

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

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

**REPLY COMMENTS OF
RURAL NEBRASKA HEALTHCARE NETWORK**

Rural Nebraska Healthcare Network (“RNHN”) hereby submits these reply comments to certain comments on the Public Notice (“Notice”)¹ released by the Wireline Competition Bureau (“Bureau”) seeking to develop a more robust record for the Rural Health Care Support Mechanism Notice of Proposed Rulemaking (“NPRM”)² in the above-referenced docket. Specifically, the Notice seeks to establish a “more focused and comprehensive record” in this proceeding for certain topics to help the Commission “craft an efficient and permanent [rural health care] program” to expand the reach and use of broadband connectivity for and by health care providers.

I. BACKGROUND

RNHN is a consortium of nine hospitals and thirty-one clinics in the Panhandle of Nebraska that have worked together strategically since 1996 to develop sustainable local health and preventative health care services in the sparsely populated area of the Nebraska Panhandle. The participating hospitals of RNHN provide crucial access to their services through fifty-five

¹ Wireline Competition Bureau Seeks Further Comment on Issues in the Rural Health Care Reform Proceeding, WC Docket 02-60, Public Notice, DA 12-1166 (rel. Jul. 19, 2012). RNHN did not submit comments on the Notice but submits these reply comments because, after reading the comments of certain parties, RNHN feels compelled to set the record straight regarding the need for health care infrastructures that are owned and controlled by health care providers (“HCPs”).

² *In re Rural Health Care Support Mechanism*, Notice of Proposed Rulemaking, 25 FCC Rcd 9371 (2010).

primary care physicians (thirty-six general practice or family practitioners, eleven internal medicine, three pediatricians, five obstetricians/gynecologists). Six psychiatrists also practice in the region. Additionally, the hospitals operate rural health clinics, which most patients view as direct extensions of the hospitals. Two of these clinics are provider-based, seven are hospital-based and another is a federally qualified health clinic that primarily serves Scottsbluff County. All of the clinics serve the uninsured.

Offering quality health care to the residents of the Nebraska Panhandle is a challenge because the Panhandle is a rural area comprising over 14,000 square miles that is inhabited by only 91,000 persons. Offering specialized health care in the Panhandle is an even greater challenge because residents in this part of Nebraska must travel significant distances for treatment that urban areas take for granted. Nevertheless, RNHN has been successful in sharing resources and overcoming many of the barriers that rural HCPs face because it was able to end its reliance on inadequate and antiquated third party services.

RNHN applied for and was awarded \$19.2 million under the Commission's Rural Health Care Pilot Program ("Pilot Program") to design, construct, operate and maintain a fiber-optic network connecting each of its member hospitals with each other and with other health care facilities. As a result, RNHN owns and operates a 750-mile ringed and redundant fiber-optic network that spans twelve counties in the Nebraska Panhandle, eight of which are designated as "frontier" counties, and connects nine primary care hospitals and thirty-one affiliated health care clinics. Additionally, the network is connected to international carrier hotels in Denver that in the future will provide access to major medical facilities in Denver, as well as connectivity to National LambdaRail, Internet2 and other telecommunications providers. The network currently has a 2 Gigabits per second backbone capable of being upgraded to 10 Gigabits per second

without requiring any major electronics replacement. Simply put, the RNHN network provides a robust, high-capacity network that was not and is not available in the region from any communications carrier at any cost.

In its initial comments filed in response to the NPRM, RNHN strongly supported the Commission's proposals to reform and reinvigorate the rural health care support mechanism by creating a Health Infrastructure Program ("HIP"), as well as the Health Broadband Services Program ("BSP"), to permit HCPs the option of deploying new and upgraded broadband infrastructures. In other words, RNHN supports HIP as one ingredient of the goal to allow HCPs the ability to choose the best means by which to meet their needs. RNHN also commented that HIP provides an opportunity to serve entire rural communities where broadband is either unavailable or insufficient and that the Commission should recognize the benefits of private/public partnerships by allowing for-profit entities to partner with rural HCPs and to contribute any matching fund requirements. RNHN further commented that the Commission should permit HCPs to not only build and/or lease networks based on their specific needs, but to permit funding administrative expenses so that HCPs can hire the expertise needed to build, operate and manage their networks. RNHN's comments argued for the need to include for-profit HCPs, which are an important part of rural health care delivery.

In these reply comments, RNHN responds to calls for eliminating or limiting infrastructure projects and imposing onerous rules on such projects. RNHN also discusses why infrastructure projects are important to the success of rural health care and why administrative expenses related to the design and construction of such projects should be funded under HIP. RNHN addresses the Commission's plans to provide limited funding of infrastructure projects

under the BSP but cautions the Commission against arbitrary caps and the cannibalization of HIP funding.

