Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554

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

COMMENTS OF THE HEALTH INFORMATION EXCHANGE OF MONTANA

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SUMMARY

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. As a successful Rural Health Care Pilot Program participant, HIEM has first-hand experience with the Commission's efforts to improve the Rural Health Care program through the Pilot Program. Back in 2010, the Commission issued an NPRM which, in light of the Pilot Program and the *National Broadband Plan*, proposed welcome changes to the Rural Health Care program including continued funding for broadband infrastructure for health care. HIEM supported the Commission's goals and urged the Commission not to "fix" existing policies that experience had shown were not broken.

HIEM urges the Commission to finish the good work it began in 2010. The Commission has an obligation to try again to fulfill the recommendations for health care contained in the *National Broadband Plan* and to meet Congress' goals regarding universal service for rural health care providers. Regarding specific policies, HIEM believes that its experience as a network construction project in the Pilot Program continues to show the utility of funding health infrastructure in situations where the competitive bidding process establishes that it is more cost effective than leasing services. Experience with the Pilot Program also shows, at a minimum, that flexible policies supporting broadband for health care are needed. Accordingly, the Commission should ensure that health care providers have a range of funding types available for broadband, including health infrastructure support.

Finally, HIEM is scheduled to complete that part of its proposed network funded through the Pilot Program in late fall 2012. HIEM is thus ready to complete the remainder of the proposed network and respectfully requests an opportunity to do so through the Commission's proposed Health Infrastructure Program.

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The Health Information Exchange of Montana ("HIEM"), by its attorneys, hereby submits these further comments in response to the Federal Communications Commission's ("FCC" or "Commission") Notice of Proposed Rulemaking, FCC 10-125, released July 15, 2010, in the above captioned proceeding.[1] The principal purpose of these comments is to introduce new information into the record to reflect developments since HIEM filed previous comments during the fall of 2010 and spring and fall of 2011.[2]

I. INTRODUCTION

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. The HIEM shared service area spans both sides of the Continental Divide and features difficult terrain, harsh and unpredictable weather, and sparse population. HIEM is the recipient of a $13.6 million Rural

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[1] *Rural Health Care Support Mechanism*, WC Docket 02-60, Notice of Proposed Rulemaking, 25 FCC Rcd 9371 (2010) (*RHC NPRM*).

[2] *See* HIEM Comments, WC Docket 02-60 (filed Sep. 8, 2010) (*HIEM NPRM Comments*); HIEM Reply Comments, WC Docket 02-60 (filed Sep. 23, 2010) (*HIEM NPRM Reply Comments*); HIEM Reply Comments, WC Docket 02-60 (filed Mar. 7, 2011) (*HIEM Supplemental Funding Comments*); HIEM Notice of Oral *Ex Parte* Presentation, WC Docket 02-60 (filed Sep. 22, 2011) (*HIEM September 2011 Ex Parte*).

Health Care ("RHC") Pilot Program ("Pilot" or "Pilot Program") funding award[3] and one of the successful infrastructure projects in that program. Among other accomplishments, HIEM has deployed a 24 fiber backbone across the Continental Divide that is making available much needed dedicated broadband connectivity to seven health care and health education providers including providers located on and serving the Blackfeet Indian Reservation.

Because the Pilot Program only partially funded the HIEM's proposed network, in an effort to complete the originally proposed network and bring its clinics and hospitals into the 21st century, HIEM previously sought more Pilot Program funding from the Commission.[4] Alternatively, HIEM now urges the Commission to move forward expeditiously with the Commission's previously proposed Health Care Infrastructure program which would provide federal universal service fund ("USF") support for 85% of the costs for the "design, construction and deployment of dedicated broadband networks that connect public or non-profit health care providers in areas of the country where the existing broadband infrastructure is inadequate."[5] Failure to promptly implement this and other proposed reforms to the RHC program will undermine the growth and development of the many statewide and regional health broadband networks such as HIEM that were funded through the Pilot Program. In addition, failure to reform the Commission's RHC program will ensure its continued and unfortunate underutilization.

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[3] *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 21 FCC Rcd 11111 (2006); *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 22 FCC Rcd 20360 (2007) (*2007 Pilot Program Selection Order*).

[4] *See* Public Notice, *Wireline Competition Bureau Seeks Comment on Health Information Exchange of Montana Request For Additional Funding Under The Rural Health Care Pilot Program*, WC Docket No. 02-60, DA 11-95 (rel. Jan. 19, 2011); *see also HIEM Supplemental Funding Comments.*

[5] *See RHC NPRM*, 25 FCC Rcd at 9379, ¶ 13.

