Before the
Federal Communications Commission
Washington, D.C. 20554

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

REPORT AND ORDER

Adopted: December 12, 2012 **Released: December 21, 2012**

By the Commission: Chairman Genachowski and Commissioners Clyburn and Rosenworcel issuing separate statements; Commissioner McDowell approving in part, concurring in part, dissenting in part, and issuing a statement; Commissioner Pai approving in part, dissenting in part, and issuing a statement.

TABLE OF CONTENTS

Heading Paragraph #

I. INTRODUCTION AND EXECUTIVE SUMMARY 1
II. BACKGROUND 11
A. The Current Rural Health Care Support Mechanism 11
B. The Rural Health Care Pilot Program 13
C. The Notice of Proposed Rulemaking 15
D. The Staff Evaluation of the Pilot Program 17
E. Benefits and Cost Savings Flowing from Broadband Connectivity 19
1. Telemedicine 21
2. Exchange of Electronic Health Records 22
3. Dissemination of Medical and Technical Expertise 25
4. Cost Savings 26
5. Enhancing Revenues for Health Care Providers 28
F. Health Care Provider Broadband Needs Assessment 29
III. PERFORMANCE GOALS AND MEASURES 31
A. Increase Access to Broadband for Health Care Providers, Particularly Those Serving Rural Areas 34
B. Foster Development and Deployment of Broadband Health Care Networks 39
C. Maximize Cost-Effectiveness of Program 41
IV. SUPPORT FOR BROADBAND CONNECTIVITY 44
A. Overview 44
B. A Consortium Approach to Creation of Broadband Health Care Networks 50
1. Key Benefits of a Consortium Approach 53
2. Eligibility to Participate in Consortia 57
3. Eligibility of Grandfathered Formerly “Rural” Sites 68
C. A Hybrid Infrastructure and Services Approach 69
D. Health Care Provider Contribution 81

1. Use of a Uniform Contribution Percentage 83
2. 35 Percent HCP Contribution 90
3. Limits on Eligible Sources of HCP Contribution 99

V. ELIGIBLE SERVICES AND EQUIPMENT 105
A. Eligible Services 107
1. Definition of Eligible Services 110
2. Minimum Bandwidth and Service Quality Requirements 116
3. Dark and Lit Fiber 120
4. Connections to Internet2 or National LambdaRail 133
5. Off-Site Data Centers and Off-Site Administrative Offices 137
6. Reasonable and Customary Installation Charges up to $5,000 149
7. Upfront Charges for Service Provider Deployment of New or Upgraded Facilities to Serve Eligible Health Care Providers 151
B. Eligible Equipment 156
C. Ineligible Costs 164
1. Equipment or Services Not Directly Associated with Broadband Services 165
2. Inside Wiring/ Internal Connections 169
3. Administrative Expenses 171
4. Cost Allocation for Ineligible Entities, Sites, Services, or Equipment 178
D. Limitations on Upfront Payments 185
E. Eligible Service Providers 193

VI. FUNDING PROCESS 196
A. Pre-Application Steps 197
1. Creation of Consortia 197
a. Designation of a Consortium Leader 198
b. Participating Health Care Providers 207
c. Letters of Agency 208
2. Determination of Health Care Provider Eligibility 213
3. Technology Planning 216
4. Preparation for Competitive Bidding 220
5. Source(s) for Undiscounted Portion of Costs 224
6. FCC Registration Number (FRN) 225
B. Competitive Bidding 226
1. "Fair and Open" Competitive Bidding Process 229
2. Requests for Proposals 234
3. USAC Posting of Request for Services 239
4. 28-Day Posting Requirement 243
5. Selection of the Most "Cost-Effective" Bid and Contract Negotiation 247
6. Competitive Bidding Exemptions 250
a. Annual Undiscounted Cost of $10,000 or Less 251
b. Government Master Service Agreements 256
c. Master Service Agreements Approved Under the Pilot Program or the Healthcare Connect Fund 259
d. Evergreen Contracts 261
e. Contracts Negotiated Under E-Rate 266
f. No Exemption for Internet2 and National LambdaRail 268
C. Funding Commitment From USAC 270
1. Requirements for Service Providers 271
2. Filing Timeline for Applicants 273
3. Required Documentation for Applicants 279
4. Requests for Multi-Year Commitments 294

5. USAC Processing and Issuance of Funding Commitment Letters 300
D. Invoicing and Payment Process 303
E. Contract Modifications 306
F. Site and Service Substitutions 313
G. Data Collection and Reporting Requirements 316
VII. ADDITIONAL MEASURES TO PREVENT WASTE, FRAUD, AND ABUSE 323
A. Recordkeeping, Audits, and Certifications 325
B. Duplicative Support and Relationship to Other RHC Programs 334
C. Recovery of Funds, Enforcement, and Debarment 339
VIII. TELECOMMUNICATIONS PROGRAM REFORM 342
IX. PILOT PROGRAM FOR SKILLED NURSING FACILITY CONNECTIONS 345
X. MISCELLANEOUS 351
A. Implementation Timeline 351
B. Pilot Program Transition Process and Requests for Additional Funds 360
C. Prioritization of Funding 365
D. Offset Rule 369
E. Delegation to Revise Rules 375
XI. PROCEDURAL MATTERS 376
A. Paperwork Reduction Act 376
B. Congressional Review Act 377
C. Final Regulatory Flexibility Analysis 378
XII. ORDERING CLAUSES 379
APPENDIX A – Summary of Funding Process
APPENDIX B – Assessment of Broadband Needs of Health Care Providers
APPENDIX C – Final Regulatory Flexibility Analysis
APPENDIX D – Final Rules
APPENDIX E – Forms
APPENDIX F – List of Commenters

I. INTRODUCTION AND EXECUTIVE SUMMARY

1. Today, the Commission reforms our universal service support programs for health care, transitioning our existing Internet Access and Rural Health Care Pilot Programs into a new, efficient Healthcare Connect Fund. This Fund will expand health care provider (HCP) access to broadband, especially in rural areas, and encourage the creation of state and regional broadband health care networks. Broadband connectivity has become an essential part of 21st century medical care. Whether it is used for transmitting electronic health records (EHRs), sending X-rays, MRIs, and CAT scans to specialists at a distant hospital, or for video conferencing for telemedicine or training, access to broadband for medical providers saves lives while lowering health care costs and improving patient experiences.[1] Telemedicine can save stroke patients lasting damage, prevent premature births, and provide psychiatric treatment for patients in rural areas.[2] Exchange of EHRs avoids duplicative medical tests and errors in prescriptions,

[1] In the remainder of this Order, "telehealth" means the broad range of health care-related applications that depend upon broadband connectivity, including telemedicine; exchange of electronic health records; collection of data through Health Information Exchanges and other entities; exchange of large image files (*e.g.* X-ray, MRIs, and CAT scans); and the use of real-time and delayed video conferencing for a wide range of telemedicine, consultation, training, and other health care purposes. *See also infra* n.42.

[2] *See generally Wireline Competition Bureau Interim Evaluation of Rural Health Care Pilot Program Staff Report*, WC Docket No. 02-60, Staff Report, 27 FCC Rcd 9387 (2012) (*Pilot Evaluation*).

and gives doctors access to all of a patient's medical history on a moment's notice. Telehealth applications save HCPs money as well. For example, a South Carolina HCP consortium funded by the Commission's Rural Health Care (RHC) Pilot Program saved $18 million in Medicaid costs through telepsychiatry provided at hospital emergency rooms. Another Pilot project in the Midwest saved $1.2 million in patient transport costs after establishing an e-ICU program.[3]

2. Today's reform builds on the success of the RHC Pilot Program. That program demonstrated the importance of expanding HCP access to high-capacity broadband services, which neither the existing RHC Telecommunications Program nor the Internet Access Program have successfully achieved. The Pilot Program also proved the benefits of a consortium-focused program design, encouraging rural-urban collaboration that extended beyond mere connectivity, while significantly lowering administrative costs for both program participants and the Fund.[4] The Pilot Program funds 50 different health care provider broadband networks, with a total of 3,822 individual HCP sites, 66 percent of which are rural.[5] The networks range in size from 4 to 477, and have received a total of $364 million in funding commitments, to be spread out over several years.[6] Through bulk buying and competitive bidding, most HCPs in the program have been able to obtain broadband connections of 10 Mbps or more.[7] The consortia were often organized and led by large hospitals or medical centers, which contributed administrative, technical, and medical resources to the other, smaller HCPs providing service to patients in rural areas.[8]

3. Drawing on these lessons, the Healthcare Connect Fund we establish today will direct Universal Service Fund (USF) support to high-capacity broadband services while encouraging the formation of efficient state and regional health care networks.[9] The new Fund will give HCPs substantial flexibility in network design, but will require a rigorous, auditable demonstration that they have chosen the most cost-effective option through a competitive bidding process.

4. In particular, like the Pilot Program, the Healthcare Connect Fund will permit HCPs to purchase services and construct their own broadband infrastructure where it is the most cost-effective option. The Healthcare Connect Fund is thus a hybrid of the separate infrastructure and services

---

[3] *See id.*, 27 FCC Rcd at 9432-33, para. 73 (Palmetto State Providers Network reports that emergency department psychiatric treatment costs dropped from $2,500 to $400 per patient, resulting in $18 million in savings over an 18 month period); *see also id.* at 9432, para. 72 (Heartland Unified Broadband Network estimates that eight hospitals in its network saved a total of $1.2 million in patient transfer costs over a 30-month period following the implementation of e-ICU services).

[4] *See generally id.* at 9388-90.

[5] Letter from Craig Davis, Vice President, Rural Health Care Division, Universal Service Administrative Company, to Julie Veach, Chief, Wireline Competition Bureau, Federal Communications Commission, WC Docket No. 02-60, at 1, 2, 4 (filed Nov. 16, 2012) (USAC Nov. 16 Data Letter).

[6] *Id.* at 1.

[7] *Pilot Evaluation*, 27 FCC Rcd at 9419, para. 53 (as of January 31, 2012, 69 percent of Pilot HCPs purchased 10 Mbps or greater connections).

[8] *Id.* at 9439-42, para. 89.

[9] The Telecommunications component of the existing Rural Health Care Program, which supports the difference between urban and rural rates for telecommunications services, will remain available. The new program will replace the Internet Access component of the existing Rural Health Care Program, which provides a 25 percent discount on Internet Access services. As explained below, we expect many participants in the Telecommunications portion of the Rural Health Care Program to migrate to the new Healthcare Connect Fund. *See infra* para. 342.

programs proposed in the Commission's July 2010 *Notice of Proposed Rulemaking*.[10] The self-construction option will only be available, however, to HCPs that apply as part of consortia, which can garner economies of scale unavailable to individual providers. With these safeguards, and based on the experience of the RHC Pilot Program, we expect the self-construction option to be used only in limited circumstances, and often in combination with services purchased from commercial providers.

5. Regardless of which approach providers choose, the Healthcare Connect Program will match two-for-one the cost of broadband services or facilities that they use for health care purposes, requiring a 35 percent HCP contribution. A two-for-one match will significantly lower the barriers to connectivity for HCPs nationwide, while also requiring all program participants to pay a sufficient share of their own costs to incent considered and prudent decisions and the choice of cost-effective broadband connectivity solutions. Indeed, with the level of support the Healthcare Connect Fund provides, and with the other reforms we adopt, we expect that HCPs will be able to obtain higher speed and better quality broadband connectivity at lower prices, and that the value for the USF will be greater, than in the existing RHC Telecommunications and Internet Access Programs.

6. Both rural and non-rural HCPs will be allowed to participate in the new program, but non-rural providers may join only as part of consortia. Moreover, to ensure that all consortia keep rural service central to their mission, we will require that a majority of the HCPs in each consortium meet our longstanding definition of rural HCPs, although we grandfather those Pilot projects with a lower rural percentage. And to ensure that the program maintains its focus on smaller HCPs that serve predominantly rural populations, we also adopt a rule limiting support to no more than $30,000 per year for recurring charges and no more than $70,000 for non-recurring charges over a five-year period for larger HCPs – defined as hospitals with 400 beds or more.

7. We also adopt a number of reforms for the Healthcare Connect Fund that will increase the efficiency of the program, both by reducing administrative costs for applicants and for USAC, and by adopting measures to maximize the value obtained by HCPs from every USF dollar. In particular, we take a number of steps in this order to simplify the application process, both for individual HCP applicants and for consortia of HCPs.

8. As a central component of today's Order, we also adopt express goals and performance measures for all the Commission's health care support mechanisms. The goals are (1) increasing access to broadband for HCPs, particularly those serving rural areas; (2) fostering the development and deployment of broadband health care networks; and (3) maximizing the cost-effectiveness of the program. These goals inform all the choices we make in this Order. As we implement today's Order, we will collect information to evaluate the success of our program against each of these goals.

9. Finally, we create a new Pilot Program to test whether it is technically feasible and economically reasonable to include broadband connectivity for skilled nursing facilities within the Healthcare Connect Program. The Pilot will make available up to $50 million to be committed over a three-year period for pilot applicants that propose to use broadband to improve the quality and efficiency of health care delivery for skilled nursing facility patients, who stand to benefit greatly from telemedicine and other telehealth applications. We expect to use the data gathered through the Pilot to determine how to proceed on a permanent basis with respect to such facilities, which provide hospital-like services.

[10] *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Notice of Proposed Rulemaking, 25 FCC Rcd 9371 (2010) (*NPRM*).

10. We note that, with today's comprehensive reform of the RHC program,[11] the Commission has now reformed all four USF distribution programs within the past three years. In September 2010, the Commission modernized the Schools and Libraries support mechanism (E-rate) for the 21st century, improving broadband access, streamlining administrative requirements, and taking measures to combat waste, fraud and abuse.[12] In October 2011, the Commission adopted transformational reforms of the high-cost program, creating the Connect America and Mobility Funds to advance the deployment of fixed and mobile broadband networks in rural and underserved areas, while putting the high-cost program on an overall budget for the first time ever.[13] In January 2012, the Commission transformed the low-income program, taking major steps to modernize the program and reduce waste, fraud, and abuse.[14] In each prior instance, and again in today's Order, we have made our touchstone aligning the universal service programs with 21st century broadband demands, while improving efficiency, accountability, and fiscally responsibility.

II. BACKGROUND

A. The Current Rural Health Care Support Mechanism

11. As part of the Telecommunications Act of 1996 (1996 Act),[15] Congress recognized the value of providing rural HCPs with "an affordable rate for the services necessary for the provision of telemedicine and instruction relating to such services."[16] The 1996 Act mandated that telecommunications carriers provide telecommunications services for health care purposes to rural public or non-profit HCPs at rates that are "reasonably comparable" to rates in urban areas.[17] Eligible HCPs, as defined in the 1996 Act, only include (1) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (2) community health centers or health centers providing health care to migrants; (3) local health departments or agencies; (4) community mental health centers; (5) not-for-profit hospitals; (6) rural health clinics; and (7) consortia of HCPs consisting of one or more entities falling into the first six categories.[18] In addition, eligible HCPs must be non-profit or public.[19]

---

[11] The Commission's "Rural Health Care Program" is made up of the traditional or "Primary" programs – the Telecommunications and Internet Access Programs – and the "Pilot" Program. *See infra*, section II.A (describing the Internet Access and Telecommunications Programs) and section II.B (describing the Pilot Program).

[12] *Schools and Libraries Universal Service Support Mechanism, A National Broadband Plan for Our Future*, CC Docket No. 02-6 *et al.*, Sixth Report and Order, 25 FCC Rcd 18762 (2010) (*Schools and Libraries Sixth Report and Order*).

[13] *See Connect America Fund et al.*, WC Docket No. 10-90 *et al.*, Report and Order and Further Notice of Proposed Rulemaking, 26 FCC Rcd 17663 (2011) (*USF/ICC Transformation Order and FNPRM), pets. for review pending sub nom. In re: FCC 11-161*, No. 11-9900 (10th Cir. filed Dec. 8, 2011).

[14] *Lifeline and Link Up Reform and Modernization et al.*, WC Docket No. 11-42 *et al.*, Report and Order and Further Notice of Proposed Rulemaking, 27 FCC Rcd 6656 (2012) (*Lifeline and Link Up Reform and Modernization*).

[15] Telecommunications Act of 1996, Pub. L. No. 104-104, 110 Stat. 56 (1996). The 1996 Act amended the Communications Act of 1934 (Communications Act or Act).

[16] S. Report No. 104-230 at 133 (1996); *see also* 47 U.S.C. § 254(b)(3), (h).

[17] 47 U.S.C. § 254(h)(1)(A).

[18] 47 U.S.C. § 254(h)(7)(B).

[19] 47 U.S.C. §§ 254(h)(1)(A), (h)(2)(A), (h)(4).

12. Consistent with Congress's directive, the Commission established the RHC Telecommunications Program in 1997 to ensure that rural HCPs pay no more than their urban counterparts for their telecommunications services.[20] The Telecommunications Program enables eligible rural HCPs to obtain a rate for each supported service that is no higher than the highest tariffed or publicly available commercial rate for a similar service in the closest city in the state with a population of 50,000 or more people, taking distance charges into account – in effect, providing a discount to the HCP in the amount of the "rural-urban differential."[21] Next, in 2003, the Commission created the RHC Internet Access Program pursuant to section 254(h)(2)(A) of the Act, which directs the Commission to establish competitively neutral rules to enhance, to the extent technically feasible and economically reasonable, access to "advanced telecommunications and information services" for public and non-profit HCPs.[22] The Internet Access Program provides a 25 percent discount off the cost of monthly Internet access for eligible rural HCPs.[23] Together the Telecommunications and Internet Access Programs are commonly referred to as the "Primary Program," to distinguish them from the RHC Pilot Program discussed below. To date, over $410 million has been disbursed through the RHC Telecommunications and Internet Access Programs.[24] Annual disbursements for those programs have grown over time, from $3.375 million in 1998 (the first funding year), to $25 million in 2003 and over $80 million in 2011.[25]

B. The Rural Health Care Pilot Program

13. In September 2006, acting pursuant to section 254(h)(2)(A), the Commission established the RHC Pilot Program (Pilot Program) to provide funding to support state or regional broadband networks designed to bring the benefits of innovative telehealth and telemedicine services to areas of the country where the need for those benefits is most acute.[26] The Pilot Program is providing funding for a limited period of time for up to 85 percent of the costs associated with: (1) the construction of state or regional health care broadband networks, and the advanced telecommunications and information services provided over those networks; (2) connecting to nationwide backbone providers Internet2 or National LambdaRail (NLR); and (3) connecting to the public Internet.[27] Pilot projects can use RHC support to purchase

---

[20] *See, e.g.*, 47 U.S.C. § 254(h)(1)(A); *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776, 9093-9161, paras. 608-749 (1997) (*Universal Service First Report and Order*) (subsequent history omitted); 47 C.F.R. Part 54, Subpart G.

[21] *Universal Service First Report and Order*, 12 FCC Rcd at 9093, para. 608.

[22] 47 U.S.C. § 254(h)(2)(A).

[23] 47 C.F.R. § 54.621. *See generally Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 18 FCC Rcd 24546 (2003) (*2003 Order and Further Notice*). A 50 percent discount (rather than 25 percent) is available for Internet access services for HCPs in states that are "entirely rural," that is, states in which every county meets the Commission's definition of rural. *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 19 FCC Rcd 24613, 24631, para. 38 (2004) (*Second Report and Order and Further Notice).*

[24] *See* Universal Service Monitoring Report, Dec. 2011, CC Docket No. 98-202, Table 2.21, *available at* http://www.fcc.gov/wcb/iatd/monitor.html (last visited Dec. 4, 2012) (*2011 Universal Service Monitoring Report*).

[25] *See id. See also* Universal Service Administrative Company, 2011 Annual Report at 13, *available at* http://www.usac.org/about/tools/publications/annual-reports/2011/index.html (last visited Apr. 17, 2012) (*2011 USAC Annual Report*).

[26] *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 21 FCC Rcd 11111, para. 1 (2006) (*2006 Pilot Program Order*).

[27] *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 22 FCC Rcd 20360, 20361, para. 2 (2007) (*2007 Pilot Program Selection Order*). Section 230(f)(1) of the Act defines the Internet as "the

(continued…)

services from third parties, or to receive service by constructing and owning their own network facilities.[28] Additionally, the Pilot Program allows participants to use funding to purchase items that are not eligible for support under the Telecommunications or Internet Access Programs, such as equipment (*e.g*. servers, routers, firewalls, switches, and other devices or equipment necessary for the broadband connection), or to upgrade their existing equipment and increase bandwidth.[29] The Pilot projects were allowed to include non-rural HCPs in their networks, as long as they had a more than *de minimis* level of participation by rural HCPs. The Commission awarded a total of $417 million in funds for the Pilot projects, spread over a three-year period.

14. Today there are 50 active Pilot projects covering 38 states; many of these projects are state-wide or regional networks of HCPs. They range in size from 4 HCPs to 477 HCPs.[30] As of November 15, 2012, USAC had committed $364.4 million in funds to approximately 3,822 individual HCP sites.[31] The Pilot projects are in different stages of implementation of their networks, with some nearing the end of their Pilot Program funding. In an Order released on July 9, 2012, the Commission extended the Pilot Program funding on a temporary basis for individual Pilot Project HCP sites that will exhaust Pilot funding before the end of this funding year (before June 30, 2013), in order to preserve the *status quo* while the Commission completes this proceeding.[32]

C. The Notice of Proposed Rulemaking

15. In July 2010, the Commission issued an *NPRM* seeking comment on several proposed reforms to the Rural Health Care support mechanism.[33] The Commission proposed to provide support for both the construction costs of new regional or statewide networks to serve public and non-profit HCPs in areas of the country where broadband is insufficient or unavailable as well as the monthly recurring costs for access to broadband services for eligible public or non-profit HCPs.[34] These proposals in the *NPRM*

(Continued from previous page)

international computer network of both Federal and non-Federal interoperable packet switched data networks." 47 U.S.C § 230(f)(1). The Supreme Court has described the Internet as a "network of interconnected computers." *National Cable & Telecommunications Ass'n v. Brand X Internet Services*, 545 U.S. 967, 974 (2005). Neither of these definitions of "Internet" distinguishes between data transmitted through the "public" Internet versus data transmitted over dedicated, private lines. In the latter case, the user of the private line has sole control over the data transmitted (*i.e.* the line does not carry "any and all" Internet traffic), but the private line can interconnect with the Internet if necessary. This is an important distinction for health care providers who are subject to stringent security and privacy requirements for certain types of health care data.

[28] *See 2006 Pilot Program Order*, 21 FCC Rcd at 11111, para. 1, 11115-16, paras. 14-15.

[29] *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20397-98, para. 74; *see also* Letter from Craig Davis, Vice President, Rural Health Care Division, Universal Service Administrative Company, to Sharon Gillett, Chief, Wireline Competition Bureau, Federal Communications Commission, WC Docket No. 02-60, at 6-7 (filed Mar. 14, 2012) (USAC Observations Letter) (explaining that unlike Primary Program participants, Pilot Program participants can use RHC support to purchase and upgrade their equipment if necessary).

[30] USAC Nov. 16 Data Letter at 1.

[31] *See id*.

[32] *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 27 FCC Rcd 7907 (2012) (*2012 Bridge Order*).

[33] *See generally NPRM*, 25 FCC Rcd 9371.

[34] *Id.* at 9415-21, paras. 3, 114-127.

were based in part on recommendations in the *National Broadband Plan*, which the Commission delivered to Congress on March 16, 2010.[35]

16. On July 19, 2012, the Commission's Wireline Competition Bureau (Bureau) released a Public Notice seeking more focused comment on several issues, in order to create a more robust and comprehensive record, particularly with respect to the proposed Broadband Services Program and participation by consortia of HCPs.[36] The Bureau solicited input in particular from current participants in the RHC programs, including the Pilot Program participants.[37]

D. The Staff Evaluation of the Pilot Program

17. The Bureau released a staff evaluation of the Pilot Program in August 2012, which provides a wealth of information about the history of the Pilot and the individual projects.[38] The report evaluates the successes and challenges of the Pilot projects to date, providing concrete data regarding the efficacy of broadband networks in delivering health care to rural America. The *Pilot Evaluation* summarizes key observations from the Pilot Program and describes the Pilot projects, their broadband networks, and the financial and telehealth benefits generated by their broadband connectivity.

18. The *Pilot Evaluation* also provides extensive information that will assist the Commission in addressing the recommendations of the U.S. Government Accountability Office (GAO) in its November 2010 report on the RHC program.[39] The *GAO Report* recommended, among other things, that the Commission assess the communications needs of rural HCPs; consult with USAC and agencies and associations representing rural HCPs; develop effective goals, performance measures, and performance evaluation plans for current and future RHC programs; and clearly articulate rules governing any new programs.[40] As discussed further, the Commission has addressed each of these recommendations, through the *Pilot Evaluation*, its outreach efforts, and the reforms adopted in this Order.

E. Benefits and Cost Savings Flowing from Broadband Connectivity

19. The reforms we adopt today build on the substantial impact the RHC program has had on improving broadband connectivity to HCPs. The Pilot Program, for example, has helped participating HCPs create local, regional, and even state-wide health care broadband networks, resulting in improved quality and lower costs of health care in rural areas.[41] As illustrated in Figure 1 below, the Pilot Program

---

[35] Federal Communications Commission, Connecting America: The National Broadband Plan, at 200 (Mar. 16, 2010), available at http://www.broadband.gov/download-plan/ (*National Broadband Plan).*

[36] *Wireline Competition Bureau Seeks Further Comment on Issues in the Rural Health Care Reform Proceeding*, WC Docket No. 02-60, Public Notice, 27 FCC Rcd 8185 (Wireline Comp. Bur. 2012) (*July 19 Public Notice*).

[37] *Id.* at 8186, para 4.

[38] *See generally Pilot Evaluation*.

[39] U.S. Gov't Accountability Office, FCC's Performance Management Weaknesses Could Jeopardize Proposed Reforms of the Rural Health Care Program, GAO 11-27 (Nov. 2010) (*GAO Report*), *available at* http://www.gao.gov/products/GAO-11-27.

[40] *Id.* at 56-57.

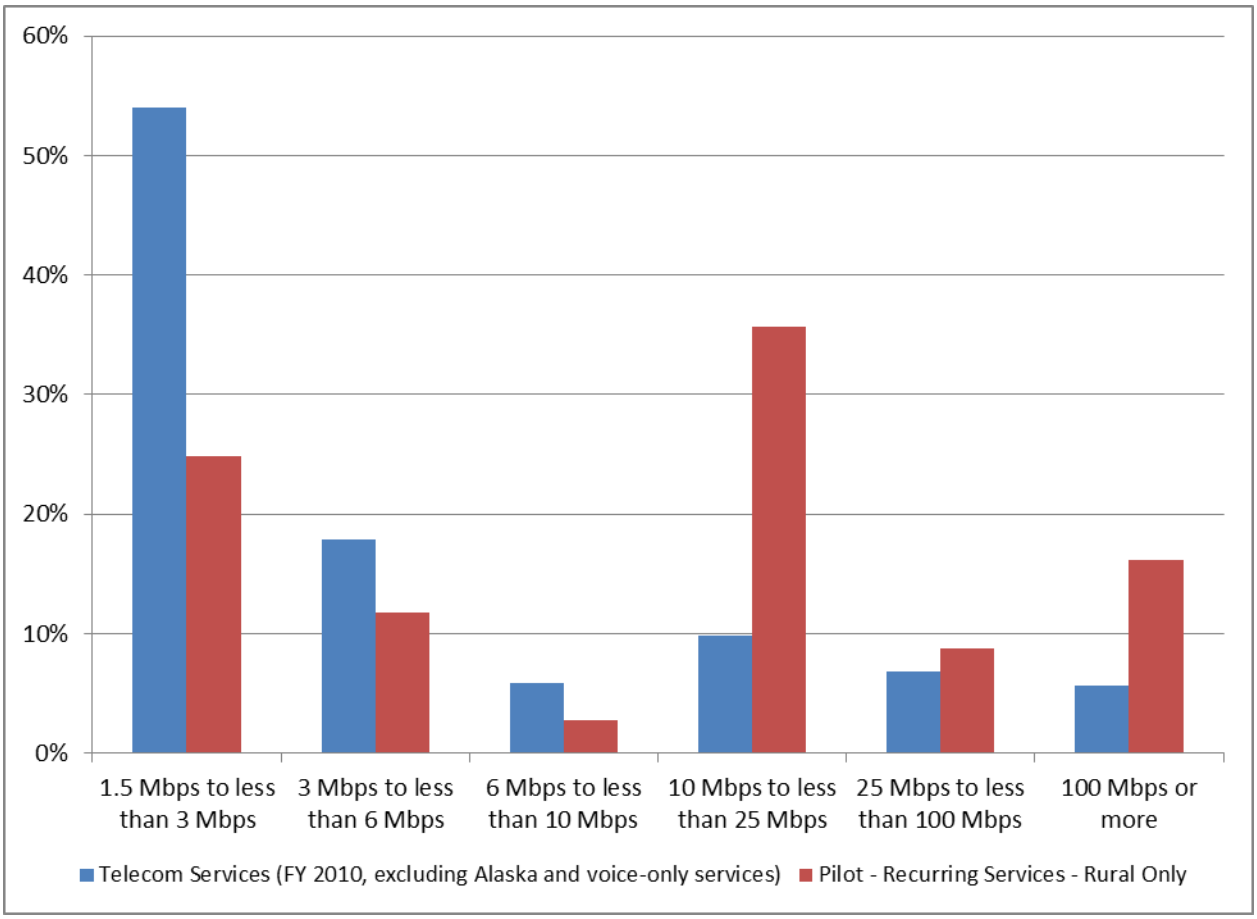
[41] The benefits of assembling networks are more apparent in the Pilot Program because the Pilot projects were required to apply as consortia, but there are also examples of such networks being fostered by the Telecommunications Program. For example, in Alaska, remote tribal villages are linked with major hospitals and clinics in Anchorage through terrestrial and satellite connections funded by that Program, and the villages use those links to provide vital telemedicine services. *See, e.g.*, GCI PN Comments at 3-4; *id.*, Attachment 1 (ANTHC Responses) at 3, 5.

enabled rural HCPs, on average, to obtain higher bandwidth connections in comparison to HCPs participating in the Telecommunications Program. These Pilot Program networks have enabled the adoption of a wide range of telehealth applications, including the provision of telemedicine, the exchange of electronic health records (EHRs), the rapid distribution of large images (such as X-rays, Magnetic Resonance Imaging (MRI), and Computerized Tomography (CT) scans), the development of health information exchanges (HIEs), and remote training of medical personnel via videoconference.[42] The telehealth benefits experienced by the Pilot projects are discussed in detail in the *Pilot Evaluation* and in the comments filed in response to the *July 19 Public Notice.*[43]

[42] In the *National Broadband Plan*, the term "telehealth" included non-clinical practices such as continuing medical education as well as e-care, which was defined as the "electronic exchange of information–data, images and video–to aid in the practice of medicine, advanced analytics." It encompasses technologies that enable video consultation, remote monitoring and image transmission (store-and-forward) over fixed or mobile networks. *National Broadband Plan* at 200. Although related to telehealth, telemedicine is usually more narrowly defined. The Centers for Medicare and Medicaid Services (CMS) define "telemedicine" as "two-way, real time interactive communication between the patient, and the physician or practitioner at the distant site." Centers for Medicare & Medicaid Services, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Telemedicine.html (last visited Dec. 4, 2012). The American Telemedicine Association defines "telemedicine" as "the use of medical information exchanged from one site to another via electronic communications to improve patients' health status." American Telemedicine Association, http://www.americantelemed.org/i4a/pages/index.cfm?pageid=3333 (last visited Dec. 4, 2012). The *National Broadband Plan* defines an electronic health record (EHR) as "a digital record of patient health information generated by one or more encounters in any care delivery setting." It includes "patient demographics, progress notes, diagnoses, medications, vital signs, medical history, immunizations, laboratory data and radiology reports." *National Broadband Plan* at 200.

[43] *Pilot Evaluation*, 27 FCC Rcd at 9426-31, paras. 64-71.

Figure 1: Comparison of Connection Bandwidths for Rural HCPs in the Current Telecommunications Program and the Pilot Program[44]



20. Below we discuss how broadband connectivity generates a number of benefits and cost savings for HCPs.

1. Telemedicine

21. The broadband networks supported by the RHC program enhance HCPs' ability to adopt and fully utilize numerous telemedicine applications.[45] Telemedicine is improving HCP access to specialists, and allowing providers in less densely populated areas to offer health care to patients that would otherwise have to travel great distances to see medical specialists or forego care entirely. As pointed out

[44] USAC Nov. 16 Data Letter at App. B & C. The analysis compared rural HCPs in the Pilot Program to rural HCPs receiving funding from the Telecommunications Program.

[45] Commenters in response to the *July 19 Public Notice* provided a number of examples of the ways in which broadband can enable HCPs to adopt telemedicine applications for the benefit of their patients. *See, e.g.*, CHCC/RMHN PN Comments at 5 (stating that it is implementing a centralized archive for medical images); Geisinger PN Comments at 7 (finding that one third of patients transferred from rural hospitals to tertiary care centers can be treated in place via telemedicine and other resources); IRHN PN Comments at 26 (predicting that training for nursing staff and medical technicians will be provided by increasingly interactive applications); IRHN PN Comments at 27 (estimating that network will allow providers to see more patients, diagnose more quickly, eliminate many patient transports, and provide telepsychology/psychiatry and cloud-based medical services).

by the National Rural Health Resource Center, "telemedicine applications will be crucial in helping to address current and projected shortages in primary care and rural physicians nationwide, as well as shortages of pharmacists in rural areas."[46] In addition to providing increased access to medical care for patients in rural America, telemedicine also can improve the speed with which care can be delivered, and thus enhance the quality of care.[47] Telemedicine can enable patients to be treated in hospitals closer to where they live, and can shorten the length of patient stays.[48]

2. Exchange of Electronic Health Records

22. Broadband HCP networks also facilitate the exchange of EHRs and the formation of robust HIEs, both of which are critical components of efforts to improve coordinated care and thereby realize savings in health care costs. The use and exchange of EHRs improves patient care in a number of ways, including more effective medication and more accurate prescriptions, reduced redundancy and errors in laboratory testing, better coordination of patient care among multiple HCPs, and enhanced preventive care.[49]

23. There have been significant advances in the move to adoption and exchange of EHRs in recent years. Most notably, in the 2009 HITECH Act, Congress adopted an incentive payment system under Medicare and Medicaid to encourage HCPs to convert to EHRs and develop the capability to exchange those records.[50] Providers qualify to receive those incentive payments when they can demonstrate that they have achieved "Meaningful Use" of EHRs.[51] By the year 2015, many HCPs will be required to adopt and exchange EHRs to receive full Medicare reimbursement.[52] The federal government also has encouraged the development of state-wide HIEs as a means to improve public health, prevent

---

[46] Letter from Chin Yoo, Attorney Advisor, Federal Communications Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 (filed Dec. 27, 2011) at 2 (NRHRC Dec. 27 *Ex Parte* Letter).

[47] As one example, the Health Information Exchange of Montana (HIEM) used its broadband network to support the Winkley Women's Center's mobile coach, which uses high-speed broadband connectivity to give-real time prompt diagnostic results for mammography, breast ultrasounds, and bone density screenings. HIEM PN Reply at 4. *See generally Pilot Evaluation*, 27 FCC Rcd at 9428-31, paras. 67-71.

[48] *Pilot Evaluation*, 27 FCC Rcd at 9428, para. 67. For example, Geisinger Health System, which serves more than 2.6 million residents throughout 44 counties in central and northeastern Pennsylvania, reports that its broadband enabled e-ICU program at Lewistown and Evangelical Hospitals has decreased length of stay for ICU and hospital patients, improved mortality rates for ICU patients, and reduced hospital transportation costs. Geisinger PN Comments at 8; Letter from Craig Davis, Vice President, Rural Health Care Division, Universal Service Administrative Company, to Sharon Gillett, Wireline Competition Bureau, Federal Communications Commission, WC Docket No. 02-60 at 2 (filed Mar. 16, 2012) (USAC Mar. 16 Site Visit Reports) (describing Lewistown and Evangelical Hospitals' experiences with e-ICU program).

[49] *See, e.g.*, *National Broadband Plan* at 201; *see also* Office of the National Coordinator for Health Information Technology, Being a Meaningful User of Electronic Health Records, http://healthit.hhs.gov/portal/server.pt?CommunityID=2998&spaceID=42&parentname=&control=SetCommunity&parentid=&in_hi_userid=12059&PageID=0&space=CommunityPage (last visited Dec. 4, 2012).

[50] *See* HHS Comments at 1.

[51] *See* Centers for Medicare & Medicaid Services, EHR Incentive Programs, http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/index.html?redirect=/EHRIncentivePrograms (last visited Sept. 18, 2012).

[52] *See* Centers for Medicare and Medicaid Services, Medicare and Medicaid EHR Incentive Program Basics, http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Basics.html (last visited Dec. 4, 2012); HHS Comments at 2.

spread of epidemics, and enable clinical quality measure data capture. HIEs achieve these goals through compilation of extensive data derived from EHRs and other sources.[53] A number of the Pilot projects are members of HIEs and have used Pilot Program support for the underlying broadband networks.[54]

24. The Pilot projects recognize the important and growing role that broadband connectivity plays in EHR adoption and exchange.[55] The Colorado Health Care Connection & Rocky Mountain HealthNet (CHCC/RMHN) Pilot projects note that "as the federal government's requirements for 'Meaningful Use' come online and intensify, the bandwidth requirement for HIE applications on [the Colorado Telehealth Network] will only grow."[56] Although the federal government will allow some hardship exceptions to its "Meaningful Use" rules for providers that can demonstrate they are in geographic areas without sufficient Internet access, the higher bandwidth connections made available through Pilot Program funds have enabled providers to work towards achieving the government's EHR adoption goals.[57]

3. Dissemination of Medical and Technical Expertise

25. Broadband networks also facilitate the sharing of technical and medical expertise and the training of health care personnel in less densely populated areas, which often face health care shortages.[58]

---

[53] The HITECH Act provided grants to states and qualified State Designated Entities "to develop and advance mechanisms for information sharing across the health care system." U.S. Department of Health and Human Services, HITECH Priority Grants Program, *available at* http://www.hhs.gov/recovery/programs/hitech/stateinfoexch.html (last visited June 15, 2012); *see also* Office of the National Coordinator for Health Information Technology, State Health Information Exchange Program, *available at* http://statehieresources.org (last visited Sept. 18, 2012) (the State Health Information Exchange Cooperative Agreements Program is designed to promote the exchange of health information that will advance mechanisms for information sharing across the health care system).

[54] Examples include the Geisinger Health System in Pennsylvania and the Health Information Exchange of Montana.

[55] *See, e.g.*, AHA PN Comments at 5 (stating that access to adequate, reliable, fast and affordable broadband are crucial prerequisites for using software-as-service or other cloud-based approaches to accessing and maintaining EHRs, as opposed to traditional server-based installations where software is implemented and maintained locally); GCI PN Comments, App. 1 at 7 (citing that ANTHC has found that reliable connectivity is perhaps the most critical issue facing remote sites as EHRs and other services become mission critical); IRHN PN Comments at 26 (stating that lack of bandwidth could become a gating factor as HIE meaningful use deadlines are fast approaching); SWTAG PN Comments at 15 (emphasizing that providers will need higher bandwidth and HIE participation to meet the meaningful use requirements and take advantage of the incentives); WNYRAHEC PN Comments at 8 (stating that the increased usage of EHRs will only increase the bandwidth that is required at each facility).

[56] CHCC/RMHN PN Comments at 5.

[57] For example, the Sanford Health Collaboration and Communication Channel (with sites in South Dakota, Iowa, and Minnesota) used Pilot funding to upgrade from T-1 lines to Ethernet services, which enabled providers to roll out EHRs. Letter from Linda Oliver, Attorney Advisor, Federal Communications Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 (filed Mar. 26, 2012) at 1-2 (Pilot Conference Call Mar. 26 *Ex Parte* Letter (WNYRAHEC *et al.*)). *See generally* Center for Medicare & Medicaid Services, CMS Medicare and Medicaid EHR Incentive Programs: Stage 2 Final Rule, *available at* http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4440&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date (last visited Sept. 20, 2012).

[58] *See, e.g.*, Letter from Chin Yoo, Attorney Advisor, Federal Communications Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 at 1 (filed Dec. 27, 2011) (NRHRC *Ex*

(continued…)

As noted in the *Pilot Evaluation*, there is a shortage of both health care professionals and health information technology (HIT) specialists in such areas.[59] Broadband HCP networks help bring that needed expertise to more remote areas. Access to health IT expertise at larger hospitals, for example, can help smaller HCPs adopt and exchange EHRs.[60] As commenters observed, training for HCPs can increasingly be provided through interactive applications like videoconferencing and webinars, which require symmetrical broadband.[61]

4. Cost Savings

26. In addition to improving the quality of health care, the broadband networks created in part with the assistance of RHC support also have enabled HCPs in more remote areas to reduce their often high travel expenses and patient transfer costs, as well as to realize reductions in human resource and administrative expenses.[62] Telemedicine provides patients in these areas the opportunity to be diagnosed and/or treated in their own communities, and can provide significant savings by reducing patient transfer or physician, patient, and/or family travel costs.[63] As one project states, linking to larger medical centers and using telemedicine "bends the cost curve."[64] Pilot projects report saving significant amounts through reducing or eliminating the cost of transporting patients to distant (often urban) locations for treatment by

(Continued from previous page)

Parte Letter); USAC Mar. 16 Site Visit Reports at 11 (describing Palmetto State Providers Network's provision of remote training for medical personnel).

[59] *Pilot Evaluation*, 27 FCC Rcd at 9438-9440, paras. 87, 89.

[60] *See, e.g.*, NRHRC Dec. 27 *Ex Parte* Letter at 1 (vendors are conducting much of the training for implementation of EHR systems via video conference, due to the shortage in health IT workforce).

[61] *See, e.g.*, IRHN PN Comments at 26; SWTAG PN Comments at 15; UTN PN Comments at 5; *see also* WNYRAHEC PN Comments at 9 (additional education, training and technical support needed to maximize the telehealth applications to their full capacity).

[62] *Pilot Evaluation*, 27 FCC Rcd at 9431-34, paras. 72-75.

[63] *See, e.g.*, USAC Mar. 16 Site Visit Reports at 10 (explaining that the adoption of PSPN's tele-OB/GYN service allows physicians to utilize the entire day seeing patients, instead of spending the day driving to rural areas and only being able to see each patient for a few minutes); *id*. at 7 (explaining that E-ICU allows patients to stay local, improving outcomes and decreasing stress and cost of travel for patients and families); Quarterly Report of Missouri Telehealth Network, WC Docket No. 02-60, at 6 (filed Jan. 31, 2012) (stating that telehealth utilization saved Missourians nearly 1,700 round trips to specialists' clinics in Columbia and Kirksville, resulting in saved fuel costs of over $293,000); Letter from Linda L. Oliver, Attorney Advisor, Federal Communications Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No 02-60 (filed Mar. 16, 2012) at 1-2 (Pilot Conference Call Mar. 16 *Ex Parte* Letter (ARCHIE *et al.*)) (explaining that keeping patients locally is "better for patients and helps rural hospitals financially").

[64] Pilot Conference Call Mar. 26 *Ex Parte* Letter (WNYRAHEC *et al.*) at 2-3.

specialists.[65] For some HCPs, telemedicine can reduce the length of hospital stays and in some cases avoid hospital admissions altogether.[66]

27. Examples abound of cost savings resulting from support provided through both the Pilot and RHC Telecommunications Programs.[67] The University of Virginia, which established a telemedicine network for rural HCPs with support from the Telecommunications Program, found that its tele-OB/GYN program reduced the rate of premature births among high-risk mothers in rural areas by 25 percent, thus saving both short and long-term health care costs associated with premature births (as well as improving health outcomes for those children).[68] As another example, South Dakota's Heartland Unified Broadband Net (HUBNet) estimates that implementation of e-ICU services with assistance from the Pilot Program saved eight hospitals in its network a total of $1.2 million in transfer expenses over a 30 month period.[69] Additionally, the Pilot Program's Palmetto State Providers Network (PSPN) in South Carolina has reported that its telepsychiatry program has saved $18 million over an 18-month period.[70] Projecting into the future, the New England Telehealth Consortium (NETC), which received $24.6 million from the Pilot Program, estimates savings to its participating HCPs of over $135 million over the next 10 years, attributable to factors such as the consortium approach, the ability to employ multiple vendors through a leased services solution, and postalized pricing.[71] The exchange of EHRs also can generate enormous cost savings for HCPs due to gains in safety and efficiency.[72]

---

[65] *Id.* at 3 (stating that a two hour flight transport costs approximately $24,000 and a two hour ambulance costs about $9,000); Quarterly Report of Missouri Telehealth Network, WC Docket No. 02-60, at 5 (filed Jan. 31, 2012) (estimating that since telehealth implementation began, 706 transport trips have been avoided, resulting in annual savings of approximately $60,000 for Missouri taxpayers); USAC Mar. 16 Site Visit Reports at 3 n.1 (stating that patients kept locally avoid helicopter transport fees of more than $10,000); *id.* at 11 (regarding Palmetto State Providers Network reduced travel time and costs for patients and families).

[66] *See* Letter from Craig Davis, Vice President, Rural Health Care Division, Universal Service Administrative Company, to Sharon Gillett, Chief, Wireline Competition Bureau, WC Docket No. 02-60 (filed Apr. 27, 2012) at 3 (USAC Apr. 27 Site Visit Reports) (noting that Satilla Regional Medical Center in Georgia has been able to reduce patients' lengths of stay with no denigration of care through its e-ICU program); USAC Mar. 16 Site Visit Reports at 7 (describing that HUBNet's e-ICU program has significantly reduced the number of days, on average, that a patient stays in the intensive care unit); *id*. at 9 (describing how Palmetto State Providers Network (PSPN) allows for patients to receive psychiatric consults "at any time, with minimal wait" instead of waiting days in hospital's emergency rooms); Letter from Linda L. Oliver, Attorney Advisor, Federal Communications Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60, at 1 (filed July 9, 2012) (call with Dr. Alan Pitt, Barrow Neurological Institute, and member, Digital Arizona Council).

[67] *Pilot Evaluation*, 27 FCC Rcd at 9425-34, paras. 63-75; *see also, e.g.*, USAC Mar. 16 Site Visit Reports at 15 (stating that Pennsylvania Mountains Healthcare Resource Development Pilot project believes that its network has enabled the development of a revenue cycle management program that has the potential to increase an HCP's bottom line by 2-3 percent, as well as reduce operating costs).

[68] Letter from Elizabeth McCarthy, Attorney Advisor, Federal Communications Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 (filed June 8, 2012) at 1 (UVA June 8 *Ex Parte* Letter).

[69] *Pilot Evaluation*, 27 FCC Rcd at 9431-32, para. 72.

[70] *Id*. at 9432-33, para. 73.

[71] NETC PN Reply at 1, 3.

[72] *See National Broadband Plan* at 201 (citing a study that hospitals generated $371 billion in savings and physicians practices generated $142 billion in savings from safety and efficiency gains over 15 years, due to use of EHRs).

5. Enhancing Revenues for Health Care Providers

28. Broadband networks used by eligible public and not-for-profit HCPs have also created opportunities for increased revenue streams for Pilot participants.[73] By continuing to serve patients in rural clinics and hospitals, telemedicine can provide HCPs in rural areas with opportunities to retain or increase their revenues.[74] A number of commenters argue that most HCPs in rural areas operate on a very thin margin, and that many operate at a loss.[75] For those HCPs, broadband connections mean they can use telemedicine to retain patients and consult with specialists remotely, "which is better for patients and helps rural hospitals financially."[76] For example, the North Country Telemedicine Project (NCTP) predicts that telemedicine capabilities will enhance local inpatient hospital revenue by nearly $4.1 million due to increased retention of patients across five specialties – general surgery, cardiology, gastroenterology, oncology, and pulmonology.[77] Additionally, the Pennsylvania Mountains Healthcare Resource Development's (PMHRD) broadband network enabled the development of a revenue cycle management program that has the potential to increase an HCP's bottom line by 2-3 percent while also reducing operating costs.[78]

F. Health Care Provider Broadband Needs Assessment

29. An assessment of the broadband needs of HCPs is an important first step in determining the appropriate level and type of support the Commission should provide in the new program. As noted above, the GAO also has recommended that the Commission undertake a needs assessment before adopting reforms to the RHC Program.[79] In Appendix B to this Order, we provide a detailed assessment of HCP needs for broadband capability in light of the current and future state of telemedicine, telehealth, and health care information technology (the *Needs Assessment).*[80] The *Needs Assessment* builds on the

---

[73] *Pilot Evaluation*, 27 FCC Rcd at 9433-34, paras. 74-75.

[74] Letter from Christianna Lewis Barnhart, Attorney Advisor, Federal Communications Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 (filed Apr. 10, 2012) at 2 (ORHP Apr. 10 *Ex Parte* Letter); *see also* NRHRC Dec. 27 *Ex Parte* Letter at 2 ("Having more patients receive care locally…helps rural hospitals to be successful."); Letter from Christianna Lewis Barnhart, Attorney Advisor, Federal Communications Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 (filed Dec. 1, 2011) at 1 (NRHA Dec. 21 *Ex Parte* Letter) (noting budget limitations for rural HCPs that prohibit telemedicine use).

[75] *See* NRHA Dec. 21 *Ex Parte* Letter at 1; NRHRC Dec. 27 *Ex Parte* Letter at 2 (stating that many critical access hospitals and other small rural hospitals "are experiencing negative margins and facing increasing difficulties in accessing capital"); *see also* USAC Mar. 16 Site Visit Reports at 14 (Jefferson County Hospital in Iowa reports that it can keep more patients in the local hospital because of the quick send and read of the radiology scans).

