

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

In the Matter of )  
 )  
 )  
Rural Health Care Universal Service Support ) WC Docket No. 02-60  
Mechanism )  
 )  
 )  
 )

**COMMENTS OF GENERAL COMMUNICATION, INC.**

Tina Pidgeon  
Megan Delany  
Chris Nierman  
GENERAL COMMUNICATION, INC.  
1350 I Street, N.W., Suite 1260  
Washington, D.C. 20005  
(202) 457-8815

John T. Nakahata  
Rachel W. Petty  
WILTSHIRE & GRANNIS LLP  
1200 Eighteenth Street, N.W.  
Washington, D.C. 20036  
(202) 730-1300

*Counsel for General Communication, Inc.*

August 23, 2012

# Table of Contents

- I. Introduction and Summary ..... 1
- II. ANY NEW PROGRAMS THE COMMISSION ADOPTS SHOULD SUPPLEMENT, RATHER THAN REPLACE, THE PRIMARY PROGRAM..... 3
- III. CONSORTIA (PN Section I)..... 4
- IV. INCLUSION OF URBAN SITES (PN Section II)..... 6
- V. ELIGIBLE SERVICES AND EQUIPMENT (PN Section III) ..... 7
  - A. Clarify the Definition of Point-to-Point Services..... 7
  - B. Support Certain Non-Recurring Costs and Parallel Services..... 7
  - C. HCPs Should Not Be Required to Own Network Facilities. .... 8
- VI. COMPETITIVE BIDDING PROCESS AND RELATED MATTERS (PN Section IV) . 10
  - A. GCI Supports the Competitive Bidding Process..... 10
  - B. “Evergreen” Contract Requirements Should Be Simplified and Clarified. .... 10
  - C. Improve Online Application Availability and Transparency..... 12
- VII. BROADBAND NEEDS OF RURAL HEALTH CARE PROVIDERS (PN Section V) .. 13
- VIII. CHANGES TO ENHANCE THE PRIMARY PROGRAM..... 15
- IX. CONCLUSION..... 17

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

In the Matter of )  
 )  
 )  
Rural Health Care Universal Service Support ) WC Docket No. 02-60  
Mechanism )  
 )  
 )

**COMMENTS OF GENERAL COMMUNICATION, INC.**

**I. Introduction and Summary**

General Communication, Inc. (“GCI”) hereby comments in response to the Wireline Competition Bureau’s July 19, 2012 Public Notice (“Public Notice”) seeking further comment with respect to the rural health care reform proceeding.<sup>1</sup>

GCI is the leading provider of broadband services to government, commercial, and residential users in Alaska, and through its ConnectMD network, supports the delivery of telemedicine services in Alaska and the Pacific Northwest. As outlined in its 2010 comments,<sup>2</sup> GCI has seen the transformational benefits of telemedicine for health care delivery in rural Alaska. Many of GCI’s telemedicine customers have relied on the RHC program to deliver telehealth services that are revolutionizing healthcare in rural Alaska. Telemedicine has not only improved health care in areas with few physicians and even fewer medical specialists, but the RHC program has also saved over \$30 million in health care-related travel costs in Alaska alone.

---

<sup>1</sup> See *Wireline Competition Bureau Seeks Further Comment on Issues in the Rural Health Care Reform Proceeding*, Public Notice, DA 12-1166, WC Docket No. 02-60 (rel. July 19, 2012) (“*Public Notice*”).

<sup>2</sup> See *Comments of General Communication, Inc.*, WC Docket No. 02-60 (filed Sept. 8, 2010) (“*GCI NPRM Comments*”).

Telemedicine is used to treat patients in many medical fields, including audiology, cardiology, dental, family medicine, neurosurgery, ophthalmology, pediatrics, psychiatry, and women's health.

To expand the benefits of telemedicine to rural communities, the Commission should continue to remove obstacles to RHC participation, simplify and clarify requirements, and establish flexibility to meet providers' needs. First, as the Commission considers the possibility of replacing pilot projects with more permanent programs, it should craft any new programs to supplement rather than replace the Primary Program, which has significantly improved health care delivery, reduced the costs of health care services, and created better outcomes in rural Alaska. The Commission should implement the lessons learned from the pilot projects in both any new programs and in the Primary Program. The programs should be as clear and flexible as possible. GCI has several suggestions and observations to help achieve that goal:

- Consortia should be optional, not required;
- Applicants should be able to include multiple sites on a single application, and substitute site and services on applications where appropriate;
- Urban sites and equipment should be supported in conjunction with both Broadband Services Program supported services and Primary Program supported services;
- The Commission should decline to adopt any new exclusions with regard to the definition of "point-to-point" services;
- The Commission should avoid any micromanaging of health care providers' networks, including such decisions as whether to own or lease facilities;
- The Commission should continue to encourage competitive bidding, which holds down costs and ensures transparency;

- Use of multi-year contracts under the RHC program is cumbersome and confusing, and should be revised to reflect the more effective process used in the E-Rate program;
- Improving access of service providers to pending applications will minimize mistakes and facilitate the review process;
- HCP bandwidth needs will continue to increase with the increased adoption of telehealth services and electronic health records.

