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I. The Commission Should Proceed With Caution Before Adopting Final Rules That Implement Its Proposed Health Infrastructure Program.

When the Commission adopted its rural health care pilot program (Pilot Program) in 2006, it emphasized the interim nature of this program and explained that the results from the three-year Pilot Program would inform the Commission’s reexamination of the entire rural health care program.¹ To that end, the Commission committed to publishing a “report detailing the results of the [Pilot Program] and the status of the health care mechanism generally, and recommend[ing] any changes that are needed to improve the programs. In addition, we intend to incorporate the information we gather as part of this pilot program in the record of any subsequent proceeding.”² While the Commission states that its proposed Health Infrastructure Program “[b]uild[s] on lessons learned from the existing Rural Health Care Pilot Program,”³ we think the Commission should first complete the report before it moves to implement the new Health Infrastructure Program. In fact, we recommend that the Commission issue a further notice of proposed rulemaking regarding its Health Infrastructure Program proposal at the conclusion of the Pilot Program and after the release of its Pilot Program report to ensure that parties can provide informed comment on the proposal.

There is a second, equally important, reason to move the proposed Health Infrastructure Program on a separate and slower track from the Commission’s proposed Health Broadband Services Program, which would provide support for half of a rural health care provider’s monthly recurring costs for broadband services. As noted by Verizon in its comments, “[rural

¹ *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 21 FCC Rcd 11111, ¶ 9 (2006) (*Rural Health Care Pilot Program Order*) (describing the Pilot Program as a “trial program”).

² *Id.*

³ *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Notice of Proposed Rulemaking, FCC 10-125, ¶ 3 (rel. July 15, 2010) (*NPRM*).

health care] support for network construction would also be additive of broadband facility support that the Commission envisions distributing in rural areas through the new Connect America Fund and the Mobility Fund.”⁴ Specifically, the Commission proposed to repurpose its existing high-cost fund, which disburses over \$4 billion/year, to target support to constructing broadband infrastructure in unserved areas,⁵ a goal that AT&T has supported for several years. This infrastructure could and would support advanced broadband applications used by rural health care providers and other anchor institutions, in addition to providing broadband Internet access to residents of high-cost areas, including consumers with low-incomes. In addition, the 2009 American Recovery and Reinvestment Act (ARRA) has targeted billions of dollars to fund deployment of broadband infrastructure throughout the country. The carriers and other service providers deploying that infrastructure, over time, likely will leverage their investment in those facilities by gradually extending their broadband networks to serve new, contiguous areas. In short, the Commission and other government agencies already have in place a number of programs, or are considering implementing new programs, to encourage deployment of broadband infrastructure that could be used to provide advanced telemedicine to health care providers in rural areas – programs that could, and likely would, render funding under the proposed Health Infrastructure Program redundant⁶ To make the most efficient use of its

⁴ Verizon Comments at 3.

⁵ *Joint Statement on Broadband*, GN Docket No. 10-66, 24 FCC Rcd 3420 (rel. March 16, 2010) (“The nearly \$9 billion Universal Service Fund (USF) and the intercarrier compensation (ICC) system should be comprehensively reformed to increase accountability and efficiency, encourage targeted investment in broadband infrastructure, and emphasize the importance of broadband to the future of these programs.”). See also *Connect America Fund, A National Broadband Plan for Our Future, High-Cost Universal Service Support*, WC Docket Nos. 10-90, 05-337, GN Docket No. 09-51, Notice of Inquiry and Notice of Proposed Rulemaking, at ¶ 17 (rel. April 21, 2010) (*Connect America Fund NOI/NPRM*).

⁶ See, e.g., American Telemedicine Association Comments at 3 (noting that the proposed program duplicates, and possibly conflicts with, the efforts of the Broadband USA program).

limited universal service dollars, it therefore seems prudent for the Commission to take a step back from its proposed Health Infrastructure Program until it issues final rules in its Connect America Fund proceeding and until all of the ARRA-funded grants have been awarded and construction using those dollars has begun. In the interim, the Commission should focus its initial rural health care reform efforts on implementing and adequately funding its proposed Health Broadband Services Program.

If the Commission nevertheless decides to proceed based on the record developed in response to the existing *NPRM*, we urge it to consider the following points.

