

**COMMENTS ON THE AMERICAN TELEMEDICINE ASSOCIATION'S
PETITION FOR RECONSIDERATION OF THE RURAL HEALTH CARE
SUPPORT MECHANISM SECOND REPORT AND ORDER**

WC Docket No. 02-60

On behalf of Good Samaritan Hospital and the rural critical care hospitals with which we contract, we appreciate the opportunity to submit comments in response to the March 13, request for comments from the FCC. This matter is in regard to the American Telemedicine Association's Petition for Reconsideration of the Rural Health Care Support Mechanism Second Report and Order (WC Docket No. 02-60).

Background

Good Samaritan Hospital has extensive experience in the area of telehealth serving as the hub site for the Mid-Nebraska Telemedicine Network since 1995. The Mid-Nebraska Telemedicine Network (MNTN) became operational in December 1995 as a result of a start-up grant awarded through the Office of Rural Health Policy. In October 1997, Good Samaritan received a second grant through the Office of Rural Health Policy – Office for the Advancement of Telehealth (OAT). In August 2000, OAT awarded a third grant for the project. In September 2004, the MNTN was awarded its first congressionally mandated grant. A second congressionally mandated grant was awarded to the project in September 2005. The MNTN has the distinction of being the longest federally funded telehealth network in the United States with thirteen years of continuous funding through Health Resources Services Administration (HRSA). In addition, the MNTN has also received two USDA- Rural Utilities Services Distance Learning & Telemedicine grants. With each funding opportunity, the MNTN expanded both services offered over the network and the number of rural hospital sites. The MNTN is currently comprised of twenty-one rural critical access hospital sites located in both Nebraska and Kansas.

The impact of the Mid-Nebraska Telemedicine Network (MNTN) on rural healthcare has been significant. Since becoming fully functioning in December 1995, the network has totaled over 10,000 patient encounters, 20,000 Teleradiology, and over 3,000 educational programs.

Funding for telecommunications support through the Universal Service Administrative Company's Rural Healthcare Division has been critical to the sustainability and expansion of the Mid-Nebraska Telemedicine Network since 1999. As a result, Good Samaritan Hospital was able to join seven other designated hub sites across Nebraska with the development of the Nebraska Statewide Telehealth Network. However, with the change in the rural definition, Good Samaritan Hospital located in Kearney, Nebraska, is now in jeopardy of losing crucial funding for telecommunications expenses related to our organization's/community's participation in the statewide network.

Currently 88 hospitals are connected through the Nebraska Statewide Telehealth Network (NSTN). These hospitals currently benefit from receiving approximately \$2.5 million in support from USAC funding. Critical Access Hospitals are connected in a hub and spoke arrangement to their respective regional hub hospitals.

The Federal Universal Services Fund support is the basis for an additional subsidy from the Nebraska Universal Service Fund for monthly line charges, as well. Research from the Nebraska Center for Rural Health Research indicated that the single greatest limitation on the use, expansion and long-term sustainability of Telehealth is ongoing line charges and issues of connectivity. This has been mitigated by a unique partnership between federal, state and private hospital participation in payment—once again, all built on the foundation of the Federal Universal Services Fund.

The value of the network is evidenced by usage data collected in 2006 for administrative meetings and education: (1) travel time saved of \$1,662,161 and (2) mileage cost savings of \$1,645,330. In addition, over 25 different clinical areas were documented with nearly 700 consultations. The NSTN activities continue to increase in 2007.

Impact of the New Definition

While the new definition of rural may have improved the eligibility of some counties to participate in the Universal Services Rural Health Care Division (RHCD) subsidies, a significant number of rural communities are now considered ineligible for RHCD after an application of the new guidelines. We are requesting that the definition of rural need not be changed, but only that sites eligible as of the date of the Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, December 2004, be grandfathered for an indefinite period.

We understand that the new definition of rural, as defined by the Second Order, is as follows:

1. If an area is outside of a Core Based Statistical Area (CBSA), it is rural and no further determination needs to occur.
2. If an area is within the CBSA, it can be either rural or non-rural, depending on the characteristics of the CBSA:
 - a. If a CBSA does not contain an urban area with a population of 25,000 or more, the site is rural and no further analysis is needed.
 - b. If the census tract contains any part of a place or urban area with a population greater than 25,000 then the census tract is not rural.

Many areas (as described in b.) are now not considered rural, but they may have a critical access hospital, a federally-qualified health center, or a community-based hospital. Such is the case in Nebraska with the statewide Telehealth network that has been developed, built on a partnership between federal, state and private entities. Without grandfathering of the about to be ineligible sites, the new definition of rural will negatively affect the delivery of health care within our state. The new definition of rural which changes the

population stipulation from 50,000 to 25,000 for community eligibility, the hub hospitals in Norfolk, Kearney and Grand Island will no longer be eligible for funding through RHCD/USF. The hubs are the location for specialty services, the experts in clinical specialties and distance learning providers. In addition, the community hospital in Fremont will lose eligibility. All of these sites are critical in maintaining the current viability of the network and moving it forward.

We recognize that the intent of implementing the new definition of rural was to improve access to the RHCD/USF for rural patients and providers. What is needed now is an assurance that the current limitations do not exclude existing eligible health care providers and diminish the good that was intended.

What Is Needed

We respectfully request that the FCC universally grandfather all current eligible rural sites with no end-date. (CMS has set a precedent for non-limiting grandfathering of telemedicine sites in its guidelines for reimbursement in the Federal Register (Nov. 1, 2001, Vol. 66, No. 212) which states, A federally funded Telehealth program in existence as of December 31, 2000, regardless of geographic location. . .).

Respectfully submitted,



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