

August 22, 2012

Ms. Marlene H. Dortch
Secretary
Federal Communications Commission
445 12th St. SW
Washington, DC 20544

Re: WC Docket 02-60 & DA 12-1166

Dear Ms. Dortch,

This letter represents MiCTA's response, based on its experience and expertise, to certain sections or sub-sections of the Commission's recent "Public Notice DA 12-1166" and is meant to support and encourage the Commission in its mission, as it has stated, "To craft a more efficient and permanent (RHC) Program."

Overview

MiCTA was originally formed as the Michigan Collegiate Telecommunications Association in 1982. By 1989, MiCTA had issued its first Request for Proposal (RFP) and successfully negotiated significant discounts for its members on valuable telecommunications services. In 1990/91 MiCTA, with the assistance of several telecommunications vendors developed the first Dial-Up Digitally Compressed Video Tele-Health and Tele-Education Network.

Some of the first users of the network were the State's Community Mental Health Department allowing its Psychiatrist's to conduct remote evaluations of the State's prison inmates, and Rural/Urban Health Care members who used the Network to collaborate on the exchange of information relative to the enhancement of Rural Health Care throughout the country.

Today MiCTA continues to support its growing national membership by providing competitively bid products and services, monitoring telecommunication and technology legislation that impacts its members, providing valuable and cost-effective professional development opportunities, supporting technology through grants, conducting research to benefit its members, and working with vendors to ensure its members technology needs are met. In addition to having gained a great deal of experience in working with telecommunications providers, MiCTA has established a record of working with USAC, including the submission of comments to E-Rate NPRMs. In 2011 MiCTA conducted an RFP for E-Rate Consultants that resulted in the certification of three of the nation's leading E-Rate consulting companies. MiCTA has also made numerous filings to the FCC relative to the RHC Program.

I. CONSORTIA

Section I. a. Consortium Application Process.

In the case of Consortia Applications, Letters of Authorization (LOAs) should be required at the filing of the Form 466-A request-for-funding-commitment stage. Knowing the available costs to consortia participants for services and/or equipment requested prior to the actual Form 466-A filing would be, as stated, “More likely to assure participation by interested Health Care Providers and more administratively efficient for the consortium.”

Typically, if they are members of a non-profit association that conducts RFPs on their behalf and are taking advantage of the association’s Master Service Agreements (MSAs), they have already given authorization for their participation in support of the activities of the association, such as the release of RFPs at the time they requested membership.

The Form 466-A should provide sub-sections for listing each participant’s request for services and/or equipment as part of the total consortia services/equipment request listed on the Form, and provide Certification by the lead entity and selected vendor verifying that the support provided is being used for eligible purposes.

Section 1.b. Post-award reporting requirements

The continuation of a condensed Quarterly Reporting for consortium applicants per the Pilot Program would seem appropriate with emphasis on the broader outcomes being reached by interaction of the collective group.

Section 1.c. Site and service substitution

The Commission should adopt a similar policy for consortia participating in the Broadband Services Program that is currently being administered under the “Pilot Program.” No changes to the policy would appear to be warranted.

II. INCLUSION OF URBAN SITES IN CONSORTIA

Section II.a. Proportion of urban or rural sites in consortia.

The Commission should continue to allow urban HCPs to receive support under the Broadband Services Program consistent with USAC’s current funding data for 2012, that being “35 percent of all HCP Pilot Program sites.” This percentage should be adopted as the proportion of urban HCP sites within a consortium.

Section II.c. Impact to fund.

Although sufficient public data doesn’t currently exist regarding the outcome the cited approach in Section II.a. would have overall on the RHC fund, it is believed that the continued inclusion of funding for urban HCPs participating in a consortium would increase overall participation of rural HCPs substantially and impact the level of health care to urban America. Given the current trending of either purchase of rural HCPs or increased collaboration with rural HCPs by urban HCPs, it would only make sense to include established urban HSPs in the RHC funding program.

