Protecting, maintaining and improving the health of all Minnesotans

August 31, 2010

Commission's Secretary
Federal Communications Commission
445 12th Street SW
Room TW-A325
Washington, D.C. 20554

Re: **Comments-Notice of Proposed Rulemaking**
Rural Health Care Support Mechanism
FCC 10-125
WC Docket No. 02-60

To the Commissioners:

The Minnesota Department of Health (MDH**)** is the state agency charged with carrying out Minnesota's commitment to public health and employs a variety of programs and strategies in the pursuit of its mission to protect, maintain, and improve the health of all Minnesotans. As the lead agency charged with developing Minnesota's health information exchange, MDH recognizes the importance of health information technologies to expand access to affordable care, improve patient safety, improve population health and increase efficiencies. We offer the following comments on elements of the request for comment to the Commission on elements of the Notice of Proposed Rulemaking (NPRM), FCC 10-125, WC Docket No. 02-60.

The comments offered below do not speak to all elements in the NPRM, but do reflect issues of importance to rural health care providers in Minnesota. In forming its comments, MDH consulted concerned stakeholders, including rural facilities that are currently participating in Minnesota's Rural Health Care Pilot Program project, the Greater Minnesota Telehealth Broadband Initiative.

HEALTH INFRASTRUCTURE PROGRAM

The FCC proposes to create a separate Health Infrastructure Program to subsidize up to 85 percent of construction costs of new regional or statewide networks that builds upon the Rural Health Care Pilot Program (RHCPP).

MDH supports the FCC's intent on expanding broadband infrastructure to support health information exchange and innovative models of health care delivery that depend upon robust telecommunications. However, we ask you to consider several concerns expressed by Minnesota's rural HCPs, as follows:

- **Clarify urban HCP eligibility for infrastructure program.** The NPRM does not clearly state whether urban non-profit and public HCPs are eligible to participate in the infrastructure program as part of a dedicated health care network. The Rural Health Care Pilot Program recognized the importance of including urban providers in a network, providing that a majority of HCPs in the network were rural. Much of remotely-delivered health care is dependent upon rural HCP access to urban providers for receipt of telehealth services and health information. This deserves clarification, and inclusion of urban providers in a dedicated health care network is essential for access to services otherwise unavailable.

- **Demonstrated broadband availability should not be a requirement for funding.** Building of a dedicated rural health care network is dependent upon a number of factors, one of which is availability of broadband services. While it is prudent to ask applicants for the infrastructure program to demonstrate that present connectivity speeds are unavailable or insufficient, **i**t should not be a requirement. In Minnesota, existing broadband mapping could provide part of the picture, but would not fully explain why networked services are insufficient or unavailable. Building a dedicated health care network that follows the referral patterns of rural health care providers is not simply a matter of telecommunications capacity, but is dependent upon both health provider relationships and telecommunications access for effective telehealth and information exchange. Asking small rural HCPs to survey and explain in detail the capabilities of Minnesota's 80+ telecommunications carriers may be unnecessarily burdensome and discourage project development. **A competitive bidding process would do more to encourage providers to improve their offerings.**

  Requiring proof of insufficient capacity relates to the issue of including urban health care providers in a network. Urban HCPs already have access to broadband services; what they are missing is access to the rural providers. Funding for infrastructure should assume varying levels of broadband access across the proposed network. Requiring proof of inadequate service across a proposed network could discourage health care network development between urban and rural HCPs.

- **Minimum broadband speed of 10 Mbps requirements for infrastructure projects may be unattainable for some rural health care providers; a more flexible approach is encouraged.** Modifying the FCC's current definition of broadband (768Kbps) is appropriate and aligns with recommendations in the National Broadband Plan. The plan, however, recognizes the varying requirements for types of health care providers, citing 4Mbps as appropriate for a small physician office, and increasing according to size of facility and type of health care provided. Requiring 10 Mbps for any provider attempting to participate in a networked solution may exclude certain rural or small providers. Setting standards for the industry while maintaining flexibility in accordance with the type of provider may be necessary to ensure broad participation and access.

  We support minimum standards for Quality of Service and latency as a component of any competitive bid. A required standard for latency of 10 milliseconds should be an expectation.