A. The Commission Should Target Funding To “Unserved” Areas Only.

The Commission proposes that up to \$100 million/year be made available for the construction of dedicated broadband networks that connect health care providers where the “existing broadband infrastructure is inadequate.”⁷ Elsewhere in the *NPRM* the Commission proposes that 10 Mbps should be the minimum speed that is deemed adequate for purposes of receiving support from the Health Infrastructure Plan.⁸ Several commenters appropriately expressed concern that, taken together, these two Commission proposals could result in universal service-funded overbuilds of existing broadband networks and services.⁹ With a universal service contribution factor that shows no sign of ever dipping below 10 percent again, we agree with these commenters that it would be inappropriate for the Commission to award scarce universal service dollars so that participants could construct “redundant networks in areas where

⁷ *NPRM* at ¶ 13.

⁸ *Id.* at ¶ 20.

⁹ *See, e.g.*, NTCA Comments at 2-3, 6 (explaining that these overbuilds could have the unintended effect of undermining broadband deployment in rural America by devaluing existing investments); Verizon Comments at 3-4.

high-capacity services are already available.”¹⁰ This view is shared by several other commenters, including health care providers.¹¹

If the Commission continues on a fast track to implement its proposed Health Infrastructure Program, we recommend that it only award funding to areas in which broadband is not available (versus those areas that have broadband but at speeds that are less than, for example, 10 Mbps). It is entirely appropriate to limit funding in this manner given the well-known constraints on the universal service fund.¹² This approach is consistent with the Commission’s proposal to target, at least initially, high-cost Connect America Fund support to “unserved areas.”¹³ In addition, we recommend that the Commission adopt a process as suggested by NTCA that would ensure the opportunity for public comment on an applicant’s assertion that broadband infrastructure is unavailable in a particular area.¹⁴ Not only should the Commission establish a public comment period for all Health Infrastructure Program applications, the Wireline Competition Bureau should be required to review any response to an applicant’s proposal and issue an order with findings regarding whether the applicant-identified area is truly unserved before the Commission could select that application for funding. In

¹⁰ NTCA Comments at 3.

¹¹ See, e.g., Virginia Telehealth Network Comments at 36 (urging the Commission to redirect proposed Health Infrastructure Program funds to the Health Broadband Services Program, where that funding “can produce immediate and substantial benefits”) and 37 (recommending that the Commission allow other federal broadband funding mechanisms to work “before layering on another USF program that creates a silo-ed broadband infrastructure”).

¹² See *National Broadband Plan* at 143 (“USF resources are finite, and policymakers need to weigh tradeoffs in allocating those resources. . . .”).

¹³ *Connect America Fund NOI/NPRM* at ¶ 43.

¹⁴ See NTCA Comments at 4-6 (recommending that the Commission establish a 60-day comment window that would allow interested parties the opportunity to submit their own data).

addition, the Commission should seek comment on the criteria it will use to evaluate applications and it should explain how its selected applicants meet these published criteria.

B. The Commission Cannot Allow Health Care Providers To Obtain An Ownership Interest In The Constructed Facilities.

In the *NPRM*, the Commission proposes that Health Infrastructure Program participants be required to “have an ownership interest, indefeasible right of use (IRU), or capital lease interest in facilities funded by the program.”¹⁵ The Commission purports to justify this proposed requirement on the grounds that “*if* a vendor becomes insolvent, a project that does not have an IRU or ownership interest could be left with a non-operational network . . .,” and “once the term of the [short-term or operating lease for network access] expires, the participant *could* potentially lose access to the network.”¹⁶ While the Commission asserts that it bases this proposal on its Pilot Program experience, it points to literally nothing to suggest that the concern animating the proposal is anything more than pure speculation. Not surprisingly, given the lack of any evidence that the Commission’s proposal is anything more than a solution in search of a problem, numerous parties expressed concerns about or outright opposed adoption of such a requirement.¹⁷ For example, several health care providers expressed concern about being forced into becoming communications service providers – a role that they are ill-equipped to perform. Health care providers are in the business of providing quality medical services, not owning and operating a telecommunications network. We agree with Qwest’s comments that it makes no

¹⁵ *NPRM* at ¶ 55.

¹⁶ *Id.* (emphasis added).

¹⁷ Charter Comments at 9; Fort Drum Regional Health Planning Organization Comments at 5-6; GCI Comments at 13; Qwest Comments at 2-7.

sense to require health care providers to spend the time and resources necessary to manage a complex telecommunications network.

