



## **BACKGROUND**

HIEM is a not-for-profit collaboration of healthcare providers in communities across northwest and north central Montana, established to develop and share electronic health information and to improve patient care throughout a shared service area.<sup>2</sup> The HIEM shared service area features difficult terrain, harsh and unpredictable weather, sparse population, and includes territory on both sides of the Continental Divide. Health care facilities within HIEM's service area face dramatically increasing needs for bandwidth – now driven partly by federal mandates regarding the adoption of electronic health records – yet have limited access to essential and affordable telecommunications infrastructure.

In November 2007, the Federal Communications Commission (“FCC” or “Commission”) selected HIEM as one of 69 original participants in the RHCPP.<sup>3</sup> The HIEM's original May 2007 RHCPP application sought support for a project that would cost \$26 million spread over five years. However, the Commission based its funding awards on the amount of funding requested as part of an applicant's first two years.<sup>4</sup> As a result, HIEM's award of \$13.6 million represented 62% of its original request.<sup>5</sup> HIEM is using its current award to provide connectivity between HIEM member organizations to support high bandwidth healthcare applications such as distance medical consultation, electronic health record storage and exchange, disaster readiness, clinical research and distance health education.

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<sup>2</sup> HIEM is a non-profit organization comprised solely of 501(c)(3) healthcare organizations.

<sup>3</sup> See Rural Health Care Support Mechanism, WC Docket No. 02-60, Order, 22 FCC Rcd 20360 (2007) Appendix A (*Pilot Program Selection Order*).

<sup>4</sup> See Pilot Program Selection Order at ¶ 35.

<sup>5</sup> HIEM's award was based on a project size of about \$16 million (rather than the original \$26 million proposed). The \$13.6 million award amount represents the 85% support available in the RHCPP.

In December 2010, HIEM requested WCB grant HIEM \$13.33 million in additional RHCPP funding.<sup>6</sup> The additional requested amount reflects the \$8.5 million un-awarded balance of HIEM's original RHCPP funding request, plus additional RHCPP funding in the amount of \$4.83 million that HIEM needs to complete its network as originally envisioned. This additional funding will enable HIEM to provide fiber connectivity to all eligible health care providers within the HIEM service area thus ensuring the existence of a secure, high capacity, cost-effective, health care grade network for the next 30 to 40 years

As of February 2011, HIEM has expended over \$ 3.3 million of its original award and has Requests for Proposals ("RFPs") in process that will commit nearly \$7 million more of the award. HIEM has used these funds to complete construction of a critical 185 mile segment of fiber backbone across the Continental Divide which will connect seven health care facilities and the RFPs in process will support efforts to establish fiber segments to an additional fifteen facilities. HIEM has also entered into a successful arrangement with a local telecommunications provider in which HIEM-funded excess capacity has been exchanged for last mile local connections to healthcare facilities. Additional similar partnerships with local telecommunications providers are in development. These arrangements are helping to sustain HIEM at no cost to the federal Universal Service Fund ("USF"), while also providing low cost wholesale capacity to commercial providers seeking to offer retail services to rural Montanans.

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<sup>6</sup> See Letter from Kipman Smith, Executive Director, Health Information Exchange of Montana, to Sharon Gillett, Chief, Wireline Competition Bureau, Federal Communications Commission, WC Docket No. 02-60 (dated Dec. 29, 2010). WCB has authority to designate successor projects and HIEM requested that WCB designate HIEM as a successor to funds relinquished by defunct pilot projects. See *Pilot Program Selection Order*, 22 FCC Rcd. at 20422, ¶ 124 ("In instances where a selected participant, including a consortium, is unable to participate in the Pilot Program ... a successor may be designated by [WCB].").

## ARGUMENT

MTA and MITS' comments reflect a continuing pattern of attacks and unfounded allegations against the HIEM.<sup>7</sup> These attacks are misplaced. MTA and MITS object to the RHCPP, which they incorrectly perceive to be an existential threat to its members. As we explain below, MTA's most recent comments reveal confusion about both how the RHCPP is intended to work, and how it is actually working in their members' service areas.

### **1. The Purpose of the Pilot Program was to Directly Fund Health Broadband Infrastructure**

The RHCPP currently covers “85 percent of the costs associated with the construction of state or regional broadband health care networks” incurred within a five year period.<sup>8</sup> For networks like HIEM that are installing their own facilities, USF support is no longer available after the initial five year period. However, because of the initial infrastructure investment which is enabled by the generous 85% RHCPP subsidy, recurring costs remain low and ongoing USF support is thus not needed. While sustainability challenges remain – particularly given the extended economic downturn – the intent and design of the RHCPP represent a sound remedy to the perpetual subsidies available in the traditional Rural Health Care (“RHC”) program and other USF programs.