- **FCC should develop objective application scoring criteria for predicting successful, sustainable network projects.** The FCC noted in its comments that some of the Pilot projects were ill prepared and that a smaller amount of projects would allow USAC to devote greater resources to ensure success. We concur. The Pilot project did not go far enough in evaluating the projected success of each application prior to funding announcements. Instead, projects were subject to an open-ended examination of their sustainability, which caused significant delays and undue burden to existing projects. Predicted success and sustainability must be part of any thorough application review. Furthermore, program requirements should be spelled out in advance, not during the implementation process.

  Applications scoring criteria should include **clear project goals, evidence of sustainability and demonstrated organizational, business, financial and technical capacity. Those failing to meet the scored criteria should receive feedback, if possible, and have an opportunity to reapply for funding in subsequent years.** This early scrutiny will serve not only the FCC in ensuring the success of funded projects through targeted technical assistance, but will also assist those projects that do not meet the funding criteria to identify areas of improvement for future successful re-application.

- **Consider separate grants for planning and subsidies for implementation.** To address the disparity in preparedness among applicants and encourage network development, **the FCC should consider a two-tiered funding process using both planning grants and implementation subsidies.** Modeled on other government assistance programs, a two-part funding process would position potential applicants to identify needs, build partnerships, and prepare for implementation and further funding under the health infrastructure program. **One-year planning grants that cover expenses for consulting, feasibility studies, meetings, travel and other administrative costs associated with preparation, readiness, and network-building would position projects for a successful application for infrastructure funding in subsequent years.**

- **Eliminate requirement to provide financial analysis showing cost savings over 15-20 years if network deployed vs. existing service.** This requirement would be extremely burdensome to both rural and urban applicants. Given the pace at which technology is changing, it is almost impossible to project what technology will be available in 15-20 years and what it will cost, relative to current options. Projects could be encouraged to include such an estimate in a sustainability plan but it should not be required.

- **We support a prioritization methodology for funding, but question the use of HPSAs in the prioritization; rather, a measure of rurality or remoteness of rural sites should be considered as a third-tier prioritization**. We support the first two tiers of priorities: 1) total number of rural HCPs in proposed network; 2) total number of HCPs (both urban and rural). However, use of a HPSA score for urban providers is not an appropriate tool. Urban providers in a rural-urban network are likely to be medical centers or specialty clinics delivering care to remote sites; HPSA scores for these type of providers would not address need as much as consideration of remoteness or low density often experienced by rural health care providers in frontier regions.

- **A direct matching requirement should be limited to fifteen percent (15%).** Although the Broadband Technology Opportunities Program (BTOP) requires a 20% match and the Broadband Initiatives Program (BIP) funds 75% in grants and 25% in loans, the FCC recognizes from its experience with the Pilot Program that many rural applicants have difficulty even meeting a 15% matching requirement. There is a significant distinction between the three programs. The first two programs mean to stimulate large service providers and other organizations to build new services and programs. The health care infrastructure program proposes to serve a disadvantaged group of health care providers to provide safe, accessible health care. **We support no more than a fifteen percent direct HCP contribution.** This is attainable for most rural HCPs and yet requires participants to have a financial stake in the success of the network.

- **Eighty-five percent support for administrative expense and maintenance costs for five years is appropriate.** We support this proposed change from the Pilot Program, which allowed no such support. It will make a significant difference for projects whose lead organizations take on the responsibilities of network design and deployment, RFP preparation, vendor negotiation and selection, and other costs associated with project management. Continuing the support for five years from the first Funding Commitment Letter will give projects adequate time to fully deploy the network and build sustainability beyond the funding period. Personnel, travel, legal, training, program administration, technical coordination costs should be considered eligible during the initial five years of support, as they are costs necessary to the long-term success of the network.

HEALTH BROADBAND SERVICES PROGRAM

The NPRM proposes replacing the current internet access program, with its 25% flat discount (50% in entirely rural states) on monthly Internet access for rural HCPs with an expanded definition of funded services and a flat 50% discount for broadband services.