[76] *See* Pilot Conference Call Mar. 16 *Ex Parte* Letter at 1-2 (ARCHIE *et al.*) at 1-2; *see also* ORHP Apr. 10 *Ex Parte* Letter at 2 (explaining that rural hospitals are reimbursed a facility fee when they seek service from a physician at an urban location via telemedicine); *see generally* NRHRC Dec. 27 *Ex Parte* Letter at 2 (discussing how telemedicine allows rural hospitals to treat patients locally).

[77] *Pilot Evaluation*, 27 FCC Rcd at 9434, para. 75.

[78] *Id.* at 9432-33, para. 73.

[79] *GAO Report* at 21.

[80] There do not appear to be consistent, settled definitions of the terms "telemedicine," "telehealth," or "Heath IT" across all agencies and health care-related groups. As used in the *National Broadband Plan,* the term "Health IT" encompasses a large group of broadband-enabled solutions that have the potential to improve health care outcomes, while controlling costs and extending the reach of the limited pool of health care professionals. *National Broadband Plan* at 199. In this *Order,* we use the term "telehealth" to encompass the full range of health care-related

(continued…)

National Broadband Plan and *OBI Health Care Technical Paper* and uses the information gathered through the Pilot and RHC Programs, the *Pilot Evaluation*, and other information in the record and in public sources.[81] We also rely on comments filed in response to the *July 19 Public Notice*, in which the Bureau asked a series of specific questions regarding HCP broadband needs.[82]

30. In the *Needs Assessment*, we conclude that HCPs need symmetrical broadband connections of high quality in order to engage in telemedicine and to adopt many other telehealth applications.[83] The bandwidth needed by a particular HCP will vary by the telehealth applications it chooses to implement, and by the size and nature of its medical practice.[84] Willingness to purchase the necessary broadband connections also will vary by HCP, but anecdotal evidence suggests that many providers serving rural populations are financially challenged, and that the Commission's RHC support mechanisms have made it possible for them to obtain the high-capacity connectivity necessary to employ a range of telemedicine and other telehealth applications.[85] We expect that these bandwidth and service quality needs will continue to grow in the future, as telemedicine and other telehealth applications are deployed more widely, although it is difficult to predict the pace at which these needs will grow.[86] There are many factors that will affect the rate of adoption of telemedicine, including reimbursement policies, equipment cost, patient and doctor acceptance, medical licensure requirements, and spread of telemedicine standards and technical expertise.[87] Similarly, it is difficult to predict the rate at which other bandwidth-intensive telehealth needs will change (for example, the rate of adoption of remote-hosted EHR solutions and exchange of high capacity medical images, and the use of videoconferencing to train remote health care personnel).

(Continued from previous page)

applications over broadband, similar to the way the term "Health IT" was used in the *National Broadband Plan*. *See supra* nn.1, 42. These would include telemedicine; exchange of EHRs; collection of data through Health Information Exchanges and other entities; exchange of large image files (*e.g.* X-ray, MRIs, and CAT scans); and the use of real-time videoconferencing and other video applications for a wide range of telemedicine, consultation, training, and other health care purposes. We use the term "telemedicine" in the way it is defined by the American Telemedicine Association: "the use of medical information exchanged from one site to another via electronic communications to improve patients' health status." American Telemedicine Association, http://www.americantelemed.org/i4a/pages/index.cfm?pageid=3333 (last visited Dec. 4, 2012).

[81] *National Broadband Plan*; Federal Communications Commission, Health Care Broadband in America: Early Analysis and a Path Forward (Aug. 2010) (*OBI Health Care Technical Paper), available at* http://download.broadband.gov/plan/fcc-omnibus-broadband-initiative-(obi)-working-reports-series-technical-paper-health-care-broadband-in-america.pdf; Letter from Craig Davis, Vice President, Rural Health Care Division, Universal Service Administrative Company, to Sharon Gillett, Chief, Wireline Competition Bureau, Federal Communications Commission, WC Docket No. 02-60 (filed Apr. 12, 2012) (USAC Apr. 12, 2012 Letter).

[82] *July 19 Public Notice*, 27 FCC Rcd at 8201-03, para. 12.

[83] *See Needs Assessment* (Appendix B) at para. 34. By "symmetrical," we mean that health care applications often require that the same bandwidth be available both upstream and downstream. By high quality, we mean that HCPs often need a high degree of reliability, service quality, and redundancy for telehealth applications, in addition to bandwidth. *See id.*, para. 26.

[84] *See id.*, paras. 6-12; *Pilot Evaluation*, 27 FCC Rcd at 9419-22, paras. 52-56.

[85] *See generally Needs Assessment* (Appendix B) at paras. 6-12; *Pilot Evaluation*, 27 FCC Rcd at 9422-25, paras. 57-61.

[86] *See Needs Assessment* (Appendix B) at para. 35.

[87] *See id.*; *Pilot Evaluation*, 27 FCC Rcd at 9425-26, para. 63 n.207.

III. PERFORMANCE GOALS AND MEASURES

31. Clear performance goals and measures will enable the Commission to determine whether the health care universal service support mechanism is being used for its intended purpose and whether that funding is accomplishing the intended results. In the *NPRM*, the Commission recognized the importance of establishing measurable performance goals, stating that "[i]t is critical that our efforts focus on enhancing universal service for health care providers and that support is properly targeted to achieve defined goals."[88] Establishing performance goals and measures also is consistent with the Government Performance and Results Act of 1993 (GPRA), which requires federal agencies to engage in strategic planning and performance measurement.[89] In its 2010 report, the GAO also emphasized that the Commission should provide the RHC support mechanism with "a solid performance management foundation" by "establishing effective performance goals and measures, and planning and conducting effective program evaluations."[90]

32. Drawing on the Commission's experience with the existing RHC programs and the Pilot Program, and based on the record developed in this proceeding, we adopt the following performance goals for the health care universal service support mechanism (both for the RHC Telecommunications Program and the Healthcare Connect Fund), which reflect our ongoing commitment to preserve and advance universal service for eligible HCPs: (1) increase access to broadband for HCPs, particularly those serving rural areas; (2) foster development and deployment of broadband health care networks; and (3) reduce the burden on the USF by maximizing the cost-effectiveness of the health care support mechanism. We also adopt associated performance measurements. Throughout this Order, we have used these goals as guideposts in developing the Healthcare Connect Fund, and these goals also will guide our action as we undertake any future reform of the Telecommunications Program. In the Reporting Requirements section, *infra*, we specify the specific reporting obligations of participants that will enable us to measure progress on the goals and performance measures described in this section.

33. Using the adopted goals and measures, the Commission will, as required by GPRA, monitor the performance of the universal service health care support mechanism.[91] If the program is not meeting the performance goals, we will consider corrective actions. Likewise, to the extent that the adopted measures do not help us assess program performance, we will revisit them as well.

---

[88] *NPRM*, 25 FCC Rcd at 9425, para. 141; *see also id.* at 9426-27, para 145. In 2007, the Commission adopted measures to "improve the productivity and efficiency" of the Rural Health Care Program, but concluded that it did not have sufficient data at that time to establish goals. *Comprehensive Review of the Universal Service Fund Management, Administration, and Oversight, et al*., CC Docket No. 96-45 *et al*., Report and Order, 22 FCC Rcd 16372, 16398-99, para. 54 (2007) (*2007 Comprehensive Review Order*).

[89] Government Performance and Results Act of 1993, Pub. L. No. 103-62, 107 Stat. 285 (1993). Under GPRA, federal agencies must develop strategic plans with long-term, outcome related goals and objectives, develop annual goals linked to the long-term goals, and measure progress toward the achievement of those goals in annual performance plans and report annually on their progress in program performance reports. *See* GPRA Modernization Act of 2010, Pub. L. 111-352, 124 Stat. 3866 (2011).

[90] *GAO Report* at 55.

[91] If the Commission identifies an outcome as a "priority goal," then it must review progress quarterly. Otherwise performance must only be reviewed annually. *See* 31 U.S.C. §§ 1116, 1120-1121, *as amended by* GPRA Modernization Act of 2010, Pub. L. No. 111-352 §§ 4-5 (2010).

A. Increase Access to Broadband for Health Care Providers, Particularly Those Serving Rural Areas

34. *Goal*. We adopt as our first goal increasing access to broadband for HCPs, particularly those serving rural areas. This goal implements Congress's directive in section 254(h) of the Communications Act that the Commission "enhance access to advanced telecommunications services and information services" for eligible HCPs and to provide telecommunications services necessary for the provision of health care in rural areas at rates reasonably comparable to similar services in urban areas.[92] As discussed above, access to the broadband necessary to support telehealth and Health IT applications is critical to improving the quality and reducing the cost of health care in America, particularly in rural areas.[93] Broadband enables the efficient exchange of patient and treatment information, reduces geography and time as barriers to care, and provides the foundation for the next generation of health innovation.[94]

35. *Measurement*. We will evaluate progress towards our first goal by measuring the extent to which program participants are subscribing to increasing levels of broadband service over time.[95] We also plan to collect data about participation in the Healthcare Connect Fund relative to the universe of eligible participants. We also will collect data about the bandwidth obtained by participants in the program, and will chart the increase over time in higher bandwidth levels. We plan to compare those bandwidth levels with the minimum bandwidth requirements recommended in the *National Broadband Plan* and the *OBI Technical Paper* to determine how HCP access to broadband evolves as technology changes and as HCPs increasingly adopt telemedicine and electronic health records. We also expect to measure the bandwidth obtained by HCPs in the different statutory categories, as that information is not administratively burdensome to collect.[96] To the extent feasible, we also will endeavor to compare the bandwidth obtained by participants in the Commission's programs with that used by non-participants, by relying on public sources of information regarding broadband usage by the health care industry, and by comparing the bandwidth obtained by new participants in the Commission's programs with what they were using prior to joining, to the extent such data is available.

36. As discussed in the *Needs Assessment*, HCP needs for higher bandwidth connections vary based on the types of telehealth applications used by HCPs and by the size and nature of their medical practices.[97] Because of this variation, and because of potential constraints on the ability of HCPs to obtain broadband (due to cost or lack of broadband availability), we are not establishing a minimum target bandwidth as a means to measure progress toward this goal.[98] We expect, nevertheless, to compare the bandwidth obtained by HCPs with the kinds of bandwidth commonly required to conduct telemedicine and other telehealth activities.[99]

---

[92] 47 U.S.C. § 254(h)(1), (h)(2)(A).

[93] *See National Broadband Plan* at 200-203; *Pilot Evaluation*, 27 FCC Rcd at 9428-30, para. 67.

[94] *See National Broadband Plan* at 201; *Pilot Evaluation*, 27 FCC Rcd at 9428-30, para. 67.

[95] *See NPRM*, 25 FCC Rcd at 9425, para. 141.

[96] As part of the application process, the applicant is required to identify which HCP statutory category each site satisfies, *see* 47 U.S.C. § 254(h)(7)(B), and the bandwidth of each supported connection. *See* Forms 460, 462. With this data, the Commission will be able to readily measure the average bandwidth for each of the statutory eligibility categories.

[97] *See Needs Assessment* (Appendix B) at para. 6.

[98] *See also infra* section V.A.2.

[99] *See generally Needs Assessment* (Appendix B).

37. We direct the Bureau to consult with the major stakeholders and other governmental entities in order to minimize the administrative burden placed on applicants and on the Fund Administrator (currently, USAC).[100] We also direct the Bureau to consult with the U.S. Department of Health and Human Services (HHS), including the Indian Health Service (IHS), and other relevant federal agencies to ensure the meaningful and non-burdensome collection of broadband data from HCPs.[101] We expect to follow health care trends (such as use of EHRs and telemedicine) and to coordinate, to the extent possible, our monitoring efforts with other federal agencies. We also direct the Bureau to engage in dialogue with HHS regarding whether and how to incorporate broader health care outcomes, including providers' "meaningful use" of EHRs, into our performance goals and measures in the future, consistent with our statutory authority.[102]

38. Finally, in order to further our progress toward meeting this goal, we also direct USAC, working with the Bureau and with other agencies, to conduct outreach regarding the Healthcare Connect Fund with those HCPs that are most in need of broadband in order to reach "meaningful use" of EHRs and for other health care purposes.[103]

B. Foster Development and Deployment of Broadband Health Care Networks

39. *Goal*. We adopt as our second goal fostering development and deployment of broadband health care networks, particularly networks that include HCPs that serve rural areas. This goal is consistent with the statutory objective of section 254(h), which is to enhance access to telecommunications and advanced services, especially for health care providers serving rural areas.[104] As discussed above and in the *Pilot Evaluation*, broadband health care networks also improve the quality and lower the cost of health care and foster innovation in telehealth applications, particularly in rural areas.[105]

40. *Measurement*. We will evaluate progress towards this second goal by measuring the extent to which eligible HCPs participating in the Healthcare Connect Fund are connected to other HCPs through broadband health care networks. We plan to collect data about the reach of broadband health care networks supported by our programs, including connections to those networks by eligible and non-

---

[100] *See GAO Report* at 56-57 (recommending that the Commission "[c]onsult with USAC, other federal agencies that serve rural health care providers (or with expertise related to telemedicine), and associations representing rural health care providers to incorporate their knowledge and experience into improving current and future programs").

[101] *See* Letter from Michael J. Jacobs, Legal Advisor to Chief, Wireline Competition Bureau, Federal Communications Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 at 1 (filed Nov. 16, 2012) (ONC Nov. 16 *Ex Parte* Letter); HHS Comments at 14; NOSORH Comments at 8 (submitted as an attachment to NCORHCC Reply Comments); ARHO Comments at 4.

[102] *See* ONC Nov. 16 *Ex Parte* Letter at 1. Several parties recommended that the Commission decline to adopt such specific performance measures now. *See, e.g.*, HHS Comments at 14 (recommending that "at this time the FCC should not align its performance measures with the meaningful use criteria and instead consider such linkage (such as 2015 for Medicare providers and 2017 for Medicaid providers, or later)"); ATA Comments at 16 (suggesting the Commission decline to adopt "meaningful use" as a criteria to determine the success of the program because "meaningful use" is intended to measure "the use of electronic records, not the use of telecommunications services to provide health services); UH TIPG Comments at 5; HIEM Comments at 19-20.

[103] *See supra* para. 23; ONC Nov. 16 *Ex Parte* Letter. *See also* Appendix B for a discussion of "meaningful use" of EHRs. *Needs Assessment* (Appendix B) at paras. 16-17.

[104] 47 U.S.C. § 254(h)(2)(A) (enhancing access to advanced services for HCPs); 47 U.S.C. § 254(h)(1) (providing telecommunications services to HCPs serving rural areas at rates comparable to rates in urban areas). *See also Pilot Evaluation*, 27 FCC Rcd at 9426, para. 64; *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20367, para. 16.

[105] *Pilot Evaluation*, 27 FCC Rcd at 9428-30, para. 67.

eligible HCP sites. We also will measure how program participants are using their broadband connections to health care networks, including whether and to what extent HCPs are engaging in telemedicine, exchange of EHRs, participation in a health information exchange, remote training, and other telehealth applications.[106] As discussed in the *Needs Assessment*, access to high speed broadband health care networks should help facilitate adoption of such applications by HCPs, including those HCPs serving patients in rural areas.[107] We direct the Bureau to work with USAC to implement the reporting requirements regarding such telehealth applications in a manner that imposes the least possible burden on participants, while enabling us to measure progress toward this goal.[108] We also direct the Bureau to coordinate with other federal agencies to ensure that data collection minimizes the burden on HCPs, which may already be required to track similar data for other health care regulatory purposes.[109] To the extent feasible, we also will endeavor to compare the extent to which participants in the new program are using telehealth applications to that of non-participants, relying on public sources of information regarding trends in the health care industry.

C. Maximize Cost-Effectiveness of Program

41. *Goal*. We adopt as our third goal maximizing the cost-effectiveness of the RHC universal service health care support mechanism, thereby minimizing the Fund contribution burden on consumers and businesses. This goal includes increasing the administrative efficiency of the program (thereby conserving Fund dollars) while accelerating the delivery of support for broadband. This goal also includes ensuring that the maximum value is received for each dollar of universal service support provided, by promoting lower prices and higher speed in the broadband connections purchased with Fund support. In addition, we seek to ensure that funding is being used consistent with the statute and the objectives of the RHC support mechanism, and we adopt throughout this Order measures to help prevent waste, fraud and abuse. The goal of increasing program efficiency is consistent with section 254(h)(2)(A) of the Communications Act, which requires that support to HCPs be "economically reasonable."[110]

42. *Measurement.* We will evaluate progress towards this goal both by measuring the administrative efficiency of the program and by measuring the value delivered with each dollar of USF support. First, we will measure the cost of administering the program compared to the program funds disbursed to recipients.[111] USAC's cost to administer the Telecommunications, Internet Access, and Pilot RHC programs was nine percent of total funds disbursed in calendar year 2011, the highest of all four universal service programs.[112] We may measure this also in terms of the percentage of administrative expenses relative to funds committed, to account for the fact that administrative expenses may be higher in years in which USAC processes a large number of applications for multi-year funding.

---

[106] *See* HHS, Office For the Advancement of Telehealth, Grantee Profiles, at 12 (FY 2010-2011), *available at* http://www.hrsa.gov/ruralhealth/about/telehealth/telehealthdirectory.pdf; *see also* OHN PN Comments at 3 (encouraging the Commission to collect information that focuses on "telehealth/telemedicine use, including types of programs and uses, solutions used, patients/populations served, and types of facilities and practices that are using telemedicine/telehealth").

[107] *Needs Assessment* (Appendix B) at paras. 33, 35.

[108] *See infra* section VI.G.

[109] *See supra* para. 37.

[110] 47 U.S.C. § 254(h)(2)(A) (enhancing access to advanced services for health care providers).

[111] *See e.g., 2007 Comprehensive Review Order*, 22 FCC Rcd 16372, 16398, para. 57.

[112] USAC Nov. 16 Data Letter at 4.

43. Second, we will measure the value delivered to HCPs with support from the Healthcare Connect Fund by tracking the prices and speed of the broadband connections supported by the program. As we found in the Pilot Program, consortium applications, in combination with competitive bidding and other program features, lead to lower prices and higher speed broadband.[113] As we did in the *Pilot Evaluation*, we expect to measure the prices and speed of connections obtained under the Healthcare Connect Fund to determine whether this goal has been accomplished, and will examine similar data from the Telecommunications Program.[114] In addition, we will monitor the results of the Administrator's audits and other reports to track progress in reducing improper payments and waste, fraud and abuse.[115]

IV. SUPPORT FOR BROADBAND CONNECTIVITY

A. Overview

44. In this Order, we create a new Healthcare Connect Fund that will provide universal service support for broadband connectivity for eligible HCPs. As designed, the new program will achieve the goals we have identified above for the reformed program: (1) increasing access to broadband for HCPs, including those in rural areas; (2) fostering the development of broadband health care networks to deliver innovation in telehealth applications; and (3) maximizing the cost-effective use of the Fund. The Healthcare Connect Fund replaces the current RHC Internet Access Program, but the RHC Telecommunications Program remains in place.[116]

45. Although we will allow the filing of both individual and consortium applications, a primary focus of the Healthcare Connect Fund will be encouraging the growth or formation of statewide, regional, or Tribal broadband health care networks that will expand the benefits we observed in the Pilot Program. Benefits of such networks include access to specialists; cost savings from bulk buying capability and aggregation of administrative functions; efficient network design; and the transfer of medical, technical, and financial resources to smaller HCPs. We will allow non-rural as well as rural health care providers to participate and receive support for critical network connections if they apply as part of a consortium, with limitations to ensure that program funds are used efficiently and that all consortia include rural participation.

46. In the *NPRM*, the Commission proposed to create two separate programs: a Health Infrastructure Program and a Broadband Services Program.[117] The former would support the construction of HCP-owned broadband networks; the latter would support the purchase of broadband services.[118] In view of the real world experience we have gained from the Pilot Program over the intervening two years,

---

[113] *Pilot Evaluation*, 27 FCC Rcd at 9435, para. 77.

[114] *Id.* at 9419-25, paras. 52-62.

[115] *See infra* section VII.A.

[116] *See infra* sections VIII, X.A, X.B. For the most part, the same rules and procedures currently applicable to that program will continue to apply. The performance goals and measures and the reporting requirements we adopt today apply to the Telecommunications Program as well, as does the offset rule. *See supra* section III; *infra* section VI.G. As discussed below, we expect to consider reform of the Telecommunications Program in the future.

[117] *NPRM*, 25 FCC Rcd at 9373, para. 3.

[118] *Id.* In the *2007 Pilot Program Selection Order*, the Commission clarified that, to the extent a selected participant purchases transmission services in lieu of deploying its own broadband network, the costs for subscribing to such facilities and services are eligible for program support. *See* 22 FCC Rcd at 20397-98, para. 74. Throughout this *Order*, we distinguish between services purchased by HCPs from third parties (which may include mechanisms such as long-term leases, prepaid leases, and indefeasible rights of use of facilities for specified period of time (IRUs)) and "self-construction" (*i.e.* network facilities constructed and owned by the HCPs).

and based on the extensive record in this docket from a broad array of affected stakeholders, we now conclude that the better approach is to adopt a single, hybrid program. The new program will support the cost of (1) broadband and other advanced services; (2) upgrading existing facilities to higher bandwidth; (3) equipment necessary to create networks of HCPs, as well as equipment necessary to receive broadband services; and (4) HCP-owned infrastructure where shown to be the most cost-effective option. The hybrid approach of the Healthcare Connect Fund provides flexibility for HCPs to create broadband networks that best meet their needs and that can most readily be put to use for innovative and effective telehealth applications, while ensuring funds are spent responsibly and efficiently. The new program will replace the current Internet Access Program and provide continuing support for Pilot Program consortia as they exhaust any remaining funding already committed under the Pilot Program.[119] As discussed below in the Implementation Timeline section, for administrative convenience, rural HCPs can continue to participate in the Internet Access Program during funding year 2013.[120]

47. As we discuss below, we expect that most HCPs will choose to obtain services from commercial providers rather than construct and own network facilities themselves, just as they did in the Pilot Program.[121] HCP-owned infrastructure will be supported under the Healthcare Connect Fund only when the HCP or HCP consortium demonstrates, following a competitive bidding process that solicits bids for both services and construction, either that the needed broadband is unavailable or that the self-construction approach is the most cost-effective option. We also impose an annual cap of $150 million that will apply, in part, to the funds available for HCP self-construction, to ensure that ample funding will remain available for HCPs choosing to obtain services.[122]

48. To promote fiscal responsibility and cost-effective purchasing decisions, we adopt a single, uniform 35 percent HCP contribution requirement for all services and infrastructure supported through the program. Use of a single, flat rate will facilitate network applications, encourage efficient network design, and reduce administrative expenses for applicants and the Fund. In requiring a 35 percent contribution, we balance the need to provide appropriate incentives to encourage resource-constrained HCPs to participate in health care broadband networks, while requiring HCPs to have a sufficient financial stake to ensure that they obtain the most cost-effective services possible. We also find that a 35 percent contribution requirement is economically reasonable and fiscally responsible, given the $400 million cap for the health care support mechanism and the anticipated demand for program support.[123]

49. We adopt the Healthcare Connect Fund pursuant to section 254(h)(2)(A) of the Communications Act, which requires the Commission to "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."[124]

---

[119] Although all funding commitments have now been made under the Pilot Program, much of the Pilot funding remains to be disbursed to many of the projects. *See* USAC Nov. 16 Data Letter at 1 (funding commitments); Letter from Craig Davis, Vice President, Rural Health Care Division, Universal Service Administrator, to Julie Veach, Chief, Wireline Competition Bureau, Federal Communications Commission, WC Docket No. 02-60, Appendix B (USAC August 9 Letter) (disbursements).

[120] We will make the Internet Access Program available through the end of funding year 2013 (through June 30, 2014), pursuant to current program rules, so that participants will not need to prepare a second application during the funding year, if they so choose. *See infra* section X.A.

[121] *See infra* para. 69.

[122] The $150 million cap will apply to all upfront payments and multi-year commitments (*i.e.* long-term investments) issued under the Healthcare Connect Fund. *See infra* sections V.D, VI.C.4.

[123] 47 C.F.R. § 54.623(a) (capping the fund at $400 million).

[124] 47 U.S.C. § 254(h)(2)(A). *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20360, para. 15 n.41.

The Commission relied on this statutory authority when it created the Pilot Program in 2006 to support HCP-owned infrastructure and services, including Internet access services,[125] and the Commission has broad discretion regarding how to fulfill this statutory mandate. In *Texas Office of Public Utility Counsel v. FCC*, the United States Court of Appeals for the Fifth Circuit upheld the Commission's authority under section 254(h)(2)(A) to provide universal service support for "advanced services" to both rural and non-rural HCPs.[126]

B. A Consortium Approach to Creation of Broadband Health Care Networks

50. The flexible, consortium-based approach of the Pilot Program fostered a wide variety of health care broadband networks that enabled better care and lowered costs, as described in section IV.B.1 below. Drawing on our Pilot Program experience, we implement a Healthcare Connect Fund that will encourage HCPs to work together to preserve and advance the development of health care networks across the country. The measures we adopt will simplify the application process for consortia of HCPs and afford them flexibility to innovate in the design and use of their networks, recognizing the importance of enabling smaller HCPs to draw on the medical and technical expertise and administrative resources of larger HCPs.

51. In section IV.B.2, we conclude that non-rural HCPs may apply and receive support as part of consortia in the Healthcare Connect Fund. To ensure that program support continues to benefit rural as well as non-rural HCPs, however, we require that in each consortium, a majority of HCP sites (over 50 percent) be rural HCPs. We also adopt measures to limit the amount of funding that flows to the largest hospitals in the country, to ensure that funding remains focused on a broad cross section of providers serving smaller communities across America.

52. Separately, in section V below, we describe the services and equipment eligible for support (including services and equipment necessary for networks), and in section VI below, we describe the funding process, including the requirements applicable to consortia.

1. Key Benefits of a Consortium Approach

53. *Background*. The 1996 Act explicitly makes eligible for support "consortia … consisting of one or more" eligible HCPs.[127] The existing RHC programs, however, do not currently allow HCPs to submit a joint application as a consortium; instead, each member of a consortium seeking support must submit a separate application for each HCP site and circuit. By contrast, the Commission required Pilot projects to apply as consortia and instituted procedures by which a project could submit a single application covering all HCPs participating in the network.[128] In the *NPRM*, the Commission proposed a similar, single streamlined application process for consortia in the proposed Health Infrastructure

[125] *2003 Order and Further Notice*, 18 FCC Rcd at 24556-57, paras. 19-22; *2006 Pilot Program Order*, 21 FCC Rcd at 11114, paras. 10-11 (2006).

[126] *Texas Office of Public Utility Counsel v. FCC*, 183 F.3d 393, 446 (5th Cir. 1999), *aff'g in part, rev'g in part, and remanding in part, Federal State Joint Board on Universal Service*, CC Docket No. 96-45, First Report and Order, 12 FCC Rcd 8776 (1997).

[127] Under the Act, a consortium of eligible HCPs is itself considered an eligible HCP. *See* 47 U.S.C. § 254(h)(7)(B)(vii).

[128] *See 2006 Pilot Program Order*, 21 FCC Rcd at 11111-12, 11116-17, paras. 1, 3, 16-17; *Pilot Evaluation*, 27 FCC Rcd at 9435-39, paras. 77-87.

Program.[129] Subsequently, the Bureau sought to further develop the record on consortium applications for the proposed Broadband Services Program in its *July 19 Public Notice*.[130]

54. *Discussion.* The *Pilot Evaluation* documented in detail the benefits from the flexible consortium-based approach used in the Pilot Program, including:[131]

- *Administrative Cost Savings*: Applying as a consortium is simpler, cheaper, and more efficient for the HCPs and for the Fund. Under the consortium approach, the expenses associated with planning the network, applying for funding, issuing RFPs, contracting with service providers, and invoicing are shared among a number of providers. Consortium applications also allow USAC to process applications more efficiently.[132]
- *Access to Medical Specialists through Telemedicine*. Consortia that include both larger medical centers and members that serve more sparsely populated areas enable the latter to obtain access to medical specialists through telemedicine, thus improving the quality and reducing the cost of care.[133]
- *Leadership of Consortia*. The organizers and leaders of many Pilot projects classified as non-rural entities under the Commission's longstanding definition of rural HCPs – especially hospitals and university medical centers—were able to shoulder much of the administrative burden associated with the consortia, thereby benefiting smaller, rural HCPs.[134]
- *Sources of Technical Expertise*. Larger sites often have the technical expertise necessary to design networks and manage the IT aspects of the network, and also often have greater expertise than smaller providers in rural areas in telemedicine, electronic health records, Health IT, computer systems, and other broadband telehealth applications.[135]
- *Financial Resources*. Many Pilot projects depend on the financial and human resources of larger sites to absorb the administrative costs of participation in the Pilot, such as the cost of planning and organizing applications, applying for funding, preparing RFPs, contracting for services, and implementing the projects.[136]
- *Efficiency of Network Design*. Network design in many cases has been more efficient and less costly in the Pilot Program than in the Telecommunications Program, because the Pilot Program funds all public and not-for-profit HCPs, even those located in non-rural areas. Pilot projects were able to design their networks with maximum network efficiency in mind because funding is not negatively impacted by inclusion of non-rural sites in those networks.[137]

---

[129] *NPRM*, 25 FCC Rcd at 9379-81, paras. 14-18.

[130] *July 19 Public Notice*, 27 FCC Rcd at 81889-90, paras. 7-8.

[131] *See Pilot Evaluation*, 27 FCC Rcd at 9435-39, paras. 77-87; USAC Observations Letter at 1-4.

[132] *Pilot Evaluation*, 27 FCC Rcd at 9435-36, 9437-8, paras. 78-80, 84.

[133] *Id.* at 9428-31, 9438-40, paras. 67-71, 87-89.

[134] *Id.* at 9438, 9441, paras. 86, 89.

[135] *Id.* at 9441, para. 89.

[136] *Id.*

[137] *Id*. Under the Telecommunications Program, circuits are only eligible for funding if one end of the circuit terminates at an eligible rural entity, which can create incentives for HCPs to maximize funding by ensuring that all

(continued…)

- *Bulk Buying Capability.* Consortium bulk buying capability, when combined with competitive bidding and multi-year funding commitments, enabled Pilot projects to obtain higher bandwidth, lower rates, and better service quality than would otherwise have been possible.[138]

55. Commenters generally support a consortium approach and agree that it can provide a number of benefits, including better pricing and administrative efficiency.[139]

56. In light of these benefits, we adopt a number of rules adopted today to encourage HCPs to work together in consortia to meet their broadband connectivity needs. Immediately below, we conclude that non-rural HCPs may participate and receive support as part of consortia, with some limitations. We also adopt a "hybrid" approach that allows consortia to receive support through a single program for services and, where necessary, self-construction of infrastructure.[140] We adopt a uniform HCP contribution percentage applicable to all HCPs and to all funded costs to simplify administration.[141] In sections V and VI below, we adopt additional measures. We make support for certain costs available only to consortia – *e.g.*, upfront payments for build-out costs and IRUs, equipment necessary for the formation of networks, and self-construction charges.[142] We also allow consortia to submit a single application covering all members, and we provide additional guidance based on Pilot Program experience for consortium applications.[143] Finally, we facilitate group buying arrangements by providing for multi-year commitments and allowing HCPs to "opt into" competitively bid master service agreements previously approved by USAC or other federal, state, Tribal, or local government agencies, without undergoing additional competitive bidding solely for the purposes of receiving Healthcare Connect Fund support.[144]

(Continued from previous page)

connections within the network terminate at an eligible rural entity. USAC Observations Letter at 5. As a technical and financial matter, this can lead to less efficient network design. For example, it may be more efficient to design the middle-mile component of a regional or statewide network by using connections between non-rural sites, rather than routing traffic through a rural site. *Id*.

[138] *See Pilot Evaluation*, 27 FCC Rcd at 9436-37, paras. 81-83; *see also* USAC Observations Letter at 1-2 (use of centralized contracting and invoicing; use of Master Services Agreements). The Commission's experience with the Pilot Program shows that consortium applications drive down costs and make it possible for HCPs to purchase higher capacity services. Service providers bidding on consortium RFPs are more willing to offer larger discounts because the consortium has multiple sites and presents a more appealing commercial proposition to the service providers. Consortium applications also encourage vendors to bid on providing broadband to sites where broadband might not already be available, because a single RFP includes all consortium HCP sites (both those that have broadband available to them and those that do not). *See Pilot Evaluation*, 27 FCC Rcd at 9437, para. 82.

[139] *See, e.g.*, Broadband Principals Comments at 10 (the reality is that many small HCPs may prefer to run their telecommunications through a group which can provide expertise and help them realize economies of scale); Internet2 Comments at 17; ACS PN Comments at 3; Geisinger PN Comments at 2; NCTN PN Comments at 2; UTN PN Comments at 1.

[140] *See infra* section IV.C.

[141] *See infra* section IV.D.

[142] *See infra* sections V.A.6, V.B, IV.C.

[143] *See generally infra* section VI.

[144] *See infra* sections VI.C.4, VI.B.6.

2. Eligibility to Participate in Consortia

57. *Background*. As noted above, the existing RHC programs (both Telecommunications and Internet Access) provide support only to HCPs located in "rural" areas. "Rural area" is defined based on the location of a HCP site relative to a Core Based Statistical Area (CBSA), a geographic area based around an urban center of at least 10,000 people.[145] In contrast, the Pilot Program allowed participation by both rural and non-rural eligible HCPs, as long as a project had more than a *de minimis* representation of rural HCPs.[146] As of November 15, 2012, all but one of the 50 active Pilot projects included at least one participant that was not a rural HCP.[147] The non-rural sites represented approximately 34 percent of the 3,822 Pilot project sites and approximately 39 percent of the funding commitments for all projects as of November 15, 2012.[148]

58. In the *NPRM*, the Commission proposed to allow non-rural participation in the Health Infrastructure Program, but not in the Broadband Services Program.[149] The Bureau sought additional comment on including non-rural sites for broadband services funding in the *July 19 Public Notice*.[150] A diverse group of commenters – including state offices of rural health, Pilot projects, the American Hospital Association, service providers, and United Way – have urged the Commission to support both non-rural and rural HCPs, citing the many benefits of non-rural participation in broadband health care

[145] *See* 47 C.F.R. § 54.5. Specifically, "rural area" is defined as an "area that is entirely outside of a Core Based Statistical Area; is within a Core Based Statistical Area that does not have any Urban Area with a population of 25,000 or greater; or is in a Core Based Statistical Area that contains an Urban Area with a population of 25,000 or greater, but is within a specific census tract that itself does not contain any part of a Place or Urban Area with a population of greater than 25,000." CBSAs are defined by the Office of Management and Budget (OMB) and "Urban Areas" and "Places" are identified by the Census Bureau. *See Rural Health Care Second Report and Order and Further Notice*, 19 FCC Rcd at 24619-20, para. 12 & nn.44-47 (explaining the basis for the current definition of "rural area"). USAC maintains a "lookup table" on its website to enable applicants quickly to determine if their location is "rural" under this definition. *See* USAC web site, "List of Eligible Rural Areas," *available at* http://www.universalservice.org/rhc/tools/Rural/2005/search.asp (last visited Nov. 7, 2012).

[146] *2006 Pilot Program Order*, 21 FCC Rcd at 11111, 11114, paras. 3, 10.

[147] USAC Nov. 16 Data Letter at 4.

[148] *Id.* at 1-2. As noted in the *Pilot Evaluation*, the funding attributed to non-rural locations likely is overstated because shared equipment and services often are attributed to non-rural locations even though they are used by all the network sites. *See also Pilot Evaluation*, 27 FCC Rcd at 9408, para. 37; Letter from Craig Davis, Vice President, Universal Service Administrative Company, to Sharon Gillett, Chief, Wireline Competition Bureau, Federal Communications Commission, WC Docket No. 02-60 (filed May 30, 2012) at 2 (USAC May 30 Data Letter). In addition to network design studies, "shared" equipment and services (*i.e.*, equipment and services that benefit the entire network and not just one site) would include switches, routers, and firewalls that are located at data centers or other facilities of lead entities that often are located in non-rural areas. *Id* at 2-3.

[149] *See NPRM*, 25 FCC Rcd at 9739, 9408, paras. 13, 93.

[150] *See July 19 Public Notice* at paras. 7-8.

networks.[151] A few commenters, however, have raised concerns that program funds could be exhausted if non-rural HCPs are made eligible for support without any limitations.[152]

59. *Discussion*. We will allow participation in the Healthcare Connect Fund consortia by both rural and non-rural eligible HCPs, but with limitations to ensure that the health care support mechanism continues to serve rural as well as non-rural needs in the future. The Pilot Program provided support to both rural and non-rural HCPs under section 254(h)(2)(A), which directs the Commission to "enhance… access to advanced telecommunications and information services for *all* public and non-profit . . . health care providers."[153] As the Fifth Circuit has found, "the language in section 254(h)(2)(A) demonstrates Congress's intent to authorize expanding support of 'advanced services,' when possible, for non-rural health providers."[154]

60. We expect that including non-rural HCPs in consortia will provide significant health care benefits to both rural and non-rural patients, for at least three reasons.

- First, even primarily rural networks benefit from the inclusion of larger, non-rural HCPs.[155] Pilot projects state that rural HCPs value their connections to non-rural HCPs for a number of reasons, including access to medical specialists; help in instituting telemedicine programs; leadership; administrative resources; and technical expertise.[156] Many non-rural HCPs in the Pilot Program devoted resources to organizing consortia, preparing applications, designing networks, and preparing RFPs.[157] Had these non-rural HCPs not been eligible for support, they might not have been willing to take on a leadership role, which in turn directly enabled

[151] *See, e.g.*, NOSORH Comments at 4 (inclusion of non-rural HCPs in a dedicated health care network is "essential for access to services otherwise unavailable"); CTN PN Comments at 5-6; IRHN PN Comments at 7-8; UTN PN Comments at 3; CTCC/RMHN PN Comments at 2; OHN PN Comments at 5; AHA PN Comments at 2; GCI PN Comments at 6; Charter PN Reply Comments at 4; United Way PN Comments at 2. The benefits cited by these commenters are similar to those discussed in the *Pilot Evaluation. See Pilot Evaluation*, 27 FCC Rcd at 9439-9442, paras. 88-90.

[152] *See, e.g.*, AHA PN Comments at 3 (Commission should allow urban participation in consortia, but ensure that the program's limited funding be used for the benefit of rural HCPs); RWHC PN Comments at 2 (agreeing with the importance of including urban referral centers in rural broadband networks, and supporting funding for non-rural HCPs in rural broadband networks to the extent that the funding for non-rural HCPs is not at the expense of rural HCPs); ACS PN Comments at 5; CHCC/RMHN Comments at 3.

[153] 47 U.S.C. § 254(h)(2(A) (emphasis added).

[154] *Texas Office of Public Utility Counsel v. FCC*, 183 F.3d at 446 (subsequent history omitted). The only statutory limitation is that HCPs must be public or non-profit entities and must be within one of the eligible statutory HCP categories. *See* 47 U.S.C. §§ 254(h)(2)(A), 254(h)(7)(B) (listing categories of eligible HCPs). In contrast, the Telecommunications Program, which limits support to rural HCPs, was implemented pursuant to a different provision of the 1996 Act, section 254(h)(1)(A), which requires telecommunications carriers to provide telecommunications services to "any public or nonprofit HCP that serves persons who reside in *rural* areas in the State at rates that are reasonably comparable to rate charged for similar services in urban areas in that State." 47 U.S.C. § 254(h)(1)(A) (emphasis added). The Telecommunications Program therefore is only available to rural HCPs.

[155] *Pilot Evaluation*, 27 FCC Rcd at 9439-42, paras. 88-89; *see supra* section IV.B.1, para. 54.

[156] *Pilot Evaluation*, 27 FCC Rcd at 9439-42, para. 89 (many Pilot projects state that participation by non-rural sites has been instrumental to their individual success).

[157] *See, e.g.*, UTN PN Comments at 3; IRHN PN Comments at 7; MiCTA PN Comments at 3; SWTAG PN Comments at 6; HSHS PN Comments at 4; VAST PN Reply Comments a 1; OHN PN Comments at 6.

smaller and more rural HCPs to participate in Pilot networks.[158] The participation of non-rural sites has also led to better prices and more broadband for participating rural HCPs, due to the greater bargaining power of consortia that include larger, non-rural sites.[159]

- Second, the Commission's longstanding definition of "non-rural" HCPs encompasses a wide range of locales, ranging from large cities to small towns surrounded by rural countryside.[160] Even within areas that are primarily rural, HCPs are likely to be located in the most populated areas. Many HCPs that are technically classified as non-rural within our rules in fact are located in relatively sparsely populated areas. For example, Orangeburg County Clinic in Holly Hill, South Carolina (population 1,277), a HCP participating in Palmetto State Providers Network's Pilot project, is characterized as non-rural. The largest cities closest to Holly Hill are Charleston, SC, and Columbia, SC, which are respectively 50 and 69 miles away from Holly Hill.[161] Moreover, even those hospitals and clinics that are located in more densely populated towns directly serve rural populations because they are the closest HCP for many patients who do live in the surrounding rural areas.[162] For example, the University of Virginia Medical Center is a major referral center for many counties in rural Appalachia.[163]
- Third, even hospitals and clinics that are located in truly urban areas are able to provide significantly improved care by joining broadband networks. The California Telehealth Network, for example, states that it "frequently encounters urban health care providers with patient populations that are as isolated from clinical specialty care as [the] most rural health care providers," including urban Indian HCPs who could better serve Native populations through broadband-centered technologies such as EHRs and telemedicine.[164] In some areas of the country, even "urban" communities may be hundreds of miles away from critical health care services such as Level 1 Trauma Centers, academic health centers, and children's hospitals.[165] Like HCPs in rural areas, these "urban" community hospitals may serve as "spoke" health care facilities that access services that are available at larger hospital "hubs." Eligible public and not-for-profit HCPs located in communities that are not classified as

---

[158] *See supra* para. 54. *See also Pilot Evaluation*, 27 FCC Rcd at 9439-42, para. 89.

[159] *Pilot Evaluation*, 27 FCC Rcd at 9437, para. 82; *see also, e.g.*, UTN PN Comments at 2; CRIHB PN Reply Comments at 1; NETC PN Reply Comments at 3-5; VAST PN Reply Comments at 1.

[160] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20421, para. 120; 47 C.F.R. § 54.5. OMB has cautioned that "[t]he CBSA classification is not an urban-rural classification" and that CBSAs and many counties outside CBSAs "contain both urban and rural populations." Office of Management and Budget, 2010 Standards for Delineating Metropolitan and Micropolitan Statistical Areas, 75 Fed. Reg. 37245, 37249 (June 28, 2010), *available at* http://www.whitehouse.gov/sites/default/files/omb/assets/fedreg_2010/06282010_metro_standards-Complete.pdf (last visited Nov. 7. 2012).

[161] For an interactive map that shows the rural/ non-rural categorization of the Pilot Program HCP sites, *see Pilot Evaluation*, 27 FCC Rcd at 9406, para. 34 (citing map at http://www.fcc.gov/maps/rural-health-care-pilot-program). An examination of the sites on the map shows that many of the non-rural HCP sites in the Pilot Program are located in or near areas with relatively low density populations.

[162] *See, e.g.*, NCTN Comments at 9; CTN PN Comments at 6.

[163] UVA June 8 *Ex Parte* Letter at 1 (UVA provides tele-psychiatry that is vital for patients in rural areas of Virginia, given that only one or two psychiatrists serve all of southwestern Virginia; the tele-psychiatry program has transformed a 50 percent patient "no-show" rate to an 85 percent "show" rate).

[164] CTN PN Comments at 6; CRIHB PN Reply at 1.

[165] UTN PN Comments at 2 (noting this is true in Utah and other areas of the intermountain west).

"rural" thus have a need for access to broadband to be able to effectively deliver health care, just as their "rural" counterparts do.

61. Some commenters express concern that unlimited non-rural HCP participation might jeopardize funding for rural HCPs if the $400 million annual program cap is reached.[166] We therefore adopt three simple limitations that should help ensure a fiscally responsible reformed health care program without unduly restricting non-rural participation, consistent with our statutory mandate to enhance access to advanced services in an "economically reasonable" manner.[167] First, non-rural HCPs may only apply for support as part of consortia that include rural HCPs; that is, they may not submit individual applications.[168] Second, non-rural HCPs may receive support only if they participate in consortia that include a majority (more than 50 percent) of sites that are rural HCPs. The majority rural requirement must be reached by a consortium within three years of the filing date of its first request for funding (Form 462) in the Healthcare Connect Fund. Third, we establish a cap on the annual funding available to each of the largest hospitals participating in the program (those with 400 or more beds). These requirements will encourage the formation of health care *networks* that include rural HCPs, while generating administrative and pricing efficiencies as well as significant telemedicine and other telehealth benefits.[169]

62. For purposes of the majority rural requirement, we "grandfather" non-rural HCP sites that have received a funding commitment through a Pilot project that has 50 percent or more non-rural HCP sites with funding commitments as of the adoption date of this Order. Such non-rural HCP sites may continue to receive support through the Healthcare Connect Fund, but unless the consortium overall reaches majority rural status overall, the project may add new non-rural HCP sites only if, in the aggregate, the new (*i.e.* non-Pilot project) HCP sites remain majority rural.[170] The grandfathering only

---

[166] *See, e.g.*, AHA PN Comments at 3 (recommending that the Commission avoid "overly onerous" restrictions on the inclusion of urban sites in consortia, but adopt policies ensuring that limited funding predominantly benefits rural providers); NTCA Comments at 8 (given the finite amount of funds available and in light of the specific need for broadband access in many hard-to-serve rural areas, the initial focus of the Commission should be addressing rural needs before turning to other locations).

[167] 47 U.S.C. § 254(h)(2)(A).

[168] The Healthcare Connect Fund will allow HCPs to submit applications for a single site ("individual applications") or for multiple sites ("consortium applications"). *See infra* section VI. Individual applications are limited to rural HCPs.

[169] Other proposed limitations are either more extensive than we believe necessary, or are administratively unworkable. *See, e.g.*, Letter from Louis Wenzlow, Rural Wisconsin Health Cooperative, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 at 1 (filed Oct. 25, 2012) (recommending that the Commission use bed size alone to determine whether urban hospitals and health clinics should be eligible for support); Letter from Doug Power, Illinois Rural HealthNet, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 at 2 (filed Oct. 31, 2012) (proposing to limit urban hospitals' participation based on their proximity to rural communities); Letter from Bradley K. Gillen, Counsel to the American Hospital Association, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 at 2 (filed Dec. 5, 2012) (suggesting that any support or caps on hospitals should be limited to exclude only outliers and those hospitals with the most excessive draws on federal funds).

[170] For example, if a consortium in the Pilot Program had 100 Pilot HCP sites with funding commitments, of which 60 sites were non-rural, it could continue to receive support under the Healthcare Connect Fund for all of these 100 specific Pilot HCP sites as they exhausted their Pilot funding. The consortium could continue to add new HCP sites under the new program, but only if it adds them in a proportion that is majority rural -- put differently, the former Pilot consortium would be in compliance if the total of its new HCP sites were majority rural. If one of the 60 original non-rural Pilot HCP sites were to leave the consortium, only the remaining 59 original non-rural Pilot HCP sites would be grandfathered. The grandfathering is specific to the sites; thus, the consortium would not be allowed

(continued…)

applies to the sites that have received a Pilot Program funding commitment as of the adoption date of this Order, and applies only so long as the grandfathered non-rural HCP site continues to participate in that consortium.

63. We recognize that large, metropolitan non-profit hospitals are more likely to provide specialized services and expertise that HCPs and patients in less populous areas (both rural and non-rural) may otherwise be unable to access, and that may serve a leadership role under which they provide significant, often unreimbursed assistance to other HCPs within the network. Thus, we see significant value in having such hospitals participate in health care broadband networks. At the same time, however, large metropolitan hospitals are located in urban areas where broadband is typically less expensive than in rural areas. Given that universal service funds are limited, we expect larger hospitals to structure their participation in Healthcare Connect Fund consortia in a way that appropriately serves the goals of the health care program to *increase* HCP access to broadband services and health care broadband networks. In other words, it would not be economically reasonable to provide support to larger hospitals for connections they would have purchased in any event, outside of their participation in the consortium.[171]

64. To protect against larger HCPs in non-rural areas joining the program merely to obtain support for pre-existing connections, we require consortium applicants to describe in their applications the goals and objectives of the proposed network and their strategy for aggregating HCP needs, and to use program support for the described purposes.[172] We also impose a limitation on the amount of funding available to large metropolitan hospitals, while recognizing that it is unlikely in the near term that large urban hospitals will consume a disproportionate amount of funds in the Healthcare Connect Fund.[173] We require that under the Healthcare Connect Fund, a non-rural hospital site with 400 or more licensed patient beds may receive no more than $30,000 per year in support for recurring charges and no more than $70,000 in support for nonrecurring charges every 5 years under the Fund, exclusive in both cases of costs shared by the network.[174] For purposes of this limit, we "grandfather" non-rural hospitals that have received a funding commitment through a Pilot project as of the adoption date of this Order.[175] We base the amount of these caps on the average charges that were supported for non-rural hospitals in the Pilot

(Continued from previous page)

to replace the departing original Pilot non-rural site with another non-rural site without regard to the majority rural requirement.

[171] *See* 47 U.S.C. § 254(h)(2) (directing the Commission to facilitate access to advanced telecommunications and information services "to the extent technically feasible and economically reasonable"). For example, it would be an inappropriate use of support if three major metropolitan hospitals formed a consortium with four rural HCPs, in order to subsidize all the pre-existing broadband connections for the metropolitan hospitals with very little value being added for the rural HCPs.