Section II.d. Impact on network design

Whether consortiums establish network connectivity through a hub-and-spoke design or other configurations such as distributive processed network, any non-profit urban HCP that serves to establish a real-time day-to-day relationship with a consortium of rural HCPs providing administrative and other forms of support either within its state or across the country should have access to funding under the RHC Program.

Excluding funding for new or enhancements to existing network equipment to establish “administrative centers” at consortium participating urban sites would be detrimental to the growth of the HCP Program. Funding should be in concert with the percentage of urban sites allowed and a new flat-rate level of discount established by the Commission as suggested in the Commission’s 2010 NPRM.

Today’s technology has the capacity to stimulate the relationship between urban and rural HCPs, and afford critical health care diagnostics such as static and dynamic imagery and testing data to be exchanged between rural and urban health care providers by the touch of a finger.

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

Removal of funding to urban providers under the Broadband Services Program who act as a project leader providing administrative, diagnostic and informational support to rural HCPs as part of a consortium would negatively impact the growth of participation in the RHC Program.

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

Setting funding limits on eligible urban sites under the Broadband Services Program, who are participants in a consortium of rural HCPs, such as in the Pilot program mentioned previously, would seem prudent.

However, given the growing potential technology has and will play in health care in this country, the Commission should re-evaluate the level of funding for urban HCPs who desire to expand their relationships and “reach out” to rural HCPs across the country providing them with real-time diagnostic assistance.

III. ELIGIBLE SERVICES AND EQUIPMENT

Section III.a. Point-to-point connectivity

The rules of the Broadband Services Program regarding network connectivity should provide more open and general terms allowing for current and future forms of design with the understanding that the technology will continue to advance.

Section III.b. Eligible non-recurring costs (NRC’s)

MiCTA supports the ATA’s concept of allowing eligible rural as well as urban health care providers, who participate in the support of a RHC consortium, to purchase equipment and services from those national non-profit Group Purchasing Organizations (GPOs) who support eligible rural and urban HCPs that are members of their respective organizations.

Allowing these GPOs to bid as a “third party” for network services and equipment on behalf of their rural and urban HCP members under the RHC Form 465 process will have a major impact on expanding the funding potential of the available dollars for not only the Broadband Services Program in particular but also the RHC Program in general. This “third party” bidding concept is not new as it currently exists within the USF Schools and Libraries Program’s (SLP’s) Form 470 process. MiCTA participates in this process on behalf of its growing number of eligible school and library membership.

This process lowers costs for not only the Program but its participants by alleviating administrative time and costs, allowing participants to focus on filing for their respective services and equipment requests.

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

It is understood that currently certain areas of the country may have service providers who are reluctant to a) provide broadband services to certain participants currently within the Pilot Program or b) their respective bids for leased services have returned costs higher than the cost of construction. It would seem prudent that investigation of leased services and equipment costs available through one of the national non-profit GPOs previously mentioned would be allowed to participate as a third party provider in the RHC Form 465 process may result in an equitable solution.

If after investigation leased costs are still not competitive, it would only stand to reason that the Pilot participant, or a new participant, be allowed to pursue the construction of broadband facilities with the understanding that the HCPs would be required “to have an ownership interest in the network facilities funded.”

Section III.d. Ineligible sites and treatment of shared services/costs

It is understood that there can exist a close relationship between non-profit and for-profit HCPs in this country, particularly in rural America. It has been stated that the Commission, relative to the Pilot Program, has allowed eligible entities to share in the cost of excess network capacity with an ineligible entity given the fact that certain conditions have been met and USAC reviews and approves these types of submissions.

In the interest of enhancing the level of health care in this country, particularly as it relates to RHCPs while striving to stabilize or even reduce costs, it would seem logical to provide access to a for-profit HCP if the Commission and USAC have seen fit to allow and approve this action based on the fact that the ineligible entity pays its “fair share.” If this process is allowed to become part of the Program it would also seem equally just to allow urban HCPs, who are not funded through the program, to enter into a “cooperative arrangement” with other providers who have been funded.

