

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

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

**REPLY COMMENTS OF GEISINGER HEALTH SYSTEM**

Douglas G. Bonner  
Aaron M. Gregory  
**SONNENSCHN NATH & ROSENTHAL LLP**  
1301 K Street, N.W., East Tower, Suite 600  
Washington, DC 20005  
(202) 408-6400  
(202) 408-6399 (facsimile)  
dbonner@sonnenschein.com

*Counsel to Geisinger Health System*

September 23, 2010

**TABLE OF CONTENTS**

	<u>Page</u>
Introduction and Summary .....	1
I. The Definition of “Eligible” Providers Should Be Expanded to Include Additional “For Profit” Health care Entities; Alternatively, Non-Eligible Entities Should Be Allowed to Share Eligible Entities’ Excess Capacity .....	1
A. Commenters Call For the Definition of “Eligible” Entities to be Expanded .....	2
B. Alternatively, the Commission Must Allow Eligible Entities to Share Excess Infrastructure Capacity with Non-eligible Health care Entities.....	3
II. The Commission Should Streamline the Application Process, Minimize Unnecessary Administrative Burdens, and Provide Sufficient Funding of Administrative Expenses in Order To Maximize the HIP’s Impact .....	4
A. Heavy Administrative Burdens Could Act as a Barrier to HIP Participation.....	4
B. Certain Legal Expenses Should Be Considered “Eligible” Administrative Costs .....	6
III. Critics who argue that HIP Programs Would Fund Duplicative Networks are Simply Wrong; Applicants Must Demonstrate That Health care- Quality Broadband Service is Unavailable .....	7
IV. The HIP Would Not Turn Health care Providers Into “Telecommunications Startups” Because Providers Would Partner With Existing Providers To Assist In The Construction, Maintenance, And Management Of The New Networks.....	9
V. The Record Shows That the Commission Should Not Limit the Potential Success of the HIP Fund by Adopting Artificially Low Caps for the Fund or by Setting Initial Inadequate Per-Project Limits.....	11
A. The \$100 Million HIP Cap Is Insufficient to Bridge the Rural Health Care Broadband Connectivity Gap .....	11
B. A \$15 Million Per-Project Cap Would Automatically Disqualify Many Worthy Infrastructure Projects and Discourage HIP Participation .....	12
Conclusion .....	12

## INTRODUCTION AND SUMMARY

The Commission's proposed Health Infrastructure Program ("HIP") promises to help bridge the broadband health care connectivity gap that exists in rural America and enable the delivery of promising telemedicine applications to all Americans, regardless of where they live. Given the successes of the Commission's Rural Health Care Pilot Program ("RHCPP") and the NTIA's Broadband Technology Opportunities Program ("BTOP"), the Commission is rightly optimistic about the HIP's potential to extend health care-quality broadband services into previously unserved areas. However, as many commenters have pointed out, the Commission should take several straightforward steps to maximize the effectiveness of the HIP.

First, the Commission should recognize the vital role that "for profit" health care entities play in America's rural communities and either make these providers directly eligible for the health care broadband support programs or allow "for profit" health care providers to share excess broadband capacity with otherwise eligible entities. Second, in order to encourage program participation, the Commission should streamline the administrative component of the program and fund administrative expenses that are unavoidably associated with infrastructure project development. Lastly, the Commission should avoid establishing arbitrary limits on the HIP fund or on individual HIP-funded projects. Instead, the Commission should set funding caps based upon demonstrated demand for similar project funding.

Taken together, these actions will strengthen the HIP into a program truly capable of bridging the broadband connectivity gap. Geisinger wholeheartedly supports the Commission's efforts in establishing these permanent rural health care support mechanisms and looks forward to working side by side with the Commission and the Universal Service Administrative Company ("USAC") to build the networks that will deliver life-saving, cost-effective, and convenient telemedicine applications to rural America.

