

December 7, 2012

VIA ELECTRONIC FILING

Marlene H. Dortch, Secretary
Federal Communications Commission
445 12th Street, S.W., Room TW-B204
Washington, DC 20554

Re: Notice of *Ex Parte* in WC Docket No. 02-60

Madam Secretary:

In accordance with Section 1.1206 of the Commission's rules, 47 C.F.R. § 1.1206, we hereby provide you with notice of an oral *ex parte* presentation in connection with the above-captioned proceeding. On December 5, 2012, Jeffrey Mitchell and undersigned counsel, on behalf of the Health Information Exchange of Montana ("HIEM") met telephonically with Michael Steffen, Legal Advisor to Chairman Genachowski, and Linda Oliver, Attorney Advisor with the Wireline Competition Bureau. We also met separately with Angela Kronenberg, Legal Advisor to Commissioner Clyburn, and with Priscilla Argeris, Legal Advisor to Commissioner Rosenworcel. We discussed specific issues related to the Commission's reforms to the Rural Health Care ("RHC") program.¹

We discussed the fact that HIEM's existing network – which does not require ongoing support from the RHC program – represented a model of cost-effective broadband deployment. We noted that HIEM's excess capacity partnerships are sustaining its network (at no cost to the USF), while making low-cost broadband available to local carriers who are in turn increasing broadband availability to rural communities.

We also discussed the importance of maintaining the existing open competitive bidding process, which ensures universal service funds are used cost-effectively. Such a process requires all vendors to compete on a level playing field to provide connectivity at the lowest possible cost

¹ See *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) (*RHC PN*); *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Notice of Proposed Rulemaking, 25 FCC Rcd 9371 (2010).

to RHC participants. For this reason we emphasized that the Commission should not adopt a two-step competitive bidding process which would foreclose competition between builders and those who claim to have available facilities sufficient for health care uses.

We also expressed concerns regarding the potential reduction of the Pilot Program's discount level below 85%. For example, a reduction to 65% would more than double the contribution required by participating health care providers (from 15% to 35%). We explained that given the challenges HIEM faced in raising the 15% match requirement, a substantial increase to 35% would represent a substantial obstacle to a project irrespective whether it is infrastructure, services, or a hybrid. We noted that the Commission previously recognized that 85% is appropriate for infrastructure deployment, and that administrative costs must be permitted to help with the start-up phase of network implementation.²

We noted further that, if the Commission does reduce the subsidy level, continuing the Pilot program's policies regarding excess capacity will be even more important. In HIEM's case, use of excess capacity, funded at incremental cost, stretched program funds much farther than would otherwise have been possible. HIEM has successfully exchanged bandwidth with rural telephone companies in its region, and exchanged bandwidth for the provision of maintenance and last-mile connectivity. HIEM has found Montana's rural telephone companies to be productive partners in assisting rural communities expand the benefits of broadband.

Finally, we stated our belief that the Commission is making overly optimistic assumptions regarding the growth of a reformed RHC support mechanism. Indeed, in the Pilot program with a subsidy level of 85%, after over five years, total commitments remain well below the \$417 million allocated to the program in 2007³ – funding which was originally expected to

² As the Commission explained in 2010:

Our experience with the Pilot Program supports the need to provide some amount of funding for administrative expenses in infrastructure projects, to support the process of designing the network and securing necessary agreements. Participants have indicated that the costs associated with infrastructure deployment can be a considerable financial burden on participants that are designing and deploying networks over vast geographic areas. Allowing a portion of funding to be used for administrative expenses could enable program participants to explore more efficient, effective means of deploying broadband for the delivery of health care. Accordingly, we propose that after a participant is selected for funding based on its initial application, it may request funding for up to 85 percent of the reasonable administrative expenses incurred in connection with the project.

See Rural Health Care Support Mechanism, WC Docket No. 02-60, Notice of Proposed Rulemaking, 25 FCC Rcd 9371, 9386-87, ¶ 37 (2010) (footnotes omitted).

³ USAC reports total RHC Pilot program commitments through November 15, 2012 totaled \$364 million. *See* Letter from Craig Davis, Vice President of Rural Health Care, USAC, to Julie Veach, Chief, Wireline Competition Bureau, WC Docket No. 02-60, at 1 (filed Nov. 16, 2012).

be committed in three years' time.⁴ Specifically, the Pilot Program assumed \$139 million per year would be committed each year for three years. Actual Pilot commitments have averaged almost half that level (\$364 million/5 years = \$73 million/year). The record from the Pilot Program is thus one of substantially slower-than-expected funds utilization – which is consistent with the entire history of the RHC program leading up to the Pilot.

In response to a request to address the view that health care providers will be able to offset the costs of the increased match requirement through cost savings and other benefits made possible by increased broadband connectivity, we provide the following: While HIEM strongly agrees that telemedicine and other services made possible by broadband will save costs to the health care system overall, the record is far from clear that these benefits or cost savings – much less actual revenue – are accruing to individual health care providers, especially those in rural areas. Indeed, as other commenters have noted, the profit margins for rural Critical Access Hospitals (CAHs) range from razor thin to negative.⁵ There are many reasons for, this including patient populations with a high percentage of Medicare participants.