There are compelling benefits to the RHCPP's infrastructure program. For example, if HIEM were to lease capacity from existing providers – as MTA and MITS urge – after the five

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<sup>7</sup> For example, MTA and MITS continue to claim incorrectly and misleadingly that HIEM has “rebuffed” offers by member companies to provide service to HIEM locations. *See* MTA comments at 4; *see also* MITS comments at 7. This is untrue as HIEM has previously explained. *See* HIEM RHC NPRM Reply Comments at 6, fn. 16. In accordance with Commission rules, each deployment phase for HIEM's network is subject to an open competitive bidding process in which HIEM is required to select the most cost effective provider of the services that HIEM's members are seeking. To the extent that MTA and MITS members either cannot or refuse to submit cost-effective bids for the services HIEM needs, such failures are an unfortunate byproduct of the competitive bidding process that protects consumers from waste.

<sup>8</sup> *See Pilot Program Selection Order* at ¶¶ 2, 4.

year period, RHCPP support at the 85% level would end and these connections may no longer be affordable to HIEM members.<sup>9</sup> The HIEM would be back where it started, without sufficient broadband connectivity, and the subsidized lease payments flowing from the government to MTA and MITS members would have been wasted. Even if somehow HIEM members could afford connections supported at a lower than 85% subsidy level, such connections would be dependent on USF subsidies in perpetuity.

Other benefits of the RHCPP model would be diminished. These include the ability of Health Care Providers to set service quality levels that *must be met* by vendors, and the ability to provision physically redundant connectivity that ensures these networks will be available when they are needed most.<sup>10</sup> Forcing health care providers to lease existing facilities – at rates, terms and conditions dictated only by telecommunication providers, undermines these important policy objectives. Many HIEM members have service quality expectations that will best be met by entering into individualized contracts, rather than accessing service pursuant to tariffs or typical carrier arrangements. Enabling such choices inures to the public benefit by forcing carriers to provide service quality at needed levels in order to compete.

Yet MTA's efforts – its persistent attacks on the HIEM and MTA's comments in the RHC rulemaking proceeding – consistently seek one thing: rules that will compel HIEM to obtain service from MTA members – irrespective of whether it is cost effective for HIEM to do so – and irrespective of whether MTA members can actually deliver reliable service sufficient

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<sup>9</sup> While the recent RHC Notice of Proposed Rulemaking (“NPRM”) proposes a 50% ongoing USF subsidy for Broadband Services which presumably would cover such connections, the fact is even at 50% such connections may not be affordable to many HIEM members. *See* Rural Health Care Universal Service Support Mechanism, CC Docket No. 02-60, Notice of Proposed Rulemaking, FCC 10-125 (rel. Jul. 15, 2010) (*RHC NPRM*).

<sup>10</sup> MTA and MITS spend significant effort attacking the idea of overbuilding. Nowhere do they consider the fact that physically redundant facilities are a critical necessity for health care providers and for emergency preparedness generally.

for health care applications on which lives depend. While permanent RHC subsidies would unquestionably benefit MTA and MITS members, it is far from clear whether the HIEM, Montana's rural and frontier residents, or the USF would also benefit.

The question of subsidizing one-time capital expenditures versus subsidizing the ongoing costs of providers such as MTA and MITS' members is part of a continuing debate in the larger USF policy arena. While HIEM believes supporting advanced services for health care presents unique challenges that must be considered separately from the larger USF policy debate, the larger debate is nonetheless instructive. A timely and relevant discussion of the investment vs. perpetual subsidy policy choice was recently provided in *The Omaha Plan*, prepared by staff of the State members of the Joint Board on Universal Service.<sup>11</sup> Staff explained:

[F]und administrators must decide whether to provide one-time construction grants or to award support based on the traditional revenue requirements data used within the telephone industry. An advantage of one-time construction grants is that they are relatively easy to administer by the issuance of a request for proposal (RFP) and the award of funding based on total capital expenditures (CAPX). The disadvantage of this process is that ongoing services such as broadband, in order to be most productive, may require ongoing maintenance support. . . . The advantage of the revenue requirement approach is that the initial outlay is less and cost recovery is spread out over a longer period of time. With a limited amount of funding available, the revenue requirement approach obviously has appeal.

The closest recent analogy to the CAPX versus revenue requirements approach is the Schools and Libraries Program. The goal of schools and libraries USF funding included in the Act was to wire every school and library in America to provide access to the Internet. Fifteen years after passage of the Act, we are still spending over \$2 billion per year "to wire every school and library in the nation to the Internet." One would think that at some point in time, we will have completed the job. The problem associated with the Schools and Libraries program is that the states and their school systems leased facilities from the incumbent carriers that were needed to extend the existing networks into the school systems rather than constructing their own facilities. Instead of a one-time

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<sup>11</sup> THE OMAHA PLAN: A White Paper to the State Members of the Federal-State Joint Board on Universal Service (February 7, 2011) ("Omaha Plan").

national problem that we could resolve at some point in time, the Schools and Libraries Program has become an entitlement program that will last forever.<sup>12</sup>

