Rural Wisconsin Health Cooperative
Comments on Rural Healthcare Support Mechanism NPRM

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RE: RWHC comments relating to the matter of the Rural Healthcare Support Mechanism (WC Docket No. 02-60)

Organization Description

The Rural Wisconsin Health Cooperative was founded in 1979 in Sauk City, Wisconsin. Owned and operated by 35 rural, acute, medical-surgical hospitals, RWHC brings a large number of Wisconsin community hospitals (as well as their affiliated physician clinics, pharmacies, and long-term care facilities) under a single loose-knit organizational umbrella. RWHC's emphasis on developing an integrated network among freestanding entities distinguishes it from alternative approaches.

Here at RWHC we have long worked to assist our member hospitals to implement health information technology (HIT) and electronic health records (EHRs). In 2003 RWHC established the RWHC Wide Area Network (WAN) that was developed in response to the significant challenges and cost inequities rural providers face when trying to connect to the Internet and other facilities. The value philosophy of the WAN is that providers pay for one connection that gives them access to numerous trading partners, rather than paying for multiple point-to-point connections. Most RWHC WAN participants utilize the current rural support mechanism, and RWHC staff provides them with assistance navigating the USAC application process.

In 2005, a RWHC-led group of stakeholders received an AHRQ planning grant for developing a collaborative EHR infrastructure for Wisconsin hospitals. This planning work eventually led to the establishment of the not-for-profit RWHC Information Technology Network (RWHC ITN), which provides a shared datacenter, electronic health record applications, and 24/7 system support to four freestanding Wisconsin critical access hospitals (CAHs) and their affiliated physician clinics. **RWHC ITN is a participant in the FCC Rural Healthcare Pilot Program.**

The commentary in this response will therefore reflect a first hand knowledge of Pilot Program, Universal Service Fund, electronic health record implementation and support, and rural HIT related issues. Our overarching principle in addressing the NPRM is to ask whether the proposed changes in

fact further the goals of providing equitable broadband facilities (consistent with the legislative intent of the Telecommunications Act) to rural healthcare providers.

Comments on Topics Identified in the Notice

1. Proposed Health Infrastructure Program

As firm believers in the cost benefits of networks and as participants in the Rural Healthcare Pilot Program (and the first network to receive a funding commitment letter), we support an infrastructure program that specifically encourages the development and expansion of rural broadband networks. We recognize that rural hospitals choose to participate in a variety of different network structures. We support expanding funding to non-rural healthcare providers participating in rural broadband networks to the extent that (1) the funding used for non-rural providers is excess funding under the $400 million cap and not at the expense of rural provider access to funding that is by statute dedicated for rural purposes and (2) the program continues to be structured in a way that supports the voice and influence of rural providers in the broadband network.

We are concerned that the Health Infrastructure Program as proposed has the potential to shift available funding away from rural providers and toward broadband networks that may utilize the funding for purposes without a rural focus. We do not claim that the latter scenario should not be funded by the Infrastructure Program, but only that it should not be prioritized over rural providers networking together in order to reduce costs. RWHC is comprised of 35 member hospitals, some of which are freestanding and others of which are owned or affiliated by regional or multi-state systems. We believe that there needs to be flexibility in the Infrastructure Program to support these multiple choices by rural hospitals and communities.

Our primary concern with the proposed language is the exclusion of short term leases from eligibility. This language would significantly reduce the number of freestanding rural-provider networks that would be eligible for the program, since many rural networks will not be in a position to fund the capital costs (even if only 15%) associated with ownership, IRUs, or capital leases. The result will likely be that Infrastructure Program projects will almost always be managed and controlled by non-rural interests.

The rationale for excluding short-term leases from the Infrastructure Program is that "funding … should confer optimal long term interests in the funded network with the least amount of risk." It is unclear to us that prohibiting short-term leases either reduces costs or risk. Short term leases, when properly bid out, allow rural providers the flexibility to find the best broadband carrier for their current needs. This still leaves them the opportunity to change carriers if and when circumstances require.

The focus of reducing costs through networks should be on encouraging as many providers to join the network as possible, since that will maximize the chances of meeting everyone's connection needs and mitigate the need for participating providers to have more than one connection to fund. Whether network participants utilize a short-term lease or a capital lease should not be paramount and may not reduce program costs at all. We are one of the Pilot Program projects that entered into short term leases, and I think it is a misrepresentation to say we were "placed at greater risk and more dependence on the vendor than if they had obtained an ownership or long-term interest … for example if a vendor becomes

insolvent." In those circumstances where multiple carriers service a location, with a short term lease we have the flexibility to get the best competitive rate and to make a change if the insolvency scenario or simply a better offering were to materialize. In those circumstances where only one carrier has a build-out to the community, it is unclear whether a capital interest would necessarily protect the network any more than a short–term lease. In any case, insolvency does not make the infrastructure go away. Another scenario, building new infrastructure to a community that already has a carrier could significantly add to the total cost of ownership when compared to contracting with the existing carrier. We would be curious to see any data (either the real world insolvency dilemma examples or the clear cost benefits of capital leases) that could justify the out-of-hand exclusion of networks like ours from the Infrastructure Program. When considering risk, the Commission should ask whether requiring 20 and 30 year capital investments in what will become old technology is not a greater risk than supporting shorter term agreements that will allow providers to adopt new technologies (including wireless) as these become standard and possibly much lower cost solutions.

Given the above, we recommend the Health Infrastructure Program be changed in the following ways:

A. Eliminate the short-term lease exclusion and allow networks participating in the Infrastructure Program to determine whether capital or short term leases are the best value for their circumstances.