II. LIMITED FUNDING FOR CONSTRUCTION OF FACILITIES

A. Where Construction of Network Facilities is More Cost Effective, it Should Be Permitted

RNHN reiterates its strong support for funding dedicated health care infrastructures under HIP as originally proposed by the Commission. Constructing a network from the ground up provides HCPs with greater flexibility and control over network services, enabling them to tailor their services to the needs of their communities. By owning the network, the HCP can realize lower costs, higher bandwidth and better service quality. Moreover, the HCP has the flexibility to modify the network at will to meet changing environments, applications and technologies. For instance, an HCP operating a wave network can light up as few or as many wavelengths as is needed; if the HCP needs to upgrade bandwidth, it can change out equipment without coordinating the upgrade with a carrier or worrying about term liability on a leased circuit; and if the HCP needs to test non-standard or experimental equipment, such equipment can be run on separate wavelengths. Carriers, on the other hand, can either not change their services or networks to meet such individual needs or they cannot do so in a timely and cost efficient manner.

Leasing capacity on legacy networks from established carriers does not further the goal of improving health care delivery; it merely perpetuates the *status quo*. Carriers mark up their services (capacity) knowing that the government subsidy will make their services attractive. This markup ability does not incent the carriers to expand or upgrade their networks for higher bandwidth, better latency or improved redundancy—it simply allows carriers to continue to sell low capacity circuits at what appears to be a reasonable price. Once the subsidy ends, any

network utilizing the carrier becomes immediately financially “unfeasible” because the user cannot afford the network without the subsidy. By contrast, the RNHN network has deployed infrastructure that will last a lifetime. It is completely self-sufficient and capable of being both operated and upgraded with new, improved electronics every five years for the next twenty years without any further governmental assistance. RNHN represents precisely what the Commission had in mind regarding the deployment of new infrastructure and in a manner that does not require continual governmental subsidies. It represents a true investment in new infrastructure versus expenditure for service on antiquated, legacy networks.

Several commenters have used this opportunity to argue for the elimination (or significant reduction) of infrastructure funding. If the Commission funds infrastructure projects, one commenter goes as far as requesting that the Commission impose a public comment period whereby infrastructure applications and applicants can be critiqued.³ Central to the opposition of infrastructure projects by these commenters is a concern about overbuilding (*i.e.*, the duplication of broadband infrastructure), the costs associated with network ownership and the lack of experience or expertise of HCPs in owning or managing a communications network. It is not surprising that these commenters are providers of telecommunications services that want to maintain the *status quo* of high prices along with minimal and inflexible service offerings. More than self-centered, such statements are simply wrong.

The Commission has recognized the risk of overbuilding and has proposed HIP rules to guard against such projects by requiring applicants to verify “either there is no available broadband infrastructure or the existing available broadband infrastructure is insufficient for

³ Comments of National Telecommunications Cooperative Association, WC Docket No. 02-60, at 4 (filed Aug. 23, 2012).

health IT needed to improve and provide health care delivery.”⁴ The same rules can be used for the proposed BSP infrastructure program. HIP not only takes into consideration overbuilding but it also encourages leveraging existing infrastructure.⁵ Indeed, many Pilot Program projects are hybrid networks that leverage existing facilities and, where appropriate, construct infrastructure.⁶

The costs associated with network ownership are not, to be sure, trivial, but it does not mean that they are an insurmountable burden. Under the Pilot Program, the Commission required sustainability plans for each project whereby the applicant was required to show that its network would be self-sustaining. The same criteria can be used under HIP and the proposed BSP infrastructure program.

Owning and running a network is not a core competency of HCPs; however, it is not a reason to eliminate or limit infrastructure projects. By funding administrative expenses (such as personnel, legal, program administration, technical consultation and coordination), HCPs can hire the expertise needed to build, operate and manage their networks. Put simply, excluding these costs is, in the opinion of RNHN, a material failing of the program and was a significant problem for the Pilot Program. After all, the Commission cannot expect HCPs to run a network nor can the Commission expect them to have the financial wherewithal to fund the costs of administering a network.⁷

⁴ *NPRM*, 25 FCC Rcd at 9382-83 ¶ 22.

⁵ *Id.* at 9395-66 ¶¶ 55-57.

⁶ See *Wireline Competition Bureau Evaluation of Rural Health Care Pilot Program*, Staff Report, WC Docket No. 02-60, DA 12-1332 ¶ 49 (rel. Aug. 13, 2012) (“*Staff Report*”).

⁷ Related to the funding of administrative costs is the importance of permitting consortia applications. Consortia allow HCPs to pool their administrative, financial and technical resources, which in turn provide costs savings through bulk buying power, centralization and sharing of administrative expenses. Moreover, as the Commission has noted, the consortium approach enables rural HCPs to draw on the expertise and leadership of large health care entities that have technical and administrative expertise in managing a large scale network. *Id.* at ¶¶ 81-87.

The Commission should refrain from imposing unduly burdensome and onerous rules on infrastructure applicants, such as a public comment period for infrastructure projects. They only serve to retard participation in these programs, add unnecessary delay into the process and undermine the core objectives of HIP by giving complaining carriers the ability to derail infrastructure projects. The current process whereby the applications are subject to USAC review and scrutiny is not without its own delays and burdens but it is an adequate watchdog.

