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SUMMARY

HIEM is a successful Rural Health Care Pilot Program participant that deployed new broadband infrastructure across northwest Montana. HIEM chose to construct new facilities rather than lease existing facilities for one reason only – because vendors offering to build and maintain those facilities offered prices that were substantially less than the prices offered by competing vendors offering to lease existing facilities. HIEM selected these lower cost bids and, three years later, has successfully deployed a future-proofed, state-of-the-art, sustainable broadband network to health care providers who have waited for years for affordable broadband access. HIEM has also successfully partnered with local carriers in the region to make privately funded excess capacity available, thereby allowing those providers opportunities to provide affordable broadband in rural communities across northwest Montana.

HIEM's success, and the success of other pilot program networks that are run by and for health care providers, demonstrate that health care providers have the expertise to manage networks. Yet more is at stake in this proceeding than simply control – what is at stake is competition and the critical importance of allowing health care providers to reduce their broadband costs, increase their bandwidth, and increase their quality of service through competition. This is the critical lesson of the pilot program and the failure to heed it will lead to the waste of precious universal service funding.

Having successfully deployed the first phase of its network, HIEM is ready to complete the remainder, which will add critical network redundancy. Accordingly, HIEM urges the Commission, in fashioning changes to the permanent RHC program, not to abandon the successful policies of the pilot program concerning health infrastructure.

First, the facilities HIEM and its members needed, in terms of speed, reliability, and affordability, were simply not there. This was proven through the competitive bidding process when existing providers bid prices to lease connectivity that were far higher than bids to construct facilities. HIEM was told outright that one carrier intended to over-build its existing plant – which undercuts the Montana Telecommunications Association’s (“MTA”) claim that the support should not be used to duplicate carrier facilities. As a result of this experience, HIEM’s simple and uncontroversial point is this: interested vendors must put their best foot forward when offering a bid to meet the needs of rural health care providers.

HIEM ultimately selected fiber builders to construct its network, not because HIEM wanted to construct facilities, but because it was much less costly to do so. While this decision has been challenged principally by MTA, no party has suggested that HIEM did not select the lowest cost bid, and no party has produced evidence traditional carriers will go out of business, or even reduce distributions, as a result of HIEM’s network.

HIEM also utilized the pilot program rules to pay out-of-pocket to install excess capacity, which it has made available to local carriers in exchange for last-mile connectivity, and which it has leased to other local carriers, thereby helping to ensure HIEM’s network sustainability. (Pilot program rules require proceeds from the leases to go to network sustainability.) In exchange, local carriers are able to extend their networks and bring improved broadband into local communities. This avoids a “siloeed” investment in health care facilities, and is a clear win-win for carriers, HIEM, the FCC, and local communities.

HIEM participants now have access to 10 Gig fiber, a virtually future proof plant, and a sustainable network model – all without dependency on perpetual universal service support. The fact is, no carrier offered anything close to these speeds and level of service throughout

northwest Montana. HIEM followed the rules, took the least cost option, and delivered a network on time and under budget. HIEM has set an example for effective use of universal service funding that should be followed, not abandoned. In contrast, proposals before the Commission to limit construction, or to make it harder to do so by requiring, for example, a public comment cycle, will harm consumers and cause the waste of program funds.

II. HIEM'S NETWORK IS IMPROVING THE LIVES OF RURAL MONTANANS

HIEM's pilot program network is live and health care providers ("HCPs") across northwest Montana are now receiving high-speed connectivity they have been waiting years for. Representatives from many of these health organizations were present on August 28, 2012, in the shadow of Glacier National Park, as HIEM formally dedicated its network. Also present were representatives of the Burlington Northern Santa Fe Railroad ("BNSF"), which made available to HIEM 184 miles of right-of-way spanning the continental divide. Representatives from three local Montana telecommunications providers who partnered with HIEM were also present as were representatives of the entire Montana congressional delegation who appeared to express appreciation on behalf of Montana's rural citizens.

The HIEM dedication was a watershed for northwest Montana and demonstrates what a successful partnership between federal agencies, private enterprise, and the local health care community can achieve. The partnership with BNSF was unprecedented when HIEM first pursued it. Because this project has succeeded, we understand that BNSF is now exploring similar fiber partnerships across the country. As a result of the partnership with BNSF, HIEM is now making affordable broadband connectivity available to health care providers on both sides of the continental divide. For example, rural clinics serving isolated populations in the Blackfoot

Nation are now linked to the regional hospital in Kalispell, Montana, bringing faster and better access to health care to at-risk populations.