The Rural Healthcare Program has been a tremendous success in Alaska. However, some of the programs rules make it difficult for healthcare providers to participate, particularly when the total amounts received may not be large. By making the processes simpler and more flexible in all programs, the Commission can make it easier for providers to participate, and to use telemedicine to deliver needed services to rural, underserved Americans.

## **II. ANY NEW PROGRAMS THE COMMISSION ADOPTS SHOULD SUPPLEMENT, RATHER THAN REPLACE, THE PRIMARY PROGRAM.**

The Public Notice seeks to further develop the record with respect to the notice of proposed rulemaking (“RHC NPRM”) issued in 2010.<sup>3</sup> That NPRM proposed to replace the existing support for Internet Access services with a new Healthcare Broadband Access Fund, and to create a Health Care Broadband Infrastructure Fund to subsidize network deployment for health care providers (HCPs) “where existing broadband infrastructure is inadequate.”<sup>4</sup> The NPRM did not propose to change the existing support mechanism for telecommunications services (the “Primary Program” or “telecommunications program”).

In its comments on the RHC NPRM, GCI demonstrated that the Primary Program has been extremely effective at improving health care service delivery, reducing the costs of health

---

<sup>3</sup> See *Rural Health Care Support Mechanism*, Notice of Proposed Rulemaking, 25 FCC Rcd. 9371, FCC10-125 (2010) (“*RHC NPRM*”).

<sup>4</sup> *Id.*, ¶ 13.

care services, and creating better outcomes in rural Alaska.<sup>5</sup> The Primary Program is well-suited to overcome Alaska’s primary challenge of distance and follows the prescriptions of Section 254(h)(1)(A) of the Communications Act to provide communications services to health care providers serving rural residents in a state “at rates that are reasonably comparable to rates charged for similar services in urban areas in that State.”

As the Commission considers more permanent mechanisms to succeed the current broadband pilot projects, it should heed an important lessons learned from the broadband pilot projects, and from the experience with the Rural Health Care program as a whole, that a high degree of flexibility—and multiple approaches—are necessary to support telemedicine in a wide range of rural geographic, demographic, and institutional environments. Accordingly, any new permanent mechanisms should complement, rather than supplant, the Primary Program.

### **III. CONSORTIA (PN Section I)**

The Public Notice seeks comment on various issues with respect to consortium applications in the proposed Broadband Services Program. GCI supports permitting consortia applications, as can be done today with respect to the Primary Program. However, both the Primary Program and the Pilot Projects provide important lessons with respect to consortia applications. This learning should be applied not just to the proposed Broadband Services Program, but also to the Primary Program, as it would benefit both programs and facilitate the expansion of telemedicine to more communities.

Consortia, however, should be optional, not required. In the Broadband Pilot Project, the Commission required HCPs to apply as consortia. This had some advantages when the consortia worked well, but also had disadvantages, because the consortia had to be organized and, in some

---

<sup>5</sup> See GCI NPRM Comments at 7-9.

cases, operate more slowly than an individual HCP can. In Alaska, the Primary Program, which permits HCPs to receive support individually, has proved to be more effective thus far at delivering support and service—in part because the regional health corporations—as larger collections of health care facilities aggregating demand and purchasing power and designing an integrated system—have many of the advantages that the pilot projects exhibited for consortia. Moreover, GCI’s ConnectMD network, through which it serves Alaska HCPs, has allowed HCPs to obtain dedicated networks that are designed to safeguard patient privacy, another benefit that the Staff Report found with consortia.<sup>6</sup>

The Commission should keep the application process as simple and flexible as possible, and eliminate unnecessary burdens in all rural healthcare support programs. As the Staff Report highlights, the pilot project consortium approach eliminated the need for each HCP to submit its own application each year.<sup>7</sup> The Staff Report demonstrates that applicants should be able to apply with respect to more than one site (and if a consortium, more than one HCP) in a single application.<sup>8</sup> As GCI explained in its RHC NPRM comments, requirement that each site or location to submit a separate application is obsolete, should be removed from the Primary Program, and should not be extended to any new programs.

The Public Notice also seeks comment on whether to permit flexibility in site and service substitution, under certain specified conditions.<sup>9</sup> As USAC noted, the “consortium application

---

<sup>6</sup> See *Wireline Competition Bureau Evaluation of Rural Health Care Pilot Program*, Staff Report, WC Docket No. 02-60, DA 12-1332 (rel. Aug. 13, 2012) (“Staff Report”).

<sup>7</sup> See Staff Report, ¶78.

<sup>8</sup> See Staff Report, ¶ 80.

<sup>9</sup> See *Public Notice*, ¶ 6.c (“Under the Pilot Program, a site or service substitution may be approved if (i) the substitution is determined to be provided for in the contract, be within the change clause, or constitute a minor modification, (ii) the site is an eligible health care provider or the service is an eligible service under the Pilot Program, (iii) the substitution

process allows USAC to more efficiently process requests to substitute HCP sites and services as a Pilot Project’s network changes over the years.”<sup>10</sup> This should be permitted for the Broadband Services Program as well as for the Primary Program. There is no reason to preclude Primary Program participants, whether individually (such as a regional provider operating a number of sites) or in a consortium, from also having this flexibility, within the conditions set forth in the Public Notice.

