August 20, 2012

The Center for Telehealth and Cybermedicine Research at the University of New Mexico Health Sciences Center is the Project Coordinator for the FCC RHCPP Southwest Telehealth Access Grid. Herein are our comments in Bold Font in response to this notice, Comments are to reference WC Docket No. 02-60 and DA 12-1166, starting with the specific questions asked starting in Section 6, respectfully and thoughtfully submitted.

PUBLIC NOTICE
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DA 12-1166
Release Date: July 19, 2012
WIRELINE COMPETITION BUREAU SEEKS FURTHER COMMENT ON ISSUES IN THE
RURAL HEALTH CARE REFORM PROCEEDING
WC Docket No. 02-60
Comment Date: August 23, 2012
Reply Comment Date: September 7, 2012

1. In this Public Notice, the Wireline Competition Bureau seeks to develop a more robust record in the pending Rural Health Care reform rulemaking proceeding, particularly with regard to the proposed Broadband Services Program. The Commission's Rural Health Care Pilot Program has helped foster the creation and growth of numerous state and regional broadband networks of health care providers (HCPs) throughout the country. These Pilot project networks have enabled health care providers in rural areas to tap into the medical and technical expertise of other health care providers on their networks, using telemedicine and other telehealth applications to improve the quality and lower the cost of health care for their patients in rural areas.3 As the Commission moves forward with reform of the Rural Health Care (RHC) program, it can benefit greatly from the experience of the Pilot projects and the lessons learned in the Pilot Program. A more focused and comprehensive record will help the Commission craft an efficient permanent program that will help health care providers exploit the potential of broadband to make health care better, more widely available, and less expensive for patients in rural areas.

6. a. Consortium application process
We seek comment on specific procedures for the application process for consortia in the proposed Broadband Services Program and ask commenters to focus on how to streamline the application process while protecting against waste, fraud and abuse.

What specific information should the Commission require from the consortium leader regarding each consortium member on the application forms?

Comment: Require only a brief statement of their typical roles in representing the consortium that would then apply in the application.

Should letters of authorization (LOAs) from participating members of the consortium be required?

Comment: No, if the consortium is representative of the participating members an LOA from the consortium leader should suffice. Requiring an LOA from each participating member is cumbersome and unnecessarily delays the process and adds to the administrative burden,

If so, should LOAs be submitted at the request-for-funding commitment stage (with the filing of the Form 466-A), rather than at the request-for services stage (with the filing of the Form 465), as is now the case under the Pilot Program?

Comment: If so, then require at the 466-A stage. Submitting the LOAs later in the process, with the Form 466-A, would appear to be more administratively efficient for the consortium, because the consortium could wait until it had completed competitive bidding and knew the pricing before soliciting the LOAs. Before they know the pricing, health care providers are likely to be less certain about whether they will want to participate and not sign an LOA earlier in the process. This approach also would be administratively simpler for USAC, as USAC would only have to confirm eligibility for that smaller group of HCPs that already know the pricing and are therefore surer that they want to participate. Another option is to only require an LOA from the representative of the consortium as a whole that may also typically be involved in group purchasing that often provides an economy of scale. This issue comes up with a Primary Care Association (PCA) that typically represents the rural FQHCs in making purchasing decisions.

We also seek comment on the alternative of requiring HCP LOAs to be submitted at the earlier (Form 465) stage, as in the Pilot Program.

Should the Commission require consortium applicants to provide details in the consortium's request for services (the Form 465) regarding the services to be purchased, such as the desired bandwidth, sites to be served, and general type of service, as is currently required in the Pilot Program?

Comment: Yes but should be flexible, since the needs within the consortium may be variable.

Should the Commission require the lead entity and selected vendor to certify that the support provided will be used only for eligible purposes, as it does in the Pilot Program in connection with Form 466-A?

Comment: Yes, unless the non-eligible entity is paying its fair share but is still a key component of the network. Other critical components of the network such as data centers and administrative hubs should be eligible even if they don't see patients at that facility!

Should the Commission require applicants to submit a "declaration of assistance," as is required with the Form 465 in the Pilot Program?

Comment: Yes if cash match require and should allow a consortium leader to submit that statement.

We encourage commenters to draw on their experience with the Pilot and Primary programs in supporting any recommendations for streamlined application procedures.