- **A flat 50 percent subsidy would significantly disadvantage remotely rural HCPs that need it most.** The NPRM is unclear as to whether the health broadband services program will replace both of the current telecommunications and internet access programs or only the internet program. **We support a minimum 50 percent broadband services discount for rural HCPs as one component of the Rural Health Care Support Mechanism, with further subsidy available to minimize or eliminate the rural/urban disparity for remotely located HCPs. We do not support a flat 50 percent discount for all rural HCPs.**

- **A minimum 4Mbps broadband speed should not prevent rural HCPs from participating in the program.** In keeping with the recommendation of the National Broadband Plan and supporting a goal of overall broadband development to support health care, 4Mbps is an appropriate minimum standard. However, there are concerns about whether small rural HCPs would be unable to access the recommended minimum due to unavailability and would therefore become ineligible for subsidy. There are still HCPs in rural areas of Minnesota that struggle to get a 1.5Mpbs connection due to limitations of local service providers and disinterest on the part of larger providers. For example, one northern Minnesota hospital with two remote clinics wants a higher level of service for its remote clinics but is unable to get it. The local service provider for that area has old equipment; it is looking to the hospital to pay for the needed upgrade, estimated at $700,000. The hospital cannot pay for the service provider's hardware upgrade, yet is limited by its access to any another service provider in its geographic area. **Rural HCPs with limited broadband access should not be required to bear the cost of service provider upgrades in order to participate in the broadband services program.**

- **Support for reasonable and customary installation charges for broadband access** (paragraph 100) equal to 50 percent would ameliorate the previous issue somewhat, but would not be sufficient to entice small service providers to stay current with standards.

- **We support the option for Pilot Program participants to transition into the Health Broadband Service Program without further competitive bidding.**

- **We support the expanded list of eligible health care providers, but believe EMS providers should also be eligible.** The addition of skilled nursing facilities and renal dialysis centers acknowledges that patient care is delivered across multiple health care settings. The proposal to add shared administrative and data centers acknowledges that many rural HCPs depend upon shared services to efficiently and effectively deliver quality patient care. However, one provider category that is critical to rural primary, emergency and trauma system care is **Emergency Medical Service (EMS).** Given the important role that rural EMS providers play in the delivery of rural health care, they should be on the list of eligible health care providers.

DATA GATHERING AND PERFORMANCE MEASURES

We support the FCC's efforts to evaluate the impact of its rural health care support mechanism and other federal programs. Collaboration with efforts in other federal agencies (such as HHS); direct data collection and analysis; and examination of existing data sources – including broadband mapping and surveys, aggregate adoption of health IT applications, and analysis of aggregate quality measures–would assist the FCC in determination of value and program effectiveness.

Do not require meaningful use of an EHR as a prerequisite to obtaining broadband support. The National Broadband Plan recommended aligning with other federal government criteria to measure efficient use of health IT, such as ONC/CMS's "meaningful use" of electronic health record criteria that certain eligible HCPs must meet in order to obtain incentive payments under Medicare and Medicaid. **This well-meaning suggestion does not belong as a component of this program for the following reasons**:

- **Rural hospitals and small providers are already behind on meaningful use.** Meeting the standards recently defined for meaningful use of an EHR is a significant burden for many small and rural providers. Data collected thus far indicates that a large number of these providers – rural non-profit and community providers – the very target for the Rural Health Care Support Mechanism – may not achieve meaningful use by 2016 and be subject to penalties under Medicare and Medicaid. Requiring HCPs to meet this HHS definition would create further and unnecessary burden.

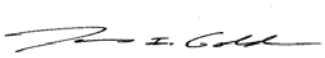
- **Meaningful use of an EHR does not measure the right thing.** Performance measures for health infrastructure investments that actually measure broadband network success, such as number of HIT services offered; network speed and reliability for participants; and achievement of project goals are appropriate measures of program and participant performance.

- **Not all program-eligible HCPs are required to meet meaningful use requirements.** Many HCPs eligible for the Rural Health Care Support Mechanism are not eligible for EHR incentive payments. These include community mental health centers, skilled nursing facilities, administrative centers, higher education teaching institutions, etc. Requiring meaningful use of EHRs for these providers would be overreaching and act as a barrier to participation.

- **The "cart before the horse".** The ability to exchange health information, a component of meaningful use, assumes a certain level of broadband connectivity to accomplish this exchange. Furthermore, telehealth and other applications that rely on data exchange require more bandwidth than many rural facilities currently have. Requiring use of either an EHR or any other health care application prior to getting adequate broadband is backwards. Broadband access should support development of these important health care applications.

Thank you for the opportunity to provide comment to the Commission on this matter.

Respectfully yours,



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