

**COLORADO HEALTH CARE CONNECTIONS AND  
ROCKY MOUNTAIN HEALTHNET  
(COLORADO TELEHEALTH NETWORK)**

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

**Summary of Comments Related to  
Use of Rural Health Care Support Mechanism for Operating Leases**

September 27, 2010

*Of all initial Comments filed in this proceeding, 14 are supportive of the Colorado Telehealth Network's position to allow for use of funds from the Rural Health Care Support Mechanism for Operating Leases. None that we found are opposed.*

**1. Comments of Avera Health, p. 3, September 9, 2010.**

Additionally, our management arrangements with some of our hospitals make short-term leases a necessity and capital leases or ownership of a circuit to those facilities impractical.

**2. Comments of Qwest Communications International Inc., p. 2-3, September 8, 2010.**

...the Commission should continue to permit longer-term operating leases or other service agreements to be eligible for funding to best protect the long-term sustainability of the networks funded by the program...it is not in the best interest of the health care providers, the program, or the public to have health care providers own the funded networks. Health care providers are not in the business of managing telecommunications networks; they are in the business of providing quality health care. It makes little sense to require health care providers to spend time and resources to own and manage a telecommunications network, especially one where the best use of that network may be to have others share in the use of that network as well.

**3. Comments of Rural Wisconsin Health Cooperative, Louis Wenzlow, p. 2-3, September 8, 2010.**

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... 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.... 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.

**4. Comments of the Health Information Exchange of Montana, Inc.,** p. 10, September 8, 2010.

... the Commission should not foreclose the opportunity for HIP program participants to use short term leases when necessary.

**5. Comments of the University of Arkansas for Medical Sciences,** p. 5, September 8, 2010.

As such, UAMS supports shorter term leases, which provide opportunities for progressively efficient and cost-effective services in subsequent years for those healthcare entities who struggle to secure affordable broadband rates. A decision to ban short-term leases from the Healthcare Infrastructure Program would destroy a mechanism that has proven beneficial to UAMS and the 400+ rural healthcare facilities the University assists in acquiring and sustaining affordable broadband.

**6. Comments of Fort Drum Regional Health Planning Organization,** p. 5, September 8, 2010.

FDRHPO strongly disagrees with the prohibition of entering into short term lease agreements for managed services. While it's possible the service provider could become insolvent, the greater issue is in regards to outdated technology or equipment.

**7. Comments of Charter Communications, Inc.,** p. 10-11, September, 8, 2010.

In some instances, Pilot Program projects opted to enter into short-term or operating leases. Oddly, the *Notice* then describes a variety of perceived deficiencies of such arrangements, without providing any support for these claims, much less any examples of problems encountered in the Pilot Program due to such non-ownership arrangements. Nor is there any indication of such problems with lease arrangements in any of the Commission's Orders relating to the Pilot Program. (footnotes omitted) ... the Commission should permit maximum flexibility in HIP participants' ownership or lease arrangements. The Commission can optimize participation in and the benefits achieved by the HIP program, as well as safeguard the government's public interest objectives for the HIP program, by crafting program rules that ensure that any leasehold arrangements fully protect a participant RHP's ability to enjoy dedicated use of funded network facilities for their entire useful life.

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**8. Comments of Oregon Association of Hospitals and Health Systems, Robin Moody, p. 2, September 8, 2010.**

Modify section 54.569 to permit subsidy for leased network capacity (including operating leases) provided that the telecommunications vendors contractually guarantee that the leased capacity will continue to be available for at least 10 years.

**9. Comments of ATC Broadband, p. 12, September 8, 2010.**

Health care providers do not need to own their own private fiber networks. It does not make economic sense. Service providers spread the cost of their networks across many thousands or millions of customers. It will be much less expensive to purchase or lease capacity from a service provider.