Comment: Covering administrative project management costs should be allowed for project leader organizations and amounts allotted scaled based on the complexity and size of the project application. Although previously not allowed the financial burden on many of the selected participants was significant. The use of "Coaches" seemed to add little value to expediting the process.

Although sustainability planning can be important it is difficult to predict out beyond 5 years what the healthcare systems and network connectivity will be in place in this period of healthcare reform and emerging new connectivity technologies. A better approach may be to ask the applicants for sustainability options that might be put in place that may lead to a return on investment (ROI).

6 b. Post-award reporting requirements

What is the least burdensome way to collect information necessary to evaluate compliance with the statute and other relevant regulations, and to monitor how funding is being used?

Comment: Focus on the actual project activities after the FCLs are received that document appropriate use of the funds, design, build-out and operations, any unexpected challenges or changes in the project, and any specific benefits gained in improving access to healthcare services and demonstrated impact.

Should the Commission require consortium applicants to submit Quarterly Reports, as in the Pilot Program?

Comment: Don't require quarterly progress reports until after funding commitment letters (FCLs) have been received since prior to that time the focus is on completing the pre-FCL paper work and procedures

Would the same information that is required for single HCP applicants be required for each HCP in a consortium application, or should the Commission permit consortium applicants to submit a reduced amount of information for each HCP, as it did in the Pilot Program?

Comment: Yes, reduced amount of information is better and could be summarized by the HCP lead organization

We encourage commenters to draw on their experience with the Pilot and Primary Program in supporting any recommendations for streamlined reporting procedures**.**

Comment: Most of the current information is redundant to the 465, 466-A forms already filed and need not be repeated as is much of the preliminary information and only updated if changed.

6 c. Site and service substitution

Should the Commission adopt a similar policy for consortia that participate in the Broadband Services Program, if adopted?

Comment: Yes and kept reasonably simple

Would any modifications to that policy be warranted for the Broadband Services Program?

Comment: Yes, as noted in the prior sections

II. INCLUSION OF URBAN SITES IN CONSORTIA

a. Proportion of urban or rural sites in consortia.

If the Commission were to provide support for broadband services to urban HCPs that are members of consortia that serve rural areas, should it adopt specific rules to ensure that the major benefit of the program flows to rural HCPs and/or to rural patients?

Comment: No, since urban healthcare broadband needs can be as great as in rural areas.

For example, should the Commission require that more than a *de minimis* number of rural HCPs be included in such consortia, as in the Pilot program, and if so, what specific metrics should be used to determine whether a sufficient number of rural HCPs are participating in the consortia?

Comment: No should be flexible and based upon defined needs not by rural or urban location.

For instance, should the Commission specify a maximum percentage of urban sites within a consortium?

Comment: No percentage should be required

Should the Commission adopt this or a different percentage as an upper limit on the proportion of urban HCP sites within the rural health care program overall or within a consortium?

Comment: No

II b. Limiting percentage of funding available to urban sites

In the alternative, should the Commission specify a maximum amount of funding that can be provided to urban sites within a consortium?

Comment: No

Given that the Commission has sought comment on how to transition Pilot Program participants into a reformed program, would adopting a requirement that urban sites receive no greater than 35 percent of total funds per funding year be a workable and appropriate restriction?

Comment: No

How would the existence of such limits on urban site funding or inclusion of urban sites affect the consortium planning process and the development and growth of consortia over time?

Comment: No limits should be implemented. In NM, connection access to urban HCPs is critical for rural sites so limiting funding for urban sites would have negative impact on rural sites access to specialty care.

II c. Impact on Fund

We welcome detailed analysis on the impact on the Fund of any limits (or lack thereof) on urban HCP participation that the Commission may adopt or that parties may propose.

Comment: The majority of rural sites depend upon affordable connectivity to urban sites and the associated specialty centers. Limiting connectivity to and within urban sites creates a barrier to access to those services, not only for telehealth related services, but also health information exchange in state or regional networks.

II d. Impact on network design

What impact would including (or excluding) urban sites from funding under the Broadband Services Program have on network design and efficiency, from both a cost perspective and a technological perspective?

Comment: Restrictions to network design would have negative impact on access and limit growth and expansion of network of networks that should include urban sites.