### **I. THE DEFINITION OF "ELIGIBLE" PROVIDERS SHOULD BE EXPANDED TO INCLUDE ADDITIONAL "FOR PROFIT" HEALTH CARE ENTITIES; ALTERNATIVELY, NON-ELIGIBLE ENTITIES SHOULD BE ALLOWED TO SHARE ELIGIBLE ENTITIES' EXCESS CAPACITY**

The initial comments reflect an overwhelming consensus within the rural health care community that the Commission recognize the undeniably important role that "for profit" health care entities play in rural communities and make them eligible for the health care broadband

support programs. “For profit” health care entities are an essential component of the rural health care system, providing safety net services to rural areas.<sup>1</sup> Indeed, as noted by the Virginia Telehealth Network, the importance of non-traditional health care entities continues to grow as financial, demographic, and regulatory pressures transform the health care system into one where “for profit” facilities play a larger and larger part.<sup>2</sup> The Commission should recognize the critical function played by “for profit” health care providers in rural communities and build sufficient flexibility into its rules to allow for the entire spectrum of health care providers to deliver needed care to rural areas, thus maximizing the impact of the Commission’s proposed programs. The primary means to accomplish this goal would be to expand the definition of “eligible” health care providers to include “for profit” entities. Alternatively, non-eligible entities should be allowed to share eligible entities’ excess broadband capacity.

#### **A. Commenters Call For the Definition of “Eligible” Entities to be Expanded**

Geisinger joins those rural health care entities supporting the expansion of the definition of “eligible” entities to include “for profit” health care entities. A significant number of commenting parties, noting the vital role that various “for profit” entities play in the delivery of health care to rural communities called for a broad definition of “eligible” entities. Commenting parties express support for expanding the definition to include a range of specific types of facilities, such as: mobile medical practices;<sup>3</sup> emergency medical service and transport providers;<sup>4</sup> “for profit” hospitals;<sup>5</sup> skilled nursing facilities;<sup>6</sup> administrative offices;<sup>7</sup> private

---

<sup>1</sup> Comments of American Hospital Association at 7 (“for profit entities are an integral part of the rural health care system”); Comments of California Hospital Association (“private clinicians and for profit CAHs are providing safety net services to their communities... The programs could be substantially improved by including these groups that provide parts of the safety net for rural health care.”); Comments of American Telemedicine Association at 8.

<sup>2</sup> Comments of Virginia Telehealth Network at 25.

<sup>3</sup> See Comments of American Academy of Home Care Physicians at 1.

<sup>4</sup> See Comments of Virginia Telehealth Network at 19.

<sup>5</sup> See Comments of Virginia Telehealth Network at 25.

<sup>6</sup> See Comments of California Public Utilities Commission at 8 (expand definition of eligible entities to include skilled nursing facilities, renal dialysis centers, and facilities that offer services traditionally provided at hospitals).

<sup>7</sup> Comments of Utah Telehealth Network at 1 (expand interpretation of “eligible health care provider” to include acute care facilities, administrative offices, physician offices).

clinics;<sup>8</sup> home health agencies;<sup>9</sup> and health information exchanges.<sup>10</sup> In addition, spurred by the deployment of ubiquitous health care-grade broadband, innovative new models may appear that provide similar or complementary services as those currently considered eligible. Indeed, the same logic that led the Commission to extend the definition of “eligibility” to include administrative offices, skilled nursing facilities, and renal dialysis centers as facilities “integral” to the delivery of rural health care suggests that the Commission should build sufficient flexibility into its final rules to allow for creative solutions to deliver needed care to rural communities, regardless of profit status.<sup>11</sup>

To the extent that the Commission chooses to limit its determination of “eligible” facilities to a list of specifically enumerated service providers, Geisinger concurs with a host of commenting parties that the Commission include Health Information Exchanges (“HIE”) as an entity specifically eligible for rural health care broadband funding.<sup>12</sup> HIEs already facilitate information sharing across great distances among a vast network of health care professionals and can be scaled up quickly to connect other providers. Funding these entities would spur the deployment of telehealth applications to an expanding network of service providers and lay the foundation for further expansion in the near future.

