

Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, DC 20554

In the Matter of:

Issues in the Rural Health Care Reform
Proceeding

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WC Docket No. 02-60

COMMENTS OF THE TELECOMMUNICATIONS INDUSTRY ASSOCIATION

TELECOMMUNICATIONS INDUSTRY ASSOCIATION

Danielle Coffey
Vice President, Government Affairs

Mark Uncapher
Director, Regulatory and Government Affairs

Brian Scarpelli
Manager, Government Affairs

TELECOMMUNICATIONS INDUSTRY ASSOCIATION
10 G Street N.E.
Suite 550
Washington, D.C. 20002
(202) 346-3240

Its Attorneys

August 23, 2012

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To: Chief, Wireline Competition Bureau

**COMMENTS OF THE
TELECOMMUNICATIONS INDUSTRY ASSOCIATION**

I. INTRODUCTION AND SUMMARY

The Telecommunications Industry Association (TIA) hereby submits comments to the Commission’s Public Notice in the above-referenced proceeding.¹ TIA supports the Commission’s efforts to transform America’s health care system through the power of broadband and information technology.² TIA is the leading trade association for the information and communications technology (“ICT”) industry, with hundreds of member companies that manufacture or supply the products and services used in global communications across all technology platforms. TIA represents its members on the full range of public policy issues affecting the ICT industry and forges consensus on industry standards. For over 80 years, TIA has enhanced the business environment for broadband, mobile wireless, information technology,

¹ Wireline Competition Bureau Seeks Further Comment on Issues in the Rural Health Care Reform Proceeding, WC Docket No. 02-60, DA 12-1166 (rel. July 19, 2012) (“PN”).

² See Comments on TIA, WC Docket No. 02-60 (filed Sept. 8, 2010) (“TIA RHC Support Mechanism Comments”).

networks, cable, satellite, and unified communications. TIA is accredited by the American National Standards Institute, and TIA's standards work³ has focused on vital technical areas, the most relevant to this proceeding being, in recent years, smart device communications and machine-to-machine ("M2M") connections.⁴ We support the Commission's efforts to develop a more robust record in the pending Rural Health Care reform rulemaking proceeding, particularly with regard to the proposed Rural Health Care Program's ("RHCP's") Broadband Services Program ("BSP").

First, TIA notes its long-standing support for the Commission's efforts in modernizing the rural health care program. We believe that since the Commission's last examination of this matter in 2010, further statistical evidence has emerged to indicate that rural health care providers will derive significant benefits from a modernized rural health care program. However, we strongly urge the Commission to be vigilant in adopting and applying flexible eligibility and compliance rules, and maintaining technology neutrality. We believe that the diversity in size, status, needs, etc. reaffirm these needs. Specifically, we support (1) the continued treatment of consortia as they are under the Rural Health Care Pilot Program ("RHCPP"); (2) the inclusion of urban sites in the RHCP; (3) the grandfathering of already-funded urban sites in order to avoid wasted investment; and (4) increased collaboration with other agencies to ensure that privacy and

³ TIA standards are available at <http://www.ihs.com/products/industry-standards/org/tia/list/index.aspx>. In addition, TIA publishes an annual report that includes the latest actions taken by each respective TIA engineering committee. See TIA, 2011-2012 Standards & Technology Annual Report (rel. Apr. 2012), available at http://www.tiaonline.org/standards/about/documents/STAR_2011-2012.pdf.

⁴ Engineering Committee TR-50 Smart Device Communications is responsible for the development and maintenance of access agnostic interface standards for the monitoring and bi-directional communication of events and information between smart devices and other devices, applications or networks. The TR-50 framework will make its functionality available to applications through a well-defined Application Programming Interface (API) that is agnostic to the vertical application domain (eHealth, Smart Grid, Industrial Automation, etc.).

security requirements on the exchange of health data are in line with program requirements under a practical and flexible framework.

Along the lines of flexibility related to eligible services and equipment, we urge the Commission from refraining the listing of specific services that would be eligible, and to instead allow evolving services and equipment to enjoy RHCP support by remaining as general as possible. We also note that this principle should apply to a request of the Commission to specifically state that at minimum the costs of routers and bridges associated with the installation of broadband services to an eligible health care provider be included under the RHCP.