HIEM also reiterates its previously submitted comments which urged the Commission to adopt the following reforms (among others):

- Retain Pilot Program policies related to the installation and use of excess broadband capacity;[6]
- Maintain the 28-day competitive bidding period for infrastructure projects;[7]
- Reduce the cash match requirement to 10% or, alternatively, allow non-cash, in-kind contributions to qualify as match funding;[8]
- Expand the types of entities eligible for RHC funding and ensure clear administrative guidelines for determining eligibility.[9]

II. THE COMMISSION SHOULD PROMPTLY IMPLEMENT LONG-AWAITED RURAL HEALTH CARE PROGRAM REFORMS

HIEM echoes other commenters that have urged the Commission to complete the 2010 rulemaking process and reform the RHC program. Instead of completing that rulemaking, the Commission continues to proceed in stop-gap fashion, with the Wireline Competition Bureau ("WCB" or "Bureau") recently proposing "bridge" funding for certain Pilot projects.[10] But such stop-gap funding is only needed because the 2010 rulemaking has not yet been acted on.[11] More important, the RHC reforms proposed in 2010 sought to realize comprehensive recommendations for the Commission concerning health care that were contained in the *National Broadband Plan*.[12] HIEM urges the Commission to revisit those recommendations. Moreover, the record in

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[6] *See HIEM NPRM Comments* at 4-7; *HIEM NPRM Reply Comments* at 3-12.

[7] *See HIEM NPRM Comments* at 10-15.

[8] *See HIEM NPRM Comments* at 16-17; *HIEM NPRM Reply Comments* at 13-14.

[9] *See HIEM NPRM Comments* at 17-19; *HIEM NPRM Reply Comments* at 14-16.

[10] *See* Public Notice, *Wireline Competition Bureau Seeks Comment on Funding Pilot Program Participants Transitioning out of the Rural Health Care Pilot Program in Funding Year 2012*, WC Docket No. 02-60, DA 12-273 (rel. Feb. 27, 2012) (*Bridge Funding PN*).

[11] *See id.* at ¶ 5 (*RHC NPRM* addressed, among other things "how to transition Pilot Program participants to the ongoing rural health care support mechanism").

[12] *See FCC, Connecting America: The National Broadband Plan*, GN Docket No. 09-51, Health Care, Chapter 10 (2010) (*National Broadband Plan*).

the RHC proceeding since the *National Broadband Plan* was released shows a continuing and growing need for affordable broadband that is capable of meeting the needs of health care.[13]

Notably, HIEM did not comment on the *Bridge Funding PN* because bridge support was directed at projects that – unlike HIEM – are dependent on recurring RHC subsidies. As an infrastructure project, HIEM has no need for (and would likely not be eligible for) recurring RHC support either through the legacy RHC program, a bridge funding mechanism, or through the Commission's previously proposed Health Broadband Services Program (HBSP).[14] Indeed, one of the reasons for the direct funding of health infrastructure is to increase broadband availability and affordability, while reducing reliance on recurring subsidies – bridge or otherwise.[15]

While HIEM does not need ongoing subsidies from the RHC program for sustainability, HIEM would like an opportunity to complete the HIEM network as it was originally proposed in

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[13] *See generally* USAC, RURAL HEALTH CARE PILOT PROGRAM, DOCKET NO. 02-60, HEALTH CARE PROVIDER BROADBAND NEEDS ASSESSMENT SUMMARY (rel. Apr. 12, 2012) (*USAC HCP Needs Assessment*); *cf.* Letter from Kathleen Sebelius, Secretary of Health and Human Services (HHS), to Julius Genachowski, Chairman, FCC, at 1 (Apr. 18, 2011) (*Sebelius Letter*) ("There is urgency to increase broadband access to health care providers . . . . Without targeted [RHC program] support over the next two years, this could have a great impact on rural America."); Brazos Valley Council of Governments et al., Reply Comments (filed May 23, 2011) in *Connect America Fund, et al.*, WC Docket No. 10-90 *et al*., Notice of Proposed Rulemaking and Further Notice of Proposed Rulemaking, 26 FCC Rcd 4554 (2011) (HIEM, three other Pilot Projects, and one potential Health Infrastructure Program applicant noting urgent need in health care for affordable dedicated broadband connectivity rather than broadband Internet access).