**B. Alternatively, the Commission Must Allow Eligible Entities to Share Excess Infrastructure Capacity with Non-eligible Health Care Entities**

Should the Commission take a narrow view regarding the entities that are considered “eligible” for HIP support, then ineligible health care providers should be allowed to share excess broadband capacity with the eligible providers, provided that they are delivering rural health care services and their participation will support the financial sustainability of the underlying infrastructure project. This will minimize costs to the eligible provider, increase

---

12

health care broadband deployment, and free up HIP funding for additional projects. In short, allowing ineligible health care providers to share excess broadband capacity will promote the delivery of rural health care by helping bridge the connectivity gap.

Verizon argues that shared access to broadband facilities has the potential to maximize the benefit of HIP-funded infrastructure.<sup>13</sup> Indeed, by maximizing the utilization of HIP-funded infrastructure, the Commission would enhance the sustainability of each individual project and provide needed connectivity to otherwise ineligible health care providers. By contrast, limiting an applicant's ability to enhance sustainability by sharing excess capacity would be an inefficient use of scarce resources.<sup>14</sup> While the primary function of the HIP should be targeted toward eligible entities, otherwise ineligible health care entities should be allowed to utilize the HIP networks if their purpose is related to the provision of health care.<sup>15</sup>

## **II. THE COMMISSION SHOULD STREAMLINE THE APPLICATION PROCESS, MINIMIZE UNNECESSARY ADMINISTRATIVE BURDENS, AND PROVIDE SUFFICIENT FUNDING OF ADMINISTRATIVE EXPENSES IN ORDER TO MAXIMIZE THE HIP'S IMPACT**

Commenters share a common concern that burdensome administrative requirements may discourage participation in the HIP and increase the compliance and administrative costs for those that do participate. Minimizing the administrative burden on program participants will serve the dual purposes of increasing meaningful participation in the HIP from smaller, resource-scarce providers as well as ensuring that HIP funding has its greatest impact. Further, taking the time to develop a focused and elegant administrative process will facilitate regulatory oversight, allowing USAC to efficiently analyze the merits of proposed projects. Finally, expanding the definition of "eligible costs" to include certain necessary expenses associated with building networks will encourage HIP participation by reducing the risk that significant and unavoidable project expenses will be borne entirely by the applicant.

### **A. Heavy Administrative Burdens Could Act as a Barrier to HIP Participation**

Excessive administrative requirements will be a deterrent to HIP participation. As proposed, the HIP will consist of an initial application phase, a project selection phase, and a

---

<sup>13</sup> Comments of Verizon at 5.

<sup>14</sup> Comments of Rural Nebraska Health care Network, Inc. at 12.

<sup>15</sup> *Accord* Comments of Iowa Health System at 2.

project commitment phase, each with its own unique set of filings and requirements.<sup>16</sup> This basic framework, while necessary, has the potential to balloon into an administrative and compliance quagmire for program applicants unless the Commission commits itself to carefully establishing selection and eligibility criteria that delivers the most useful information while imposing the least possible burden on program applicants.

As some commenters have noted, if the Commission does not carefully craft its program application, selection, and commitment phase requirements to be as streamlined as possible, the administrative costs associated with pursuing HIP funding will dissuade many otherwise qualified applicants from participating.<sup>17</sup> This participation gap would affect all potential participants, but would be acutely felt by smaller, resource-scarce health providers who are less well equipped to navigate the application, selection, and commitment process. In addition, as the NPRM makes clear, unsuccessful program applicants will not be able to recoup any of their administrative expenses.<sup>18</sup> This poses a foreboding prospect for an applicant that will incur significant consultant and overhead expenses to meet application requirements. The combination of uncertain funding and the high costs of preparing an application will likely dissuade many potential participants from pursuing funding for otherwise meritorious projects.

Ongoing compliance costs may also be significant, but can be minimized by focusing on several features of the program's ongoing reporting requirements. The RHCPP's onerous administrative process leaves much room for improvement.<sup>19</sup> For example, under the RHCPP, a participating health care provider is required to engage in a lengthy and elaborate qualification and coordination effort simply to engage a single vendor, followed by a continuing obligation to verify and submit vendor invoices.<sup>20</sup> Based on its experience, and drawing upon the comments

---

<sup>16</sup> Comments of American Hospital Association at 3.