Appearing at the recent HIEM network dedication was the Winkley Women's Center mobile mammography coach. This 40-foot mobile facility travels to rural clinics and hospitals across northwest Montana and features state-of-art digital mammography, breast ultrasound, and DEXA bone density screening equipment. Prior to the availability of the mobile clinic, providers would perform basic screening on site, but diagnostic results could not be provided until several days later, after the data and images were read and analyzed back in Kalispell. Not only did this waiting increase patient anxiety, but some patients would fail to return days later to obtain their test results. This failure to return can be due to a number of factors, including culture, poverty, or simply the difficulty of getting transportation back to the clinic from a very remote area. Obviously, for a patient with an adverse screening result, this means missed or delayed diagnosis and treatment. Prompt diagnosis increases the likelihood of successful patient outcomes.

Fortunately, with the advent of the HIEM network, clinics visited by the Winkley Women's Center's mobile coach now have high speed broadband connectivity. Diagnosis can now occur in real time, with patients receiving their results before they leave the coach. This provides peace of mind to anxious patients and, ultimately, saves lives by increasing the rates of early diagnosis and treatment for breast cancer. HIEM's network is delivering dramatic change for rural clinics and their patients. It has particularly benefitted Blackfeet Nation residents where the problem of failure to return was greatest. This is just one example of how the HIEM network is bringing big improvements to the lives of rural Montanans.

III. THE PILOT PROGRAM DEMONSTRATES THAT HEALTH CARE PROVIDER CONTROLLED NETWORKS ARE SUCCESSFULLY FULFILLING STATUTORY GOALS FOR UNIVERSAL SERVICE FOR HEALTH CARE

HIEM's successful pilot project continues to be denigrated in an uninformed manner by the MTA. Other groups such as the National Telecommunications Cooperative Association ("NTCA") (representing mostly small rural carriers) and the American Telemedicine Association ("ATA") challenge the idea that hospitals and health care providers have the expertise to manage networks.

In HIEM's case, these comments don't ring true. For example, at the Kalispell Regional Medical Center, its executives confront complex capital improvement projects all the time. Adding or extending a building requires among other things, managing contractors, subcontractors, budgeting, fund raising, zoning and environmental approvals. Millions of dollars are at stake. Capital investments in new IT, medical technology, and ongoing operations are all complicated transactions.²

If the pilot program has proven anything, it is that: (1) regional health care networks offer tremendous promise for reducing the cost of broadband for health care and increasing access to care; and (2) there are many different ways to establish regional health care networks

² HIEM hired an executive director whom has capably managed the FCC's pilot program processes. They have worked with public and private sector partners to bring HIEM's network together. The complexity of the task, while substantial, is not made greater by the fact that HIEM built its network, as opposed to leasing facilities from a telephone company. Other pilot program participants may decide that they do not wish to manage their network, and HIEM strongly supports the notion that they should retain that right. Likewise, those who desire and have the capability to manage a network must be given the option, especially if it can be demonstrated that it would use support funds more efficiently. Based on initial comments to the *RHC PN* it is clear that many other pilot projects own and/or manage all of or part of their networks. To name a few, these include: Geisinger Health System, Hospital Sisters Health System (St. Joseph's Hospital pilot project), Indiana Telehealth Network, Illinois Rural HealthNet, the Iowa Rural Health Telecommunications program (coordinated by the Iowa Hospital Association), the New England Telehealth Consortium, the Rural Nebraska Healthcare Network, and the Rural Wisconsin Health Cooperative. The mere existence of these HCP controlled networks – some of whom were in existence for years prior to the pilot program – refutes the claims of ATA, NTCA, MTA, and others that health care providers lack sufficient expertise.

and local circumstances influencing the best approach for a region vary widely.³ As a result, the Commission should continue to provide flexible policies that enable health care providers to determine the most efficient use of program funds and what works best for their particular situation.⁴

However, HIEM agrees with the American Hospital Association (“AHA”) that the RHC program has long suffered from substantial complexity that has made it difficult for program participants to fulfill the Commission’s objective of accelerating broadband deployment serving rural health care providers.⁵ As a result, the Commission must ensure its new rules are simple and manageable. The need for simplicity, however, does not mean the Commission should design a program that forces health care providers to take-or-leave what is offered by their local telecommunications provider, especially when the offering is substantially inferior to the needs of rural health care providers.

