

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

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

REPLY COMMENTS OF RURAL NEBRASKA HEALTHCARE NETWORK, INC.

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SUMMARY

RNHN, in its opening comments, offered its strong support for the Commission's proposals to reform the Rural Health Care Support Mechanism by implementing a Health Infrastructure Program ("HIP") to deploy new and upgraded broadband infrastructure and a Health Broadband Services Program ("HBSP") to support the monthly recurring costs of advanced broadband services to public and non-profit rural health care providers. RNHN also offered several suggestions on how to make these promising programs better so that they work for, and not against, rural health care providers by encouraging maximum participation in the programs and permitting rapid deployment of the advanced broadband infrastructure and services that rural health care providers desperately need.

Driving RNHN's comments is the belief that the Commission should not impose any constraints on participating in the programs, such as minimums or maximums, and that participation should be open to everyone, profit and non-profit alike. In that manner, the Commission will be presented with projects that provide choice to rural health care providers but which are not constrained by artificial limitations.

The opening comments submitted in this proceeding resoundingly support and validate RNHN's concerns and recommendations. Indeed, the record provides overwhelming evidence that, in order to fulfill the health care recommendations of The National Broadband Plan, HIP and HBSP must be flexible, must not impose arbitrary limitations and caps, and must not impose over burdensome rules on the application process. Although there were commenters that called for the elimination of HIP, they provide no substantiated grounds for their recommendation. A few commenters expressed concern regarding the Commission's proposal that health care providers have an ownership interest in the network because that would place health care providers in the business of operating a network. While this is a valid concern, it is no reason to

eliminate HIP or reform it to remove infrastructure ownership altogether. As RNHN recommends, any rules adopted by the Commission should permit health care providers to build a network based on their needs—whether that means constructing a new network or utilizing existing infrastructure. Moreover, by funding administrative expenses, rural health care providers can hire the expertise needed to build, operate, and manage a network.

The comments also showed widespread support for permitting applicants to build excess capacity into their network. A primary reason for this is to include for-profit health care providers, which are important part of rural health care delivery. Additionally, it makes no sense to build an advanced broadband network dedicated only to health care in rural areas where broadband is unavailable or insufficient. The entire community will benefit from the network if shared use is permitted. Similarly, for-profit entities should be allowed to partner with rural health care providers and contribute to the matching contribution requirement.

The record also demonstrates that rural communities are not homogenous—a one size fits all policy simply will not do. The Commission must build in flexibility in its rules to take into account the varying demographics of rural communities, such as affordability of broadband and the medical needs of the area.

By adopting its proposed rules with the changes recommended by RNHN, and supported by the record, the Commission will help bridge the broadband connectivity gap faced by rural health care providers, and, in the process, improve the health care experience of rural America.

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Rural Nebraska Healthcare Network, Inc (“RNHN”), hereby submits these reply comments in response to comments submitted in the above-captioned Rural Health Care Support Mechanism Notice of Proposed Rulemaking (“NPRM”).¹

I. INTRODUCTION

RNHN, in its opening comments, offered strong support for the continued efforts of the Commission to reform the Rural Health Care Support Mechanism in accordance with The National Broadband Plan.² The measures proposed by the Commission are critical to closing the broadband connectivity gap that exists for rural health care providers.

Many of the Commission’s proposals, however, would actually hinder participation in the proposed programs and perpetuate the underutilization of the Rural Health Care Support Mechanism. To correct these problems, RNHN offered several important changes aimed at maximizing participation in and success of a revamped Rural Health Care Support Mechanism. Among other things, RNHN recommended that the Commission eliminate funding and project caps and minimum speed requirements, fund administrative expenses, include participation by

¹ *In re Rural Health Care Support Mechanism*, Notice of Proposed Rulemaking, 25 FCC Rcd 9371 (2010) (“NPRM”).