<sup>17</sup> Comments of Office of Telemedicine of the University of Virginia Health System at 5 (“greater utilization of the RHCS program will occur with administrative simplification”); Comments of AHA at 3; Comments of The Health Information Exchange of Montana, Inc. at 18.

<sup>18</sup> NPRM, ¶ 38 (only successful applicants will be reimbursed for administrative expenses incurred in connection with the project).

<sup>19</sup> See Comments of American Telemedicine Association at 9-10 (describing current application process as onerous to rural health providers and describing the process as a “barrier to [program] participation.”).

<sup>20</sup> Geisinger has attached its internal RHCPP checklist for vendor approval and ongoing filings to illustrate the multiple steps needed to qualify just a single vendor. Geisinger used five

of others in this proceeding, Geisinger proposes the following improvements for the HIP. First, AT&T's recommendations regarding the Healthcare Broadband Support Program ("HBSP") invoicing process should also apply to the HIP. That is, USAC should be authorized to provide funding directly to health care providers for eligible costs and services rendered, rather than engage in multi-party coordination for each invoice.<sup>21</sup> Second, project applications and follow-on reporting obligations should be posted in a single media form to a single online portal, rather than requiring providers to post to multiple locations, in multiple forms, by different means of communication, as under the RHCPP. Indeed, as recommended by GCI, the Commission and USAC should focus on improving the program's online functionality, thereby increasing online application availability and transparency.<sup>22</sup> Lastly, as suggested by several parties, the use of multiple-year "evergreen" contracts should be encouraged by the Commission and USAC to minimize the need for ongoing filing requirements for previously approved contracts.<sup>23</sup>

#### **B. Certain Legal Expenses Should Be Considered "Eligible" Administrative Costs**

The Commission should recognize that legal expenses are a necessary component of designing and building an efficient broadband network.<sup>24</sup> As such, certain legal expenses should be considered "eligible" under the HIP, as they were under the NTIA's BTOP program.<sup>25</sup> The Benton Foundation correctly argues that certain legal costs are "unavoidable" and that, in order to "to develop contracts that are for multiple years, involve millions of dollars, and involve issues of service levels and liability, it would be irresponsible to preclude the use of contract attorneys to ensure that the appropriate measures are included in the contract."<sup>26</sup> Rather than

---

(Cont'd)

different service providers for its RHCPP project, but one can easily envision situations in which a HIP grant recipient would utilize ten or more service providers. See Geisinger RHCPP Vendor Checklist, attached hereto as *Attachment A*.

<sup>21</sup> See Comments of AT&T at 10-11.

<sup>22</sup> See Comments of GCI at 24-25.

<sup>23</sup> See Comments of American Telemedicine Association at 9; Comments of Charter Communications, Inc. at 16.

<sup>24</sup> Comments of the Benton Foundation at 3; Comments of the Health Information Exchange of Montana, Inc. at 25; Comments of Rural Nebraska Health care Network, Inc. at 8.

<sup>25</sup> Comments of the American Hospital Association at 6-7 ("unlike the Commission's proposals in the NPRM, which would severely limit reimbursement of legal expenses, BTOP does not exclude relevant legal costs from reimbursement. The FCC's program should not do so either.").

<sup>26</sup> Comments of the Benton Foundation at 3.

preclude legal fees entirely, the Commission should recognize that certain legal costs are invariably associated with project development and, thus, provide that legal costs incurred in the negotiation of critical contracts are eligible for administrative expense support.<sup>27</sup> By recognizing the value of legal advice in building sustainable networks and reimbursing applicants accordingly, the Commission would reduce the risk that certain costs would be borne entirely by the applicant, thus encouraging greater program participation.<sup>28</sup>

### **III. CRITICS WHO ARGUE THAT HIP PROGRAMS WOULD FUND DUPLICATIVE NETWORKS ARE SIMPLY WRONG; APPLICANTS MUST DEMONSTRATE THAT HEALTH CARE-QUALITY BROADBAND SERVICE IS UNAVAILABLE**

Several groups of incumbent telecommunications and broadband providers have criticized the HIP as a program that would “overbuild” existing networks, leading to “duplicative” efforts that might even “imperil” infrastructure supported by other universal service programs.<sup>29</sup> Even a cursory read of the Commission’s proposal confirms that this argument is a *non sequitur* that cannot be taken seriously. Indeed, the NPRM requires that “applicants under the health infrastructure program [must] demonstrate that broadband... is presently unavailable or insufficient for health IT[.]”<sup>30</sup> However, since the argument was raised by more than one party, Geisinger feels compelled to rebut this baseless contention.