A number of service providers opposed the proposal, noting that it would likely dissuade them from participating in any Health Infrastructure Program. In its comments, for example, Qwest explained that this proposal would “likely render Qwest unable to participate in the rural health care broadband infrastructure program.”¹⁸ Among other reasons, Qwest explained that if it were required to grant a financial interest in its facilities constructed with rural health care dollars, “it would potentially be in breach of certain financial agreements with lenders;” “[a]greeing to obligations that would restrict Qwest’s ability to enhance, upgrade, or use its network or assets, or that would limit its ability to make strategic business decisions related to its network, customers, and competitive positioning could be detrimental to Qwest’s shareholders,” to whom it has a fiduciary obligation; “Qwest may not have the right to grant a security interest in the entire end-to-end network” that would be constructed with rural health care dollars; and “IRUs or long-term leases are typically provided based on the end-to-end locations of the circuits being provisioned to support a finished service” and that, for “rural health care broadband infrastructure projects, both non-funded and funded Qwest-owned facilities are likely to be used.”¹⁹ If Qwest could not use non-funded existing facilities to provide the finished services, “it would need to build redundant facilities that mirror the existing Qwest facilities,” which plainly is an inefficient use of universal service dollars and where those funded facilities do not provide a stand-alone network, “an IRU or other ownership interest in those funded facilities

¹⁸ Qwest Comments at 5.

¹⁹ *Id.* at 5-6.

would provide a bridge to nowhere.”²⁰ Obviously, the Commission should act cautiously before taking any action that would dissuade providers of broadband services from participating as potential bidders in this new program.

Wholly apart from these practical considerations weighing against adoption of such requirement, it is by no means clear that the Commission would have authority to adopt it. Indeed, the language of section 254(h) of the Communications Act of 1934, as amended (Act) suggests that the Commission can provide support for the provision of advanced telecommunications and information services to health care providers, and for the extension of networks to provide such services, only to telecommunications carriers.²¹ While the Commission reasonably interpreted section 254(h) to permit it to provide funding for internal connections provided by non-telecommunications carriers in schools and libraries, it did so based on language in section 254(h)(2)(A) making clear Congress’s intent that the Commission establish rules to ensure access to advanced telecommunications and information services for “classrooms,” which would require that internal connections be upgraded to accommodate such services. In contrast, nothing in the language of section 254(h) suggests that Congress intended that the Commission provide support for internal connections for health care providers. Rather, the language plainly limits support only for advanced telecommunications and information services provided by telecommunications carriers. And, insofar as section 254(h) contemplates funding for infrastructure to provide health care providers access to broadband services, it plainly limits such support to infrastructure to connect to a carrier’s network – not for a broadband

²⁰ *Id.* at 6.

²¹ 47 U.S.C. §254(h)(1)(A), (2)(B).

network owned and operated by the health care provider itself.²² The Commission thus may not require Health Infrastructure Program participants to “have an ownership interest, indefeasible right of use (IRU), or capital lease interest in facilities funded by the program,” as proposed in the *NPRM*, it also may not *allow* them to do so.²³

C. The Commission’s “Shared Use” Proposal Is Both Confusing and Troubling.

The Commission devotes several pages to discussing whether and how Health Infrastructure Program participants could “share” any excess capacity in their rural health care-funded network with non-eligible entities consistent with the requirements of the Act. In particular, the Commission acknowledges that section 254(h)(3) provides that “[t]elecommunications services *and network capacity* provided to a public institutional telecommunications user under this subsection may not be sold, resold, or otherwise transferred by such user in consideration for money or any other thing of value.”²⁴ The Commission nevertheless asserts that sharing excess capacity with the community, for-profit entities, or some other ineligible entity would not violate this prohibition “because, in such instances, health care providers would retain ownership of the additional capacity, and the payments to the network for the use of such additional capacity would be retained to sustain the network,” and seeks comment on this analysis.²⁵ The Commission fails, however, to provide parties sufficient information regarding what, exactly, it is proposing to enable parties to comment on its proposal

²² 47 U.S.C. § 254(h)(2)(B) (requiring the Commission to establish rules “to define the circumstances under which a telecommunications carrier may be required *connect its network* to such public institutional telecommunications users.” Emphasis added).