[14] *See generally RHC NPRM*, 25 FCC Rcd at 9407-15, ¶¶ 90-113.

[15] This critical point may have eluded the Montana Telecommunications Association ("MTA") which, in its most recent comments, apparently opposes providing bridge funding for Pilot projects that are dependent on such ongoing support for sustainability. *See Comments of the Montana Telecommunications Association to the Bridge Funding PN*, at 4-7 (filed Apr. 18, 2012) (*MTA Bridge Funding Comments*) ("The PN proposes to transform the Pilot program into a perpetual funding program . . . ."). But MTA, by categorically opposing direct RHC funding for health infrastructure is effectively arguing that *only* perpetual recurring subsidies should be permitted in the RHC program. MTA completely misses the point that bridge funding is needed for certain Pilot Projects *precisely because they took the path that MTA advocates* – they obtained services that require perpetual support rather than constructing or leasing infrastructure. While HIEM has never advocated that networks must or even should own infrastructure, networks should be permitted to pursue the most cost effective solution to meeting their connectivity needs – and constructing or owning infrastructure should not be categorically excluded as an option where it is a more efficient use of scarce support funding.

its Pilot Program application back in 2007.[16] Moreover, HIEM was not conceived as a static network and the demand exists for HIEM to grow and add new members. Thus HIEM continues to support the Commission's proposed Health Infrastructure Program and urges the Commission to delay no further in implementing it. HIEM is currently scheduled to complete construction on its current Pilot Program project in the late fall of 2012 and HIEM respectively requests an opportunity to apply for and justify additional funding through the proposed Health Infrastructure program at that time.[17]

III. THE COMMISSION SHOULD IMPLEMENT THE PROPOSED HEALTH INFRASTRUCTURE PROGRAM

A. The Success of HIEM and Other Infrastructure Projects in the Pilot Program Justifies an Ongoing Infrastructure Program

The *National Broadband Plan* specifically recommended creation of a Health Care Broadband Infrastructure Fund which the Commission attempted to implement in 2010.[18] The record in this proceeding since 2010 provides further support for such a program. Specifically, data shows that direct infrastructure investment has been a significant part of the successes in the Pilot Program. For example, USAC recently reported that 8 of the 50 active Pilot projects requested and were approved for funding for the construction of health care provider-owned facilities representing over 16% of total funding approved so far in the Pilot Program.[19]

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[16] *See HIEM Application for Rural Health Care Network Pilot Program Project*, WC Docket 02-60 (2007) (seeking award of $26 million) (available at http://apps.fcc.gov/ecfs/document/view?id=6519409796).

[17] The record suggests that for RHC program reforms to be implemented beginning July 1, 2013, the Commission would need to act before the end of 2012. *See* Letter from Craig Davis, Vice President, RHC Division, USAC, to Sharon Gillett, Chief, WCB, FCC, WC Docket No. 02-60, at 8 (dated Mar. 14, 2012) (advising Bureau that twelve months may be needed to administratively implement significant programmatic reforms).

[18] *See National Broadband Plan* at 215; *RHC NPRM*, 25 FCC Rcd at 9378-9406, ¶¶ 11-89.

[19] *See* Letter from Craig Davis, Vice President of Rural Health Care, USAC, to Sharon Gillett, Chief, WCB, FCC, WC Docket No. 02-60, at 2-4 (dated May 4, 2012) (*USAC Pilot Data*) (reporting 8 projects with over $35 million in approved funding for "network construction" out of over $217 million in approved funding for all projects as of January 31, 2012).

However, this excludes spending for IRUs and dark fiber leases which should also be included when considering the percentage of Pilot Program funding that went to "infrastructure."[20] As a result, the percentage of Pilot Program infrastructure spending is likely much greater than 16%. Therefore, notwithstanding the well-documented issues related to the launch of the Pilot Program, the proportion of funding that went to infrastructure in the Pilot Program may well be close to the proportion of RHC funding the FCC originally proposed devoting to the Health Infrastructure Program ($100 million out of $400 million available annually, or one-fourth).[21] Accordingly, the experience with the Pilot Program supports a Health Infrastructure Program of that size.