#### **IV. INCLUSION OF URBAN SITES (PN Section II)**

GCI agrees that it can be helpful to permit urban sites to be included in the Broadband Services Program, at a minimum with respect to the on-site equipment needed for rural telemedicine. As the Staff Report shows, urban sites are often the focal point for telemedicine in many rural communities, and a workable telemedicine network needs to be able to support the provision of service at the urban end, as well as the rural end of a telemedicine link.<sup>11</sup> The Staff Report also notes the significant benefit of using telemedicine to treat patients locally rather than simply to “patch and ship.”<sup>12</sup> To the extent that the Broadband Services Program supports routers and other equipment necessary for the urban end, it should provide that support in conjunction with both Broadband Services Program supported services and Primary Program supported services.

---

does not violate any contract provision or state or local procurement laws, and (iv) the requested change is within the scope of the controlling FCC Form 465, including any applicable Request for Proposal”).

<sup>10</sup> USAC Observations on the FCC Rural Healthcare Pilot Program, at 3-4, WC Docket No. 02-60 (filed Mar. 14, 2012).

<sup>11</sup> See Staff Report, ¶ 89.

<sup>12</sup> See *id.*

## **V. ELIGIBLE SERVICES AND EQUIPMENT (PN Section III)**

The Public Notice also seeks comment on specific aspects of the NPRM proposal, including limiting funding to “point-to-point” connectivity, the non-recurring costs of routers and bridges, and proposed requirements for HCPs to have an ownership interest in certain network infrastructure.

### **A. Clarify the Definition of Point-to-Point Services.**

GCI supports the suggestion to clarify that “point-to-point” includes services deployed in a variety of configurations, including ring, mesh, hub and spoke, and line. The Primary Program does not now have any exclusions, and there is no reason to create new exclusions in the Primary Program or any new program. GCI has deployed a substantial number of hub and spoke networks under the Primary Program, as well as ring solutions where those are possible.

### **B. Support Certain Non-Recurring Costs and Parallel Services.**

GCI also agrees that the new healthcare broadband services program should support non-recurring costs for the equipment necessary to establish basic connectivity, such as routers and bridges. As discussed above, it is critical to have both ends of the communications link equipped. If the Commission provides this support for non-recurring costs, it should make clear that a Primary Program participant could also apply for Broadband Service Program support for these non-recurring costs.

If the RHC program supports bridges, it should also support the services provided via those bridges, such as conferencing services, which provide the same function for users as video and audio bridges. Supporting the equipment without the attendant services could artificially skew an HCP’s decision to purchase equipment rather than services, which can be more convenient for an HCP with limited technical resources. As GCI noted in its earlier comments,

conferencing services are already supported under the E-Rate program and there seems to be no policy reason why they should not also be available to rural healthcare providers.<sup>13</sup>

**C. HCPs Should Not Be Required to Own Network Facilities.**

The Public Notice seeks comment on whether HCPs should be required or permitted to construct and own network facilities. While support for new construction or dark facilities IRUs may make sense in some instances, the Staff Report confirms GCI's point from its comments that *requiring* a Health Broadband Infrastructure program participant to own or hold an IRU with respect to underlying facilities makes no sense and would force health care providers into becoming network operators.<sup>14</sup> While multi-year contracting should be encouraged, mandating facilities ownership, an IRU, or a capital lease simply denies HCPs flexibility in determining how best to procure networks and to provide for future growth.

The Staff Report's observations parallel GCI's comments:

“There may be several reasons why Pilot projects have not generally chosen to construct and own their own broadband facilities. First, running a network is a complex and technical task, and using third-party services can be simpler. Second, it has not always proven necessary for projects to own the facilities in order to obtain broadband deployment to sites previously unserved by high-speed connections. In many cases, service providers have laid fiber and made other investments where necessary to enable them to provide the services requested. Third, through long-term contracts, prepaid leases, and IRUs, projects have been able to obtain low prices for long terms as well as high service quality and reliability and virtual private network configurations. Thus, for many projects it has been unnecessary for the Pilot projects to own the network facilities in order to secure good pricing and high service quality. Fourth, by purchasing services as opposed to owning the network, projects can obtain the underlying services from a range of service providers, and thus can obtain a broader geographic reach, coordinated services, and often lower prices. Fifth, purchasing services allows HCPs to avoid the risk and cost of owning facilities. Finally, HCPs are not permitted to sell, resell, or otherwise

---

<sup>13</sup> See GCI NPRM Comments at 27; Schools and Libraries Support Mechanism Eligible Services List for Funding Year 2012, *available at* [http://www.usac.org/\\_res/documents/sl/pdf/ESL\\_archive/EligibleServicesList-2012.pdf](http://www.usac.org/_res/documents/sl/pdf/ESL_archive/EligibleServicesList-2012.pdf), at 4.

