

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

In the matter of)
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Rural Health Care Support Mechanism) WC Docket No. 02-60
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REPLY COMMENTS OF GENERAL COMMUNICATION, INC.

General Communication, Inc. (“GCI”), by its undersigned counsel, hereby submits this reply to comments filed in response to the Further Notice of Proposed Rulemaking in the above captioned-proceeding (“FNPRM” or “Notice”). GCI concurs with the Federal Communications Commission (“Commission” or “FCC”) regarding the critical nature of rural health care services. GCI supports efforts to ensure that the rural health care (“RHC”) support mechanism is more fully utilized. To that end, GCI encourages the FCC to avoid actions that would essentially narrow the scope of those providers and health care services eligible for support under the RHC mechanism as described herein.

I. BACKGROUND

GCI is a facilities-based telecommunications and cable services provider serving over 220 communities in Alaska via its fiber optic transmission facilities, cable system, metropolitan area networks, undersea cable, and satellite transmission facilities. In addition to providing local, long distance, and cable television services to Alaskan consumers, GCI is a leader in the introduction of innovative satellite-provided broadband service in rural Alaska.

As part of that leadership, in the health care area, GCI is providing broadband services to 110 rural health clinics, bringing technological diagnostic advances – including on-site diagnosis

and digital radiology – to some of the most isolated villages in Alaska. Through GCI-provided telecom services, RHC providers throughout Alaska are able to exchange data, voice, and real-time video. RHC providers are also able to connect with specialists in other parts of the state and Seattle, Washington, allowing them to securely share information, such as confidential patient records and lab results; diagnose and prescribe treatment for remote patients; and obtain continuing medical education credits. Additionally, given Alaska’s unique geography, telehealth services improve the quality of care for patients in rural communities by allowing them to access specialty care, expand treatment options, and eliminate expensive and sometimes unnecessary air ambulance trips. When inclement weather prevents medical evacuations, telehealth services help make life-saving treatments possible, linking remote village health care professionals with doctors or specialists from other locations.

II. DEFINITION OF “RURAL AREA”

In its Notice, the FCC asked for comments on whether the definition of “rural area” for the RHC universal support mechanism should be modified, and if so, what that definition should be.¹ The weight of the comments in this proceeding focused attention to this issue.

GCI supports the comments of several parties that it is difficult to find one national definition of “rural” for the RHC support mechanism that works for every state.² Indeed, Alaska is a perfect example of why a one-size-fits-all approach to defining rural will not work, where rural has a different meaning than other places in the country. Alaska is characterized by small, compact isolated pockets of population, separated by vast wilderness expanses without roads in

¹ FNPRM ¶¶ 63-64.

² See *Iowa* Utilities Board Comments at 4; National Organization of State Offices of Rural Health Comments at 1; California Primary Care Association Comments at 1.

contrast to the thinly populated rural areas of the lower 48.³ Often the only way to travel to one of the more than 200 rural communities is by small plane or boat, weather permitting. Patients in rural, insular areas may be flown to the nearest health facility or hospital when it is not necessary or may be unable to fly when it is necessary. It is possible that such inaccessible communities which qualify as “rural” today would not continue to qualify under some proposals. This would be a great detriment to the residents of such communities.

As such, a flexible, multi-definitional approach to defining “rural” is the best way to take into consideration the differences in rural areas nationwide. Several parties suggest such a multi-definitional approach, advocating that if an applicant meets any of the suggested criteria it should be deemed eligible for the RHC support mechanism.⁴ GCI concurs with the comments of the National Rural Health Association that one criterion should not serve as the sole determinant for defining rural because the result may be to exclude many areas that should otherwise be really deemed rural.⁵

The FCC also asked parties to comment on whether a definition of rural based on the U.S. Census Bureau’s definition of “urbanized areas” and “non-urbanized areas” is a workable change.⁶ GCI urges the FCC to reject re-defining “rural area” for the purposes of the RHC support mechanism as only those areas categorized as non-urbanized. No party has provided a reasonable basis for this change nor demonstrated any plausible nexus between areas now deemed urbanized by the U.S. Census Bureau for population purposes and a lack of need for rural health care funding for critical telehealth applications in those same areas. Reliance on

³ See *Attachment - Alaska Year Round Road System* - highlighting the number of rural communities throughout the state of Alaska not served by a connected road system, fiber or microwave systems.

