



August 20, 2012

Sharon Gillett
Chief, Wireline Competition Bureau
Federal Communications Commission
445 12th Street, SW
Washington, DC 20554

Re: WC Docket No. 02-60 and DA 12-1166

Dear Ms. Gillett:

Thank you for the opportunity to provide additional comment on the reform of the Rural Health Care program. The Iowa Rural Health Telecommunications Program (IRHTP) received and is using an award from the Rural Health Care Pilot Program. The Health Care Broadband Access and Infrastructure Funds can provide needed support to rural providers for the monthly recurring costs and the construction of broadband networks where there is insufficient or unavailable coverage. Our comments are organized by section.

The Iowa Rural Health Telecommunications Program (IRHTP) is a joint effort consisting of a consortium of 85 Iowa rural and urban hospitals, two South Dakota urban hospitals, the Iowa Hospital Association (IHA) and the Iowa Communications Network (ICN) with the purpose to connect participating hospitals to a dedicated broadband fiber network using existing ICN infrastructure. The Iowa Hospital Association (IHA) is functioning as the project coordinator and administrator for the Iowa Rural Health Telecommunications Program (IRHTP).

Iowa has 118 acute care hospitals and using Medicare definitions 21 are in urban cities and 97 are located in rural communities. The IRHTP network has 87 hospitals of which 12 are located in urban cities and 75 are located in rural communities.

Section I. Consortia

6a. Consortium application process

The IRHTP project focused on creating a broadband network core and building out the last mile fiber connection for participating hospitals. We found having the letter of authorization at the request-for-services (465 competitive bidding) stage was very helpful. While 5 hospitals opted to not participate after the costs were known, as the project developed three of those hospitals chose to participate at a later date and were easily added back into the request-for-funding (466A) stage. For a consortium we suggest a letter of authorization should be required from each participating hospital at the request-for-services stage. To date IRHTP has submitted five request-for-services (465) competitive bidding packages and twenty-six request-for-funding-commitment (466A) packages. The required information and certifications on forms 465 and 466A, the attachments and the network cost worksheet are appropriate. The “declaration of assistance” was also appropriate.

6b. Post-Award reporting requirements

IRHTP has been filing quarterly reports since July 2008. While progress in the multi-year build out is reflected in the quarterly reports, some of the information initially submitted does not change. Filing as a consortium, the frequency and required content should be minimized. The quarterly reporting requirement in the Pilot program is to frequent. We would suggest a minimum of annual reporting for the Health Care Broadband Infrastructure fund.

6c. Site and service substitution

Through the Pilot program, we needed to use this provision and found it to be reasonable. Change occurs and a mechanism to effectively address change is important to the success of the Broadband Service Program. The ability to add and delete sites is an important component of the policy. We suggest a site and service substitution policy with similar provisions for consortia should be adopted.

Section II. Inclusion of Urban sites in Consortia

8a. Proportion of urban and rural sites in consortia

As stated earlier the IRHTP network has twelve urban hospitals and seventy-five rural hospitals. The value urban hospitals bring to rural hospitals was discussed in the public notice. The need for infrastructure and monthly fee subsidy for rural providers has also been well documented. The value of the IRHTP network is found in the number of hospital sites and inclusion of urban sites. If the intent of the Broadband Service Program is to primarily support rural providers, then some proportion greater than the *de minimis* number needs to be established. From a consortia perspective we would suggest a simple majority of the eligible provider sites should be rural.

8b. Limiting percentage of funding available to urban sites

The IRHTP project was a capital build-out and the rural last mile connections were typically longer than the urban connections. The same rural minimum noted above regarding funding can be established. We recommend that a simple majority of the funds should go to rural provider sites. These rural minimums rather than an urban limit can be applied to both funds.

8f. Grandfathering of urban sites already participating in Pilot projects

If the Commission chooses not to fund urban sites, we suggest the Commission should provide funding for the urban sites that received funding under the Pilot program. This will help support and sustain the consortia / network into the future. We believe funding should continue as long as an urban site is a member of the consortium with rural health care providers.

III. Eligible Services and Equipment

10b. Eligible non-recurring costs (NRCs)

IRHTP has several hospital systems that are using the IRHTP network. We believe Infrastructure funds should be used to subsidize the cost of equipment to enable the formation of networks among consortium members as is the case in the Pilot program. Creation of networks of system affiliated hospitals will improve sustainability of the consortia.

10c. Limited Funding for Construction of Facilities in Broadband Service Program

We recommend Infrastructure funds should also be used to fund the construction of network facilities that would be owned by an eligible health care provider. Vendor bids from the competitive bidding process during the Pilot program clearly demonstrated whether an IRU or actual construction/ownership was the most cost effective approach. In a couple of situations IRHTP faced, the capabilities or existence of a local service provider dictated the choice between fiber construction versus using an indefeasible right of use (IRU) contract.

10d. Ineligible sites and treatment of shared services/costs

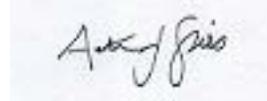
With the development of Accountable Care Organizations (ACOs) and focus on population health, hospitals need to coordinate care across many different provider groups and settings many of which are considered ineligible. We suggest ineligible health care providers should be allowed to be part of a network or consortia and they should pay their fair share of the reasonable costs of the shared services and equipment of the consortia. To provide needed flexibility to address various circumstances we recommend the Commission should just require that the allocation of the costs of shared services and equipment among consortia members be reasonable and not specify any specific approaches.

V. Broadband Needs of Rural Health Care Providers

Applications developed and initiated by IRHTP participating hospitals and systems may include: transmission of various image files, PACS consolidation, remote radiology reads, specialty consultations (e.g. cardiology, dermatology and psychiatry), remote ICU and pharmacy monitoring (e-ICU, e-pharmacy), administrative (e.g. billing) and clinical data (e.g. EMR) transmission, various patient portals, healthcare Intranet, clinical and non-clinical education and training programs provided on a network-wide basis (distance learning) and consolidation or centralization of various back office and IT functions (remote server hosting, remote server back-up and storage, health IT service, centralized billing and accounting). Enterprise activities of hospitals in the same system will initiate similar applications but just for their system hospitals. As applications are initiated greater amounts of bandwidth will be needed and used by participating hospitals. The IRHTP network was designed to provide up to a 1 Gb/s pathway to a 10 Gb/s network core. Currently most of the rural hospitals are using 30 mbps bandwidth. As configured each participating hospital has ample bandwidth to meet future needs.

We would be pleased to discuss our comments with you.

Respectfully submitted,



Arthur J. Spies
IRHTP Project Coordinator
Senior Vice President
Iowa Hospital Association
515-288-1955
spiesa@ihaonline.org