costs $100 per month in Milan, Missouri, but only costs $50 in St. Louis, Missouri, then the per month RHCD subsidy for the Milan connection should be $50 per month.

6. **The FCC should eliminate the distinction between telehealth networks and information networks.** The delivery of telehealth services is moving toward an Internet Protocol (IP) environment. In that sense, whether the transport mechanism is T1, ISDN, Frame Relay, ATM, or DSL, the IP environment is still the same. In this regard, the FCC must recognize the convergence of telehealth networks and informational networks because audio/video and data are running within the same informational stream within an IP network environment.

   With the convergence of networks toward IP and the transport mechanism being moot, we ask the FCC not to differentiate between telehealth networks and informational networks and to continue to look at comparable bandwidth options between rural and urban areas.

7. **The FCC should require that telecommunication providers confirm through that State's Public Utility Commission that the negotiated rate for a particular service is the lowest advertised rate available to suit the needs of the healthcare provider.** Recognizing that telecommunication carriers often have special tariffs for education, healthcare and other type of applications, they should not be allowed to abuse the system by raising their rates to the highest tariffed or publicly available commercial rate, as allowed under the current regulations. For example, in one state, a telecommunications provider who was charging a client $600 a month for T1 services under a discounted arrangement, simply increased the cost to $1,200 a month (highest tariff) because they knew the client would still pay the same under the discount mechanism. This is a simple indication of how one telecommunications provider legally raised rates, while exploiting the support mechanism for an additional $600 per month. We don't believe Congress intended for such behavior to occur.

Additionally, allowing telecommunication providers to charge their highest tariffed or publicly available commercial rate does not create an incentive for that provider to invest in new infrastructure that may bring newer and more affordable services to rural areas.

8. **Internet Access should be underwritten to support any form of Internet access provided to rural healthcare providers as long as the cost to provide such services in rural areas exceeds the same level of service in any urban area of the State. The discounts should apply to telecommunication and non-telecommunication service providers.** In some communities, other providers of telecommunications technology, such as the local cable operator or public utility board, have chosen to invest in infrastructure so as to provide broadband access to the Internet. We believe that healthcare providers who choose to access those services should be eligible for discounts, if that telecommunications technology provides quality of service that support its use for medical purposes.

9. **The FCC should consider underwriting the cost of access via satellite or other wireless connections, if no other terrestrial based service is available (remote and insular areas), or if the satellite rate costs no more than the highest tariffed rate of a comparable terrestrial based service.** The authors believe it is reasonable to compare and discount these rates in a similar fashion to terrestrial based services in that State, or closest state, if outside the continental United States. The authors also feel it would be reasonable to underwrite the cost of access via satellite in rural areas, within the context of the recommendation, because such access would create a level of competition that typically does not exist in rural areas.

10. **The FCC should provide discounts for insular areas.** For purposes of securing discounts in insular areas, we would recommend that rates be compared to those in any urban area in the nearest state, recognizing that the cost of providing services to that insular area will indeed be high. This includes areas that are outside the continental United States. Such discounting is necessary, in order to provide necessary health services to this population of patients.

11. **The FCC should consider allowing Mobile Satellite Ventures Subsidiary (MSV) and similar companies, to become an eligible provider under the USM, but only when the following conditions are met:**

1. The satellite services are provided **ONLY** via a mobile unit that will serve a minimum of four (4) rural communities within a State.
2. Under no circumstance would MSV or a similar company be eligible under the USM when installing a fixed based unit in an area where terrestrial based services are available, unless they can demonstrate that the rates are equal to the highest tariffed rates of the LEC.
3. Discounts for this service would be calculated the same as discounts for terrestrial based service.
4. The healthcare provider using the mobile service must maintain a detailed log of all network time used, the date it was used and the location from which the mobile service was provided. These logs must be submitted to the RHCD within 45 days of the closing of a funding year.