²³ *NPRM* at ¶ 55.

²⁴ *Id.* at ¶ 82 (citing 47 U.S.C. § 254(h)(3) (emphasis added)).

²⁵ *Id.* at ¶ 82.

and analysis. For this reason alone, the Commission should defer action on this new program until it provides a more complete explication of its proposal. At a minimum, the Commission must defer action on its shared use proposal until it explains how that proposal would work so that parties can evaluate whether and how it would comply with the plain language of section 254(h)(3).

While there is universal agreement that the “Telecommunications Act of 1996 is not a model of clarity,”²⁶ the blanket prohibition against resale contained in section 254(h)(3) is strikingly clear. That provision clearly and unequivocally provides that *any* telecommunications services or network capacity provided to a health care provider at discounted rates under section 254(h) may not be “sold,” “resold,” or “otherwise transferred” “for money or *any other thing of value*.” The sweeping language of this provision thus would appear to preclude health care providers from sharing any services or network capacity funded through universal service to any other entity. In its *Universal Service First Report and Order*, the Commission seemed to acknowledge as much, noting that the “Joint Explanatory Statement [in the legislative history of this provision] explains that this section ‘clarifies that telecommunications services and network capacity provided to health care providers . . . may not be resold or transferred for monetary gain.’”²⁷

In the decade following the *Universal Service First Report and Order*, no one questioned that health care providers obtaining services or capacity funded through universal service could not share such capacity or services with other entities. However, in its 2007 *Rural Health Care*

²⁶ *AT&T Corporation, et al. v. Iowa Util. Bd., et al.*, 525 U.S. 366, 397 (1999).

²⁷ *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, 12 FCC Rcd 8776, ¶ 717 (1997) (quoting Joint Explanatory Statement at 133) (*Universal Service First Report and Order*).

Pilot Program Selection Order (i.e., in the order identifying which entities would receive funding under the Rural Health Care Pilot Program, not in the order actually establishing the program), the Commission for the first time suggested that, notwithstanding the plain language of section 254(h)(3), entities purchasing subsidized services or network capacity might share capacity with ineligible entities. Specifically, the Commission stated that “[a] selected participant cannot sell its network capacity supported by funding under the Pilot Program but could share network capacity with an ineligible entity as long as the ineligible entity pays its fair share of network costs attributable to the portion of network capacity used.”²⁸ This statement (which, like AT&T, many parties likely missed because it was buried in an order selecting participants in the Pilot Program) is as clear as mud, making it impossible to determine whether and how shared use of facilities funded through the Pilot squares with section 254(h)(3), and thus whether the Commission’s shared use proposal here violates the statute. One of the commenters, Health Information Exchange of Montana (HIEM), reads that sentence to mean that a Pilot Program participant can pay, out of its own pocket (i.e., neither using universal service dollars nor any part of the participant’s 15 percent required Pilot Program contribution), to construct capacity beyond that which it sought in its application, and to share such excess capacity with others. HIEM suggests that, since this added capacity was not purchased with rural health care dollars, the resale restriction of section 254(h)(3) does not apply and the participant is permitted to resell that excess capacity to ineligible users.²⁹ While it is by no means clear that even that arrangement is consistent with section 254(h)(3), if that is, in fact, what the Commission intended to say, it must make itself clearer in its final order, because the more natural reading of

²⁸ *Rural Health Care Support Mechanism*, WC Docket No. 02-60, 21 FCC Rcd 11111, ¶ 107 (2007) (*Rural Health Care Pilot Program Selection Order*).

²⁹ HIEM Comments at 6.

that sentence in the *Rural Health Care Pilot Program Selection Order* (and the references to that sentence in the *NPRM*) is that a rural health care provider that has received support to deploy broadband facilities may resell excess network capacity on those universal service-funded facilities to a local business,³⁰ for example, so long as the local business pays its “fair share” for the capacity it uses. Of course such a proposal would violate section 254(h)(3) and must be rejected.

