

**Before the
Federal Communications Commission
Washington, D.C. 20554**

In the Matter of)	
)	
Rural Health Care Support Mechanism)	WC Docket No. 02-60
)	
Wireline Competition Bureau Seeks Further)	
Comment on Issues in the Rural Health Care)	DA 12-1166
Reform Proceeding)	

**COMMENTS OF COLORADO HEALTH CARE CONNECTIONS
AND ROCKY MOUNTAIN HEALTHNET**

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INTRODUCTION

Colorado Health Care Connections (CHCC) and Rocky Mountain HealthNet (RMHN) submit these comments as participants in the Rural Health Care Pilot Program (RHCPP). CHCC and RMHN have jointly implemented their Pilot Projects as the Colorado Telehealth Network (CTN).

We welcome this opportunity to help develop a more robust record in the pending Rural Health Care reform rulemaking proceeding. We congratulate the Commission for moving forward with this proceeding and committing to issuing a final rulemaking by the end of calendar year 2012 as stated in the FCC 12-74, the "Bridge Funding" order.

Our comments below are labeled in accordance with the numbering in DA 12-1166 (the Notice). We have focused on those questions in the Notice for which our experience best contributes to the rulemaking record.

I. CONSORTIA

- a. Consortium application process. We agree with the suggestion in the Notice that submitting the LOAs later in the process, with the Form 466-A, would appear to be more administratively efficient for consortia. It was in fact our experience that many of the HCPs submitting LOAs during the Form 465 process later withdrew because of eligibility and pricing issues that developed later in the process.
- b. Post-award reporting requirements. We support continuing to use Quarterly Reports (with reduced amount of information for each HCP, as in the Pilot Program) as the basis for collecting necessary information about project performance.
- c. Site and service substitution. We support adopting a policy similar to that of the Pilot Program, including the four criteria listed in the Notice.

II. INCLUSION OF URBAN SITES IN CONSORTIA

- a. Proportion of urban or rural sites in consortia. As the Notice observes, the general consensus is that urban sites must be included in consortia as they are essential to the delivery of adequate health care in rural areas. We argue for flexibility in determining the proportion of urban or rural sites in consortia. Therefore, we see no need to quantify or bound beyond the *de minimus* participation of rural sites restriction in the Pilot Program establishment order (FCC 06-144). As the Notice observes, that language resulted in a set of workable rural/urban allocations, with approximately 65% rural representation, whether counted by site or by support dollar.
- b. Limiting percentage of funding available to urban sites. The option of counting funding vs. counting sites is offered in this section. We do not support this option, simply because it is easier and more meaningful to count sites. Moreover, as per the Notice, the average for the Pilot Program was 35% whether counted by site or by dollar awarded.
- c. Impact on fund. A conceptual framework is needed to answer the question of the impact on the RHC funding mechanism by including urban sites in consortia funded under the proposed Broadband Services Program (BSP). Some salient points in that framework would include:
 1. The Pilot Program award order (FCC 07-198) awarded approximately \$140 million per year to the pilot programs. Combining this with the average Primary Program funding of approximately \$75 million per year (USAC Data and Observations Letter of August 2,

2012, Appendix C), yields a total conceptual RHC commitment in the neighborhood of \$215 million, or roughly half of the current RHC cap of \$400 million per year.

2. According to the Pilot Program establishment order, only about 10% of the available RHC funding was being utilized, this being a primary reason for establishing the Pilot Program. Part of the success of the Pilot Program was due to the inclusion of urban sites (see March 14, 2012 USAC Observations letter, pp. 4-5). The impact of some inclusion of urban sites, through consortia, has been to increase RHC utilization closer to 50% as noted above. It is unclear whether a new program without urban funding would be as successful in stimulating utilization.
3. At its funding cap of \$500 million, RHC funding would represent approximately 6% of USF payments (taking 2010 disbursements as a baseline, see 2011 Universal Service Fund Monitoring Report). The Schools & Libraries program comprised approximately 30% of 2010 disbursements. There would appear to be some room to raise the cap on RHC funding to accommodate growth in the BSP if needed.
4. Growth in the BSP would likely capture some of the sites funded under the Primary Program, so that total funding of the Primary Program may go down somewhat as the BSP grows.
5. The BSP, including its allocation of about 35% of funds to urban sites, could more than double in size without impacting the RHC cap. This is based on assuming the Primary Program remaining steady at about \$75 million per year and the BSP growing to \$325 million per year).

