



and the Brazos Valley Council of Governments (“BVCOG”) who would like to bring affordable broadband to health care providers across the vast rural areas of Texas that it serves.<sup>3</sup>

Commenters supporting the Petition are AT&T, Inc. (“AT&T”) and the Montana Telecommunications Association (“MTA”).

## **I. NETWORK SELF-PROVIDERS ARE NOT RESELLING CARRIER PROVIDED SERVICES**

Petition supporters are incorrect that the prohibition against resale contained in Section 254(h)(3) applies to self-provisioned facilities such as the networks HIEM and RNHN have successfully deployed.<sup>4</sup> As HIEM has explained, health care providers in these networks are not “reselling” anything; rather they are self-provisioning their own network capacity as a last resort in areas where existing providers have proved unable to cost-effectively provide broadband service sufficient to support health care applications. Commission rules allow ineligible entities – such as for-profit hospitals or doctors’ offices – to join these self-provisioned networks as long as they share fairly in the costs.<sup>5</sup> This “fair share” requirement assures that these ineligible network participants do not receive the direct benefit of the universal service subsidy. This requirement is analogous to RHC legacy rules which have long permitted ineligible consortium members to obtain the benefit of lower pricing made possible by the bulk purchase of services by a group of eligible entities.<sup>6</sup>

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<sup>3</sup> BVCOG comments at 2.

<sup>4</sup> 47 U.S.C. section 254(h)(3) provides: “(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.”

<sup>5</sup> See 47 C.F.R. § 54.639(d)(1)(ii) (requiring proration of the undiscounted price for shared facilities between eligible and ineligible sites).

<sup>6</sup> See 47 C.F.R. § 54.604(a)(1) (“A consortium may include ineligible private sector entities if such consortium is only receiving services at tariffed rates or at market rates from those providers who do not file tariffs.”).

Petition supporters who oppose these rules focus on the “fair share” requirement for ineligible network participants as evidence that this constitutes prohibited resale.<sup>7</sup> As RNHN correctly notes, however, the Commission has long defined resale as the reoffering of carrier-provided services to the public for profit.<sup>8</sup> Citing legislative history, RNHN explains that the element of profit (“monetary gain”) was central for Congress when it enacted Section 254(h)(3).<sup>9</sup> Thus, for “resale” to be occurring there must be both a carrier-provided service that is being resold, and a profit. In the case of self-provisioned networks under the RHC pilot and the new *Healthcare Connect Fund*, there is neither.

RNHN further explains that joint purchasing and network-sharing arrangements have also long been recognized and permitted under Commission rules.<sup>10</sup> Thus, allowing ineligible entities to self-provision network services in the same network with eligible health care providers – but without the benefit of the universal service discount – is both lawful and in-line with long established principles.<sup>11</sup> Network sharing is also efficient, spreading network costs among a

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<sup>7</sup> See AT&T comments at 2-3 (“Congress did not establish any exception from the resale prohibition for HCPs that are successful in obtaining a ‘fair price’ from their customers.”).

<sup>8</sup> See RNHN comments at 5. The Commission’s implementation of Section 254(h)(3) expressly applies only to “services.” See 47 C.F.R. § 54.671(a) (“Services purchased pursuant to universal service support mechanisms under this subpart shall not be sold, resold, or transferred in consideration for money or any other thing of value.”).

<sup>9</sup> See RNHN comments at 5.

<sup>10</sup> See RNHN comments at 5-6; see also, e.g., *In re Federal-State Joint Board on Universal Service*, Report and Order, 12 FCC Red 8776, 9146, ¶ 719 (1997) (*First Report and Order*) (adopting with slight modification “the Joint Board’s recommendation to encourage health care providers to enter into aggregate purchasing and maintenance agreements for telecommunications services with other entities and individuals, as long as the entities not eligible for universal service support pay full rates for their portion of the services.”).