The rationale for this recommendation follows:

1. Providing telehealth services via a mobile-based satellite program may save some networks from installing fixed based systems by terrestrial means in areas where utilization would be minimal at best.

2. There would be some financial breakeven point for USAC in such an arrangement. For example, if the cost of providing the mobile satellite service to USAC was four times higher than the cost of terrestrial based services, then rotating the mobile service through four rural communities would simply mean USAC would break-even on the amount that would have been underwritten in those four areas, had fixed terrestrial based services been installed. In fact, adding more rural sites in this example would result in USAC saving monies by not having to pay discounts on fixed services installed in any other rural site receiving the mobile service.

3. Allowing MSV, or other similar companies, to be an eligible provider under the Universal Service mechanism would create an alternative communication service in a community where Local Exchange Carriers tend to dominate or monopolize a market area. In a sense, this may help create the competition among carriers the Act hoped to create. The authors would expect that having such competition would result in lower rates for telecommunication services required for telehealth.

4. We also recognize the potential for fraud and abuse in this situation because the mobile service could easily be used in an urban area as easily as it could be used in a rural setting.

12. <u>Other comments as requested by the FCC</u>

A. Pro-rata reductions if annual cap exceeded:

The authors agree with the need to reduce distribution if the cap is exceeded. We would recommend an elimination of discounts provided to those rural communities in which enhanced competition has developed, in the form of three or more providers of broadband services available in that community.

B. Ensuring the Selection of Cost-Effective Services:

The way the statute and rules are currently written, there is no way to truly ensure the selection of cost-effective services because telecommunication providers can legally charge their highest tariffed rate under the USM. Thus, if the highest rate is charged, one cannot expect to receive a cost-effective service.

C. Encouraging partnerships with clinics in schools and libraries:

We recommend that a school-based clinic be allowed access to the discounts afforded through the schools and libraries (S&L) program, as those discounts have generally been associated with greater discounts than those associated with the rural healthcare support mechanism. Justification in grouping of school-based clinics with S&L includes the use of these clinics for health related educational programs for children.

Additionally, we feel that schools, libraries and healthcare institutions should collaborate in the delivery of necessary services. At the same time, schools receiving funding under USAC's S&L program, should not be penalized by having their subsidy prorated, if health services are delivered to a school via telehealth.

The authors often wonder why such a disparity seems to exist between what USAC pays as a subsidy for healthcare relative to what they pay for S&L. In short, S&L appear to pay only a fraction of the amount for similar services when compared with what healthcare providers pay. For most rural healthcare facilities, the ability to continue paying a $500 to $700 (after USF

discounts) bill each month for T1 service, without additional outside funding, may not be an option in the future. Thus, we would ask the FCC to consider developing a similar S&L discount formula for the healthcare program.

D. Effect on Demand for Support

The authors feel that it is unlikely that with the changes proposed in this document that healthcare providers will come out of the woodwork in search of the Universal Service discounts for healthcare. We say that, because there are still other barriers for telehealth to overcome before it is engrained in the everyday way healthcare is delivered. For instance, there are still pressing issues related to:

a) the lack of reimbursement for providing many telehealth services (many will not participate until reimbursement for telehealth is completely available);
b) the concerns about cost and meeting the network privacy and security demands imposed upon us by HIPAA;
c) credentialing of physicians in remote institutions to ensure that a credible provider is on the other end of the telehealth connection;
d) the perceived overall expense of purchasing telehealth equipment; and
e) the operational complexity of launching and managing programs that naturally keeps demand at a modest level.

While many of these barriers have eased to some extent over the past 5 years, the one that still remains strong is the recurring cost of telecommunication services. Couple the high cost of telecommunication services with the barriers above and one can easily understand why the demand to tap the USM for healthcare has been limited. We believe demand will continue to be limited until such time all cost, and other policy barriers, have been adequately dealt with and competitive rates for broadband services are widely available. How long that process will take is anyone's guess.