A. Competitive Bidding Prevents Waste of Limited Universal Service Funds

The most successful aspect of the pilot program has been using competition to increase program efficiency. The Bureau has recognized that increased competition has produced lower rates, higher bandwidth, and better service quality.⁶ This should not be surprising. As the Commission explained some fifteen years ago in the First Report and Order:

³ See *Illinois Rural HealthNet (“IRHN”) Comments*, at 2 (filed Aug. 15, 2012) (“Different parts of the country, of a state, of a county, have different broadband environments, which need to be ‘mined’ to find the most cost-effective solution.”).

⁴ See *id.* (“The critical factor [for a successful] Broadband Services Program [is] to allow for multiple types of broadband solutions . . . to create the most cost-efficient solution for each area . . .”).

⁵ See *AHA Comments*, at 2 (filed Aug. 22, 2012) (“overly complex and burdensome application and reporting requirements have been the primary reason that the Rural Health Care program historically has been underutilized.”).

⁶ See Wireline Competition Bureau, Evaluation of Rural Health Care Pilot Program, Staff Report, WC Docket 02-60, DA 12-1332, ¶ 81 (rel. Aug. 13, 2012) (*Bureau Staff Report*) (noting that, in contrast to the primary program where only 16% of funding requests included competitive bids, pilot program

We adopt a competitive bidding requirement because we find this requirement should help minimize the support required by ensuring rural health care providers are aware of cost-effective alternatives. . . . [T]his approach ‘ensures that the universal service fund is used wisely and efficiently.’⁷

Indeed, competitive bidding is central to the design of the rural health care and schools and libraries programs. As the Commission explained in the Fourth Report and Order:

We have attempted to design the universal mechanisms so that schools, libraries, and rural health care providers utilize, and obtain the advantages of, competition, to the fullest extent possible. The competitive bidding process is a key component of the Commission's effort to ensure that universal service funds support services that satisfy the precise needs of an institution, and that the services are provided at the lowest possible rates.⁸

For that reason, the disclosures by USAC regarding lack of competitive bidding in the primary RHC program (outside of Alaska)⁹ are of great concern.

One clear advantage to the pilot program is that it put an end – at least for a time and for some HCPs – to the potential for waste and abuse that comes in the absence of competition. The pilot program did this because it allowed non-traditional providers, including fiber builders, to bid against incumbent providers and to try and beat the price those incumbents were offering to provide equivalent services. As previously explained, this is exactly what happened in HIEM's case. As a result, HIEM saved its members money, conserved and stretched the impact of its pilot program award, and made additional investments intended to prevent its network from being dependent upon perpetual USF subsidies.

applications typically generated many competitive bids with 14 projects receiving more than 10 competitive bids).

⁷ See *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776, ¶ 688 (1997) (internal citation omitted) (*First Report and Order*).

⁸ See *Federal-State Joint Board on Universal Service*, CC Docket Nos. 96-45 and 97-21, Fourth Order on Reconsideration, 13 FCC Rcd 5318, 5426, ¶ 185 (1997) (*Fourth Order on Reconsideration*).

⁹ See *RHC PN* at ¶ 11.b, n.52 (between 2006 and 2010, outside of Alaska, only 11% of applicants in the legacy RHC program received competitive bids in response to requests for services)

NTCA and MTA representing primarily incumbent carriers predictably urge the Commission to walk away from this kind of competition. MTA has suggested in the past that HIEM ignored bids received from local providers – rather than acknowledging that HIEM reviewed those bids and could not responsibly accept them. Indeed, had HIEM accepted these bids it would have used up its pilot program in about five years, served fewer sites, and would have had no network. Competition gave HIEM choices, and those choices saved considerable program funds.

In response to the *RHC PN*, quite a number of pilot projects specifically noted that the competitive bidding process provides a sufficient basis to determine whether facilities should be leased or constructed.¹⁰ HIEM’s experience comparing the costs of leasing to building corroborates those commenters. However, to ameliorate concerns about potential overbuilding: HIEM proposed the following modifications to the competitive bidding process: (1) requiring the decision on construction to be based on an RFP is neutral on the question of building vs. leasing; and (2) requiring overall cost to be the primary factor on the question of building vs. leasing. These are reasonable and workable changes that would not risk further bogging down the RHC applications process.