IV. COMPETITIVE BIDDING PROCESS AND RELATED MATTERS

Section IV.a. Competitive Bidding Process

As touched on earlier, MiCTA believes that all interested national GPOs who support rural/urban HCP membership within their organizations, if allowed to file Form 465(s) on behalf of their members as is currently allowed in the Schools and Libraries Program, would provide an even larger impact to the reduction of services/equipment pricing and help to “drive” the deployment of broadband into rural America as has been MiCTA’s experience in many instances.

In the Schools and Libraries Universal Service Program all participants seeking funding are required to file a Form 470 or become a member of a consortium that has filed a Form 470 that covers all consortia

members, thereby allowing all members to equally take advantage of the impact on costs this single RFP provides all members, no matter how large or small they may be.

Section IV.b. Requirement to obtain competitive bids

Given the fact that there are several nationwide consortiums that hold single or multiple Master Service Agreements (MSAs), it would be advantageous for an individual HCP to investigate the potential for cost savings this type of relationship can provide.

Section IV.c. Multi-year contracts

It has been MiCTA's experience that Multi-Year MSAs provide extremely aggressive services and/or equipment pricing over the term of the contract and have developed a "living documents" (MSA) structure that allows MiCTA to amend any contract to lower costs and add new technology for its members over the term of the contract. Basically, a potential five (5) year award to a vendor who meets or exceeds the requirements of the RFP has been the rule of thumb based on two of those years as voluntary extensions.

MiCTA membership includes governmental and non-profit entities and it conducts the Schools and Libraries Form 470 filing (bid) in concert with its internal RFP program, ensuring that all members receive aggressive pricing while maintaining a high quality of services and products. USAC's SLD requires that participants who use multi-year contracts must still file a Form 471 "Request for Services" annually. This process provides the applicant the opportunity to make changes to their funding request from year to year if they so choose either up, down or status quo, and provides the SLD with the opportunity to project future potential funding demand.

Section III.d. Existing Master Services Agreements

The Commission should allow applicants for the Broadband Services Program or the RHC Primary Program (eligible HCPs) to use existing MSAs, including those negotiated by national consortiums that have gone through a federally conducted competitive bid process such as the USF Schools and Libraries, RHC or RHC Pilot Programs.

Section IV.e. Eligible service providers

We suggest that the FCC adopt the Service Provider Form 498 that already exists within the Schools and Libraries Program and allow USAC to oversee the service provider information gathering process as it already does for the SLD Program.

V. BROADBAND NEEDS OF RURAL HEALTH CARE PROVIDERS

Section V.a. Telemedicine

MiCTA believes that in the area of Telemedicine, driven by the acceleration of technology, there are 2 areas of capability, and therefore funding, which need to be addressed immediately as their impact to the heightened quality and cost reduction of medical treatment for not only rural but urban HCPs can be realized.

There is a third area, emergency medical treatment, that will also be addressed so that the Commission has insight into the future capability of treatment of a patient at the “place of occurrence” typically referred to as a 911 accident.

1. Mobile Broadband Data

With the recent expansion of cellular service into the area of “Broadband” transmission levels and the creation of medical instrumentation and software that can “function” on these formats, visionary rural and urban HCPs are providing remote healthcare to senior and physically impaired patients in their homes or other remote physical locations in the community designated for that type of treatment. Using laptops, notebooks, notepads, and other types of PD’s (Personal Devices) equipped with medical software applications, nurses, therapists, and other medical staff are able to transmit critical medical data to their respective HCPs real-time electronically into a patient’s medical file or interact with the patient’s primary care provider. There are also portable medical devices that can test and transmit patient data over mobile broadband. One of the most promising remote diagnostics potentials is the use of Portable Ultrasound technology (Sonography) to transmit remotely images of potential soft tissue ailments to the rural HCP.