<sup>11</sup> See *id.*; *supra* fn.6.

larger number of participants and helping to conserve limited funds.<sup>12</sup>

## **II. LEASING EXCESS CAPACITY PAID FOR WITHOUT UNIVERSAL SERVICE SUPPORT IS NOT RESALE**

Commission rules allow health care providers to install excess capacity at their own expense provided it does not increase costs for the universal service supported portion of the network.<sup>13</sup> Because health care providers own this excess capacity, it can be used for any purpose; however the Commission prohibited the outright sale of such excess capacity and limited how proceeds from leasing out excess capacity can be used.<sup>14</sup> Petition supporters incorrectly argue that sharing or leasing this health-care provider owned excess capacity also constitutes prohibited resale.<sup>15</sup>

As RNHN and HIEM both noted, because the excess capacity at issue is fully paid for with private funds, not universal service funds, it cannot constitute the reselling of universal service supported services.<sup>16</sup> The fact that the Commission prohibits the outright sale of health care provider-owned excess capacity, and requires proceeds from leasing health-care provided

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<sup>12</sup> AT&T complains also of the possibility of “artificially low rates.” To be sustainable, these networks must recover their costs, so there is nothing artificial about “fair share.” The Commission should also note that AT&T’s desire to equate cost-sharing with prohibited resale goes beyond the issue of allowing ineligible entities to participate in health care provider-constructed networks. Their reasoning clearly extends to sharing network equipment such as core network routers. For example, health care providers who lease connectivity as a service but operate a network operations center (“NOC”) are also permitted to allow ineligible entities to participate in their networks by paying a fair share of common costs. But in AT&T’s view, this would apparently also constitute the prohibited resale of excess network capacity because “in the absence of significant universal service support [these facilities] would not exist.” Thus, the cost sharing principle being challenged applies not just to a small number of pilot networks that constructed networks, such as HIEM and RNHN; rather it affects any RHC pilot project that owns core routers or shares any kind of network equipment – and perhaps even affects projects providing any shared network services.

<sup>13</sup> See 47 C.F.R. § 54.633(d).

<sup>14</sup> *Id.*

<sup>15</sup> See AT&T comments at 3-4.

<sup>16</sup> RNHN comments at 6; HIEM comments at 5.

excess capacity to be used only to support the network, does not change this essential fact.<sup>17</sup>

These limitations are reasonable and simply avoid creating unnecessary incentives to construct new facilities.<sup>18</sup>

### **III. THE OPTION TO BUILD OR LEASE FACILITIES INCREASES ACCESS TO HEALTH CARE AND HELPS ENSURE UNIVERSAL SERVICE FUNDS ARE NOT WASTED**

Petition supporters do not question that the challenged rules – recently codified by the *Healthcare Connect Order* but in effect since 2007 through the RHC pilot – have succeeded in fulfilling their statutory purpose: “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.”<sup>19</sup> Indeed the record in this proceeding is overwhelming that the RHC pilot, which first implemented policies allowing health care provider-owned infrastructure, was successful in achieving this objective.

In HIEM’s case, many of its members are now using their broadband connections to provide better and faster access to health services than before the implementation of the HIEM network. These improvements may never have occurred for HIEM’s members – and certainly would not have occurred as quickly as they did, but for the ability to obtain dark fiber or construct new facilities where more cost effective.<sup>20</sup> RNHN comments that these policies allowed it “to convert an antiquated and expensive network of carrier-provided T-1 lines (1.544 Mbps) to a state-of-the-art network,” in the process improving RNHN members’ ability to

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<sup>17</sup> See 47 C.F.R. § 54.633(d)(7). These reasonable limitations avoid unnecessary incentives to construct new facilities.

<sup>18</sup> See also 47 C.F.R. § 54.633(d)(1) (cannot consider excess capacity proceeds when considering whether building new facilities is more cost effective than leasing existing facilities.).

<sup>19</sup> 47 U.S.C. § 254(h)(2)(A).