² Federal Communications Commission, *Connecting America: The National Broadband Plan* (rel. Mar. 16, 2010), available at http://hraunfoss.fcc.gov/edocs_public/attachmatch/DOC-296935A1.pdf.

for-profit entities, permit and encourage building and sharing of excess capacity, and provide discounts ranging from 50 to 100 percent for HBSP.

In these reply comments, RNHN responds to calls for the elimination of HIP and comments supporting the Commission's plans to adopt rules that limit a participant's option to choose the technology and contractual arrangements that fits its needs and cap funding on the programs. RNHN also discusses the widespread support for including in-kind and for-profit entities as eligible sources for the contribution requirement, permitting excess capacity and shared use by non-eligible entities, and increased discounts for HBSP applicants.

II. DISCUSSION

A. The Health Infrastructure Program Is At the Heart Of Meeting the Broadband Needs of Rural Health Care Providers

The Commission has been charged by Congress to ensure that every American has “access to broadband capability.”³ To that end, Congress instructed the FCC to devise a strategy for achieving broadband affordability and maximizing broadband use to advance “consumer welfare, civic participation, public safety and homeland security, community development, health care delivery, energy independence and efficiency, education, employee training private sector investment, entrepreneurial activity, job creation and economic growth and other national purposes.”⁴ In response to that directive, The National Broadband Plan establishes specific imperatives to achieve Congress's objectives: greater broadband competition, availability, adoption and use, with a specific mandate to replace the existing Internet Access Fund with a Health Care Broadband Access Fund and establish a Health Care Broadband Infrastructure Fund

³ American Recovery and Reinvestment Act of 2009, Publ. L. No. 111-5, § 6001(k)(2)(D), 123 Stat. 115, 516 (2009).

⁴ *Id.*

to subsidize network deployment to health care delivery locations where existing networks are insufficient.⁵

Notwithstanding this clear direction from Congress and the findings of The National Broadband Plan, several of the commenters either want to eliminate HIP altogether or refocus the program to eliminate infrastructure construction projects.⁶ Central to the opposition of HIP is a concern of overbuilding, *i.e.*, the duplication of broadband infrastructure. The Commission, however, has recognized the risk of overbuilding and has proposed rules to guard against such projects by requiring applicants to verify “either there is no available broadband infrastructure or the existing available broadband infrastructure is insufficient for health IT needed to improve and provide health care delivery.”⁷ Additionally, HIP not only considers the building of new infrastructure where needed, but it also encourages the leveraging of existing infrastructure by allowing the funding of IRUs and capital leases.⁸

It is not surprising that incumbent telecommunications carriers want to maintain the *status quo* of high prices, minimal service options and beholden rural health care providers. They assert that funding HIP projects will discourage broadband investment, displace jobs, and waste universal service funds.⁹ For good reason, these claims are unsubstantiated. If broadband

⁵ *National Broadband Plan*, at 215-16 (Recommendations 10.6 and 10.7).

⁶ *See, e.g.*, Montana Telecommunications Association (“MTA”) Comments at 5-8 (asserting that HIP misallocates universal service funds); Eastern Montana Telemedicine Network (“EMTN”) Comments at ¶ 1 (proposing that HIP should be “re-targeted” to cover one time construction costs for facilities from the central office to health care facilities); American Telemedicine Association (“ATA”) Comments at 2-4 (proposing that HIP funds be “reprogrammed” to cover equipment and non-recurring connection charges).

⁷ *NPRM*, 25 FCC Rcd at 9382-83 ¶ 22.

⁸ *Id.* at 9395-66 ¶¶ 55-57.