B. The Rural Healthcare Pilot Program had language that required more than a de minimis of rural providers to participate in the network for it to qualify for the program. While there is some proposed language that prioritizes rural provider networks, there seems to be no corresponding de minimis requirement in the NPRM. We encourage the agency to include language that safeguards the program from turning into something that loses its rural provider focus. Yes, allow non-rural providers to be funded, but ensure that rural providers have an appropriate paramount role in governing infrastructure projects that are funded through the rural support mechanism.

C. We also believe that the 15% match requirement may be too high, particularly for rural networks that represent the communities with a high urban/rural cost differential. We recommend considering a 10% match. We also recommend allowing in-kind contributions to count toward the match.

2. Proposed Health Broadband Services Program

We support the concept of creating a new health broadband services program, as long as the existing telecommunication program continues to fund our most rural communities at the urban/rural differential rate. As everyone knows, the smallest and most remote rural communities will have the very highest telecommunication costs, since there is a direct correlation between population size and the cost of any individual's telecommunication services. Remote, low population areas simply have fewer customers to pay for and support what is already a higher cost of a larger build out to a remote area. This reality is the reason we have the rural support mechanism. It's the same reason we had subsidy programs to bring telephone and electricity to rural America.

The proposed Broadband Services program is better than nothing, since it will help rural providers with a lower than 50% urban-rural cost differential, but it will not help those rural providers most in need of assistance, since providers in remote rural areas get a subsidy of 60, 70, even 90% or more through the Telecommunications (rural-urban differential) program.

A. We believe the 50% subsidy (though higher than the 25% Internet subsidy) is too low for dedicated connection costs. To increase utilization of the Broadband Program, the 50% should be raised to a point where more rural providers will be advantaged by participating. We believe that raising the subsidy percentage will increase the utilization of the program without exceeding the program's funding cap.

B. We are assuming that the $500,000 one-time costs discussed in the Broadband Program section are for infrastructure build-out, since otherwise rural providers that do not have access to networks in their region will be disadvantaged. Allowing $500,000 for infrastructure build out is an important step for helping the providers with the highest telecommunications cost reduce those costs over time. However, the 50% match requirement ensures that very few providers will be able to take advantage of this provision. The infrastructure build-out funding percentage should by changed to no less than what is allowed for the participants of the Infrastructure Program, which has been proposed at 85%. It is not reasonable to fund *non-rural* provider infrastructure build outs at 85% in the Infrastructure program, but to fund *rural* provider infrastructure build-out at only 50% in the Broadband Services Program.

3. Proposed Expansion of Eligibility Requirements

We strongly support the inclusion of the new rural provider types and of the rural provider controlled datacenters and administrative offices. Given that electronic health records and other HIT systems are often provisioned from remote datacenters, this eligibility change is overdue and should be implemented as soon as possible.

4. Proposed Prioritization Methodology

As indicated in our introductory statements, we do not believe that the Infrastructure Program, especially in its current form, should ever be allowed to create a situation where rural providers would see their level of funding either eliminated or reduced in the other programs. Additionally, we believe that the methodology for prioritizing Infrastructure projects should be first and foremost based on the number of rural healthcare providers in the proposed network, as is proposed.

5. Proposed Evaluation Measures (i.e. conditioning funding on "meaningful use.)

The proposal to make telecommunications funding contingent on meaningful use of electronic health records, if enacted, would dramatically reduce the funding available to our most needy rural providers, since small and rural providers are the most likely not to achieve meaningful use. CMS's Final HIT Incentive Rule estimates that between 40 and 75% of eligible professionals and 52% of critical access hospitals (the smallest rural hospitals) will not achieve meaningful use by 2016. These will generally be the providers with a higher rural/urban telecommunications cost differential. What could be the rationale for withholding basic telecommunications support from such a large group of disadvantaged providers (who by the way will already be paying penalties to CMS for their inability to meet the meaningful use standard)?

USAC eligibility should never be tied to meaningful use, because (1) it would create a double penalty and (2) it would ensure that non-meaningful users would likely never become meaningful users. How can you take away Broadband for not being a meaningful user, when Broadband is required in order to

achieve meaningful use? This provision could end up contributing to the closing of small hospitals that are near a death spiral and must be rejected.

We believe that evaluation measures should be clearly focused on the extent to which fund recipients are utilizing the subsidized broadband for healthcare related purposes, whether or not these purposes add up to comprehensive meaningful use. The Commission should consider developing an evaluation form that elicits detailed information on how the broadband is being utilized to benefit the provider's patients, whether that is for teleradiology (which allows for the expedited remote reading of radiology studies), telemedicine (which allows for remote consultations), accessing electronic health records (which may or may not equate to meaningful use), or other beneficial purposes.

6. Comments on the Existing Telecommunications Program

We are disappointed that the proposed changes create minimal benefit for the most disadvantaged providers, most of who will remain in the Telecommunications Program. Implementing the $500,000 infrastructure build-out provision in the Telecommunications Program (in addition to the Broadband Program) would be one way to enhance and eventually reduce the ongoing cost of the broadband services of those rural providers most in need of assistance. One way to handle this is for the FCC to allow providers to receive Broadband Program last mile support at 85% (as recommended above) and also to receive the urban/rural difference for the recurring service (rather than the Broadband Program 50%) when circumstances merit.

7. Administrative Burden

We support the proposal to make certain administrative expenses qualify for the Infrastructure Program and would like to see similar provisions for the other Universal Service programs. We believe that the NPRM does not go far enough to mitigate the complexity of navigating the program, which is one of the primary reasons that many rural providers do not participate. However, we appreciate that some of the complexity is due to safeguards in place to ensure that a reasonable selection process occurs. One way to address this problem is to fund the reasonable administrative expenses of providers participating in the Telecommunications and the Broadband programs.

Thank you for considering our comments.