Given the potential increase in critical medical services at a substantial cost savings Mobile Broadband can bring to rural health care, the Commission should provide funding for non-recurring and recurring costs for Mobile Broadband in the next funding cycle.

2. Interactive/Collaborative Imagery Diagnostics

Under the RHC Program OC3 (Optical Carrier 155Mbps/s) is fundable. The Commission should be aware that with the advent of digital software enhancements to MRI, CAT and CT imaging, the data requirements for a single image has been reduced for the gigabit (Billions of bits) to the Megabit level (Millions of bits) level. Combined with HD Codecs (High Definition Coding/Decoding devices) and the advancement of imaging fields (LED Screens) and other related software and hardware devices, HCPs have the capability to interact with either a single or multiple location via a video bridge (Multi-Port Device) allowing HCPs to send static and dynamic MRI, CAT or CT images to the “field” that can be collaboratively annotated, calibrated, set in 3-D motion for example, and shared instantaneously with multiple specialist in the country in a virtual diagnostic setting. This is possible today and some visionary HCPs have already started deploying this equipment and are interacting with other stated HCPs in an effort to save lives and reduce medical costs. MiCTA seriously recommends that the Commission consider funding at some level these virtual diagnostic rooms within the RHC Program.

3. Emergency Medical Treatment

Under an emergency medical situation in the field, such as an automobile accident, once technology has reduced the size of a digital CAT or CT system so that it can be installed in an EMT van along with a broadband wireless transmitting device, a paramedic, who has been trained in emergency surgical procedures, would be able to determine if a victim had sustained a life threatening injury and using currently existing technology, transmit real-time images and medical data to the closet HCP diagnostic site as described in #2 above.

Once entering the diagnostic environment at the HCP, the emergency physician will be able to view images the paramedic has already transmitted to the diagnostic center.

These CAT/CT images will enable the physician to accurately instruct the paramedic on the best procedures to use to stabilize the patient. Only the size of the CAT/CT system remains to become a reality, as all of the other technologies discussed are currently available. MiCTA suggests that tests with portable Ultrasound systems, because of their current size, would be a way to begin evaluating the effectiveness of this emergency medical treatment scenario.

Section V.b. Electronic health records

The practice of digital health record recording and storage, driven by the Medicare/Medicaid Programs, at rural HCPs will increase dramatically. Individual rural HCPs will face two major issues as ultimately “record exchange” becomes a reality. First, they will need the capability to either transmit or receive patient records from any participating rural or urban HCP across the country. Second, they will be faced with the cost of purchasing a gigabit storage devices or obtaining “cloud storage services” from a licensed vendor.

Section V.d. Service quality requirements

Because of the criticalness of the images, and the level of privacy as required by law, MiCTA recommends that the Commission require at least a minimum of 128 bits of encryption be deployed on each packet of information sent. Any “carrier” who engages in providing service under either the Broadband Services Program or the RHC Primary Program should be required to provide this minimum level of security over its service lines or transmissions.

Section V.e. Cost savings from broadband connectivity

Although MiCTA does not have current data relative to today’s cost savings by the use of Telemedicine, it none- the-less supports the Commission’s expansion of the deployment of broadband to rural HCPs. This support is rooted in MiCTA’s experiences in the early 90’s with MiCTA Net. MiCTA Net was one of the first rural video health care networks in the World and linked multiple rural hospitals throughout the State of Michigan and beyond. Health care participants in this network reported that it enabled them to be able to increase the number of patients treated, reduce patient transportation and its related cost, and expedite processing and sharing of information regarding patient treatment.

If the Commission has any questions regarding the comments and information presented, MiCTA would be pleased to provide any information or technical support the Commission may request.

Respectfully submitted on behalf of MiCTA by

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