¹⁰ See, e.g., *Hospital Sisters Health System Comments*, at 5 (filed Aug. 17, 2012) (“The competitive bidding process would serve as a mechanism to determine the most cost effective option between leasing services and construction.”); *Illinois Rural HealthNet Comments*, at 13 (filed Aug. 15, 2012) (noting that in deciding whether to obtain IRUs, lease bandwidth, or construct for various elements of their pilot program funded network “[w]e compared costs for 10-year periods for multiple scenarios, and picked the solutions that were most cost-effective, in terms of price and the capabilities allowed by the proposed solution(s).”) (emphasis in original); *Iowa Rural Health Telecommunications Program Comments*, at 2 (filed Aug. 20, 2012) (“Vendor bids from the competitive bidding process during the Pilot program clearly demonstrated whether an IRU or actual construction/ownership was the most cost effective approach.”); *Missouri Telehealth Network Comments*, at 3 (filed Aug. 24, 2012) (“HCPs could easily demonstrate cost-effectiveness by comparing the cost of owning and managing an infrastructure vs. leasing services. For example, an analysis using a five year period and a ten year period, using cost information received from a bidding process would show which option provides lower cost over time.”).

The Commission should reject NTCA’s proposal for a lengthy public comment period on any project that chooses construction as the most efficient option. Such a process would impose uncertainty, delays, and tremendous additional cost on health care providers, with no corresponding public benefit. Given the funding match requirement (and strict limitations on the sources of match funding), health care providers already have strong incentives to select the most cost-effective solution.¹¹

In sum, the Commission must focus on two objectives: meeting the needs of rural citizens and the using program funds efficiently. Any proposal, especially those put forth by parties with narrow profit-driven interests, must be rejected if they impede these two objectives.

B. Where Constructing Facilities Proves more Cost Effective, Installation of HCP-funded Excess Capacity is Lawful And Should Be Permitted

Permitting HCPs to install excess capacity at their own expense allows rural communities to benefit from the FCC investment and ensures that networks are sustainable, without perpetual dependency on universal service support.¹² Under the pilot program, any proceeds from the sale or lease of excess capacity must be used solely to sustain the network. This ensures that excess capacity is available to local carriers at low cost, enabling them to better serve their communities with increased broadband capacity and availability. HIEM’s successful partnerships with local

¹¹ 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); *2003 RHC Order*, 18 FCC Rcd 24575-6, ¶ 58 (HCP responsibility for “significant portion of service costs” ensures health care providers will select most cost-effective services).

¹² HIEM has more fully discussed the problem of perpetual universal services subsidies in previous comments. See HIEM RHC Supplemental Funding Reply Comments, WC Docket 02-60, at 4-7 (filed Mar. 7, 2011) (*HIEM Supplemental Funding Comments*); HIEM RHC NPRM Further Comments, WC Docket 02-60, at 6-9 (filed May 25, 2012) (*HIEM Further Comments*).

carriers involving leases and bandwidth exchanges of excess capacity have proved out this model as a classic win-win. It should be promoted in the new health care program as a model for others to follow.

MTA continues to ignore these facts, attacking HCP owned infrastructure, including excess capacity, as unlawful under the Telecommunications Act. MTA has previously argued (without any supporting facts) that infrastructure investments benefitting health care providers poses a threat to the rural carrier business model.¹³ HIEM again briefly addresses both arguments.

MTA's claim that the Telecommunications Act provisions pertaining to health care do not authorize investment in infrastructure is at odds with the Commission's long-held interpretation of section 254(h)(2)(A).¹⁴ From the outset the Commission recognized that section 254(h)(2)(A) provides:

[T]he authority . . . to implement a program of universal service for infrastructure development as method to enhance access to advanced telecommunications and information services . . . as long as such a program is competitively neutral, technically feasible, and economically reasonable.¹⁵

Regarding the Act's resale prohibition (section 245(h)(3)¹⁶), HIEM observes once again that the lease of excess capacity that was paid for by a health care provider and not the RHC program

¹³ See, e.g., MTA Comments, at 3-5 (filed Feb. 18, 2011) (arguing that HIEM removes traffic from existing networks thereby undermining investment in rural infrastructure).