[172] *See infra* Section VI.B.3.

[173] On average, non-rural and rural HCPs in the Pilot Program are allocated about the same amount of funds per HCP. *See* USAC Nov. 16 Data Letter at App. A & B.

[174] The non-recurring cost cap applies for a five-year period. Thus, for example, a non-rural HCP could receive support for non-recurring costs for $20,000 in year one and then again for up to $50,000 in year three. We limit support for nonrecurring costs over a five-year period in order to prevent the result that a hospital might attempt to convert recurring charges into non-recurring charges as a way to avoid the cap. We will require non-rural hospitals to indicate whether they have 400 or more licensed patient beds on FCC Form 460. Thus, if a hospital has less than 400 beds at the time of applying for support, it need not inform USAC that its status has changed to a "large" hospital, unless it seeks an additional funding commitment. *See* Appendix D, new rule 54.630(c).

[175] The grandfathering only applies as long as the grandfathered non-rural hospital continues to participate in that consortium.

Program.[176] The American Hospital Association (AHA) defines "large" hospitals as those with 400 or more staffed patient beds.[177] We will use the AHA classification as a guide for our own definition of a "large" hospital, which is any non-rural hospital with 400 or more licensed patient beds.[178] Based on our experience with the Pilot Program, it appears that the vast majority of Pilot participant hospitals have fewer than 200 beds. We do not anticipate, therefore, that the funding caps for large hospitals that we adopt here will be likely to affect most of the hospitals that are likely to join consortia in the Healthcare Connect Fund. We will monitor use of support by large hospitals closely in the new program, and if it appears that such hospitals are utilizing a disproportionate share of program funds despite our caps, we may consider more explicit prioritization rules to ensure that program dollars are targeted to the most cost-effective uses. As discussed below, we plan to conduct a further proceeding to examine possible approaches to prioritizing funding.[179]

65. We expect that, on average, the actual number of rural members in the consortia will be substantially higher than 51 percent, as was the case in the Pilot Program, and we will evaluate this over time. We will not begin receiving applications from new consortia until 2014, and based on our experience with the Pilot Program, we know that it may take some time for consortia to organize themselves and apply for funding. We therefore direct the Bureau to report to the Commission on rural participation by September 15, 2015. If we observe that the trend of rural participation in the new program does not appear to be on a comparable path as we observed in the Pilot Program (where average rural participation reached 66 percent),[180] we will open, by the end of 2015, a proceeding to expeditiously re-evaluate the participation requirement.

66. We emphasize that the limitations above do *not* prevent any non-rural HCP from *participating* in a health care broadband network; entities ineligible for support may participate in networks if they pay their "fair share" (*i.e.* an "undiscounted" rate) of network costs.[181] Non-profit

---

[176] USAC Nov. 16 Data Letter at 4 (stating that as of November 15, 2012, the average monthly recurring undiscounted costs for non-rural hospitals in the Pilot Program, excluding shared network expenses, is $3,007 per site; the average undiscounted non-recurring charge for such hospitals is $92,731 per site). The caps adopted herein are calculated by increasing these two data points to provide a cushion for those hospitals with above-average costs, multiplying each by 65% (the amount of support provided under the Healthcare Connect Fund), and rounding the result to $30,000 and $70,000 respectively. These caps are equivalent to undiscounted recurring charges of $46,154 monthly and nonrecurring charges of $107,692.

[177] The AHA classifies hospital size based on "staffed" patient bed count, as follows: "small" (under 100 beds), medium (100-399 beds), and large (400 + beds). AHA DataViewer, Glossary, http://www.ahadataviewer.com/glossary/. The AHA defines "bed size" for purposes of its data collection as "the number of beds regularly maintained (set up and staffed for use) for inpatients as of the close of the reporting period," as opposed to the number of "licensed beds," which refers to the maximum number of beds the hospital is licensed to operate. AHA DataViewer, Glossary, http://www.ahadataviewer.com/glossary/; Agency for Healthcare Research and Quality, Standardized Hospital Bed Definitions, http://www.ahrq.gov/research/havbed/definitions.htm.

[178] We recognize that hospitals often maintain fewer staffed beds than they are licensed to operate at capacity, and thus our definition, which uses "licensed" patient beds, may capture as "large" hospitals some hospitals that the AHA would classify as medium. *See* Agency for Healthcare Research and Quality, Standardized Hospital Bed Definitions, http://www.ahrq.gov/research/havbed/definitions.htm. Because the number of licensed beds is readily ascertainable by hospitals and is less subject to fluctuation, we believe it is the best measure of hospital size for the purposes of targeting assistance in the Healthcare Connect Fund.

[179] *See infra* section X.C.

[180] *See* USAC Nov. 16 Data Letter at 2.

[181] *See infra* section V.C.4 (defining "fair share").

entities, including non-rural HCPs, may also serve as consortium leaders even if they do not receive universal service support.[182]

67. In light of the limitations adopted above, we do not anticipate that our decision to allow both rural and non-rural HCPs to receive support through the Healthcare Connect Fund will cause program demand to exceed the $400 million cap in the foreseeable future, especially in light of our decision to require a 35 percent participant contribution and our adoption of a $150 million annual cap on support for upfront payments and multi-year commitments. Furthermore, the pricing and other efficiencies made possible through group purchasing should drive down the cost of connections as some Telecommunications Program participants migrate to the Healthcare Connect Fund. We will closely monitor program demand, and stand prepared to consider whether additional program changes are necessary, including, as discussed below, establishing rules that would give funding priority to certain HCPs.[183]

3. Eligibility of Grandfathered Formerly "Rural" Sites

68. In June 2011, the Commission adopted an interim rule permitting participating HCPs that were located in a "rural" area under the definition used by the Commission before July 1, 2005, to continue being treated as if they were located in a "rural" area for the purposes of determining eligibility for support under the RHC program.[184] We conclude that HCPs that were located in "rural areas" under the pre-July 1, 2005 definition used by the Commission, and that were participating in the Commission's RHC program before July 2005, also will be treated as "rural" for purposes of the new Healthcare Connect Fund.[185] Many such facilities play a key role in providing health care services to rural and remote areas, and discontinuing discounted services to these grandfathered providers could jeopardize their ability to continue offering essential health care services to rural areas.[186] Extending eligibility for these grandfathered HCPs in the Healthcare Connect Fund helps ensure that these valuable services are not lost in areas that need them, and thus ensures continuity of health care for many rural patients.[187] For

---

[182] *See infra* section VI.A.2. *See also* 47 U.S.C. § 254(h)(7)(B).

[183] *See infra* section X.C; *see also NPRM*, 25 FCC Rcd at 9421-23, paras. 128-134 (seeking comment on possible prioritization rules).

[184] *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order and Notice of Proposed Rulemaking, 26 FCC Rcd 9145, 9149, para. 10 (2011) (*Grandfathering Order and NPRM*); 47 C.F.R. § 54.601(a)(3)(i). From 1997 to 2005, the Commission considered an area to be "rural" if it was not located in a county within a Metropolitan Statistical Area (MSA) as defined by the Office of Management and Budget (OMB), or if it was specifically identified as rural in the Goldsmith Modification to the 1990 census data. *See Universal Service First Report and Order*, 12 FCC Rcd at 9115-16, para. 649. Effective Funding Year 2005, the Commission adopted a new definition stating that a rural area is one that is not located within or near a large population base that exceeds 25,000. 47 C.F.R. § 54.5; *see Second Report and Order and Further Notice*, 19 FCC Rcd at 24619-20, para. 12 & nn.44-47 (explaining the basis for the current definition of "rural area").

[185] This means that such grandfathered HCPs will be counted as "rural" for all purposes in the Healthcare Connect Fund. If a grandfathered HCP site moves to a new address, we direct USAC to determine whether the new address would also have been considered "rural" under the old definition. If so, the HCP continues to retain its rural classification. If not, it becomes "non-rural."

[186] *See Grandfathering Order and NPRM*, 26 FCC Rcd at 9149-50, paras. 13, 14. ("grandfathered facilities, while not located themselves in a 'rural area' under current Commission definitions, play a key role in providing health care to 'fundamentally rural areas'").

[187] Services provided by grandfathered facilities include emergency services, preventative care, interactive video, counseling, specialist consultations, oncology, psychiatry, neurology, tele-trauma, teleradiology, health professional and community education, and other telehealth and telemedicine applications. *See id.*, 26 FCC Rcd at 9150, para 14.

similar reasons, we also have grandfathered those Pilot projects that do not have the majority rural HCP membership required of consortium applicants in the Healthcare Connect Fund.[188]

C. A Hybrid Infrastructure and Services Approach

69. *Background*. In the *NPRM*, the Commission proposed to create separate infrastructure (HCP-constructed and owned broadband networks) and broadband services programs.[189] The Commission also proposed to allocate up to $100 million annually for infrastructure projects.[190] While many commenters supported the infrastructure proposal in the *NPRM* as a way to enhance broadband access for HCPs, other commenters argued that focusing on services obtained from commercial service providers is a better way to encourage infrastructure deployment because it does not risk duplicate construction of facilities.[191] The *Pilot Evaluation* found that while some Pilot projects found construction of their own networks to be the most cost-effective solution, most HCPs in the Pilot Program did not want to own and manage broadband networks.[192] Instead, the majority of Pilot projects have chosen to purchase services from third-party providers, and many have taken advantage of mechanisms such as long-term leases, prepaid leases, and indefeasible rights of use (IRUs) to obtain the bandwidth and service quality they needed.[193] In the *July 19 Public Notice*, the Bureau solicited additional comment on whether to provide limited funding for construction of facilities within the context of the proposed Broadband Services Program in circumstances where the needed broadband capability is not available or where self-construction is the most cost-effective option.[194] Commenters argued both for and against an infrastructure option in response to the *July 19 Public Notice*.[195]

70. *Discussion*. We conclude that a hybrid approach that supports both broadband services and, where necessary, HCP-constructed and owned facilities as part of networks, will best fulfill our goal of developing broadband networks that enable the delivery of 21st century health care.[196] In addition to funding HCP-owned network facilities, we also include as an essential component of this hybrid approach the provision of funding for equipment needed to support networks of HCPs and the provision of support for upgrades that enable HCPs to obtain higher bandwidth connections.[197]

71. We expect that HCP-owned infrastructure will be most useful in providing last-mile broadband connectivity where it is currently unavailable and where existing service providers lack

---

[188] *See supra* Section IV.B.2.

[189] *NPRM*, 25 FCC Rcd at 9381-9383, 9395-9397, paras. 19-25, 55-59.

[190] *Id.* at 9421, para. 128.

[191] *Compare* HIEM Comments at 4; RNHN Comments at 1; RWHC Comments at 2 (supporting infrastructure proposal); *with* ATC Comments at 9; ACS Comments at 6-7; NTCA Comments at 2-3; GCI Comments at 12-13 (opposing infrastructure proposal).

[192] *Pilot Evaluation*, 27 FCC Rcd at 9390 (Executive Summary); *see also* NCTA PN Comments at 3.

[193] *Pilot Evaluation*, 27 FCC Rcd at 9390, 9414-18, 9452, Executive Summary and paras. 47-51, 109.

[194] *July 19 Public Notice*, 27 FCC Rcd at 8185, para. 10.

[195] *Id.*; *compare* HIEM PN Comments at 6, 10-11; IRHN PN Comments at 13-14; SWTAG PN Comments at 8; RNHN PN Reply at 3 (supporting infrastructure component); *with* NTCA PN Comments at 2-4; GCI PN Reply at 3, 4 (recommending a services-only program).

[196] *See supra* para. 46.

[197] *See infra* sections V.B, V.A.6.

sufficient incentives to construct it.[198] As the American Hospital Association observed: "Although many rural providers lease broadband services, some construction is still needed. For many of the AHA's rural members, the ability to ensure access to 'last mile' broadband connections to rural health care facility locations is a fundamental problem restricting broadband access."[199] We have learned that when providers are unable to build a business case to construct fiber in rural areas, last-mile fiber self-construction may be the only option for a HCP to get the required connectivity.[200] We note that other federal programs – such as the Broadband Telecommunications Opportunities Program (BTOP) – have provided support for construction of "middle mile" facilities, and if HCPs can obtain support for last-mile connections from the Healthcare Connect Fund, they can take advantage of such middle mile backbone networks.[201]

72. Providing a self-construction option will also promote our goal of ensuring fiscal responsibility and cost-effectiveness by placing downward pressure on the bids for services. As the Health Information Exchange of Montana observes, the option to construct the network may constrain pricing offered by existing providers, particularly in areas that have little or no competition.[202] When an RFP includes both a services and a self-construction option, bidders will know that if the services prices bid are too high, the HCPs can choose to build their own facilities.[203]

73. We adopt safeguards to ensure that the self-construction option will be exercised only where it is absolutely necessary to enable the HCPs to obtain the needed broadband connectivity. First, the HCP-owned infrastructure option may be employed only where self-construction is demonstrated to be the most cost-effective option after competitive bidding.[204] We require USAC carefully to evaluate this showing; USAC already has experience in evaluating cost-effectiveness for large-scale projects from the Pilot Program.[205] Consortia interested in pursuing self-construction as an option must solicit bids both for

---

[198] *See Pilot Evaluation*, 27 FCC Rcd at 9416, para. 48 (the six Pilot projects that self-constructed some, but not all, facilities used those funds primarily for last-mile facilities).

[199] AHA PN Comments at 3.

[200] *See, e.g.*, MTN PN Comments at 2-3; Geisinger PN Comments at 4; RWHC PN Comments at 3.

[201] The American Recovery and Reinvestment Act of 2009 provided $4.7 billion for NTIA to establish the BTOP program to increase broadband access and adoption. *See* American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5 § 6001 (codified at 47 U.S.C. § 1305).

[202] *See* HIEM PN Comments at 9.

[203] Other commenters made similar observations about the role of support for HCP-owned infrastructure in certain circumstances. *See, e.g.*, ACS PN Comments at 10; RWHC PN Comments at 3; MTN PN Comments at 2-3; HIEM PN Comments at 6, 9-11; IRHN PN Comments at 13; Pilot Conference Call Mar. 26 *Ex Parte* Letter (WNYRAHEC *et al.*) at 1 (noting that having a private fiber network as part of the larger network helped St. Joseph's to control costs and ensure long-term success, as it could be cost-prohibitive to buy from a carrier the 1 to 10 Gbps connections needed to move medical images); Letter from David LaFuria, Counsel for Health Information Exchange of Montana, to Marlene H. Dortch, Secretary, WC Docket No. 02-60, at 2 (filed Sept. 22, 2011) (stating that HIEM's network would be a small fraction of what it is now if HIEM had simply leased facilities from the outset, and arguing that the Commission should retain the option for program participants to construct network facilities, as removing that option from competitive bidding will change how incumbent carriers approach the bid process).

[204] The Commission has defined "cost-effective" for purposes of the existing RHC support mechanism as "the method that costs the least after consideration of the features, quality of transmission, reliability, and other factors that the HCP deems relevant to . . . choosing a method of providing the required health care services." *See 2007 Pilot Program Selection Order*, 22 FCC Rcd 20400-01, paras. 78-79. *See infra* section VI.A.4.

[205] *See Pilot Evaluation*, 27 FCC Rcd at 9398, para. 18. We note that the most cost-effective option is not always the cheapest, as HCPs are permitted to consider service quality and other factors in addition to cost.

services and for construction, in the same posted Request for Proposals (submitted with Form 461), so that they will be able to show either that no vendor has bid to provides the requested services, or that the bids for self-construction were the most cost-effective option. RFPs must provide sufficient detail so that cost-effectiveness can be evaluated over the useful life of the facility, if the consortium pursues a self-construction option. We also permit HCPs that have received no bids on a services-only posting to then pursue a self-construction option through a second posting. We discuss the mechanics of the competitive bidding process in more detail below,[206] and delegate to the Bureau the authority to provide administrative guidance for conducting the competitive bidding process, for the treatment of hybrid (services and construction) RFPs, excess capacity and shared costs, and other necessary guidelines for effective operation of this aspect of the Healthcare Connect Fund.[207]

74. Second, by setting the discount at the same level regardless of whether HCPs choose to purchase broadband services from a provider or construct their own facilities, we ensure that there is no cost advantage to choosing self-construction. We require that all HCPs provide a 35 percent contribution to the cost of supported networks and services, which will help ensure prudent investment decisions.[208] Pilot projects have stated that ownership of newly constructed facilities only makes economic sense for them where there are gaps in availability.[209] And as many HCPs have stated in this proceeding, HCPs are generally not interested in owning or operating broadband facilities, but rather are focused on the delivery of health care.[210]

75. Finally, we impose a $150 million cap on the annual funds that can be allocated to up-front, non-recurring costs, including HCP-owned infrastructure, and we require that non-recurring costs that exceed an average of $50,000 per HCP in a consortium be prorated over a minimum three-year period. These measures will help ensure that the Fund does not devote an excessive amount of support to large up-front payments for HCP self-construction, which could potentially foreclose HCPs' ability to use the Fund for monthly recurring charges for broadband services.[211] This also addresses the comments of

---

[206] *See infra* section VI.B.

[207] Compliance with Bureau administrative guidance would constitute a "safe harbor" for applicants and others who rely on the guidance. In other words, applicants who comply with the requirements set forth in the Bureau guidance will be deemed to have complied with the relevant Healthcare Connect Fund requirements, and any subsequent changes to the guidance by the Bureau or by the Commission will apply only prospectively. We note that providing support for a hybrid solution (both services and HCP-owned infrastructure construction) creates several potential practical issues in connection with the competitive bidding process, which may warrant further guidance to USAC. These might include, for example, guidance on structuring bids that include both services and infrastructure options, establishing criteria for evaluating competing bids, and demonstrating cost-effectiveness. *See, e.g.*, IRHN PN Comments at 14.

[208] The requirement that HCPs make a significant up-front investment if they choose to self-construct should help address concerns that they will make inappropriate "build-vs.-buy" decisions, as suggested by the National Telecommunications Cooperative Association. NTCA Comments at 3.

[209] Pilot Conference Call Mar. 16 *Ex Parte* Letter (ARCHIE *et al.*) at 3; IRHN PN Comments at 13 (new construction may not be cost-viable for most HCPs).

[210] *See, e.g.*, Colorado Feb. 28 *Ex Parte* Letter at 2 (Colorado projects did not want to divert resources away from their core competency, health care, into communications operations); Letter from Christianna Lewis Barnhart, Attorney Advisor, Federal Communications Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 (filed Mar. 13, 2012) at 3 (Pilot Conference Call Mar. 13 *Ex Parte* Letter (PMHA *et al.*)) (group of Pilot projects stating that their core competencies did not include constructing and owning networks, and that they preferred to purchase services).

[211] *See infra* section V.D.

several parties, who suggested that providing funding for infrastructure could put undue pressure on the Fund.[212]

76. In addition to these safeguards, we expect that several other mechanisms in this Order will help create incentives for commercial service providers to construct the necessary broadband facilities, so that HCPs will rarely have to construct, own, and operate such facilities themselves. For example, by allowing consortia to include both rural and non-rural sites and to design networks flexibly, we expect to encourage HCPs to form larger consortia that are more attractive to commercial service providers, even if some new broadband build-out is necessary to win the contract.[213] Indeed, in the Pilot Program, we observed that, thanks to consortium bidding, the majority of Pilot projects attracted multiple bids from a range of different service providers.[214] In addition, as in the Pilot Program, the Healthcare Connect Fund will provide support for upfront payments, multi-year funding commitments, prepaid leases, and IRUs.[215] These mechanisms enabled many HCPs in the Pilot Program to meet their broadband connectivity needs without having to construct and own their own broadband facilities.[216]

77. With the limitations above, and based on our experience with the Pilot Program, we do not expect HCPs to choose to self-construct facilities very often, and when they do, it will be because they have shown that they have no other cost-effective option for obtaining needed broadband. The self-construction option was rarely exercised in the Pilot Program. Only two of 50 projects entirely self-constructed their networks, even though the Pilot Program was originally conceived of as a program supporting HCP construction of broadband networks. The six projects that did self-construct some facilities used those funds primarily for last-mile facilities.[217] We believe the hybrid approach adopted for the Healthcare Connect Fund will preserve the benefits of HCP-owned infrastructure while minimizing the potential for inefficient, duplicative construction of facilities.

78. In light of the safeguards we adopt, we reject arguments that when HCPs construct their own networks, rather than purchasing connectivity from existing commercial service providers, they remove key anchor institutions from the public network, thereby increasing the costs of providing service in rural areas and creating disincentives for network investment in rural areas.[218] Rather, allowing the self-construction option should create incentives for service providers to charge competitive prices for the services offered to anchor institutions such as HCPs, which reduces burden on the rural health care mechanism. Moreover, experience under the Pilot Program suggests that a self-construction option for HCPs can provide incentives for commercial service providers to work cooperatively together with HCPs to construct new broadband networks in rural areas, with each party building a portion of the network,

---

[212] *See, e.g.*, UAMS PN Comments at 6-7.

[213] *See* Letter from Craig Davis, Vice President, Rural Health Care Division, Universal Service Administrative Company, to Julie Veach, Chief, Wireline Competition Bureau, Federal Communications Commission, WC Docket 02-60 (filed Aug. 2, 2012) at 4 (USAC Aug. 2 Data Letter)*; Pilot Evaluation*, 27 FCC Rcd at 9436-37, paras. 81-83.

[214] *See Pilot Evaluation*, 27 FCC Rcd at 9436, 9467-8, para. 81 and App. D (List of Winning Vendors); USAC May 30 Data Letter at 1-2.

[215] *See infra* sections V, VI.C.4.

[216] *See Pilot Evaluation*, 27 FCC Rcd at 9436-37, paras. 81-83.

[217] *Id.* at 9416, para. 48.

[218] *See* MTA PN Comments at 7-8. *See also* NTCA PN Comments at 3; Qwest Comments at 2 ("Qwest strongly disagrees with the Commission's proposals to require health care providers to have an ownership interest . . . in program-funded facilities. . . ."); MITS Comments at 5-6; Horizon Reply Comments at 2; TSTC Reply Comments at 2; GCI PN Reply Comments at 2-3.

and providing excess capacity to the other party under favorable terms, to the benefit of both the HCPs and the greater community.[219]

79. We are also unpersuaded by commenters that argue the Commission lacks authority to provide universal service support for construction of HCP-owned broadband facilities.[220] As the Commission concluded in authorizing the Pilot Program, section 254(h)(2) provides ample authority for the Commission to provide universal service support for HCP "access to advanced telecommunications and information services," including by providing support to HCP-owned network facilities.[221] Nothing in the statute requires that such support be provided only for carrier-provided services. Indeed, prohibiting support for HCP-owned infrastructure when self-construction is the most cost-effective option, would be contrary to the command in section 254(h)(2)(A) that support be "economically reasonable."[222]

80. The Montana Telecommunications Association (MTA), which represents telecommunications providers in Montana, also argues that funding HCP-owned infrastructure violates section 254(h)(3) of the Communications Act, which provides that "[t]elecommunications service and network capacity provided to a public institutional telecommunications 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."[223] MTA's argument is unconvincing. 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."[224] 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"[225] because only subsidized services and network capacity can be said to have been "provided … under this subsection." The protections we adopt in this Order to ensure that non-eligible entities pay their fair share of the cost of health care networks they participate in will help ensure that this principle is satisfied.[226] In 2008, the Bureau provided guidance to the Pilot projects and USAC regarding excess capacity on network facilities supported by universal service funds.[227] We adopt similar guidelines in this Order for the treatment of excess capacity on HCP-owned facilities.[228] Under those guidelines, the use of excess capacity by non-HCP entities would not violate the restrictions against sale, resale, or other transfer contained in section 254(h)(3) because HCPs would

---

[219] *See* Letter from Jeffrey Mitchell, counsel for HIEM, to Marlene H. Dortch, Secretary, Federal Communications Commission, filed October 15, 2012 (attachment).

[220] MTA PN Comments at 3; *see also* MTA Comments at 10-11; MTA Reply Comments at 5-6; AT&T Reply Comments at 7-8. Other commenters simply state without elaboration that they question the Commission's statutory authority to fund HCP-owned network infrastructure. *See* ATA Comments at 3; NTCA PN Comments at 1 n.3 (stating that there is "a legitimate question" about the Commission's authority).

[221] *See 2006 Pilot Program Order*, 21 FCC Rcd at 11114, para 11.

[222] 47 U.S.C. § 254(h)(2)(A).

[223] 47 U.S.C. § 254(h)(3); *see* MTA Comments at 10. *See also* AT&T Comments at 9.

[224] *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20416, para. 107.

[225] *Id.*

[226] *See infra* section V.C.4.

[227] Letter from Dana R. Shaffer, Chief, WCB, to Scott Barash, Acting CEO, USAC, WC Docket No. 02-60 (Oct. 24, 2008) (Dana Shaffer Oct. 24, 2008 Letter), *available at* http://transition.fcc.gov/cgb/rural/wcbletter.pdf (last visited Dec. 5, 2012).

[228] *See infra* para. 103.

retain ownership of the excess capacity and because payments for that excess capacity may only be used to support sustainability of the network.[229] As discussed above, allowing HCPs to own network facilities when it is the most cost-effective option can yield better prices for the acquired broadband services or facilities used in the health care networks, in furtherance of the objectives of section 254(h)(2) and responsible management of universal service funds. Thus, our interpretation of section 254(h)(3) not only advances the universal service goals of section 254(h)(2), but is consistent with the restrictions on subsidies to ineligible entities incorporated in paragraphs (h)(3), (h)(4), and (h)(7)(B) of section 254.

D. Health Care Provider Contribution

81. *Background*. As discussed above, the Commission currently provides support to eligible HCPs through the Telecommunications Program, the Internet Access Program, and the Pilot Program.[230] The Telecommunications Program supports the amount of the urban-rural rate differential for telecommunications services;[231] the Internet Access Program provides a 25 percent flat-rate discount for Internet access;[232] and the Pilot Program provides support for a limited number of years for up to 85 percent of the eligible costs of broadband HCP networks, with the requirement that such networks be self-sustainable thereafter.[233] In the *NPRM*, the Commission proposed to create a new health infrastructure program that would support up to 85 percent of the construction costs of new regional or statewide networks, and a separate health broadband services program that would support up to 50 percent of the monthly recurring costs for access to broadband services.[234] The Commission also proposed to include a sustainability requirement for the infrastructure program.[235]

82. *Discussion*. As described in more detail below, we adopt a requirement that all HCPs receiving support under the Healthcare Connect Fund contribute 35 percent towards the cost of all items for which they seek support, including services, equipment, and all expenses related to infrastructure and construction. A flat, uniform percentage contribution is administratively simple, predictable, and equitable, and has broad support in the record. Requiring a significant contribution will provide incentives for HCPs to choose the most cost-effective form of connectivity, design their networks efficiently, and refrain from purchasing unneeded capacity. Vendors will also have an incentive to offer services at competitive prices, knowing that HCPs will be unwilling to increase unnecessarily their out-of-pocket expenses.

---

[229] *See NPRM*, 25 FCC Rcd at 9403-04, para. 82. *See also, e.g.,* HIEM Comments at 6-10; RNHC Comments at 12-13; Benton Comments at 5.

[230] *See supra* paras. 12-14.

[231] Specifically, the Telecommunications Program ensures that eligible HCPs pay no more than their urban counterparts for their telecommunications needs in the provision of health care services, as provided in section 254(h)(1)(A) of the Act. To accomplish this, the Commission requires telecommunications carriers to charge eligible rural HCPs a rate for each supported service that is no higher than the highest tariffed or publicly available commercial rate for a similar service in the closest city in the state with a population of 50,000 or more, taking distance charges into account. *See* 47 C.F.R. §§ 54.604, 54.605, 54.607.

[232] 47 C.F.R. § 54.621. In states that are "entirely rural," the discount rate increases to 50%. Only the territories of Guam, American Samoa, U.S. Virgin Islands, and the Northern Mariana Islands are considered entirely rural and therefore eligible for a 50% discount on Internet Access. 47 C.F.R. § 54.621(c).

[233] *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20361, para. 2.

[234] *NPRM*, 25 FCC Rcd at 9373, para. 3.

[235] *Id.* at 9399-9400, paras. 65-66.

1. Use of a Uniform Contribution Percentage

83. We adopt a flat-percentage approach to calculating an HCP's contribution under the Healthcare Connect Fund.[236] This flat rate will apply uniformly to all eligible expenses and all eligible HCP sites.

84. The use of a uniform participant contribution will facilitate consortium applications and reduce administrative expenses, both for participating HCPs and for the Fund Administrator.[237] In the Telecommunications Program, varying support levels have historically discouraged potential applicants due to "the complexity of … identify[ing] the amount of program reimbursement associated with the difference between rural and urban rates."[238] A uniform participant contribution will eliminate this complexity. Many commenters support a flat-rate approach for this reason.[239] Indeed, based on this record, we anticipate that the relative administrative simplicity of the uniform flat discount approach will help attract HCPs to the Healthcare Connect Fund that may have declined to participate in the Telecommunications Program. We expect that the use of a uniform flat discount will therefore further all three of our program goals – increasing HCP access to broadband, fostering health care networks, and maximizing cost-effectiveness of the program.

85. A uniform HCP contribution requirement will also facilitate efficient network design because support will not vary based on network configuration.[240] As the Bureau observed in the *Pilot Evaluation*, a uniform HCP contribution requirement for both services and infrastructure in the Pilot Program enabled consortia to design their networks for maximum network efficiency because there was no negative impact on funding from including nodes with a lesser discount level within the network.[241] A uniform percentage contribution requirement will also ensure that HCPs make purchasing decisions based on cost-effectiveness, regardless of the location or type of the HCP or the services, equipment, or infrastructure purchased.

86. Adopting a uniform contribution requirement will also help eligible HCPs to conduct better long-range planning for their broadband needs and obtain better rates.[242] A clear, uniform rate will allow

---

[236] Although we adopt a flat-rate discount approach here due to the substantial benefits of that approach, we continue the availability of support based on an urban/rural differential or "mileage based support" under the existing Telecommunications Program for those health care providers that choose to remain in that program. *See infra* Section VIII; 47 C.F.R. §§ 54.605, 54.607, 54.609; USAC Observations Letter at 6.

[237] *Pilot Evaluation*, 27 FCC Rcd at 9449, para. 102; *see also* USAC Observations Letter at 7.

[238] CenturyLink Reply at 4 n.9.

[239] *See also* NOSORH Comments at 5 (stating that in many cases, rural HCPs eligible for the Telecommunications Program believe that the staff effort required for the initial application is not worth the financial gain); NRHA Comments at 14 (submitted as an attachment to NCORHCC Reply Comments) (administrative complexity of Telecommunications Program is a key reason the program has not met expectations since its inception); Broadband Principals Comments at App. A; VTN Comments at 31-32.

[240] *See, e.g.*, USAC Observations Letter at 5 (in the RHC Telecommunications Program, circuits are only eligible for funding if one end of the circuit terminates at an eligible rural entity, which can create incentives for HCPs to maximize funding by ensuring that all connections within the network terminate at an eligible rural entity, rather than using a more efficient hub-and-spoke design).

[241] *Pilot Evaluation*, 27 FCC Rcd at 9438-42, para. 89.

[242] *See id.* at 9448-49, paras. 101-03. The *National Broadband Plan* recommended that, to better encourage participation in the health broadband services program, the Commission should provide clarity as to the level of support that HCPs can reasonably expect to receive. *National Broadband Plan* at 215 (NBP Recommendation 10.6).

HCPs to better project anticipated support over a multi-year period, plan accordingly for their broadband services, and as appropriate, enter into multi-year contracts to take advantage of more favorable rates.[243]

87. A flat-rate approach also provides HCPs with a strong incentive to control the total cost of the broadband connectivity, as a participating HCP will share in each dollar of increased costs and each dollar of cost savings. In contrast, in the Telecommunications Program, an HCP using the rural-urban differential pays only the urban rate, so it has little incentive to control the overall cost of the service (*i.e.* the rural rate). Any increases in the overall cost of the service are borne directly by the Fund, which pays the difference between the urban and rural rates.

88. Finally, a flat rate is consistent with the Act. In 2003, the Commission concluded that a flat discount for the Internet Access Program would be consistent with section 254(b)(5), which requires support to be "specific, sufficient, and predictable."[244] We now conclude that a flat discount for the Healthcare Connect Fund is also consistent with section 254(b)(5).

89. A number of commenters suggest that the Commission adopt different HCP contribution percentages depending on the identity of the health care provider or based on other factors, and such an approach was also recommended in the *National Broadband Plan.*[245] The proffered justification for a varying percentage contribution requirement is to enable the targeting of scarce resources to those HCPs or geographic areas most in need.[246] Some commenters suggest that discount rates should be increased for certain HCPs, such as HCPs located in Health Professional Shortage Areas or Medically Underserved Areas, or for HCPs that are in particular need of support to achieve "meaningful use" of electronic health records under the Affordable Care Act.[247] While supporting providers in areas with health care professional shortages and promoting achievement of meaningful use are both important public policy goals, we are not persuaded at this time that providing a non-uniform discount is necessary in order to accomplish these goals. We note that the statutory categories of eligible HCPs in the Act already capture many health care providers who serve underserved populations, including rural health clinics, community and migrant health centers, and community mental health centers.[248]

2. 35 Percent HCP Contribution

90. *Background.* Having determined that a hybrid approach of having a single program for services and infrastructure with a uniform HCP contribution percentage will best serve our goals, we must next decide on the appropriate contribution from the HCP. There is broad consensus that the 75 percent

---

[243] *See Pilot Evaluation*, 27 FCC Rcd at 9437, 9448-49 paras. 83, 100-103.

[244] 47 U.S.C. § 254(b)(5); *2003 Order and Further Notice,* 18 FCC Rcd at 24560, para. 27.

[245] *National Broadband Plan* at 215 (NBP Recommendation 10.6) (recommending that the Commission base discount levels for the health broadband services program on criteria that address such factors as lack of broadband access, lack of affordable broadband, price discrepancies for similar broadband services between health care providers, the health care provider's inability to afford broadband services, special status for health care providers in the highest Health Professional Shortage Areas (HPSAs) of the country, and special status for public or safety net institutions). *See also, e.g.,* CPUC Comments at 7-8; ATA Comments at 14-15; NRHA Comments at 10; FDRHPO Comments at 6; ATC Broadband Comments at 44.

[246] *See, e.g.,* RNHN Comments at 16 (stating that the "minimum subsidy under the HBS Program should be 50 percent and the FCC should allow for higher subsidies based on affordability and other criteria").

[247] *See, e.g.,* HHS Comments at 10 (recommending that the discount level be set at 90 percent for eligible rural health care providers who are also eligible for HHS's "meaningful use" incentive payment program for adoption of electronic health records); RNHN Comments at 16-18 (proposing higher discounts for HCPs in HPSAs or MUAs).

[248] 47 U.S.C. § 254(h)(7)(B).

HCP contribution required in the Internet Access Program is likely too high,[249] whereas the 15 percent contribution requirement utilized in the Pilot Program was generally viewed as achievable. Many commenters, however, recommended a provider contribution lower than the 50 percent proposed for the Broadband Services Program.

91. *Discussion.* We find that requiring a 35 percent HCP contribution appropriately balances the objectives of enhancing access to advanced telecommunications and information services with ensuring fiscal responsibility and maximizing the efficiency of the program. A 35 percent HCP contribution results in a 65 percent discount rate, which represents a significant increase over the 25 percent discount provided today for Internet access, and the 50 percent proposed for the Broadband Services Program in the *NPRM*. We believe that a 35 percent contribution appropriately balances the need to provide sufficient incentives for HCPs to participate in broadband networks, while simultaneously ensuring that they have a sufficient financial stake to seek out the most cost-effective method of obtaining broadband services.

92. We base our conclusion on a number of factors. First, many state offices of rural health, which work most directly with rural HCPs, believe that a 65 percent discount is required to provide a "realistic incentive" for many eligible rural HCPs to participate.[250] A 65 percent discount rate is also similar to the average effective discount rate in the Telecommunications Program, which is approximately 69 percent, excluding Alaska.[251] The effective discount rate in the Telecommunications Program provides a reasonable proxy for the discount rate that will be sufficient to allow health care providers in rural areas, which tend to have high broadband costs, to participate in the program.[252] The discount level we set also falls between the proposed discount levels in the *NPRM* (50 percent for the Broadband Services Program and 85 percent for the Health Infrastructure Program) – a reasonable choice given the

[249] *See* CPUC Comments at 5 ("doubling the discount rate to 50 percent would likely substantially increase utilization of broadband services and participation in the new Health Broadband Services Program"); Broadband Principals Comments at 13 ("USF funding was underutilized . . . because many rural health care providers found that the resources involved in caring for the paperwork, the bidding process, and the service changes was disproportionately high for the amount of savings achieved. Most of this paperwork and due diligence is necessary to preserve the integrity of the program, but raising the subsidy level from 25% to 50% will make the savings worth the effort.").

[250] *See* NOSORH Comments at 5. All fifty states maintain a state office of rural health focused on developing partnerships, creating programs, and providing resources to help meet the health care needs of their rural citizens. The National Organization of State Offices of Rural Health (NOSORH) submitted comments to the NPRM on behalf of the fifty state offices. *See* NOSORH Comments at 1. The state offices of rural health in Colorado, Georgia, Iowa, Kentucky, New Hampshire, North Carolina, Rhode Island, South Carolina, and West Virginia also submitted separate comments supporting the positions taken by NOSORH.

[251] USAC May 30 Data Letter at 1. In comparison, the average effective discount rate in Alaska is nearly 98 percent. *Id.* Health care providers in Alaska face unique costs because the state's vast size, harsh winter weather, and sparse population make it challenging to deploy fiber or wireless networks in many rural areas. In many parts of rural Alaska, expensive satellite services may be the only option available. *Pilot Evaluation*, 27 FCC Rcd at 9404, n.87. Telecommunications services thus can be much more expensive to provide in rural Alaska locations than in urban Alaska locations, which helps to explain the relatively high discount rate in the Telecommunications Program in Alaska. Rural HCPs in Alaska use telemedicine and other telehealth applications extensively. *See, e.g.* Letter from John T. Nakahata, Counsel to General Communication, Inc., to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket 02-60, Attachment at 2-6 (filed Apr. 13, 2012).

[252] Non-rural areas of the country typically have lower costs for broadband services. Therefore, we assume that any discount rate that would provide an incentive for rural participation is also sufficient to provide an incentive for non-rural participation.

hybrid nature of the program we adopt.[253] A 35 percent HCP contribution is also within the range of the match required in other federal programs subsidizing broadband infrastructure. For example, the BTOP program required a 20 percent match, while the U.S. Department of Agriculture's Broadband Initiatives Program overall provided an average of 58 percent of its funding in the form of grants, with 32 percent of its funding in loans (which the recipients ultimately repay), and 10 percent recipient match.[254]

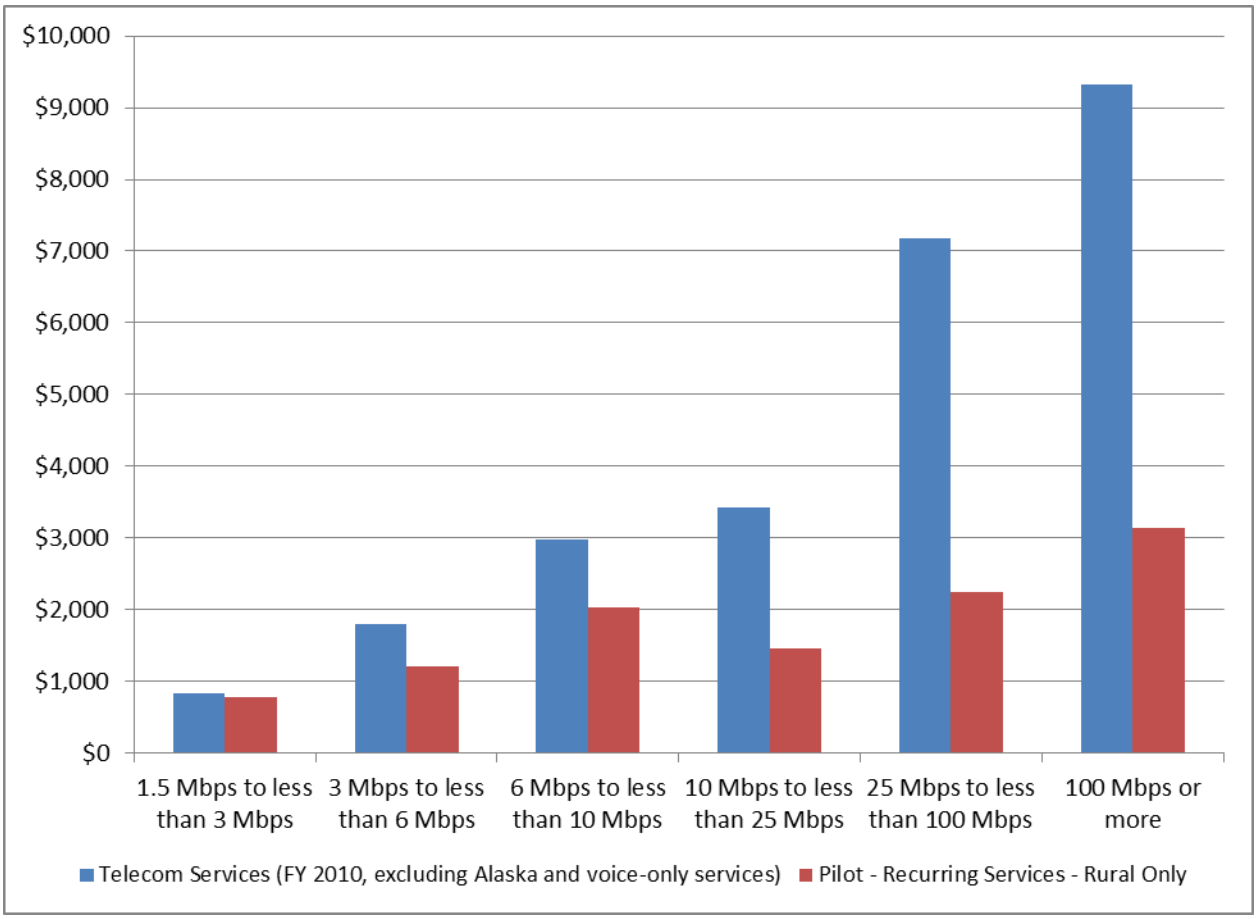
93. We also expect that the 65 percent discount will be sufficient to induce many HCPs to participate in the Healthcare Connect Fund – both those currently in the Telecommunications Program and those that have not participated in that program before. We expect that at a 65 percent discount, eligible HCPs participating in consortia in the Healthcare Connect Fund will generally pay less "out-of-pocket" when purchasing the higher bandwidth connections necessary to support telehealth applications than they would pay as individual participants in the Telecommunications Program. The Pilot Program showed that bulk buying through consortia, coupled with competitive bidding, can reduce the prices that rural HCPs pay for services and infrastructure through their increased buying power, as illustrated in Figure 2.[255]

[253] *NPRM*, 25 FCC Rcd at 9373, para. 3.

[254] *See* NTIA, BTOP Recipient Handbook at 3 (Feb. 2012), http://www2.ntia.doc.gov/files/Recipient_Handbook_v1.1_122110.pdf ("Unless waived by the Assistant Secretary for Communications and Information, BTOP requires at least a 20 percent non-Federal match toward the total eligible project costs."); U.S. Dept. of Agriculture, Broadband Initiatives Program Awards Report at 2-3 (Jan. 2011), http://www.rurdev.usda.gov/supportdocuments/RBBreport_V5ForWeb.pdf.

[255] *Pilot Evaluation*, 27 FCC Rcd at 9437, para. 83.

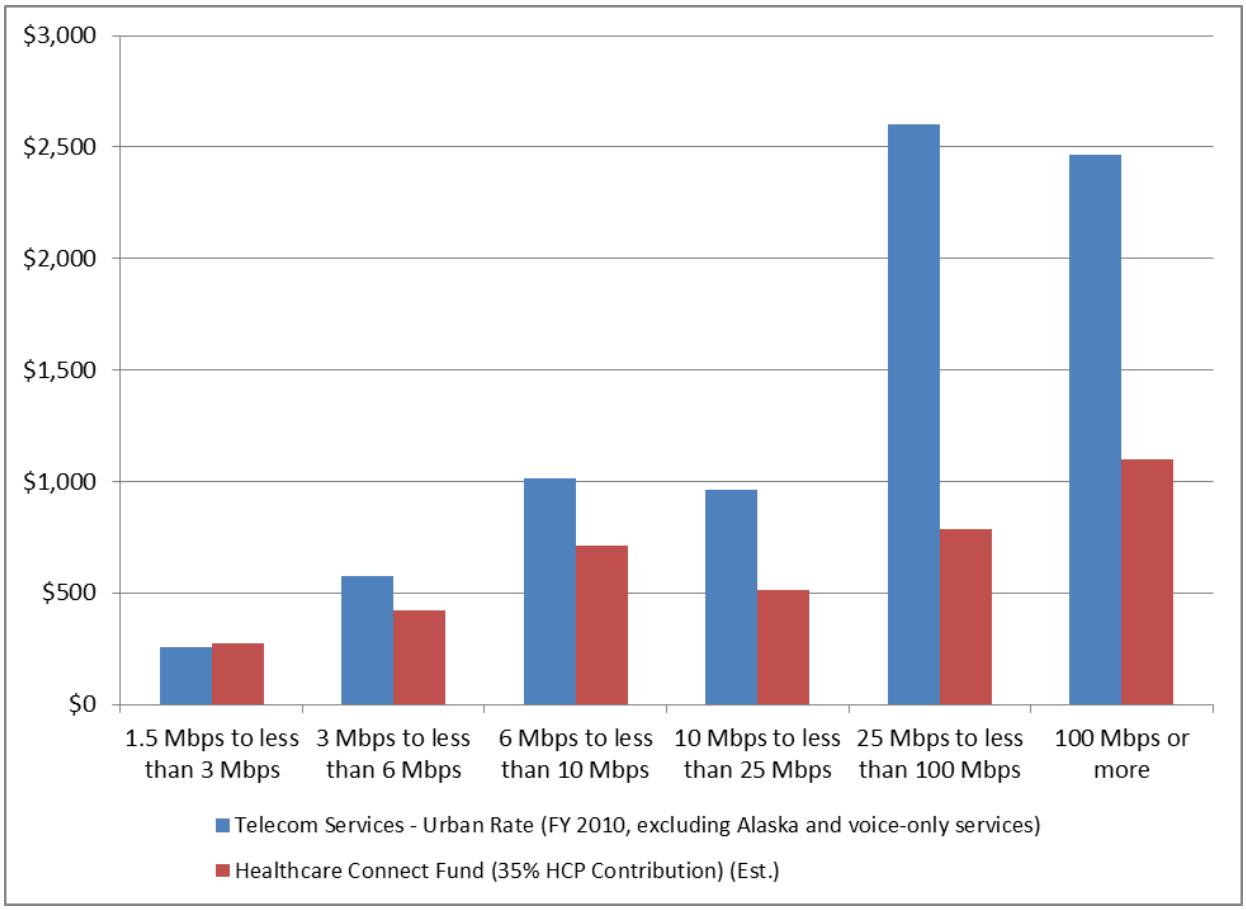
Figure 2: Comparison of Monthly Undiscounted Average Expense for Rural HCPs in the Current Telecommunications Program and Pilot Program[256]



94. This lower out-of-pocket cost is illustrated in Figure 3 below, which compares, by bandwidth tier, the average recurring rural HCP out-of-pocket expense under the Telecommunications Program (excluding Alaska) and projected expenses for similar connections under the Healthcare Connect Fund, assuming pricing similar to the Pilot Program.

[256] USAC Nov. 16 Data Letter at App. B & C. The analysis compared rural HCPs in the Pilot Program to rural HCPs receiving funding from the Telecommunications Program.

Figure 3: Projections of Monthly Out-of-Pocket Average Expense for Rural HCPs in the Current Telecommunications Program and Proposed Healthcare Connect Fund[257]



95. Other attractive features of the Healthcare Connect Fund include the lower administrative costs and the broader eligibility of services and equipment, relative to the Telecommunications Program.[258] These factors may offset to some degree concerns regarding the size of the contribution requirement from those who advocated a lower HCP contribution. We also note that from a program efficiency perspective, the better prices negotiated by consortia in the Pilot Program, relative to the prices paid by Telecommunications Program participants, will mean that USF dollars will go further in the new

[257] USAC Nov. 16 Data Letter at App. B & C. The projected out-of-pocket expenses are calculated based on the average total undiscounted recurring costs observed under the Pilot Program for rural HCPs. *See id.* at App. B.