<sup>14</sup> See GCI NPRM Comments at 13.

transfer communications services or network capacity purchased through the rural health care mechanism.”<sup>15</sup>

These observations are fundamentally correct. In GCI’s experience, HCPs do not want to become network providers, and want the ability to adapt their communications procurements to their changing needs and service advances. Alaska has been a good laboratory, because its HCPs are regional health corporations that, with support from the Bureau of Indian Affairs, provide health services in many village clinics spanning a region—and thus are much more like the consortia envisioned in the Pilot Projects.

If HCPs are permitted to construct and own network facilities they must be entitled to make decisions about their own telecommunications needs, as required under the Commission’s rules.<sup>16</sup> USAC should not be in the business of second-guessing HCPs projections of the bandwidth needed to support the services they need, although it may make sense of the Commission to require a technology plan if HCPs are going to seek funding for construction. The Commission should recognize that HCPs will often lack the expertise to determine the true costs of constructing and maintaining network facilities.

The Commission should eschew the temptation to micromanage telemedicine network procurements by subdividing between the Health Infrastructure Program for non-recurring construction and the Broadband Services Program for recurring costs. These are simply two different models for procuring a network, with one approach or the other appropriate depending on the amount of risk that the HCP wishes to assume. By creating two different programs and artificially dividing these two strategies, the Commission risks distorting HCP procurements and

---

<sup>15</sup> Staff Report, ¶ 92 (citations omitted); *see also* GCI Comments at 13.

<sup>16</sup> *See, e.g., Rural Health Care Support Mechanism*, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 18 FCC Rcd. 24546, 24563, ¶33 (2003) (stating that “rural health care providers are best able to determine what telecommunications services best meet their needs”).

pushing HCPs into suboptimal network designs in order to fit within the two support mechanisms' structures.

## **VI. COMPETITIVE BIDDING PROCESS AND RELATED MATTERS (PN Section IV)**

### **A. GCI Supports the Competitive Bidding Process.**

GCI agrees that competitive bidding has “led to lower prices, better service quality, and more broadband deployment,” as well as increased transparency.<sup>17</sup> As USAC has noted, in Funding Year 2010, Alaska has the highest percentage of competitive bids in the country, with nearly 46% of Form 465 postings in the Primary Program receiving multiple bids, as compared to 9.63% nationally.<sup>18</sup> The Form 465 request for services is minimally burdensome and ensures transparency for both HCPs and service providers, and should continue to be required for all requests for service without exclusion.<sup>19</sup>

### **B. “Evergreen” Contract Requirements Should Be Simplified and Clarified.**

GCI agrees that multi-year contracts can help reduce program costs and provide better long term assurance for HCPs.<sup>20</sup> Multi-year contracts also provide a more stable basis upon which a provider can agree to extend service. However, the “evergreen” contracts requirements can be formalistic, with failures to follow strict—but unpublished—“rules” resulting in “non-evergreen” status. Although the USAC webpage on Evergreen Contracts provides for evergreen status for the contract as a whole,<sup>21</sup> the letter sent to HCPs and service providers allows

---

<sup>17</sup> *Public Notice*, ¶ 11.

<sup>18</sup> *See* USAC Data on the FCC Rural Health Care Pilot Program, at 2, WC Docket No. 02-60 (filed June 27, 2012).

<sup>19</sup> *See* 47 C.F.R. § 54.603(b); *RHC NPRM*, ¶ 110.

<sup>20</sup> *See* Staff Report, ¶ 100.

<sup>21</sup> *See* Evergreen Contracts, USAC, at <http://www.lifelinesupport.org/rhc/health-care-providers/evergreen-contracts.aspx> (last accessed Aug. 23, 2012).

evergreen status only on a service-by-service basis. Thus, if there is a need to increase or reduce bandwidth, substitute service, or even make regular adjustments to price, it must restart the entire Form 465 process, even if such changes *are already contemplated by the approved contract*. Even common issues, such as credit for service outages, cannot be addressed without HCPs and service providers facing substantial administrative burdens. This micromanaging of RHC funding stands in stark contrast to the way evergreen contracts function under the E-Rate program.

Under E-Rate, contracts are evaluated as a whole for eligibility, not just for the service in a specific application for funding. Accordingly, under E-Rate, a multi-year contract containing growth options allowing for the logical expansion of services through the contract term to cover such contingencies as student population growth and technology changes would be evaluated for all eligible services levels, not just for individual line items pertaining to a single application within a single year. If the contract is eligible and the service requested by the applicant is justified within the approved contract, it is eligible for funding. This allows the applicant to request funding to cover possible changes with a single application each year and with varying amounts from year to year supported by the approved contract.

In contrast, the Rural Health Care Program uses the term “evergreen contract” not to refer to a *contract* as a whole, but only to a *service* listed within that contract as applied for on a single Form 466. Even though the contract is deemed evergreen, any change to that service fully covered in the contract, would require a new Form 466 to be submitted and the evergreen contract to be reevaluated for evergreen status for the new service. This should be corrected for any new Broadband programs, and for the Primary Program as well, to reduce the need for year-to-year resubmission and reevaluation of the contract. This would not undermine the

competitive bidding requirement so long as the initial contract was competitively bid in a competition that contemplated a multi-year arrangement. This is consistent with the Public Notice's proposed treatment of service and site substitution.<sup>22</sup>

In addition, the Commission should require USAC to revise its Form 466 process for multi-year contracts. At present, because multi-year contracts are not required to file Form 465 after the first year, in subsequent years Form 466 must be filed in paper form, rather than online.<sup>23</sup> There is no program protection reason for this, and it should be fixed for the Primary Program as well as for any Broadband programs.