First, as a threshold matter, the express purpose of the HIP fund is to bridge the health care broadband connectivity divide in those areas where private market participants have failed to deliver desired services. HIP funding would only be forthcoming in those areas where current broadband networks are unavailable or insufficient for health care purposes.<sup>31</sup> Thus, the program is not funding “overbuilt” or “duplicative” networks, but is actually supporting the construction of “greenfield” health care networks where adequate broadband infrastructure is lacking.

---

<sup>27</sup> See Comments of the Benton Foundation at 3; Comments of the Health Information Exchange of Montana, Inc. at 24.

<sup>28</sup> Accord Comments of American Hospital Association at 6 (“Inadequate funding of administrative costs will discourage many applicants from participating.”).

<sup>29</sup> See Comments of National Telecommunications Cooperative Association at 4; Comments of Alaska Communications Systems at 2; Comments of Montana Telecommunications Association at 5-6.

<sup>30</sup> NPRM, ¶ 11.

<sup>31</sup> *Id.*

Further, even in those areas that possess some level of existing infrastructure, applicants would be required to demonstrate that these networks are “insufficient.” As the Commission recognizes, dedicated line health care-grade broadband is substantially different from mass-market broadband suitable for personal use.<sup>32</sup> Indeed, as pointed out by the *National Broadband Plan*, mass-market broadband cannot support the operations of health care providers larger than a solo practitioner’s office.<sup>33</sup> Healthcare-grade broadband requires substantially higher speeds and better throughput performance characteristics than those generally available to individual consumers.<sup>34</sup>

There is also a fundamental difference between a “duplicative” network and one that is “sufficient” for health care purposes. As many parties have noted, network redundancy is essential to telemedicine applications. Thus, even in those areas where a single, existing network delivers health care-grade broadband, there may be cause to find its network “insufficient” because “[m]any existing networks serving [rural areas] under the current program are subject to outages, which can have disastrous effect on the provision of patient services.”<sup>35</sup> Indeed, as pointed out by Alaska Communications Systems, network redundancy becomes increasingly critical as providers rely more and more upon telemedicine applications to diagnose and treat patients “in serious and, at times, life-threatening circumstances.”<sup>36</sup> Aside from ensuring that individual patients receive reliable care, network redundancy “minimiz[es] the risk that network failure could inhibit the health care community’s ability to respond quickly to pandemics and other national crises.”<sup>37</sup>

Finally, the argument that other universal support funds already (or soon will) support broadband infrastructure is an equally unconvincing rationale for opposing the HIP. For the

---

<sup>32</sup> NPRM, ¶ 3.

<sup>33</sup> NBP at 211.

<sup>34</sup> See NBP at 210, Exhibit 10-C (noting required actual speeds for service location categories: 10 Mbps for “small primary care practice” of 2-4 physicians; 10 Mbps for nursing homes; 10 Mbps for “rural health centers”; 25 Mbps for “Clinic/Large Physician Practice of 5-25 physicians; 100 Mbps for hospitals; 1,000 Mbps for “Academic/Large Medical Center.”).

<sup>35</sup> Comments of Charter Communications, Inc. at 4.

<sup>36</sup> Comments of Alaska Communications Systems at 10.