⁴ See *e.g.* Shasta Consortium of Community Health Centers at 2; California Healthcare Association Comments at 4; Virginia Department of Health Comments at 2.

⁵ See Comments of the National Rural Health Association (stating that the FCC should not rely on RUCA as the sole criteria for defining rural because the result would be to exclude areas of the country that would otherwise be considered rural under other methodologies).

⁶ FNPRM ¶ 63.

urbanized vs. non-urbanized classifications to determine eligibility for health care dollars also fails to take into consideration other factors impacting the health care needs in that area, including the insular nature of that location. Indeed, the U.S. Census Bureau itself recognizes the limitation of its categories of urbanized and non-urbanized, stating that such classifications should only be used for presentation and comparison of census statistical data and may not be appropriate for any other use.⁷ Cities now deemed urbanized as a result of the 2000 Census classifications may not have changed at all and thus negated the need for RCH funding.⁸ The U.S. Census Bureau simply changed their definitions.

Finally, in the event the FCC elects to adopt changes to the definition of rural, GCI urges the FCC to “grandfather” existing areas that currently qualify as rural if they no longer qualify under a new definition.⁹ This point is critical. Sudden elimination of funding to existing telemedicine projects could result in harm to the health care providers and patients.

III. SUPPORT FOR SATELLITE SERVICES FOR MOBILE RURAL HEALTH CLINICS

Pursuant to existing FCC policy, rural health care providers that are located in areas with no terrestrial-based alternatives, may receive support for satellite services under the RHC program.¹⁰ This policy is unchanged. In the foregoing *Report and Order* in this proceeding, the FCC went a step further and revised its policy to allow rural health care providers to receive discounts for satellite services *even where* terrestrial-based services may be available.¹¹ The FCC indicated, however, that in this latter scenario, such discounts would be capped at the

⁷ See U.S. Census Bureau - 2000 Urban and Rural Classification webpage available at www.census.gov/geo/www/ua/ua_2k.html.

⁸ See also Rural Healthcare Center/California Rural Healthcare Comments at 8.

⁹ FNPRM ¶ 63. See also Rural Healthcare Center/California Rural Healthcare Comments at 8.

¹⁰ See *In the Matter of Rural Health Care Support Mechanism*, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, WC Docket No. 02-60, released Nov. 17, 2003 at ¶ 42.

¹¹ *Id.* at ¶ 44. See also C.F.R. § 54.609 (3)(i).

amount providers would have received if they purchased functionally similar terrestrial-based alternatives. The FCC asks now if this same modified policy should be applied to mobile rural health care providers.¹² As a threshold matter then, the FCC should clarify that where there are no functionally similar terrestrial services available for mobile rural health care units, there is no relative cap to apply. This is consistent with existing FCC policy.

The FCC should not assume, for the purposes of applying a cap, that terrestrial-based services, when available, are necessarily a less expensive or preferred facility.¹³ As the comments of Healthcare Anywhere indicate, terrestrial based offerings, where available, can be more expensive and often include complex and costly installations at every location from which the mobile unit operates.¹⁴ Such non-recurring charges only add to the total administrative costs especially where the mobile health care provider has to deal with multiple terrestrial-based providers – changing with every new location. On the other hand, working with a satellite vendor that can serve many if not all of a mobile unit’s locations, may produce greater operating efficiencies, including potential discounts for volume or recurring usage of those facilities.

This same principle plainly applies for non-mobile (i.e. site-based) satellite operations. In order for a cap on supported satellite-provided services (where alternative terrestrial facilities are in place) to make sense, the threshold question in a comparison of satellite and terrestrial facilities is whether the terrestrial and satellite-based options are capable of providing comparable services. Thus, by “comparable”, the terrestrial-based service should provide the supported services at the same quality and be capable of delivering at least the same level of applications, bandwidth, and speeds as the satellite-based services.