Would it be possible to limit funding for urban sites to recurring and non-recurring charges associated with equipment necessary to create hubs at urban HCP sites?

Comment: No, that would unnecessarily limit the design and construction when it may be a critical component of the healthcare network.

Would such a limitation unnecessarily restrict participation by urban HCPs or otherwise limit the effectiveness of the program?

Comment: Not necessarily, but limiting charges to those components that enhance connectivity to rural sites could create a barrier to expanding access from urban centers.

Network design should allow the design and modeling of creating a true network of networks, including potential entities that are not currently participating in the FCC rural health care programs, as well as ineligible participants who may prove critical participates in the final network of networks. Some othe eligible components of the network design could include public health sites, IHS or tribal sites, VA and DoD sites, even if they won't be necessarily requesting connectivity funds from the FCC.

Lastly, a truly sustainable broadband networks should incorporate other non health related applications, such as education, government and business to achieve a true economy of scale within the network design and an ROI.

II e. Role of urban health care providers if not funded

If the Commission were to exclude urban sites that are part of consortia serving rural communities from receiving funding under the Broadband Services Program, would there be administrative benefits to allowing such urban providers still to serve as project leaders even though they do not receive any support?

Comment: Yes since they re usually key providers of specialty services not available at urban sites but they should be allowed to receive support. Not doing so could preclude their willingness to participate.

What incentives would urban providers have to participate as a **project leader** if they are unable to receive any support?

Comment: None in the short term, but a project leader would need administrative and potential network operating center (NOC) support. Otherwise they are doing it because it seems like the right thing to do or they believe it may increase their market or improve efficiencies in providing care to rural communities That would be a real challenge without FCC financial incentives.

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

If the Commission chooses not to provide funding to urban sites under the Broadband Services Program, or sets limits on such funding as discussed in paragraph (b) above, should the Commission nevertheless provide funding to urban sites that have received funding under existing Pilot projects?

Comment: Yes, the needs will not have changed.

Should the Commission limit the funding to existing Pilot project urban sites only for so long as the urban site is a member of a consortium with rural HCPs?

Comment: No, not if the urban site is providing is providing services to a new consortium.

III. ELIGIBLE SERVICES AND EQUIPMENT

In light of the Pilot Program experience and the comments in the record, we seek more focused comment on questions related to this proposal.

III a. Point-to-point connectivity

Should the definition of services to be funded under the Broadband Services Program omit the phrase "point-to-point"?

Comment: Yes, multipoint often makes sense for certain healthcare applications; e.g. ECHO, Interpreter services, or other simultaneous multi-specialty services, or health and public health information exchange. Furthermore more and more services will be provided via a "cloud" architecture, as opposed to "point-to-point."

We seek comment on whether the rules for the Broadband Services Program should enumerate a wide range of connectivity solutions such as those listed above, or should be more general, in recognition of the likely change and evolution of services utilized by health care providers that will occur over time.

Should there be any distinction in the types of services that would be funded if the applicant is part of a consortium, as opposed to individual applicants?

Comment: Be more general and flexible as networks mature and there are new emerging options for healthcare, such as health information exchange.

III b. Eligible non-recurring costs (NRCs)

The American Telemedicine Association has recommended that the Commission, at a minimum, support the costs of routers and bridges associated with the installation of broadband services to an eligible health care provider, USAC notes that the availability of funding for certain types of equipment in the Pilot Program ("servers, routers, firewalls, and switches") facilitates the ability of health care providers to upgrade circuits or create private networks.

We seek more focused comment on whether the NRCs eligible to receive support under the Broadband Services Program should include equipment to enable the formation of networks among consortium members, similar to the Pilot Program.

Comment: Yes, this type of equipment is critical to network and network of networks connectivity functionality to support both telehealth and health information exchange that is often multi-point and requires technology to support these approaches and also provide appropriate security, FCC should allow support at 85% subsidy as otherwise provided in the Pilot program.

III c. Limited Funding for Construction of Facilities in Broadband Services Program

We seek to further develop the record on whether it would be appropriate under the proposed Broadband Services Program, if adopted, to provide funding to recipients to construct and own network facilities under limited circumstances.
Would it be appropriate, for instance, in a situation where the applicant could demonstrate that self-provisioning the last mile facility to connect to an existing health care network is more cost-effective than procuring that last mile connectivity from a commercial service provider?
Comment: Yes

What requirements would need to be in place to ensure that construction and ownership is the most cost-effective option?
Comment: Demonstration of benefit – financial, technical, and operationally.