**C. Improve Online Application Availability and Transparency.**

As GCI stated in its comments, under the Primary Program today, there is no online way for a chosen service provider to help ensure that mistakes do not derail the evaluation process. USAC should fix this for any new Broadband support programs and for the Primary Program as well. The RHC program would benefit from implementing a program similar to the one USAC has developed for E-Rate applications, which provides a receipt acknowledgement letter to both the applicant and selected E-Rate provider with basic details about the application received and under review.<sup>24</sup> The service provider would then be able to correct simple transcription or other errors early. The online systems USAC currently has available for the RHC program do not resolve these issues, and have in fact made the process more opaque to service providers. In one instance, an HCP was able to provide a printed version of the submitted online application to GCI, but the key information remained blank in the printed copy, including SPIN, contract rural rate, etc.

---

<sup>22</sup> See n. 10, *supra*.

<sup>23</sup> See GCI NPRM Comments at 24.

<sup>24</sup> See GCI NPRM Comments at 23-24.

## VII. BROADBAND NEEDS OF RURAL HEALTH CARE PROVIDERS (PN Section V)

The Public Notice requested comment on the broadband needs of rural health care providers to supplement the record.

- Telemedicine bandwidth. GCI's experience dovetails with that summarized in USAC's April 12, 2012 summary of health care provider bandwidth needs.<sup>25</sup> GCI is now provisioning 3 or 5 Mbps connections for health clinics utilizing high definition video conferencing, as is reflected by the "typical" bandwidth range in USAC's summary. Going forward, as HCPs are able to take advantage of more services and new technology, bandwidth needs will also increase. The Alaska Tribal Health Consortium makes a similar assessment, and notes that it is increasingly necessary to be able to support multiple, simultaneous high definition video-conferences.<sup>26</sup> In that situation, 2-3 T-1 equivalents would not provide sufficient bandwidth.
- Electronic Health Records and Service Quality Requirements. GCI has found that its HCP customers need, where possible, to have real-time connections in order for electronic health records systems to operate. As the Public Notice reflects, these systems are increasingly required. However, electronic health records systems are designed with low-latency environments in mind, and the substantial delays that come with satellite communications substantially reduce their functionality in most cases. This means that, for rural HCPs, it is important to be able to use terrestrial facilities when available, even if more costly than satellite services. The Alaska Native Tribal Health Consortium observes:

---

<sup>25</sup> See Health Care Provider Broadband Needs Assessment, Summary, at Attachment, WC Docket No. 02-60 (filed Apr. 12, 2012).

<sup>26</sup> See Alaska Native Tribal Health Consortium Responses on the Benefits and Needs of Alaska Telemedicine Providers, Attachment 1 at 3 ("ANTHC Responses").

“Combined with the issue of satellite latencies, we are seeing Alaska sites opting to host their own EHR systems, which is contrary to the move in the lower-48 to allow EHR vendors to provide hosted solutions. In other words, concerns about the connectivity force organizations into approaches that demand higher local skills, higher local knowledge, and limit their choices to have remote hosted solutions. And these are locations in which those skills or skilled professionals are hard to find and keep.”

The FCC should require USAC to take that into account when conducting Program Integrity Reviews of applications. Bandwidth needs will also continue to grow with the trend toward adoption of electronic health records.

- Cost savings from broadband connectivity. The expanding use of telemedicine has led to substantial cost savings. The Alaska Native Tribal Health Consortium (“ANTHC”) describes how utilization of telehealth has increased exponentially over the last decade. Many services, such as teleradiology, remote patient monitoring (home telehealth), and live video-conferencing, have “become mainstream delivery.”<sup>27</sup> For other primary and specialty care services, ANTHC finds that the number of telehealth services provided in its network has increased from 897 in 2001 to 25,977 in 2011—an increase of nearly 2,800 percent.<sup>28</sup> Wait times for ANTHC patients seeking treatment from a specialist have also decreased dramatically; for example, for audiology and ENT appointments, “47% of new patient referrals would wait 5 months or longer to obtain an in-person” consultation prior to the use of telemedicine.<sup>29</sup> Within just a few years, however, that number dropped to less than 3% of all patients.<sup>30</sup> Cost savings have been equally dramatic. For transportation costs for travel between villages, regional facilities, and Anchorage, approximate savings have increased

---

<sup>27</sup> ANTHC Responses at 1.

<sup>28</sup> *See id.* at page 2, Table 1.

<sup>29</sup> *Id.* at 4.