<sup>20</sup> See also RNHN comments a 7-8 (noting failure of existing carriers to provide these needed services as reason itself for these investments).

provide patients timely diagnoses and treatment.”<sup>21</sup> These demonstrated benefits are why the Wireline Competition Bureau, in its assessment of the RHC pilot, concluded that “funding of network construction and upgrades can be essential in order to provide rural HCPs . . . access to broadband where it is not already available.”<sup>22</sup>

The record is also clear that competition increases the options available to health care providers to meet their broadband needs and is in line with long-established Commission policy that ensures wise use of universal service funding.<sup>23</sup> Indeed, the rules do not encourage new construction but rather allow it to occur in situations where a cost comparison to available alternatives establishes that it is the better option.<sup>24</sup>

Indeed, as commenter BVCOG observes, whether new facilities are required to meet the broadband needs of health care providers in a particular region can and should be determined through an open and neutral competitive bid process; it should not be determined here and now, by eliminating constructing or leasing dark fiber as an option.<sup>25</sup> Forcing health care providers to purchase excessively priced inferior services will not bring the increased bandwidth and service quality desperately needed by many rural health care providers. HIEM’s members well know that the most rural areas can languish for years waiting for private investment to deliver

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<sup>21</sup> *Id.* at 2.

<sup>22</sup> See *Wireline Competition Bureau Interim Evaluation of Rural Health Care Pilot Program Staff Report*, WC Docket No. 02-60, Staff Report, 27 FCC Rcd 9387, ¶ 91 (2012) (*Pilot Evaluation*); see also *id.* at ¶ 93. (“[T]he ability to use program funds for some construction, even in limited circumstances, benefited projects. . . . In many cases, last mile and even middle mile broadband facilities do not exist in some of the rural areas that Pilot projects serve, so construction was an important element in providing broadband capability to HCPs located in those areas.”).

<sup>23</sup> *HIEM Comments* at 2-3 and n.3.

<sup>24</sup> See 47 C.F.R. § 54.636(a)(2) (“Support for participant-constructed and owned network facilities is only available where the consortium demonstrates that constructing its own network facilities is the most cost-effective option after competitive bidding . . .”).

<sup>25</sup> BVCOG comments at 2-3.

broadband. When the Commission establishes innovative universal service policies which successfully stimulate new and upgraded facilities in such areas, such as occurred here, it is to be applauded.

#### **IV. RECONSIDERATION IS PROCEDURALLY DEFFICIENT**

HIEM agrees with RNHN that the Petition does not meet the Commission’s standards for reconsideration and should be dismissed.<sup>26</sup> HIEM also noted in its comments that the arguments raised by USTelecom have already been “thoroughly considered” in this proceeding and rejected. Specifically, as HIEM and RNHN both note, the Petition’s argument that dark fiber is not a service has twice been fully considered and rejected by the Commission: once in this proceeding and once in the E-rate docket.<sup>27</sup> Other commenters simply restated these previously rejected arguments.<sup>28</sup>

As previously noted, Commission policies promoting health care provider-owned infrastructure were first implemented in 2007 in the RHC pilot where the Commission concluded that participation by ineligible participants in these networks did not violate the resale prohibition as they paid a “fair share” of the cost and thus did not receive the benefit of the

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<sup>26</sup> See 47 C.F.R. § 1.429(1)(3) (“Petitions for reconsideration of a Commission action that plainly do not warrant consideration . . . may be dismissed or denied [including, for example, petitions that (3)] Rely on arguments that have been fully considered and rejected by the Commission within the same proceeding.”); RNHN Comments at 2-3.

<sup>27</sup> See RNHN comments at 8-9 (citing specific comments in E-rate docket that raised the same dark fiber arguments raised in the Petition); HIEM comments at 6; *see also Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, ¶¶ 123-24 and n.334 (rel. Dec. 21, 2012) (*Healthcare Connect Order*); *Schools and Libraries Universal Service Support Mechanism, A National Broadband Plan For Our Future*, CC Docket No. 02-6, GN Docket No. 09-51, Sixth Report and Order, FCC 10-175, ¶ 12 (2010) (*E-Rate Sixth Report and Order*).