B. Health Infrastructure Spending Is an Efficient Use of Scarce USF Funds

Pilot projects that elected to own their own facilities did so for one principal reason – it was the most cost effective way to provide access to broadband to their eligible participants. In addition, because each Pilot project was required to obtain the 15% match funding themselves, this ensured that program awardees used funds cost-effectively.[22] Moreover, it is not hard to see how owning infrastructure can be more cost effective in certain situations than simply leasing services. A recently provided sample of recurring costs for leased line services in rural areas

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[20] *See RHC NPRM*, 25 FCC Rcd at 9395-96, ¶¶ 55-56, (dark fiber IRUs eligible for support in proposed Health Infrastructure Program).

[21] *RHC NPRM*, 25 FCC Rcd at 9456 (proposed 47 C.F.R. § 54.675). USAC reports that "[t]he majority of funding provided in the Pilot Program has been for leased services." *See USAC Pilot Data* at 3. USAC also reports $19.3 million was committed for network equipment, plus the $35 million committed for construction. *See id.* at 3-4. Assuming a bare majority of funding was committed for leased services, this leaves over $50 million potentially committed to IRUs and dark fiber leases, or as much as $85 million ($35 million construction plus $50 million IRUs and dark fiber leases) – almost 40% of the $217 million – committed to infrastructure.

[22] *See National Broadband Plan* at 215 ("The [15%] match requirement [used in the Pilot Program] aligns incentives and helps ensure that the health care provider values the broadband services being developed and makes financially prudent decisions regarding the project."); *cf. Federal-State Joint Board on Universal Service*, Report and Order, 12 FCC Rcd 8776, ¶ 727 (1997) (*Universal Service Order*) (rejecting additional requirements on HCPs because of adequate program incentives to "not waste their own resources by paying" for services they do not need); *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 18 FCC Rcd 24546, 24575-6, ¶ 58 (2003) (HCP responsibility for "significant portion of service costs" ensures health care providers will select most cost-effective services).

across several Plains states shows why.[23] For example, the leased line costs for 39 health care sites for one health care network based in South Dakota – with bandwidths ranging from T-1s (1.5 Mbs) to redundant DS-3's (45 Mbs) were over $1.4 million annually – excluding one-time costs for installation and equipment.[24] This equates to $36,000 per year on average of potential ongoing USF subsidy per HCP ($1.4 million/39 sites) just for enhanced connectivity. Projecting this annual cost out 20-years would cost the USF over $28 million.

In contrast, data from the Pilot program shows one-time costs on average of $150,000 per HCP for the pilot projects that relied purely or partly on construction.[25] Dividing that cost by 20 years – the expected useful life for fiber[26] – yields an annualized cost of $7500 per HCP. More specifically, in comparison to the South Dakota-based network noted above, HIEM is deploying a 10 Gigabit backbone that will make exponentially greater capacity available to HCPs – up to Gigabit direct fiber connections to primary care hospitals and clinics – at substantially less annualized cost to the USF per HCP.[27]

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[23] *See* Department of Health and Human Services ("HHS"), Office for the Advancement of Telehealth (OAT), Office of Rural Health Policy (ORHP), WC Docket No. 02-60, *Notice of Ex Parte Communication,* Attachments 1 and 2 (Mar. 13, 2012) (summary submitted Apr. 10, 2012 by Christianna Lewis Barnhart, Attorney Advisor, Telecommunications Access Policy Division (TAPD), WCB) (pricing attachments reflecting the "cost of connectivity for [selected] rural health providers" in the states of South Dakota, North Dakota, Iowa, Nebraska, Minnesota, and Wyoming).

[24] *See id.*, Attachment 2 ("HUBNet Budget") (reflecting $1,685,198 in "annual line costs" for 39 health care providers who received "enhancements" to their connections and who are participating in the HUBNet network). Applying the 85% subsidy to these annual line costs equates to a $1,432,418 cost to the USF – *which would be eligible for support every year under the proposed HBSP*.

[25] *See USAC Pilot Data* at 4 ("Construction commitments of $35 million over 230 HCPs equates to approximately $150,000 per HCP.").

[26] *See RHC NPRM,* 25 FCC Rcd at 9395, ¶ 56 (noting useful life of dark fiber is generally about 20 years).

[27] HIEM expects to spend $16 million on its network of which 85% will be subsidized, or about $13.6 million. With 23 sites on the network this equates to an average subsidy per site of about $590,000. Dividing that amount by 20 years equates to an average annualized subsidy per HCP of about $29,500 – significantly below the average annual HUBNet subsidy of $36,000 (which excluded significant subsidies for equipment and other one-time investments).