II. IN SHAPING THE RURAL HEALTH CARE PROGRAM, THE COMMISSION SHOULD EMPHASIZE MAXIMUM FLEXIBILITY FOR ELIGIBLE PARTICIPANTS

A. TIA Reiterates Its Support of the Commission's Modernization of the Rural Health Care Program

TIA has long supported the Commission expanding and making permanent RHCPP, and we reiterate our support for the proposal to create a permanent health care BSP.⁵ The new BSP will be an important step toward expanding investment in broadband health care technology, while at the same time driving deployment of critical communications infrastructure for the delivery of health-services to rural areas, where broadband is unavailable or insufficient.

As it has been some time since the Commission's 2010 Notice of Proposed Rulemaking ("NPRM") was issued in this matter, we agree that it is appropriate to refresh the record with

⁵ See TIA RHC Support Mechanism Comments at 3-5.

broadband needs of rural health care providers in the areas of telemedicine, electronic health records (“EHRs”), other telehealth applications, service quality requirements, and potential cost saving from broadband connectivity.⁶ As detailed in TIA’s 2011 Market Review & Forecast,⁷ TIA’s research has found that a rapidly growing component of the data services market is machine-to-machine (“M2M”) services, which generated \$3.2 billion in 2011, or approximately 4 percent of the data services market. M2M connects communications machines and devices so they automatically transmit information, serving the growing demand for real-time information. M2M devices have traditionally been used by the trucking industry to help fleet owners track shipments, but have moved to, among other important areas, the healthcare market, which we consider to be among the fastest-growing M2M sectors. In healthcare, cardio, diabetes and blood pressure readings can be sent automatically to physicians, and the onset of problems can be quickly determined. In addition, inventory tracking can provide automatic re-ordering and more efficient inventory control over crucial pharmaceuticals in a hospital pharmacy.

TIA believes that there is , since 2010, ample evidence which shows that health care providers have and will continue to experience numerous benefits as a result of M2M services. For instance, a heightened ease in implementing telemedicine and telehealth applications will result in an increase in the quality of health care delivered, as well as more efficient time and resource management.⁸ The healthcare industry is finding numerous applications for high-speed

⁶ PN at 17-18.

⁷ This data, as well as all other projections and statistics provided in this document which are not cited to otherwise, are derived from the *TIA 2011 ICT Market Review & Forecast*, a proprietary annual publication from TIA containing distilled data and analysis on information and communications technology industry trends and market forecasts through the end of 2014. This document is available for purchase at http://www.tiaonline.org/market_intelligence/mrf/.

⁸ See FCC, Wireline Competition Bureau Evaluation of Rural Health Care Pilot Program Staff Report, WV Docket No. 02-60, DA 12-1332 (rel. Aug. 13, 2012) at ¶¶ 63-75 (“FCC RHCPP Staff Report”).

wireless networks: hospitals with mobile staffs are ideal locations for wireless local area networks (“WLANs”), which allow (for) constant communication; practitioners can access patient information at their bedsides, enabling faster responses to emergency situations. Additionally, through telemedicine, patients in remote areas can now have access to doctors and testing facilities previously available only at the largest medical centers.

B. The Diverse Needs of Participants Highlights the Need for Flexibility in Broadband Services Program Compliance Rules

As rural health care broadband solutions proliferate and benefits are realized, increased use will inevitably result in higher bandwidth needs, highlighting the need for flexibility in implementation on the part of the Commission. Based on the variety of participants and their needs, we urge the Commission to take as broad a view as possible on the types of services and equipment that can be funded. If the Commission structures the RHCP in a way that maximizes flexibility, both with respect to the types of applicants and projects eligible for support and with regard to the types of broadband networks that might be relied upon by health care providers, the program’s funding choices will be driven by the demands and preferences of these providers and their patients – the parties best suited to evaluating which services will best advance the nation’s health-care needs.