¹² FNPRM ¶ 66.

¹³ See FNPRM ¶ 66.

¹⁴ Comments of Healthcare Anywhere, Inc. at 8.

Moreover, the terrestrial services used in the comparability analysis must be those that would be available at the same geographic location where the mobile unit would otherwise use satellite services. Specifically, the FCC should clarify that the comparison be made to *existing* terrestrial-based service options on the specific route, rather than to region, state or nationwide benchmarks. Cost and availability can vary significantly from location to location, so an apples-to-apples comparison is critical.

Given the unique geography of Alaska, for example, any cost of comparable terrestrial service that is derived from lower 48 benchmarks would be inappropriate and likely inaccurate because it would fail to take into account the extreme terrain over considerable distances which typically separate the various Alaskan communities. These differences alone mean that it is far more costly to deploy terrestrial facilities, like fiber and microwave, than satellite, which is precisely why many communities in Alaska receive supported services via satellite transmission.

IV. ADMINISTRATIVE ISSUES

In the Notice, the FCC asked parties to comment on administrative issues relative to the RHC mechanism with the goal of streamlining the application process and generating greater participation in the program.¹⁵ To that end, GCI supports the FCC's suggestion of multi-year applications.¹⁶ This approach is more efficient, cutting down on burdensome and complex annual filing requirements. Indeed, in GCI's experience, the current level of paperwork associated with the RHC support mechanism can be a barrier to participation in the program itself.

Relatedly, GCI also seeks clarification from the FCC relevant to multi-year contracts and the competitive bidding process. Currently, even when a provider is in a multi-year contract, it is

¹⁵ FNPRM at ¶ 69.

¹⁶ See also Placer County Health and Human Services Administration at 8.

told to post Form 465 every year in order to remain eligible for support of any potential changes in services that may arise. Providers are also told, however, not to reject responses to Form 465 postings because they are in multi-year contracts. This raises conflicting guidance regarding the validity of multi-year contracts. The FCC should provide greater written guidance to post Form 465 when a provider is within the term of an existing multi-year contract and the provider's responsibilities to entertain and report bids received during the term of that existing multi-year contract.

Additionally, GCI appreciates the efforts of Universal Service Administrative Company ("USAC") in the last two years to streamline the application process. One such step included the elimination of Form 468—the technical-based form filled out by the underlying service provider and used by the health care provider in its description of its telecommunications needs in its Form 466. Unfortunately, now the applicant does not have a formal technical document upon which it can base its application and describe the services for which it is requesting support. Indeed, since the elimination of Form 468, in the year 2003, GCI has seen a dramatic increase in calls from the USAC's Rural Health Care Division with technical questions regarding the services provided to GCI's health care customers applying for support. While GCI is not advocating a resurrection of Form 468, GCI urges the FCC to consider a streamlined informational form that service providers would fill out and give to the health care provider to use as the basis of the technical description of the applicant's services in Form 466.

Finally, GCI urges the FCC and USAC to make greater use of its online resources and to explain in greater detail, online, any rule changes that have been made relevant to the application process and how an applicant needs to adjust its paperwork and supporting documentation to

account for the required changes. Several process changes over the last two years have added to the confusion of rural health care applicants.

V. CONCLUSION

Based on the foregoing, GCI urges the Commission to adopt a multi-definitional approach to defining “rural area” for the RHC support mechanism. The FCC should reject any effort to apply a one-size-fits-all definition of rural to all parts of the country and should specifically reject the use of non-urbanized areas to define areas eligible for RHC funding. In the event the FCC places a cap on support to satellite services to mobile rural health clinics where terrestrial-based options are available, the FCC should limit its comparison for determining a cap to *existing* terrestrial-based services that are available in the same location from which the health care provider currently utilizes satellite options and to services that are truly comparable to the satellite-based services. Finally, GCI urges the FCC to make changes to the administration of the RHC support mechanism as described herein.

Respectfully submitted,

By: /s/_____

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