The need for infrastructure projects in rural areas served by rural HCPs is as great as ever. Although Pilot Program projects have helped alleviate some of the gaps in broadband access and price disparities for broadband services in rural areas, rural HCPs continue to lack access to broadband services that are needed to support advanced telehealth applications. The Commission should not now back away from its proposals, which, by the way, follow the recommendations in the National Broadband Plan.

Although eligible to participate in the Rural Health Care Program, thousands of rural HCPs currently do not take advantage of the program.⁸ Less than twenty-five percent of the approximately 11,000 eligible institutions are participating in the Rural Health Care Program, and those that do are not acquiring connections capable of meeting their needs.⁹ There are a variety of reasons for this unfortunate circumstance but as the National Broadband Plan shows, rural HCPs have difficulty accessing broadband services that are needed to support advanced telehealth applications because they are located in areas that lack sufficient infrastructure or areas where broadband service at needed speeds is significantly more expensive.

⁸ Federal Communications Commission, *Connecting America: The National Broadband Plan*, at 214 (rel. Mar. 16, 2010), available at http://hraunfoss.fcc.gov/edocs_public/attachmatch/DOC-296935A1.pdf (“*National Broadband Plan*”).

⁹ *Id.* See also *id.* at 209-13 (discussing data showing the gap in broadband services available to rural HCPs).

The hypocrisy of the comments from carriers that propose eliminating or reducing the funding for infrastructure projects is readily apparent when looked at in light of the facts in the National Broadband Plan—if these carriers had adequate (or any) facilities available at a reasonable cost in the areas where rural HCPS serve, then the National Broadband Plans findings would paint a different picture.¹⁰

Due to this lack of adequate physical broadband infrastructure, the National Broadband Plan recommended that the Commission “establish a Health Care Broadband Infrastructure Fund to subsidize network deployment to health care delivery locations where existing networks are insufficient.”¹¹ Specifically, the National Broadband Plan recommended that the Commission should “*permanently* continue [the Pilot Program] by creating a Health Care Broadband Infrastructure Fund” due to the “overwhelming interest in the Pilot Program.”¹²

In short, due to the limitations of health care delivery in rural areas, the utility and need for the flexibility and benefits provided by HIP and the proposed BSP infrastructure program should be apparent. As RNHN recommends, any rules adopted by the Commission should permit HCPs to build a network based on their needs—whether that means constructing a new network, utilizing existing infrastructure or a combination of both is best for them to determine.

¹⁰ Adding to the hypocrisy is the record in response to the 2004 Further Notice of Proposed Rulemaking in this same docket, 19 FCC Rcd 24613 (2004), where carriers expressed support for infrastructure projects when the funds would be used to subsidize the carrier’s construction of new infrastructure and where such infrastructure would remain the property of the carrier, and not be acquired, directly or indirectly, by the beneficiary HCP. *See, e.g.*, Comments of CenturyTel, WC Docket No. 02-60, at 3-9 (filed Apr. 8, 2005); Comments of United Utilities, WC Docket No. 02-60, at 6-10 (filed Apr. 8, 2005).

¹¹ *Id.* at 215 (Recommendation 10.7).

¹² *Id.* (emphasis added).

B. No Cap Should Be Placed on the Total Funding Amount for Each Project or on the Total Number of Projects Funded

The Commission should not impose caps on the amount funded or the total projects funded under either HIP or BSP nor should the Commission cannibalize funding under HIP to fund BSP infrastructure projects.

As RNHN stated in its initial comments to the NPRM, project funding should be based on the project's proposal and justifiable need and costs, not on any cap. If necessary, projects should be prioritized based on such factors as lack of adequate or affordable broadband in the proposed geographic area, the underserved area classification of the location where the project will be deployed and the types of HCPs that will utilize the network. A per project funding cap would cause applicants to limit projects to meet funding limitations or to not apply at all, which may once again lead to unused funds and unmet needs for rural health care delivery. No one benefits when funds go unused. Moreover, setting a per project cap or cannibalizing HIP funding in favor of BSP infrastructure funding could have the effect of depriving adequate funding to an applicant who has demonstrated significant need for an infrastructure project.

III. CONCLUSION

RNHN respectfully urges the Commission to maintain its commitment to the construction of facilities in locations where broadband facilities are insufficient or non-existent. RNHN's self-sustaining implementation of a Pilot Program network built from the ground up is a prime

example of how such funding can be successful and the lack of effective broadband alternatives to RNHN is a prime example of why such funding is needed.

Respectfully submitted,

RURAL NEBRASKA HEALTHCARE
NETWORK



By: _____
Randall B. Lowe
Richard A. Gibbs
Davis Wright Tremaine LLP
1919 Pennsylvania Avenue, N.W.
Suite 800
Washington, D.C. 20006
Tel: (202) 973-4200

Its Attorneys

September 7, 2012