[258] Administrative costs will be lower in the Healthcare Connect Fund because of the flat rate discount, the consortium application process, and competitive bidding exemptions. HCPs that need to pay for build-out costs or new network equipment to receive broadband services or wish to purchase services from non-telecommunications carriers should see a net gain, because the Healthcare Connect Fund, unlike the Telecommunications Program, will provide support for such costs. Today, HCPs only can purchase telecommunications services through the Telecommunications Program, and therefore are not able to purchase broadband services offered on a private carriage basis, which may be more cost-effective and more suitable for health care applications. *See infra* sections V.A, V.B.

program, particularly as HCPs demand the higher bandwidth and better service quality needed for telehealth applications.[259]

96. We recognize that a 35 percent contribution will be a significant commitment for many health care providers, and that many commenters argued for a lower contribution amount from HCPs.[260] One of our core objectives, however, is to ensure that HCPs have a financial stake in the services and infrastructure they are purchasing, thereby providing a strong incentive for cost-effective decision-making and promoting the efficient use of universal service funding.[261]

97. We acknowledge that some current Pilot participants have argued that a discount rate lower than 85 percent will preclude new sites from being added to existing networks and may even result in existing sites dropping off the network.[262] We nonetheless believe a cautious approach is justified given that the new Healthcare Connect Fund will expand eligibility and streamline the application process compared to the existing Telecommunications Program, which we hope will increase the number of participating HCPs.[263] Even within the existing program, the number of participating HCPs has steadily increased in recent years, averaging just under 10 percent annual growth for the past five years.[264] Meanwhile the Pilot Program has attracted over 3,800 HCPs, the majority of which were not previously participating in the RHC Program.[265]

98. A 65 percent discount rate will help keep demand for the overall health care universal service, including the Healthcare Connect Fund, below the $400 million cap for the foreseeable future, even as program participation expands. We estimate that there are approximately 10,000 eligible rural HCPs nationwide,[266] of which approximately 54 percent (5,400) are participating in the RHC

---

[259] *See Needs Assessment* (Appendix B); *see also Pilot Evaluation*, 27 FCC Rcd at 9421, 9423, paras. 54, 60 (Figures 13(b), 15). For example, the average monthly undiscounted cost of a 10 to 25 Mbps connection was approximately $1,519 under the Pilot Program in comparison to $3,429 under the Telecommunications Program (excluding Alaska). USAC Nov. 16 Data Letter at App. A & C.

[260] *See, e.g.*, HHS Comments at 7-8, 9-10 (urging the Commission to raise the discount level to 90% under the Broadband Services Program for rural HCPs that qualify for meaningful use incentive program and further urging the Commission to provide up to 100% discount for infrastructure); NETC Comments at 2-3 (arguing for 85% discount rate for the Broadband Services Program); OHN Comments at 9 (explaining that "rural HCPs will struggle to come up with even a proposed 15% match"); ATC Broadband Comments at 44 (suggesting that a discount level of more than 80% is needed to impact broadband deployment); Internet2 Comments at 19 (suggesting an 85% discount for non-recurring and recurring charges associated with "[v]erified core infrastructure"); EMTN Comments at 2 (arguing for 85% discount); PSPN Comments at 18 (arguing for a discount rate of between 75 and 85%); FDRHPO Comments at 6 (suggesting a 70% baseline discount rate).

[261] *NPRM*, 25 FCC Rcd at 9413, para. 107.

[262] Letter from Steven Summer, President and CEO, Colorado Hospital Assn., to Marlene Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 (filed Nov. 16, 2012) at 1.

[263] *See supra* sections IV.B.1, IV.B.2. With respect to existing Pilot sites, we note that they were required to demonstrate sustainability after completion of the Pilot.

[264] USAC Nov. 16 Data Letter at 2.

[265] *Id.* at 1 (USAC issued funding commitments for 3,822 Pilot Program HCP sites as of November 15, 2012). *See Pilot Evaluation*, 27 FCC Rcd at 9397, para. 15 ("The Pilot Program generated overwhelming interest from the health care community, and the Commission received 81 applications representing approximately 6,800 HCPs.").

[266] Our estimate of approximately 10,000 eligible rural HCPs nationwide is comprised of the following figures: (i) 625 rural public/nonprofit post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools, *Universal Service First Report and Order*, 12 FCC Rcd at 9142 para. 706 n.1845; (ii) 2,612 Federally Qualified Health Centers (FQHCs), *National Broadband Plan* at 221 n.103; (iii) 2,136 rural local health

(continued…)

Telecommunications, Internet Access, or Pilot Programs.[267] If we assume that in five years (1) the rural HCP participation rate increases from 54 percent to 75 percent,[268] (2) the number of rural HCPs participating in the Telecommunications Program does not significantly decrease,[269] and (3) the average annual support per HCP is $14,895 in the Healthcare Connect Fund (including support for both recurring and non-recurring costs),[270] the projected size of the annual demand for funding (including non-rural and rural HCPs) would be approximately $235 million.[271] We will continue to monitor the effect of the 35 percent contribution requirement on participation in the program and on the USF, and stand ready to adjust the contribution HCP requirement or establish additional prioritization rules, should it prove necessary.

3. Limits on Eligible Sources of HCP Contribution

99. Consistent with the Pilot Program, we limit the sources for HCPs' contribution (*i.e.*, the non-discounted portion) to ensure that participants pay their share of the supported expenses.[272] Only funds

(Continued from previous page)

departments, calculated by multiplying the percentage of rural counties in each state with the number of local health departments in the state, *see* National Association of County and City Health Officials, Local Health Department Index, available at http://www.naccho.org/about/lhd/ (last visited Nov. 19, 2012); (iv) 263 rural community mental health centers, *see* Health Resources and Services Administration, Area Resource File, available at http://www.arf.hrsa.gov/purchase.htm (last visited Nov. 19, 2012) (providing estimate of the number of community mental health centers that was adjusted based on the FCC's definition of rural health care provider); (v) 1,674 rural non-profit hospitals, calculated by multiplying the percentage of rural community hospitals by the total number of non-profit hospitals, *see* American Hospital Association, Fast Facts on Hospitals, 1, http://www.aha.org/research/rc/stat-studies/101207fastfacts.pdf (last updated Jan. 3, 2012); and (vi) 2,741 rural health clinics, John Gale Mar. 29 *Ex Parte* Letter at 2.

[267] USAC Nov. 16 Data Letter at 3 (stating that approximately 5,409 unique rural HCPs are participating in the Pilot and RHC Primary (Telecommunications and Internet Access) programs combined).

[268] Under this scenario, 7,500 rural HCPs would receive Fund support.

[269] Although this calculation is provided solely as an illustrative example, we believe it represents a conservative scenario because we anticipate that Telecommunications Program participation will likely decrease as HCPs choose to take advantage of the additional benefits in the Healthcare Connect Fund. In Funding Year 2010 (the last year for which full funding year data is available), approximately 2,517 HCPs received a total of $86.3 million in commitments for non-voice services through the Telecommunications Program. USAC Nov. 16 Data Letter at 4. Thus, for purposes of this estimate, we assume that 2,517 rural HCPs will participate in the Telecommunications Program, and we assume that Telecommunications Program demand will be $86.3 million. This means that in the Healthcare Connect Fund, 4,983 rural HCPs (7,500 -2,517) and up to an additional 4,983 non-rural HCPs could receive support. We also employ a conservative assumption that every Healthcare Connect Fund consortium will include the maximum allowable number of non-rural HCPs, although it is unlikely that this will be the case. *See* USAC Nov. 16 Data Letter at 2 (stating that non-rural HCPs make up 34% of the total in the Pilot Program as of November 15, 2012).

[270] In the Pilot Program, the annual average undiscounted cost (recurring and non-recurring) per HCP (rural and non-rural) was $20,254. As of November 15, 2012, the Pilot Program had funding commitments supporting 3,822 rural and non-rural HCP sites for a total of $26,965,437 in annualized undiscounted non-recurring charges, assuming a 20-year life for HCP-owned infrastructure and a 5-year life for non-recurring charges not captured in another category and a total of $50,443,449 in undiscounted annual recurring charges. *See* USAC Nov. 16 Data Letter at 1, 2-3 & App. A. Assuming a 2.5 percent compound annual growth rate, over five years the average would be $22,915 per site. With a 65 percent discount rate, the average support would be $14,895.

[271] The total cost to the Fund would be $86,300,000 + (4,983 * $14,895) + (4,983 * $14,895) = $234,740,942.

[272] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20399-20400, para. 77.

from an eligible source will apply towards a participant's required contribution. In addition, consortium applicants are required to identify with specificity their source of funding for their contribution of eligible expenses in their submissions to USAC, as discussed below.[273] Requiring participants to pay their share helps ensure efficiency and fiscal responsibility and helps prevent waste, fraud, and abuse.[274]

100. Eligible sources include the applicant or eligible HCP participants; state grants, funding, or appropriations; federal funding, grants, loans, or appropriations except for other federal universal service funding; Tribal government funding; and other grant funding, including private grants. Any other source is not an eligible source of funding towards the participant's required contribution. Examples of ineligible sources include (but are not limited to) in-kind or implied contributions; a local exchange carrier (LEC) or other telecom carrier, utility, contractor, consultant, vendor or other service provider; and for-profit entities. We stress that participants that do not demonstrate that their contribution comes from an eligible source or whose contribution is derived from an ineligible source will be denied funding by USAC. Moreover, participants may not obtain any portion of their contribution from other universal service support program, such as the RHC Telecommunications Program.

101. We conclude that these limitations on eligible sources are necessary to help safeguard against program manipulation and to help prevent conflicts of interest or influence from vendors and for-profit entities that may lead to waste, fraud, and abuse. Accordingly, we are unconvinced by commenters that argue the eligible sources should include in-kind contributions;[275] contributions from carriers, network service providers, or other vendors;[276] and contributions from for-profit entities.[277] First, allowing in-kind or implied contributions would substantially increase the complexity and burden associated with administering the program. It would be difficult to accurately measure the value of in-kind or implied contributions to ensure participants are paying their share,[278] and the costs and challenges associated with policing in-kind and implied contributions would likely be substantial. Second, allowing carrier, service provider, or other vendor contributions would distort the competitive bidding process and reduce HCPs' incentives to choose the most cost-effective bid, leading to potential waste, fraud, and abuse.

102. Some commenters urge the Commission to allow for-profit entities to pay an eligible HCPs contribution because "[t]he benefits of improved telehealth capabilities cannot be fully achieved if for-profit health care services providers are not part of the health care delivery network."[279] This argument is based on a faulty premise. To be clear, the prohibition against a for-profit HCP paying the contribution of an eligible HCP does not prevent the for-profit HCP from participating in one or more networks that receive Healthcare Connect Fund support, as long as the for-profit pays its "fair share."[280]

---

[273] *See infra* section VI.C.3.

[274] *See, e.g.*, *Universal Service First Report and Order*, 12 FCC Rcd at 9035-36, para. 493 ("Requiring schools and libraries to pay a share of the cost should encourage them to avoid unnecessary and wasteful expenditures because they will be unlikely to commit their own funds for purchases that they cannot use effectively.").

[275] *See, e.g.*, Charter Reply at 8; Comcast Reply at 8; HHS Comments at 8; NATOA Reply Comments at 4.

[276] *See, e.g.*, Charter Reply at 8; Hawaii Telecom Reply Comments at 9.

[277] *See, e.g.*, IHS Comments at 5; AHA Comments at 8.

[278] *See* MTA Reply Comments at 8.

[279] AHA Comments at 8. *See also* IHS Comments at 5 ("It is critical to the concept of creating a health care network to include for-profit entities.").

[280] *See infra* section V.C.4.

Rather, the prohibition helps avoid creating an incentive for participating eligible HCPs to use support to benefit ineligible entities (*e.g.*, for-profit HCPs).

103. *Future Revenues from Excess Capacity as Source of Participant Contribution.* Some consortia may find, after competitive bidding, that construction of their own facilities is the most cost-effective option. Due to the low additional cost of laying additional fiber, some Pilot projects who chose the "self-construction" option found that they were able to lay more fiber than needed for their health care network and use revenues from the excess capacity as a source for their 15 percent contribution.[281] We conclude that under the following limited circumstances, consortia in the Healthcare Connect Fund may use future revenues from excess capacity as a source for their 35 percent match.

- The consortium's RFP, as discussed in section VI.B.2 of this Order, must solicit bids for both services provided by third parties and for construction of HCP-owned facilities, and must show that "self-construction" is the most cost-effective option. Applicants are prohibited from including the ability to obtain excess capacity as a criterion for selecting the most cost-effective bid (*e.g.* applicants cannot accord a preference or award "bonus points" based on a vendor's willingness to construct excess capacity).
- The participant must pay the full amount of the additional costs for excess capacity facilities that will not be part of the supported health care network. The additional cost for excess capacity facilities cannot be part of the participant's 35 percent contribution, and cannot be funded by any health care universal service support funds. The inclusion of excess capacity facilities cannot increase the funded cost of the dedicated network in any way.
- An eligible HCP (typically the consortium, although it may be an individual HCP participating in the consortium) must retain ownership of the excess capacity facilities. It may make the facilities available to third parties only under an IRU or lease arrangement. The lease or IRU between the participant and the third party must be an arm's length transaction. To ensure that this is an arm's length transaction, neither the vendor that installed the excess capacity facilities, nor its affiliate, would be eligible to enter into an IRU or lease with the participant.[282]
- The prepaid amount paid by other entities for use of the excess capacity facilities (IRU or lease) must be placed in an escrow account. The participant can then use the escrow account as an asset that qualifies for the 35 percent contribution to the project.
- All revenues from use of the excess capacity facilities by the third party must be used for the project's 35 percent contribution or for sustainability of the health care network supported by the Healthcare Connect Fund. Such network costs may include administration, equipment, software, legal fees, or other costs not covered by the Healthcare Connect Fund, as long as they are relevant to sustaining the network.

104. We delegate authority to the Bureau to specify additional administrative requirements applicable to excess capacity, including requirements to ensure that HCPs have appropriate incentives for efficient spending (including, if appropriate, a minimum contribution from funds other than revenues from excess capacity), and to protect against potential waste, fraud, and abuse, as part of the infrastructure component of the program.

---

[281] *See, e.g.* Rural Nebraska Healthcare Network, Quarterly Report, WC Docket No. 02-60, at 9 (filed Oct. 31, 2012); Health Information Exchange of Montana, Quarterly Report, WC Docket No. 02-60, at 10-11 (filed Oct. 30, 2012).

[282] For purposes of this requirement, "affiliate" would have the meaning given to it pursuant to 47 U.S.C. § 153(2).

V. ELIGIBLE SERVICES AND EQUIPMENT

105. *Overview*. In this section, we discuss the services and equipment for which the Healthcare Connect Fund will provide support. We also provide examples of services and equipment that will not be supported. Section 254(h)(2)(A) of the Act directs the Commission to establish competitively neutral rules to "enhance… access to advanced telecommunications and information services… for health care providers."[283] Pursuant to that authority, we will provide support for services whether provided on a common carrier or private carriage basis, reasonable and customary one-time installation charges for such services, and network equipment necessary to make the broadband service functional. For HCPs that apply as consortia, we will also provide support for upfront charges associated with service provider deployment of new or upgraded facilities to provide requested services, dark or lit fiber leases or IRUs, and self-construction where demonstrated to be the most cost-effective option. Requests for funding that involve upfront support of more than $50,000, on average, per HCP will be subject to certain limitations. In general, we find that this approach will ensure the most efficient use of universal service funding.

106. Immediately below is a chart summarizing what services and equipment are eligible for support under the Healthcare Connect Fund.

[283] 47 U.S.C. § 254(h)(2)(A).

Eligible Services and Equipment

	INDIVIDUAL Applicants	CONSORTIUM Applicants
Eligible Services (§ V.A.1)	✓	✓
Reasonable & Customary Installation Charges (§V.A.6) (≤$5,000 undiscounted cost)	✓	✓
Lit Fiber Lease (§V.A.3)	✓	✓
Dark Fiber (§V.A.3)		
• Recurring charges (lease of fiber and/or lighting equipment, recurring maintenance charges)	✓	✓
• Upfront payments for IRUs, leases, equipment	No	✓
Connections to Research & Education Networks (§V.A.4)	✓	✓
HCP Connections Between Off-Site Data Centers & Administrative Offices (§V.A.5)	✓	✓
Upfront Charges for Deployment of New or Upgraded Facilities (§V.A.7)	No	✓
HCP-Constructed and Owned Facilities (§ IV.D)	No	✓
Eligible Equipment (§V.B)		
• Equipment necessary to make broadband service functional	✓	✓
• Equipment necessary to manage, control, or maintain broadband service or dedicated health care broadband network	No	✓

A. Eligible Services

107. In this section, we describe the services that will be eligible for support under the Healthcare Connect Fund. We are guided, among other considerations, by our statutory directive to enhance access to "advanced telecommunications and information services" in a competitively neutral fashion.[284] We conclude that providing flexibility for HCPs to select a range of services, within certain

[284] 47 U.S.C. § 254(h)(2)(A).

defined limits, and in conjunction with the competitive bidding requirements we adopt below, will maximize the impact of Fund dollars (and scarce HCP resources).

108. Specifically, we will provide support for advanced services without limitation as to the type of technology or provider. We allow HCPs to utilize both public and private networks, and different network configurations (including dedicated connections between data centers and administrative offices), and lease or purchase dark fiber, depending on what is most cost-effective. We also provide support for reasonable and customary installation charges (up to an undiscounted cost of $5,000). For consortium applicants, we will also provide support for upfront payments to facilitate build-out of facilities to HCPs. We limit such funding to consortia because we anticipate that group buying for such services and equipment will lead to lower prices and better bids, resulting in more efficient use of Fund dollars.

109. At this time, we decline to adopt a minimum bandwidth requirement for the supported services because many rural HCPs still lack access to higher broadband speeds. We will, however, limit certain types of support to connections that provide actual speeds of 1.5 Mbps (symmetrical) or higher, in order to ensure that we do not invest in networks based on outdated technology.

1. Definition of Eligible Services

110. *Background*. In the *NPRM*, the Commission proposed to allow eligible HCPs to receive support for any advanced telecommunications service or information service that provides broadband access. The Commission proposed to define as eligible any "advanced telecommunications and information services that enable rural HCPs to post their own data, interact with stored data, generate new data, or communicate over private dedicated networks or the public Internet for the provision of health IT."[285] The Commission defined "health IT" in the *NPRM* to include "billing and scheduling systems, e-care, EHRs, telehealth, and telemedicine."[286] It defined "E-care" as "the electronic exchange of information – data, images, and video – to aid in the practice of medicine and advanced analytics."[287]

111. *Discussion.* We adopt a rule to provide support for any service that meets the following definition:

> Any advanced telecommunications or information service that enables HCPs to post their own data, interact with stored data, generate new data, or communicate, by providing connectivity over private dedicated networks or the public Internet for the provision of health information technology.[288]

The definition we adopt today differs from the NPRM proposal in only two respects. First, because we allow all HCPs to participate in consortia and receive support (subject to the limitations on non-rural HCPs discussed above), we have removed the language referring to "rural" HCPs. Second, we delete the word "broadband access" from the definition originally proposed, to make clear that eligible services include not only broadband Internet access services, but also high-speed transmission services offered on a common carrier or non-common carrier basis that may not meet the definition of "broadband" that the Commission has used in other contexts.[289] This broad definition allows HCPs to choose from a wide

[285] *NPRM*, 25 FCC Rcd at 9409, para. 96; *id.* at 9442 (App. A, proposed § 54.631(b)).

[286] *Id.* at 9372, para. 2 n.4 (citing *National Broadband Plan* at 200).

[287] *Id.*

[288] *See* Appendix D, 47 C.F.R. § 54.634(a).

[289] *See, e.g., Inquiry Concerning the Deployment of Advanced Telecommunications Capability to All Americans in a Reasonable and Timely Fashion*, GN Docket No. 11-121, Eighth Broadband Progress Report, 27 FCC Rcd 10342, 10346-47, para. 6 (2012).

range of connectivity solutions, all of which enhance their access to advanced services, based on their individual health care broadband needs as available technology evolves over time; decisions will be made in the marketplace without regard to regulatory classification decisions of the connectivity solutions.[290]

112. Public and Private Networks. We conclude that eligible HCPs may receive support for services over both the public Internet and private networks (*i.e.*, dedicated connections that do not touch the public Internet). As discussed in the *NPRM*, access to advanced telecommunications and information services for health care delivery is provided in a variety of ways today. For example, due to privacy laws and EHR requirements, HCPs may find that it best suits their needs to securely transmit health IT data to other HCPs over a private dedicated connection.[291] In other instances (*e.g.*, communicating with patients via a web site), HCPs may need to utilize the public Internet, or it may simply be more cost-effective to utilize Dedicated Internet Access services for certain types of traffic.[292] Several Pilot projects have determined that a mix of both public and private networks best fits the needs of their HCPs.[293]

113. Network Configurations. Under the new rule, "eligible services" may include last mile, middle mile, or backbone services, as long as support for such services is requested and used by an eligible HCP for eligible purposes in compliance with other program rules.[294] HCPs emphasize that they

[290] *See, e.g.*, CHCC/RMHN PN Comments at 3 (recommending that connectivity be defined broadly and flexibly); IRHN PN Comments at 11 (recommending enumeration of a wide range of connectivity solutions); ITN PN Comments at 3 (encouraging the Commission to be more general in defining the connectivity services and equipment that would be eligible under the new Broadband Services Program); VTN Reply at 5-6 (VTN believes the Commission should not handcuff HCPs' decisions by limiting the services that would be eligible for funding since rural HCPs are in the best position to determine the type of services they require). In an October 1, 2011 *ex parte* letter, MiCTA suggested that the Commission "enhance the Rural Health Care Eligible Services List [to] align with the existing [schools and libraries] Eligible Services List." *See* Letter from Gary Green, MiCTA, to Sharon Gillett, Chief, WCB, Federal Communications Commission, WC Docket No. 02-60 (filed Jan. 19, 2011) at 2. For the Healthcare Connect Fund, we decline to adopt an Eligible Services List similar to that utilized in E-rate, given the overwhelming support in the record for a broad and flexible definition of eligible services. *See, e.g.* IRHN PN Comments at 11; UTN PN Comments at 4; TIA PN Comments at 3, 5, 9-10.

[291] *NPRM*, 25 FCC Rcd at 9409, para. 95; *see also* Avera Comments at 4 (Avera supports funding of dedicated connections, because they are more secure, more reliable, and can carry greater amounts of bandwidth than broadband services that travel the public Internet).

[292] "Dedicated Internet Access" (DIA) is access to the Internet that is obtained through a dedicated high-speed facility. *See AT&T Inc. and BellSouth Corp., Application for Transfer of Control*, Memorandum Opinion and Order, 22 FCC Rcd 5662, 5728, para. 122 (2007). Unlike mass-market "business class" Internet services, DIA does not require HCPs to share their bandwidth with other customers. The *OBI Technical Paper* noted that DIA solutions often offer higher bandwidth and better service level agreements than mass-market "small business" Internet access solutions. The *OBI Health Care Technical Paper* also noted that most larger practices must currently purchase DIA to meet their needs. *OBI Health Care Technical Paper* at 8.

[293] *See, e.g.*, USAC Mar. 16 Site Visit Reports at 9 (PSPN provides standard service of 5 MB symmetrical commodity Internet and 5 MB private broadband); IRHN PN Comments at 7 (one of the benefits of a dedicated health care network is to allow locations to send traffic to each other via the "internal," private network, which reduces the amount of ISP bandwidth that HCPs need to purchase); CTN Comments at 21 (CTN agrees that both public and private networks should be allowed); NETC PN Reply at 4 (stating that NETC provides both direct connections between HCPs and commodity Internet access).

[294] We use the term "backbone" to refer to both commercial and non-profit backbone services. Commercial backbone services may be provided, for example, by national operators such as AT&T. Non-profit backbone services can be provided by national networks such as Internet2 or National LambdaRail, or statewide or regional research and education networks. *See infra* section V.A.4; Letter from Randall B. Lowe, Counsel for CENIC, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60, at 1 (filed Jan. 13,

(continued…)

need the ability to control the design of their networks, even if the network relies on leased services.[295] Our Pilot Program experience also indicates that HCPs are likely to tailor their funding requests based on what services are already available. For example, if a region already has a middle mile network suitable for health care use, the applicant may choose to focus its funding request on last mile facilities to connect to the middle mile or backbone network.[296] On the other hand, if there is no pre-existing middle mile connection between the HCPs in the network, providers may choose to seek funding to lease such capacity instead.[297] Therefore, we find that allowing flexibility in the network segments supported will best leverage prior investments by allowing maximum use of existing infrastructure.

114. In the *NPRM*, the Commission proposed that the Broadband Services Program would subsidize costs for any advanced telecommunications and information services that provide "point-to-point broadband connectivity."[298] In response to the *NPRM*, some commenters expressed concern that only traditional point-to-point circuits might be eligible for funding, and such a limitation could preclude use of more cost-effective point-to-multipoint, IP-based, or cloud-based architectures.[299] Based on our full consideration of the record, we conclude that support under the Healthcare Connect Fund will not be limited to "point-to-point" services. Rather, any advanced service is eligible, and HCPs may request support for any type of network configuration that complies with program rules (*e.g.*, is the most cost-

(Continued from previous page)

2011) (CENIC Jan. 13, 2011 *Ex Parte*) (describing the California Research and Education Network, "a private, broadband, fiber backbone owned and operated by the research and education community").

[295] Letter from Christianna Lewis Barnhart, Attorney Advisor, Federal Communications Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60, at 3 (filed Mar. 13, 2012) (Pilot projects preferred to lease services, but all agreed that it was important to have "the ability to control what the network looked like when completed") (Pilot Conference Call Mar. 13 *Ex Parte* Letter (PMHA *et al.*)). Some Pilot projects, for example, have chosen a network design whereby smaller facilities (*e.g.* clinics) connect to a larger facility (*e.g.* a nearby hospital), and high-capacity circuits connect the larger facilities. In this example, the hospitals serve as "mini-hubs" that aggregate the traffic from the clinics. The hospital network can then interconnect with a national or regional backbone provider at the provider's point of presence. *See, e.g.*, Quarterly Report of Arkansas Telehealth Oversight and Management, WC Docket No. 02-60, at 9-12 (filed Oct. 31, 2012). Another example is that HCPs might seek to incorporate redundant, secondary or fail-over services (to be used in case of an outage) into their networks. Such services are eligible for support, but the cost and bandwidth of the service must reasonably reflect its use as a secondary service, and it must be the most cost-effective option available. The applicant must also indicate that it is seeking secondary services on its request for services, so that vendors can appropriately scale their responses to the planned use of the service. *See* USAC, *Learn More About RHC Funding for Redundant Circuits* (Sept. 9, 2009), *available at* http://usac.org/rhc/tools/news/news-2009.aspx.

[296] *See, e.g.*, NCTN PN Comments at 1, 4 (noting that there is a BTOP-funded middle mile project in North Carolina, and there were no HCPs or consortia who wanted to own or operate significant cross-country fiber infrastructure and interconnecting middle mile electronics); IRHTP PN Comments at 1 (noting that purpose of Pilot project is to connect hospitals to a dedicated broadband fiber network using existing Iowa Communications Network infrastructure).

[297] *See, e.g.*, Letter from Kim Klupenger *et al.*, Oregon Health Network, Christianna Lewis Barnhart, Attorney Advisor, Federal Communications Commission, WC Docket No. 02-60 at 3 (filed Feb. 28, 2012) (OHN Feb. 28 *Ex Parte* Letter) (discussing middle-mile facilities leased for Oregon Health Network).

[298] *NPRM*, 25 FCC Rcd at 9408, para. 93.

[299] *See* CTN Comments at 21 (noting that every major service provider and major business have moved to cloud-based networks, and point-to-point circuits are often not the most cost-effective solution to providing interconnectivity among diverse participants); ACS PN Comments at 10-12; RWHC PN Comments at 3; Internet2 Comments at 17; AHA PN Comments at 4.

effective).[300] This approach comports with the statutory directive that the Commission enhance access to advanced services in a manner that is "competitively neutral."[301]

115. Technology. Consistent with the statutory requirement that our rules be competitively neutral, we conclude that eligible services may be provided over any available technology, whether wireline (copper, fiber, or any other medium), wireless, or satellite.[302] We also find that a competitively neutral approach will best ensure that HCPs can make cost-effective use of Fund support.[303] Below, we provide additional guidance regarding fiber leases,[304] and minimum bandwidth and service quality requirements.[305]

2. Minimum Bandwidth and Service Quality Requirements

116. *Background.* In the *Needs Assessment*, we describe the bandwidth and service quality needs of HCPs.[306] In the *NPRM*, the Commission sought comment on whether it should define a minimum level of broadband capability for purposes of providing support under the new Broadband Services Program. The Commission sought comment on whether 4 Mbps would be an appropriate minimum for purposes of the Broadband Services Program, or whether it should require different minimum speeds depending on the type of HCP.[307] The Commission also sought comment on whether it should require a minimum level of reliability, including physical redundancy, to support health IT services and what can be done to encourage reliability. The Commission also sought comment on the minimum quality of service standards necessary to meet health IT needs, and whether the broadband services program should include a minimum quality of service requirement (including metrics such as reliability, bit delay, jitter, packet dropping probability, and/or bit error rate).[308]

117. *Discussion.* At this time, we will not impose minimum bandwidth and service quality requirements for the Healthcare Connect Fund, based on the *Needs Assessment* and the record in this proceeding.[309] Commenters agree that HCPs need certain minimum levels of reliability, redundancy, and quality of service, but they note that the exact requirement may vary depending on the application, and that not all HCPs will have access to services that provide a specified level of reliability and quality. While our goal is to encourage HCPs to obtain broadband connections at the speeds recommended in the *National Broadband Plan*, the record indicates that in some areas of the country, HCPs face limited

[300] *See* 47 C.F.R. § 54.603(b)(4). As GCI notes, broadband networks may be deployed in a variety of configurations, including but not limited to ring, mesh, hub and spoke, and line. *See* GCI PN Comments at 7.

[301] 47 U.S.C. § 254(h)(2).

[302] 47 U.S.C. § 254(h)(2) (competitively neutral requirement).

[303] *See, e.g.*, IRHN PN Comments at 9 (stating that, in part, it was the allowance of "any currently available technology" that enabled IRHN to implement a hybrid network that makes cost-effective use of a variety of technologies).

[304] *See infra* section V.A.3.

[305] *See infra* section V.A.2.

[306] *See generally Needs Assessment* (Appendix B).

[307] The Commission proposed higher minimum broadband speeds when funding is provided specifically for broadband deployment *(e.g.* through the proposed health infrastructure program). *NPRM*, 25 FCC Rcd at 9409, para. 97. The Commission proposed setting 10 Mbps as the minimum broadband speed for infrastructure deployment supported under the health infrastructure program. *Id.* at 9381, para. 20.

[308] *Id.* at 9409-10, para. 97.

[309] *See Needs Assessment* (Appendix B) at paras. 6-12 (describing variability in HCP needs for bandwidth and service quality).

options in obtaining speeds of 4 Mbps or above.[310] Commenters note that in areas where higher speed connections are not available, telemedicine networks have nevertheless been able to operate with connections at speeds less than 4 Mbps.[311] Commenters also state that some of the smallest rural HCPs simply may not be able to afford higher bandwidth connections, even when such connections are available. These commenters express concern that a minimum bandwidth requirement could result in HCPs either (1) being forced to buy bandwidths that are not cost-effective for their circumstances; or (2) being unable to receive health care universal service discounts (due to the cost of the required minimum-bandwidth connection).[312] We do not wish to prevent the neediest HCPs from receiving discounts, especially if they are able to address their connectivity needs in the near term by utilizing a connection below a defined minimum.[313] After reviewing the record, we conclude that it would be difficult to set a minimum speed requirement at this time that would not have the unintended effect of potentially precluding some HCPs from obtaining connectivity currently appropriate for their individual needs.[314] We therefore conclude it would be premature now to set a minimum threshold speed for connections that are supported in the Healthcare Connect Fund.[315]

118. We will continue to provide support in the Healthcare Connect Fund for services that have been historically supported through the Internet Access Program, including DSL, cable modem, and

[310] *See, e.g.*, Avera Comments at 5 (stating that Avera agrees with some minimum levels of reliability, physical redundancy, and quality of service (QOS) standards, but it "may be tough to meet the minimum" depending on the service provider and local availability, and the Commission should therefore allow the HCP to determine its own minimum levels of reliability, physical redundancy and QOS standards); NCTN Comments at 10 (expressing concerns about setting minimums or maximums for bandwidth, latency, jitter, reliability, etc. in a way that might force either inefficiency or preclude the mounting of a viable service); *see also* TIA PN Comments at 7 (urging the Commission to adopt parameters that are as flexible as possible for bandwidth and quality of service features).

[311] ATA Comments at 13 (noting that telemedicine networks in Arizona and Virginia have been able to operate with sites connecting at 1.5 to 3 Mbps speeds and a 45 Mbps and 10 Mbps backbone, respectively); Marshfield Reply at 5 (stating that Marshfield's network is comprised primarily of 10 Mbps fiber connections, but several sites are connected with a 1.5 Mbps T-1 connection and run voice, video, and data at the same time).

[312] ATA Comments at 13 (expressing concern that the minimum speed requirements could result in overbuilding, which could drain funds away from other eligible applicants); UAMS Comments at 7 (supports a low threshold for program eligibility of 1.5 Mbps, because a minimum may limit the ability of the most deserving providers to obtain the benefits of the program, forcing HCPs to buy more than they need); UH TIPG Comments at 4 (stating that a 4 Mbps minimum capacity requirement, even at a 50 percent discount, may be too costly for HCPs in the Pacific Island territories); VTN Reply at 5 (imposing a 4 Mbps floor could discourage utilization and thus be counter-productive); WRHA Comments at 3-4 (stating that 4 Mbps is an appropriate minimum standard, but it has concerns about whether small rural HCPs would be able to access the recommended minimum).

[313] *See, e.g.* Letter from Linda Oliver, Attorney Advisor, Telecommunications Access Policy Division, Wireline Competition Bureau, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 at 1 (filed Apr. 12, 2012) (summarizing *ex parte* that most community mental health centers in the Hill Country Community Mental Health and Development Disabilities Centers organization have dedicated T-1 connections that allow two to three video telemedicine sessions at a time).

[314] HHS Comments at 10 (questioning the need for a minimum speed); AHA Comments at 5 (also stating that the Commission does not need to set a "high bar" on the minimum level of broadband capability); RNHN Reply at 13 (opposing minimum speed requirement and stating that HCPs are in the best position to know their needs and what makes economic sense to themselves and their patients); CHCC/RMHN PN Comments at 3 ("minimum bandwidth standards are not required, as the health care provider market will set these de facto as services and needs continue to evolve").

[315] *See also* ONC Nov. 16 *Ex Parte* Letter at 1.

other similar forms of Internet access.[316] We expect recipients to migrate to services over time that deliver higher capabilities. We do, however, adopt one limitation designed to ensure that the focus of the program remains on advancing access to the bandwidths that increasingly will be needed for health care purposes. No upfront payments will be eligible for funding for services that deliver less than 1.5 Mbps symmetrical (*i.e.* less than T-1 speeds), except for reasonable installation costs under $5,000 as outlined in section V.A.6 below. We have chosen the 1.5 Mbps threshold because HCPs have indicated that they can successfully implement telemedicine services over a 1.5 Mbps connection, if that is the only practical option.[317] Therefore, we conclude that 1.5 Mbps is the minimum threshold at which HCPs should be able to obtain support for upfront costs for build-out or infrastructure upgrades.

119. We note that the Pilot Program allowed most participants to obtain speeds of 4 Mbps or above,[318] and we expect that the reforms adopted in this Order will generally allow HCPs to obtain access to the bandwidths recommended in the *National Broadband Plan*.[319] We agree with the National Rural Health Association and the California Telehealth Network that we should benchmark actual speeds obtained under the Healthcare Connect Fund to determine how well the program is meeting HCPs' broadband needs.[320] Therefore, as discussed above, we will also require participants to report basic information regarding bandwidth associated with the services obtained with universal service discounts.[321] To enable HCPs to have the information necessary to file such reports, we will require all service providers participating in the Healthcare Connect Fund to disclose the required metrics to their HCP customers.[322]

3. Dark and Lit Fiber

120. *Background*. In this section, we address the *NPRM* proposal to allow eligible HCPs to receive support for the lease of dark or lit fiber to provide broadband connectivity.[323] For clarity, we use the term dark fiber to refer to "unused" fiber within an existing fiber optic cable that has not been activated through optical equipment to make it *capable* of carrying communications services.[324] Fiber must be activated, or "lit," before it can be used to provide communications services.[325] A key distinction is the *entity* that furnishes the modulating electronics and other equipment necessary to light the fiber. If

[316] *See* 47 C.F.R. § 54.634(a); ATA Comments at 12 (urging the Commission to adopt a provision whereby Internet access support can still be available to existing RHC program participants, as many of them will still need assistance with gaining Internet access).

[317] *See supra* n. 311.

[318] *Pilot Evaluation*, 27 FCC Rcd at 9421-22, paras. 54-55.

[319] *National Broadband Plan* at 209-213.

[320] NRHA Comments at 9 (suggesting that the Commission assess current actual usage statistics to drive its policies determining minimum broadband speed to help the Commission better adjust to changes and measure actual usage trends); CTN Comments at 22-23 (suggesting that a benchmark speed, as opposed to a mandated minimum speed, would be an acceptable compromise over the next few years).

[321] *See supra* section III.A.

[322] *See* Appendix D, 47 C.F.R. § 54.640(b).

[323] *NPRM*, 25 FCC Rcd at 9411, para. 101.

[324] *Review of the Section 251 Unbundling Obligations of Incumbent Local Exchange Carriers*, WC Docket No. 04-313 *et al.*, Order on Remand, 20 FCC Rcd 2533, 2607, para. 133 (2005).

[325] Fiber that has not been "lit" in this sense is called "unlit" (or sometimes, simply "dark") fiber. *See Schools and Libraries Sixth Report and Order*, 25 FCC Rcd at 18766-7, para. 9 (requiring applicants who choose to lease dark unlit fiber to light it immediately in order to receive E-rate support).

the service provider provides the equipment to light the fiber, the resulting connectivity is typically referred to as "lit" fiber or a fiber-based service. In contrast, if the customer provides the equipment, the lease of the fiber is typically referred to as "dark fiber."[326] When a customer provides the equipment, it is typically responsible for lighting the fiber and the resulting connectivity over that lit fiber.

121. *Discussion.* Service providers today provide numerous broadband services over fiber that the service provider manages and has "lit" (*i.e.*, the service provider has furnished the modulating equipment and activated the fiber). HCPs are currently able to receive support for telecommunications services and Internet access services provided over such fiber, as are schools and libraries in the E-rate program. The Healthcare Connect Fund will continue to support broadband services provided over service provider-lit fiber. The *NPRM* proposal, however, raised two additional issues: (1) the eligibility of dark fiber, and (2) support for costs associated with dark or lit fiber leases, including upfront payments associated with leases or indefeasible right of use (IRU) arrangements for lit or dark fiber. We address both issues below.

122. Eligibility of dark fiber. We conclude that eligible HCPs may receive support for "dark" fiber where the customer, not the service provider, provides the modulating electronics. In the *NPRM*, the Commission noted that under such an approach, applicants would, for instance, be able to lease dark fiber that may be owned by state, regional or local governmental entities, when that is the most cost-effective solution to their connectivity needs.[327] Consistent with our practice in the E-rate program, however, we will only provide support for dark fiber when it is "lit" and is actually being *used* by the HCP; we will not provide support for dark fiber that remains unlit.[328]

123. Consistent with Commission precedent, we find that dark fiber is a "service" that enhances access to advanced telecommunications and information services consistent with section 254(h)(2)(A) of the Act.[329] As in the E-rate program, we conclude that supporting dark fiber provides an additional competitive option to help HCPs obtain broadband in the most cost-effective manner available in the marketplace.[330] HCPs generally support making dark fiber eligible.[331] For example, IRHN states that the varying broadband environments in rural areas throughout the country need to be "mined" to find the most cost-effective solution, including existing fiber infrastructure that can be brought into use by HCPs seeking dark fiber.[332] Commenters also agree that making dark fiber eligible will allow the cost-

[326] *See the Matter of Applications for Authority Pursuant to Section 214 of the Communications Act of 1934 to Cease Providing Dark Fiber Service*, 8 FCC Rcd 2589, para. 1 (1993) (referring to "dark fiber" as "the provision and maintenance of fiber optic transmission capacity between customer premises where the electronics and other equipment necessary to power or 'light' the fiber are provided by the customer"); *Southwestern Bell Tel. Co. v. FCC*, 19 F.3d 1475, 1478 (D.C. Cir. 1994) ("The provision of the fiber optic lines without the necessary electronic equipment to power the fiber is commonly known as 'dark' fiber service . . . ."); *Schools and Libraries Sixth Report and*, 25 FCC Rcd at 18765, para. 8 n.6 (referring to "dark fiber" as fiber capacity "that does not include modulating electronics").

[327] *NPRM*, 25 FCC Rcd at 9411, para. 101.

[328] *See infra* para. 127; *cf. Schools and Libraries Sixth Report and Order*, 25 FCC Rcd at 18766-67, para. 9.

[329] *Schools and Libraries Sixth Report and Order*, 25 FCC Rcd at 18769, para. 12.

[330] *Id.* at 18764, para. 6.

[331] RNHN Comments at 15-16 (noting that fiber solutions are the most cost-effective facilities to provide the bandwidth needed by health information technology applications now and in the future); ATA Reply at 3; CTN Comments at 24; NETC Comments at 4; PEM Filings Comments at 2.

[332] IRHN PN Comments at 2; *see also* Letter from Linda L. Oliver, Attorney Advisor, Federal Communications Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60, at 3 (continued…)

effective leveraging of existing resources and investments, including state, regional, and local networks.[333]

124. As the Commission concluded in the E-rate context, we are not persuaded by arguments that entities who are not telecommunications providers, such as HCPs, "have a poor track record making dark fiber facilities viable for their services."[334] While dark fiber will not be an appropriate solution for all HCPs, Pilot projects have demonstrated that they can successfully incorporate dark fiber solutions into a regional or statewide health care network.[335] We are also not persuaded by the argument that dark fiber solutions may not be cost-effective. HCPs will be required to undergo competitive bidding, and our actions today merely ensure that HCPs have an additional option to consider during that process.[336] If service providers can provide comparable, less expensive lit fiber alternatives, we anticipate that such providers will bid to provide services to HCPs, who are required to select the most cost-effective option. As the Commission found in the *Schools and Libraries Sixth Report and Order*, if more providers bid to provide services, the resulting competition should better ensure that applicants – and the Fund – receive the best price for the most bandwidth.[337]

125. In order to further ensure that dark fiber is the most cost-effective solution, however, we will limit support for dark fiber in two ways. First, requests for proposals (RFPs) that allow for dark fiber solutions must also solicit proposals to provide the needed services over lit fiber over a time period comparable to the duration of the dark fiber lease or IRU. Second, if an applicant intends to request support for equipment and maintenance costs associated with lighting and operating dark fiber, it must include such elements in the same RFP as the dark fiber so that USAC can review all costs associated with the fiber when determining whether the applicant chose the most cost-effective bid.

126. We are not persuaded that allowing a HCP to purchase dark fiber from state, regional, or local government entities will negate the HCP's ability to "maintain a fair and open competitive bidding environment" if the HCP is "linked" to the governmental entity in question.[338] As discussed below, we adopt requirements that prohibit potential service providers, including government entities, from also acting as either a Consortium Leader or consultant or providing other types of specified assistance to HCPs in the competitive bidding process.[339] Allowing HCPs to lease dark fiber should increase competition among fiber providers and ensure a more robust bidding process. HCPs still must demonstrate that the bid they choose is the most cost-effective. As the Commission stated in the E-rate

(Continued from previous page)

(filed Mar. 16, 2012) (summarizing *ex parte* that nonprofit electrical companies in Tennessee were willing to share fiber with the Erlanger Pilot project for use in its health care network).

[333] *See* ATA PN Comments at 3; CTN Comments at 23-24; NETC Comments at 4. The *NPRM* noted the National Broadband Plan recommendation that "federal and state policies should facilitate demand aggregation and use of state, regional, and local networks when that is the most cost-efficient solution for anchor institutions to receive their connectivity." *See NPRM*, 25 FCC Rcd at 9411, para. 101 (quoting *National Broadband Plan* at 154 (NBP Recommendation 8.20)).

[334] CenturyLink Reply at 4.

[335] *See, e.g.*, Quarterly Report of Illinois Rural Healthnet, WC Docket No. 02-60, at 11 (filed Oct. 25, 2012).

[336] *See infra* section VI.B; *cf.* Qwest Comments at 8 ("at a minimum, [Qwest recommends] if the Commission moves forward with supporting leasing of dark fiber, it must ensure that an applicant is appropriately and fully evaluating whether leasing dark fiber is the most cost-effective solution.").

[337] *Schools and Libraries Sixth Report and Order*, 25 FCC Rcd at 18769, para. 13.

[338] Verizon Comments at 7.

[339] *See infra* section VI.B.1.

context, we believe our competitive bidding rules will protect against the possibility of waste, fraud, or abuse in that context.[340] To the extent there are violations of the competitive bidding rules, such as sharing of inside information during the competitive bidding process, USAC will adjust funding commitments or recover any disbursed funds through its normal process. As the Commission concluded in the E-rate context, our RHC rules and requirements, including the competitive bidding rules, apply to all applicants and service providers, irrespective of the entity providing the fiber network.[341]

127. Fiber leases and IRUs. As proposed in the *NPRM*, eligible HCPs may receive support for recurring costs associated with leases or IRUs of dark (*i.e.*, provided without modulating equipment and unactivated) or lit fiber.[342] We conclude that HCPs may not use fiber leases and IRUs to acquire unneeded fiber strands or warehouse excess dark fiber strands for future use. If a HCP chooses to lease (or obtain an IRU) for "dark" (*i.e.*, unactivated) fiber, recurring charges under the lease or IRU are eligible only for fiber strands that have been lit within the funding year, and only once the fiber strand has been lit.[343]

128. Eligible HCPs applying as consortia may also receive support for upfront charges associated with fiber leases or IRUs, subject to the limitations applicable to all upfront charges discussed in section V.C below. An IRU or lease for dark fiber typically requires a large upfront payment, even if no new construction is required.[344] In some cases, however, service providers may deploy new fiber facilities to serve HCPs under the lease or IRU, and may seek to recover all of part of those costs through non-recurring charges (sometimes called "special construction charges").[345] Such "build-out" costs are eligible for support. Consistent with the general rule we adopt today, we will provide support for build-out costs from an off-premises fiber network to the service provider demarcation point.[346] We decline to

[340] *See* 47 C.F.R. § 54.603; 47 C.F.R. § 54.619 (Audits and Recordkeeping).

[341] *Schools and Libraries Sixth Report and Order*, 25 FCC Rcd at 18771-2, para. 17 n.46.

[342] An IRU is an indefeasible right to use facilities for a certain period of time that is commensurate with the remaining useful life of the asset (usually 20 years, although the parties may negotiate a different term). As a contract law matter, an IRU differs from a lease because it confers on the grantee the vestiges of ownership. *NPRM*, 25 FCC Rcd at 9395-96, para. 56. For purposes of the e-rate program, however, the Commission has chosen to treat IRU purchase agreements as "leases." *Schools and Libraries Sixth Report and Order*, 25 FCC Rcd at 18772, para. 19 n.51. We similarly treat IRUs and leases as interchangeable for purposes of the Healthcare Connect Fund, especially with respect to upfront payments.

[343] Similarly, if a HCP obtains a multi-year commitment for a dark fiber lease or IRU, recurring charges are eligible only for fiber strands that have been lit during or prior to the funding year, and only once the fiber strand has been lit. *Cf. Wireline Competition Bureau Provides Guidance Following Schools and Libraries Universal Service Support Program Sixth Report and Order*, CC Docket No. 02-6 *et al.*, Public Notice, 25 FCC Rcd 17332, 17335 (Wireline Comp. Bur. 2010) ("E-rate Sixth R&O Guidance PN") (explaining that E-rate participants cannot receive funding for dark fiber until it is lit).

[344] The upfront payment can be based on multiple factors, including the length of the IRU or lease and the number of miles or fiber miles. *See NPRM*, 25 FCC Rcd at 9395-96, para. 56. In the E-rate context, the Commission allowed support for such upfront payments associated with IRUs, as long as they were consistent with existing E-rate requirements regarding upfront costs. *Schools and Libraries Sixth Report and Order*, 25 FCC Rcd at 18772-3, para. 19 n.51. The Commission noted that it did not intend to disfavor or discourage multi-year or pre-paid contract agreements between service providers and eligible schools and libraries, when the appropriate circumstances are present for such contracts. *Id.*

[345] *NPRM*, 25 FCC Rcd at 9411, para. 102.

[346] *See infra* section V.A.7.

provide support for such charges after the service provider demarcation point, consistent with the Commission's current policy of not supporting internal connections for HCPs.[347]

129. In the E-rate program, fiber must be lit within the funding year for non-recurring charges to be eligible. We adopt this requirement in the Healthcare Connect Fund. HCPs, however, unlike schools, do not have a summer vacation period during which construction can take place without disrupting normal operations. Furthermore, in some rural areas, weather conditions can cause unavoidable delays in construction. Therefore, we will allow applicants to receive up to a one-year extension to light fiber if they provide documentation to USAC that construction was unavoidably delayed due to weather or other reasons.

130. Maintenance Costs. We also find that HCPs may receive support for maintenance costs associated with leases of dark or lit fiber.[348] Only HCPs applying as consortia may receive support for upfront payments for maintenance costs, however, subject to the limitations in section V.D below.

131. Equipment. As we discuss below, we will provide support for equipment necessary to make a broadband service functional. Consistent with that standard, we find that HCPs may receive support for the modulating electronics and other equipment necessary to light dark fiber. If equipment is leased for a recurring monthly (or annual) fee, HCPs may receive support for those recurring costs. HCPs applying as consortia may also receive support for upfront payments associated with purchasing equipment, subject to the limitations discussed below.[349]

132. Eligible Providers. The Commission has previously authorized schools and libraries to lease dark fiber, and authorizes schools and libraries to lease any fiber connectivity (not just dark fiber) from any entity, including state, municipal or regional research networks and utility companies.[350] Consistent with our discussion in section V.E below, we will allow HCPs to lease fiber connectivity from any provider.[351]

4. Connections to Internet2 or National LambdaRail

133. *Background*. The *NPRM* proposed to provide support for the cost of connecting state and regional broadband networks to two non-profit nationwide research and education network backbone providers, Internet2 and National LambdaRail, Inc. (NLR), an expense that was also supported in the

[347] *See infra* section V.C.2. This rule is slightly different from that in E-rate, which supports certain types of fiber within school premises as "Priority 2" internal connections. The Commission stated in the *Schools and Libraries Sixth Report and Order* that it preferred to seek further comment in a subsequent proceeding on the potential effect of allowing special construction charges in the E-rate program for "special construction charges" for dark fiber that may be incurred to build out connectivity from applicants' facilities to an off-premises fiber network. *Schools and Libraries Sixth Report and Order,* 25 FCC Rcd at 18773, para. 19.