While the RHCPP follows the CAPX approach, the traditional RHC program and the proposed Broadband Services Fund reflect the permanent entitlement model of the Schools and Libraries Program. Wisely, the Commission, in its recent *RHC NPRM* proposed to pursue both approaches – CAPX through the proposed Health Infrastructure Fund and permanent subsidies through the Broadband Services Fund. This is wise because of the unique needs of health care providers – including ever increasing needs for higher levels of bandwidth and reliable physical redundancy – and because the RHC program remains small enough<sup>13</sup> to provide the Commission with a valuable laboratory in which to evaluate the competing benefits of these different approaches.<sup>14</sup>

HIEM and other pilot projects that have made investments in health broadband infrastructure represent the culmination of an important and innovative effort by the Commission to try a different USF funding model. HIEM represents one of a minority of pilot projects that is actually achieving the Commission's RHCPP goals of installing infrastructure dedicated to meeting the unique needs of health care providers. HIEM's additional funding request would allow the network to realize its full potential and to bring incredible advances in health care access to even more rural Montanans. Moreover, as we explain in the next section, HIEM's model represents a potential opportunity, not a mortal threat to MTA and MITS members.

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<sup>12</sup> See *id* at 7-8.

<sup>13</sup> Based on Universal Service Administrative Company data from 2009 (the most recent available), RHC disbursements represented less than 1% of overall USF disbursements.

<sup>14</sup> HIEM certainly acknowledges the criticisms of the RHC and RHCPP contained in the Government Accountability Office report. See U.S. Government Accountability Office Report: FCC's Performance Management Weaknesses Could Jeopardize Proposed Reforms of the Rural Health Care Program, GAO-11-27. November 2010 (available at <http://www.gao.gov/products/GAO-11-27>). However, as noted successful pilot projects like HIEM present the Commission with a valuable resource for assessing the success and value of the RHCPP and RHC.

2. HIEM Excess Capacity Supports Network Sustainability and Represents an Opportunity for Commercial Telecommunications Providers to Reach More Customers Thereby Benefitting Montana’s Rural and Frontier Communities

MTA’s comments opposing HIEM’s request for more funding tellingly reveal confusion about how it is that the RHCPP and HIEM are actually working with, and to the benefit of, MTA member telephone companies. Specifically, MTA remarks:

In fact, as HIEM indicates, in some cases HIEM is partnering with existing broadband providers, leveraging existing assets “**at no cost to the Rural Health Care Pilot Program**” to deliver broadband health care services to communities such as Cut Bank, Heart Butte, Browning, Conrad and Shelby. (emphasis [sic] added.)

It is precisely this kind of partnership, rather than building duplicative, wasteful and unnecessary infrastructure that MTA encourages, and commends HIEM for undertaking.<sup>15</sup>

While HIEM welcomes this rare praise from MTA, the partnership at issue was made possible by HIEM-funded excess capacity that HIEM is able to make available to retail providers including MTA and MITS members.<sup>16</sup> Specifically, HIEM was able to exchange leased bandwidth with an existing retail provider and thereby obtain connections to HIEM members without needing to expend USF funds. The retail provider gained access to HIEM excess capacity and will be able to improve the reach, capacity and redundancy of its network. This was a mutually beneficial arrangement that saved the USF money, enhanced the sustainability of the HIEM, and was clearly advantageous to an existing retail carrier.

This example – and there will be others – illustrates the unfortunate gulf between the strident rhetoric of MTA and MITS, and reality. On one hand, MTA has repeatedly attacked the concept of RHCPP excess capacity, while on the other hand MTA praises HIEM for making that

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<sup>15</sup> MTA comments at 4 (footnotes omitted).

<sup>16</sup> The RHCPP allows dedicated health networks funded by RHC funds to construct excess capacity available for non-health care use and to lease that capacity out, provided all proceeds are used to sustain the network. See RHCPP Excess Bandwidth and Excess Capacity Scenarios, scenarios 3 and 8.

capacity available to its members. It is critically important for the Commission to understand how the program is actually working in Montana, and that it can continue to work to the mutual benefit of HIEM and MTA and MITS members. The true beneficiaries of HIEM's participation in the FCC's infrastructure program are rural Montanans who will enjoy increased access to advanced health care capabilities as well as affordable access to advanced information services through their local telephone companies.<sup>17</sup>

### **CONCLUSION**

HIEM is one of a select group of projects realizing the goals and objectives the Commission set for the Pilot Program. In addition, HIEM represents a vital and essential part of a rapidly evolving health care delivery system – an evolution that has accelerated considerably since the RHCPP was launched in 2007. With respect to the alleged detrimental impacts on existing providers, HIEM has shown increasing examples where the HIEM network is enhancing rather than undermining the rural broadband ecosystem. Accordingly, the Commission should support HIEM in its efforts to complete its network as originally envisioned by granting its requests for relinquished Pilot Program funding.

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<sup>17</sup> This should provide comfort to MITS that HIEM is concerned about providing health care services rather than becoming a competitive commercial telecommunications provider. *See* MITS Comments at 6.

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