⁹ *See, e.g.*, NTCA Comments at 2-3; MTA Comments at 5-7. MTA also states that because the FCC’s Omnibus Broadband Initiative Technical Paper No. 5 concluded that the “major barrier for medium and large [health care] providers is not access—it is price,” the Commission’s emphasis on building infrastructure is misplaced. Federal Communications Commission, Omnibus Broadband Initiative Technical Paper No. 5, *Health Care Broadband in America: Early Analysis and a Path Forward*, at 10 (rel. Aug. 27, 2010) (“*OBI Technical Paper No. 5*”). Even if

investment was interested in providing broadband to rural health care providers, rural health care providers would have the same ubiquitous access to broadband options available to their urban counterparts. The truth of the matter is, however, they do not. Indeed, this market failure is one of the very reasons underlying the need for HIP.¹⁰ The argument that HIP displaces jobs falls for the same reason, *i.e.*, there are no jobs to displace because broadband investment is not interested in providing broadband to rural health care providers. As to whether it is a waste of universal service funds, those funds are clearly needed to fulfill the broadband needs of rural health care providers who, to date, have not been provided with the broadband services required to bring them into the 20th century of health care? Indeed, it is exactly what universal service and HIP are all about.

The Commission should not fall prey to the false claims of telecommunications providers and their industry associations that somehow broadband deployment in the area where a HIP project is required to meet the needs of rural health care providers will result in overbuilds, displace jobs and waste universal service funds. These concerns are red herrings because the mere fact that investment has not happened in these areas in the first place necessitates the need for HIP.

B. The Commission Should Develop Flexible Rules That Will Allow HIP Participants to Build the Network That Supports Their Needs

RNHN did not specifically address the Commission's proposals regarding facilities ownership, IRU or capital lease requirements because it generally agreed with the Commission's

MTA was correct, what better vehicle than an alternative network, such as a network funded under HIP, to reduce price? MTA Comments at 8.

¹⁰ Unlike these detractors, The National Broadband Plan substantiates that a large number of small health care providers face a broadband connectivity gap. *National Broadband Plan*, at 211. See also *OBI Technical Paper No. 5*, at 10.

proposal.¹¹ There were several commenters, however, that expressed concern with requiring health care providers to own the network because they do not have the staff or the expertise to operate and maintain a telecommunications network.¹²

RNHN agrees that health care providers should not be in the business of running a telecommunications network and may not be qualified to do so. This is precisely the reason why administrative expenses, such as personnel, technical consultants and legal fees, should be funded. For similar reasons, there is widespread support for funding these expenses throughout the initial comments.¹³

RNHN can serve as an example. RNHN hired a firm, which is expert in the field of fiber optic networks, to design its network. Once the network is built and operational, the firm will continue to oversee the project and act as the interface between RNHN and the vendors. The firm works with RNHN's lawyers, who are also expert in the field of fiber optic networks, to develop terms and conditions of construction, indefeasible right of use, collocation and operations and maintenance. RNHN has been able to proceed with its network by obtaining the services of third parties. In other words, it does not need to rely on an expertise that it does not have, yet it is successfully proceeding with the construction of its network.

¹¹ See *NPRM*, 25 FCC Rcd 9395-66 ¶¶ 55-57

¹² See, e.g., TeleQuality Communications, Inc. ("TeleQuality") Comments at 3; Qwest Communications International ("Qwest") Comments at 2-3; Montana Independent Telecommunications Systems ("MITS") Comments at 9; Oregon Health Network/Telehealth Alliance of Oregon ("OHN/TAO") Comments at 5; General Communications, Inc. Comments at 13; Verizon and Verizon Wireless ("Verizon") Comments at 2-3; ATA Comments at 4; Utah Telehealth Network Comments at ¶ 5.

¹³ See, e.g., North Carolina TeleHealth Network ("NCTN") Comments at 3; New England Telehealth Consortium ("NETC") Comments at 6; Nebraska Statewide Telehealth Network ("NSTN") Comments at 3; OHN/TAO Comments at 7; Texas Health Information Network Collaborative ("THINC") and CHRISTUS Health Comments at 4; Forth Drum Regional Health Planning Organization ("FDRHPO") Comments at 3; Health Information Exchange of Montana ("HIEM") Comments at 23-25; Illinois Rural HealthNet Comments at 2, 7, 8; California Telehealth Network ("CTN") Comments at 14; Benton Foundation Comments at 3; American Hospital Association Comments at 6-7; Broadband Principals Comments at 3-4; Rural Wisconsin Health Cooperative Comments at 5.