<sup>37</sup> Comments of AT&T at 5-6; *accord* Comments of Nebraska Statewide Telehealth Network at 4 (“redundancy is necessary in reasonably providing a service that can reliably meet the needs of the desired users as well as remain functional in a public health disaster or emergency.”).

reasons discussed above, the speed and performance targets called for in the *National Broadband Plan* are substantively different than those proposed in the HIP. While the *National Broadband Plan* calls for nationwide availability of 4 Mbps actual broadband speeds by 2020, the HIP calls for dedicated health care broadband solutions delivering speeds in excess of 10 Mbps or higher. Even if the *National Broadband Plan* succeeds in closing the nation's mass-market broadband connectivity gap, the speeds available would still be insufficient for current and near-term telehealth applications.<sup>38</sup> Instead, the proper way to view the HIP in relation to existing and proposed USF programs is as a complementary, but not identical, program since they are directed at different requirements and both serve to bridge the broadband gap. For these reasons, Geisinger is pleased that a wide range of parties, from public interest groups such as the Benton Foundation<sup>39</sup> to broadband providers like Qwest<sup>40</sup> support the Commission's HIP proposal, with its promise to deliver life-saving healthcare-grade broadband to underserved communities.

#### **IV. THE HIP WOULD NOT TURN HEALTH CARE PROVIDERS INTO "TELECOMMUNICATIONS STARTUPS" BECAUSE PROVIDERS WOULD PARTNER WITH EXISTING PROVIDERS TO ASSIST IN THE CONSTRUCTION, MAINTENANCE, AND MANAGEMENT OF THE NEW NETWORKS**

Another criticism that has been leveled at the HIP is that it would turn rural health care providers into "telecommunications startups," a role that health care providers are ill-suited to play.<sup>41</sup> As noted by Verizon, "rural health care providers... are not generally in the business of running broadband networks, and this situation becomes even more complicated if a program applicant could be allowed... to provide broadband services to both itself and to others."<sup>42</sup> This

---

<sup>38</sup> See NBP at 211 ("Although some delivery settings currently function at lower connectivity and quality, those levels are straining under increasing demand and are unable to support needs likely to emerge in the near future."); see also *id.*, Exhibit 10-B.

<sup>39</sup> See Comments of Benton Foundation at ("Benton fully supports the creation of a health infrastructure program that will fill the gaps in the delivery of health care services by funding the creation of regional and statewide networks where broadband has not yet been deployed.").

<sup>40</sup> See Comments of Qwest Communications International Inc. at 1 ("Qwest supports the Commission creating a health infrastructure program that would support up to 85% of the construction costs of new regional or statewide networks to serve public and non-profit health care providers in areas of the country where broadband is unavailable or insufficient.").

<sup>41</sup> See Comments Office of Telemedicine of the University of Virginia Health System at 4-5 ("infrastructure deployment initiatives convert rural health care providers into telecommunications start-ups... a role which we, as a Pilot Program awardee have struggled").

<sup>42</sup> Comments of Verizon at 5.

would be a fair criticism if rural health care providers were required to run the broadband network in a vacuum, without outside assistance or expertise, but that is simply not the case.

Rural health care providers actively partner with broadband providers to perform vital network construction and management functions when these needs arise. By building flexibility into the rules regarding shared use, required provider ownership interests, and lease terms and lengths, the partnership of public and private sectors can jointly facilitate the growth of broadband services in those areas where the business case for health care-grade broadband services may be challenging.<sup>43</sup> By using the HIP program to build networks out to rural health care providers, the business case for follow-on broadband deployment is improved, bridging the connectivity gap faster than if rural areas were forced to wait solely on private sector solutions to deliver needed bandwidth.

Indeed, given the realities of the rural marketplace, the need for infrastructure funding is needed now more than ever. It has been well documented in recent years that many of the larger, more resource-rich incumbent wireline carriers have been exiting the incumbent wireline carrier business, particularly in rural, sparsely populated areas. In approving the Verizon-Frontier transaction earlier this year, for example, the Commission noted that “Verizon has not focused investment in these [rural] areas, and has shown no indication that it will change course in the future.”<sup>44</sup> Similarly, in 2008, the Commission noted that Verizon had stopped the roll-out of its “capital intensive New Hampshire FiOS project in June of 2006” and that FairPoint was more likely to deliver broadband solutions to many rural service areas for the first time.<sup>45</sup> This trend of larger carriers abandoning high cost rural areas indicates that it is becoming increasingly unlikely that infrastructure investments will be made by incumbent to bridge the broadband connectivity gap in rural America without the assistance from programs like the HIP.

---

<sup>43</sup> NBP at 214; *accord* Comments of Rural Nebraska Healthcare Network, Inc. at 10.