[348] The Pilot Program supported maintenance costs for dark fiber, as does the E-rate program. *See 2007 Pilot Program Selection Order,* 22 FCC Rcd at 20397-98, para. 74 (allowing support for "maintaining" networks); *E-rate Sixth R&O Guidance PN,* 25 FCC Rcd at 17335-36 (maintenance of leased dark fiber is eligible for support in the E-rate program).

[349] *See infra* section V.D. We do not anticipate that the cost of modulating electronics will be large. *See Schools and Libraries Sixth Report and Order,* 25 FCC Rcd at 18773, para. 19, n.55 (finding that costs of "lighting" a dark fiber connection are relatively small).

[350] *Schools and Libraries Sixth Report and Order,* 25 FCC Rcd at 18766-7, para. 9.

[351] *See* CENIC Jan. 13, 2011 *Ex Parte* at 2 (urging the Commission to allow HCPs to receive support for service provided via fiber by "any entity," similar to the rule in the E-rate program).

Pilot Program.[352] These research and education backbones link a number of institutions that house significant medical expertise, such as government research institutions and academic, public and private HCPs.[353] Unlike commercial Internet backbone providers, non-profit research and education network providers such as Internet2 and NLR typically charge participating institutions an annual membership fee to connect and access other institutions on their networks.[354] Participating institutions must separately obtain connectivity between their networks and the selected backbone network, and may choose to purchase additional connectivity services from the backbone network.[355] The *NPRM* proposed to provide support for both the *membership fees* for participants to connect their networks to Internet2 and NLR, and to provide support for any recurring costs of obtaining *broadband services* (including the actual connections between HCP networks and Internet2 or NLR).[356] The *NPRM* proposed to exclude *other* recurring costs related to NLR or Internet2 – for example, additional fees paid for subscriptions to videoconferencing services provided by Internet2.[357]

134. In the Pilot Program, the Commission waived competitive bidding and cost-effectiveness rules for applicants who wished to pre-select NLR or Internet2 as their backbone provider.[358] The *NPRM* proposed to allow a participant to "pre-select" NLR or Internet2, or to seek competitive bids from NLR and Internet2 through the normal competitive bidding process.[359]

135. *Discussion.* As discussed above, "broadband services" in this context includes backbone services. We find that the membership fees charged by Internet2 and NLR are part of the cost of obtaining access to the backbone services provided by these organizations, and thus are eligible for support as recurring costs for broadband services. We delegate authority to the Wireline Competition Bureau to designate as an eligible expense, upon request, membership fees for other non-profit research and education networks similar to Internet2 and NLR. We further find that broadband services required to connect *to* Internet2 or NLR should be eligible for support under the Healthcare Connect Fund, as well as any broadband services obtained directly *from* Internet2 or NLR.[360] Commenters generally support

---

[352] *NPRM*, 25 FCC Rcd at 9388, para. 40. *See* Internet2 Comments at 13 (describing Internet2); NLR Comments at 1-3 (describing NLR); *Pilot Program Order on Reconsideration*, 22 FCC Rcd at 2556-7, para. 5.

[353] *Id.*; *see also* Internet2 Comments at 13 (noting that research, education and health care organizations often focus on common issues with the aim of promoting the public good, and that non-profit research and education network backbones are specifically designed to provide optimal nationwide access to health care organizations, including Cancer Centers, Academic Medical Centers, Children's Research Hospitals, and VA Medical Centers).

[354] Internet2 Comments at 13; NCTN Comments at 4.

[355] *See, e.g.*, Internet2 Rural Health Care Pilot Program Network Usage Application, *available at* http://www.internet2.edu/network/rhcpp/ (requiring Pilot participants to connect to Internet2 through a recognized "Internet2 Network Connector"); *see generally* Internet2 web site at http://www.internet2.edu/network/fees.html (last visited Nov. 16, 2012) (describing various services that can be obtained through Internet2).

[356] *NPRM*, 25 FCC Rcd at 9388, para. 40 & n.80. The *NPRM* proposed to provide support for membership fees through the Health Infrastructure Program, and for broadband services through the Broadband Services Program. *Id.* at 9388, para. 40.

[357] *Id.* at 9388, para. 40 n.80.

[358] *Pilot Program Order on Reconsideration*, 22 FCC Rcd at 2558, para. 8. The Commission also allowed applicants to request funding to connect their networks to the public Internet, but did not provide a competitive bidding exemption for such connections. *Id.* at 2555, para. 2 n.5.

[359] *NPRM*, 25 FCC Rcd at 9388-89, para. 41.

[360] For clarity, these services are eligible because they are "broadband" services, not because of any special preference for Internet2 or NLR. Broadband services required to connect to any other backbone provider, or obtained from any other backbone provider, are also eligible for support. We clarify that if a service is otherwise

(continued…)

providing support for both membership fees and for the broadband services required to connect health care networks to Internet2 and NLR.[361] In addition, some commenters believe that these networks may provide a level of service not available from commercial providers in certain situations.[362]

136. We conclude, however, that it is appropriate to require participants to seek competitive bids from NLR and Internet2, or any other research and education network, through our standard competitive bidding process.[363] We recognize and anticipate that in some cases, Internet2 or NLR services may be the most cost-effective solution to meet a HCP's needs. As noted by commenters, these networks can provide many benefits, and the most cost-effective solution for HCP needs may come from Internet2 or NLR.[364] There may be instances, however, under which a more cost-effective solution is available from a commercial provider, or a non-profit provider other than Internet2 or NLR.[365] Many

(Continued from previous page)

ineligible (*i.e.*, is not a broadband service), it is not rendered eligible simply because it is obtained from Internet2 or NLR. For example, the *NPRM* cited the example of videoconferencing services obtained from NLR because videoconferencing services, in general, are not eligible for support under the rural health care program, and will not be eligible under the Healthcare Connect Fund. *NPRM*, 25 FCC Rcd at 9388, para. 40 n.80; *see infra* section V.C.1 (ineligible services). We remind applicants and service providers that Commission requires recovery of funds erroneously disbursed for ineligible services. *See 2007 Comprehensive Review Order*, 22 FCC Rcd at 16386, para. 30.

[361] HHS Comments at 6-7; NCTN Comments at 4; NETC Comments at 3; PSPN Comments at 7; RNHN Comments at 9; WWHI Comments at 2; *see also* Internet2 Comments at 13; NLR Comments at 2.

[362] *See, e.g.*, Internet2 Comments at 13 (stating that these advanced backbones are uniquely capable of reliably supporting demanding HD videoconferencing and large dataset transport by providing infrastructure with minimal or no packet loss and little or no congestion); PSPN Comments at 7 (stating that Internet2 provides a "highly reliable" alternative to commodity Internet, which has far more traffic and higher incidences of hacking into presumed secure files); RNHN comments at 9 ("While commercial backbones are sufficient for certain Internet uses, there has been a market failure when it comes to advanced broadband applications for medical applications. Commercial networks are not optimized to support advanced broadband applications like telepresence and telemedicine. Moreover, commercial networks do not offer next-generation Internet technologies like IPv6 and IP multicast, which are critical to telepresence and telemedicine."). We make no finding here as to whether the services offered by non-profit research and education backbone networks are better suited for health care purposes than those offered by commercial providers.

[363] *See NPRM*, 25 FCC Rcd at 9388-89, para. 41 (proposing that Health Infrastructure Program participants could either pre-select to connect with either Internet2 or NLR, or seek competitive bids from NLR and Internet2 through the normal competitive bidding process). The generally applicable competitive bidding exemption discussed below in section VI.B.6, however, would apply to any research and education network services. For example, HCPs who can connect to NLR or Internet2, or other research and education networks, through a government master services agreement that meets the requirements in section VI.B.6.b could take advantage of the competitive bidding exemption for such agreements.

[364] We note that in the rural health care support mechanism, price need not be the primary factor in determining what service is "most cost-effective;" rather, the most cost-effective solution is the method that "costs the least after consideration of the features, quality of transmission, reliability, and other factors that the HCP deems relevant to choosing a method of providing the required health care services." 47 C.F.R. § 54.603(b)(4); *see also 2003 Order and Further Notice*, 18 FCC Rcd at 24575-76, para. 58 (affirming that HCPs should not be required to use the lowest-cost technology because factors other than cost, such as reliability and quality, may be relevant to fulfill their telemedical needs).

[365] Many Pilot projects have connected to Internet2. *See Pilot Evaluation*, 27 FCC Rcd at 9414, para. 46 and n.139; USAC Nov. 16 Data Letter at 2 (although over 20 Pilot projects have Internet2 or LambdaRail connections, only six had requested funding commitments from USAC for such connections). Pilot projects that have received commitments for Internet2 or NLR need not conduct competitive bidding to continue receiving disbursements based

(continued…)

commenters opposed the Commission's proposal to exempt National LambdaRail and Internet2 from competitive bidding, arguing, among other things, that such an exemption would be anti-competitive by disadvantaging other telecommunications providers.[366] A competitive bidding requirement that applies equally to all participants will ensure that HCPs can consider possible options from all interested service providers. Because applicants must already engage in competitive bidding for all other services, we do not believe it would be overly burdensome to require applicants to also include Internet2 or NLR in their competitive bidding process. While we encourage all applicants to fully consider the benefits of connecting to non-profit research and education networks such as Internet2 and NLR, we emphasize that it is not a requirement to connect to Internet2 or NLR.[367]

5. Off-Site Data Centers and Off-Site Administrative Offices

137. *Background*. The Commission's current rules for the RHC Telecommunications Program allow an eligible HCP to seek support for connections between an eligible HCP site and off-site data centers or off-site administrative offices, when one end of the connection terminates at an HCP location.[368] The Telecommunications Program rules do not allow a HCP to seek support for connections between two off-site data centers, between two off-site administrative offices, or between off-site data centers or off-site administrative offices and the public Internet or another network.

138. The Pilot Program provides support for connections between two off-site data centers and for the connections between off-site data centers and the public Internet or another network. The Pilot Program also provides funding for network equipment at an off-site data center.[369] As of November 15, 2012, 19 Pilot projects received funding commitments to support off-site data centers, including network equipment located at the data center and connections between off-site data centers and the public Internet or other networks.[370] By supporting these additional connections, the Pilot Program provided participants with additional flexibility to create more efficient network designs.[371]

(Continued from previous page)

on their Pilot Program commitments. However, if such projects subsequently seek funding for Internet or NLR connections through the Healthcare Connect Fund, they must undergo competitive bidding before they can select Internet2 or NLR as their provider.

[366] *See, e.g.*, ATA Comments at 5 (noting that both Internet2 and NLR are "very reputable non-profit corporations that have contributed significantly to the development of broadband connectivity," but questioning "why the Commission has chosen not to encourage healthcare providers from seeking fair and open competition for the best service and the lowest prices among all telecommunications companies"); *id.* at 14 (noting that "[t]here are numerous national backbone networks available and all are interoperable"); CenturyLink Reply at 5-6 (arguing that there is no justification for establishing a preference for particular backbone providers, and that the Commission should be guided by its other stated principals that a particular rural health care proposal must be cost-efficient, reliable, and sustainable); VTN Reply at 8 (perceived favoritism for Internet2 or NLR may discourage participation of other broadband providers). *See generally* ATA Comments.

[367] *See* VTN Comments at 38 (noting that Internet2 and NLR do not reach all (or even most) rural HCPs, and that "perceived favoritism" for those providers may result in some eligible HCPs choosing not to apply for rural health care support).

[368] *NPRM*, 25 FCC Rcd at 9416, 9418, paras. 116, 120. Under the Telecommunications Program, at least one end of the supported connection must terminate at an eligible HCP site. *See* 47 C.F.R. § 54.613(a).

[369] *See* Rural Health Care Pilot Program, Frequently Asked Questions and Answers, FAQ #5, http://www.fcc.gov/encyclopedia/rural-health-care-pilot-program#faq5 (last visited Dec. 7, 2012). Connections from off-site administrative offices to the Internet or to other locations are not supported in the Pilot Program.

[370] USAC Nov. 16 Data Letter at 2.

[371] *See* USAC Observations Letter at 5.

139. In the *NPRM*, the Commission proposed to make off-site administrative offices and off-site data centers eligible for discounts under a reformed program, noting that many HCPs house activities that "are critical to the provision of clinical care by rural HCPs" in such off-site administrative offices or data centers.[372]

140. *Discussion*. Based on our experience with the RHC Telecommunications and Pilot Programs, we adopt a rule that provides support under the Healthcare Connect Fund for the connections and network equipment associated with off-site data centers and off-site administrative offices used by eligible HCPs for their health care purposes, subject to the conditions and restrictions set forth below.[373] There has been significant change in how HCPs use information technology in the delivery of health care since the Commission originally adopted the rules for the Telecommunications Program that do not provide support for off-site data centers and administrative offices. As discussed in more detail below, this new rule appropriately recognizes "best practices" in health care facility and infrastructure design and the way in which HCPs increasingly accomplish their data storage and transmission requirements. It also enables HCPs to use efficient network connections, rather than having to re-route traffic unnecessarily in order to obtain support. Many commenters pointed out the operational and network efficiency gains from this approach, as discussed more fully below.[374]

141. For purposes of the rule we adopt today, an "off-site administrative office" is a facility that does not provide hands-on delivery of patient care, but performs administrative support functions that are critical to the provision of clinical care by eligible HCPs.[375] Similarly, an "off-site data center" is a facility that serves as a centralized repository for the storage, management, and dissemination of an eligible HCP's computer systems, associated components, and data.[376] Under the new rule, we expand the connections that are supported for already eligible HCPs to include connections to these locations when purchased by HCPs in the Healthcare Connect Fund.[377]

---

[372] *NPRM*, 25 FCC Rcd at 9416, para. 117; *see also National Broadband Plan* at 216 (NBP Recommendation 10.8).

[373] In adopting this rule, we decline to expand our interpretation of "health care provider" to include off-site administrative offices or off-site data centers as eligible HCP sites, as proposed in the *NPRM*. *See NPRM*, 25 FCC Rcd at 9416, 9418, paras. 117, 120. Because we do not take the definitional approach proposed in the *NPRM*, support for these additional connections and network equipment associated with off-site data centers and administrative offices is limited to the Healthcare Connect Fund. This outcome better aligns with the Healthcare Connect Fund's focus on fostering HCP networks, rather than simply funding individual HCP connections (as is the case in the Telecommunications Program).

[374] *See, e.g.*, ACS Comments at 12; ATA Comments at 8; Avera Comments at 7-8; CTN Comments at 26; HIEM Comments at 17-18; HHS Comments at 11-12; IRHN Comments at 17; IHS Comments at 9; NCTN Comments at 11-12; NETC Comments at 3; NTCA Comments at 9; RWHC Comments at 4.

[375] Appendix D, 47 C.FR. § 54.637(a)(1). For example, administrative support functions include, but are not limited to, coordinating patient admissions and discharges, ensuring quality control and patient safety, maintaining the security and completeness of patients' medical records, and performing ministerial tasks, such as billing and collection, claims processing, and regulation compliance. *See* American Hospital Association, "Redundant, Inconsistent and Excessive: Administrative Demands Overburden Hospitals," Trendwatch, July 2008, at 1, *available at* www.aha.org/research/reports/tw/twjuly2008admburden.pdf.

[376] Appendix D, 47 C.F.R. § 54.637(a)(2).

[377] *See NPRM*, 25 FCC Rcd at 9416, 9418, paras. 117, 120. One Pilot Program participant suggested we fund administrative offices retroactively, and going forward, until the termination of the Pilot program. *See* SWAMH Comments at 1-2 (urging that "eligible pilot program participants' administrative offices . . . be funded, retroactively, from the initial implementation date and continue to receive funding for the duration of the pilot program"). In light of the reforms we adopt today, which are intended in part to transition eligible HCPs from the Pilot program to a new, improved support program, we decline to expand eligibility to Pilot participants. Moreover,

(continued…)

142. Specifically, subject to the conditions and restrictions set forth below, we provide support in the Healthcare Connect Fund for connections used by eligible HCPs: (i) between eligible HCP sites and off-site data centers or off-site administrative offices, (ii) between two off-site data centers, (iii) between two off-site administrative offices, (iv) between an off-site data center and the public Internet or another network, and (v) between an off-site administrative office and an off-site data center or the public Internet or another network. We also expand the eligibility of network equipment to provide support for such equipment when located at an off-site administrative office or an off-site data center. In addition, we establish that support for such connections and/or network equipment is available both to single HCP applicants or consortium applicants under the Healthcare Connect Fund. Finally, for the reasons given below, we include support for connections at such off-site locations even if they are not owned or controlled by the HCP.

143. We adopt this rule today with certain conditions and restrictions to ensure the funding is used to support only eligible public or non-profit HCPs and to protect the program from potential waste, fraud, and abuse.[378] First, the connections and network equipment must be used solely for health care purposes.[379] Second, the connections and network equipment must be purchased by an eligible HCP or a public or non-profit health care system that owns and operates eligible HCP sites.[380] Third, if traffic associated with one or more ineligible HCP sites is carried by the supported connection and/or network equipment, the ineligible HCP sites must allocate the cost of that connection and/or equipment between eligible and ineligible sites, consistent with the "fair share" principles set forth below.[381] These conditions and requirements should fully address the concerns of those commenters who fear that these additional supported connections may be used long-term for non-health care purposes.[382]

144. As commenters point out, HCPs often find increased efficiencies by locating administrative offices and data centers apart from the site where patient care is provided.[383] This is especially true for groups of HCPs, including smaller HCPs, who often share administrative offices and/or data centers, to save money and pool resources.[384] Furthermore, it does not make practical sense to

(Continued from previous page)

the deadline for filing funding commitment requests has already passed in the Pilot Program. Expanding eligibility for the Pilot program, especially retroactively as requested, would also be administratively burdensome. We encourage any current Pilot Program participants to obtain support for these connections through the Healthcare Connect Fund.

[378] *See, e.g.*, Marshfield Reply Comments at 4 (suggesting that the FCC "ensure proper controls are in place to validate that a data center is indeed, a critical component of [the] overall approach to delivering health care services for the HCP").

[379] *See* Appendix D, 47 C.F.R. § 54.637(b)(2); *see also* IHS Comments at 9 (suggesting that the Commission guarantee that the supported services "be used long-term for health care purposes"); TeleQuality Comments at 6.

[380] *See* Avera Comments at 7-8.

[381] *See infra* section V.C.4; *see, e.g.*, NCTN Comments at 11-12 (supporting the use of a "fair share" arrangement similar to the Pilot Program).

[382] *See* IHS Comments at 9; *see also* Marshfield Reply Comments at 4 (requesting the Commission put in place the necessary controls to ensure funding is indeed supporting eligible HCP sites).

[383] *See, e.g.*, *NPRM*, 25 FCC Rcd at 9417, para. 118 n.235; CTN Comments at 26 (explaining that it has become a best practice for HCPs to locate their administrative facilities off site from the provider's primary facility).

[384] *See, e.g.*, Broadband Principals Comments at 14 (stating that that "many small [HCPs] may prefer to run their telecommunications through a group which can provide expertise and help them realize economies of scale."); USF Consultants Comments at 2 (stating that "[a] consortium of small hospitals can cost effectively share a single health

(continued…)

distinguish administrative offices and/or data centers that are located off-site but otherwise perform the same functions as on-site facilities, and which require the same broadband connectivity to function effectively.[385] While off-site administrative offices and off-site data centers do not provide "hands on" delivery of patient care, they often perform support functions that are critical to the provision of clinical care by HCPs.[386] For example, administrative offices may coordinate patient admissions and discharges, ensure quality control and patient safety, and maintain the security and completeness of patients' medical records.[387] Administrative offices also perform ministerial tasks, such as billing and collection, claims processing, and regulation compliance.[388] Without an administrative office capable of carrying out these functions, an eligible HCP may not be able to successfully provide patient care.

145. Similarly, off-site data centers often perform functions, such as housing electronic medical records, which are critical to the delivery of health care at eligible HCP sites.[389] For example, the Utah Telehealth Network uses a primary data center in West Valley City, Utah with a backup secondary data center in Ogden, Utah to deliver approximately 2,500 clinical and financial applications to eligible HCP sites.[390] North Carolina Telehealth Network plans to use data center connectivity to help public health agencies comply with "meaningful use" of EHRs.[391]

146. By providing support for the additional connections (*e.g.*, those connections beyond the direct connection to an eligible HCP site) and network equipment associated with off-site administrative offices and off-site data-centers, eligible HCPs will be able to design their networks more efficiently. For example, the use of remote cloud-based EHR systems has become a "best practice," especially for smaller HCPs, for whom that solution is often more affordable.[392] In such cases, a direct connection from the HCP off-site administrative office and/or off-site data center to the network hosting the remote cloud-based EHR system enables the more efficient flow of network traffic.[393] In comparison, if these additional connections and network equipment were not supported, an HCP may be forced to route traffic from its off-site administrative office or off-site data center that is destined for the remote EHR system

(Continued from previous page)

care computer (located in an offsite location) supporting multiple applications via a dedicated high bandwidth connection.").

[385] *See, e.g.*, IHS Comments at 9.

[386] *See, e.g.*, Avera Comments at 7-8; NCTN Comments at 11-12; TIA Comments at 8-9; *see also* American Hospital Association, "Redundant, Inconsistent and Excessive: Administrative Demands Overburden Hospitals," Trendwatch, July 2008, at 1, *available at* http://www.aha.org/aha/trendwatch/2008/twjuly2008admburden.pdf.

[387] American Hospital Association, "Redundant, Inconsistent and Excessive: Administrative Demands Overburden Hospitals," Trendwatch, July 2008, at 1, *available at* www.aha.org/research/reports/tw/twjuly2008admburden.pdf.

[388] *Id.*

[389] *NPRM*, 25 FCC Rcd at 9418, para. 120; *see, e.g.*, Avera Comments at 8; WWHI Comments at 5-6.

[390] Utah Telehealth Network, Quarterly Report for Q17, WC Docket No. 02-60, at 41 (filed July 30, 2012).

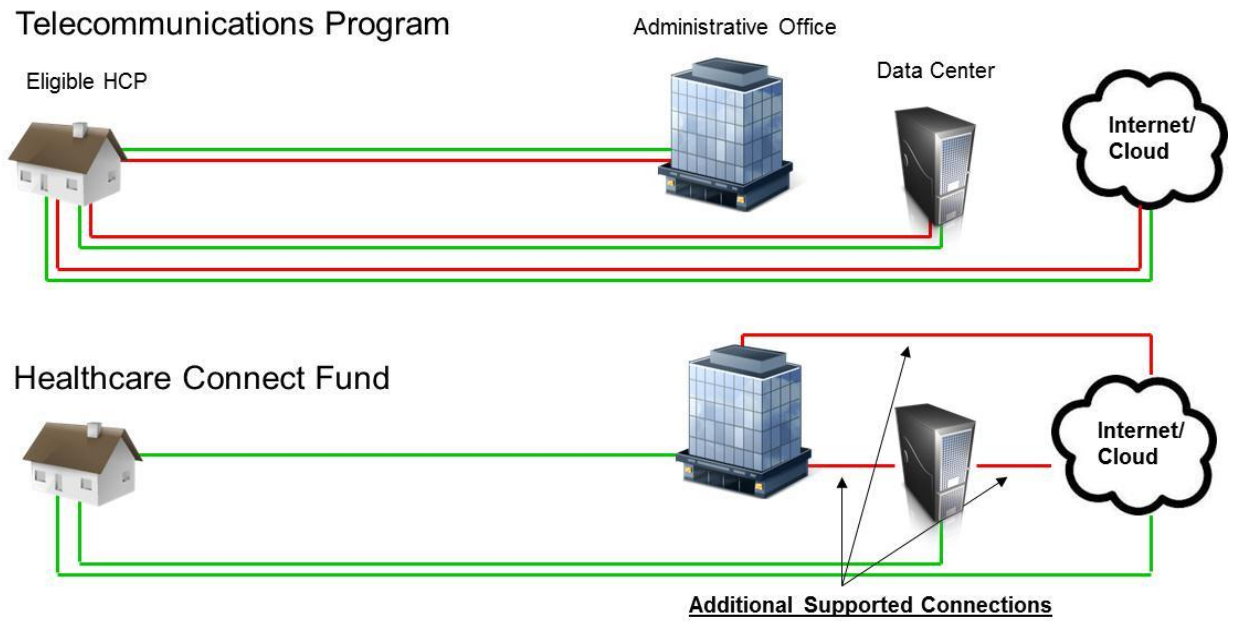
[391] North Carolina Telehealth Network, Quarterly Report, WC Docket No. 02-60, at 42 (filed Oct. 31, 2012).

[392] *See* AHA PN Comments at 5; *see also* Letter from Linda L. Oliver, Attorney Advisor, Federal Communications Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 at 2 (filed Jan. 6, 2012) (ONC Jan. 6 *Ex Parte* Letter).

[393] *See* Letter from Timothy J. Cooney, Counsel for American Hospital Association, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 (filed Oct. 11, 2012) at 3 (AHA Oct. 11 *Ex Parte* Letter).

back through the eligible HCP site, as illustrated in Figure 4 below, potentially resulting in substantial inefficiency in the use of funding.[394]

Figure 4: Network Efficiency Illustration



147. After reviewing the record, we conclude that requiring that an eligible HCP to have majority ownership or control over an off-site administrative office or data center in order for it to be eligible for support would impose an unnecessary burden on HCPs seeking to use broadband effectively to deliver health care to their patients.[395] Providing support for eligible expenses associated with off-site administrative offices and off-site data centers was widely endorsed by commenters,[396] but commenters noted that there is a wide variation in the way that HCPs structure their physical facilities.[397] For example, HHS explains that an HCP often has no ownership or control of the off-site data center hosting

[394] As USAC has noted, "[i]n the Primary Program, circuits are only eligible for funding if one end of the circuit terminates at an eligible rural entity. HCPs who wish to create a tele-health network in the Primary Program may be incentivized to design a network to maximize funding by ensuring that all connections within the network terminate at an eligible rural entity, resulting in network inefficiencies." USAC Observations Letter at 5.

[395] *See* HHS Comments at 11-12; *see also* RNHN Comments at 20-21 (stating that "[l]ocations that are leased or licensed are no less critical to the delivery of health care than a location that is at least 51% owned or controlled by a health care provide"); Internet2 Comments at 21; Broadband Principals Comments at 10, 14; TeleQuality Comments at 6; UH TIPG Comments at 4-5.; Comcast Reply Comments at 2.

[396] *See, e.g.*, ACS Comments at 12; ATA Comments at 8; Avera Comments at 3; CTN Comments at 26; HIEM Comments at 17-18; HHS Comments at 11-12; IRHN Comments at 17; IHS Comments at 9; NCTN Comments at 11-12; NETC Comments at 3; NTCA Comments at 9; RWHC Comments at 4.

[397] *See* HHS Comments at 11-12; *see also* RNHN Comments at 20-21 (stating that "[l]ocations that are leased or licensed are no less critical to the delivery of health care than a location that is at least 51% owned or controlled by a health care provide"); Internet2 Comments at 22; Broadband Principals Comments at 10, 14; TeleQuality Comments at 6; UH TIPG Comments at 4.

its health care related equipment and servers.[398] NCTN suggests that the Commission identify "eligible functions" rather than evaluating ownership.[399] The adopted rule addresses these concerns and provides eligible HCPs with the flexibility to use off-site data centers and administrative offices irrespective of ownership or control, subject to the above conditions and requirements.[400]

148. The adopted approach also accommodates a variety of arrangements for the operation of off-site administrative offices and/or off-site data centers. For instance, one commenter was concerned that the *NPRM* proposal unreasonably excluded support for the off-site administrative offices and off-site data centers owned by a public or non-profit health care system rather than by one or more eligible HCP sites.[401] Under the rule we adopt today, the network equipment and connections associated with these off-site facilities owned by public or non-profit health care systems are eligible for support to the extent they satisfy the above conditions and restrictions.[402] Any network equipment and connections shared among a system's eligible and ineligible HCP sites may only receive support to the extent that the expenses are cost allocated according to the guidelines discussed in section V.C.4 of this order.[403] We believe this approach is consistent with the intent of the statute and best balances the objectives of fiscal responsibility and increasing access to broadband connectivity to eligible HCPs.

6. Reasonable and Customary Installation Charges up to $5,000

149. *Background.* In the *NPRM*, the Commission proposed to allow support for reasonable and customary installation charges for broadband services. "Installation charges" were defined as "charges that are normally charged by service providers to commence service." Importantly, the term "installation charges" as used in the *NPRM excludes* "charges that are based on amortization or pass through of construction or infrastructure costs."[404] "Installation charges" are currently supported in both the Telecommunications Program and Internet Access Program.[405]

150. *Discussion.* We will provide support for reasonable and customary installation charges for broadband services, up to an undiscounted cost of $5,000 (*i.e.*, up to $3,250 in support) per HCP

---

[398] HHS Comments at 11-12; *see also* TeleQuality Comments at 6 (explaining that funding eligibility for off-site administrative offices and data centers should not be determined by the ownership of the physical building, rather eligibility should turn on whether "the telecom service is used for healthcare purposes"). HCP data centers are often just rented rack space in a collocation facility or other facility not owned or controlled by the HCP.

[399] NCTN Comments at 11-12.

[400] *See supra* para. 143.

[401] *See* Avera Comments at 7-8 (stating that Avera has two administrative offices and a data center that are separate from any of the hospitals and that the administrative offices and data center provide services to all of Avera's hospitals and are not owned or controlled by the hospitals).

[402] *See supra* para. 143.

[403] *See infra* section V.C.4. *See also* Avera Comments at 8 (suggesting that the support for off-site administrative offices and off-site data centers "be pro-rated based on an allocation of services provided to eligible and ineligible [health care] providers").

[404] In other words, the definition of "installation charges" we adopt today does not include the costs of construction or infrastructure upgrades necessary to provide the requested level of broadband services, where such infrastructure does not exist. *See NPRM*, 25 FCC Rcd at 9410-11, para. 100.

[405] *See* USAC, Rural Health Care web site, Frequently Asked Questions, Question 30 ("Are onetime or installation charges covered for eligible HCPs?"), *available at* http://www.universalservice.org/rhc/about/getting-started/faqs.aspx (last visited Sept. 13, 2012); *see also id.*, Question 29 "What services may be discounted for eligible HCPs?" (stating that "[s]pecial construction and maintenance charges" are not eligible for support).

location.[406] Commenters generally agree with providing support for installation charges.[407] ACS suggests, however, that in order to preserve funds, the Commission should limit the scope of this funding to only the most medically underserved areas (*i.e.*, those with the highest HPSA score).[408] We conclude, however, that the better course is to limit the amount of installation charges per eligible HCP location. Because our experience with the RHC Telecommunications and Pilot Programs indicates that undiscounted installation charges are typically under $5,000 per location, we conclude that setting a cap at this level will ensure that as many HCPs can obtain the benefits of broadband connectivity as possible. HCPs who are subject to installation charges higher than this amount may seek upfront support for eligible services or equipment, as discussed more fully below, if those charges independently qualify as eligible expenses (*e.g.*, upfront charges for service provider deployment of facilities, costs for HCP-constructed and owned infrastructure, network equipment, etc.).

7. Upfront Charges for Service Provider Deployment of New or Upgraded Facilities to Serve Eligible Health Care Providers

151. *Background.* In this section, we address the issue of upfront charges for service provider deployment of new or upgraded facilities in order to serve eligible HCPs. As discussed in the *National Broadband Plan*, lack of availability of broadband services can be a challenge for some small rural HCPs.[409] In the *NPRM*, the Commission recognized that service providers may deploy new facilities to serve eligible HCPs in some situations, and seek to recover all or part of those costs through non-recurring charges when service is initiated.[410] The Commission proposed to limit upfront support for such non-recurring charges consistent with policies adopted in the E-rate program. Specifically, the Commission proposed that if non-recurring charges are more than $500,000, they must be part of a multi-year contract, and must be prorated over a period of at least five years.[411]

152. *Discussion.* Eligible consortia may obtain support for upfront charges for service provider deployment of new or upgraded facilities to serve eligible HCP sites that are applying as part of the consortium, including (but not limited to) fiber facilities as discussed in section V.A.3 above. Although the Pilot Program has helped thousands of HCPs to obtain broadband services, many HCPs in more remote, rural areas still lack access to broadband connections that effectively meet their needs.[412]

---

[406] *See* USAC Nov. 16 Data Letter at 2 (based on experience in the Pilot and Primary Programs, normal and reasonable undiscounted installation costs for broadband services should be no more than $5,000).

[407] *See* RNHN Comments at 18 (stating reasonable and customary installation charges for broadband access should be eligible for support because they are an integral component of providing broadband services); HHS Comments at 11; UAMS Comments at 8; TeleQuality Comments at 5; ACS Comments at 12-13; IRHN Comments at 16; WNYRAHEC PN Comments at 6.

[408] ACS Comments at 13.

[409] *See National Broadband Plan* at 211 (noting that small physician offices in rural areas are disproportionately affected by a lack of high bandwidth broadband services).

[410] In some cases, telecommunications providers may choose to recover the cost of deploying or upgrading facilities by simply incorporating those costs into monthly recurring charges. As Geisinger notes, however, this can make the recurring costs unaffordable. Geisinger PN Comments at 4.

[411] *NPRM*, 25 FCC Rcd at 9411, para. 102.

[412] *See* AHA PN Comments at 3 ("[f]or many of the AHA's rural members, the ability to ensure access to 'last mile' broadband connections to rural health care facility locations is a fundamental problem restricting broadband access"); Letter from Craig Davis, Vice President, Rural Health Care Division, Universal Service Administrative Company, to Sharon Gillett, Chief, Wireline Competition Bureau, Federal Communications Commission, WC Docket No. 02-60, at 13 (filed Apr. 12 2012) (USAC Apr. 12, 2012 Letter) (noting an instance in which a 10 Mbps

(continued…)

The Pilot Program demonstrated that many HCPs prefer not to own the physical facilities comprising their networks, but can still assemble a dedicated health care network if funds are available for service provider construction and upgrades where broadband facilities are not already available.[413] In a number of instances, Pilot projects found that support for upfront charges for deployment of service provider facilities allowed them to find the most cost-effective services to meet their needs while obtaining the benefits of connecting to existing networks.[414]

153. Commenters recommend that the Healthcare Connect Fund support service provider build-out charges, arguing that will result in cost-effective pricing,[415] which in turn reduces the cost to the Fund. This solution may be particularly useful when a health care network covers a large region served by multiple vendors, because the network can maximize the use of existing infrastructure and seek funding for build-out only where necessary. For example, OHN's multi-vendor leased line network utilized 151.06 miles of existing infrastructure, and stimulated 86.41 miles of new middle-mile connectivity.[416]

154. We adopt a rule to provide support for service provider deployment of facilities up to the "demarcation point," which is the boundary between facilities owned or controlled by the service provider, and facilities owned or controlled by the customer.[417] In other words, the demarcation point is the point at which responsibility for the connection is "handed off" to the customer. Thus, charges for "curb-to-building installation" or "on site wiring" are eligible if they are used to extend service provider

(Continued from previous page)

Ethernet service was available and preferred by the HCP, but the HCP ended up bonding 8 T-1s due to a $30,000 construction expense for the 10 Mbps service).

[413] *Pilot Evaluation*, 27 FCC Rcd at 9443-44, paras. 91-92; Letter from Linda L. Oliver, Attorney Advisor, Federal Communications Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 (filed Mar. 26, 2012) at 2 (Pilot Conference Call Mar. 26 *Ex Parte* Letter (AEN *et al.*)) (noting that most stakeholders prefer not to own the physical facilities comprising their network, but would rather defer to service providers that have experience and expertise in these matters to complete any build out, and stating that in cases where construction is necessary, the HCP may issue one RFP for construction and a second RFP for an experienced entity to manage the network on behalf of the HCP); Pilot Conference Call Mar. 16 Ex Parte Letter (ARCHIE *et al.*) at 3 (stating that while the Pilot Program helped prompt the deployment of fiber or other high capacity facilities to many HCP sites where such facilities were not previously available, HCPs do not want to own the network facilities); Avera Comments at 5 (stating that support for non-recurring costs is reasonable because it allows service providers to recover costs for installing last-mile fiber to a HCP, and it makes more sense for the SP to own the entire circuit because having the provider own the last mile could lead to "finger-pointing" if something went wrong); UTN PN Comments at 4.

[414] For example, the Indiana Telehealth Network utilized funding for infrastructure and plant upgrades by telecommunications providers to serve participating HCPs with fiber connections. Several HCPs in the network required construction builds of over 20 miles of fiber to reach the nearest fiber node. *See* ITN PN Comments at 3 (noting that in such cases, "rural health care providers and their surrounding communities would continue to be without adequate broadband services if not for the assistance of the [Pilot Program]").

[415] IRHN PN Comments at 12 (recommending that the latitude allowed in the Pilot Program be continued in the Broadband Services Program (*e.g.*, purchase/own or lease equipment, IRUs, purchase pre-paid bandwidth, non-traditional and traditional service providers); allowing non-recurring costs is a critical tool for obtaining cost-effective pricing); Geisinger PN Comments at 2.

[416] Letter from Kim Klupenger *et al.*, Oregon Health Network, to Christianna Lewis Barnhart, Attorney Advisor, Federal Communications Commission, WC Docket No. 02-60, at 1-2 (filed Feb. 28, 2012) (OHN Feb. 28 Ex Parte Letter).

[417] Such customer facilities may include, for example, terminal equipment, protective apparatus, or wiring. *Cf.* 47 C.F.R. § 68.3 (defining "demarcation point" for purposes of telephone networks).

facilities to the point where such facilities meet customer-owned terminal equipment or wiring.[418] If the additional build-out is not owned or controlled by the service provider, it will not be eligible as service provider deployment costs under this section. In contrast, consistent with current RHC program rules, "inside wiring"[419] and "internal connections"[420] are not eligible for support.[421]

155. Because upfront charges for build-out costs can be significant, we limit eligibility for such upfront charges to consortium applications. Our experience of over a decade with the RHC Telecommunications Program suggests that individual HCPs are unlikely to attract multiple bids, which would constrain prices.[422] As HCPs themselves acknowledge, and as we learned in the Pilot Program, consortium applications are more likely to attract multiple bidders, due to the more significant dollar amounts associated with larger projects.[423] Furthermore, we anticipate that individual HCPs will benefit from participating in a consortium in numerous ways, including pooling administrative resources (*e.g.* for the competitive bidding process), and increased opportunities for cooperation with other HCPs within their state or region.[424] Consortia seeking funding for build-out costs must apply and undergo the competitive bidding process through the consortium application process described below.[425] As in the

[418] *See* UTN PN Comments at 4 (noting that leased services often have non-recurring costs for installation, including curb-to-building installation charges); CTN PN Comments at 10-12 ("CTN recommends that the Broadband Services Program allow funding to include on site wiring and technical assistance . . . just as the circuits and routers are covered in the Pilot Program. In CTN's experience, if we do not complete the installation so that the HCP is fully operational in a turnkey fashion, sites are less likely to utilize the broadband connection.").

[419] "Inside wiring" is customer-owned or controlled wire on the *customer's* side of the demarcation point. *See* 47 C.F.R. § 68.3.

[420] "Internal connections" is a concept used in the context of the E-rate mechanism, and refers to services used for internal networks within school or library premises – more specifically, services "necessary to transport information within one or more instructional buildings of a single school campus or within one or more non-administrative buildings that comprise a single library branch." 47 C.F.R. § 54.502(a)(4).

[421] *2003 Order and Further Notice*, 18 FCC Rcd at 24562, para. 30 (finding that there is insufficient information in the record to provide support for internal connections, and expressing concern that providing support for internal connections may place an undue burden on the rural health care support mechanism); *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20398, para. 75 (concluding that "inside wiring" is an ineligible cost "except for equipment that terminates a carrier's or other provider's transmission facility and any router/switch that is directly connected to either the facility or the terminating equipment"); USAC RHC web site, *available at* http://www.universalservice.org/rhc/health-care-providers/step01/eligible-services.aspx (equipment and "wiring" not supported in the RHC Primary Programs) (last visited Nov. 15, 2012).

[422] *Pilot Evaluation*, 27 FCC Rcd at 9436-37, para. 81 (only an estimated 16 percent of funding requests received even a single bid in the Primary Program, whereas 94 percent of Pilot projects received multiple bids).

[423] *Pilot Evaluation*, 27 FCC Rcd at 9437, para. 82; s*ee also* NCTN PN Comments at 2; Testimony of Rebecca Sanders, Director, Indiana Telehealth Network, Before the House Small Business Committee, Subcommittee on Healthcare and Technology, at 10-11 (Feb. 15, 2012), *available at* smallbusiness.house.gov/uploadedfiles/sanders_testimony.pdf (last visited Nov. 15, 2012) (Pilot Program funding allowed the service provider to accelerate planned deployment of fiber to certain areas); USAC Apr. 12, 2012 Letter at 14-15 (experience is showing that rural and frontier health care facilities must partner with larger organizations for economies of scale).

[424] *See, e.g.*, Geisinger PN Comments at 2 (consortium applications will take the administrative burden off small HCPs who do not have the time or resources to apply for funds in a new program); NCTN PN Comments at 2 (the consortium approach allowed NCTN to "leverage [its] buying leverage with telecom companies and to create an operations model that leverages the consortium's consumer focus to assure that individual customers get better service than they could expect to get working alone as a single small customer").

[425] *See infra* section VI.C.

Pilot Program, an RFP that includes a build-out component need not be *limited* to such costs (for example, some HCPs included in the RFP may not need any additional build-out to be served, but rather only need discounts on recurring services). We expect HCPs to select a proposal that includes carrier build-out costs only if that proposal is the most cost-effective option.[426] In addition, upfront charges for build-out are subject to the limitations in section V.D below.

B. Eligible Equipment

156. *Background.* Prior to the Pilot Program, the RHC support mechanism did not provide support for any form of equipment. In the Pilot Program, the Commission allowed support for certain network equipment, in both HCP-owned networks and in networks utilizing third-party services.[427] Pilot projects were allowed to use support to purchase or lease equipment at both the "edge" (*i.e.*, equipment necessary for individual HCPs to make their broadband connections function),[428] and at the "core" (equipment necessary to manage the health care broadband network as a whole).[429] Such equipment can include, for example, servers, firewalls, routers, and switches.[430] In response to the *July 19 Public Notice*, commenters emphasized the importance of providing support in a reformed program for both "edge" equipment[431] and "core" equipment that enables the formation of networks.[432]

---

[426] *See infra* section VI.A.4 (providing definition of "most cost-effective").

[427] As of January 2012, Pilot projects had sought support for equipment to be deployed in both HCP-owned networks ($10.3 million) and in networks utilizing third-party services (including leases or IRUs of third-party owned facilities) ($9.0 million). Commitments for network equipment in the Pilot Program (including engineering and installation) were approximately $19.3 million for 698 HCPs in 25 projects, as of January 2012. *Pilot Evaluation*, 27 FCC Rcd at 9416, Fig. 10(b); *id.* at 9417-18, para. 50.

[428] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20398, para. 75 (allowing support for "equipment that terminates a carrier's or other provider's transmission facility and any router/switch that is directly connected to either the facility or the terminating equipment").

[429] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20398, para. 75 (allowing support for "computers, including servers, and related hardware (*e.g.*, printers, scanners, laptops) . . . used exclusively for network management," "software . . . used for network management, maintenance, or other network operations," and "development of software that supports network management, maintenance, and other network operations").

[430] USAC Observations Letter at 5; UTN PN Comments at 4 (stating that routers, switches, firewalls and other network management tools should be eligible for support as long as they are a necessary part of the WAN infrastructure being deployed).

[431] ATA Reply at 2 (stating that an important barrier for many rural HCPs is the fact that they do not have the funds to pay for the core infrastructure allowing them connect to a network, and arguing that providing discounted broadband services but not adequately supporting the costs of installation or related equipment to connect to the network is "tantamount to building a highway with no on or off ramps"); ITN PN Comments at 3 (supporting, at a minimum, the inclusion of the initial costs for routers and bridges associated with the installation of broadband services to eligible HCPs); CTN PN Comments at 8 (recommending that the Commission continue the Pilot Program practice of funding associated routers, switches, firewalls, border proxy, and other edge equipment necessary to configure broadband network services for HCP sites, and noting that California Community Clinics, CAHs, and FQHCs often cannot invest in obtaining sufficient broadband and equipment without the help of federal grants and subsidies).

[432] IRHTP PN Comments at 2 (stating that funds should be used to subsidize the cost of equipment to enable the formation of networks among consortium members); TIA PN Comments at 10 (stating that a broad view of the types of eligible equipment for funding should be taken); UTN PN Comments at 4 (non-recurring costs that enable the formation of networks should be encouraged); SWTAG PN Comments at 7 (arguing same, and stating that "this type of equipment is critical to network and network of networks connectivity functionality to support both telehealth and health information exchange that is often multi-point and requires technology to support these

(continued…)

157. *Discussion.* We will provide support for network equipment necessary to make a broadband service functional in conjunction with providing support for the broadband service.[433] In addition, for consortium applicants, we will provide support for equipment necessary to manage, control, or maintain a broadband service or a dedicated health care broadband network.[434] Equipment support is not available for networks that are not dedicated to health care. We conclude that providing support for such equipment is important to advancing our goals of increasing access to broadband for HCPs and fostering the development and maintenance of broadband health care networks, for three reasons.[435]

158. First, providing support for equipment will help HCPs to upgrade to higher bandwidth services. USAC states that Pilot Program funding for equipment allowed such HCPs to upgrade bandwidth without restrictions based on what their existing equipment would allow.[436] We note that small rural hospitals and clinics often lack the IT expertise to know that they will need new equipment to use new or upgraded broadband connections, and finding funding to pay for the equipment can cause delays.[437]

159. Second, support for the equipment necessary to operate and manage dedicated broadband health care networks can facilitate efficient network design. USAC states that urban centers, where most specialists are located, are natural "hubs" for telemedicine networks, but the cost of equipment required to serve as a hub can be a barrier for these facilities to serve as hubs. In the Pilot Program, funding network equipment eliminated this barrier to entry.[438] OHN explains that connecting to urban hubs can also

(Continued from previous page)

approaches and also provide appropriate security"); WNYRAHEC PN Comments at 6 (recommending eligibility for network routers).

[433] Because support for equipment is contingent upon it being necessary for achieving broadband connectivity, we will only provide support for equipment if the associated broadband service is funded under the Healthcare Connect Fund. GCI argues that if the new program supports routers and other equipment, it should also support such equipment for services supported under the existing RHC program. GCI PN Comments at 6, 7. We expect to address potential reforms to the RHC Telecommunications Program at a future date. *See infra* section VIII.

[434] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20397-98, para. 74 (supporting "costs of constructing dedicated broadband networks that connect health care providers").

[435] Certain equipment (*e.g.*, a network router) is necessary to make a broadband service functional, regardless of whether the broadband service is being used for telemedicine or some other application unrelated to health care. Providing support for such equipment is within the scope of our statutory directive to provide "access to advanced telecommunications and information services." In contrast, while equipment such as telemedicine carts and telemedicine software may be necessary to engage in telemedicine, it is not necessary to making a broadband connection functional. *See infra* section V.C.1. The Commission previously has concluded that it lacked statutory authority to support telemedicine equipment. *See 2003 Order and Further Notice*, 18 FCC Rcd at 24562, para. 30 and n.97 (responding to Washington Rural Health Association's request that the Commission fund "services and equipment necessary for the provision of health care," including "radiologic imaging equipment" and "video conferencing equipment"); *see also Changes to the Board of Directors of the National Exchange Carrier Association, Inc., Federal-State Joint Board on Universal Service*, CC Docket No. 96-45 *et al.*, Fifteenth Order on Reconsideration, 14 FCC Rcd 18756, 18781-82, paras. 39-40 (1999).

[436] USAC Observations Letter at 6-7.

[437] *Pilot Evaluation* 27 FCC Rcd at 9417-18, para. 50; OHN PN Comments at 9-10; UTN PN Comments at 4 (stating that leased services often have non-recurring costs for installation, including applicable network equipment).

[438] USAC Observations Letter at 5.

reduce the need for rural sites to manage firewalls at their locations, which allows the rural sites to reduce equipment costs while adhering to security industry best practices and standards.[439]

160. Finally, support for network equipment can also help HCPs ensure that their broadband connections maintain the necessary reliability and quality of service, which can be challenging even if the HCP has a service level agreement (SLA) with its telecommunications provider.[440] Support for network equipment has enabled some Pilot projects to set up Network Operations Centers (NOCs) that can manage service quality and security in a cost-effective manner for all of the HCPs on the network.[441] The NOC can proactively monitor all circuits and contact both the service provider and HCP whenever the status of a link drops below the conditions specified in the SLA. This allows proactive monitoring to find and deal with adverse network conditions "in real time and before they have a chance to impact the delivery of patient care."[442] A HCP-operated NOC in some cases may be more cost-effective for larger networks (*e.g.*, statewide, or even multi-state networks), particularly when the NOC may be monitoring and managing circuits from multiple vendors.[443]

161. We do not express a preference for single- or multi-vendor networks here, nor do we suggest that it is always more efficient for a dedicated health broadband network to have its own NOC. For example, a network that chooses to obtain a single-vendor solution and obtain NOC service from that

[439] OHN PN Comments at 7 (explaining that rural sites do not have to manage firewalls if they utilize a dedicated connection to an urban hub and have all their public internet traffic managed by the hub location).

