

April 10, 2012

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

Re: Notice of *Ex Parte* Communication, WC Docket No. 02-60

Dear Ms. Dortch:

On March 13, 2012, Sherilyn Pruitt, Director, Office for the Advancement of Telehealth (OAT), Office of Rural Health Policy (ORHP); Mike McNeely, Public Health Analyst, (ORHP); Steven Hirsch, Program Analyst, ORHP; and Aaron Fischbach, Public Health Analyst, ORHP, all at the Department of Health and Human Services (HHS) spoke via telephone with Linda Oliver and Christianna Lewis Barnhart of the Wireline Competition Bureau. The purpose of the call was to discuss the telecommunications needs of rural health care providers in response to the Commission's July 15, 2010 Notice of Proposed Rulemaking in the above-referenced docket.

Rural Health Care Providers in the United States. The group discussed the number of rural, non-profit health care providers in the United States eligible to participate the Rural Health Care Program of the Universal Service Fund (RHC Program). The OAT and ORHP participants (hereafter "HHS") explained that although all CMS certified "Rural Health Clinics" were considered "rural" at the time they received CMS certification, CMS is unable to decertify Rural Health Clinics located in areas that have become more urban. Accordingly, it is unknown how many Rural Health Clinics would qualify today as "rural." Nevertheless, as of June 30, 2010, HHS reported that there were 3798 Rural Health Clinics of which 1787 were for-profit, 633 were government-owned, and 1378 were non-profit. The HHS participants also explained that migrant health centers are a class of Community Health Centers, along with homeless and public housing centers. Statutorily, all Community Health Centers are public or non-profit entities, and at least 40% of their patients are expected to live in rural areas. HHS estimated that slightly more than 40% of Community Health Centers are located in rural areas.

Connectivity Needs of Health Care Providers. The connectivity needs of health care providers, particularly as they relate to the adoption of meaningful use requirements, were also discussed. Rural hospitals need sufficient broadband speed to enable transmission of medical imagery (e.g., x-rays, EKG/ECG) without disrupting email and other Internet activity. Additionally, HHS explained that meaningful use requirements will enhance demand for broadband, because more rural providers will seek to implement electronic health records ("EHRs") to avoid Medicare payment penalties, which will start in 2015. They said that HHS has found that as of March 31, 2011, out of 1327 Critical Access Hospitals (CAHs), 187 have attested to Stage 1 meaningful use and 40 have received incentive payments for adopting meaningful use EHR technology. HHS also explained that small CAHs are having trouble purchasing and implementing EHR systems designed for them because these products may not yet exist. They also explained that although Rural Health Clinics and Federally Qualified Health Centers (FQHCs) are not subject to penalties in 2015 if they do not adopt meaningful use requirements, they can receive Medicare and Medicaid incentive payments for adopting meaningful use of EHRs.

Implementation of Telemedicine. HHS also said that health care providers were interested in telemedicine and broadband adoption before meaningful use requirements were created. Specifically, teleradiology has been the driving force behind the adoption of telemedicine and the need for broadband connectivity. Previously, patients in rural areas would sometimes have to stay overnight to get their radiology results

because health care providers only sent radiology images in the evening hours—sending results during the day required too much bandwidth. Unfortunately, although teleradiology has shortened patient wait times, HHS noted that images for teleradiology, even when compressed, can still require too much bandwidth for some health care providers.

Obstacles to Telemedicine. Obstacles that rural health care providers face in implementing telemedicine were also discussed. They include: a lack of information about the availability of telemedicine and how it can improve patient quality of care, difficulty in establishing partnerships with other health care providers, difficulty in obtaining access to medical specialists (who are often very busy already), difficulty in training a workforce in telemedicine, licensure issues, a lack of broadband, and unfamiliarity with telemedicine reimbursement.

Regarding reimbursement, HHS discussed problems in receiving Medicare reimbursement for telemedicine services. Many telemedicine services are not reimbursable. When a service is reimbursable, depending on the insurance coverage, the distant site receives full payment, while the originating site receives only a nominal “facility fee.” For example, when a patient at a rural hospital seeks service from a physician at an urban hospital via telemedicine, the urban location will be reimbursed by Medicare for those services according to the standard fee schedule, while the rural hospital receives a separate facility fee payment. This is separate from any other fees associated with hospitalizing that patient. In addition, rural health centers can also receive training via telemedicine technology.

Savings and Reimbursement from Telemedicine. The HHS participants also discussed savings that have resulted from telemedicine. They noted that although there are financial savings to Medicare and other payers resulting from telemedicine, savings are often in the form of patients avoiding travel costs to receive care, as well as being healthier and requiring less medical intervention.

Office for the Advancement of Telehealth Grant Programs. Ms. Pruitt discussed two of OAT’s grant programs, the Telehealth Network Grant Program and the Telehealth Resource Grant Program. The Telehealth Network Grant Program provides grantees up to \$250,000 a year, up to four years, to implement a telehealth networks program or telehealth home monitoring program. Under this program, grantees can use up to 40% of the grant for equipment, but cannot use the funds for broadband connections.

The Telehealth Resource Grant Program is a competitive grant program that provides support for the establishment and development of Telehealth Resource Centers (TRCs). There are 11 TRCs in the United States, and each has a state-wide toolkit and curriculum to assist health care organizations, health care networks, and health care providers in the implementation of cost-effective telehealth programs to serve rural and medically underserved areas and populations.

Finally, HHS provided FCC staff with two spreadsheets (attached) regarding the cost of connectivity for rural health care providers.

Respectfully submitted,

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Christianna Lewis Barnhart

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