<sup>28</sup> See, e.g., AT&T comments at 4-5 (asking the Commission not to compound its error by again finding that dark fiber is supportable as a service).

universal service funding.<sup>29</sup> At that time the Commission anticipated the arguments that were later raised in comments leading to the *Healthcare Connect Order* and which are now set forth in the Petition.<sup>30</sup> As noted by HIEM and RNHN, the *Healthcare Connect Order* considered and specifically rejected these arguments<sup>31</sup> – arguments which are repeated one last time by commenters AT&T and MTA.<sup>32</sup>

## V. CONCLUSION

The Commission should dismiss those parts of the Petition challenging the new Healthcare Connect Fund rules on dark fiber and excess capacity because the Petition simply

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<sup>29</sup> See *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 22 FCC Rcd 20360, 20416, ¶ 107 (2007) (*2007 Pilot Program Selection Order*) (“[T]he prohibition on resale does not prohibit for-profit entities, paying their fair share of network costs, from participating in a selected participant’s network. Section 254(h)(3) of the 1996 Act and section 54.617(a) of the Commission’s rules are not implicated when for-profit entities pay their own costs and do not receive discounts provided to eligible health care providers.”) (internal citations omitted); see also *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 21 FCC Rcd 11111, ¶ 14 (2006) (*2006 Pilot Program Order*) (finding that section 254(h)(2)(A) “authorizes support for construction of facilities for the purposes of this pilot program.”) (citing *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776, ¶ 634 (1997)).

<sup>30</sup> See *Healthcare Connect Order* at ¶ 80 (“As the Commission determined in connection with the Pilot Program, ‘the prohibition on resale does not prohibit for-profit entities, paying their fair share of network costs, from participating in a selected participant’s network.’ It concluded that the resale provision is ‘not implicated when for-profit entities pay their own costs and do not receive discounts provided to eligible health care providers’ because only subsidized services and network capacity can be said to have been ‘provided ... under this subsection.’”) (internal citations omitted).

<sup>31</sup> RNHN comments at 3-4 (noting arguments previously advanced by Qwest Communications International, Inc., Montana Telecommunications Association (“MTA”), Verizon and Verizon Wireless, AT&T, and National Cable & Telecommunications Association opposing the eligibility of dark fiber; and arguments previously advanced by MTA and AT&T opposing health care provider-owned infrastructure); see also HIEM comments at 1, 6. RNHN also comments that under 47 C.F.R. Section 1.429(b) the petition should be dismissed for failure to raise arguments that could have been raised at an earlier stage in the proceeding. *Id.* at 4.

<sup>32</sup> The tired arguments raised in the Petition have been repetitively asserted by MTA for years. HIEM has specifically been singled out by MTA with regular accusations that HIEM’s Pilot Program network is unlawful. Yet to this day MTA refuses to address HIEM’s responses to these accusations – for example, how an incumbent provider could justify offering services to HIEM at prices far in excess of the cost for HIEM to install entirely new facilities. Assuming there is such a justification, it is too late now to provide it; the Commission considered all of these arguments in the lead up to the *Healthcare Connect Order*, and found them “unconvincing” – see *Healthcare Connect Order* at paragraph 80. It is time to finally move on.

reasserts the same tired arguments which the Commission has repeatedly considered and rejected. In the event the Commission nonetheless reaches the merits of the Petition, it is uncontested that the challenged rules, which have effectively been in operation for over six years, have furthered the statutory goals of Section 254(h)(A)(1) to increase access to advanced and information services to healthcare providers. Finally, Petitioner's understanding of what constitutes resale is flawed both legally and factually and thus the prohibition on resale does not apply. Accordingly, the Petition should be denied with respect to reconsideration of Rural Health Care Program rules permitting health care providers to lease dark fiber or construct new network facilities in cases where it is more cost effective than available alternatives.

Respectfully submitted,

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