VIA ELECTRONIC DELIVERY Date: November 26, 2013

Marlene H. Dortch, Secretary
Federal Communications Commission
Office of the Secretary
445 12th Street, SW
Room TW-A25
Washington, DC 20554

RE: Oregon Health Network – Request for Review of Decision of the Universal Service Administrator to Reverse Decision on the Exclusion of Urban Clinics and Increased Administrative Burden and Delay of New Healthcare Connect Fund

Dear Secretary Dortch,

On behalf of the Oregon Health Network (OHN), and our parent organization OCHIN, please find OHN's request for Review of Decision of the Universal Service Administrator.

OHN, pursuant to 47 C.F.R. §§ 601, 630(b), 719, respectfully requests that the following determination of ineligibility by USAC Rural Health Care Division be reviewed and the decision reversed. Specifically, OHN respectfully requests that the Secretary rule that non-rural, non-profit clinics be deemed eligible if they are a part of a consortium application, provided the same rural/non-rural minimum threshold ratio is maintained, per the current Rule and Order.

Should you have any questions, please do not hesitate to contact me.

Respectfully Submitted,

Kim Klupenger
VP, Business Development & Account Management, OCHIN Inc.
Project Coordinator, Oregon Health Network

Introduction & Summary: Appeal of USAC Eligibility Determination regarding HCP

Oregon Health Network (OHN) is one of the FCC Rural Health Care Pilot Program's (RHCPP's) top three largest and most successful of the original 62 RHCPP's rolled out across the country. OHN's leased and monitored network-of-networks model has proven technologically effective, efficient, scalable and sustainable and has been referenced as a model for other RHCPP healthcare networks nationwide. Upon receipt of the FCC's fifth largest RHCPP subsidy award of $20.182M, OHN's urban-rural, multiple-vendor network that is monitored 24/7/365 by a third party network operations center (NOC), has not only met, but exceeded the FCC's requirements and vision to identify and support the next generation of national, integrated broadband infrastructure. This infrastructure is not desired, but rather fundamentally required to support the national agenda to improve the access to quality healthcare at reduced costs, improve patient outcomes and increase efforts surrounding the advanced coordination of care.

Through OHN's innovative model and commitment, the majority of OHN's FCC $20.182M investment will be fully utilized come June 2014. Additionally, this FCC funding has successfully supported the deployment of new fiber infrastructure where needed, and also utilized existing infrastructure when possible (reducing overbuild and unnecessary cost) to maximize the use and expansion of connectivity across the state. As a result of this funding, FCC-funded infrastructure has benefitted 35 out of the 36 urban, rural and frontier counties in Oregon. This includes 229 RHCPP-eligible funded hospital, clinic, Oregon Department of Corrections, Oregon Youth Authority and community college (that provide healthcare education) connections.

As stated and referenced in numerous OHN exparte notices from 2009 to 2012 to the FCC, and as clearly supported by the FCC itself after being sited within the FCC's Healthcare Connect Fund (HCF) final rule and order, the inclusion of eligible urban healthcare provider locations has proven itself to be a fundamental element in building out networks of these kind that are needed to advance the national healthcare, economic and workforce objectives on both the state and federal levels. Urban providers serve as the anchor tenants in networks of this type and size. They house the data, specialists and populations that support the overall value and sustainability of the best and original "consortium networks" like OHN.

OHN respectfully requests that the Secretary reverse USAC's determination of the eligibility for "Non-rural Health Clinic" sites because USAC's determination of the eligibility contradicts the language of the Order and USAC's reasoning for criteria not explicitly stated in the HCF Order or HCF Order FAQs.

A RHCPP-Consortium Network's Fragile & Innovative Path to Sustainability

The introduction and value of the HCF "consortium network" concept was birthed out of the best practices and lessons learned from the RHCPP. As stated in many of OHN's exparte notices, there are several primary success factors critical to the success of a sustainable consortium network within this complex and newly developing healthcare landscape.

A core factor of OHN's financial sustainability was based upon its ability to obtain the support and initial seed funding of urban anchor tenant members (hospitals and health systems) and general funds allocation through Oregon's Department of Human Services. Without this initial start-up funding, OHN would not have been able to exist. Secondly, after this financial and community support was obtained, OHN had to learn gradually what this new market and membership (sites) could afford as it related to annual membership fees to help cover the costs of OHN's long-term sustainability requirements. Through OHN's high-performance network, customer service and timely valued wrap-around federal program management, health IT and telehealth solutions, a well-accepted and fair membership fee structure has been identified and implemented to cover the basic costs associated with managing a core societal healthcare "utility" network such as the Oregon Health Network. These fees are based upon the assumption that eligible urban clinics will continue to be covered as stated within the HCF. With a mere 6.5 full time employees, OHN provides an expansive array of services to assist membership in the full use and adoption of the FCC programs and the network to support healthcare transformation and delivery. OHN has proudly proven itself to be one of the leading and leanest RHCPP's in the country.