In Montana, 45 of the 59 hospitals are CAHs. The only hospitals in the HIEM network that are not CAHs are Kalispell Regional Health Care and Community Medical Center. In 2010, the average operating margin for the almost 1300 CAHs in the country was 0.75%; for Montana, the average operating margin for CAHs was -0.47%. (Operating margin reflects the ratio of net operating income to operating revenue.)⁶ The data thus shows that Montana CAHs do not have “excess” revenue for broadband or any of the other investments that they are being required to make as the nation upgrades its health information technology infrastructure.

In addition, while access to broadband drives efficiencies and lower costs, we are aware of nothing in the record to suggest that access to broadband through the RHC Pilot program has improved the situation for Montana CAHs so much that a substantial reduction in the discount level can be easily absorbed.⁷ When it comes to rural critical care facilities, the Commission

⁴ See *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 22 FCC Rcd 20360, 20361, ¶ 2 (2007).

⁵ See, e.g., Letter from B. Russell (“Rusty”) Hensley, Esq, Vice President Legal and Government Affairs, Healthland, to Marlene H. Dortch, Secretary, Federal Communications Commission, in WC Docket 02-60, at 1 (dated Dec. 4. 2012) (noting rural hospitals typically operate with narrow margin of profit and often operate with loss).

⁶ See *Flex Monitoring Team Data Summary Report No. 10: CAH Financial Indicators Report: Summary of Indicator Medians by State*, Flex Monitoring Team, University of Minnesota, University of North Carolina at Chapel Hill, University of Southern Maine, at 4 (August 2012) (“Flex Monitoring Report”), available at http://www.flexmonitoring.org/documents/DataSummaryReportNo10_StateMedians2012.pdf.

⁷ Evidence suggests instead that broadband access is not yet a factor in profit margins. See *Improving Financial Performance Of CAHs National Conference of State Flex Programs*, Slide Presentation, slides 21-22 (Jul. 12, 2011), available at http://flexmonitoring.org/documents/FMT-Finance-Update_FlexConference2011_Pink.pdf (recent

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should act incrementally. A dramatic decrease that cuts services to CAH facilities should not be undertaken without solid record evidence. By far the better course is to act incrementally and continue to develop the record each year on how rural providers are faring in the permanent program.

We also spoke with Ms. Oliver via telephone on December 6, 2012, and discussed whether HIEM supported including skilled nursing facilities as eligible entities. While HIEM is very supportive of broadening the definitions of eligible health care providers to include entities such as skilled nursing facilities, HIEM believes that reducing the discount level to 65% or even 75% would make this change of little value. This is because rural health care providers – especially those who, like HIEM, desire to make long-term investments in their networks – will be unable meet such a match requirement.

In conclusion, HIEM applauds the Commission for finalizing rules to reform the Rural Health Program, thereby completing its reform efforts for the four USF support mechanisms. A copy of our presentation slides is enclosed.

If you have any questions or require any additional information, please contact undersigned counsel directly.

Sincerely,



David A. LaFuria
Counsel for Health
Information Exchange of Montana

Enclosure

survey of CAH CEOs and CFOs identified increased investment in information technology as producing “mediocre” results on margins; do not even identify broadband connectivity as factor positively affecting margins).