Many of the detractors of ownership believe that long term operating leases are a better alternative to ownership.¹⁴ In keeping with the general theme of its initial comments, RNHN believes that the health care providers are in the best position to determine which means will best suit their needs and therefore, the program’s funding choices should be driven by demands and preferences of the providers and their patients. Accordingly, the Commission should fashion rules that provide participants with the utmost flexibility to select the technology and contractual arrangements that suit their needs in an economical way. In one instance, it may be that IRUs are called for whereas in another instance, a lease. It all depends on the situation at hand, a situation that the Commission should review beforehand and make a decision based on a showing of the applicant.

C. Eligible Sources for the 15 Percent Contribution Should Include In-kind Contributions and For-Profit Entities, Including Telecommunications Carriers

The Commission proposed that ineligible sources for the 15 percent contribution would include “(1) in-kind or implied contributions; (2) a local exchange carrier (LEC) or other telecom carrier, utility, contractor, consultant, or other service provider; and (3) for-profit participants.”¹⁵ In its initial comments, RNHN proposed that such sources should be allowed, subject to adequate safeguards and monitoring, as was adopted by the National Telecommunications and Information Administration (“NTIA”) in the Broadband Technologies Opportunity Program (“BTOP”).¹⁶

While a few commenters supported the Commission’s proposed 15 percent contribution requirement, many more support elimination of some or all of the Commission’s unwarranted

¹⁴ See, e.g., Oregon Association of Hospitals and Health Systems Comments at 2; Qwest Comments at 2-4; OHN/TAO Comments at 3, 6; General Communications Comments at 15; FDRHPO Comments at 5-6; Colorado Health Care Connections/Rocky Mountain HealthNet Comments at 2-5; Illinois Rural HealthNet Comments at 9; CTN Comments at 17; Charter Communications Comments at 9-11.

¹⁵ *NPRM*, 25 FCC Rcd at 9392 ¶ 47.

¹⁶ RNHN Comments at 10-11.

prohibition on eligible sources.¹⁷ As noted in many of the comments, without the ability to obtain support from these sources, rural and non-profit health care providers will be hard pressed to meet the 15 percent contribution requirement. Stated differently, these restrictions will significantly retard participation in the program.

There is no good reason for prohibiting either for-profit or in-kind contributions. The tax scheme is based entirely off of for-profit contributions, as is the universal service fund. Why, then, is it unacceptable in this instance? The same holds true for in-kind contributions. In-kind, if properly valued, is the same as cash. NTIA recognized as such for the BTOP program.¹⁸ There is no reason, therefore, why the Commission should not give in-kind contributions similar recognition in this instance. The significance of permitting for-profit and in-kind contributions lies with the need to give rural health care providers, most of which do not have the financial means by which to contribute 15 percent, the opportunity to meet their broadband needs.

D. For-Profit Hospitals and Other Community Users Should Be Allowed to Use Excess Capacity At Incremental Costs

The Commission requested comment on whether eligible health care providers should be allowed to share excess capacity with non-eligible entities and, if so, with which entities and how should such non-eligible entities pay for use of excess capacity.¹⁹ RNHN proposed that the Commission should permit and encourage applicants to include excess capacity or facilities in their plans to be shared with non-eligible entities (such as for-profit health care providers and

¹⁷ See, e.g., Arizona Rural Health Office Comments at 3; NSTN Comments at 4; Iowa Health System (“IHS”) Comments at ¶ 47; FDRHPO Comments at 5; Virginia Telehealth Network (“VTN”) Comments at 37; University of Arkansas for Medical Sciences Comments at 3-4; HIEM Comments at 16-17; California Hospital Association Comments at 1-2; Illinois Rural HealthNet Comments at 8-9; University of Hawaii Telecommunications and Information Policy Group Comments at 3; CTN Comments at 12; Charter Communications Comments at 8; Benton Foundation Comments at 4-5; American Hospital Association Comments at 7-8; Broadband Principals Comments at 5-6; Rural Wisconsin Health Cooperative Comments at 3.