d. Impact on network design. The reasoning for including urban sites — and funding for urban sites — was covered in item a) above. Further, their frequent role as hubs in hub-and-spoke designs is also reason for their inclusion. Excluding urban hubs would have direct negative impacts on network design.

e. Role of urban health care providers if not funded. We disagree with the premise of this section: urban sites are an integral part of the rural health care system.

f. Grandfathering of urban sites already participating in Pilot projects. Again, we disagree with the premise of this section. Urban sites belong in rural consortia, as eligible and funded participants, whether they were participants in the Pilot projects or not.

III. ELIGIBLE SERVICES AND EQUIPMENT

a. Point-to-point connectivity. Connectivity should be defined broadly and flexibly. Just as services have evolved since the last major RHC reform, they will continue to evolve. An enumeration of solutions is therefore inappropriate. We suggest the following functional definition:

"any advanced telecommunications and information service that provides for the exchange of health care information, including voice, data, image and video, among health care providers."

We do not believe the words from NPRM Paragraph 93 — "point-to-point", "broadband", or "Dedicated Internet Access" — need be included, as these are subsumed by this definition. However, we do believe the addition of the clause — "voice, data, image and video" — is necessary, to make it explicitly clear that modern telecommunications is multi-media and all necessary equipment and services to support multi-media exchange of health care information are eligible. Finally, we believe minimum bandwidth standards are not required, as the health care provider market will set these de facto as services and needs continue to evolve.

- b. Eligible non-recurring costs (NRCs). Clearly, a network is not a network without core and edge services and equipment. A network is not a collection of point-to-point circuits. As the purpose of the Broadband Services Program is to support regional and statewide health care networks, it follows that the NRCs — and MRCs — associated with network equipment and services should be eligible. It is clear from the record in the docket that the majority of Pilot Programs used leased services and did not own the equipment necessary to form networks. Thus, appropriate and customary NRCs for managed networks as a service should be supported, including servers, routers, firewalls and switches, as noted in the Notice, but also including video bridges and associated edge-site network equipment. The transmission and routing of video is a proper element of telecommunications service (please see proposed definition of connectivity above, section III.a). Regarding this addition of video network equipment as eligible, we should make it clear that end-user equipment such as CODECS would not be eligible as these devices are not network transmission devices.
- c. Limited Funding for Construction of Facilities in Broadband Services Program. We agree with the Notice that in some cases, limited construction of facilities will be needed to add new HCPs to a network. For example, we expended funds in our Pilot Projects to provision "last inch" facilities from the service provider demarcation to the HCP equipment room.
- d. Ineligible sites and treatment of shared services/costs. We strongly support the "fair share" doctrine used to govern the participation of ineligible sites in Pilot Program projects. However, the definition of "fair share" should be incorporated and made explicit in the final rulemaking. The only guidance we were able to find on this issue was in a letter to USAC from the WCB dated October 24, 2008.

IV. COMPETITIVE BIDDING PROCESS AND RELATED MATTERS

- a. Competitive bidding process. We support a requirement that applicants prepare and obtain prior approval from USAC for RFPs to be used in the competitive bidding process. Since federal funding commitments are based on the results of the competitive bidding on the RFP, federal oversight of the RFP is both constructive (e.g., helpful to the applicants) and conservative (e.g., defensive against fraud, waste and abuse). However, we support exempting consortia from competitive procurement for projects of less than \$100,000.
- b. Requirement to obtain competitive bids (only for consortia, not individual). We concur with the suggestion in the Notice that competitive bidding should be required of consortia, but not of individual applications. We note the record shows the great majority of individual applicants go forward after receiving no bids. So, it makes sense not to require bidding at all for smaller projects.
- c. Multi-year contracts. We support the practice, as in the Pilot Program, of allowing both multi-year awards and multi-year contracts. A consortium is like an aircraft carrier — it takes a long time to turn. Thus, it makes sense for consortia to issue multi-year RFPs and negotiate multi-year contracts based on multi-year awards. One-year funding simply does not leave consortia enough room to manage their affairs. Further, we disagree with the current stance of not recognizing contract extensions as Evergreen, even those written into the initial contract and not added by amendment. We encourage the FCC to consider contracts with extensions to have "Evergreen" status, thus not requiring the re-compete process, when the contract is renewed according to its terms.