[440] An SLA is an agreement between a user and a service provider defining the nature of the service provided and establishing metrics for that service, trouble reporting procedures and penalties if the service provider fails to perform. *See National Broadband Plan* at 353. As discussed in the *Needs Assessment*, HCPs need services that are reliable, especially in emergency situations, and must meet stringent privacy and security standards. *See, e.g.*, OHN PN Comments at 9-10, 15 ("[i]n order for a site to rely on a network connection for real-time health care delivery, the HCP must be able to trust the connection will provide a quality level adequate to meet their needs *whenever that need arises*") (emphasis in original); *Needs Assessment* (Appendix B) at para. 3, 21. SLAs, however, typically require the customer to register a complaint and have the vendor respond reactively, rather than having the service provider proactively monitor service levels. *See* OHN PN Comments at 15 (stating that most service providers do not have alarms or alerts set for metrics like jitter, latency, and packet loss (despite established SLAs), and issues related to these metrics are handled in a reactive manner by the vendor putting a probe in place when a complaint is registered). Furthermore, if multiple service providers are involved in providing a connection, identifying the service provider responsible for remedying a problem can take "an inordinate amount of time." *Id.* This could pose a particular challenge for smaller rural HCPs, given their limited resources, lack of technical expertise, and limited broadband options.

[441] *See, e.g.*, IRHN PN Comments at 10 (explaining that the IRHN is managed and operated by a best-in-class NOC that can track each location because of the installation of IRHN-owned network terminal devices at each HCP location and optical switches in key network node locations).

[442] OHN PN Comments at 15; *see also* NETC PN Reply at 3 (one benefit of the NETC network is "the ability of the NOC to proactively respond and hold vendors accountable for meeting their service level obligations").

[443] For example, NETC states that constructing fiber infrastructure was not feasible given the size and remoteness of its service area (New Hampshire, Vermont, and Maine), and it had to leverage existing carrier infrastructure from multiple service providers. Therefore, a significant part of NETC's start-up costs reflected investment in equipment, including "large routers at the network core," and this one-time investment was a critical part of the estimated $135 million in cost savings estimated for participating HCPs. NETC Reply at 2-5. Similarly, IRHN states that it could not have accomplished a cost-efficient network with a single RFP for all services. One vendor did submit such a response, which was more than ten times the amount of IRHN's Pilot Program award. Instead, IRHN has utilized leased services (from for-profit and not-for profit service providers), wireless point-to-point, IRUs, owned equipment, leased equipment, and owned last-mile fiber laterals (approximately 1600 miles of fiber-based services) to stitch together a network transparent to the hospital users. IRHN PN Comments at 9-10.

vendor may receive support for the NOC service as a broadband service, if that solution is the most cost-effective. Our actions today simply facilitate the ability of a consortium to operate its own NOC, if that is the most cost-effective option.

162. Eligible equipment costs include the following:

- Equipment that terminates a carrier's or other provider's transmission facility and any router/switch that is directly connected to either the facility or the terminating equipment.[444] This includes equipment required to light dark fiber, or equipment necessary to connect dedicated health care broadband networks or individual HCPs to middle mile or backbone networks;[445]
- Computers, including servers, and related hardware (*e.g.*, printers, scanners, laptops) that are used exclusively for network management;[446]
- Software used for network management, maintenance, or other network operations, and development of software that supports network management, maintenance, and other network operations;[447]
- Costs of engineering, furnishing (*i.e.*, as delivered from the manufacturer), and installing network equipment;[448] and
- Equipment that is a necessary part of HCP-owned facilities.[449]

163. Support for network equipment is limited to equipment purchased or leased by an eligible HCP that is used for health care purposes.[450] We do not authorize support, for example, for network equipment utilized by telecommunications providers in the ordinary course of business to operate and manage networks they use to provide services to a broader class of enterprise customers, even if eligible HCPs are utilizing such services. Non-recurring costs for equipment purchases are subject to the limitations below on all upfront charges.

C. Ineligible Costs

164. Services and equipment eligible for support under the Healthcare Connect Fund are limited to those listed in sections V.A and V.B above. For administrative clarity, however, we also list below some specific examples of costs that are not supported.

---

[444] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20398, para. 75; *cf. NPRM*, 25 FCC Rcd at 9389-90, para. 42.

[445] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20397-8, para. 74 (supporting the costs of connecting networks to the public Internet, Internet2, or NLR).

[446] *See id.* at 20398, para. 75; *cf. NPRM*, 25 FCC Rcd at 9389-90, para. 42. We clarify that "network" refers to the broadband network, not (for example) the organization ("network") of HCPs.

[447] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20398, para. 75; *cf. NPRM*, 25 FCC Rcd at 9389-90, para. 42.

[448] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20397-98, para. 74; *cf. NPRM*, 25 FCC Rcd at 9386, para. 35.

[449] *See supra* section IV.C.

[450] *See, e.g.*, NETC PN Reply at 2 (noting that the NETC leased services network includes HCP-owned network routers).

1. Equipment or Services Not Directly Associated with Broadband Services

165. *Background.* Broadband services and dedicated health broadband networks enable HCPs to run numerous broadband-enabled health care applications (for example, videoconferencing, medical image transfer, and EHRs). Some commenters requested that the Fund support equipment or services associated with these applications.[451]

166. *Discussion.* In keeping with our goals to increase access to broadband, foster development of broadband health care networks, and maximize cost-effectiveness, we provide support under the Healthcare Connect Fund for the cost of equipment or services necessary to make a *broadband service* functional, or to manage, control, or maintain a *broadband service* or a *dedicated health care broadband network.*[452] Certain equipment (*e.g.*, switches, routers, and the like) are necessary to make the broadband service functional – conceptually, these are "inputs" into the broadband service. Other equipment or services (*e.g.*, telemedicine carts, or videoconferencing equipment, or even a simple health care-related application) "ride over" the broadband connection – *i.e.*, in those cases, the broadband connectivity is an "input" to making the equipment or service functional. In this latter case, the equipment or service is not eligible for support.[453] This distinction is consistent with that utilized in the Pilot Program.[454]

167. In particular, costs associated with general computing, software, applications, and Internet content development are not supported, including the following:

- Computers, including servers, and related hardware (*e.g.*, printers, scanners, laptops), (unless used exclusively for network management, maintenance, or other network operations);
- End user wireless devices, such as smartphones and tablets;[455]

[451] *See, e.g.,* Geisinger PN Comments at 2 (arguing that funding for telemedicine equipment would help specialized organizations like Geisinger provide simpler, more usable telehealth solutions to resource-constrained community hospitals); UAMS Comments at 12-13 (arguing that training for the use of telemedicine applications should be an eligible cost);TIA Comments at 8 (recommending that the Commission provide funding for wireless user devices and video/web conferencing equipment with program funds); WWHI Comments at 3-4 (suggesting that the Commission fund wireless user devices as well as telemedicine applications and software). We note that the U.S. Department of Health and Human Services, through the Office of the National Coordinator, already provides extensive support for entities seeking to adopt electronic medical records. *See, e.g.,* HHS Comments at 2.

[452] *See* 47 U.S.C. § 254(h)(2)(A). We also find that limiting support to such equipment and services is consistent with the statutory directive that support be "economically reasonable." *Id.*

[453] To use the American Telemedicine Association's analogy, we provide support for the "on and off ramps" to the "highway" that is the broadband connection (*i.e.*, the terminating equipment, last mile build-out, etc.). We do not provide support, however, for the "cars" (*i.e.*, applications) that move over that highway, nor any equipment or services required to make use of, or maintain, a certain "car." *See* ATA Reply at 2.

[454] *See 2007 Pilot Program Selection Order,* 22 FCC Rcd at 20397-98, paras. 74-75.

[455] The Universal Service Fund historically has not supported end user devices. For example, in the *Lifeline and Link Up Reform and Modernization Order,* the Commission noted that the expense of consumer equipment necessary to accept the Internet has been shown to be a major barrier to broadband adoption, particularly for low-income households. Because the Fund has historically been used for services, not equipment, however, the Commission determined that it would not subsidize equipment purchase as part of the Lifeline pilot program. *See Lifeline and Link Up Reform and Modernization,* 27 FCC Rcd at 6804-6805, paras. 348-349; *see also Schools and Libraries Universal Service Support Mechanism,* CC Docket No. 02-6 *et al.*, Report and Order, 27 FCC Rcd 11348,

(continued…)

- Software (unless used for network management, maintenance, or other network operations);
- Software development (excluding development of software that supports network management, maintenance, and other network operations);
- Helpdesk equipment and related software, or services (unless used exclusively in support of eligible services or equipment);[456]
- Web hosting;
- Website portal development;
- Video/audio/web conferencing equipment or services; and
- Continuous power source.

168. Furthermore, costs associated with medical equipment (hardware and software), and other general HCP expenses are not supported. For example, the following is not supported:

- Clinical or medical equipment;
- Telemedicine equipment, applications, and software;
- Training for use of telemedicine equipment;
- Electronic medical records systems; and
- Electronic records management and expenses.

2. Inside Wiring/ Internal Connections

169. *Background*. The RHC Telecommunications Program has not historically provided support for "inside wiring" or "internal connections."[457] "Inside wiring" is customer-owned or controlled

(Continued from previous page)

11355 (App. B at para. 18) (Wireline Comp. Bur 2012) (listing smartphones and tablets as ineligible end-user equipment).

[456] In general, the Commission allows Fund recipients to utilize cost allocation for products or services that contain both eligible and ineligible functions. For "Help Desk" services (*i.e.* technical support contracts), however, the Commission has previously found that it is administratively difficult and burdensome to derive reasonable cost allocations for the eligible portions of services provided under the contract, given that vendors supply complex packages of services in the rapidly-changing technology marketplace. Therefore, the Commission has previously found in the E-rate context that technical support, including on-site Help Desks, is not eligible for support if it provides any ineligible features or functions. *See Schools and Libraries Universal Service Support Mechanism*, CC Docket No. 02-6, Third Report and Order and Second Further Notice of Proposed Rulemaking, 18 FCC Rcd 26912, 26922, para. 24 (2003). We find that the same considerations exist here. For example, HCPs could obtain a single technical support contract that includes support for eligible broadband services and ineligible telemedicine or EHR software. In such an instance, deriving and auditing a reasonable cost allocation between the eligible and ineligible component would be administratively difficult.

[457] *2003 Order and Further Notice*, 18 FCC Rcd at 24562, para. 30 (finding that there is insufficient information in the record to provide support for internal connections, and expressing concern that providing support for internal

(continued…)

wire on the *customer's* side of the demarcation point.[458] "Internal connections" is a concept used in the context of the E-rate program, and refers to services used for internal networks within school or library premises – more specifically, services "necessary to transport information within one or more instructional buildings of a single school campus or within one or more non-administrative buildings that comprise a single library branch."[459] Internal connections can be either wired or wireless.

170. *Discussion.* The American Telemedicine Association requests that the Commission provide support for "internal wiring."[460] As discussed above, the Healthcare Connect Fund will provide support for service provider build-out to the customer demarcation point, and for network equipment necessary to make a broadband connection functional. We conclude that support is better targeted at this time toward providing broadband connectivity *to* the HCP rather than internal networks *within* HCP premises. The record does not indicate that small HCPs (such as clinics) likely will incur large expenses for inside wiring or internal connections in order to utilize their broadband connectivity. For larger institutions such as hospitals, however, the cost of providing discounts for internal connections could be substantial.[461] Furthermore, as the Commission has acknowledged, it can be difficult to distinguish from "internal connections" and ineligible computers or other peripheral equipment.[462] In the E-rate context, the Commission relied on the congressional directive that the Fund provide connectivity all the way to *classrooms.*[463] There is no similar statutory directive with respect to HCPs. For these reasons, we decline to provide support for inside wiring or internal connections under the Healthcare Connect Fund.

3. Administrative Expenses

171. *Background*. In the Pilot Program, the Commission defined "administrative expenses" as the expenses associated with completing the application process and participating in the program, as well as other expenses that are not directly associated with network design, deployment, operations, and maintenance.[464] Neither the RHC Telecommunications Program nor the Pilot Programs provide funding for administrative expenses.[465]

(Continued from previous page)

connections may place an undue burden on the rural health care support mechanism); *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20398, para. 75 ("inside wiring" is an ineligible cost "except for equipment that terminates a carrier's or other provider's transmission facility and any router/switch that is directly connected to either the facility or the terminating equipment"); USAC RHC web site, *available at* http://www.universalservice.org/rhc/health-care-providers/step01/eligible-services.aspx (equipment and "wiring" not supported in Primary Program) (last visited Nov. 15, 2012).

[458] *See* 47 C.F.R. § 68.3.

[459] 47 C.F.R. § 54.502(a)(4).

[460] *See* ATA Comments at 6.

[461] *See Universal Service First Report and Order*, 12 FCC Rcd at 9012, para. 454 (noting that the cost of providing discounts for internal connections is substantial). *But compare* ATA Comments at 6 n.7 (estimating that it would only take $5,000 per site to provide internal connections wirelessly).

[462] *Universal Service First Report and Order*, 12 FCC Rcd at 9015, para. 459.

[463] *Id.* at 9013, paras. 455-56.

[464] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20399, para. 75; *see also NPRM*, 25 FCC Rcd at 9386, para. 37.

[465] *See, e.g.*, 47 C.F.R. §§ 54.601, 54.609; *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20398, para. 75.

172. The *NPRM* proposed to provide limited support for administrative expenses under the proposed Health Infrastructure Program, but not for the proposed Broadband Services Program.[466] The Commission acknowledged that some parties had argued that planning and designing network infrastructure deployment can place a burden on HCPs. The Commission also recognized, however, that "the primary focus of the program should be to fund infrastructure and not project administration."[467]

173. *Discussion.* Consistent with the objectives of streamlining oversight of the program and ensuring fiscal responsibility, we decline to fund administrative expenses associated with participation in the Healthcare Connect Fund. As discussed more fully below, we are taking significant steps today to streamline and simplify the application process, which will lessen the time and resources needed to participate in the program. Moreover, because we expect that most HCPs in the new program will choose to purchase services rather than construct and own facilities, the rationale for funding of administrative expenses is lessened.[468]

174. The Commission has recognized that administrative expenses of organizing networks and applying for universal service support can be substantial.[469] In response, we are taking steps throughout this Order to minimize the administrative burden of participating in the Healthcare Connect Fund.[470] First, we put in place a streamlined application process that facilitates consortium applications, which should enable HCPs to file many fewer applications and to share the administrative costs of all aspects of participation in the program.[471] Second, we adopt a uniform flat-rate discount to simplify the calculation of support, particularly when compared with the urban/rural differential approach of the Telecommunications Program.[472] Third, we enable multi-year funding commitments, long-term arrangements (*e.g.*, IRUs and pre-paid leases), and the use of existing MSAs.[473] Fourth, we expand eligibility to include all HCPs, with rules in place to ensure a reasonable balance of rural and non-rural sites within health care networks.[474] In the Pilot Program, HCPs that did not meet our long-standing definition of "rural" HCPs frequently provided administrative and technical support to the consortia, thereby reducing the burden on individual HCPs. Finally, we eliminate the competitive bidding requirement for applicants seeking support for $10,000 or less of total undiscounted eligible expenses for a single year.[475] We find that the combination of these reforms, among others, should significantly reduce

---

[466] *See NPRM*, 25 FCC Rcd at 9386, para. 37 ("We propose that, for the health infrastructure program only, reasonable administrative expenses incurred by participants for completing the application process may be eligible for some limited support.").

[467] *See NPRM*, 25 FCC Rcd at 9387, para. 38.

[468] Commenters generally recognize that the administrative burdens associated with a services program are far less than under an infrastructure program. *See, e.g.*, Geisinger Reply Comments at 4-6 (discussing the substantial administrative burdens of the Health Infrastructure Program); HEIM Reply Comments at 10 (discussing the "unexpectedly burdensome" infrastructure funding process). As in the Pilot Program, we expect the vast majority of HCPs to purchase services rather than deploy HCP-owned infrastructure. *Pilot Evaluation* at 9414-14, paras. 47-49.

[469] *See, e.g.*, *Pilot Evaluation* at 9445-46, para. 95 (discussing the burden of ineligible administrative expenses under the Pilot Program); *NPRM*, 25 FCC Rcd at 9386-87, para. 37.

[470] *See, e.g.*, Geisinger Reply Comments at 4 ("Minimizing the administrative burden on program participants will serve the dual purposes of increasing meaningful participation in the HIP from smaller, resource scarce providers as well as ensuring that HIP funding has its greatest impact.").

[471] *See supra* section VI.

[472] *See supra* section IV.D.1; *see* 47 C.F.R. § 54.609(a).

[473] *See supra* section VI.C.4.

[474] *See supra* section IV.B.2.

the administrative burden on participants in terms of the complexity, volume, and frequency of filings, thereby addressing concerns raised by some commenters regarding the administrative burdens of participating in the program. In contrast, if we were to provide direct support for administrative expenses, it would necessitate additional and more complex application requirements, guidelines, and other administrative controls to protect such funding from waste, fraud, and abuse.[476] This would significantly increase the administrative burden on USAC and on applicants as well.

175. We recognize that many commenters support the provision of support for administrative expenses.[477] Some commenters suggest that the funding of reasonable administrative expenses is necessary to ensure participation in the program.[478] However, experience with the existing programs suggests that HCPs will participate even without the program funding administrative expenses.[479] Neither the Telecommunications nor Pilot Programs fund administrative expenses, but both programs have significant participation. The number of participating HCPs in the Telecommunications Program has grown by nearly 10 percent year-over-year for the past five years.[480] Similarly, the Pilot Program has experienced substantial and sustained interest with just over 3,800 HCP sites receiving funding

(Continued from previous page)

[475] *See infra* section VI.B.6.a.

[476] Competitive grant programs, such as Broadband Technology Opportunities Program (BTOP) or Broadband Initiatives Program (BIP), typically impose detailed and cumbersome compliance requirements for the funding of administrative expenses to guard against waste, fraud, and abuse. *See, e.g.*, AHA Comments at 6-7; Broadband Technology Opportunities Program, U.S. Department of Commerce, National Telecommunications and Information Administration, Round 2 Grant Guidance at 88, http://www2.ntia.doc.gov/files/BTOP_NOFA2GrantGuidance_100319.pdf (Mar. 19, 2010) (requiring for administrative expenses that the applicant "provide a breakout of position(s), time commitment(s) such as hours or level-of-effort, and salary information/rates with a detailed explanation, and additional information as needed").

[477] *See, e.g.*, HHS Comments at 5-6; NCTN Comments at 6; CTN Comments at 14; Internet2 Comments at 12; NATOA Reply Comments at 8; WNYRAHEC PN Comments at 7 (suggesting that "the Commission should provide administrative reimbursement to the consortiums for the time invested in preparation of the RFP, the RFP processing, bid reviews and vendor selection as a percentage of the initial award amount").

[478] *See* RWHC Comments at 5; *see also* AHA Comments at 2 (suggesting that "heavy administrative burdens limit participation" in the current Rural Health Care programs); RNHN PN Reply Comments at 6 (stating that the exclusion of administrative expenses is "a material failing of the program and was a significant problem for the Pilot Program").

[479] *See, e.g.*, CTN Comments at 14 (selecting an "architecture and service model that relied heavily upon existing providers, who could amortize administrative and technical support costs into their standard pricing models and legitimately receive subsidies from FCC, part of which cover such costs"); Quarterly Report of Indiana Telehealth Network, WC Docket No. 02-60 (filed Jan. 27, 2012) at 34 (covering administrative expenses by charging participating hospitals and other rural health care facilities $2,400 and $1,200 respectively per year); Pilot Conference Call Mar. 26 *Ex Parte* Letter (WNYRAHEC *et al.*) at 3 (network partners contribute money towards administrative expenses); *Pilot Evaluation*, 27 FCC Rcd at 9442, para. 89 (stating that "[m]any of the Pilot projects have depended on the financial and human resources of urban entities to absorb the administrative costs of participation in the Pilot").

[480] USAC Nov. 16 Data Letter at 2.

commitments.[481] We expect that the participation in the RHC support mechanism will only increase with the implementation of the Healthcare Connect Fund and its more streamlined administrative process.[482]

176. In addition, commenters have not explained how we could readily distinguish reasonable from unreasonable administrative expenses and ensure fiscal responsibility and cost effective use of the finite support available for eligible HCPs.[483] Without a clear standard, there would be increased complexity and cost in policing the reimbursement of these expenses to guard against waste, fraud, and abuse.[484] By reducing the administrative burden, rather than directly funding administrative expenses, we seek to facilitate increased participation while still ensuring fiscal responsibility and the efficient use of scarce universal service funding.

177. Consistent with the approach taken by the Commission in the *Pilot Program Selection Order*, we conclude that administrative expenses will not be eligible for support under the Healthcare Connect Fund. Ineligible expenses include, but are not limited to, the following expenses:[485]

- Personnel costs (including salaries and fringe benefits), except for personnel costs in a consortium application that directly relate to designing, engineering, installing, constructing, and managing the dedicated broadband network. Ineligible costs of this category include, for example, personnel to perform program management and coordination, program administration, and marketing.
- Travel costs, except for travel costs that are reasonable and necessary for network design or deployment and that are specifically identified and justified as part of a competitive bid for a construction project.
- Legal costs.
- Training, except for basic training or instruction directly related to and required for broadband network installation and associated network operations. For example, costs for end-user training, such as training of HCP personnel in the use of telemedicine applications, are ineligible.
- Program administration or technical coordination (*e.g.*, preparing application materials, obtaining letters of agency, preparing request for proposals, negotiating with vendors, reviewing bids, and working with USAC) that involves anything other than the design, engineering, operations, installation, or construction of the network.
- Administration and marketing costs (*e.g.*, administrative costs; supplies and materials (except as part of network installation/construction); marketing studies, marketing activities, or outreach to potential network members; evaluation and feedback studies).
- Billing expenses (*e.g.*, expense that service providers may charge for allocating costs to each HCP in a network).
- Helpdesk expenses (*e.g.*, equipment and related software, or services); technical support services that provide more than basic maintenance.[486]

---

[481] *Id.* at 1.

[482] *See, e.g.*, UVA Comments at 5 (suggesting that "greater utilization of the RHCS program will occur with administrative simplification"); *see also* HEIM Comments at 18 (suggesting that administrative burden has discouraged HCPs from participating in the RHC program).

[483] *See, e.g.*, RNHCN Comments at 8 (suggesting that funding should be provided for any cost that that "can be shown to be reasonable and related to the project"); IHS Comments at 4 (seeking to relax the proposed limits on administrative expense funding); HIEM Comments at 23-24 (suggesting that support for administrative be expanded to include reasonable legal expenses and expenses incurred prior to applying for support).

[484] *See supra* n.476.

[485] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20398, para. 75.

4. Cost Allocation for Ineligible Entities, Sites, Services, or Equipment

178. *Background.* Sections 254(h)(4) and (h)(7)(B) of the Act limit the entities eligible to receive support under the health care support mechanism to eligible public or non-profit "health care providers," as defined in those sections of the Act.[487] Section 254(h)(3) of the Act provides that telecommunications services and network capacity provided to an eligible HCP through the health care support mechanism may not be "sold, resold, or otherwise transferred by [the HCP] in consideration for money or any other thing of value" (the "resale prohibition").[488] Section 254(h)(2)(A) of the Act, which describes the scope of the Commission's authority to provide support to HCPs, forms the basis for the eligible services and equipment that will be supported through the Healthcare Connect Fund.[489] Taken together, these three statutory provisions, as interpreted in this Order, define the scope of eligible participants and services/equipment for Healthcare Connect Fund support.

179. *Discussion.* Costs associated with ineligible sites or ineligible components of services or equipment are ineligible for support, except as otherwise specified in this Order.[490] Ineligible sites, however, may participate in consortia and dedicated broadband health networks supported through this program, as long as they pay a fair share of the undiscounted costs associated with the consortium's funding request. Similarly, an applicant is only eligible to receive support for the eligible components of a service or a piece of equipment.

180. There are a wide variety of contexts in which it may be more cost-effective for eligible HCPs to share costs with ineligible entities,[491] or to procure a service or piece of equipment that includes both eligible and ineligible components. The Commission has allowed such cost-sharing in the past in the RHC Telecommunications Program and the Pilot Program, and we will allow it in the Healthcare Connect Fund.[492] Such permissible cost-sharing includes the following:

- *Sharing with ineligible entities.* In the case of statewide or regional health care networks, it may be useful for health care purposes to have both eligible and ineligible HCPs participate in the same network, and share certain backbone or network equipment costs between all participants in the network. Having both eligible and ineligible entities contribute to shared costs may lead to lower overall costs for the eligible HCPs, and enables HCPs to benefit from connections to a greater number of other HCPs, including for-profit HCPs that are not eligible for funding under section 254 but nevertheless play an important role in the overall health care system.[493] The Commission has previously found that the resale prohibition does not

(Continued from previous page)

[486] *Cf. Schools and Libraries Universal Service Support Mechanism*, CC Docket No. 02-6, Third Report and Order and Second Further Notice of Proposed Rulemaking,18 FCC Rcd 26912, 26922, para. 24 (2003) (clarifying that technical support, including on-site Help Desks, is not eligible for support if it provides more than basic maintenance).

[487] 47 U.S.C. §§ 254(h)(7)(B), 254(h)(3).

[488] 47 U.S.C. § 254(h)(3).

[489] 47 U.S.C. § 254(h)(2)A).

[490] *See supra* section V.A.5.

[491] "Ineligible entities" include both HCPs who are not eligible for program support, and entities who are not HCPs.

[492] *2003 Order and Further Notice*, 18 FCC Rcd at 24554-55, para. 15; *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20399, 20416, paras. 76, 107-108.

[493] *See, e.g.,* Geisinger PN Comments at 2 (arguing that many for-profit community hospitals treat underserved populations and are severely resource-constrained); CTN PN Comments at 9-10 (stating that rural safety net doctors

(continued…)

prevent Pilot Program networks from "sharing" facilities with for-profit entities that pay their "fair share" of network costs (*i.e.*, that do not receive discounts provided to eligible HCPs, but instead pay their full *pro rata* undiscounted share as determined by the portion of network capacity used).[494]

- *Allocating cost between eligible and ineligible components.* A product or service provided under a single price may contain both eligible and ineligible components. For example, a service provider may provide a broadband internet access service (eligible) and, as a component of that service, include web hosting (ineligible). While it may be simpler to buy the eligible and ineligible components separately, in some instances it is more cost-effective for HCPs (and the Fund) to buy the components as a single product or service. In such cases, applicants may need guidance on if, and how, they should allocate costs between the eligible and ineligible components.
- *Excess capacity in fiber construction.* In the *NPRM*, the Commission noted that it is customary to build excess capacity when deploying high-capacity fiber networks, because the cost of adding additional fiber to the conduit is minimal.[495] In the Pilot Program, the Commission found that a Pilot participant could not "sell" network capacity supported by Pilot funding, but could "share" network capacity with ineligible entities paying a fair share of network costs attributable to the portion of network capacity used.[496] Consortia that seek support to construct and own their own fiber networks may wish to put in extra fiber strands during construction and make the excess capacity available to other users.
- *Part-time eligible HCPs.* Under current rules, entities that provide eligible health care services on a part-time basis are allowed to receive prorated support commensurate with their provision of eligible health care services. For example, if a doctor operates a non-profit rural health clinic on a non-profit basis in a rural community one day per week or during evenings in the local community center, that community center is eligible to receive prorated support, because it serves as a "rural health clinic" on a part-time basis.[497]

181. In the settings described above, we conclude that eligible HCP sites may share costs with ineligible sites, as long as the ineligible sites pay a "fair share" of the costs. We use "fair share" here as a term of art that, in general, refers to the price or cost that an ineligible site must pay to participate in a supported network, or share supported services and equipment, with an eligible HCP.[498] To determine fair share, an applicant is required to apply the following principles:

(Continued from previous page)

in rural communities typically have a for-profit tax status); UAMS PN Comments at 7 (recommending that the Commission adopt rules which expressly encourage the participation of for-profit consortium members).

[494] *2006 Pilot Program Order*, 21 FCC Rcd at 11116-17, para. 17.

[495] *NPRM*, 25 FCC Rcd at 9400, para. 67 and n.133.

[496] *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20416, para. 107.

[497] *2003 Order and Further Notice*, 18 FCC Rcd at 24555-56, para. 15.

[498] Indiana Rural Health Association *et al.* state that transactions between HCPs are, in great part, controlled by federal bodies of law generally known as the Stark law and the Anti-Kickback statute, which are part of the Social Security Act. See 42 U.S.C. § 1395nn (Stark Act); 42 U.S.C. § 1320a-7b (anti-kickback statute). IRHA et al. state that safe harbors and exceptions under these laws generally dictate that the transaction be completed at fair market value or in some financial arrangement that meets the specific dictates of the applicable exception or safe harbor. *See* IRHA *et al*. PN Comments at 19-20. The comments, however, do not include sufficient detail to enable us to determine whether the interaction of these health care statutes and section 254 of the Act raise additional issues that

(continued…)

- First, if the service provider charges a separate and independent price for each site, an ineligible site must pay the full undiscounted price.[499] For example, if a consortium has negotiated certain rates that are applicable to all sites within the consortium, an ineligible HCP site must pay the full price without receiving a USF discount. Similarly, if the consortium has received a quote from the service provider for the individualized costs of serving each member of the consortium, an ineligible member must pay the full cost without receiving a USF discount.
- Second, if there is no separate and independent price for each site, the applicant must prorate the undiscounted price for the "shared" facility (including any supported maintenance and operating costs) between eligible and ineligible sites on a proportional fully-distributed basis, and the applicant may seek support for only the portion attributable to the eligible sites. Applicants must make this cost allocation using a method that is based on objective criteria and reasonably reflects the eligible usage of the shared facility. For example, a network may choose to divide the undiscounted price of the shared facility equally among all member sites, and require ineligible sites to pay their full share of the price.[500] Other possible metrics, depending on the services utilized, may include time of use, number of uses, amount of capacity used, or number of fiber strands.[501] The applicant bears the burden of demonstrating the reasonableness of the allocation method chosen.

182. Because we define eligible services and equipment for the Healthcare Connect Fund broadly in this Order, we do not anticipate that applicants will encounter many situations in which they purchase or lease a single service or piece of equipment that includes both eligible and ineligible components. Nonetheless, we also provide guidelines herein for allocating costs when a single service or piece of equipment includes an ineligible component.[502] Applicants seeking support for a service or equipment that includes an ineligible component must also explicitly request in their RFP that service providers should also provide pricing for a comparable service or piece of equipment that includes only eligible components. If the selected provider also submits a price for the eligible component on a stand-

(Continued from previous page)

must be addressed herein. We note that our fair share standard defines the *minimum* costs that an ineligible entity must bear in order to ensure that it does not receive support from the Fund. Nothing in our rules prevents an ineligible HCP from paying more than its "fair share" in order to ensure that it also complies with any applicable health care laws.

[499] By "undiscounted price," we mean the price that the site would pay before application of USF support amounts (*i.e.*, the 65 percent discount, for which the site is ineligible). If a consortium receives a discount as a result of the normal group buying/ competitive bidding process, ineligible sites may take advantage of the group discount.

[500] It is permissible for program participants to set up classes of pricing based on reasonable factors other than Healthcare Connect Fund eligibility. For example, a consortium may wish to set different rates for hospitals versus rural health clinics, given that rural health clinics in general can be more resource-constrained than hospitals.

[501] *See, e.g., 2003 Order and Further Notice*, 18 FCC Rcd at 24571-72, paras. 50-51 (providing "safe harbor" examples). Consortium applicants who construct their own facilities may wish to bear the full additional cost of installing extra strands of fiber (*i.e.* no Fund support for the extra strands), then use future revenues from such excess capacity to meet their 35 percent contribution requirement. In such an instance, additional restrictions apply to the consortium's use of the revenues from the excess capacity, and the consortium must retain ownership of the extra fiber strands. *See supra* section IV.D.3.

[502] As discussed above in n.456, technical support, including on-site Help Desks, is not eligible for support (*i.e.* on a cost-allocated basis) if it provides any ineligible features or functions.

alone basis, the support amount is capped at the stand-alone price of the eligible component.[503] If the service provider does not offer the eligible component on a stand-alone basis, the full price of the entire service or piece of equipment must be taken into account, without regard to the value of the ineligible components, when determining the most cost-effective bid.[504]

183. We delegate authority to the Bureau to issue further guidelines, as needed, to interpret the cost allocation methods above or provide guidance on how to apply the methods to particular factual situations.

184. Applicants must submit a written description of their allocation method(s) to USAC with their funding requests. Allocations must be consistent with the principles set forth above. If ineligible entities participate in a network, the allocation method must be memorialized in writing, such as a formal agreement among network members, a master services contract, or for smaller consortia, a letter signed and dated by all (or each) ineligible entity and the Consortium Leader. For audit purposes, applicants must retain any documentation supporting their cost allocations for a period consistent with the recordkeeping rules in section VII.A of this Order.

D. Limitations on Upfront Payments

185. *Background.* In the *NPRM*, the Commission proposed to require upfront charges more than $500,000 to be part of a multi-year contract and prorated over a period of at least five years.[505] As discussed above, obtaining a broadband connection suitable for health care purposes, or implementing a dedicated health care broadband network, can involve a number of upfront charges. These may include, for example, service provider build-out costs, upfront charges associated with leases or IRUs for dark or lit fiber, equipment, or HCP self-construction costs.

186. In the Pilot Program, approximately 87 percent of HCPs have received commitments for some amount of non-recurring charges (excluding ordinary installation charges). Total support for non-recurring charges was $25,000 or less per site for approximately 68 percent of Pilot sites; $50,000 or less per site for approximately 80 percent of sites; and $100,000 or less per site for approximately 88 percent of sites.[506]

187. *Discussion.* Support for upfront payments can play an important part in ensuring that HCPs can efficiently obtain the broadband connections they need in a cost-effective manner. We therefore adopt a rule providing support for upfront payments, but include certain limitations to ensure the

[503] For example, if a service that includes both an eligible and ineligible component costs $100, and the service provider separately sells just the eligible component for $50, then support is limited to 65 percent of $50. On the other hand, if the service provider separately sells just the eligible component for $150, then support is limited to 65 percent of $100 (the price for the service that includes both eligible and ineligible components).

[504] This requirement implements the standard that the service must be "the most cost-effective means of receiving the eligible services, without regard to the value of the ineligible functionality." *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20399, para. 76 ("We note that if a product or service contains both eligible and ineligible components, costs should be allocated to the extent that a clear delineation can be made between the eligible and ineligible components. The clear delineation must have a tangible basis and the price for the eligible portion must be the most cost-effective means of receiving the eligible service. If the ineligible functionality is ancillary to an eligible component, the costs need not be allocated to the ineligible functionality. An ineligible functionality may be considered "ancillary" if (1) a price for the ineligible component that is separate and independent from the price of the eligible components cannot be determined, and (2) the specific package remains the most cost-effective means of receiving the eligible services, without regard to the value of the ineligible functionality.").

[505] *NPRM*, 25 FCC Rcd at 9411, para. 102.

[506] USAC Nov. 16 Data Letter at 3.

most cost-effective use of Fund support and to deter waste, fraud, and abuse. The limitations in this section apply to all non-recurring costs, other than reasonable and customary installation charges of up to $5,000.[507] USAC reports that in both the "Primary" (Telecommunications and Internet Access and Pilot Programs, service providers do not typically assess "installation charges" in excess of $5,000 if no new build-out is required to provide a service (*i.e.*, the "installation charge" is entirely for the cost of "turning on" services over existing facilities).[508] Therefore, we find that it is appropriate to treat installation charges of up to $5,000 as "ordinary" installation charges, and apply limitations only to charges above that amount.[509]

188. The limitations are as follows. First, as discussed above, upfront payments associated with services providing a bandwidth of less than 1.5 Mbps (symmetrical) are not eligible for support.[510] By their nature, upfront payments are intended to amortize the cost of new service deployment or installation that will be enjoyed for years in the future; in other words, HCPs should continue to reap the benefits from the upfront payments beyond the funding year in which support is requested. We do not believe it is an efficient use of the Healthcare Connect Fund to support upfront payments for speeds which may increasingly become inadequate for HCP needs in the near future.

189. Second, we limit support for upfront payments to consortium applications, to create greater incentives for HCPs to join together in consortia and thereby obtain the pricing benefits of group purchasing and economies of scale, as demonstrated in the Pilot Program.[511]

190. Third, we impose a $150 million annual limitation on total commitments for upfront payments and multi-year commitments.[512] We do so in order to limit major fluctuations in Fund demand, although we anticipate that the $150 million should be sufficient to meet demand for upfront payments given the other limitations we impose in this section. Fourth, we will require that consortia prorate support requested for upfront payments over at least three years if, on average, more than $50,000 in upfront payments is requested per HCP site in the consortium.[513] Fifth, upfront payments must be part of

[507] As discussed above, eligible HCPs may receive support for up to $5,000 in reasonable and ordinary installation charges. *See supra* section V.A.6. The limitations on upfront payments do not apply to such installation costs. Thus, for example, eligible HCPs may receive support for reasonable and ordinary installation charges up to an undiscounted cost of $5,000 even if they are seeking support for an internet access service at speeds that are 1 Mbps or less (symmetrical). Similarly, eligible HCPs may apply as individual applicants (rather than as part of consortium applications), and still receive support for reasonable and ordinary installation charges up to $5,000.

[508] USAC Nov. 16 Data Letter at 2.

[509] *See supra* section V.A.6.

[510] *See supra* section V.A.2.

[511] *Pilot Evaluation*, 27 FCC Rcd at 9436-37, paras. 81-83 (lower rates, higher bandwidth, better service quality); *id.* at 9435, para. 77 (availability of administrative resources to smaller HCPs); *id*. at 9437, para. 82 (willingness of vendors to serve remote sites).

[512] *See infra* section VI.C.4 (discussion of multi-year commitments).

[513] For example, if an eligible hospital owns an eligible rural health clinic which is located in a different town, the $50,000 limit would apply separately to the hospital and to the rural health clinic The $50,000 limit only applies to upfront payments, not recurring charges. Furthermore, $50,000 is an *average* per site limit; it is not a limit on the upfront payments that can be requested for any individual HCP. We apply this methodology in order to ensure that HCPs located in areas where access to broadband facilities is particularly expensive to obtain can participate in consortia. For example, if a consortium has four sites, upfront payments for the consortium must be prorated over at least three years if the amount of upfront support requested is more than $200,000 ($50,000 x 4). Within the consortium, one site may need $100,000 in build-out costs, and another may only require $25,000.

a multi-year contract.[514] At $50,000 per site, $50 million per year would provide upfront support to 1,000 HCP sites. Given that total participation in the Pilot Program since 2006 has been approximately 3,900 providers to date,[515] we believe this is an adequate level of funding to meet HCP needs in the immediate future; we can revisit this conclusion if experience under the new program proves otherwise.

191. We do not adopt a per-provider cap for upfront payments at this time. Although most HCPs in the Pilot Program were able to obtain any necessary build-out at a cost below $50,000, a small percentage of HCPs incurred very high build-out costs.[516] Requiring these HCPs to apply as part of consortia should help them to obtain service at a lower cost; however, adopting a per-provider cap could have the unintended consequence of excluding the highest-cost HCPs from such consortia. Although we do not adopt a per-provider cap, we note that because the HCP will be responsible for paying a substantial contribution towards the cost of services received (*i.e.*, 35 percent), we anticipate that consortia will have every incentive to obtain the lowest prices possible.[517]

192. Finally, as discussed below in section VI.C.4, consortia that seek certain types of upfront payments will be subject to additional reporting requirements and other safeguards to ensure effective use of support.[518]

E. Eligible Service Providers

193. *Background.* In the *NPRM*, the Commission proposed to allow Broadband Services Program participants to seek supported services from any broadband provider, consistent with section 254(h)(2)(A),[519] as long as the participant selects the most cost-effective option to meet its health care needs.[520] The Commission noted that it had previously permitted HCPs to seek discounts on "the most cost-effective form of Internet access, regardless of the platform."[521] Furthermore, the Commission proposed to allow eligible HCPs to receive support for the lease of dark or lit fiber from any provider, including dark fiber that may be owned by state, regional or local governmental entities.[522]

194. *Discussion.* We conclude that eligible service providers for the Healthcare Connect Fund shall include any provider of equipment, facilities, or services that are eligible for support under the program, provided that the HCP selects the most cost-effective option to meet its health care needs.[523]

---

[514] We do not dictate the form of agreement that HCPs may use to obtain services that include such upfront payments.

[515] USAC Nov. 16 Data Letter at 1.

[516] *Id.* at 3.

[517] *See infra* section VI.D.

[518] *See infra* para. 296.

[519] 47 U.S.C. § 254(h)(2)(A).

[520] *NPRM*, 25 FCC Rcd at 9410, para. 98; *id.* at 9443, App. A (proposed § 54.635 (Eligible Service Providers)).

[521] *Id.* at 9410, para. 98 & n.185 (citing *2003 Order and Further Notice*, 18 FCC Rcd at 24561, para. 28, and *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20367-68, para. 16).

[522] *Id.* at 9411, para. 101.

[523] *See 2006 Pilot Program Order*, 21 FCC Rcd at 11114, para. 11 (allowing HCPs to choose any "provider of broadband connectivity needed to provide telehealth, including telemedicine, services"); *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20403, para. 83, n.268 (noting that "service provider" for the Pilot Program refers to any eligible provider of equipment, facilities, or services). For simplicity, we use the term "service provider" and the provision of "services" to include the provision of such items as equipment and the construction or upgrade of facilities (*e.g.*, an IRU) by a vendor to an eligible HCP or HCP consortium. For a summary of invoicing and payment procedures in the existing RHC programs, *see* USAC RHC Process Overview,

(continued…)

We reiterate that eligible services may be provided through any available technology, consistent with our competitive neutrality policy.[524] Commenters generally support a broad definition of eligible service providers, and state that allowing a wide variety of vendors will provide more competing options and thus will be more cost-effective.[525] We note that the Pilot Program, which allowed similar flexibility, had over 120 different vendors win contracts to provide services.[526]

195. We also adopt the *NPRM* proposal to allow eligible HCPs to receive support for the lease of dark or lit fiber from any provider, including dark fiber that may be owned by state, regional or local governmental entities,[527] and conclude that eligible vendors are not limited to telecommunications carriers or other types of entities historically regulated by the Commission.[528] Both non-profit (*e.g.*, Internet2 and NLR) and commercial service providers are eligible to participate. As discussed below in section VI.A.1.a, however, we will not allow a state government, private sector, or other non-profit entity to simultaneously act as a Consortium Leader/consultant *and* potential service provider, in order to preserve the integrity of the competitive bidding process.[529] We emphasize that HCPs must select the most cost-effective bid, and are under *no* obligation to select a particular vendor merely due to its "non-profit" status or its receipt of other federal funding (*e.g.*, BTOP grants, or Connect America Fund support), although we anticipate that providers who receive other federal funding may be in a position to provide services to HCPs at competitive rates.

(Continued from previous page)

http://www.universalservice.org/_res/documents/rhc/pdf/handouts/RHC-Welcome-Packet.pdf (last visited Oct. 18, 2012).

[524] *See, e.g.,* TIA PN Comments at 9 (noting that section 254 of the Communications Act requires that competitively neutral rules govern access to advanced telecommunications and information services for HCPs); WNYRAHEC PN Comments at 5 (recommending that the Commission remain technology neutral and provide flexibility in the program for technology advancements); IRHN PN Comments at 9 (stating that it was the allowance of "any currently available technology," in part, that enabled IRHN to implement a hybrid network that makes cost-effective use of a variety of technologies). The Pilot Program allowed projects to use "any currently available technology." *2007 Pilot Program Selection Order,* 22 FCC Rcd at 20376-77, para. 40.

[525] *See* CTN Comments at 23; NCTN Comments at 2 (supporting the proposal for discounts to be distributed to all types of service providers, which would help support broadband provided by municipalities and other non-traditional service providers); IRHN Comments at 16 (arguing that the capability for the use of non-traditional as well as traditional providers will measurably shorten the timeframe required to meet the nation's broadband objectives); RNHN Comments at 16 (stating that it does not matter which service provider offers connection, and by allowing legal latitude the FCC will serve the public interest by increasing option and reducing costs); WWHI Comments at 4 (arguing that limitations on service providers will only serve to increase costs to HCPs, and the Commission should allow for as many competing options as are feasible); IHS Comments at 7.

[526] *Pilot Evaluation,* 27 FCC Rcd at 9436-37, para. 81.

[527] *NPRM,* 25 FCC Rcd at 9411, para. 101.

[528] *Cf.* CENIC Jan. 13, 2011 *Ex Parte* at 1 (expressing concern that proposed definition of eligible service provider might be too narrow to include connections to state and regional nonprofit educational backbone networks). We use the terms "vendor" and "service provider" interchangeably in this order, and these terms include vendors of (1) network equipment supported as discussed in section V.B and (2) inputs necessary for the construction of HCP-constructed and owned facilities as discussed in section IV.C. Although an eligible vendor need not be a telecommunications carrier or other traditional telecommunications provider, for administrative purposes all vendors that participate in the Healthcare Connect Fund must obtain a Service Provider Identification Number (SPIN) from USAC. *See infra* section VI.C.1.

[529] *See infra* section VI.A.1.a.

VI. FUNDING PROCESS

196. USAC shall, working with the Bureau, develop the necessary application, competitive bidding, contractual, and reporting requirements for participants to implement the requirements set forth below to ensure the objectives of the program are met. A summary of the application process is provided in Appendix A.

A. Pre-Application Steps

1. Creation of Consortia

197. The Healthcare Connect Fund will provide support for both individual applications and consortium applications. With the reforms we adopt today, we encourage eligible entities to seek funding from the new program by forming consortia with other HCPs in order to obtain higher speed and better quality broadband and to recognize efficiencies and lower costs. For purposes of Healthcare Connect Fund, a "consortium" is a group of multiple HCP sites that choose to request support as a single entity.[530]

a. Designation of a Consortium Leader

198. *Background.* In the Pilot Program, each project was required to identify an organization that would be legally and financially responsible for conduct of activities supported by the Fund (the "lead entity").[531] In addition, each lead entity was required to identify an individual (the "project coordinator") who would be the point of contact for the project in its interactions with USAC. Consistent with Commission practice in the E-rate program, the Pilot Program allowed certain entities other than eligible HCPs (*i.e.* state organizations, public entities and non-profits) to act as administrative agents for eligible HCPs within a project.[532]

199. In the *NPRM*, the Commission proposed that consortium applicants for the proposed Health Infrastructure Program designate a lead entity that would be responsible for completing the application process. The Commission also proposed, similar to the Pilot Program, that state organizations, public entities and non-profits be allowed to apply on behalf of eligible HCPs as part of a consortium (*i.e.* as lead entities) to function in an administrative capacity for eligible HCPs within the consortium. The Commission noted, however, that such state organizations, public entities and non-profits would be prohibited from receiving any funding because they are not eligible HCPs. Instead, the *NPRM* proposed that the full value of any discounts, funding, or other program benefits secured by a state organization, public sector (governmental) entity or non-profit entity acting as a consortium leader would be passed on to the consortium members that are eligible HCPs.[533]

200. *Discussion.* Each consortium seeking support from the Healthcare Connect Fund must identify an entity or organization that will be the lead entity (the "Consortium Leader"). As a preliminary matter, we note that the *consortium* and the *Consortium Leader* can be the same legal entity, but are not required to be. For example, the consortium may prefer to designate one of its HCP members as the Consortium Leader or, as described below, an ineligible state or Tribal government agency or non-profit organization.

201. The consortium need not be a *legal* entity, although the consortium members may wish to form as a legal entity for a number of reasons. For example, if the consortium itself is to be legally and financially responsible for activities supported by the Fund (*i.e.* serve as the "Consortium Leader"), the

[530] *See* Appendix D, 47 C.F.R. § 54.630(a).

[531] *2006 Pilot Program Order*, 21 FCC Rcd at 11116, para. 17.

[532] *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20396-97, paras. 72-73.

[533] *NPRM*, 25 FCC Rcd at 9384, para. 27.

consortium should constitute itself as a legal entity.[534] In addition, the consortium may wish to constitute itself as a legally recognized entity to simplify contracting with vendors (*i.e.* if the consortium is not a legal entity, each individual participant may need to sign an individual contract with the service provider, or one of the consortium members may need to enter into a master contract on behalf of all of the other members).

202. The Consortium Leader may be the consortium itself (if it is constituted as a legal entity), an eligible HCP participating in the consortium, or an ineligible state organization, public sector (governmental) entity (including a Tribal government entity), or non-profit entity. An eligible HCP may serve as the Consortium Leader and simultaneously receive support. If an ineligible entity serves as the Consortium Leader, however, the ineligible entity is prohibited from receiving support from the Healthcare Connect Fund,[535] and the full value of any discounts, funding, or other program benefits secured by the ineligible entity must be passed on to the consortium members that are eligible HCPs.[536]

203. Certain state organizations, public sector entities (including Tribal government entities), or non-profit entities may wish to perform multiple roles on behalf of consortia, including (1) serving as lead entities; (2) providing consulting assistance to consortia; and/or (3) serving as a service provider (vendor) of eligible services or equipment for which consortia are seeking support. Potential conflict of interest issues arise in the competitive bidding process, however, if an entity serves a dual role as both Consortium Leader/consultant *and* potential service provider. The potential conflict is that the selection of the service provider may not be fair and open but may, in fact, provide an unfair advantage to the lead entity as service provider.