First, in regard to entity eligibility, the Commission asks a number of questions on whether to continue RHCPP participation parameters for consortia,⁹ and whether to allow for

⁹ See PN at 5.

participation by urban health care providers in the BSP.¹⁰ Based on our position that the Commission should ease restrictions that would limit funding to worthy projects as much as possible,¹¹ as well as the successful nature of the RHCPP,¹² we support the continuation of the treatment of consortia.¹³ However, we believe that excluding urban sites from the program would be inappropriate,¹⁴ and would have a detrimental effect on network design and efficiency, and thus harm the overall effectiveness of the BSP. The Commission has recently noted that RHCPP projects benefited significantly from the inclusion of urban health care providers in their networks,¹⁵ and a number of health care providers have reinforced to the Commission the need for inclusion of urban providers.¹⁶ Finally, we believe that it will be crucial in the transition from the RHCPP to a permanent RHCP, that urban sites already funded under the RHCPP be grandfathered under the BSP in order to avoid wasted investment.

While the benefits noted above are generally widely acknowledged, as the Commission has recently noted, many RHCPP projects are at widely disparate levels of funding and

¹⁰ See PN at 5-8.

¹¹ See TIA RHC Support Mechanism Comments at 8-9.

¹² FCC RHCPP Staff Report at ¶ 108 (“The universal service support provided through the Pilot Program has done much to foster the creation and extension of broadband networks of health care providers throughout the country. The Pilot projects successfully demonstrate the value of broadband connectivity among rural and urban health care providers. They offer numerous examples of how telemedicine and other telehealth applications provided over broadband can produce better quality health care for patients in rural areas, better access to medical specialists, and lower health care costs.”).

¹³ For example, the Commission notes that the consortium bulk buying capability of multiple HCPs, combined with the RFP and competitive bidding process, has enabled many Pilot projects to obtain lower rates for services and to realize other purchasing efficiencies. *See Id.* at ¶ 81-83. The Commission also concludes in this report that the RHCPP “demonstrates the cost savings, relative administrative simplicity, and network-facilitating value of a consortium approach.” *Id.* at ¶ 110.

¹⁴ See PN at 7-8.

¹⁵ See FCC RHCPP Staff Report at ¶ 88-90.

¹⁶ See, e.g., Comments of the New England Telehealth Consortium, WC Docket No. 02-60, at 3 (filed Sept. 7, 2010).

implementation.¹⁷ As more and more projects are completed, and health care provider staff and patients experience the benefits brought on by increased broadband connectivity to health care providers, there will be an inevitable need for increased bandwidth. Those projects, supplemented by other Federal efforts such as the Centers for Medicare & Medicaid Services' ("CMS") Medicare Advantage EHR program,¹⁸ as well as various state government-level efforts, health care providers will greatly increase their use of broadband-enabled solutions. The Commission's own analysis of the RHCPP demonstrated that as of January 2012, 80 percent of the program participants purchased connections above 3 Mbps, and 69 percent purchased 10 Mbps or greater connections.¹⁹ However, we agree with the Commission that "because a wide variety of HCP types are eligible for support under the Act, different categories of HCPs will have different bandwidth needs and financial resources to pay for those needs."²⁰ Furthermore we reiterate that the Commission should/must remain vigilant in ensuring technology neutrality, and provide program participants the flexibility to select the technology platform that suits their needs in an economical way.²¹ Commission rules should not unintentionally curtail the use of any specific technology platform that could be well positioned to provide service. For these reasons, TIA urges the Commission to adopt parameters which are as flexible as possible for bandwidth and quality of service ("QoS") features for the BSP and RHC programs.

¹⁷ See FCC RHCPP Staff Report at ¶ 28-33. In this area of the report summarizing awards, commitments, and disbursements as of January 2012, the Commission describes how "projects are in widely different stages of completion and spending," noting that "[o]nly about 28 percent of projects (14) had received disbursements of over half of their award, as of January 30, 2012."

¹⁸ See, e.g., Government Accountability Office ("GAO"), *Number and Characteristics of Providers Awarded Medicare Incentive Payments for 2011*, GAO-12-778R (Jul. 26, 2012), available at <http://www.gao.gov/products/GAO-12-778R?source=ra>.

¹⁹ See FCC RHCPP Staff Report at ¶ 53.

²⁰ *Id.* at ¶ 62.

²¹ See TIA RHC Support Mechanism Comments at 10-13.