¹⁸ See Broadband Technologies Program, Notice of Funds Availability, 75 Fed. Reg. 3792, 3800 (Jan. 22, 2010).

¹⁹ NPRM, 25 FCC Rcd at 9400 ¶ 67.

other community users) at incremental costs, because the entire community will benefit from having access to advanced broadband infrastructure.

The record shows that there is support for building excess capacity or facilities and such excess capacity or facilities should be made available to other entities and community uses at incremental costs.²⁰ As stated by RNHN in its comments, and widely supported by the record, fully distributed cost models should not be used to price excess capacity or facilities because there are no universally accepted models that are not arbitrary and subjective.²¹ Incremental or marginal costs models are acceptable methodologies that are easy to understand and allow for cost control, better planning and the isolation of direct or variable costs.

Like RNHN, commenters believe that permitting the building and sharing of excess capacity will only help and not harm the community. Excess capacity can be made to non-eligible entities such as for-profit health care providers and hospitals, a goal specifically recognized by The National Broadband Plan.²² Moreover, the income from shared use of excess capacity can be used to sustain networks dedicated to health care, which in turn will be less of a drain on Rural Health Care Support funds.

One commenter²³ states that allowing excess capacity to be built violates sections 254(h)(1)(A), which limits health care providers to purchasing telecommunications services from telecommunications carriers,²⁴ and 254(h)(3), which prohibits the sale, resale, and transfer of

²⁰ See, e.g., Internet2 Ad Hoc Health Group Comments at 16; HIEM Comments at 7-10; Illinois Rural HealthNet Comments at 2, 12-13.

²¹ Only one commenter supported using a fully distributed costs model for pricing excess capacity or facilities. See Geisinger Health System Comments at 13.

²² *National Broadband Plan*, at 214.

²³ See MTA Comments at 9-11.

²⁴ See 47 U.S.C. § 254(h)(1)(A).

telecommunications services purchased pursuant to the Communications Act.²⁵ As an initial matter, the programs proposed by the Commission are being implemented under the Commission’s authority in section 254(h)(2), not section 254(h)(1)(A); therefore, the latter section is not applicable. As explained in RNHN’s initial comments, the Commission has interpreted section 254(h)(2) to mean that both telecommunications carriers and non-telecommunications carriers are eligible to receive funding.²⁶ Furthermore, the Commission has determined that section 254(h)(3) “does not prohibit [non-eligible] entities, paying their fair share of network costs, from participating in a selected participant’s network” and that the section and its rules “are not implicated when [non-eligible] entities pay their own costs and do not receive discounts provided to eligible health care providers.”²⁷ Accordingly, there are no legal barriers to the sharing of excess capacity by non-eligible entities as long as such use complies with the Commission’s decisions on the matter.

E. Eligible Administrative Expenses Should Include Technology Consulting and Legal Expenses

The Commission proposes to provide limited support under HIP for reasonable administrative expenses incurred by participants for completing the application process.²⁸ The Commission also proposes to limit support for administrative expenses to 36 months, to \$100,000 per year, and to 10 percent of the total budget for the project.²⁹

In its opening comments, RNHN pointed out to the Commission, using the Commission’s findings, that not funding certain administrative expenses was detrimental to the Rural Health

²⁵ See 47 U.S.C. § 254(h)(3).

²⁶ See RNHN Comments at 14-16.