204. For that reason, we conclude that state organizations, public sector entities, or non-profit entities may serve as lead entities or provide consulting assistance to consortia if they do not participate as potential vendors during the competitive bidding process.[537] Conversely, if such entities wish to provide eligible services or equipment to consortia, they may not simultaneously serve as project leaders, and may not provide consulting or other expertise to the consortium to assist it in developing its request for services.[538] This restriction does not prohibit eligible HCPs from conducting general due diligence to determine what services are needed and to prepare for an RFP. Part of such due diligence may involve reaching out to known service providers – including state or other public sector entities – that serve the area to determine what services are available. Nor does the restriction prevent a service provider, once

---

[534] *See infra* para. 206 (providing additional information on legally and financially responsible entities within a consortium).

[535] *See infra* section IV.B.2.

[536] *NPRM*, 25 FCC Rcd at 9384, para. 27; *see* Appendix D, 47 C.F.R. § 54.631(b); *compare* 47 C.F.R. § 54.519 (E-rate). For example, suppose that Consortium A is comprised of a group of eligible HCPs. Consortium A designates B, a non-profit organization that is not itself an eligible HCP, as its Consortium Leader. B is not eligible to receive support from the Healthcare Connect Fund. However, Consortium A may receive support from the Healthcare Connect Fund, including support for shared services and equipment, and B may administer the services and equipment on behalf of Consortium A.

[537] *See infra* section VI.B.3 (requiring applicants to submit "Declaration of Assistance").

[538] We note that this restriction should not be an issue for eligible HCPs who are currently participating in, or wish to join, Pilot Program networks, because those networks have already completed competitive bidding under Pilot Program rules, and we adopt a competitive bidding exemption below for services provided under current Pilot Program contracts. Furthermore, Pilot Project Consortium Leaders generally are not service providers themselves, but instead negotiated contracts with vendors who actually received the Pilot Program funding. We also note that this should not be an issue for federal HCPs who are required to purchase supported services from a federal master contract, as we provide a competitive bidding exemption for such providers below. *See infra* section VI.B.6.b.

selected through a fair and open competitive bidding process, from assisting an eligible HCP with implementing the purchased services.

205. We recognize that certain state governmental entities, for example, may be large enough to institute an organizational and functional separation between staff acting as service providers and staff providing application assistance. Consistent with current practice in the E-rate program, we will allow state organizations, public sector entities, or non-profit entities, if they so choose, to obtain an exemption from this prohibition by making a showing to USAC that they have set up an organizational and functional separation.[539] This exemption, however, must be obtained before the consortium begins preparing its request for services. Examples of appropriate documentation for such a showing include organizational flow charts, budgetary codes, and supervisory administration.

206. The Consortium Leader's responsibilities include the following:

- *Legal and Financial Responsibility for Supported Activities.* The Consortium Leader is the legally and financially responsible entity for the conduct of activities supported by the Fund. By default, the Consortium Leader will be the responsible entity if audits or other investigations by USAC or the Commission reveal violations of the Act or our rules by the consortium, with the individual consortium members being jointly and severally liable if the Consortium Leader dissolves, files for bankruptcy, or otherwise fails to meet its obligations. We recognize that in some instances, a consortium may wish to have a Consortium Leader serve only in an administrative capacity and to have the consortium itself, or its individual members, retain ultimate legal and financial responsibility. Except for the responsibilities specifically described below, we will allow consortia to have flexibility to allocate legal and financial responsibility as they see fit, provided that this allocation is memorialized in a formal written agreement between the affected parties (*i.e.* the Consortium Leader, and the consortium as a whole and/or its individual members), and the written agreement is submitted to USAC for approval with or prior to the Request for Services (Form 461). The agreement should clearly identify the party(ies) responsible for repayment if USAC is required, at a later date, to recover disbursements to the consortium due to violations of program rules. USAC is directed to provide, in writing by the expiration of the 28-day competitive bidding period, either approval or an explanation as to why the agreement does not provide sufficient clarity on who will be responsible for repayment. If USAC provides such comments, it shall provide the Consortium Leader with a minimum of 14 calendar days to respond. USAC is prohibited from issuing a funding commitment to the consortium until the Consortium Leader either takes on the default position as responsible entity, or provides an agreement that adequately identifies alternative responsible party(ies).
- *Point of Contact for the FCC and USAC.* The Consortium Leader is responsible for designating an individual who will be the "Project Coordinator" and serve as the point of contact with the Commission and USAC for all matters related to the consortium. The Consortium Leader is responsible for responding to Commission and USAC inquiries on behalf of the consortium members throughout the application, funding, invoicing, and post-invoicing period.
- *Typical Applicant Functions, Including Forms and Certifications.* The Consortium Leader is responsible for submitting program forms and required documentation and ensuring that all information and certifications submitted are true and correct. As stated above, this

[539] *See* USAC web site on Educational Service Agencies, http://www.usac.org/sl/applicants/beforeyoubegin/esa.aspx (last visited Dec. 3, 2012) (discussing how state educational agencies may avoid conflicts of interest in the E-rate program).

responsibility may not contractually be allocated to another entity. The Consortium Leader may be asked during an audit or other inquiry to provide documentation that supports information and certifications provided. The Consortium Leader must also collect and retain a Letter of Agency (LOA) from each member, as discussed below.

- *Competitive Bidding and Cost Allocation.* The Consortium Leader is responsible for ensuring that the competitive bidding process is fair and open and otherwise complies with Commission requirements. If costs are shared by both eligible and ineligible entities, the Consortium Leader must also ensure that costs are allocated in a manner that ensures that only eligible entities receive the benefit of program discounts.
- *Invoicing.* The Consortium Leader is responsible for the invoicing process, including certifying that the participant contribution has been paid and that the invoice is accurate.
- *Recordkeeping, Site Visits, and Audits.* The Consortium Leader is also responsible for compliance with the Commission's recordkeeping requirements, and coordinating site visits and audits for all consortium members, as outlined in section VII.A of this Order.[540]

b. Participating Health Care Providers

207. Next, the consortium should identify all HCPs who will participate. The Consortium Leader will need to provide this information to USAC in order to request program support. We intend for eligible HCPs to have broad flexibility in organizing consortia according to their health care needs. For example, a consortium may be a pre-existing organization formed for reasons unrelated to universal service support (*e.g.* a regional telemedicine network, a statewide health information exchange), or a group newly formed for the purpose of applying for Healthcare Connect Fund support. Consortium members may be affiliated (formally or informally) or unaffiliated. As discussed above, ineligible HCPs may participate in consortia, although they are not eligible to receive support and must pay full cost (fair share) for all services received through the consortium.[541]

c. Letters of Agency

208. *Background.* Under the Pilot Program, each consortium applicant was required to include with its FCC Form 465 (the request for services) a Letter of Agency from each participating health care facility to authorize the lead project coordinator to act on its behalf. The purpose of the LOA requirement was to demonstrate that each HCP had agreed to participate in the applicant's network and to avoid improper duplicate support for HCPs participating in multiple Pilot networks or in the RHC Telecommunications or Internet Access Programs.[542] In the *NPRM*, the Commission proposed that as part of the initial application phase for infrastructure projects, applicants must identify (1) all eligible HCPs on whose behalf funding is being sought, and (2) the lead entity that will be responsible for completing the application process.[543] In addition, the *NPRM* proposed that the Commission require, as in the Pilot Program, that the application include a LOA from each participating HCP, confirming that the HCP has agreed to participate in the applicant's proposed network, and authorizing the lead entity to act

[540] *See infra* section VII.A.

[541] *See supra* para. 11 and nn.18-19 (listing types of eligible health care providers).

[542] *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20406, para. 87.

[543] *See NPRM*, 25 FCC Rcd at 9384, para. 26.

as the HCP's agent for completing the application process.[544] In the *July 19 Public Notice*, the Bureau asked for additional comment on the proposed LOA requirement.[545]

209. *Discussion.* The letter of agency requirement helps ensure that participating entities are eligible to receive support, and that the HCPs have given the project leaders the necessary authorization to act on their behalf. After considering our experience in the Pilot Program, and reviewing the comments filed regarding letters of agency, we conclude that each Consortium Leader must secure the necessary authorizations through an LOA from each HCP seeking to participate in the applicant's network that is *independent* of the Consortium Leader. LOAs are not required for those participating HCP sites that are owned or otherwise controlled by the Consortium Leader (and thus are not "independent").[546] Similarly, one LOA is sufficient for multiple HCP sites that are owned or otherwise controlled by a single consortium member.

210. We adopt an approach that creates a two-step process of LOAs: in the first step, a Consortium Leader must obtain LOAs from members to seek bids for services, and in the second step, the Leader must obtain LOAs to apply for funding from the program. This two-step approach addresses an issue that arose in the Pilot Program, where some prospective member HCPs were reluctant to provide LOAs that would commit them to participate in a consortium network before they knew the pricing of services from prospective bidders. Under the Healthcare Connect Fund, we require that each Consortium Leader secure authorization, the required certifications,[547] and any supporting documentation from each consortium member (i) to submit the request for services on its behalf (Form 461) and prepare and post the request for proposal on behalf of the member for purposes of the Healthcare Connect Fund and (ii) to submit the funding request (Form 462) and manage invoicing and payments, on behalf of the member.[548] The first authorization is required prior to the submission of the request for services (Form 461), while the second authorization is only required prior to the submission of the request for funding (Form 462). An applicant may either secure both required authorizations upfront or secure each authorization as needed.[549] Consortium Leaders may also obtain authorization, the required certifications, and any supporting documentation from each member to submit Form 460, if needed, to certify the member's eligibility to participate in the Healthcare Connect Fund.[550] If the Consortium Leader does not obtain such authorization for a given member, that member will have to submit its own Form 460. In addition, we delegate authority to the Bureau to develop model language for the LOA required for each of the above authorizations.

---

[544] *Id*.

[545] *July 19 Public Notice*, 27 FCC Rcd at 8188-90, para. 6.

[546] *See, e.g.*, CCHCS PN Comments at 2.

[547] The consortium may decide that the Consortium Leader should have sole legal and financial responsibility for making certain certifications (*e.g.*, certifying that the service provider selected is the most cost-effective service provider available). In that case, the consortium may wish to omit this certification from member LOAs. We will allow such arrangements as long as a formal written agreement makes the division of responsibilities clear. *See* para. 206 above.

[548] *See* Appendix D, 47 C.F.R. §§ 54.532 (Letters of agency), 54.642(e)(1) and 54.643(a)(2) (certifications); Appendix E, Forms 461 and 462.

[549] Under the two-step process, the Administrator may only issue a funding commitment after the Consortium Leader secures and submits the required second LOA. Although the two-step process provides consortia with additional flexibility, it may increase the amount of time needed to obtain funding.

[550] *See* Appendix D, 47 C.F.R. § 54.601(b).

211. In addition to the necessary authorizations, the LOA must include, at a minimum, the name of the entity filing the application (*i.e.*, lead applicant or consortium leader); name of the entity authorizing the filing of the application (*i.e.*, the participating HCP/consortium member); the physical location of the HCP/consortium member site(s);[551] the relationship of each site seeking support to the lead entity filing the application; the specific timeframe the LOA covers; the signature, title and contact information (including phone number, mailing address, and email address) of an official who is authorized to act on behalf of the HCP/consortium member; signature date; and the type of services covered by the LOA.[552] For HCPs located on Tribal lands, if the health care facility is a contract facility that is run solely by a Tribal Nation, the appropriate Tribal leader, such as the Tribal Chairperson, President, or Governor, or Chief, shall also sign the LOA, unless the health care responsibilities have been duly delegated to another Tribal government representative.[553] In all instances, electronic signatures are permissible.[554]

212. The approach we adopt today addresses many of the concerns expressed by commenters, while still ensuring applicants have the necessary authority to act on behalf of their members. Some commenters correctly point out that under the Pilot Program, an HCP was often reluctant or unable to execute an LOA that required the HCP to agree to participate in a network before accurate pricing was available.[555] Other commenters stressed that requiring LOAs as part of the Form 465 submission was a net benefit because it enabled the project to "vet" the eligibility of interested HCPs at the outset of the application process.[556] We conclude that the adopted approach provides flexibility to allow consortium applicants to tailor the LOA process to meet the needs of their members, within the necessary constraints set forth above.

2. Determination of Health Care Provider Eligibility

213. *Background.* Section 254(h)(7)(B) of the Act restricts eligibility for support to specific types of HCPs.[557] Under current procedures, the timing of the eligibility determination can create difficulties for applicants. In both the existing RHC programs and in the Pilot Program, applicants submit information on HCP eligibility to USAC with the "request for services" (the information to be provided to potential vendors for competitive bidding).[558] Thus, HCPs must prepare and submit a request for services (and in many cases, an RFP) before knowing whether they are eligible for the program. Furthermore, HCPs must wait until USAC can confirm eligibility before they can complete the competitive bidding process and begin receiving support. In the Pilot Program, for example, the GAO found that 25 Pilot

---

[551] The HCP should provide sufficient information regarding its physical location in order to allow USAC to determine whether a particular site qualifies as "rural." *See* Appendix D, 47 C.F.R. § 54.600. For example, if the site's mailing address does not correspond to its street address, the street address should be provided. If the site is so rural that it does not have a street address, other geolocation information may be provided (*e.g.*, latitude/ longitude data). HCPs applying for sites that do not have a street address are encouraged to contact USAC for further guidance on how to provide physical location information.

[552] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20406, para. 87 n.290.

[553] *Id.*

[554] *See* Appendix D, 47 C.F.R. § 54.680.

[555] *See, e.g.*, Geisinger PN Comments at 2-3; RWHC PN Comments at 2; SWTAG PN Comments at 2.

[556] *See* ITN PN Comments at 1; OHN PN Comments at 2; WNYRAHEC PN Comments at 2.

[557] *See supra* para. 11 and nn.18-19 (listing types of eligible health care providers).

[558] *See* 47 C.F.R. § 54.603(b).

projects initially included an entity that was later determined to be ineligible, and that 36 projects were delayed by difficulties in compiling and submitting the documentation needed to establish eligibility.[559]

214. *Discussion.* Consistent with other measures we adopt to improve the efficiency and operation of the Healthcare Connect Fund, we institute a new process for obtaining faster eligibility determinations from USAC by permitting HCPs to submit Form 460 at any time during the funding year to certify to the eligibility of particular sites. By separating the eligibility determination from the competitive bidding process, we provide HCPs with the option of receiving an eligibility determination before they move forward with preparing an application for funding.[560] HCPs who have previously received an eligibility determination from USAC (*i.e.* HCPs who already participate in the existing RHC programs) are not required to submit a Form 460 prior to submission of a Form 461. All HCPs, however, are required to submit an updated Form 460 within 30 days of a material change, such as a change in the HCP's name, site location, contact information or eligible entity type, or for non-rural hospitals, an increase in the number of licensed patient beds such that the hospital goes from having fewer than 400 licensed beds to 400 or more licensed beds.

215. For each HCP listed, applicants will be required to provide the HCP's address and contact information, identify the eligible HCP type, provide an address for each physical location that will receive supported connectivity, provide a brief explanation for why the HCP is eligible under the Act and the Commission's rules and orders, and certify to the accuracy of this information under penalty of perjury.[561] Consortium leaders should obtain supporting information and/or documents to support eligibility for each HCP when they collect LOAs; leaders also may be asked for this information during an audit or investigation. USAC should notify each applicant of its determination (or whether it needs additional time to process the form) within 30 days of receipt of Form 460. We caution applicants that it is their obligation to submit accurate information and certifications regarding their eligibility. Because HCP eligibility is limited by the Act, the Commission does not have discretion to waive eligibility requirements, and must recover any support erroneously disbursed to ineligible entities.[562] We direct USAC to assign a unique identifying number to each HCP location in order to facilitate tracking of the location throughout the application process.

3. Technology Planning

216. *Background.* The level of formal technology planning required for support in the current RHC program currently varies, depending on the program under which the HCP is receiving support. In the Telecommunications and Internet Access Programs, applicants are not required to provide any specific evidence of technology planning. USAC encourages participants to describe their needs in general terms (rather than requesting a specific service or bandwidth) because the competitive bidding

[559] *GAO Report at 36-37;* CHCC/RMHN PN Comments at 2.

[560] *See* ITN PN Comments at 1 (the benefit of identifying and thoroughly vetting the eligibility of interested HCPs from the outset far outweighs the additional administrative efforts). Applicants may also submit Form 460 at the same time as the funding request.

[561] HCPs who have questions regarding their eligibility for the program may wish to contact USAC for additional guidance in advance of filing the form. For community mental health centers, USAC requires applicants to complete an additional check-off form listing the services offered at the facility. *See* USAC Community Mental Health Center Certification, *available at* http://www.universalservice.org/_res/documents/rhc/pdf/forms/2012/CMHC-Certification.pdf (last visited Dec. 3, 2012). We delegate authority to the Bureau to provide any further guidance needed on the documentation that applicants may provide to demonstrate their eligibility.

[562] *See Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Memorandum Opinion and Order, 15 FCC Rcd 7170, 7178, para. 13 (1999).

process may reveal that a vendor can meet their needs through a different service at a lower cost.[563] In contrast, Pilot projects were required to identify goals and objectives of the proposed network; identify a strategy for aggregating the specific needs of HCPs (including providers that serve rural areas) within a state or region; and identify a strategy for leveraging existing technology to adopt the most efficient and cost effective means of connecting those providers.[564] In the *NPRM*, the Commission proposed that infrastructure projects be required to specify, as part of the project description, how the dedicated broadband network will be used by eligible HCPs for health IT to improve or provide health care delivery.[565]

217. *Discussion.* We encourage all applicants to carefully evaluate their connectivity needs before submitting an application. We decline at this time to require applicants in the Healthcare Connect Fund to submit technology plans with their requests for service, but we may re-evaluate this decision in the future based on experience with the new program. Our goal is reduce administrative burdens and delay associated with participating in the Healthcare Connect Fund, especially for the HCPs with the fewest resources and greatest need to participate.

218. The record indicates that HCPs are a diverse group with a diverse set of needs.[566] Our intent, consistent with precedent, is to allow HCPs to identify their specific broadband needs, which, together with the competitive bidding requirements and the required HCP 35 percent contribution, will help ensure that universal services funds are used most cost-effectively. We recognize that the amount of planning required will vary depending on a number of factors, such as the HCP's size and planned utilization of health IT, and that the amount of IT expertise and other resources available for formal planning will vary widely between different types of HCPs.[567] In the planning process, applicants may wish to consider questions such as the following:

- What applications do we plan to use over our broadband connection (*e.g.* exchange of EHRs, videoconferencing, image transfers, and other forms of telehealth or telemedicine)? How do these applications fit into our overall strategy to improve care and/or generate cost savings? How many users do we need to support for each application?
- What broadband services do we need to support the planned applications and users?
- Do we have a plan to train our staff to use the applications?
- Do we have the necessary IT resources to deploy the broadband services and applications?
- Have we considered the benefits and drawbacks of short-term versus multi-year contracts (*e.g.* cost savings in long-term contracts versus potential decreases in prices, technology advances, and termination fees)?
- How will we pay for the undiscounted portion of supported services and equipment, and any unsupported costs?

---

[563] Universal Services Administrative Company, Welcome Packet at 7, *available at* http://www.usac.org/_res/documents/rhc/pdf/handouts/RHC-Welcome-Packet.pdf.

[564] *2006 Pilot Program Order,* 21 FCC Rcd at 11116, paras. 16-17.

[565] *NPRM,* 25 FCC Rcd at 9394, para. 53.

[566] *See generally Pilot Evaluation*, 27 FCC Rcd at 9406-92, 9419-25, paras. 34-42, 52-62; *Needs Assessment* (Appendix B), paras. 21-27.

[567] *Needs Assessment* (Appendix B), paras. 21-27; *Pilot Evaluation*, 27 FCC Rcd at 9435, 9438, paras. 78, 86.

- Should we consider joining with other HCPs to apply as a consortium? If a consortium, should we include other HCPs?
- What resources are available to help us?

219. We encourage prospective applicants to consult available resources, including those previously published by the Commission and resources available through HHS, in conducting their technology planning.[568]

4. Preparation for Competitive Bidding

220. *Background.* Under existing rules, during the competitive bidding process, applicants must select the "most cost-effective" method of providing services.[569] Applicants must certify that they have selected the most cost-effective bid on their requests for funding.[570] In addition, Pilot participants must submit competitive bidding documentation with their funding requests.

221. *Discussion.* The Commission has defined "cost-effective" for purposes of the existing RHC support mechanism as "the method that costs the least after consideration of the features, quality of

---

[568] A number of resources are available to help HCPs in evaluating health IT and broadband needs. A few of them include the following:

Broadband and health care: A discussion of the broadband needs of HCPs appears in the health care chapter of the National Broadband Plan (www.broadband.gov/plan/issues/healthcare.html) (last visited Dec. 17, 2012); the *OBI Health Care Technical Paper* , (http://download.broadband.gov/plan/fcc-omnibus-broadband-initiative-(obi)-working-reports-series-technical-paper-health-care-broadband-in-america.pdf) (last visited Dec. 17, 2012); the *Pilot Evaluation* (www.fcc.gov/document/rural-health-care-pilot-program-evaluation-staff-report) (last visited Dec. 17, 2012); and the *Needs Assessment* (Appendix B).

Electronic health records: HHS's Office of the National Coordinator for Health Information Technology (ONC) is the principal federal entity charged with coordination of nationwide efforts to implement and use the most advanced health information technology and the electronic exchange of health information. ONC has funded 62 Regional Extension Centers (RECs) to help more than 100,000 primary care providers adopt and use EHRs. REC services include outreach and education, EHR support (such as working with vendors, or helping providers choose a certified EHR system), and technical assistance in implementing health IT and using it in a meaningful way to improve care. A listing of RECs is available at http://www.healthit.gov/providers-professionals/regional-extension-centers-recs (last visited Dec. 3, 2012).

Telehealth: The Office for the Advancement of Telehealth (OAT) promotes the use of telehealth technologies for health care delivery, education, and health information services. The office is part of the Office of Rural Health Policy, located within HHS's Health Resources and Services Administration (HRSA). HRSA's mission is to assure quality health care for underserved, vulnerable, and special needs populations. *See* Health Resources and Services Administration, Telehealth, http://www.hrsa.gov/ruralhealth/about/telehealth/ (last visited Nov. 8, 2012).

As part of its mission, OAT funds 15 Telehealth Resource Centers nationwide. These include 12 Regional Centers, all with different strengths and regional expertise, and 3 National Centers which focus on areas of technology assessment, telehealth policy and technical assistance regarding state policies affecting the use and deployment of telehealth services. *See* Telehealth Resource Centers, http://www.telehealthresourcecenter.org/ (last visited Dec. 17, 2012).

Health IT for rural HCPs: The National Rural Health Resource Center (NRHRC) is a technical assistance and knowledge center focusing on rural health, including the area of health information technology. The NRHRC provides a number of resources for rural HCPs, including the Health Information Technology Toolkit for rural HCPs at http://www.raconline.org/hit/. *See generally* http://www.ruralcenter.org/hit (last visited Dec. 17, 2012).

[569] 47 C.F.R § 54.603(b)(4).

[570] *Id*.

transmission, reliability, and other factors that the HCP deems relevant to . . . choosing a method of providing the required health care services."[571] The Commission does not require HCPs to use the lowest-cost technology because factors other than cost, such as reliability and quality, may be relevant to fulfill their health care needs.[572] Furthermore, initially higher cost options may prove to be lower in the long-run, by providing useful benefits to telemedicine in terms of future medical and technological developments and maintenance.[573] Therefore, unlike the E-rate program, the RHC program does not require participants to consider price as *the* primary factor in selecting a service provider.[574] Instead, applicants identify the factors relevant for health care purposes, and then select the lowest price bid that satisfies those considerations. We conclude that continuing this approach is appropriate for the Healthcare Connect Fund.

222. Applicants must develop appropriate evaluation criteria for selecting the winning bid *before* submitting a request for services to USAC to initiate competitive bidding. The evaluation criteria should be based on the Commission's definition of "cost-effective," and include the most important criteria needed to provide health care, as determined by the applicant. For smaller applicants (*e.g.* those requesting support for recurring monthly costs for a single T-1 line), criteria such as bandwidth, quality of transmission, reliability, previous experience with the service provider, and technical support are likely to be sufficient. For more complex projects (including projects that involve designing or constructing a new network or building upon an existing network), additional relevant non-cost factors may include prior experience, including past performance; personnel qualifications, including technical excellence; management capability, including solicitation compliance; and environmental objectives (if appropriate).[575]

223. Typically, an applicant will develop a scoring matrix, or a list of weighted evaluation criteria, that it will use in evaluating bids.[576] Once the applicant has developed its evaluation criteria, it should assign a weight to each in order of importance. No single factor may receive a weight that is greater than price. For example, if the HCP assigns a weight of 40 percent to cost, other factors must receive a weight of 40 percent or less individually (with the total weight equaling 100%).[577] Each bid

[571] 47 C.F.R. § 54.615(c)(7).

[572] *See 2003 Report and Order and FNPRM*, 18 FCC Rcd at 24576, para. 58.

[573] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20406, para. 79.

[574] *Compare Universal Service First Report and Order*, 12 FCC Rcd at 9134, para. 687, *with* 47 C.F.R. § 54.504(b)(2)(vii) (E-rate).

[575] The Commission has permitted participants in both the Telecommunications and Internet Access and the Pilot Programs to consider these evaluation factors when reviewing and selecting bids. *See Universal Service First Report and Order*, 12 FCC Rcd at 9134, para. 687, n.1803; *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20400, para. 78. *See also Request for Review by the Department of Education of the State of Tennessee of the Decision of the Universal Service Administrator, Request for Review by Integrated Systems and Internet Solutions, Inc., of the Decision of the Universal Board of Directors of the National Exchange Carrier Association, Inc.*, CC Docket Nos. 96-45 and 97-21, Order, 14 FCC Rcd 13734, 13739-40, para. 10 (1999) (*Tennessee Order*) (in the context of the e-rate program, concluding that non-price evaluation factors, such as prior experience, personnel qualifications, and management capability, may form a reasonable basis on which to evaluate whether a bid is cost-effective).

[576] Although we do not require a specific format, HCPs may contact USAC for a sample scoring sheet, keeping in mind that the criteria should be developed based on the needs of each individual HCP, not the example provided.

[577] For example, an applicant could give price a maximum of 40 points, bandwidth a maximum of 40 points, and reliability a maximum of 20 points (for a total of 100 points maximum). However, the applicant could not give price a maximum of 40 points, bandwidth a maximum of 41 points, and reliability a maximum of 19 points.

received should be scored against the determined criteria, ensuring they are all evaluated equally. All applicants who are not exempt from competitive bidding will be required to submit bid evaluation documentation with their funding requests.

5. Source(s) for Undiscounted Portion of Costs

224. Although applicants are not required to submit documentation regarding sources for the undiscounted portion of costs until they complete the competitive bidding process, they should begin identifying possible sources for their 35 percent as early as possible.[578] This is especially important for larger consortia that intend to undertake high-dollar projects. In the Pilot Program, many projects experienced delays due, in part, to difficulty in obtaining the required contribution.[579]

6. FCC Registration Number (FRN)

225. All applicants must obtain FCC registration numbers (FRNs), if they do not have one already. An FRN is a 10-digit number that is assigned to a business or individual registering with the FCC, and is used to uniquely identify the business or individual in all of its transactions with the FCC.[580] Obtaining an FRN is a quick, online process that can typically be completed in a manner of minutes through the Commission's web site.[581] Consortium applicants may obtain a single FRN for the consortium as a whole, if desired (*i.e.* instead of requiring each participating HCP to obtain a separate FRN).

B. Competitive Bidding

226. *Background.* All applicants in the RHC program must seek competitive bids for supported services and select the most "cost-effective" provider. Currently, applicants submit a "request for services" (FCC Form 465) that includes a description of the services for which the HCP is seeking support. FCC Form 465, along with any attachments, is posted on USAC's web site for viewing by interested service providers, who submit bids directly to the applicant. HCPs must wait at least 28 days from the date on which the Form 465 is posted on USAC's website before selecting a service provider.[582]

227. *Discussion.* Competitive bidding remains a fundamental pillar supporting our goals for the Healthcare Connect Fund, as it will allow HCPs to obtain lower rates (thereby increasing access to broadband) and increase program efficiency.[583] The outlines of the competitive bidding process for the new program will remain the same as our existing programs: all HCPs will submit a request for services for posting by USAC, wait at least 28 days before selecting a service provider, and select the most cost-effective bid. In addition, in some circumstances, applicants will be required to prepare a formal request for proposals as well. Below, we provide a more detailed overview of the process.

228. While competitive bidding is essential to the program, we acknowledge that it is not without administrative costs to participants and to the Fund. As discussed more fully in section VI.B.6.

---

[578] Eligible sources are identified in section IV.D.3 above.

[579] *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 25 FCC Rcd 1423, 1426, para. 5 (*2010 Extension Order*). We note that program rules adopted below will require HCPs to certify, when submitting invoices to USAC, that they have paid their 35 percent minimum contribution. *See* Appendix D, 47 C.F.R. § 54.645.

[580] *See* 47 C.F.R. §§ 1.8001-1.8004.

[581] *See* FCC Registration web site, https://fjallfoss.fcc.gov/coresWeb/publicHome.do (*last visited* Dec. 3, 2012).

[582] 47 C.F.R. §§ 54.603(b)(3), 54.615.

[583] *See supra* section III.

below, we conclude that in three situations, exempting funding requests from competitive bidding in the Healthcare Connect Fund will strike a common-sense balance between efficient use of program funds and reducing regulatory costs.[584] First, based on our experience with the Telecommunications and Internet Access Programs, we find that it will be more administratively efficient to exempt applicants seeking support for relatively small amounts. The threshold for this exemption is $10,000 or less in total annual undiscounted costs (which, with a 35 percent applicant contribution, results in a maximum of $6,500 annually in Fund support). Second, if an applicant is purchasing services from a master service agreement negotiated by a governmental entity on its behalf, and the master service agreement was awarded pursuant to applicable federal, state, Tribal, or local competitive bidding processes, the applicant is not required to re-undergo competitive bidding. Third, we conclude that applicants who wish to request support under the Healthcare Connect Fund while utilizing contracts previously endorsed by USAC (Master Services Agreements under the Pilot Program or the Healthcare Connect Fund, or evergreen contracts in any of the health care programs, or master contracts the E-rate program) may do so without undergoing additional competitive bidding, as long as they do not request duplicative support for the same service and otherwise comply with all program requirements. In addition, consistent with current RHC program policies, applicants who receive evergreen status or multi-year commitments under the Healthcare Connect Fund are exempt from competitive bidding for the duration of the contract, as discussed below.[585] Applicants who are exempt from competitive bidding can proceed directly to submitting a funding commitment request.

1. "Fair and Open" Competitive Bidding Process

229. *Background.* In establishing the RHC support mechanism, the Commission determined that a competitive bidding requirement was necessary to "help minimize the support required by ensuring that rural HCPs are aware of cost-effective alternatives" and "ensure that the universal service fund is used wisely and efficiently."[586] In the Pilot Program, competitive bidding played a key part in allowing many HCPs to obtain lower rates for services and to realize other purchasing efficiencies.[587] Furthermore, competitive bidding furthers the competitive neutrality requirement in section 254(h)(2)(A) of the Act by ensuring that universal service support does not disadvantage one provider over another, or unfairly favor or disfavor one technology over the other.[588]

230. *Discussion.* Unless they qualify for one of the competitive bidding exemptions described below, all entities participating in the Healthcare Connect Fund must conduct a fair and open competitive bidding process prior to submitting a request for funding Form 462. Although it is not possible to anticipate all possible factual circumstances that may arise during the process, we set forth here three basic principles and some specific guidance that should help applicants comply with this requirement.[589]

---

[584] The exemptions described below do not apply to applicants in the Telecommunications Program.

[585] *See infra* sections VI.B.6.d, VI.C.4.

[586] *Universal Service First Report and Order*, 12 FCC Rcd at 9134, para. 688; *Federal-State Joint Board on Universal Service, Access Charge Reform, Price Cap Performance Review for Local Exchange Carriers, Transport Rate Structure and Pricing, End User Common Line Charge*, Fourth Order on Reconsideration in CC Docket No. 96-45, 13 FCC Rcd 5318, 5425-5426, para. 185 (1997) (*Universal Service Fourth Order on Reconsideration*).

[587] *Pilot Evaluation*, 27 FCC Rcd at 9436-37, paras. 81-83.

[588] 47 U.S.C. § 254(h)(2)(A).

[589] *See* Appendix D, 47 C.F.R. § 54.642.

231. First, service providers who intend to bid should not also simultaneously help the HCP choose a winning bidder.[590] More specifically, service providers who submit bids are prohibited from (1) preparing, signing or submitting an applicant's Form 461 documents;[591] (2) serving as Consortium Leaders or other points of contact on behalf of applicants; (3) being involved in setting bid evaluation criteria; or (4) participating in the bid evaluation or vendor selection process (except in their role as potential vendors).[592] Consultants, other third-party experts, or applicant employees who have an ownership interest, sales commission arrangement, or other financial stake with respect to a bidding service provider are also prohibited from performing any of the above four functions on behalf of the applicant.[593] As discussed further below, all applicants must submit a "Declaration of Assistance" with their request for services (Form 461) to help the Commission and USAC identify third parties who assisted in the preparation of the applications.

232. Second, all potential bidders and service providers must have access to the same information and must be treated in the same manner. Any additions or modifications to the documents submitted to, and posted by, USAC must be made available to all potential service providers at the same time and using a uniform method.[594] We direct USAC to facilitate this process by allowing applicants to submit any additions or modifications to USAC, for posting on the same web page as the originally posted documents.

233. Finally, as is the case in the Telecommunications, Internet Access, and Pilot Programs, all applicants and service providers must comply with any applicable state or local competitive bidding requirements.[595] The Commission's requirements apply in addition to, and are not intended to preempt, such requirements.[596]

---

[590] *Cf. Schools and Libraries Sixth Report and Order,* 25 FCC Rcd 18799-800, para. 86 ("an applicant violates the Commission's competitive bidding rules if the applicant turns over to a service provider the responsibility for ensuring a fair and open competitive bidding process") (*discussing Request for Review by Mastermind Internet Services, Inc.,* CC Docket No. 96-45, Order, 16 FCC Rcd 4028, 4032, para. 9 (2000)).

[591] This does not prohibit an HCP from obtaining information on its current services from its existing service provider. In general, an existing relationship between an applicant and its existing service provider does not violate the rule that the competitive bidding process remain fair and open. *Cf. Schools and Libraries Sixth Report and Order,* 25 FCC Rcd at 18799, para. 86, n.249. But any contractual provision that would provide the incumbent service provider an inherent advantage over other potential bidders – such as a right of first refusal for future contracts – could impair a fair and open competitive bidding process.

[592] *Cf. Schools and Libraries Sixth Report and Order,* 25 FCC Rcd at 18799-800, para. 86.

[593] *Cf. Schools and Libraries Sixth Report and Order,* 25 FCC Rcd at 18799-800, para. 86; *Request for Review by SEND Technologies, L.L.C. of the Decision of the Universal Service Administrator,* CC Docket Nos. 96-45, 97-21, Order, 22 FCC Rcd 4950, 4952-53, para. 6 (2007) (finding that applicant's 15 percent ownership interest in service provider resulted in a conflict of interest in service provider resulted in a conflict of interest that impeded fair and open competition); *Request for Review by Approach Learning and Assessment Center, Federal-State Joint Board on Universal Service,* CC Docket No. 96-45, 22 FCC Rcd 5296, 5304 para. 19 (2007) (finding that when an applicant gives an entity the ability to control the dissemination of information regarding the service requests and that entity also participates in the competitive bidding process as a prospective service provider, the applicant impairs its ability to hold fair and open competitive bidding process).

[594] *Cf. Schools and Libraries Sixth Report and Order,* 25 FCC Rcd at 18799-800, para. 86. For clarity, this does not prohibit applicants from seeking additional information about particular products or services during the competitive bidding process, or potential vendors from supplying it. *Id.* at 18803, para. 92.

[595] *1997 Universal Service First Report and Order,* 12 FCC Rcd 9134, at para. 686.

[596] *Cf. Schools and Libraries Sixth Report and Order,* 25 FCC Rcd at 18788, para. 55.

2. Requests for Proposals

234. *Background.* An RFP is a formal bidding document that describes a project and requested services in sufficient detail so that potential bidders understand the scope, location, and any other requirements. In the Telecommunications Program, an RFP is optional, but can provide an opportunity for a HCP to specify detailed requirements about its needs.[597] In the Pilot Program, projects were required to submit a "scope" document that, in effect, served as an RFP.[598]

235. In the *NPRM*, the Commission proposed to require participants in the health infrastructure program to prepare a detailed RFP that provides sufficient information to define the scope of the project, due to the complexity of infrastructure projects. The Commission proposed to exempt infrastructure projects of $100,000 or less, or projects that are subject to mandatory state or local procurement rules, from these requirements.[599] In the *July 19 Public Notice*, the Bureau sought further comment on whether it should require consortium applicants in the Broadband Services Program to prepare an RFP, and whether the Commission should exempt consortia from the RFP requirement if they are applying for less than a specified amount of support (*e.g.* $100,000).[600]

236. *Discussion.* We will require submission of RFPs with Form 461 for (1) applicants who are required to issue an RFP under applicable state, Tribal, or local procurement rules or regulations; (2) consortium applications that seek more than $100,000 in program support in a funding year; and (3) consortium applications that seek support for infrastructure (*i.e.* HCP-owned facilities) as well as services.[601] Applicants who seek support for long-term capital investments, such as HCP-constructed infrastructure or fiber IRUs, must also seek bids in the same RFP from vendors who propose to meet those needs via services provided over vendor-owned facilities, for a time period comparable to the life of the proposed capital investment. This is to allow USAC to determine if the option chosen is the most cost-effective. In addition, any applicant is free submit an RFP to USAC for posting, but all applicants who utilize an RFP in conjunction with their competitive bidding process must submit the RFP to USAC for posting and provide USAC with any subsequent changes to the RFP. We conclude that our requirement strikes a reasonable balance between ensuring larger consortia and the Fund benefit from the

---

[597] *See* USAC web site, "Evaluation Criteria and Service Requests," http://www.usac.org/rhc/health-care-providers/step02/default.aspx (last visited Dec. 17, 2012). All applicants for rural health care support are currently required to provide a short description of its service needs on Form 465 (request for services).

[598] *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20406, para. 86 (requiring Pilot projects to "provide sufficient information to define the scope of the project and network costs to enable an effective competitive bidding process").

[599] The Commission noted that in federal procurements, a less stringent simplified acquisition procedure is used for contracts of $100,000 of less. *See* 41 U.S.C. § 134. The Commission also recognized that in certain smaller projects, or in projects that are subject to mandatory state or local procurement rules, the proposed RFP preparation and distribution requirements might not be practical or cost-effective. *NPRM*, 25 FCC Rcd at 9405-6, para. 86. We note that HCPs who are required by law to obtain services from a competitively bid federal or state government master contract can utilize the exemption below for Government Master Service Agreements. *See infra* section VI.B.6.b.

[600] *July 19 Public Notice*, 27 FCC Rcd at 8198, para. 11.

[601] Pursuant to requirements set forth elsewhere in this order, applications seeking support for dark fiber must include modulating equipment and other related expenses in the same RFP. Applications that include a self-construction option must allow for the submission of bids to provide the requested services as leased services for a period comparable to the useful life of the proposed facility. *See supra* sections V.A.3; IV.C.

cost savings resulting from the RFP process, while limiting the administrative burden on individual HCPs and smaller consortia.[602]

237. As discussed below, applicants who have or intend to issue an RFP must submit a copy of the RFP with their request for services. We recognize that a consortium may not know the exact cost of the project until after it completes the competitive bidding process and selects a vendor. If a consortium chooses to forego an RFP, however, its support will be capped at $100,000.

238. The Commission does not specify requirements for RFPs in the current RHC program, and USAC does not approve RFPs. Therefore, applicants may prepare RFPs in any manner that complies with program rules and any applicable state, Tribal, or local procurement rules or regulations.[603] The RFP, however, should provide sufficient information to enable an effective competitive bidding process, including describing the HCP's service needs (as discussed further in the next section) and defining the scope of the project and network costs (if applicable). The RFP should also specify the period during which bids will be accepted.[604] The RFP should also include the scoring criteria that will be used to evaluate bids for cost-effectiveness, in accordance with the requirements described in sectionVI.A.4 above, and solicit sufficient information so that the criteria can be applied effectively. A short, simple RFP may be appropriate for smaller consortia, or for consortia whose needs are less complex.[605] We note

[602] *See* IRHN PN Comments at 17 (RFPs provide opportunities for both traditional and non-traditional service providers to offer competitive pricing and, in some cases, alternate approaches); OHN PN Comments at 11-12 (competitive bidding is a balancing act (higher initial administrative burden versus reduced costs to the HCPs later)); RWHC PN Comments at 4 (recommending that if the Commission does not fund administrative costs, it consider exempting projects under $100,000 from an RFP requirement); CHCC/RMHN PN Comments at 4 (supporting exemption from RFP requirement for projects of less than $100,000); ITN PN Comments at 3, 4 (a single HCP should not have to go through a detailed RFP process).

[603] *See, e.g.,* Appendix D, 47 C.F.R. § 54.642(b) (prohibiting participation of potential vendors in preparing an applicant's request for services). *See* SWTAG PN Comments at 11-12 (recommending that parties be allowed to follow/adhere the procurement policy, procedures, rules and regulations they already have in place). *See also Schools and Libraries Sixth Report and Order,* 25 FCC Rcd 18799 para. 86 n.248 (noting that in some instances, applicants may prepare a Request for Quotes rather than an RFP); OHN PN Comments at 11-12 (stating that in some instances, a simpler "Request for Quotes" as opposed to a full-fledged RFP may be more suitable).

[604] At the applicant's discretion, this may be the 28-day minimum period required by Commission rules, or a period longer than 28 days. We will not allow applicants to simply submit in the RFP "a list of all the eligible services" under the program, as suggested by CCHCS. Such a blanket description does not provide adequate specificity to allow bidders to prepare responsive bids, increasing the likelihood that one or more bidders will obtain access to "inside information" in violation of the Commission's rules. Furthermore, allowing applicants to simply submit a list of all eligible services decreases the applicants' incentives to conduct adequate technology planning. *See* CCHCS PN Comments at 4. *Cf. Request for Review by Ysleta Independent School District of the Decision of the Universal Service Administrator,* CC Docket Nos. 96-45, 97-21, Order, 18 FCC Rcd 26407, 26418-20, paras. 24-28 (2003) (*Ysleta Order*) (stating in the E-rate context that a request for services listing virtually all eligible products and services violates the Commission's competitive bidding requirements).

[605] To assist applicants in preparing their RFPs, we direct the Bureau and USAC to post a representative sample of RFPs submitted by Pilot projects (including both large and small projects) on an easily accessible page on the Commission and USAC's public web sites. By doing so, we do not endorse any particular RFP in either substance or format. Applicants should tailor their RFPs to address their particular circumstances and needs. *Cf.* IRHN PN Comments at 17 (suggesting that USAC post a model of a relatively simple RFP on its web site); ITN PN Comments at 3 (requesting that an RFP template be developed).

that consortia may choose to submit single or multiple requests for services (and multiple RFPs), depending on the structure that makes most sense for the particular project.[606]

3. USAC Posting of Request for Services

239. *Background*. In the current RHC program, the first form submitted to USAC is FCC Form 465 (Description of Services Requested & Certification Form).[607] Form 465 currently serves two purposes: first, to certify to USAC that the HCP is eligible to receive support; and second, to request bids for the desired services. As discussed above, in the Healthcare Connect Fund we will separate the process (and forms) for obtaining eligibility determinations from the process of requesting bids applying for funding. The eligibility determination process is discussed in section VI.A.2 above. In this section, we discuss the process for initiating competitive bidding for requested services.

240. *Discussion.* Applicants subject to competitive bidding must submit new FCC Form 461 and supporting documentation (as described below) to USAC. The purpose of these documents is to provide sufficient information on the requested services to enable an effective competitive bidding process to take place and to enable USAC to obtain certifications and other information necessary to prevent waste, fraud, and abuse.

241. Documents to be submitted to USAC with the "request for services" include the following:

- Form 461. Applicants should submit Form 461, the "request for services," to provide information about the services for which they are seeking support. On Form 461, applicants will provide basic information regarding the HCP(s) on the application (including contact information for potential bidders), a brief description of the desired services, and certifications designed to ensure compliance with program rules and minimize waste, fraud, and abuse. An applicant must certify under penalty of perjury that (1) it is authorized to submit the request and that all statements of fact in the application are true to the best of the signatory's knowledge; (2) it has followed any applicable state or local procurement rules; (3) the supported services and/or equipment will be used solely for purposes reasonably related to the provision of health care service or instruction that the HCP is legally authorized to provide under the law of the state in which the services are provided and will not be sold, resold, or transferred in consideration for money or any other thing of value; and (4) the HCP or consortium satisfies all program requirements and will abide by all such requirements.[608] Applicants not using an RFP should provide on Form 461 sufficient information regarding the desired services to enable an effective competitive bidding process, including, at a minimum, a summary of their service needs, the dates for service (including whether the contract is potentially for multiple years), and the dates of the bid evaluation period.[609] Consortium Leaders should provide the required information on behalf of all participating HCPs.

---

[606] IRHN PN Comments at 16 (noting that sometimes it takes more than a single RFP (*i.e.* multiple consortium-level RFPs) to achieve the consortium's objective).

[607] *See* 47 C.F.R. § 54.603(b).

[608] *See* Appendix D, 47 C.F.R. § 54.642(e)(1).

[609] *See Universal Service First Report and Order*, 12 FCC Rcd at 9134, para. 686 (explaining that the request for services "may be as formal and detailed as the health care provider desires or as required by any applicable state or federal laws or other requirements," but should "contain information sufficient to enable the [service provider] to identify and contact the requester and to know what services are being requested").

- Applicants who include a particular service provider's name, brand, product or service on Form 461 or in the RFP must also use the words "or equivalent" in the description, in order to avoid the appearance that the applicant has pre-selected the named service provider or intends to give the service provider preference in the bidding process.[610] In addition, an applicant may wish to describe its needs in general terms (*e.g.*, "need to transmit data and medical images" rather than requesting a specific service or bandwidth), because the applicant may not be aware of all potential service providers in its market. Using general terms can allow an applicant to avoid inadvertently excluding a lower-cost bid from a service provider using a newer technology.[611]
- Bid Evaluation Criteria. The requirements for bid evaluation criteria are discussed in section VI.A.4 above.
- Request for Proposal. Certain applicants *must* use an RFP in the competitive bidding process, and any applicant *may* use an RFP. Applicants who use an RFP should submit it (along with any other relevant bidding information) as an attachment to Form 461.[612]
- Network Planning for Consortia. Consortium applicants must submit a narrative attachment with Form 461 that includes the following information:

  (1) Goals and objectives of the proposed network;

  (2) Strategy for aggregating the specific needs of HCPs (including providers that serve rural areas) within a state or region;

  (3) Strategy for leveraging existing technology to adopt the most efficient and cost effective means of connecting those providers;

  (4) How the broadband services will be used to improve or provide health care delivery;

  (5) Any previous experience in developing and managing health IT (including telemedicine) programs; and

  (6) A project management plan outlining the project's leadership and management structure, and a work plan, schedule, and budget.[613]

  The above network planning requirements are consistent with those in the Pilot Program. For purposes of the Healthcare Connect Fund, however, submission of this information is

[610] *See Request for Review of the Decision of the Universal Service Administrator by Queen of Peace High School*, CC Docket No. 02-6, Order, 26 FCC Rcd 16466, para. 1 (Wireline Comp. Bur. 2011).

[611] *See* USAC web site on competitive bidding, http://www.universalservice.org/rhc/health-care-providers/competitive-bidding.aspx (last visited Nov. 14, 2012).

[612] In the 1997 *Universal Service Fourth Order on Reconsideration*, the Commission declined to adopt a requirement for the Fund administrator to post RFPs for schools, libraries, and rural HCPs on the administrator's web site, due to concerns that such a requirement could impose significant costs and potential delays on the administrator's ability to build technical systems for the implementation of the programs. *Universal Service Fourth Order on Reconsideration*, 13 FCC Rcd at 5410-13, paras. 160-62 (noting that some RFPs may number over a hundred pages, including diagrams and specifications). Given advances in technology since 1997, we find that posting a RFP in Adobe PDF, Word, or other formats should no longer pose difficulties for USAC, the current administrator of the Fund. We note that the Commission and USAC now both routinely post PDF documents that are a hundred pages or more in length, and USAC has experienced no technical difficulties in posting RFPs for the Pilot Program on its web site.

[613] *2006 Pilot Program Order*, 21 FCC Rcd at 11117, para. 17.

a minimum requirement, not a scoring metric for choosing funding recipients. We do not intend for this planning to be an undue administrative burden, and will continue to allow consortia to put forth a variety of strategies for accomplishing their goals, as the Commission did in the Pilot Program.[614]

Consortium applicants are required to use program support for the purposes described in their narrative.[615] As discussed below in Section VII.A, all applicants are subject to the Commission's procedures for audits and other measures to prevent waste, fraud, and abuse.