Regarding the Commission’s inquiry into whether privacy and security requirements applicable to health care data exchange will affect health care providers broadband service quality needs,²² we note that as of the latest proposal from CMS, Meaningful Use Stage 2 would require EHR incentive program recipients to “provide patients the ability to view online, download, and transmit information about a hospital admission.”²³ Further complicating the issue, the Department of Health and Human Services’ (“HHS”) Office for Civil Rights (“OCR”) already solely enforces the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”)²⁴ Privacy Rule, which protects the privacy of individually identifiable health information, as well as the HIPAA Security Rule, which sets national standards for the security of electronic protected health information. We have noted²⁵ for CMS that its proposal under Stage 2 Meaningful Use may therefore be supplanting OCR’s role in its enforcement of the Health Information Technology for Economic and Clinical Health (“HITECH”) Act²⁶ and HIPAA. While CMS’ decision remains to be finalized, we strongly urge the Commission to consult with HHS and CMS in determining practical and flexible QoS requirements.

²² PN at 18.

²³ *Medicare and Medicaid Programs; Electronic Health Record Incentive Program—Stage 2*, Department of Health and Human Services Centers for Medicare & Medicaid Services, CMS-0044-P, 77 Fed. Reg. 13718-13720 (March 7, 2012).

²⁴ Pub. L. No. 104-191, 110 Stat. 1936 (1996), *codified*, as amended, at 42 U.S.C.A. §1320 *et seq.*

²⁵ See Comments of TIA to CMS, Medicare and Medicaid Programs; Electronic Health Record Incentive Program--Stage 2, CMS-0044-P (filed May 7, 2012), *available at* <http://bit.ly/OngeNs>.

²⁶ Pub. L. No. 111-5 (2009), at § 13000 *et seq.*

III. THE COMMISSION'S BROADBAND SERVICES PROGRAM SHOULD CONTINUE THE RURAL HEALTH CARE PILOT PROGRAM'S SUCCESSFUL POLICY ON ELIGIBLE SERVICES AND EQUIPMENT

In the PN, the Commission asks a number of questions related to eligible services and equipment. Specifically, the Commission seeks comment on the term “point-to-point” connectivity and whether it should enumerate services that would qualify for funding under the BSP.²⁷ We reiterate our position that eligible health care providers participating in the BSP should be able to choose their preferred technology platform, so long as it is capable of meeting their needs. We note that this is in alignment with the National Broadband Plan, which found that “[t]he connectivity needs of different health delivery settings will vary depending on their type and their size.”²⁸ The Commission’s RHCPP, in TIA’s view, is an excellent example of an approach that includes this type of project and design flexibility. As the Commission has highlighted, projects funded by the RHCPP have involved different platforms (e.g., wired, wireless) for providing broadband capacity tailored to meet the varied demands of health care providers.²⁹ Finally, we note that Section 254 of the Communications Act³⁰ requires that competitively neutral rules govern access to advanced telecommunications and information services for health care providers. Accordingly, we urge the Commission that, rather than “enumerate a wide range of connectivity solutions,” the Commission be more general “in

²⁷ See PN at 9-10.

²⁸ Federal Communications Commission, *Connecting America: The National Broadband Plan* (Mar. 16, 2010) at 210-211.

²⁹ See *Rural Health Care Support Mechanism*, Notice of Proposed Rulemaking (rel. July 15, 2010) at ¶ 50, n. 104 (highlighting the wired and wireless network plans of the Rural Wisconsin Health Cooperative Information Technology Network and the Michigan Public Health Institute).

³⁰ 47 U.S.C. § 254.

recognition of the likely change and evolution of services utilized by health care providers that will occur over time.”³¹

The Commission also requests input on the American Telemedicine Association’s recommendation that, at minimum, the BSP support the costs of routers and bridges associated with the installation of broadband services to an eligible health care provider.³² We again urge the Commission to take a very broad view of the types of services and equipment that can be funded.³³ Eligible equipment should include any that is used to form networks amongst consortium members.

³¹ PN at 10.

³² *Id.*

³³ See TIA RHC Support Mechanism Comments at 8.

IV. CONCLUSION

For the foregoing reasons, TIA encourages the Commission to take action in this proceeding consistent with the recommendations set out above.

Respectfully submitted,

TELECOMMUNICATIONS INDUSTRY ASSOCIATION

By: /s/ Danielle Coffey

Danielle Coffey
Vice President, Government Affairs

Mark Uncapher
Director, Regulatory and Government Affairs

Brian Scarpelli
Manager, Government Affairs

TELECOMMUNICATIONS INDUSTRY ASSOCIATION
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Suite 550
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