- d. Existing Master Service Agreements (MSAs). We have no comment on this section.
- e. Eligible service providers. Eligible service providers should be defined broadly. The definition should include (not by enumeration, but in concept) regional fiber networks that have been constructed throughout our state and many states through the initiative of local, self-defined communities (e.g., the San Luis Valley of Colorado, or Southwestern Colorado, Southeastern Colorado, etc.). These regional networks were in most cases designed to serve all sectors of the community, including the health care sector.

V. BROADBAND NEEDS OF RURAL HEALTH CARE PROVIDERS

To date, CTN's focus has been on deploying our network to give our members a tool to use for telehealth and telemedicine. Our deployment was just recently completed. Going forward, our strategy will be to look to our HCPs as "laboratories of discovery" of innovative and effective ways to use broadband telecommunications to improve health care quality and reduce cost.

We see the need for broadband among our members is growing. We have already upgraded several of our service connections. Many of our members have reported a desire to move to greater speeds. Much of this growing demand is explained by the increasing deployment of telehealth applications, as described below.

- a. Telemedicine. We are investigating deploying statewide telepsychiatry using video conferencing technology. Urban consults to rural HCPs are currently occurring and we anticipate launching a pilot project by the end of this calendar year.
- b. Electronic health records. The two health information exchange organizations in Colorado rely on CTN as a principal transport for health information exchange. They are not building separate, parallel networks, nor are they relying entirely on the public Internet. As the requirements for "meaningful use" come online and intensify, the bandwidth requirement for HIE applications on CTN will only grow. For example, the requirement for EMRs will often be met through remotely hosted services, which require large bandwidth to provision.
- c. Other telehealth applications. We have begun to implement a centralized archive for medical images. This is expected to be the main method for both storage and exchange of medical images in Colorado. As this service grows, the bandwidth used for image transfer on CTN will grow exponentially.
- d. Service quality requirements. Service quality is essential to our members, both rural and urban. In response, we provide an enterprise-grade private network, with automatic encryption and Quality of Service routing. By operating a private network, we minimize latency and jitter and maximize privacy and security. Our network is monitored 7 by 24 by our service provider.
- e. Cost savings from broadband connectivity. We note two kinds of cost savings: savings in information technology (IT) infrastructure cost, and savings in health care delivery and outcomes. Regarding IT infrastructure, straightforward savings are captured when several single-purpose circuits are consolidated into one multi-purpose CTN circuit. For the HCPs, of course, the support of the Universal Service Fund provides substantial cost savings at the local facility level — so much so that in many cases broadband HIE would not otherwise be possible. Further IT cost savings stem from the purchasing power of our network — comprised of some 200 connections — in negotiating cost-effective terms with service providers. Finally, IT costs savings stem from shared value-added services, such as medical image storage, videoconferencing, and other advanced integrated communications services as they become adopted.

Cost savings in health care delivery — taken hand-in-hand with improvement in health care quality and outcomes — will take longer to develop and quantify. We have begun to collect and report anecdotal evidence of life-saving uses of our broadband network. We are designing a formal program to categorize, monitor, and track the health care impact of our broadband network consistent with the Data Gathering and Performance Measuring section of the NPRM. While we expect our HCPs to lead the way in how to use broadband effectively, we will also advocate for necessary regulatory and statutory changes in reimbursement and deploy shared resources that support emerging clinical telehealth applications.

Dated this 22nd day of August 2012.

Respectfully submitted,

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