The Commission's proposed Health Infrastructure Program recognized, as reflected in the real-world examples above, that it can be more cost-effective in certain cases to make one-time investments rather than to be dependent on perpetually subsidized leased connections – especially when such connections are slower or of inferior quality. HIEM has raised this issue before, but it is worth repeating: the question of subsidizing one-time capital expenditures versus subsidizing ongoing costs is part of a healthy and continuing general universal service policy debate.[28] *The Omaha Plan*, prepared last year by staff for State members of the Joint Board on Universal Service, offered refreshingly frank discussion of the investment (CAPX) vs. perpetual subsidy ("revenue requirement") question:

> 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 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.[29]

Further, a recent proposal to reform the Schools and Libraries notes similar problems with perpetual subsidies and suggests that grants rather than recurring subsidies may be more cost effective for both the USF and intended beneficiaries:

> The mandatory use of discounts for services provided to schools and libraries has arguably prevented the program from being offered in ways that may have saved schools and libraries money. Because service providers determine the basis for the discount, there is an information

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[28] *See HIEM Supplemental Funding Comments* at 6-7.

[29] THE OMAHA PLAN: A WHITE PAPER TO THE STATE MEMBERS OF THE FEDERAL-STATE JOINT BOARD ON UNIVERSAL SERVICE, at 7-8 (February 2011) (OMAHA PLAN).

> asymmetry. Providers will always know more about the actual cost of service delivery than USAC administrators or the FCC. There is no way to ensure that schools and libraries are actually paying less for E-rate services than they might have otherwise paid through aggressive negotiations. [30]

The Commission, in the *RHC NPRM* wisely proposed to pursue both approaches – CAPX through the proposed Health Infrastructure Fund and ongoing subsidies through the Health Broadband Services Fund. This dual approach will potentially save millions in never-ending subsidies and makes sense given the vast diversity of situations faced by health care providers and health broadband networks across the country. Indeed, the wide variety of approaches taken by successful Pilot projects is itself testimony of the need for a diverse set of RHC funding mechanisms.

Finally, HIEM has previously addressed the continued claims that hospitals don't want to, or should not be in the business of designing or operating networks.[31] While no FCC rule should require hospitals to own RHC-funded facilities, many health systems clearly believe it is important to their missions and continue to be successful in doing so.[32]

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[30] *See* Lynne Holt, Mary Galligan, *Is it Time to Recreate the E-rate Program?* 64 FED. COMM. L.J. 275, 313 (2012). The problem of information asymmetry is more severe when there is only a single bidder, a situation that is not uncommon in the RHC program. *See HIEM NPRM Reply Comments* at 4-5; *see also, e.g., USAC HCP Needs Assessment* at 22 (noting Pilot Program recipient receiving single bid to provide broadband in rural Virginia); Hank Fanberg, CHRISTUS Health, *Notice of Ex Parte Communication*, WC Docket No. 02-60, at 1 (Dec. 12, 2011) (summary submitted Jan. 17, 2012 by Linda Oliver, Attorney Advisor, TAPD, WCB) (noting that in Texas "in many cases there is only one potential broadband provider in rural communities, and thus no competitive price pressure.").

[31] *See HIEM NPRM Reply Comments* at 10-13 (noting that hospitals lack the core competency of hospital construction, yet hospitals construct and expand their physical plant all the time).

[32] *See, e.g.*, St. Joseph's Hospital of Wisconsin, *Notice of Ex Parte Communication*, WC Docket No. 02-60, at 1 (Feb. 24, 2012) (summary submitted Mar. 26, 2012 by Linda Oliver, Attorney Advisor, TAPD, WCB) ("Having a private fiber network as part of the larger network helped St. Joseph's to control costs and ensure long-term success, as they found that it could be cost-prohibitive to buy from a carrier the 1-10 Gbps connections needed to move medical images."); *American Hospital Association (AHA) RHC NPRM Comments*, at 4 (filed Sep. 8, 2010) (supporting Health Infrastructure Program); *see also USAC Pilot Data*, Appendix D (listing Pilot projects using funding for some construction – which again excludes hospitals that obtained IRUs or dark fiber leases).