**10. Comments of Internet2 Ad Hoc Health Group, Michael Sullivan, p. 16, September 8, 2010.**

The prohibition of entering into "short term" lease agreements for managed services is not acceptable as written. In at least one instance from the RHCPP, "Short Term" is actually 10 years, a length of time encouraged by the Commission. The demands of health care are such that it is appropriate to meet that demand from the most appropriate sector including the private sector. By aggregating the demand of the health care sector in Colorado, the statewide network has caused substantial private sector investment (est. \$20M), leveraging the Commission's support by over 2-to-1. Deploying the statewide network through a leased services agreement with a competitive vendor has led to increased bandwidth availability at reduced cost in rural areas.

**11. Comments of Verizon and Verizon Wireless, p.5, September 8, 2010.**

Rural healthcare providers, however, are not generally in the business of running broadband networks, and this situation becomes even more complicated if a program applicant could be allowed (or even expected) to provide broadband services to both itself and to others.

**12. Comments of California Telehealth Network and the University of California Davis Health System, Thomas Nesbitt, MD, p. 17, September 8, 2010.**

As to Paragraphs 55 through 58 regarding facilities ownership, IRU or capital lease requirements, CTN argues that the exclusion of short term operating leases effectively and unilaterally excludes programs from using the existing telecommunications services that in many circumstances are far more cost-effective than IRU/ownership. The realities in rural and underserved areas are such that existing infrastructure is frequently in place, but underutilized for a variety of reasons such as cost. This older infrastructure has been installed many years previous, at a time when the absence of environmental impact studies, high labor costs, etc., made such projects financially practical. In many cases, the infrastructure is fully amortized, but has not been upgraded because the service providers do not project a sufficient demand at a price

point that they deem profitable. It seems counterintuitive to assume that even substantially subsidized infrastructure projects (with intrinsically higher cost), can ultimately achieve sustainability in the same environment, recognizing that telecommunications vendors typically amortize costs over a twenty-plus year period, while FCC is proposing a five-year support subsidy. FCC should consider permitting short term operating leases when programs can adequately demonstrate that it is the low-cost alternative. Such a policy would also take proper note of the fact that a successful program would engender aggregation of demand, resulting in more financially viable IRU-based or full ownership-based projects in future.

**13. Comments of General Communication, Inc., p. 13, September 8, 2010.**

Requiring ownership or leasing the network facilities forces the health care provider into being a communications network operator, and to incur all the costs and managerial burdens of operating and maintaining the network. Moreover, because operating the network is not the health care providers' area of core expertise, the likely result is underutilized facilities, as the health care provider is less likely to keep up with advances in fiber optic wave technology or microwave transmission. In GCI's experience, health care providers want and need a reliable service that gives them the capacity they need to run their health care applications, not physical ownership of or long term property interests in underlying facilities.

**14. Comments of Broadband Principals, p. 8-9, September 8, 2010.**

The target beneficiaries for this program are generally small to mid-sized clinics and hospitals. They have core competencies in the business of providing health care, and not in owning and managing networks. This is not their business, not their strength, and they do not have resources to care for this. On the other hand, it is the business and core strength of carriers to build and operate networks. Carriers want to own and operate networks on an ongoing basis; this is how they remain viable and sustain their businesses. However, very few of them want to be in the business of constructing networks, only to turn the network's ownership over to another owner after the construction is completed. They are much more motivated to build when they can forecast a steady stream of future revenues for 15 or 20 years after the build is completed. Otherwise, they are relegated to being "one-off" construction companies, which is not the profitable part of the business for most of them. Without allowing carriers to continue ownership of networks they build, there will be few of them interested in bidding to do these infrastructure build-outs. Likewise, there will be less health care providers willing to take the risk of being burdened with owning and managing networks they know nothing about. (In addition to the obvious day-to-day ownership and management issues, the health care providers owning networks for the first time could also be subjected to additional tax burdens, additional government regulations, new and unfamiliar interconnection fees, and they would not experience the economies of scale that even smaller carriers have with respect to network management. This places the health care providers in an undesirable position when considering ownership. There will be many more program applicants if, as with the BIP program, Telcos and carriers are allowed to own the networks.