How would a health care provider or consortium make such a showing?
Comment: Cost-comparison in the situation described above (self-provisioning the last mile being more cost-effective then procuring last mile connectivity from a commercial provider) or a clear explanation of the tech benefit (e.g., self-provisioning more sustainable in terms of upgrades, flexibility, robustness and sustainability.

Would it be necessary to wait until after the competitive bidding process is completed in order for an applicant to be able to make that showing?
Comment: No, a HCP or consortium could provide documentation, even from cost comparisons from commercial service providers similar to what is allowed, in order to demonstrate the benefits, perhaps making the competitive bidding process unnecessary in the event self-provisioning was the desired goal and more cost effective.

Are there other more preliminary milestones during the competitive bidding process after which an applicant could make a showing?
Comment: Applicant could make a showing concurrent with the evaluation and (no)bid selection to demonstrate that self-provisioning is the best option.

If the Commission were to make this option available, should there be specific caps on funding available to construct HCP-owned facilities?
Comment: No, if the network design/equipment/non-recurring services including installation are within order/statute guidelines.

III d. Ineligible sites and treatment of shared services/costs.
We seek comment on whether there is a need to adopt specific rules in the Broadband Services Program (if adopted), regarding the participation of ineligible HCP sites (*e.g*., for-profit rural health clinics or, if not included in the Broadband Services Program, urban HCPs) in consortia that receive funding for broadband services provided to eligible members.

Even if not funded, there may be other health care and financial reasons why providers that are not funded through the program may wish to enter into cooperative arrangements with other providers that are funded, in order to create local and regional health care networks. By acting together, providers are more likely to receive lower pricing and a wider array of services to meet their health care needs.

Should the Broadband Services Program have a “fair share” requirement comparable to the Pilot Program?

Comment: Yes, with potential benefits as noted above. Also many rural hospitals are turning their administrative management over to regional or national for-profit companies, but those communities would still benefit from affordable enhanced broadband connectivity.

In particular, should the Commission adopt a specific approach to shared services and costs for consortium applicants, or should the Commission just require that the allocation of the costs of shared services and equipment among consortia members be reasonable?

Comment: Adopting a specific approach may have unintended consequences and inhibit development/growth for consortia that include ineligible HCPs. Continued requirement for a standard of reasonableness for “fair share” may limit any unintended negative consequences.

We welcome further comment on whether the procedures utilized by USAC to implement the fair share requirement in the Pilot Program are workable or burdensome, and what measures would best address potential waste, fraud and abuse in a reformed program.

Comment: Don’t make the process too complicated and cumbersome. Provide reasonable options for cost allocation formulas.

IV. COMPETITIVE BIDDING PROCESS AND RELATED MATTERS

We now seek more focused comment on issues relating to the competitive bidding process.

IV a. Competitive bidding process

Building on the experience gained from the Pilot Program, what specific requirements should be in place for competitive bidding in the Broadband Services Program, if adopted?

Comment: The stakeholders and administrative parties should simply be allowed to follow/adhere the procurement policy, procedures, rules and regulations they already have in place. If USAC is looking for a uniform set of procurement rules and regulations, I'd suggest that they adopt the latest version of the American Bar Association "Model Procurement Code"

http://openlibrary.org/books/OL22109579M/The_model_procurement_code_for_state_and_local_governments

Most States and government entities procurement laws, rules and regulations are based upon this document (NM falls if fairly closely).The system USAC

had in place, simply did not lend itself to standard procurement practices and was very difficult to interpret and implement.

Should the Commission require consortium applicants in the Broadband Services Program to prepare a Request for Proposal (RFP), as applicants in the Pilot Program were required to do?
Comment: Yes

Should the Commission exempt consortia from the RFP requirement if they are applying for less than a specified amount of support (for example, if they are applying for less than $100,000 in support)?
Comment: It seems difficult to create a lower level threshold with the exception of self-provisioning.

Are there other elements of the competitive bidding process utilized in the Pilot Program that should be applied to the Broadband Services Program, either as is or with changes that the parties suggest to improve the process?
Comment: There appears to be excessive cross checking by USAC that slows the process, could be eliminated, and thus expedite the process.