C. Health Infrastructure Support Does Not Result in Overbuilds ("No Carriers Were Harmed in the Making of this Network")

Critics of universal service support for health infrastructure insist that such support results in overbuilds which undermine the competitive position of existing providers.[33] HIEM's experience building its network has repeatedly shown that this is not the case. As discussed further below, HIEM's partnerships with existing service providers are bringing affordable broadband for health care to its members, increasing general broadband availability in rural communities, and conserving scarce USF funds. Indeed, HIEM is simply interested in obtaining connectivity for its members in the most cost-effective way. If leasing existing dark fiber is more cost effective than building new, HIEM will naturally choose to lease existing fiber.[34]

Recent HIEM partnerships with local service providers continue to show the broad benefits of direct health infrastructure funding. In one case, after competitive bidding for the Kalispell to Libby leg of its network,[35] HIEM selected a vendor to construct fiber with RHC funding to serve HIEM members, while HIEM used its own money to fund excess capacity fiber. HIEM is leasing that excess capacity wholesale to an existing local service provider that will

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[33] *See, e.g.*, Letter from Geoff Feiss, General Manager, MTA, to Marlene Dortch, Secretary, FCC, *Notice of Ex Parte Communication*, WC Docket No. 02-60 (dated Jul. 29, 2011) ("[T]he HIEM project wastes precious universal service funds by duplicating existing network facilities.").

[34] *See HIEM September 2011 Ex Parte*, slides 10-13 (providing two specific examples where bids for leased fiber were substantially less cost effective than bids for constructing fiber). Moreover, as HIEM has previously explained:

> If a program vendor has fiber deployed in an area where a program participant needs capacity, then the vendor should have no trouble submitting a bid that is lower than the cost of building new facilities. If a carrier can't do that, when its existing plant was built with the help of subsidies, then something is amiss.
>
> Alternatively, if there is no fiber in an area where a program participant needs capacity, then there is nothing in the Communications Act requiring a program participant to select a bid from any company if a more cost-effective alternative exists. In fact, it would amount to misuse of government funds for program participants to select a higher-cost bid.

See HIEM RHC NPRM Reply Comments, at 6-7.

[35] This 90 mile stretch is HIEM's "Yellow Route." *See HIEM September 2011 Ex Parte*, at slide 3.

now be able to provide expanded services including competitively priced consumer broadband in its service area. Pursuant to Pilot Program rules, HIEM is using the proceeds from leasing the excess capacity to ensure sustainability of its health care network and thereby avoiding the need for "bridge" funding or other ongoing RHC program support.[36] This is a classic win-win which the Commission should embrace:

- HIEM members who are providing health care and health education to rural communities win by obtaining affordable, state-of-the-art broadband connectivity;
- The Commission and the USF win by cost-effectively achieving long-sought after USF goals for broadband for health care without perpetual subsidies;
- The local community wins with greater access to affordable broadband services as a by-product of HIEM's and the FCC's investments;
- The local service provider wins because it is able to obtain competitively priced wholesale capacity which allows it offer new and affordably priced broadband services to the community.

In another example, after competitively bidding to obtain fiber connections between Missoula and Whitefish,[37] HIEM selected the most cost-effective bid which was from a vendor to construct fiber. Consistent with the scope of its winning bid, the vendor has entered into an innovative arrangement with a local telecommunications provider, who is also a Broadband Technology Opportunities Program grant recipient, to use a combination of built and leased fiber in order fulfill its commitment to HIEM. In addition, HIEM-funded excess capacity leased to the local telecommunications provider will support sustainability of the HIEM network. In turn, the local telecommunications provider benefits by obtaining competitively priced wholesale fiber

[36] Regarding the Commission placing limits on the amount of excess capacity fiber, see *RHC NPRM* at 25 FCC Rcd at 9402, current experience suggests such limits are not needed. Because projects must use their own money to fund excess capacity, and because the proceeds from leasing excess capacity can be used only to sustain the health care network, there is a natural disincentive to install more excess capacity than is needed to sustain the network.

[37] This 135 mile route is the southern section of HIEM's "Red Route." *See HIEM September 2011 Ex Parte*, at slide 3.

which it can use to provide more and better quality services to its rural customers. And again, the Commission and the USF also benefit because universal service goals for broadband deployment are being furthered in a timely and cost-effective manner.

IV. CONCLUSION

The Commission deserves praise for its recent efforts in this proceeding. It is clear that highly motivated staff attorneys are again dedicated to the Rural Health Care program and the opportunity is thus there to complete the rulemaking begun in 2010. We urge the Commission not to miss this opportunity. Failing to act this year would impose continued uncertainty on a program that needs and deserves the Commission's full attention.

Respectfully submitted,

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