

**Before the
Federal Communications Commission
Washington D.C. 20554**

In the Matter of)
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Rural Health Care Universal Service Support) WC Docket No. 02-60
Mechanism)
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REPLY COMMENTS OF GENERAL COMMUNICATION, INC.

General Communication, Inc. (“GCI”) submits these reply comments in response to the Wireline Competition Bureau’s July 19, 2012 Public Notice (“Public Notice”) with respect to the Rural Health Care (“RHC”) Program reform proceeding.¹ GCI has extensive experience providing of telecommunications services to rural healthcare providers and understands the transformational benefits of telemedicine for health care delivery in rural Alaska. As GCI explained in its initial comments,² many healthcare providers (“HCPs”) rely on the RHC’s Primary Program to treat patients in Alaska’s rural areas, rather than transporting patients from small villages and regional communities to regional health facilities or larger hospitals in Anchorage or Fairbanks. GCI is confident that the Commission can increase efficiencies in the RHC Program, which would encourage participation and expand the benefits of telemedicine to even more rural communities.

As GCI explained in its initial comments, with supporting data from the Alaska Native Tribal Health Consortium (ANTHC), the Primary Program has successfully promoted and

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

² See *Comments of General Communication, Inc.*, WC Docket No. 02-60 (filed Aug. 23, 2012) (“*GCI PN Comments*”).

supported the adoption of telehealth services by rural HCPs, and has improved the quality of healthcare in rural Alaska, while also producing a number of significant cost savings.³ The comments submitted in this proceeding have largely echoed GCI's experience, and overwhelmingly confirm the success of both the Primary Program and the pilot programs at promoting telehealth services and increasing access to telemedicine. Given the substantial benefits that the Primary Program is delivering, any new programs should supplement the Primary Program, not replace it.⁴

Facilities Ownership and Construction. As GCI and others argued in initial comments HCPs should not be required to maintain an ownership interest in underlying network facilities.⁵ To the extent the Commission provides funding for HCPs to construct and own network facilities, it should take necessary precautions.⁶ The Commission should recognize that HCPs will often lack the expertise to determine the true costs of constructing and maintaining network facilities and should require a technology plan before approving funding for construction.⁷ Moreover, as NTCA and others suggest, the Commission should not fund construction of new network facilities if existing facilities are already available as "funding infrastructure could

³ See GCI PN Comments at 3-4 and attachment (ANTHC statement). See also Comments of General Communication, Inc., WC Docket No. 02-60 (filed Sep. 8, 2010) ("GCI NPRM Comments").

⁴ See GCI PN Comments at 4; Comments of Alaska Communications Systems Group, Inc., at 5, WC Docket No. 02-60 (filed Aug. 23, 2012) ("ACS PN Comments").

⁵ See GCI PN Comments at 8.

⁶ See GCI PN Comments at 8-9; see also Comments of the Michigan Collegiate Telecommunications Association, at 4. WC Docket No. 02-60 (filed Aug. 23, 2012)(filed as 'Gary Green')("MiCTA PN Comments"); Comments of the University of Arkansas for Medical Sciences, at 6-7, WC Docket No. 02-60 (filed Aug. 23, 2012) ("UAMS PN Comments").

⁷ See GCI PN Comments at 9.

create a substantial risk of unnecessary and wasteful overbuilding of existing networks.”⁸

Building new infrastructure that duplicates existing facilities in rural areas—which are already costly to serve—would duplicate costs rather than realize efficiency gains by consolidating demand.⁹ This is especially true given that rural health care providers are major consumers of telecommunications services in sparsely populated areas.

As NTCA explains, the long term costs of maintaining infrastructure and indirect costs actually makes owning facilities less cost effective than leasing, even if it initially appears cheaper.¹⁰ Likewise, the Montana Telecommunications Association cited to information in the recent WCB Staff Report, demonstrating that “it is more efficient to purchase services than to build facilities.”¹¹

The Health Information Exchange of Montana fails to appreciate the true costs of network construction by arguing simply that infrastructure support is appropriate because “one-time investments in facilities can reduce the demand for perpetual subsidies.”¹² These purported “one-time investments” do not account for both the long-term costs of maintaining infrastructure and the indirect costs associated with owning and managing telecommunications facilities, both of which will continue long after any initial support has ended.¹³ In addition, attracting and

⁸ Comments of the National Telecommunications Cooperative Association, at 1, WC Docket No. 02-60 (filed Aug. 23, 2012)(“NTCA PN Comments”); *see also*, GCI PN Comments at 8-9; Comments of the Montana Telecommunications Association, at 6, WC Docket No. 02-60 (filed Aug. 23, 2012)(“MTA PN Comments”).