Assuming that HIEM’s interpretation of the Commission’s order is correct and the Commission’s shared use proposal has made it over the section 254(h)(3) statutory hurdle, other commenters have identified several concerns that the Commission must address before it could adopt that proposal. As Verizon notes, the *NPRM*’s shared use paragraphs highlight how an infrastructure program that supports shared-use facilities could become so complicated that it could make the Health Infrastructure Program “unworkable.”³¹ Together with the Commission’s proposed ownership requirements, its proposed shared use rules would turn health care providers into communications service providers, a role that they are not well-suited to perform and that many have indicated they do not want. Additionally, solely because of their receipt of rural health care support, participants could be in the position of having excess network capacity to lease to other entities. This raises significant policy issues that the Commission has never, to date, addressed such as, would this Commission proposal have the effect of undermining investment by private sector rural broadband providers?³² What Commission regulations,

³⁰ The Commission sought comment on whether it should encourage Health Infrastructure Program participants to provide “additional capacity” to local businesses. *NPRM* at ¶ 78.

³¹ Verizon Comments at 5-6 (noting the *NPRM*’s suggestion that rural health care providers “engage in the same kind of fully-distributed cost and common cost allocations as network providers”).

³² NTCA Comments at 2-3.

beyond the cost allocation requirements noted in the *NPRM*, would govern such a transaction? For example, would the participant be subject to competitive bidding requirements if it were to sell excess capacity to a school or some other governmental entity? There likely are other issues that the Commission would have to address, but until the Commission provides more detail concerning its shared use proposal, how it would work, and how the Commission would square that proposal with the prohibition in section 254(h)(3), parties simply are in no position to provide the Commission the input it needs. Accordingly, the Commission should hold off on adopting its shared use proposal until that proposal is more fully baked, and parties have had a reasonable opportunity to comment on it.

D. The Commission Should Reconsider Its Proposed Minimum Connectivity Speeds.

The Commission proposed setting 10 Mbps as the “minimum broadband speed for infrastructure deployment supported under the health infrastructure program.”³³ As several parties pointed out, the Commission has failed to justify any such requirement. As an initial matter, and as noted by Qwest, the Commission has failed to indicate whether the minimum broadband speed requirement is for actual speeds, downloads, uploads or both,³⁴ making it impossible for AT&T and other parties to meaningfully evaluate the merits of the Commission’s proposal. In any event, based on our experience providing broadband services to health care providers, it is far from clear that such a requirement is necessary. In this regard, we agree the American Hospital Association that a 10 Mbps minimum speed requirement could result in

³³ *NPRM* at ¶ 20.

³⁴ Qwest Comments at 7.

“unnecessary expenditures and preclude the use of cost-effective technologies that could adequately serve the needs of rural facilities. . . .”³⁵ As Qwest explains, the increased cost of deploying and maintaining a higher-speed network, and purchasing higher-speed broadband services, “even when subsidized, may render obtaining the network and the service unaffordable to rural healthcare providers,” which, of course, is at odds with the stated goals of the proposed Health Infrastructure Program.³⁶ And as the American Telemedicine Association points out, such “extreme overbuilding of networks will drain funds away from other eligible applicants, cause substantial delays in the rollout of this program and lead to widespread misuse of universal service healthcare funds for non-healthcare activities.”³⁷

For these reasons, the Commission should reconsider its proposal to establish a minimum speed for projects funded under the proposed Health Infrastructure Program and, instead, evaluate requests for funding based on whether the proposed rural health care-funded facilities will support the applications that the health care providers need.³⁸ As we noted above, the Commission’s priority should be to target funding to unserved areas. In doing so, it should not preclude applicants from selecting certain technologies because of some Commission-established, unnecessarily high minimum speed or, for that matter, reject otherwise meritorious applications as too expensive because the applicants were required to request support to construct a proposed network designed to the 10 Mbps standard.

³⁵ American Hospital Association Comments at 5.

³⁶ Qwest Comments at 7.

³⁷ American Telemedicine Association Comments at 13.

³⁸ *See id.* (explaining how the *NPRM*’s “artificially high minimum speeds are considerably above current telemedicine usage in almost all of the existing telemedicine networks except in very limited cases”).