²⁷ *In re Rural Health Care Support Mechanism*, Order, 22 FCC Rcd 20360, 20416 ¶ 107 (2007).

²⁸ *NPRM*, 25 FCC Rcd at 9386 ¶ 37.

²⁹ *Id.* at 9387 ¶ 38.

Care Pilot Program.³⁰ RNHN proposed that only those expenses that do not assist the applicant in enhancing access to advanced telecommunications and information services should be excluded.³¹ Specifically, costs such as personnel, travel, legal, program administration, and technical consultation and coordination, which are all necessary expenses incurred to assist eligible health care providers to deploy and access advanced telecommunications and information services, should be eligible costs.

Commenters that support HIP agree that the Commission should include support for administrative expenses.³² Many state their support for including funding for technical consulting and legal fees.³³ Such expenses are as integral to getting a project off of the ground and running as is its construction, maintenance and operation. A few commenters, however, believe administering the complex undertaking of an infrastructure build and operating a network, for which health care providers do not have the expertise, should be left to telecommunications carriers.³⁴ While building and operating a network is a complex undertaking, the job can be done by health care providers with technical and legal assistance. As discussed above, RNHN is proof that such a model can work. There is no logical basis for excluding these costs and, in the process, dooming projects from the start because of lack of sufficient support for needed administrative expenses.

³⁰ RNHN Comments at 7-8.

³¹ *Id.* at 8.

³² *See supra* note 11.

³³ *See, e.g.*, NSTN Comments at 3; HIEM Comments at 23; Benton Foundation Comments at 3; American Hospital Association Comments at 6-7.

³⁴ *See supra* note 10.

F. The Entire \$400 Million Should Be Made Available for HIP and HBSP With No Per Project or Project Caps

The Commission proposes to place caps on the amount of HIP projects, HIP project funding and total funding for HIP.³⁵ RNHN recommends that no arbitrary caps be used and the full \$400 million of Rural Health Care Support funds be made available for HIP and HBSP projects.³⁶

There is widespread support in the record for eliminating the proposed caps on per project funding and the number of projects to be funded under HIP.³⁷ Arbitrary caps do not allow for considerations of the scope and efficacy of a project. Moreover, caps may have the unintended effect of deterring applicants from proposing networks that truly meet their needs or applying at all. Simply put, a project should be selected based on its merits and should not be ruled out because of its price tag. Prioritization and a merits based approach to project selection will ensure a complete distribution of Rural Health Care Support funds to worthy projects instead of the underutilization that has plagued the program.

G. HBSP Support Should Range From 50 Percent to 100 Percent

The Commission proposes a flat 50 percent discount level for HBSP support.³⁸ Many commenters propose a flat 85 percent or higher discount.³⁹ RNHN does not believe that such a

³⁵ *NPRM*, 25 FCC Rcd at 9385 ¶¶ 30-31, 9421-22 ¶¶ 128-129.

³⁶ RNHN Comments at 6-7, 21.

³⁷ *See, e.g.*, NETC Comments at 5; NSTN Comments at 3; Modern Technologies Group/AirCom Consultants, Inc./Quality Tower Services Ltd Comments at 17 (“MTG/AirCom/QTSL”); Internet2 Ad Hoc Health Group Comments at 11, 22-23; IHS Comments at 4; Geisinger Health System Comments at 5-8; HIEM Comments at 22; Telecommunications Industry Association (“TIA”) Comments at 6; Illinois Rural HealthNet Comments at 7; CTN Comments at 12-13.

³⁸ *NPRM*, 25 FCC Rcd at 9412-14 ¶¶ 104-109.