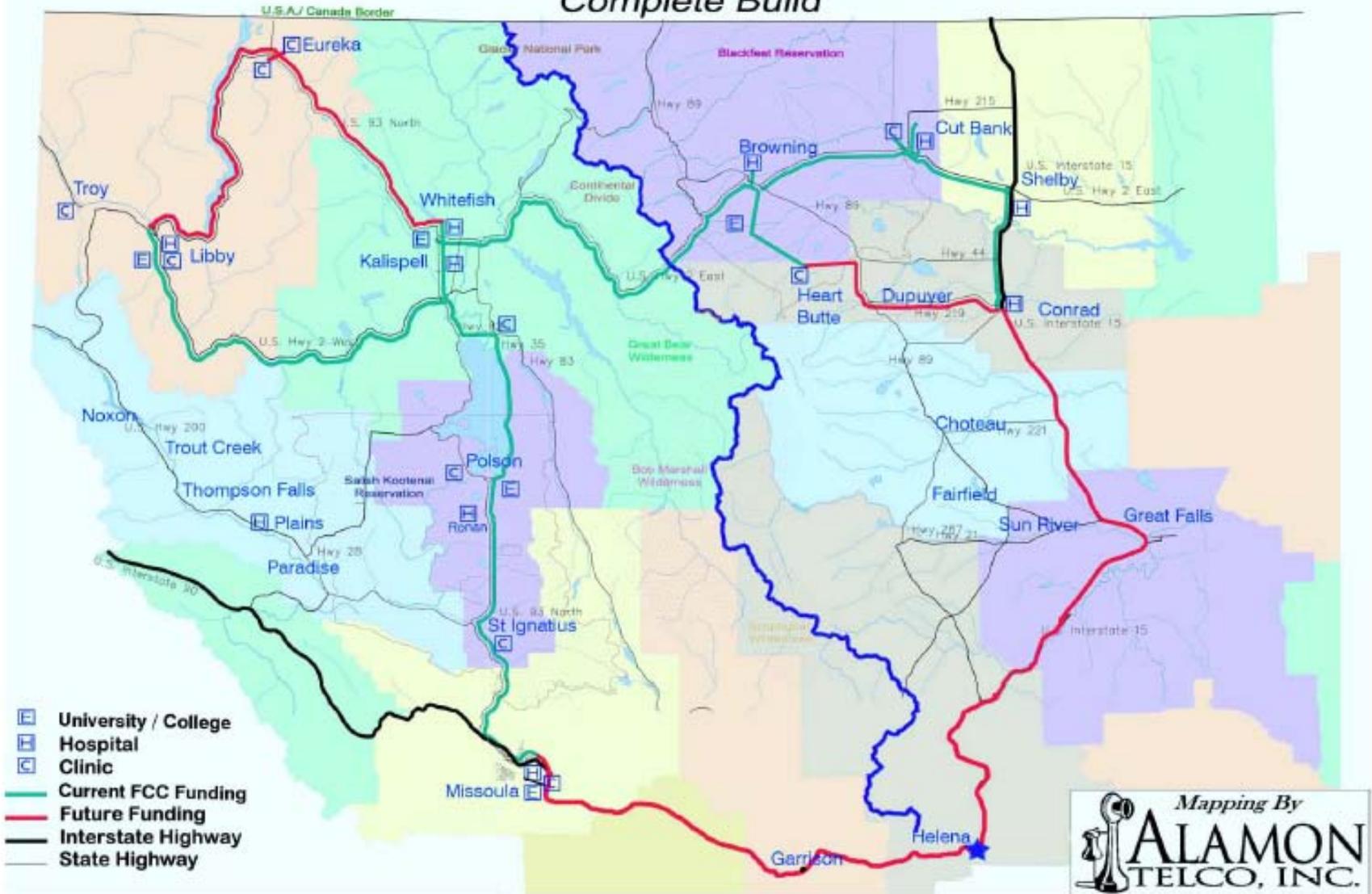
HEALTH INFORMATION EXCHANGE OF MONTANA

Rural Health Care Program

Ensuring Effective Reforms

December 2012

Health Information Exchange of Montana Complete Build



Rural Health Care Pilot Program

Policies that are working:

- Competitive bidding increases cost effectiveness.
- Excess capacity is helping to sustain networks and provide opportunities for carriers.
- 15% program match provides incentives to participants without setting the bar too high.

Competition is the Answer

- *Competitive bidding leads to “Lower Rates, Higher Bandwidth, and Better Service Quality”*
 - Bureau Pilot Program Evaluation at paras. 81-83
- *HIEM saved program funds by selecting a build/maintain option.*
 - HIEM was agnostic as to build vs. lease
 - Bidders offering to lease existing facilities did not offer competitive pricing
 - Leasing costs were so high, HIEM would not have been able to establish a sustainable network
 - HIEM’s network does not require ongoing RHC subsidies to maintain
- *May the lowest cost option win*
 - No “two-step” competitive process needed for infrastructure;
 - Those with existing facilities should be able to offer a lease price that is competitive with a build/maintain option

Excess Capacity Creates Partnerships

- HIEM has provided excess capacity to carriers seeking to expand at low cost, in exchange for access to last mile carrier fiber.
- HIEM has partnered with BNSF to extend broadband access across Continental Divide.
- Reciprocal dark fiber agreements with Montana BTOP winner.

Excess Capacity Makes Sense

- Beneficial
 - Local carriers obtain access to low cost fiber which they can use to provide affordable broadband to local communities
 - Local communities benefit at no cost to USF
- Sustainable
 - Excess capacity proceeds improve sustainability of RHC networks
- Efficient
 - Excess capacity partnerships ensure no silos of RHC-only facilities
- Lawful
 - Construction of excess capacity does not use program funds and does not violate the Act
- Vital
 - Reduction of discount from 85% would make excess capacity options more important

15% Match Funding Ensures Wise Investments

- Pilot's 85% discount was not easy
 - *No eligibility for administrative costs*
 - *Large up-front costs (esp. infrastructure projects and pre-pays)*
- Increasing match will disproportionately impact those rural HCPs that are the most remote
 - *Most remote rural HCPs have largest NRCs*
 - *Networks like HIEM with high proportion of remote rural HCPs also will be disproportionately affected*
- New RHC Health Infrastructure Program originally proposed 85% subsidy and eligibility for administrative start-up costs (up to \$300K)
 - *BTOP is 80/20% and permitted in-kind contributions (i.e., labor).*