<sup>30</sup> *See id.*

from \$58,500 in 2001 to over \$6,000,000 in 2011—totaling over \$30 million over the eleven-year period.<sup>31</sup>

### **VIII. CHANGES TO ENHANCE THE PRIMARY PROGRAM**

GCI has put forward a number of recommendations for improvements that the Commission can adopt to advance the goals of the RHC program by making the existing RHC program easier for both health care providers and service providers. The Commission should:

- Disburse support more frequently than twice per year. This would better align reimbursement with the HCP’s invoices, and will encourage participation by eliminating the burden on participants who must manage long delays in payment.<sup>32</sup>
- Require applicants to submit their applications within 120 days of the start of the funding year, or of the service start date, whichever is later. This will spread USAC’s processing load more evenly throughout the year, reducing backlog and processing times.<sup>33</sup>
- Clarify that reimbursement for satellite services should not be capped by rates for unavailable terrestrial services. As GCI explained in its NPRM Comments, the Rural Health Care Division of USAC (“RHCD”) has limited support for satellite connections to the terrestrial rate “when there are any lower-priced terrestrial circuits in place on a route, even if those terrestrial circuits are not actually available for use by the RHC program funding recipient,” such as when terrestrial capacity is already exhausted.<sup>34</sup> As GCI described in its earlier comments, this practice can result in health care providers and

---

<sup>31</sup> See *id.* at 5, Table 2.

<sup>32</sup> See GCI NPRM Comments at 20-21.

<sup>33</sup> See *id.* at 21.

<sup>34</sup> *Id.* at 22.

their patients going without the telehealth services they need because of the support shortfall.<sup>35</sup>

- As discussed above, increase service provider access information about pending applications to speed error corrections.<sup>36</sup>
- As discussed above, increase online application availability and transparency.<sup>37</sup>
- Decline to apply the proposed “majority of beds” test to determine the eligibility of a health care provider, at least in small communities that are unlikely to have more than one site for the provision of health care services. As GCI explained in its NPRM Comments, the proposed rule is particularly ill suited for small rural communities. For example, many Alaskan villages have small populations under a few hundred residents, and must rely on multi-purpose facilities that provide such disparate services as acute care, skilled nursing, end-stage renal dialysis, and other purposes.<sup>38</sup> Such facilities would fail the majority of beds test. The Commission should therefore decline to adopt this test for eligibility, or should create an exemption to any such requirement for communities with only a small number of healthcare delivery sites.
- As discussed above, eliminate the location requirement under 47 C.F.R. § 54.601(a)(4), which requires a separate application for each site because each site is treated as a separate HCP. As GCI explained in its NPRM Comments, this requirement is unnecessary and means that many more applications must be filed.<sup>39</sup>

---

<sup>35</sup> *See id.*

<sup>36</sup> *See supra* at Section V.C.

<sup>37</sup> *See id.*

<sup>38</sup> *See* GCI NPRM Comments at 25.

<sup>39</sup> *See* GCI NPRM Comments at 26.

- As discussed above, expand funding to conference services.<sup>40</sup>

## IX. CONCLUSION

GCI appreciates this opportunity to share its experience serving the telecommunications needs throughout Alaska. GCI urges the Commission to adopt its proposals to enhance the Rural Health Care program, to further support of services that improve the quality and delivery of health care for rural providers.

Sincerely,



Tina Pidgeon  
Megan Delany  
Chris Nierman  
GENERAL COMMUNICATION, INC.  
1350 I Street, N.W., Suite 1260  
Washington, D.C. 20005  
(202) 457-8815

John T. Nakahata  
Rachel W. Petty  
WILTSHIRE & GRANNIS LLP  
1200 Eighteenth Street, N.W.  
Washington, D.C. 20036  
(202) 730-1300

*Counsel for General Communication, Inc.*

August 23, 2012

---

<sup>40</sup> See *supra* at Section IV.B.

## **ATTACHMENT 1:**

### **ANTHC Responses on the Benefits and Needs of Alaska Telemedicine Providers**

## **ANTHC Responses on the Benefits and Needs of Alaska Telemedicine Providers**

The following information is provided by the Alaska Native Tribal Health Consortium (ANTCH), and reflects best known estimates as of August 13, 2012. ANTHC was formed in December 1997 to manage statewide health services for Alaska Natives. ANTHC employs approximately 2,000 people and has an operating budget of more than \$430 million. ANTHC manages the Alaska Federal Health Care Access Network (AFHCAN) telehealth program which has been in use since 2001. The AFHCAN system allows providers at 250 sites throughout Alaska to capture and share patient information on an "as needed" basis. The system has been used for more than 140,000 clinical cases across 30 autonomous organizations. With an annual consultation rate of more than 30,000 cases per year, this system now provides care to more than 22,000 Alaskans annually and is considered an integral part of the day-to-day health care delivery system in the Alaska Tribal Health Systems (ATHS).

### **1. Can you provide aggregate data regarding the number of telehealth services provided in Alaska, broken down by:**

- **Year;**
  - We do not track teleradiology cases, remote patient monitoring (home telehealth), or live video-conferencing. There is a very large amount of teleradiology in Alaska and we simply do not try to capture reports on that activity as it has become mainstream delivery. Videoconferencing similarly is mainstream within each Tribal partner for providing care to patients, distance education, etc. The numbers we can provide are on "store and forward" telemedicine within the Alaska Tribal Health System.
  - "Primary Care" cases are cases that do not involve specialists or a tertiary care medical center. Typically, these are cases that occur between a "Community Health Aide/Practitioner" and a family doctor.
  - "Specialty Care" cases originate at a primary care setting (e.g. village clinic or regional hospital) but then require consultation from a specialist at a tertiary care facility.