To date, operating on a very thin margin, OHN services over 231 funded connections (representing 229 health care providers and educational institutions) with a $1.050M annual budget to provide the following services:

- FCC/USAC program management services: eligibility and funding, RFP management/scoring, invoicing/subsidy drawdown and reconciliation, auditing, and monthly reporting
- MS SharePoint portal management for members to support education, outreach, auditing, billing, and interconnectivity to federal program systems that greatly reduce paperwork and improve efficiencies
- Network mapping and scoping
- Management of 13 Oregon telecommunications service providers; private, public, local and national
- Management of the third party Network Operations Center (NOC) to monitor our members' connections 24/7/365
- Statewide outreach, education and advocacy
- National outreach, education and sharing of best practices with other RHCPP's to assure full use and adoption on the network and new healthcare strategies & technologies

Assuming that the FCC supports the HCF as written (including urban provider sites as eligible for funding), OHN anticipates bringing on 36 new urban and 88 new rural connections in Oregon, Washington, Idaho, Montana and Alaska, sustainably. OHN's revenue structure is based entirely upon current and new membership fees, with the urban anchor tenants absorbing the majority of the costs to ensure affordable access and connectivity to the rural member locations. Outside of the financial implications of not allowing new urban sites to join the network with HCF funding, there are additional cascading effects that contribute to the gradual demise of the value of the network and the healthcare landscape statewide.

OHN advocated for and supported the final HCF rule and order, and has based its business model and outreach efforts upon the FCC and USAC management of that rule and order, as well as preceding presentation materials from the FCC and USAC that stated urban providers would be eligible. Currently, and in conflict with the final rule and order, USAC has stated that it will not allow the addition of urban sites; resulting in added eligibility barriers that never existed in the RHCPP, and has consistently put upon OHN additional and unjust administrative burden as well as sustainability stress. This is true for most all other projects across the nation as well. In addition, the recent staff turn-over and administrative change at USAC has provided us with project coaches that lack the experience and expertise that we were provided with in the RHCPP. We have been provided little direction, guidance or instruction in a timely manner. This has resulted in OHN and our state being over three months behind in rolling out the HCF. This subsidized infrastructure is required to support the Office of the National Coordinator and Centers for Medicare & Medicaid's electronic health record, health information exchange and accountable care coordination (ACO) models that have penalties taking effect 2014 for providers of all types and locations. This is something OHN can simply not sustain.

OHN and other RHCPP's (and now HCF Consortium Networks) are now being told through USAC that the FCC is worried about the HCF (as written) exceeding the $400M Rural Health Care Pilot Program cap. This concern is not valid as referenced below in the actual site data and average (conservative) install and monthly recurring cost breakdown.

HCF "Cap Analysis": Financial Forecast across all 52 projects

Annual national average *re-occurring* cost for non-rural "urban" clinics at 65% subsidy:

Annual national re-occurring cost @ 65%	$14,775
Number of projects	52
Average number of non-rural "urban" clinics per project	19
Total (number of existing projects multiplied by average number of non-rural "urban" clinics)	988
Annual national re-occurring cost for urban clinics	**$14,598,038**

Annual national average of all other sites (rural, non-urban):

Average number of all other sites per project (rural, non-urban)	200
Number of projects	52
Total (number of existing projects multiplied by average number of other sites (rural, non-urban)	10,400
Annual national cost of all other sites (rural, non-urban)	**$153,663,554.20**

Annual national average *install* of non-rural, "urban" clinics:

Average annual install	$6,876
Total new non-rural, "urban" clinics forecasted per project	100
Number of projects	52
Total (number of existing projects multiplied by average number of new urban site installs)	5,200
Annual national cost of all new site installs for non-rural, "urban" clinics	**$35,754,414.58**

Grand Total Forecasted Cost at 200 sites per project, 52 projects, and 100 new sites per project:

$189,417,968.78

Given the above breakdown, including the national average of both installation and monthly reoccurring costs for both existing and new sites, rural and non-rural, the FCC has no reason to believe that the annual cap would be breached, and should therefore, without delay, advise USAC to abide by the approved HCF to allow eligible urban clinics access to these program funds.