⁹ *See, e.g.*, NTCA PN Comments at 3-4; GCI NPRM Comments at 13.

¹⁰ *See* NTCA PN Comments at 2-3.

¹¹ MTA PN Comments at 4-5 (citing *Wireline Competition Bureau Evaluation of Rural Health Care Pilot Program*, Staff Report, WC Docket No. 02-60; DA 12-1332 (rel. Aug. 13, 2012)).

¹² Comments of the Health Information Exchange of Montana, at 6, WC Docket No. 02-60 (filed Aug. 23, 2012).

¹³ *See, e.g.*, NTCA PN Comments at 2-4.

retaining the skilled employees necessary to operate and maintain complicated network facilities can be prohibitively difficult in many of the rural communities most in need of telehealth services.

In its comments, NTCA highlights inefficiencies caused by funding construction of new facilities: (1) funding “the construction of redundant telecommunications infrastructure would effectively use one universal service fund mechanism (rural health care) to imperil already-existing infrastructure supported by another universal service fund mechanism (high cost);” (2) funding for new networks would essentially remove “major health care consumers from the addressable market for [] existing rural service provider[s];” and (3) new construction would “directly compete with Rural Utilities Service loans, stimulus funding grants, and other private sources of capital obtained by existing telecommunications providers to deploy infrastructure.”¹⁴ While GCI does not share NTCA’s aversion to competition, fracturing demand and subsidizing parallel facilities’ infrastructures runs counter to the Commission’s decision in the *USF/ICC Transformation Order* to eliminate support for multiple networks in the same geographic area, in favor of a single supported network.¹⁵ Commenters also note that funding facilities construction may exceed the statutory authority of the RHC Program.¹⁶

¹⁴ NTCA PN Comments at 3-4.

¹⁵ See *Connect America Fund; A National Broadband Plan for Our Future; Establishing Just and Reasonable Rates for Local Exchange Carriers; High-Cost Universal Service Support; Developing a Unified Intercarrier Compensation Regime; Federal-State Joint Board on Universal Service; Lifeline and Link-Up; Universal Service Reform--Mobility Fund*; Report and Order and Further Notice of Proposed Rulemaking, ¶316, FCC 11-161, 26 FCC Rcd. 1766 (2011) (“*USF/ICC Transformation Order*”).

¹⁶ See NTCA PN Comments at 1 n.3; Montana Telecommunications Association PN Comments at 3. In its comments, ACS seeks to have the Commission impose capital network savings “pass through” requirements on recipients of RHC support that also operate facilities that construct at least in part with federal grants or loans. See ACS PN Comments at 18-19. Aside from being unimplementable because of the difficulty in defining and determining

Multi-year (“Evergreen”) Contracts. Commenters broadly agree that simplifying the rules for multi-year contracts would improve the RHC Program—both in any new broadband support mechanism(s) as well as in the Primary Program.¹⁷ Multi-year contracts can improve efficiencies and provide long-term stability for both HCPs and providers.¹⁸ Revising the guidelines for granting “evergreen” status to multi-year contracts would also be consistent with the Public Notice’s proposed treatment of service and site substitution, which is similarly supported in the comments.¹⁹ Any changes made to simplify the treatment of multi-year contracts should apply equally to the Primary Program; it would be wrong to leave inefficiencies in the Primary Program, which could artificially depress participation and harm the RHC Program as a whole.

“capital network savings,” and its failure to recognize that loans require repayment, this proposal is well beyond the scope of this proceeding.

¹⁷ *See, e.g.*, GCI PN Comments at 11-12; Comments of the Utah Telehealth Network, at 4, WC Docket No. 02-60 (filed Aug. 24, 2012); Comments of the Missouri Telehealth Network, at 3-4, WC Docket No. 02-60 (filed Aug. 24, 2012); Comments of the California Correctional Health Care Services, at 4-5, WC Docket No. 02-60 (filed Aug. 23, 2012).

¹⁸ *See* GCI PN Comments at 10.

¹⁹ *See* GCI PN Comments at 11-12; UAMS PN Comments at 4; MiCTA PN Comments at 2; ACS PN Comments at 4-5.

CONCLUSION

GCI appreciates the opportunity to share its experience and perspective on how to improve the Rural Health Care Program and incorporate new lessons from the pilot programs, as the Commission seeks to support services that improve the quality and delivery of health care for rural providers.

Sincerely,



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