Are there any competitive bidding requirements used in the Schools and Libraries Universal Service Support Mechanism that the Commission should apply to the Broadband Services Program, if adopted?
Comment: We are unfamiliar with the Schools and Libraries Support Mechanism but if there are processes within that program that could decrease the cumbersome nature of the healthcare programs and expedite the process, they should be considered.

IV b. Requirement to obtain competitive bids.

In response to the *NPRM*, VTN recommends that the Commission consider a streamlined service provider selection process for HCPs that do not have multiple broadband service options, such as simply requiring an HCP to submit a simple certification of its efforts to identify all broadband providers and a description of the broadband service option selected.

In the Broadband Services Program, should competitive bidding only be required for consortium applicants, given the experience to date with the current competitive bidding requirement for individual HCPs in the Primary Program?
Comment: In some cases it may be clear that there may be only one potential bidder for that service provider can predictably offer the best service at the lowest price and the competitive bidding process may be unnecessary. This is similar to providing documentation for sole-sourcing .

We particularly seek comment on this question from HCPs who have experience with competitive bidding as individual HCPs in the Primary Program.
Should the Commission consider not applying a competitive bidding requirement to individual applicants who request only a limited amount of funding?

Comment: That would be difficult to determine without some guidelines and rationale

Are there any other applicants that the Commission should exempt from competitive bidding requirements under a Broadband Services Program, if adopted?

Comment: Only with the exceptions as noted previously

IV c. Multi-year contracts.

The Nebraska Statewide Telehealth Network (NSTN) recommends that a "true" evergreen provision be applied to HCPs with multi-year contracts, which would allow for HCPs with multi-year contracts to apply only once for multiple years of funding.

Would permitting evergreen contracts (as they are implemented today, with the annual filing requirement) be sufficient to allow consortia in the Broadband Services Program to reap the potential benefits of multi-year contracts, while minimizing administrative burdens?

Comment: Possibly, as long as consortia with multiple participants would not still be burdened with extensive administration and paperwork if otherwise they had been required to re-file annually.

Or, would evergreen status need to be coupled with a multi-year award, and if so, would three years be sufficient for the term of the award, or would some other period be more appropriate?

Comment: Three years seems to be a reasonable term for the award as it would allow for changes to maintenance agreements/equipment upgrades if necessary. Some flexibility in the evergreen status would seem prudent if there are no significant changes predicted in the contracts.

We note that long-term prepaid leases and IRUs generally involve a large, upfront payment. For example, the full cost for a dark fiber IRU is typically paid for in advance.
If the Commission permitted long-term prepaid leases and/or IRUs in the Broadband Services Program, how should it deal with upfront payments?

Comment: There would need to be documentation provided that the upfront higher payments would result in longer term subsequent lower costs and this a net overall savings or reduced costs.

How would funding multi-year contracts impact the calculation and forecasting of demand for RHC support?

Comment: Not necessarily if clearly outlined in the application.

What protections should be put in place to protect against waste, fraud and abuse?

Comment: Currently, there appears to be administrative waste within the current USAC programs. The uses of engaging another company to provide "coaches" did not appear to add significant value. Prospective, ongoing evaluation of the benefits of the FCC programs would also allow appropriate monitoring and demonstration of true benefits.

No system is perfect in protecting against potential fraud and abuse. Reasonable approaches to reporting and accountability for use of the funds seems to be the minimum requirement with possible periodic random audits similar to other programs or perhaps the IRS.

For instance, would the measures used in the Pilot Program for such arrangements be useful in the Broadband Services Program (such as sustainability plans, minimum contract length, and repayment requirements)?

Comment: Periodic reporting to evaluate the effectiveness of the programs and demonstrate value and benefits gained and allow continued quality improvements, lessons learned, and testing of the ROI and sustainability plans.

If so, should those same measures be used, or should they be modified in any respect?

Comment: Requiring that programs address sustainability in their proposals is an important step for program development, but should not be a formal requirement for award. Both advances in network technology and equipment, as well as changes in health care delivery and systems will affect a program's sustainability goals, and their participation in the Broadband Services Program should not limit the flexibility of their goals. Furthermore, there should be some method of testing the hypotheses incorporated in the sustainability plans, i.e. did they work and give a reasonable ROI?