**Table 1**

<b>Calendar Year</b>	<b>Primary Care</b>	<b>Specialty Care</b>	<b>Grand Total</b>
2001	896	1	897
2002	3120	305	3425
2003	3672	1380	5052
2004	5492	1557	7049
2005	5824	1932	7756
2006	6783	2016	8799
2007	8611	2519	11130
2008	8742	2321	11063
2009	11522	2663	14185
2010	18450	2946	21396
2011	21278	4699	25977

- **Type of service; and**

- Telehealth in Alaska is used by virtually all specialties and all departments. A recent survey of the Alaska Native Medical Center found the following departments are active users of telemedicine:

Audiology  
 Cardiology  
 Care Coordination Center  
 Dental  
 Dermatology  
 Emergency Department  
 Endocrinology  
 Family Medicine  
 Gastroenterology  
 HIS  
 Internal Medicine  
 Neurosurgery  
 Ophthalmology  
 Orthopedics  
 Otolaryngology  
 Pediatrics-Outpatient  
 Podiatry  
 Pulmonology  
 Rheumatology  
 Surgery  
 Urology  
 Women's Health

- **Location (region or otherwise)?**
  - These results are primarily limited to the State of Alaska, and by users within the Alaska Tribal Health System. It should be noted that users also exist within the Department of Defense and State of Alaska Public Health Nursing sites.

**2. Are the bandwidth needs for specific telehealth services reported by USAC in Appendix A of its April 12, 2012 letter comparable to your experience? If not, how does your experience differ?**

- a. Alaskan sites have really adopted broadband connectivity for a wealth of health care applications – from video-teleconferencing (“VtC”) to Store-and-forward telehealth to remote access to electronic health records (“EHRs”).
- b. While we have lived within the confines of 1 or 2 or 3 T1 circuits to village clinics, the reality is that many clinics have multiple VtC endpoints and suffer when they are limited to 1 or 2 T1 circuits. Many physicians are really convinced of the power of high definition (“HD”) VtC to support health care, and we need the ability to run multiple HD sessions to a village clinics where we may have behavioral health patients, trauma patients, distance education, and other functions all happening simultaneously.
- c. The numbers listed for standard definition (“SD”) and HD video sound reasonable for “typical” usage at remote clinics and small hospitals. The numbers for “optimal” sound high to us for small clinics – but may be appropriate for large installations where multiple VtC sessions need to occur in parallel.
- d. The breakdown by specialty in Appendix A seems somewhat capricious and hard to understand. “Specialist Care” is very broad and it’s hard to understand why this demands more bandwidth than “speech therapy” which itself benefits greatly from HD VtC. Overall – for our sites – the “typical” values look reasonable, and the “optimal” seem somewhat high end and would be hard to justify in our environment.

**3. Can you provide data regarding the costs of providing telehealth services, both on a per-service and an aggregate basis, including ongoing operational, training, and technical support costs to rural health care providers?**

- a. Data unavailable.

**4. Do you have any data demonstrating improved patient outcomes due to telehealth services?**

- a. The AFHCAN system in Alaska was used by 1,443 providers in 2011. It served 22,763 patients in 2011 (16% of the entire Alaska Native population) and was used in about 3% of all outpatient encounters throughout the state.
- b. In a recent 16-year retrospective analysis of ENT specialty clinic wait times on all new patient referrals made by NSHC providers before (1992- 2001) and after the initiation of telemedicine (2002 – 2007), we found that prior to use of telemedicine by audiology and ENT, 47% of new patient referrals would wait 5 months or longer to obtain an in-person ENT appointment; this dropped to 8% of all patients in the first three years with telemedicine, then less than 3% of all patients in next three years using telemedicine. The average wait time during the first three years using telemedicine was 2.9 months, a 31% drop compared to the average wait time of 4.2 months for the preceding years without telemedicine. The wait time then dropped to an average of 2.1 months during the next three years of telemedicine, a further drop of 28% compared to the first three years of telemedicine usage.
- c. It is not uncommon for patients to wait weeks or months to see a specialist. A recent study of the wait times for a telehealth consultation at ANMC found that during the 3 month period from Jan-Mar 2012:
  - i. 28% of all telehealth consultations were returned to the originating site with a response in less than 1 hour.
  - ii. 43% were returned within 2 hours, 73% within the same day, and 91% within 1 business day.
  - iii. The speed of consultation is vastly higher than what can be achieved through normal “in person” referral channels.
- d. Store-and-forward telemedicine is as effective as in-person evaluation for planning elective major ear surgery, resulting in faster methods for planning and providing surgical interventions to patient. A recent study reviewed charts for major elective ear surgeries resulting from telemedicine referrals during a 13 month period. These patients were referred using store-and-forward telemedicine (electronic consultation) that included digital images, clinical history, and audiology data. Consultants reviewed the telemedicine case and documented the recommended surgery and estimated operative time. These charts were matched with patients who were seen in-person during a standard evaluation and had identical surgeries recommended. For the telemedicine evaluation and in-person evaluation groups, the recommended surgeries were compared with actual surgeries performed and the estimated time was compared with the actual operative time. Forty five ear surgeries were recommended by the telemedicine evaluation and were matched with 45 surgeries from the standard evaluation and included tympanoplasty with or without canalplasty, mastoidectomy, stapes surgery and myringoplasty. Telemedicine and in person evaluation accurately