¹⁴ 47 U.S.C. § 254(h)(2)(A) (“The Commission shall establish competitively neutral rules . . . to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for all public and nonprofit . . . health care providers . . .”).

¹⁵ See *First Report and Order*, 12 FCC Rcd 8776, at ¶ 634 (citation omitted).

¹⁶ See 47 U.S.C. § 254(h)(3) (“(3) Terms and conditions [:] Telecommunications services and network capacity provided to a [health care provider] user under this subsection may not be sold, resold, or otherwise transferred by such user in consideration for money or any other thing of value.”).

cannot violate this provision.¹⁷ Nothing in the Act precludes transactions among private parties that have used private funds to build private networks.

MTA's offers no facts to support its second claim, that permitting health care providers to invest in infrastructure undermines the business model for rural carriers. HIEM's successful partnerships with local carriers in Montana, including some MTA members, adequately rebut that claim. Nevertheless, if the Commission wishes to look further into the matter, it will need to compare the new business opportunities that local providers gain through access to HIEM fiber to the potential loss of a small number of health care provider customers in a particular area. Observing networks like HIEM will be a good place to start, as it will soon become apparent whether the parade of horrors suggested by MTA play out, requiring additional government support of their business model.

In the absence of any evidence to the contrary, the record reflects the following: HIEM sought the most cost-effective means to provision its network and, through an open competitive bidding process, selected the most cost-effective offer. MTA members had an opportunity to bid, and in some cases did so. Unfortunately, the prices offered to lease those facilities were so high, it was less costly to build.¹⁸ Why carriers who have received millions in High Cost

¹⁷ HIEM has elsewhere addressed the importance of continuing the pilot program rule of allowing health care providers to pay for excess capacity at incremental cost. Given that failure to install excess fiber can actually increase the cost of a build – for example when the number of fibers needed for HCP use is less than the number in an industry standard fiber bundle – installation of excess capacity almost always makes economic sense. *See HIEM Comments*, WC Docket 02-60, at 7-10 (filed Sep. 8, 2010). Installation of excess fiber at incremental cost should be prohibited only where it increases the cost of fiber being installed for eligible use.

¹⁸ Note that in evaluating the bids, HIEM did not take into consideration potential proceeds from excess capacity if it accepted the offer to build facilities. (In HIEM's initial comments to the *RHC PN*, HIEM proposed a rule that would prohibit consideration of such proceeds when evaluating competing bids. *See HIEM Comments*, WC Docket 02-60, at 10, fn.20 (filed Aug. 23, 2012).)

support¹⁹ and who have access to loans subsidized by the RUS, were unable or unwilling to offer their facilities at anything close to a competitive price is a question that has not been answered, and need not be answered here.

The most important thing the Commission can do to make the new program successful is to ensure that program participants continue to have the flexibility they need to choose the most efficient, least cost option available through competitive bidding. HIEM's experience is instructive. In just a few short years, HIEM has made a sustainable broadband network available to health care providers across an extremely remote and rugged area of the country, at what is essentially a bargain price for its members and for the citizens who contribute to the universal service program. These entities simply would not have access to affordable high capacity links but for HIEM and the RHC pilot program. The Commission must adopt policies going forward that recognize that an option to build will, at a minimum, ensure that all vendors offer competitive prices. As noted previously, HIEM is agnostic as to constructing or leasing network elements. But the FCC must not abandon the principle of competition, which absent expensive and intrusive Commission oversight, is the only tool that can ultimately deter waste in the RHC program.

IV. CONCLUSION

With a decision on the future of the RHC program apparently imminent, HIEM expresses its gratitude for the diligent work of Commission staffers. The Commission must maintain this commitment by continuing to permit the construction of facilities where it is less costly to do so. No party has introduced any evidence or persuasive argument why health care providers should

¹⁹ USAC quarterly filings indicate MTA member companies have received over \$331 million in High Cost support since 2003.

be forced to lease capacity from common carriers at a cost exceeding that required to construct a network, especially where the health care network has the ability and desire to construct and sustain its own network. HIEM's experience teaches that there are substantial win-win opportunities among health care providers and carriers, increasing capacity and availability of broadband for rural citizens. Limiting this program to a leasing model is certain to waste limited universal service subsidies by reducing competition and forcing health care providers to take services that do not fully meet their needs.

Respectfully submitted,

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