³⁹ *See, e.g.*, Oregon Association of Hospitals and Health Systems at 2; NETC Comments at 2-3; Internet2 Ad Hoc Health Group Comments at 19; OHN/TAO Comments at 9; FDRHPO Comments at 6; EMTN Comments at 2; Utah Telehealth Network Comments at 2; VTN at 5, 14-18; University of Hawaii Telecommunications and Information Policy Group Comments at 4; CTN Comments at 24-25; Rural Wisconsin Health Cooperative Comments at 4. *But*

flat subsidy will be sufficient in all locations and proposed a tiered discount level in its comments. RNHN believes that its proposed tiered discount model set forth in its comments serves the goals of the HBSP.⁴⁰

Based on a review of comments filed, however, affordability is a primary concern. For example, as shown by Utah Telehealth Network, “a 50% discount applied to a 5 MB [Ethernet] connection for a remote rural health care provider will cost more tha[n] a 50 MB connection for an urban health care provider.”⁴¹ Based on these comments, RNHN suggests a change to the model it proposed. At each discount level, a health care provider should be given an additional 10 percent discount for a demonstrated financial need or, as suggested by Virginia Telehealth Network, an additional discount percentage based on the rural/urban price differential.⁴²

	Discount in %
Areas other than below	0%
Rural	50%
MUA or HPSA	50%
Rural + HPSA	65%
Rural + MUA	75%
Rural + MUA + HPSA	90%
Additional discount for demonstrated financial need	Up to +10% or rural/urban price differential

A tiered system is preferable to a flat discount level for all health care providers because as the Commission notes, section 254(h)(2)(A) is not limited to health care providers in rural areas⁴³ and therefore, only the areas that are in the most need should obtain the highest discounts.

see also Arizona Rural Health Office Comments at 1 (proposing 65% discount); Washington Rural Health Association Comments at IV (proposing 65% discount).

⁴⁰ *See* RNHN Comments at 16-18.

⁴¹ Utah Telehealth Network Comments at 2.

⁴² *See* VTN Comments at 32-33.

⁴³ *NPRM*, 25 FCC Rcd at 9408 ¶ 93.

Furthermore, all rural areas are not alike and have different needs. The blended, tiered discount system proposed by RNHN ensures that those areas that are in the most need receive additional support by taking into account factors based on population, medical need and affordability.

H. Threshold Bandwidth Speeds Should Not Be Adopted for HBSP

The Commission proposes minimum threshold speeds for HIP and HBSP.⁴⁴ RNHN opposes any minimum threshold speed requirements.⁴⁵ Comments submitted showed no consensus on the issue—some commenters opposed thresholds, some agree with the Commission’s proposed threshold, and some believe the threshold should be higher.⁴⁶

The lack of consensus on what should be the threshold broadband speed, both for HIP and HBSP, demonstrates that no minimum speed should be adopted. Instead, the Commission should empower health care providers to select the technology and speed required according to their needs. Health care providers are in the best position to know their needs and what makes economic sense to themselves and their patients.

III. CONCLUSION

RNHN respectfully urges the Commission to adopt the changes to the programs suggested in its comments and the change to the tiered compensation system proposed by RNHN in this reply. Without these changes, health care providers will be subject to artificial limitations that will result in projects that fall short of their needs or discourage them from applying for

⁴⁴ *NPRM*, 25 FCC Rcd at 9381 ¶ 20, 9409 ¶ 97.

⁴⁵ RNHN Comments at 18-19.

⁴⁶ No minimum—NCTN Comments at XIX; Internet2 Ad Hoc Health Group Comments at 8-9; Washington Rural Health Association Comments at III; General Communications Comments at 16; American Hospital Association Comments at 5; Lower minimum proposed—Qwest Comments at 7-8; University of Arkansas for Medical Sciences Comments at 7-8; Higher minimum proposed—Iowa Health System Comments at 3, 7; THINC Comments at 5; HIEM Comments at 21; Avera Health Comments at 4-5; Illinois Rural HealthNet Comments at 3, 15; CTN Comments at 10, 22-23.

needed funding. As a result, the programs will suffer from the same under utilization that currently plagues the current Rural Health Care Support Mechanism.

Respectfully submitted,

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