OHN: A National RHCPP and Healthcare Transformation Success Story

The State of Oregon continues to take a lead role nationally in playing a critical role in healthcare transformation. As a leading RHCPP, OHN has in the last year continued in its tradition of being a vision and innovation lead by being the first FCC RHCPP to merge with a CMS Regional Extension Center (REC) to better serve federal and state government's efforts to redesign our healthcare system to improve care and reduce costs. Urban health care providers play a major role in coordinating care efforts, as well as reducing overall costs by allowing our rural providers the ability to connect with them through the OHN. Oregon's Regional Extension Center (called O-HITEC) is run by a health IT non-profit service provider called OCHIN. By aligning these two federal programs, OHN and OCHIN/O-HITEC are better positioned to assist all

providers, regardless of type and location, to successfully move from the silo'd systems of the past on to the integrated and coordinated system models of the future. All healthcare providers must be connected at a network, systems, data and workflow level to make the desired change our country seeks. The FCC was charged in identifying the healthcare networks of the future required to do so through the RHCPP, and as a result of their findings, designed a very fair and conservative program to support transformation expansion in the HCF. Unfortunately and as stated prior, USAC's translation of that final rule and order includes the elimination of urban clinics, as well as other administratively burdensome obstacles that not only undermine the language of the HCF, they undermine the transformation of healthcare and the viability of communities nationwide.

Overview of Costs & Current Action Associated with HCF Changes & Delay

The decision to exclude urban clinics from participating in the HCF fund came months after OHN began its onboarding process for both current providers who are choosing to transition from the RHCPP to the HCF as well as new providers who wish to participate. Immediately following the FCC's release of the HCF Final Rule and Order, one of OHN's top priorities has been collecting provider data, working on the design of the network including engineering and architecture, developing new partnerships for shared patient services, telemedicine programs, image sharing and new HIT functionality in preparation for the upcoming HCF program. OHN has been conducting massive outreach efforts including on-site visits with providers across the state of Oregon (and beyond) to prepare both existing and new members for the upcoming program. This has included not only the initial onboarding process as mentioned above, but also the obtaining of necessary legal and process documentation. For OHN staff specifically, this has attributed to over 7,000 hours of staff time and over $300,000 in administrative overhead for onboarding activities that include working with our urban providers.

Additionally, OHN has been working with Representative Greg Walden's office (including Ray Baum) and the rest of the Oregon delegation for over three years to assist the FCC in creating a final program rule and order that would maximize the commission's RHCPP investments, and better serve the needs of the healthcare community which in turn support the needs of the patients they're charged to serve. Since our inception, OHN has publically recognized and considered the FCC a courageous thought leader in rolling out and learning from the RHCPP, and was pleased with the final rule and order even when additional items that we advocated for were not included in the final rule.

However, with the unfortunate set-backs we've experienced with the recent rollout of the HCF (administrative hurdles and the elimination of urban clinics) , the sustainability of consortium networks like OHN are greatly threatened, as well as the healthcare communities they're supposed to support and expand upon. Therefore, we have asked for continued assistance from our delegation to support our efforts. Specifically, we are in direct correspondence with Representative Walden's office to better assist us in making sure the original rule and order is maintained.

Direct Reference to the Healthcare Connect Fund Final Rule & Order

USAC's determination that Non-rural Health Clinics are ineligible stands in direct contradiction of the HCF Order and accompanying FAQs, specifically paragraphs 59 through 61 of the HCF Order and paragraphs 9 through 12 of the HCF Order FAQs.

OHN respectfully requests that the Secretary reverse USAC's determination of eligibility for "Non-rural Health Clinic" sites because USAC's determination of eligibility contradicts the language of the Order and USAC's reasoning for criteria not explicitly stated in the HCF Order or HCF Order FAQs.

The Commission decided to "allow participation in the Healthcare Connect Fund consortia by both rural and non-rural eligible HCPs, [with limitations]." HCF Order para. 59. The Commission's reasons for allowing participation by non-rural eligible HCP's included: 1) primarily rural networks benefit from participation by larger non-rural HCP's; 2) many HCPs that are technically classified as non-rural within our rules in fact are located in relatively sparsely populated areas; and 3) even hospitals and clinics that are located in truly non-rural areas are able to provide significantly improved care by joining broadband networks. HCF Order para. 60. The Commission limited participation by non-rural eligible HCP's in three ways: 1) non-rural HCP's must participate in a consortium; 2) the consortium must consist of a majority of rural sites; and 3) the Commission established a cap on annual funding for hospitals licensed for more than 400 beds. Id. para 60. In defining Eligible Services, the Commission explicitly removed language referring to "rural" HCPs "because [the Commission allows] all HCPs to participate in consortia and receive support." HCF Order para. 111. The Commission justified its decision to decline to provide support for administrative expenses in part because "[it] expand[ed] eligibility to include *all* HCPs [.]" HCF Order para. 174, (emphasis added). The plain language of the Commission in the HCF Order clearly communicates its intent to broadly apply subsidy to HCPs within a majority-rural consortium with only narrow regard to an individual HCP's rural/non-rural status.

As we close, we respectfully look for your due consideration to this appeal.