E. The Commission Should End The Pilot Program’s Backbone Duopoly.

Predictably, NLR (and Internet2 to a far lesser extent) seek to justify the Commission’s proposal to cement their favored status as the only backbone providers for the rural health care program by attempting to distinguish their backbones from those of commercial providers, like AT&T. Their attempts miss the mark in all respects and the Commission should modify its proposed rules to make clear that competitive bidding requirements should apply to all aspects of the proposed Health Infrastructure Program. NLR, for example, trots out several unfounded claims that it raised previously with NTIA, claims that we refuted in our comments and thus will not address here.³⁹ NLR offers several new arguments that are equally unpersuasive. For example, NLR asserts that, because its network is “owned, managed and controlled by its members who are members of the research and education community,” it “is therefore not constrained by third-party rules.”⁴⁰ However, NLR provides no explanation of precisely to which “third-party” rules it refers, much less explain why or how that is a benefit that would justify granting them favorable status as one of only two backbone providers for the rural health care program.

Additionally, after explaining the importance of the competitive bidding process (“to ferret out the best solution to the need at hand,” factoring in “price, delivery, management, experience, and financial wherewithal”), NLR states that these factors “are not necessarily appropriate for non-profits, such as NLR.”⁴¹ NLR does not explain why this is the case. Instead,

³⁹See AT&T Comments at 8-10 (disputing NLR’s assertions that commercial backbones are not “optimized to support advanced broadband applications” like telepresence and telemedicine and commercial networks do not offer “next generation Internet technologies like IPv6 and IP multicast,” which are critical to certain applications). See NLR Comments at 4 (raising these same arguments).

⁴⁰ NLR Comments at 4.

⁴¹ *Id.* at 4-5.

it merely lists the following characteristics, which NLR seems to believe demonstrate why it need not be subject to the Commission's competitive bidding requirements: NLR: "is a not-for-profit organization;" "is a dedicated, nationwide backbone;" "provides access to advanced telecommunications and information services;" "is more reliable and stable than the public Internet;" and "links public and private health care institutions that are repositories of medical expertise and information."⁴² Other than the first characteristic mentioned (that NLR is a non-profit), AT&T meets all of these criteria and, for that matter, so do other nationwide backbone providers.⁴³ Thus, if the factors identified by NLR justify eliminating competitive bidding requirements for NLR, they would do so for other backbone providers as well.

As we explained in our comments, NLR, Internet2, and the Commission have never explained what relevance these two providers' tax status has on awarding them an unfair competitive advantage, in violation of section 254(h)(2) of the Act and the Commission's rules.⁴⁴ Plainly, this factor is not relevant, which may explain why NLR does not even try to elaborate on its astounding statement that "price, delivery, management, experience, and financial wherewithal" do not matter when a non-profit is the service provider.⁴⁵ At least one other

⁴² *Id.* at 5.

⁴³ NLR claims that its network is "more reliable and stable than the public Internet." NLR seems to be trying to confuse the Commission by mixing apples and oranges. If selected by a Health Infrastructure Program participant to be its backbone provider AT&T, and other providers, would utilize a private VPN to serve that customer. This VPN would also be "more reliable and stable than the public Internet."

⁴⁴ AT&T Comments at 7.

⁴⁵ NLR Comments at 4-5. In a footnote, NLR states that "[i]t can be presumed that the costs of NLR membership or connection to NLR's network are reasonable. . . ." NLR Comments at n.13. In addition to being an unsound policy decision (i.e., essentially writing a blank check to a service provider because it is a non-profit), of course a non-profit entity's charges could be unreasonably high if, for example, it were mismanaged.

commenter, the American Telemedicine Association, disagrees with NLR, stating that the “commercial vendor selected should be the lowest bidder that meets the requirements set forth by the healthcare provider without any restriction set by the FCC on whether that entity is commercial for-profit or non-commercial non-profit entity. There are numerous national backbone networks available and all are interoperable. This allows the healthcare provider to choose among the most cost-effective and most reliable service providers.”⁴⁶

Other commenters are similarly troubled by the Commission’s proposal to require Health Infrastructure Program participants to select either NLR or Internet2 in order to obtain a significant discount for connecting to a nationwide backbone provider. The Virginia Telehealth Network explained how the “NPRM signals a preference for supporting Internet2 and NLR, even though these networks do not reach all (*or even most*) rural health care providers. As a result some eligible providers may consider themselves to be at a disadvantage for securing funding under the proposed Health Infrastructure program and choose not to apply.”⁴⁷ Like AT&T, Verizon states that the Commission’s proposal to give NLR and Internet2 “special funding status” is contrary to the Commission’s principle that its “universal service rules must be competitively neutral to avoid providing an unfair advantage to any one class of providers or any one technology over another.”⁴⁸ According to Verizon, NLR and Internet2 “provide dedicated nationwide network backbone services like many competing network service providers. Similar services provided by all network service providers must be eligible or ineligible for [rural health care] fund support on a competitively neutral basis regardless of the provider that offers the

⁴⁶ American Telemedicine Association Comments at 14.