IV d. Existing Master Services Agreements (MSAs).

Should the Commission permit applicants for the Broadband Services Program to take services from an MSA, so long as the original master contract was awarded through a competitive process?

Comment: Yes

What specific rules should be in place (*e.g.*, an exception to the competitive bidding requirement) in order for HCPs to take advantage of MSAs?

Comment: Applicants should provide some reasonable documentation that an MSA the most cost effective approach. Most MSA are developed on that premise.

Should Pilot program participants that have exhausted Pilot program funding be able to obtain support from the Broadband Services program for services pursuant to MSAs that were negotiated by the Pilot projects?

Comment: Yes

IV e. Eligible service providers

We seek more focused comment on the specific definition that should be adopted in our rules for eligible providers under the Broadband Services Program, if adopted.

Comment: We agree that the definition of broadband access service provider should be expanded to include and encourage the widest range of service providers, as well as having a mechanism by which HCPs can justify selection of a service provider that may fall outside whatever specific definition is adopted. The emerging new wireless and cellular networks may offer more cost effective methods of providing ubiquitous broadband that can support telehealth and HIE.

V. BROADBAND NEEDS OF RURAL HEALTH CARE PROVIDERS

In light of developments since the issuance of the *NPRM*, we seek to refresh the record on various questions relating to the broadband needs of rural HCPs, with particular attention to how the answers may vary based on the size and type of HCP, and how the broadband needs may change over time

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V a. Telemedicine

What bandwidth is needed for various types of telemedicine applications?

Comment: This is dynamically changing with new technologies and expanding applications. High definition video, large image files, genomic data, and multi-point connectivity will like require increased bandwidth. Connections of over 100 megabits or even Gigabit connections are feasible bandwidth needs in the not too distant future.

In particular, how widespread is the use of teleradiology, and what bandwidth is required?

Comment: Teleradiology is becoming extremely widespread and a standard of care for providing radiology services 24/7, particularly in rural or smaller facilities, hospitals and clinics, As image files can be large and will likely be incorporated into HIEs as well, bandwidth demand will likely increase as noted above. Incorporation of hig speed backbones; commodity networks, Internet2 and National Lamda Rail will also likely be incorporated to handle to the increasing traffic and lager data sets.

How widespread is the use of videoconferencing in providing telemedicine, and what bandwidth is required?

Comment: Videoconferencing is one of the standard components incorporated into telemedicine for providing real-time interaction being providers and between provider and patients similar to in-person face to face encounters. Higher resolution video improves the quality of the interaction and ability to evaluate and develop a diagnosis for the patient at a distant site. Bandwidth requirement will increase as these applications increase and provision of telemedicine services becomes more and more a standard of care.

Will broadband needs associated with telemedicine likely change over time?

Comment: The broadband needs will increase as access to telemedicine services becomes an expected standard of care regardless of location, improving health outcomes, avoiding unnecessary variations in care, better continuity of comprehensive care providing "second opinions" and expert guidance, tele-monitoring, better triage, avoiding complications and need for transport.

What factors will cause the needs to grow?

Comment: Health care provider organizations will incorporate in these systems of care, such as accountable care organizations and creation of patient-centered medical homes. Consumers of healthcare and patients will increase this demand as they see the added value, particularly among the younger generation that is extremely technology savvy.

How important are connections between rural HCPs and urban HCPs?

Comment: Broadband networks of the future will face potential challenges heretofore unknown. Interoperability and flexibility will be important considerations for developing effective networks. Determining the present needs of various applications may not correctly predict the needs of future applications. The Broadband Services Program should use the most advanced broadband parameters of today as a baseline for support for future use. We believe broadband needs will inevitably increase over time as systems develop more sophisticated electronic communication techniques for all telemedicine applications.

V b. Electronic health records

How will the current trend toward adoption and exchange of electronic health records affect bandwidth needs?

Comment: It will likely increase the need, particularly as they link to HIE networks and incorporate images.

What is the impact of “meaningful use” incentive payments and requirements on likely demand for broadband connectivity for rural HCPs?

Comment: In order to take advantage of the meaningful use incentives and achieve the requirements, and see the advantages, providers will need more bandwidth and be part of an HIE.