predicted the actual surgery 89% and 84% of the time respectively. The average difference of “actual time” and “estimated time” for the actual surgical procedures performed was not statistically different between the two groups: 32 minutes for the telemedicine evaluation group and 35 minutes for the in-person evaluation group.

**5. Can you provide data regarding cost savings realized through telehealth services, e.g.**

- **Reductions in the number and length of hospital stays;**
  - We do not have that info.
- **Savings in patient and HCP transport costs;**
  - The AFHCAN system queries providers about the impact of telehealth on travel. We estimate from more than 40,000 responses that 75% of all specialty cases prevent travel, whereas approximately 10-30% of all primary cases prevent travel. Using gross average for travel between villages and regional facilities and Anchorage, the following estimates have been obtained for travel savings by the AFHCAN program in Alaska:

**Table 2**

<b>Year</b>	<b>Primary Care</b>	<b>Specialty Care</b>	<b>Grand Total</b>
2001	\$58,500.00		\$58,500.00
2002	\$275,700.00	\$234,000.00	\$509,700.00
2003	\$279,000.00	\$1,201,500.00	\$1,480,500.00
2004	\$408,300.00	\$1,468,800.00	\$1,877,100.00
2005	\$315,300.00	\$1,787,400.00	\$2,102,700.00
2006	\$752,700.00	\$2,153,700.00	\$2,906,400.00
2007	\$841,800.00	\$2,769,300.00	\$3,611,100.00
2008	\$603,900.00	\$2,474,100.00	\$3,078,000.00
2009	\$749,400.00	\$2,792,700.00	\$3,542,100.00
2010	\$2,460,600.00	\$2,881,800.00	\$5,342,400.00
2011	\$3,036,300.00	\$3,006,900.00	\$6,043,200.00

- Other Health IT applications, including the consolidation of billing and scheduling functions, transmission and remote storage of images and medical records, and video-based training of health care and health IT professionals; or
- Savings to other governmental entities through reductions in Medicare, Medicaid, or Indian Health Service expenditures.

- A recent study accurately modeled the impact of telehealth specialty consultations on saving travel costs for Medicaid-eligible patients in Alaska. A total of 5,925 store-and-forward telehealth specialty consults were conducted at the Alaska Native Medical Center (ANMC) from 2003 to 2009 for 3,663 unique patients. Alaska Medicaid reimbursed ANMC for professional fees totaling \$269,893.52. Provider reviews indicate that 75% of all telehealth specialty consults at ANMC prevent patient travel, resulting in savings to the Medicaid program of \$3.1 million in avoided patient travel. This represents a savings of \$11.50 to the Medicaid program for every \$1 spent on reimbursement. Telehealth also prevented 4,777 lost days at work for adults and 1,444 lost days at school for children.

**6. Are there certain telemedicine applications that will become more critical in the future and are there any limitations, including bandwidth requirements or satellite latency, that may impede the widespread development and growth of these applications in Alaska?**

- a. It is very clear that remote sites need access to Electronic Health Records, Health Information Exchanges, and other data systems. Satellite access introduces latencies for which these applications are not designed to support. We doubt any EHR vendors optimize their products for performance over satellite, so removing the latency of satellite is becoming a critical issue.
- b. Reliable connectivity is perhaps the most critical issue facing remote sites as the reliance on EHRs and other service becomes mission critical. When reliability is a concern, sites are forced to self-host solutions, which is often less than desirable.
- c. Combined with the issue of satellite latencies, we are seeing Alaska sites opting to host their own EHR systems, which is contrary to the move in the lower-48 to allow EHR vendors to provide hosted solutions. In other words, concerns about the connectivity force organizations into approaches that demand higher local skills, higher local knowledge, and limit their choices to have remote hosted solutions. And these are locations in which those skills or skilled professionals are hard to find and keep.

**7. Do you have specific recommendations for improving the success of the FCC's Rural Health Care program?**

- a. There must be a concerted effort to support the current subsidy offered to Alaska sites. AK sites will continue to consume more and more bandwidth and lead the nation in using that bandwidth for telehealth and other health related services. But the subsidy is key to not only maintaining what we have built over the past 15 years, it's crucial to expanding and growing our options.

- b. One of the key recommendations for AK health care would be to subsidize “services” over broadband connectivity – such as centralized video management. Each organization currently “owns” their own VtC system – which generates challenges when integrating these into a cohesive health care system. Subsidized services would lead to centralized management at an affordable cost with higher quality than is currently provide through the disparate efforts of independent organizations.