⁴⁷ Virginia Telehealth Network Comments at 38 (emphasis added).

⁴⁸ Verizon Comments at 6 (citing *Universal Service First Report and Order* at ¶¶ 46-51).

service.”⁴⁹ The American Telemedicine Association echoes this concern: “The [Health Infrastructure Program], as proposed, gives priority to awarding contracts with two private telecommunications organizations. . . . ATA [] fails to see why the Commission has chosen not to encourage healthcare providers from seeking fair and open competition for the best service and the lowest prices among all telecommunications companies.”⁵⁰ We agree and for these reasons and those contained in our comments, we urge the Commission to put an end to the Pilot Program’s unlawful backbone duopoly and permit participants to receive the same level of discount (e.g., 85 percent) regardless of which backbone provider it selects through a competitive bidding process.

II. The Commission Should Reconsider Its Dark Fiber Proposal.

As part of its proposed Health Broadband Services Program, the Commission proposes that health care providers “should be able to receive support for the lease of dark or lit fiber to provide broadband connectivity from any provider. Under such an approach, applicants would, for instance, be able to lease dark fiber that may be owned by state, regional or local governmental entities, when that is the most cost-effective solution to their connectivity needs.”⁵¹ Both Verizon and Qwest express concern with this proposal as it presents a potential conflict with the rural health care competitive bidding requirements and dark fiber is not a “service” and

⁴⁹ *Id.* at 6-7.

⁵⁰ American Telemedicine Association Comments at 5.

⁵¹ *NPRM* at ¶ 101.

thus cannot be considered a service that is supported by the rural health care program.⁵² We agree.

As we stated in the Commission’s E-rate proceeding, we do not believe that it is appropriate to allow participants to receive support for the lease of dark fiber as it is not a “service” as that term is used in section 254(h).⁵³ It is merely a physical facility that can only be used to provide a service if electronics are attached to it. In addition, funding dark fiber when it is leased by a non-telecommunications carrier such as a municipality to provide telecommunications would violate the Commission’s obligation to establish competitively neutral rules under section 254(h)(2). If the Commission insists on supporting dark fiber, which it should not, it must also implement appropriate safeguards, including a requirement that the health care provider perform appropriate financial analyses to prove it is the most cost-effective solution. Finally, if the Commission elects to allow health care providers to receive support for dark fiber it should do so in a manner that furthers the national policy goal of increasing broadband deployment in unserved areas.

III. Conclusion

For the forgoing reasons, we recommend that the Commission seek further comment on its Health Infrastructure Program (in particular the issues we have identified above) at the conclusion of its Pilot Program and after it releases its “report detailing the results of the [Pilot

⁵² Verizon Comments at 7; Qwest Comments at 8.

⁵³ *See, e.g.*, Letter from Mary L. Henze, AT&T, to Marlene Dortch, FCC, CC Docket No. 02-6 (filed Sept. 16, 2010); Letter from Mary L. Henze, AT&T, to Marlene Dortch, FCC, CC Docket No. 02-6 (filed Aug. 27, 2010); Comments of AT&T Inc., CC Docket No. 02-6 & GN Docket No. 09-51 (filed July 9, 2010).

Program] . . . and recommend[ing] any changes that are needed to improve the programs.”⁵⁴ As others have noted, until then, the “need for a separate support mechanism for the deployment of health care-dedicated broadband capability is not yet clear . . . and could have unintended negative consequences.”⁵⁵ If the Commission proceeds without seeking further comment, we recommend that it target support to unserved areas only; it dispense with its proposals to require participant ownership of facilities and minimum connectivity speeds; and it should rewrite its proposed rules to make clear that participants can select any backbone provider, after a competitive bid, and receive the same level of discount for doing so. Finally, we recommend that the Commission reconsider its Health Broadband Services Program dark fiber proposal.

Respectfully Submitted,

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⁵⁴ *Rural Health Care Pilot Program Order* at ¶ 9.

⁵⁵ Virginia Telehealth Network Comments at 40.