What is the likely impact of participation by rural HCPs in Health Information Exchanges?

Comment: More effective and efficient sharing of health information that will enhance their ability to manage their patients locally, leading to better outcomes.

V c. Other telehealth applications

What are the likely broadband needs for other telehealth applications (*e.g.*, training and technical support for health care purposes and health IT applications)?

Comment: These needs should increase as demand and need for services over distance increase. There is a mounting need to attract local rural students into healthcare professions and IT support that can be facilitated and supported through adequate bandwidth into the rural communities, creating the “pipeline” for increase the workforce in these areas. Furthermore access to ongoing training, education, and new knowledge through these connections should increase recruitment and retention of future professional into those communities.

V d. Service quality requirements

We also seek comment on the needs of rural HCPs for such service quality features as dedicated connections, redundancy, low latency, and lack of jitter.

How much will these added levels of quality add to the cost of broadband services for HCPs?

Comment: This may initially increase costs but actually could increase demand and use through demonstrated value, thus eventually lowering cost though improved quality of the encounters, higher volume and expanding applications to achieve an economy of scale and investment by a broader spectrum of service providers.

Will privacy and security requirements applicable to health care data exchange affect HCP broadband service quality needs?

Comment: In order to maximize the benefit of rural broadband and its importance to telemedicine, considering service/signal quality is paramount. Telehealth applications depend on consistent performance in order to be effective for both providers and for patients. As indicated, the most advanced broadband parameters of today, including quality standards, should be

considered a baseline from which to improve, when estimating costs. Adherence to security standards, HIPAA, and protection of patient privacy will be a standard requirement of networks using HIE and telemedicine. As part of these efforts external third party network IT security audits may become a standard requirement.

V e. Cost savings from broadband connectivity

We solicit specific information regarding the nature and magnitude of cost savings that HCPs have been able to achieve through use of broadband, as well as information and data regarding potential for cost savings through telemedicine and other telehealth applications. We solicit the submission of specific information on all these possible sources of cost savings, including cost data and any studies documenting cost savings.

Comment: There is mounting evidence and data in the literature demonstrating the value of telemedicine and HIE in improving health outcomes and reducing costs through improved access to care, sharing knowledge, and health information exchange that enhances continuity of comprehensive quality care independent of location, that is , the right care, at right time , at the right place. We are also demonstrating and publishing that information. We also refer you to the wealth of information being published in the Journal of Telemedicine and eHealth, and several other Journals. In addition the American Telemedicine Association (ATA) can provide further access to information regarding the value being provided through Telemedicine to improve health outcomes and reduce costs. All of these applications require adequate broadband to achieve and expand these valuable outcomes across the United States. Adequate affordable broadband is part of the solution in achieving a truly reformed healthcare system as many of the telehealth applications were already in place before the FCC programs and pilot initiative. A recent Institute of Medicine (IOM) workshop symposium held in August 2012 further reiterated that value and we refer the FCC to that report that is forthcoming. The FCC, in turn, needs to objectively evaluate demonstrate the value they have added in this process with data directly related to these efforts and that monies have been used judiciously and effectively. We need to work collaboratively with FCC and across other federal agencies, health care provider organizations, service providers and industry to achieve these goals

The Process that has been using USAC to manage the FCC programs needs a major overhaul to expedite, and not complicate access to FCC support.

There need to be programs that support ubiquitous broadband, not with just an emphasis on rural, but urban as well.

There has not been adequate coordination with other federal initiatives; e.g, BTOP, BIP, GIG.U, US Ignite etc. and more effective use of the funds and avoiding duplication of effort and there does not appear to be adequate communication with organizations that represent the end users such as ATA. There is an apparent need to develop some form of advisory council to improve upon coordination and implementation of these efforts that includes the representative stakeholders.

We anxiously await the final order from FCC over two years since the original NPRM. Thank you for this opportunity to respond,

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VI. PROCEDURAL MATTERS

Comments are to reference **WC Docket No. 02-60 and DA 12-1166** and may be filed using the Commission's Electronic Comment Filing System (ECFS). *See Electronic Filing of Documents in Rulemaking Proceedings*, 63 FR 24121 (1998).

Electronic Filers: Comments may be filed electronically using the Internet by accessing the ECFS: http://fjallfoss.fcc.gov/ecfs2/.