February 2, 2010

Ms. Marlene H. Dortch
Secretary
Federal Communications Commission
445 12th Street SW
Washington DC, 20554

Re: Notice of Ex Parte Communication
GN Docket Nos. 09-47, 09-51, 09-137

Dear Ms. Dortch,

On January 15, 2010, Michael McGill, Manager of Health Sciences, Internet2, sent the attached information via email to me. The information contains a summary of input Mr. McGill received about rural health questions posed to him by FCC staff.

Disclosure of this presentation has not been made by the presenter, by the next business day after the presentation, as required pursuant to 47 C.F.R. § 1.1206(b). Disclosure herein in no way changes the presenter's obligations under 47 C.F.R. § 1.1206(b).

Regards,

Spencer Hutchins
National Broadband Task Force
Federal Communications Commission

To: Pierce Graham-Jones
Spencer Hutchins

Re: FCC-- Healthcare Question from National Broadband Plan

We have taken the opportunity to address your questions of January 12th and have pulled together several responses from the Internet2 ad hoc group on the Rural Health Care Pilot and Health Network Initiative.

> Thank you for your comments to our public notice, and all the help you've provided the FCC as we work towards the National Broadband Plan. As we are drafting the section on reforming the FCC's rural health program, there is one area where the record is surprisingly weak. Just under 3,000 locations participate in the program (excluding the Pilot), which we think is a little under 25% of the eligible institutions. We're hoping to understand more about that 75%. Do they not participate because they don't know about the program? The application is too cumbersome? Broadband costs are not a problem? The subsidy isn't sufficient? Etc. We have a tremendous number of helpful comments from program participants (including yourselves) describing problems with the program, and also a lot of information from ineligible institutions (e.g. urban IHS sites), but not much on eligible rural sites that aren't participating. We would very much like any information Internet2 (or anyone) might have on those locations and there reasons for not participating. The more quantified the better. We'd also like data on how many healthcare delivery locations there are that aren't in the Pilot, but are in need of broadband infrastructure. We're trying to understand how large the 'remaining demand' after the Pilot Projects are completed, both within existing FCC eligibility rules as well as whether there is important un-met demand from institutions currently ineligible for receiving funding.

The responses have been aggregated and broken into both the concerns and recommendations that have also been made. Unfortunately, it turns out that there is too little quantitative data. However, most of the comments come from first hand observations and are very insightful.

We hope this is a valuable resource and would be happy to discuss it with you as appropriate.

Challenges / Concerns

- The price differential between urban and rural broadband is only a few percentage points. But, we don't have availability everywhere. One way to read this is that in places where the urban-rural differences might be big, the telcos just don't provide service at all. So, the incentives to participate are low - even though the service is needed. Even where service is available, public non-profit providers tend to afford themselves only inadequate (capacity and reliability) services. This indicates a need for deeper discounts than "urban" pricing.

- The budget stress is especially hard right now given the recession and the need for better broadband services is especially high as providers start to take on HIE, meaningful use of EHRs, and similar programs requiring reliable high capacity links. Applying is a barrier as well- the typical public health agency, free clinic, small hospital finds the process daunting. e.g. telehealth apps). These sites are of course the ones that are most in need of better links at affordable prices.

- Many advanced broadband uses can't be taken up by typical sites without additional funding and technical support.

- Overly complex, cumbersome, daunting, bureaucratic, slow, intimidating, poor track record of funds being disbursed, no administrative fees, the word "failure" is increasingly heard.

- Our state receives a large amount of regular RHC funding, it has been a struggle to keep the small clinics in the program. The process is very paperwork intensive and the complexity of the filing is daunting to small rural sites operating with limited staff. Often we get someone trained in how to do the paperwork, they leave, and the next year nothing is filed.

- Even though this program provides the majority of the cost for the connectivity, often even with the subsidy, the $395/month remainder is more than a small clinic can afford. These clinics really are operating on a shoestring.

- Another issue is eligibility. Many times one clinic is used for mental health, social services, primary care and a host of other services. These are very small communities and adding one ineligible service to a clinic can cause it to become ineligible for the program.

- Even with the RHCPP funds, I think we will continue to find the same problems with small sites. There really isn't any sustainable model for a small rural clinic.

- The *subsidies aren't impressive*. Participants must choose between the regular program and the Pilot program. The Pilot pays 85% of all eligible network costs, at least for the duration of that program. Such a high percentage of monthly and one-time costs means a greater benefit for us as compared to the regular program, which pays only the difference between urban and rural monthly rates. Also , more sites qualify for funding under the Pilot program as compared to the regular program.

- Rural health clinics often don't really even know what kind of bandwidth they have or how much they are currently spending

- The feedback from those that have applied is that it takes about 6 months to see any funds come back from USAC, and by then the filing year is almost over.

- The problem is the perception that, especially among clinics and smaller hospitals, that there is not enough bang for buck. In other words, their belief is that the potential subsidies available do not justify the cost or burden of the process. The process is also cumbersome and difficult.

- We *didn't know about the Rural Health program* until we got involved in the Pilot. In fact, the Technical Services team, which currently runs the Pilot Program, were given custody of the project several months after FCC award was announced.

- *Bureaucracy, both State and Federal*. We have enough trouble with our State telecommunications office in the best of times. Our troubles are mitigated a tiny amount in the Pilot program because we have the benefit of a larger and broader group of participants. Such strength-in-numbers lends us a bit more credibility and clout in our discussions with the telecoms office.

Recommendations

- Policy change that will A) provide public non-profits (urban or rural) with deep discounts and B) support intermediary organizations (at state or regional level) that shield the local sites from the complexity of applying and administering a discounted link while giving the FCC accountability and ease of program management. C) be complemented by funding and program/tech support by non-FCC parties (e.g. HHS, HRSA, state agencies).

- If there were an easier way to communicate to eligible providers in concrete terms the amount of money that could be available to them, more would participate. Of course, simply making the determination about potential savings is not always an easy thing to do. Some would still not play because they might not feel that the dollar amounts justify the hassle.