<sup>44</sup> *Applications Filed by Frontier Communications Corporation and Verizon Communications, Inc. for Assignment or Transfer of Control*, Memorandum Opinion and Order, WC Docket No. 09-95, 25 FCC Rcd 5972, ¶ 56 (2010).

<sup>45</sup> *Applications Filed for the Transfer of Certain Spectrum Licenses and Section 214 Authorizations in the States of Maine, New Hampshire, and Vermont from Verizon Communications Inc. and its Subsidiaries to FairPoint Communications, Inc.*, Memorandum Opinion and Order, WC Docket No. 07-22, 23 FCC Rcd. 514, ¶ 30 (2008).

However, if rural health care providers are given the option of partnering with communications providers to meet their needs, this added flexibility makes it more likely that networks will be built in a manner that maximizes their efficiency and provides the foundation for additional deployment. Thus, the HIP should properly be viewed as facilitating public-private partnerships that will more quickly and efficiently bridge the gap.

**V. THE RECORD SHOWS THAT THE COMMISSION SHOULD NOT LIMIT THE POTENTIAL SUCCESS OF THE HIP FUND BY ADOPTING ARTIFICIALLY LOW CAPS FOR THE FUND OR BY SETTING INITIAL INADEQUATE PER-PROJECT LIMITS**

As noted by the American Hospital Association, it is important that the Commission avoid imposing “artificial caps on program funds” because doing so would “delay the expansion of broadband services where health care providers are ready to implement facilities but cannot do so without the appropriate federal support.”<sup>46</sup> Indeed, by placing a cap on the HIP fund at the outset of the program, before program demand is known, the Commission risks “slow rolling” the deployment of telehealth networks at the very moment when promising applications are becoming widely available.<sup>47</sup> Geisinger agrees that now is “the time to be aggressive about telehealth projects.”<sup>48</sup> The Commission should not impose arbitrary limits on either the overall HIP fund size or on individual HIP projects, but should take into account the lessons of the RHCPP and the BTOP to set initial project limits at a level higher than demonstrated past demand.

**A. The \$100 Million HIP Cap Is Insufficient to Bridge the Rural Health Care Broadband Connectivity Gap**

As argued by several parties in the initial round of comments, setting a \$100 million overall cap on the HIP is not only “arbitrary,”<sup>49</sup> but may discourage and disqualify meritorious program applications.<sup>50</sup> Indeed, as noted by Geisinger and others, the proposed \$100 million cap fails to take into account the demand for infrastructure evidenced already under the RHCPP and

---

<sup>46</sup> Comments of American Hospital Association at 9.

<sup>47</sup> See Comments of California Telehealth Network and the University of California Davis Health System at 13.

<sup>48</sup> *Id.*

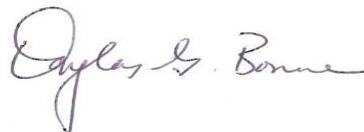
<sup>49</sup> *Id.*

<sup>50</sup> See Comments of Rural Nebraska Healthcare Network at 21.

the NTIA's recent BTOP programs.<sup>51</sup>

the commenting parties and either expand the definition of eligible entities to include “for profit” health care facilities or permit excess capacity on HIP-funded networks to be shared with non-eligible providers. The Commission should set the cap on the overall HIP fund to at least \$200 million and should raise the “per-project” cap as well. In order to encourage HIP participation the Commission should focus on creating a streamlined application process, minimize administrative burdens on program applicants, and expand the definition of “eligible” administrative costs to include certain legal fees. Taken together, these actions will create a strong Health Infrastructure Program that will enable health care providers to deliver life-saving, convenient, and cost-effective telemedicine applications to rural America.

Respectfully submitted,



Douglas G. Bonner  
Aaron M. Gregory  
**SONNENSCHN NATH & ROSENTHAL LLP**  
1301 K Street, N.W., Suite 600 East Tower  
Washington, DC 20005  
(202) 408-6400  
(202) 408-6399 (facsimile)  
dbonner@sonnenschein.com

*Counsel for Geisinger Health System*

Date: September 23, 2010