- Form 460. Applicants should submit Form 460 to certify to the eligibility of HCP(s) listed on the application, if they have not previously done so.[616]
- Letters of Agency for Consortium Applicants. Consortium applicants should submit letters of agency demonstrating that the Consortium Leader is authorized to submit Form 461, including required certifications and any supporting materials, on behalf of each participating HCP in the consortium.[617]
- Declaration of Assistance. As the Commission did in the Pilot Program, we require that all applicants identify, through a declaration of assistance, any consultants, service providers, or any other outside experts, whether paid or unpaid, who aided in the preparation of their applications.[618] The declaration of assistance must be filed with the Form 461.[619] Identifying these consultants and outside experts facilitates the ability of USAC, the Commission, and law enforcement officials to identify and prosecute individuals who may seek to defraud the program or engage in other illegal acts. To ensure participants comply with the competitive bidding requirements, they must disclose all of the types of relationships explained above.[620]

242. Applicants may submit Form 461 starting 180 days before the beginning of the funding year.[621] Our experience in the Pilot Program is that it can take as long as six months for more complex

[614] We recognize that existing HCP networks may already have such strategies in place. Pilot Program networks have strategies already approved by the Commission, which may only require minor modifications or extensions in order to add new participants to the network. Therefore, current Pilot Program consortia are not required to develop new strategies and evaluations for purposes of meeting this requirement in the Healthcare Connect Fund; instead, they may seek rely on existing documentation, updated as necessary to the extent they seek to extend existing networks.

[615] Applicants will have the opportunity to amend the narrative, if needed, when they submit their requests for funding commitments. *See infra* section VI.C.3.

[616] *See supra* section VI.A.2.

[617] *See supra* section VI.A.1.c.

[618] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20415, para. 104.

[619] *See* Appendix D, 47 C.F.R. § 54.642(e)(3).

[620] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20415, para. 104.

[621] For the first funding year only of the Healthcare Connect Fund, we anticipate that the filing window for Form 461 will open on or around July 1, 2013, rather than 180 days before the commencement of the funding year. We direct USAC to open the funding window as soon as feasible after the Paperwork Reduction Act approval is obtained from the Office of Management and Budget for the new information collection requirements in this order. *See infra* section X.A.

projects to complete bid evaluation and select a vendor.[622] To allow sufficient time to complete this process prior to the beginning of the funding year, HCPs should submit Form 461 as soon as possible after the filing window opens. USAC may provide applicants with the opportunity to cure errors on their submissions, up to the date of posting of the Form 461 package. The responsibility to submit complete and accurate information to USAC, however, remains at all times the sole responsibility of the applicant.

4. 28-Day Posting Requirement

243. After the HCP submits Form 461, USAC will post the form and any accompanying documents (the Form 461 "package") on its web site.[623] USAC may institute reasonable procedures for processing Form 461 and the associated documents and may provide applicants with an opportunity to correct errors in the submissions.[624] We caution applicants, however, that they remain ultimately responsible for ensuring that all forms and documents submitted comply with our rules and any other applicable state or local procurement requirements. We also remind applicants that they must certify under penalty of perjury on Form 461 that all statements of facts contained therein are true to the best of their knowledge, information, and belief, and that under federal law, persons willfully making false statements on the form can be punished by fine, forfeiture, or imprisonment.[625] If an applicant makes any changes to its RFP post-submission, it is responsible for ensuring that USAC has a current version of the RFP for the web site posting.

244. The *NPRM* proposed that applicants seeking infrastructure bids should be required to distribute their RFPs in a method likely to garner attention from interested vendors.[626] In keeping with our objective of minimizing administrative costs to applicants, however, we decline to adopt a formal requirement for applicants to distribute an RFP beyond the USAC posting process.[627] We do encourage applicants, however, to disseminate their requests for services (Form 461 package) as widely as possible, in order to maximize the quality and quantity of bids received. Such methods could include, for example, (1) posting a notice of the Form 461 package in trade journals or newspaper advertisements; (2) send the RFP to known or potential service providers; (3) posting the Form 461 package (or a link thereto) on the HCP's web page or other Internet sites, or (4) following other customary and reasonable solicitation practices used in competitive bidding.[628]

245. After posting of the Form 461 package, USAC will send confirmation of the posting to the applicant, including the posting date and the date on which the applicant may enter into a contract with the selected service provider (the "Allowable Contract Selection Date," or ACSD). Once USAC posts the package, interested bidders should submit bids directly to the applicant. Applicants must wait at

---

[622] USAC Nov. 16 Data Letter at 3.

[623] *See* Appendix D, 47 C.F.R. § 54.642. The term "package" simply refers to all documentation associated with a particular filing - *i.e.* the FCC form and any attachments.

[624] *See, e.g., Request for Review of the Decision of the Universal Service Administrator by Bishop Perry Middle School, et al.,* File Nos. SLD-487170, *et al.,* CC Docket No. 02-6, Order, 21 FCC Rcd 5316, 5326-27, paras. 23-24 (2006) (in the E-rate context, directing USAC to allow applicants to correct administrative or ministerial errors in their submissions).

[625] *See* Appendix D, 47 C.F.R. § 54.642(e)(1); *see also* 47 U.S.C. §§ 502, 503(b); 18 U.S.C. § 1001.

[626] *NPRM,* 25 FCC Rcd at 9436, para. 85.

[627] *See* IHS Comments at 6-7 (arguing that vendors are familiar with the USAC posting and response process, and there is no reason to require applicants to incur increased administrative (and non- reimbursable) costs by requiring extensive publication elsewhere).

[628] *See NPRM*, 25 FCC Rcd at 9405, para. 85.

least 28 calendar days from the date on which their Form 461 packages are posted on USAC's web site before making a commitment with a service provider, so the ACSD is the 29th calendar day after the posting.[629] Applicants may not agree to or sign a contract with a service provider until the ACSD, but may discuss requirements, rates, and conditions with potential service providers prior to that date. Applicants who select a service provider before the ACSD will be denied funding.

246. Applicants are free to extend the time period for receiving bids beyond 28 days from the posting of Form 461 and may do so without prior approval. In addition, some applicants who propose larger, more complex projects may wish to undertake an additional "best and final offer" round of bidding. Allowing sufficient time and opportunity for all potential bidders to develop and submit bids can lead to more and better bids, and has the potential to enhance the quality and lower the price of services ultimately received. We encourage HCPs contemplating more complex projects (including those with an infrastructure component) to utilize a longer bidding period, as done by many Pilot projects. If an applicant has plans to utilize a period longer than 28 days, it should so indicate clearly on the Form or in accompanying documentation. An applicant that decides to extend the bidding period after USAC's posting of Form 461 should notify USAC promptly, so that USAC can update its web site posting with notice of the extension.

5. Selection of the Most "Cost-Effective" Bid and Contract Negotiation

247. Once the 28-day period expires, applicants may evaluate bids, select a winning bidder and negotiate a contract. As indicated in section VI.A.4 above, applicants should develop appropriate evaluation criteria for selecting the "most cost-effective" bid according to the Commission's rules before submitting a Form 461 package to USAC.[630] Applicants should follow those evaluation criteria in evaluating bids and selecting a service provider. All applicants subject to competitive bidding will be required to certify to USAC that the services and/or infrastructure selected are, to the best of the applicant's knowledge, the most cost-effective option available.[631]

248. Applicants must submit documentation to USAC to support their certification that they have selected the most cost-effective vendor, including a copy of each bid received (winning, losing, and disqualified), the bid evaluation criteria, and any other related documents, such as bid evaluation sheets; a list of people who evaluated bids (along with their title/role/relationship to the applicant organization); memos, board minutes, or similar documents related to the vendor selection/award; copies of notices to winners; and any correspondence with service providers during the bidding/evaluation/award phase of the process. Below, we explain how applicants may seek confidential treatment for these documents.[632] We do not require bid evaluation documents to be in a certain format, but the level of documentation should be appropriate for the scale and scope of the services for which support is requested. Thus, for example, we expect that the documentation for a large network project will be more extensive than for an individual HCP seeking support for a single circuit. Applicants should also retain the supporting documentation for five years from the end of the relevant funding year, pursuant to the recordkeeping requirements adopted in section VII.A of this Order.[633]

249. Certain tariffed or month-to-month services are typically not provided pursuant to a signed, written contract. For all other services, the contract should be negotiated and signed before

---

[629] *See* Appendix D, 47 C.F.R. § 54.642(g).

[630] *See supra* section VI.A.4.

[631] *See Universal Service First Report and Order*, 12 FCC Rcd at 9134, para. 687.

[632] *See infra* n.697.

[633] *See infra* section VII.A.

applicants submit a request for a funding commitment. As discussed further below, applicants who wish to enter into a multi-year contract and be exempt from competitive bidding for the duration of the contract ("evergreen status") should ensure that the contract identifies both parties; is signed and dated by the HCP or Consortium Leader after the Allowable Contract Selection Date; and specifies the type, term, and cost of service(s).[634] Applicants will be required to submit a copy of the final contract(s) with their funding requests.

6. Competitive Bidding Exemptions

250. An applicant that qualifies for any of the exemptions below (and does not wish to use the competitive bidding process) is not required to prepare and post a Form 461. Instead, the applicant may proceed directly to filing the request for funding commitment (Form 462). If the applicant has not previously submitted Form 460 to certify to its eligibility, it should submit that form at the same time, or prior to, submitting Form 462.[635] As stated above, the exemptions below only apply to participants receiving support through the Healthcare Connect Fund, not the existing RHC or Pilot Programs.

a. Annual Undiscounted Cost of $10,000 or Less

251. *Background.* Under Telecommunications Program rules and procedures, an HCP must post a Form 465 for each HCP site and circuit. These small, single site requests rarely generate bids.[636] When no bids are received during the required 28-day bidding period, an HCP may then contact its local service provider and enter into a contract for the requested service.[637] In comparison, Pilot RFPs typically sought service for multiple HCP sites, creating the opportunity for more substantial service contracts. The Pilot projects attracted substantially more interest from vendors, producing measurably better results with the competitive bidding process. All of the Pilot Projects received at least one bid; 24 of the 50 projects had 6 or more vendors bid on some component of the project; and 14 had more than ten vendors bid.[638]

252. The *NPRM* sought comment on whether there are "certain types of situations that should be exempted from the competitive bidding requirements."[639] The *July 19 Public Notice* specifically sought comment on whether the Commission should exempt applicants from the competitive bidding requirements "if they are applying for less than a specified amount of support."[640]

253. *Discussion.* Based on our experience with the Telecommunications and Pilot programs, we adopt an exemption to the competitive bidding requirements under the Healthcare Connect Fund for an applicant and any related applicants that seek support for $10,000 or less of total undiscounted eligible expenses for a single year (*i.e.*, with a required HCP contribution of 35 percent, up to $6,500 in Fund support).[641] This exemption does not apply to multi-year contracts. This approach recognizes that for

---

[634] *See infra* section VI.B.6.d.

[635] *See supra* section VI.A.2.

[636] In the RHC Primary Program, USAC estimates that bids are received for services representing only 16 percent of funding requests; the remainder do not receive competitive bids after posting for such bids. *Pilot Evaluation*, 27 FCC Rcd at 9436-37, para. 81.

[637] *See* 47 C.F.R. § 54.603(b)(3); USAC May 30 Data Letter at 1.

[638] *Pilot Evaluation*, 27 FCC Rcd at 9436-37, para. 81.

[639] *NPRM*, 25 FCC Rcd at 9414, para. 110.

[640] *July 19 Public Notice*, 27 FCC Rcd at 8189-8201, para. 11.

[641] *See, e.g.*, CHCC/RMHN PN Comments at 4 (suggesting that "smaller projects" be exempted from the competitive bidding requirements); *see also* RWHC PN Comments at 4 (suggesting that the Commission reduce the

(continued…)

applicants pursuing small dollar value contracts, the administrative costs associated with the competitive bidding process may likely outweigh the potential benefits.[642] Even with the exemption, however, we encourage smaller applicants to consider using the competitive bidding process to help ensure they are receiving the best service and pricing available.

254. The $10,000 annual limit is based on the average undiscounted recurring monthly cost of a 1.5 to 3.0 Mbps connection as observed under both the Telecommunications and Pilot programs.[643] Based on this limit, small applicants, typically single HCP sites, should be able to secure support for a T-1 line or similar service without having to go through the competitive bidding process. A consortium application seeking support for undiscounted costs of $10,000 or less is also exempt from competitive bidding if the total of all consortium members' undiscounted costs for which support is sought, in this and any other application combined, is not more than $10,000 for that year.[644] We recognize that as a practical matter, this will likely prevent all but the smallest consortia from qualifying for the exemption, but as observed under the Pilot Program, consortia can substantially benefit from the competitive bidding process in terms of better pricing and higher quality of service.[645]

255. We recognize that an applicant may not always be able to exactly predict its annual eligible expenses in advance. If the applicant chooses to forego competitive bidding, however, its annual support will be capped at $6,500 (65 percent of $10,000) for any services that are not subject to an exemption.[646] If a qualifying applicant later discovers that it requires additional services beyond the $10,000 limit, the applicant may receive support for the additional services if it first completes the competitive bidding process for the additional services.

b. Government Master Service Agreements

256. *Background*. The *July 19 Public Notice* sought comment on whether the Commission should provide support for services purchased from a Master Services Agreement (MSA), so long as the

(Continued from previous page)

"administrative burden of the competitive bidding requirement in those circumstances where competitive options do not exist"); ITN PN Comments at 4 (suggesting a "streamlined service provider selection process" for single HCP applicants); VTN Comments at 34 (suggesting "a streamlined process for health care providers that do not have multiple broadband service options").

[642] *See, e.g.*, VTN Comments at 34 (stating that "[m]any rural health entities choose to forego needed funding as a result of [the] complex administrative burdens" associated with the application process); UAMS Comments at 8-9; RWHC PN Comments at 4.

[643] *Pilot Evaluation*, 27 FCC Rcd at 9421, 9423-24 (Figs. 13(b), 15).

[644] In other words, (1) the $10,000 annual limit applies regardless of whether the requested support is spread across multiple applications (*i.e.* a HCP or consortium cannot avoid the competitive bidding requirement by splitting a $100,000 funding request for one or more sites into 10 different funding requests), and (2) the limit does not increase based on the number of HCP sites that are part of the application (the limit does not increase to $100,000 because an application includes 10 sites). As discussed above in section VI.A.2, USAC is required to assign each HCP site a unique identifying number for tracking purposes to help ensure, in part, that an applicant is not inappropriately avoiding the competitive bidding requirements.

[645] *See Pilot Evaluation*, 27 FCC Rcd at 9436-37, para. 81; *see also* GCI PN Comments at 10 (agreeing that "competitive bidding has led to lower prices, better service quality, and more broadband deployment" (internal quotation omitted)).

[646] For example, if an applicant purchases services from a government master services agreement, as described in the next section, those services are not counted toward the $10,000 limit. However, if an applicant chooses to purchase more than $10,000 in services that are not subject to any other competitive bidding exemption described in this section, the applicant's support for those services is capped at $6,500.

original master contract was awarded through a government competitive bidding process.[647] Such MSAs permit applicants to opt into a contract for eligible services that have been negotiated by federal or state government entities without having to engage in negotiations with individual service providers. The U.S. Department of Health and Human Services also has recommended that the Commission exempt from competitive bidding requirements federal HCPs (such as the Indian Health Service) that are required to use the General Services Administration Networx contract for telecommunications services.[648]

257. *Discussion.* We adopt a competitive bidding exemption for HCPs who are purchasing services and/or equipment from MSAs negotiated by federal, state, Tribal, or local government entities on behalf of such HCPs and others, if such MSAs were awarded pursuant to applicable federal, state, Tribal, or local competitive bidding requirements.[649] This exemption helps streamline the application process by removing unnecessary and duplicative government competitive bidding requirements while still ensuring fiscal responsibility.[650] Because these MSAs have government requirements for competitive bidding, this fairly "removes the burden from the Rural Health Care Provider to conduct an additional competitive bid."[651] This exemption only applies to MSAs negotiated by, or under the direction of, *government* entities and subject to government competitive bidding requirements.[652] Applicants must submit documentation demonstrating that they qualify for the exemption, including a copy of the MSA and documentation that it was subject to government competitive bidding requirements.[653] In many cases these government contracts were negotiated on behalf of a large number of users, so are likely to generate similar cost efficiencies as those derived through the Healthcare Connect Fund competitive bidding process.

258. Commenters generally support the adoption of a competitive bidding exemption that allows applicants to take services from a government MSA, so long as the original master contract was subject to a competitive bidding process.[654] For instance, CCHCS "recommends that the Commission

[647] *See July 19 Public Notice*, 27 FCC Rcd at 8197-8201, para. 11.

[648] *See* HHS Comments at 3.

[649] *See* Appendix D, 47 C.F.R. § 54.642(h)(2).

[650] *See* UAMS PN Comments at 7-8 (explaining that an exemption for MSAs that were originally awarded through a competitive bidding process "would continue to ensure fair, competitive pricing while allowing consortia to avail themselves of favorable, negotiated rates without accruing additional undue administrative costs"); UTN PN Comments at 4-5 (stating that such an approach "has the opportunity to be a win-win, by receiving the benefits of the competitive bidding process while streamlining the administrative process"); VAST PN Reply Comments at 2 (explaining that such an exemption would remove the burden of conducting an additional competitive bidding process where the original MSA "met the state or federal requirements for competitive bidding").

[651] VAST PN Reply at 2.

[652] *See* CCHCS PN Comments at 5 (stating that "the Commission should permit applicants for the Broadband Services Program to take services from an MSA, so long as the original master contract was awarded through a competitive process").

[653] *See id.* at 5-6 (suggesting that "[t]he Commission should require applicants to submit the Request for Proposal package and subsequent MSA at the funding request phase - with the submittal of Form 466 - as a method of verification/validation of the competitive bid process"); SWTAG PN Comments at 12 (suggesting that "[a]pplicants should provide some reasonable documentation that an MSA [is] the most cost effective approach").

[654] *See, e.g.*, IRHN PN Comments at 21; ITN PN Comments at 4; UAMS PN Comments at 7; UTN PN Comments at 4; WNYRAHEC PN Comments at 7. We decline to take action at this time on proposed competitive bidding exemptions for the RHC Telecommunications Program, as suggested by one commenter. *See* MiCTA PN Comments at 5. As discussed below, we intend to consider potential reforms to the Telecommunications program on a more comprehensive basis in the future.

exempt from competitive bidding requirements State HCPs that are required to use the State mandated Master Services Agreements for the procurement of telecommunication and/or broadband services."[655] Similarly, VAST argues that the "Commission should allow eligible Health Care Providers to take services from a federal or state Master Service Agreement (MSA) that has been awarded through a competitive bidding process."[656]

c. Master Service Agreements Approved Under the Pilot Program or the Healthcare Connect Fund

259. *Background.* Through the Pilot Program competitive bidding process, projects often secured multi-year contracts with favorable terms, including the ability to add additional HCP sites.[657] Several Pilot projects have indicated that they want to add additional HCP sites once support from the new program is available.[658] In addition, the *July 19 Public Notice* sought comment on whether an applicant could obtain support from the new program for services purchased from a MSA that was subject to the Pilot Program competitive bidding requirements.[659] A number of commenters pointed out that allowing additional HCPs to join these Pilot project networks would enhance sustainability for the Pilot projects, allow these HCPs to take advantage of the investments in these statewide or regional networks made by the Fund and other entities, and promote national policy objectives of enhancing coordination in the provision of health care.[660]

260. *Discussion.* We adopt a competitive bidding exemption for HCPs purchasing services or equipment from an MSA, whether the contract was originally secured through the competitive bidding process under the Pilot Program or in the future through the Healthcare Connect Fund.[661] As the Commission stated in the *Bridge Order*, sufficient safeguards are in place to protect against waste, fraud, and abuse in these situations because HCPs have already gone through the competitive bidding process to identify and select the most cost-effective service provider in instituting these contracts.[662] This exemption also applies to MSAs that have been secured through competitive bidding with funding

---

[655] CCHCS PN Comments at 5.

[656] VAST PN Reply Comments at 2.

[657] *See* NCTN PN Comments at 4-5; IRHN PN Comments at 21 (explaining that IRHN's long-term agreements "allow for future locations to be added" to the contracts).

[658] *See, e.g.*, NCTN PN Comments at 1; CTN PN Comments at 5; OHN PN Comments at 5; Letter from Ed Bostick, Executive Director, Colorado Telehealth Network, to Marlene H. Dortch, Secretary, FCC, WC Docket No. 02-60, at 3 (dated Dec. 4, 2012) (Colo. Telehealth Network Dec. 4 *Ex Parte* Letter).

[659] *July 19 Public Notice*, 27 FCC Rcd at 8197-8201, para. 11. In response to the *NPRM*, one commenter requested that the Commission "clearly delineate the circumstances and requirements" under which a project may transition from the Pilot Program to the new program. CTN Comments at 23.

[660] *See, e.g.*, CTN PN Comments at 5; OHN PN Comments at 5; Letter from Steven Summer, President and Chief Executive Officer, Colorado Hospital Association, to Marlene H. Dortch, Secretary, FCC, WC Docket No. 02-60, at 1 (dated Nov. 16, 2012) (Colo. Hosp. Ass'n Nov. 16 *Ex Parte* Letter).

[661] *See, e.g.*, IRHN PN Comments at 21 (suggesting that services purchased under long-term contracts secured through the Pilot Program competitive bidding process be eligible for support); UAMS PN Comments at 7 (suggesting that the Commission exempt MSAs from the competitive bidding requirements that were negotiated through the Pilot Program competitive bidding process); SWTAG PN Comments at 12.

[662] *See 2012 Bridge Order*, 27 FCC Rcd at 7914-15, para. 18; *see also* UAMS PN Comments at 7-8 (stating that this approach "would continue to ensure fair, competitive pricing while allowing consortia to avail themselves of favorable, negotiated rates without accruing additional undue administrative costs").

approved by USAC during the Pilot Program bridge period.[663] In addition, the exemption will apply to services or equipment purchased during an MSA extension approved by USAC.[664] The exemption is limited to those MSAs that were developed and negotiated from an RFP that specifically sought a mechanism for adding additional sites to the network. This exemption does not extend to MSAs or extensions thereof that are not approved by USAC.

d. Evergreen Contracts

261. *Background.* The Telecommunications Program allows "evergreen" contracts, meaning that for the life of a multi-year contract deemed evergreen by USAC, HCPs need not annually rebid the service or post an FCC Form 465.[665] An HCP covered under an evergreen contract must still apply annually for support by filing an FCC Form 466 or 466-A.[666] In addition, in the Primary Program an HCP must post a Form 465 and undergo a new competitive bidding process whenever it seeks to add services, make cardinal changes, or renew or extend the contract (including optional extensions).[667] In the *NPRM*, the Commission proposed to codify the existing evergreen contract procedures for the new reformed program.[668]

262. *Discussion.* As proposed in the *NPRM*, and as supported in the record, we allow contracts to be designated as "evergreen" in the Healthcare Connect Fund.[669] As stated in the *NPRM* and echoed by commenters, evergreen procedures likely will benefit participating HCPs by affording them: (1) lower prices due to longer contract terms; and (2) reduced administrative burdens due to fewer required Form 465s.[670]

263. A contract entered into by an HCP or consortium as a result of competitive bidding will be designated as evergreen if it meets all of the following requirements: (1) signed by the individual HCP or consortium lead entity; (2) specifies the service type, bandwidth and quantity; (3) specifies the term of the contract; (4) specifies the cost of services to be provided; and (5) includes the physical addresses or other identifying information of the HCPs purchasing from the contract. Consortia will be permitted to add new HCPs if the possibility of expanding the network was contemplated in the competitive bidding process, and the contract explicitly provides for such a possibility.[671] Similarly, service upgrades will be

---

[663] *See 2012 Bridge Order*, 27 FCC Rcd at 7914-15, para. 18 (explaining that "in instances where the contract for eligible services ends before or during funding year 2012, or is not an "evergreen" contract that is valid until June 30, 2013, HCPs seeking bridge funding must complete the competitive bidding process and submit a Form 465 to seek additional funding for the period of time not covered by their existing contract").

[664] *See infra* section VI.B.6.d.

[665] USAC, Rural Health Care Webpage, Evergreen Contracts, http://www.usac.org/rhc/health-care-providers/evergreen-contracts.aspx (last visited Oct. 10, 2012). Applicants with multi-year contracts without evergreen status still must file the FCC Form 465 and participate in competitive bidding each year. *Id*.

[666] *Id*.

[667] *Id*. In section VI.E *infra*, we describe and adopt for the Healthcare Connect Fund the long-standing Commission policy that determines when a contract modification requires re-bidding of the contract. In section VI.F, we adopt a site and service substitution policy for Healthcare Connect Fund that is substantially similar to that used in the Pilot Program.

[668] *See NPRM*, 25 FCC Rcd at 9414-15, para. 112.

[669] *Id*.

[670] *Id*.; CTN Comments at 25; Marshfield Reply Comments at 5-6; NSTN Comments at 6; UAMS Comments at 8-9.

[671] This definition differs slightly from the evergreen policy currently utilized for the existing RHC programs. For example, USAC procedures currently require that both parties sign the contract, not just the beneficiary. *See*

(continued…)

permitted as part of an evergreen contract if the contemplated upgrades are proposed during the competitive bidding process, and the contract explicitly provides for the possibility of service upgrades.

264. Participants may also exercise voluntary options to extend an evergreen contract without undergoing additional competitive bidding, subject to certain limitations.[672] First, the voluntary extension(s) must be memorialized in the evergreen contract. Second, the decision to extend the contract must occur before the participant files its funding request for the funding year when the contract would otherwise expire.[673] Third, voluntary extension(s) may not exceed five years, after which the service(s) must be re-bid.[674] We find that this limitation strikes an appropriate balance between two competing considerations: (1) providing HCPs with the price and administrative savings of entering into a long-term contract; and (2) ensuring that HCPs periodically re-evaluate whether they can obtain better prices through re-bidding a service.

265. We also conclude that, if an HCP has a contract that was designated as evergreen under Telecommunications Program or Internet Access Program procedures prior to January 1, 2014, it may choose to seek support for services provided under the evergreen contract from the Healthcare Connect Fund instead without undergoing additional competitive bidding, so long as the services are eligible for support under the Healthcare Connect Fund, and the HCP complies with all other Healthcare Connect Fund rules and procedures. The Commission noted in the *NPRM* that codifying the evergreen policy "would maintain consistency while transitioning from the existing internet access program to the new health broadband services program."[675] Allowing HCPs who have already competitively bid (and received evergreen status for) multi-year contracts seamlessly to transition into the Healthcare Connect Fund furthers our program goals to streamline the application process and promote fiscal responsibility and cost-effectiveness.[676] Pilot Program participants who have negotiated a long-term contract that extends beyond the period of their Pilot awards may also seek to have their contracts designated as "evergreen" by USAC for purposes of the Healthcare Connect Fund without undergoing a new competitive bidding process, as long as the existing contract meets the requirements outlined above for an evergreen contract. If an evergreen contract approved under the Telecommunications Program, Internet Access Program, or a Pilot Program contract designated as evergreen under the Healthcare Connect Fund includes voluntary extensions, HCPs utilizing such contracts in the Healthcare Connect Fund may also exercise such voluntary extensions consistent with the requirements above.

e. Contracts Negotiated Under E-Rate

266. *Background*. Section 54.501(c) of our rules allows eligible schools and libraries, HCPs, and other public sector entities such as municipalities and state universities to form consortia to seek

(Continued from previous page)

USAC, Rural Health Care Webpage, Evergreen Contracts, http://www.usac.org/rhc/health-care-providers/evergreen-contracts.aspx (last visited Oct. 10, 2012).

[672] *See, e.g.*, CHCC/RMHN PN Comments at 4 (recommending that the Commission allow evergreen status for contract extensions, when the contract is renewed according to its terms).

[673] *Cf.* Universal Service Company, E-Rate, Selecting Service Providers, http://www.usac.org/sl/applicants/step03/contracts.aspx (last visited Nov. 8 2012). If the original contract expires during a funding year, the applicant must submit a Form 462 prior to the end of the original contract in order to begin receiving support as soon as the voluntary extension starts.

[674] For example, an HCP may exercise five successive one-year extensions, or a single five-year extension.

[675] *NPRM*, 25 FCC Rcd at 9414-15, para. 112.

[676] *See supra* section III.

competitive bids for supported services.[677] MiCTA, a consultant for non-profit entities, requests that its HCP members be allowed to use the Master Service Agreements (MSAs) that MiCTA holds for its E-rate members instead of engaging in the RHC competitive bidding process.[678] MiCTA argues that exempting its HCP members from competitive bidding and allowing them to use existing E-rate MSAs will encourage more MiCTA HCP members to participate in the RHC program."[679]

267. *Discussion.* Consistent with section 54.501(c)(1) of our rules, we conclude that an HCP entering into a consortium with E-rate participants and becoming a party to the consortium's existing contract should be exempt from the RHC competitive bidding requirements, so long as the contract was competitively bid consistent with E-rate rules, approved for use in the E-rate program as a master contract, and the Healthcare Connect Fund applicant (*i.e.* the individual HCP or consortium) otherwise complies with all Healthcare Connect Fund rules and procedures.[680] An applicant utilizing this exemption must submit documentation with its request for funding that demonstrates that (1) the applicant is eligible to take services under the consortium contract; and (2) the consortium contract was approved as a master contract in the E-rate program. We agree with MiCTA that such an exemption will reduce HCPs' individual administrative burdens and encourage consortia, and likely will save universal service funds due to the lower contract prices often associated with consortia bulk-buying.[681] We thus find that a competitive bidding exemption for HCPs entering into contracts negotiated under the E-rate program will further our program goals to streamline the application process, facilitate consortium applications, and promote fiscal responsibility and cost-effectiveness.[682] We note that an HCP in a consortium with E-rate participants may receive support only for services eligible for support under the RHC programs.

f. No Exemption for Internet2 and National LambdaRail

268. *Background*. In the Pilot Program, the Commission exempted connections to Internet2 and National LambdaRail from the competitive bidding rules, finding that, "allowing an applicant to pre-select National LambdaRail or Internet2 will provide the applicant with an opportunity to more fully develop the specific elements of its infrastructure proposal, particularly where only a specific non-profit nationwide backbone provider will fulfill the applicant's network plan or meet its need to access a

[677] *See* 47 C.F.R. § 54.501(c).

[678] *See* Letter from Gary L. Green, MiCTA, to Sharon Gillett, Chief, Wireline Competition Bureau, FCC, WC Docket No. 02-60 (filed Jan. 18, 2011) (MiCTA Letter); *see also Wireline Competition Bureau Seeks Comment on a Request by MiCTA for Waiver of the Rural Health Care Program Rules*, WC Docket No. 02-60, Public Notice, 26 FCC Rcd 2020 (2011); MiCTA PN Comments at 3-4 (stating that "allowing national non-profit Group Purchasing Organizations (GPOS) to bid as a 'third party' on behalf of their HCP members would lower costs for the program and for participants by alleviating administrative time and costs" and that "[t]his 'third party' bidding concept is not new as it currently exists in the e-rate program, in which MiCTA participates"). It is our understanding that the MSAs to which MiCTA refers are private MSAs which were put out for bids by MiCTA on behalf of its member entities, not to be confused with state MSAs which are put out for bids by state government entities for use by others. *See supra* section VI.B.6.b.

[679] MiCTA Letter at 1.

[680] *See* 47 C.F.R. § 54.501(c). We note that this exemption, like all competitive bidding exemptions discussed in this section, applies only to applicants receiving support through the Healthcare Connect Fund, not to other existing RHC programs.

[681] *See* MiCTA Letter at 1.

[682] *See supra* section III.

particular institution that is currently connected to only one nationwide network."[683] In the *NPRM*, the Commission proposed that participants in the health infrastructure program may either: (1) pre-select to connect with either Internet2 or National LambdaRail and seek funding for such connection without engaging in competitive bidding; or (2) seek bids from National LambdaRail and Internet2 through the normal competitive bidding process.[684]

269. *Discussion*. As explained more fully in section V.A.4 above, we require participants to seek competitive bids from any research and education networks, including Internet2 and National LambdaRail, through our standard competitive bidding process. As noted above, there may be instances where a more cost-effective solution is available from a commercial provider, or even a non-profit provider other than Internet2 or National LambdaRail, and a competitive bidding requirement will ensure that HCPs consider options from all interested service providers. Many commenters opposed the Commission's proposal to exempt National LambdaRail and Internet2 from competitive bidding, arguing, among other things, that such an exemption would be anti-competitive by disadvantaging other telecommunications providers.[685] We find that requiring HCPs to seek bids from National LambdaRail and Internet2 through the normal competitive bidding process could result in lower-priced bids, and should therefore be required. This approach furthers our program goal to promote fiscal responsibility and cost-effectiveness.[686]

C. Funding Commitment From USAC

270. Once a service provider is selected, applicants in the current RHC program submit a "Funding Request" (and supporting documentation) to provide information about the services selected and certify that the services were the most cost-effective offers received. If USAC approves the "Request for Funding," it will issue a "Funding Commitment Letter." USAC's role is to review the funding request for accuracy and completeness. Once an applicant receives a funding commitment, it may invoice USAC after receiving a bill from the service provider, as discussed in section VI.D below. Applicants do not need to file a Form 467 to notify USAC that the service provider began providing services for which the applicant is seeking support.

1. Requirements for Service Providers

271. All vendors that participate in the Healthcare Connect Fund are required to have a Service Provider Identification Number (SPIN).[687] The SPIN is a unique number assigned to each service provider by USAC, and serves as USAC's tool to ensure that support is directed to the correct service

---

[683] *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order on Reconsideration, 22 FCC Rcd 2555, 2557-58, para. 7 (2007) (*Pilot Program Order on Reconsideration*).

[684] *See NPRM*, 25 FCC Rcd at 9388-89, para. 41.

[685] *See supra* n.366 and accompanying text.

[686] *See supra* section III.C.

[687] To obtain a new SPIN, a service provider must complete and file with USAC a Form 498 (Service Provider Identification and Contact Information). Complete instructions on filing Form 498 are available on USAC's web site at http://www.usac.org/sp/about/498/default.aspx. *See* USAC, Obtain a Service Provider Identification Number, *available at* http://www.usac.org/sp/about/498/obtain-spin.aspx (last visited Dec. 17, 2012). We note that non-telecommunications service providers may apply for and receive a SPIN. In Block 13 of the Form 498, a SPIN applicant may characterize itself as an NTP ("Non-Traditional Provider"), or "a Company that does not provide telecommunications services." *See* FCC Form 498, Block 13, http://www.usac.org/sp/about/498/obtain-spin.aspx (last visited Dec. 13, 2012); FCC Form 498 Instructions at 15, *available at* http://www.usac.org/_res/documents/cont/pdf/forms/2012/form-498-fy2012-instructions.pdf (last visited Dec. 13, 2012).

provider. SPINs must be assigned before USAC can authorize support payments. Therefore, all service providers submitting bids to provide services to selected participants will need to complete and submit a Form 498 to USAC for review and approval if selected by a participant before funding commitments can be made.[688]

272. Service providers in the Healthcare Connect Fund must certify on Form 498, as a condition of receiving support, that they will provide to HCPs, on a timely basis, all information and documents regarding the supported service(s) that are necessary for the HCP to submit required forms or respond to FCC or USAC inquiries. In addition, USAC may withhold disbursements for the service provider if the service provider, after written notice from USAC, fails to comply with this requirement.[689]

2. Filing Timeline for Applicants

273. *Background*. Under current rules, requests for funding may be submitted at any point during the funding year. Although USAC cannot commit funds to a HCP until it receives a funding request, the applicant may request support for services provided at any time during the funding year after it signs a valid contract (or otherwise enters into a service agreement) with its selected service provider. In the current Primary Program, applicants frequently initiate services at their own risk while their funding requests are pending. For example, if a HCP enters into a valid contract on July 1 and begins receiving services on July 2, it may submit a funding request on October 1 that requests funding beginning on July 2.

274. Section 54.623(c) of the Commission's rules directs USAC to implement a "filing window" that treats all rural HCPs filing within the period as if their applications were simultaneously received.[690] If funding requests received during the "filing window" exceed the annual funding cap, USAC is required under current rules to apply a pro-rata reduction to the support available to each applicant in order to bring total support below the cap.[691] Because RHC program demand has never approached the cap, USAC has never had to pro-rate support, and accepts funding requests for the Telecommunications Program until the last day of the funding year.

275. *Discussion.* Unless and until the Commission adopts other procedures to prioritize requests for funding, we retain the rule that requests for funding may be submitted at any point during the funding year, and direct USAC to process and prioritize funding requests on a rolling basis (according to the date of receipt) until it reaches the program cap established by the Commission. Given the historical utilization of RHC support and the implementation timetable for funding year 2013, we do not currently anticipate that demand will exceed the $400 million cap in FY 2013 or for the foreseeable future.[692] We conclude, however, that this longstanding default rule will apply in the unlikely event that the cap is exceeded, unless and until the Commission adopts a different rule for prioritizing funding requests.[693] We also direct USAC to periodically inform the public, through its web site, of the total dollar amounts (1)

---

[688] Only service providers that have not already been assigned a SPIN by USAC will need to complete and submit a Form 498. Form 498 can be found on the USAC website on its forms page, *available at* http://www.usac.org/cont/tools/forms/default.aspx (last visited Dec. 7, 2012). Service providers who elect the direct reimbursement option under our revised offset rule, *see infra* section X.D, may also make the election on Form 498. Form 498 will be revised in accordance with the new requirements in this order.

[689] *See* Appendix D, 47 C.F.R. § 54.640.

[690] 47 C.F.R. § 54.623(c)(4), (f).

[691] 47 C.F.R. § 54.623(f).

[692] *See supra* para. 98.

[693] *See infra* section X.C.

requested by HCPs and (2) actually committed by USAC for the funding year, as well as the amounts committed in upfront payments (for purposes of the $150 million cap on upfront payments).[694]

276. We also direct USAC to establish a filing window for funding year 2013 and for future funding years as necessary, for both the Telecommunications Program and the Healthcare Connect Fund. When USAC establishes a filing window, it should provide notice of the window in advance via public notice each year. The filing window may begin prior to the first day of the funding year, as long as actual support is only provided for services provided during the funding year.

277. As in the Telecommunications Program, applicants may initiate services at their own risk during the funding year pending the processing of their funding requests, as long as the services are provided pursuant to a contract or other service agreement that complies with program requirements (including the competitive bidding process). The contract must be signed (or the service agreement entered into) before the applicant submits a funding request.

278. As discussed in more detail in the Effective Dates and Implementation Timeline section below, funding will be available for Pilot participants starting July 1, 2013, and starting January 1, 2014, for other applicants.

3. Required Documentation for Applicants

279. This section describes the information that should be submitted to USAC to support a request for commitment of funds.

280. *Form 462.* Form 462 is the means by which an applicant identifies the service(s), rates, service provider(s), and date(s) of service provider (vendor) selection. In the Primary Program, applicants are required to submit a separate form for each service or circuit for which the applicant is seeking support. In the Healthcare Connect Fund, we will not require separate forms for each service or circuit, thereby lessening administrative burden on potential Fund recipients. Each individual applicant will submit a single form for each service provider that lists the relevant information for all service(s) or circuit(s) for which the individual applicant is seeking support at the time. Similarly, each consortium applicant will submit a single form for each service provider that lists the relevant information for all consortium members, including the service(s) or circuit(s) for which each member is seeking support at the time.[695]

281. *Certifications.* Applicants must provide the following certifications on Form 462.[696]

- The person signing the application is authorized to submit the application on behalf of the applicant, and has examined the form and all attachments, and to the best of his or her knowledge, information, and belief, all statements of fact contained therein are true.
- Each service provider selected is, to the best of the applicant's knowledge, information, and belief, the most cost-effective service provider available, as defined in the Commission's rules.
- All Healthcare Connect Fund support will be used only for the eligible health care purposes, as described in this Order and consistent with the Act and the Commission's rules.
- The applicant is not requesting support for the same service from both the Telecommunications Program and the Healthcare Connect Fund.

[694] *See supra* para. 190.

[695] *See* Appendix E, Form 462.

[696] Section VII.A below discusses who may sign and submit certifications on behalf of the applicant.

- The applicant satisfies all of the requirements under section 254 of the Act and applicable Commission rules, and understands that any letter from USAC that erroneously commits funds for the benefit of the applicant may be subject to rescission.
- The applicant has reviewed all applicable requirements for the program and will comply with those requirements.
- The applicant will maintain complete billing records for the service for five years.

282. *Contracts or other documentation.* All applicants must submit a contract or other documentation that clearly identifies (1) the vendor(s) selected and the HCP(s) who will receive the services; (2) the service, bandwidth, and costs for which support is being requested; (3) the term of the service agreement(s) if applicable (*i.e.* if services are not being provided on a month-to-month basis). For services provided under contract, the applicant must submit a copy of a contract signed and dated (after the Allowable Contract Selection Date) by the individual HCP or Consortium Leader. If the service is not being provided under contract, the applicant must submit a bill, service offer, letter, or similar document from the service provider that provides the required information. In either case, applicants must ensure that the documentation provided specifies all charges for which the applicant is receiving support (for example, if the contract does not specify all such charges, applicants should submit a bill or other similar documentation to support their request). In addition, applicants may wish to submit a network or circuit diagram for requests involving multiple vendors or circuits.

283. *Competitive bidding documents.* As discussed in section VI.B.5 above, applicants must submit documentation to support their certifications that they have selected the most cost-effective option. Relevant documentation includes a copy of each bid received (winning, losing, and disqualified), the bid evaluation criteria (as discussed in section VI.A.4 above), and any other related documents, as described in paragraph 248 above.[697] Applicants who are exempt from competitive bidding should also submit any relevant documentation to allow USAC to verify that the applicant is eligible for the exemption (*e.g.*, a copy of the relevant government MSA and documentation showing that the applicant is eligible to purchase from the MSA, or USAC correspondence identifying and approving a contract previously approved for the Pilot Program).

284. *Cost allocation for ineligible entities or components.* Applicants who seek to include ineligible entities within a consortium, or to obtain support for services or equipment that include both eligible and ineligible components, should submit a description of their cost allocation methodology per the requirements in section V.C.4 above. Applicants should also submit any agreements that memorialize cost-sharing arrangements with ineligible entities.

285. *Evidence of viable source for 35 percent contribution.* Many projects in the Pilot Program experienced implementation delays, in part due to the difficulty in obtaining their required contribution. In the *NPRM*, the Commission suggested participants in the proposed infrastructure program be required to demonstrate they have a reasonable and viable source for their contribution by

[697] Applicants may check a box on the relevant forms to request nondisclosure of confidential commercial and financial information, including, but not limited to, pricing, bids, and contract terms, under the "trade secret/ privileged or confidential commercial or financial information" exemption of the Freedom of Information Act (FOIA), in lieu of submitting a separate request for confidentiality pursuant to section 0.459 of the Commission's rules. *See* 5 U.S.C. § 552(b)(4); 47 C.F.R. § 0.459(a)(4). All decisions regarding disclosure of company-specific information will be made by the Commission. Because the information submitted by the HCP to USAC may be competitively sensitive, we encourage vendors who have concerns about the confidentiality of bidding information to raise the issues of USAC confidentiality requests early in the competitive bidding process with the HCP.

submitting letters of assurances confirming funds from eligible sources to meet the contribution requirement.[698]

286. We require all consortium applicants to submit, with their funding requests, evidence of a viable source for their 35 percent contribution. We adopt this requirement to minimize administrative processing of applications that do not have a source for the required match, which will lessen USAC's administrative costs and thereby lessen the burden on the Fund. As stated above, applicants, especially those that intend to undertake high-dollar projects, should begin identifying potential sources for their contribution as early as possible.[699] The funding request is the last major step in the application process before applicants receive a funding commitment, and at this stage applicants should be well advanced in determining the amount of their contribution and the source for that contribution.[700] We also note that program participants will be required to submit a certification that they have paid their 35 percent contribution before USAC will disburse universal service support, so it is important for participants to have a ready source of payment before they begin receiving services.

287. Consortia may provide evidence of a viable source by submitting a letter signed by an officer, director, or other authorized employee of the Consortium Leader. The letter should identify the entity that will provide the 35 percent contribution, and the type of eligible source (*e.g.* HCP budget, grant/loan, etc.). If the applicant contribution is dependent on appropriations, grant funding, or other special conditions, the applicant should include a description of any special conditions and general information regarding those conditions. If the applicant has already identified secondary sources of funding, it should also include information regarding such sources in its letter. If the source for the participant contribution is excess capacity, applicants must identify the entit(ies) who will pay for the excess capacity, and submit evidence of arrangements made to comply with the requirements in section IV.D.3 above.[701]

288. Consortium applicants are not required to identify the funding source for each consortium member if each consortium member will pay its contribution individually. Instead, the Consortium Leader should (1) verify that each member will pay its contribution from an eligible source (*e.g.*, by requesting a certification to that effect in the consortium member's LOA) and (2) submit documentation (*e.g.* consortium membership agreement) that shows that each member has agreed to pay its own contribution from an eligible source.

289. We delegate authority to the Bureau to provide more specific guidance, if needed, on the content of the letter and documentation to be submitted. USAC may, as needed, request additional documentation from applicants in order to ensure compliance with this requirement.

290. *Additional documentation for consortium applicants.* Consortium applicants should submit any revisions to the project management plan, work plan, schedule, and budget previously submitted with the Request for Services (Form 461). If not previously provided with the project management plan, applicants should also provide (or update) a narrative description of how the network will be managed, including all administrative aspects of the network (including but not limited to invoicing, contractual matters, and network operations.) If the consortium is required to provide a sustainability plan (as discussed in the next paragraph), the revised budget should include the budgetary factors discussed in the sustainability plan requirements Finally, consortium applicants will be required

[698] *NPRM*, 25 FCC Rcd at 9391-92, paras. 46-47.

[699] *See supra* section VI.A.5.

[700] *See* PSPN Comments at 5.

[701] *See supra* section V.D.3.

to provide electronically (via a spreadsheet or similar method) a list of the participating HCPs and all of their relevant information, including eligible (and ineligible, if applicable) cost information for each participating HCP. USAC may reject submissions that lack sufficient specificity to determine that costs are eligible.

291. *Sustainability plans for applicants requesting support for long-term capital expenses.* In the *NPRM*, the Commission proposed to require sustainability plans similar to those required in the Pilot Program for HCPs who intended to have an ownership interest, indefeasible right of use, or capital lease interest in facilities funded by the Fund.[702] We adopt the proposal in the *NPRM*, and require that consortia who seek funding to construct and own their own facilities or obtain IRUs or capital lease interests to submit a sustainability plan with their funding requests demonstrating how they intend to maintain and operate the facilities that are supported over the relevant time period. A sustainability plan for such projects is appropriate to protect the Fund's investment, because such projects are requesting support for capital expenses that are intended to have long-term benefits.[703]

292. We largely adopt the same specific requirements for sustainability plans proposed in the *NPRM* and utilized in the Pilot Program.[704] Although participants are free to include additional information to demonstrate a project's sustainability, the sustainability plan must, at a minimum, address the following points:

- Projected sustainability period. Indicate a reasonable sustainability period that is at least equal to the useful life of the funded facility. Although a sustainability period of 10 years is generally appropriate, the period of sustainability should be commensurate with the investments made from the health infrastructure program. For example, if the applicant is purchasing a 20 year IRU, the sustainability period should be a minimum of 20 years. The applicant's budget should show projected income and expenses (*i.e.* for maintenance) for the project at the aggregate level, for the sustainability period.
- Principal factors. Discuss each of the principal factors that were considered by the participant to demonstrate sustainability. This discussion should include all factors that show that the proposed network will be sustainable for the entire sustainability period. Any factor that will have a monetary impact on the network should be reflected in the applicant's budget.
- Terms of membership in the network. Describe generally any agreements made (or to be entered into) by network members (*e.g.*, participation agreements, memoranda of understanding, usage agreements, or other documents). If the consortium will not have agreements with the network members, it should so indicate in the sustainability plan. The sustainability plan should also describe, as applicable: (1) financial and time commitments made by proposed members of the network; (2) if the project includes excess bandwidth for growth of the network, describe how such excess bandwidth will be financed; and (3) if the network will include eligible HCPs and other network members, describe how fees for joining and using the network will be assessed.

[702] *NPRM*, 25 FCC Rcd at 9399-9400, para. 65.

[703] Commenters largely supported a sustainability plan requirement. *See, e.g.*, Comments at 4NCTN Comments at 5-6; WRHA Comments at 3; PSPN Comments at 13-14; UAMS Comments at 5; *compare* GCI Comments at 14, Internet2 Comments at 16 (opposing sustainability plan requirement).

[704] We will not require consortia to include a discussion of the status of obtaining the participant contribution in their sustainability plans, as proposed in the *NPRM*, because we separately require them to submit this information (see para. 285 above).

- Ownership structure. Explain who will own each material element of the network (*e.g.*, fiber constructed, network equipment, end user equipment). For purposes of responding to this question, "ownership" includes an IRU interest. Applicants should clearly identify the legal entity who will own each material element so that USAC can verify that only eligible entities receive the benefits of program support.[705] Applicants should also describe any arrangements made to ensure continued use of such elements by the network members for the duration of the sustainability period.
- Sources of future support. If sustainability is dependent on fees to be paid by eligible HCPs, then the sustainability plan should confirm that the HCPs are committed and have the ability to pay such fees. If sustainability is dependent on fees to be paid by network members that will use the network for health care purposes, but are not eligible HCPs under the Commission's rules, then the sustainability plan should identify such entities. Alternatively, if sustainability is dependent on revenues from excess capacity not related to health care purposes, then the sustainability plan should identify the proposed users of such excess capacity. Projects who have multiple sources of funding should address each source of funding and the likelihood of receiving that funding. Eligible HCPs may not receive support twice for the same service. For example, if the Healthcare Connect Fund provides support for a network to procure an IRU to be used by its members, and the network charges its members a fee to cover the undiscounted cost of the IRU, the members may not then individually apply for program support to further discount the membership fee.
- Management. The applicant's management plan should describe the management structure of the network for the duration of the sustainability period, and the applicant's budget should describe how management costs will be funded.

293. The Pilot Program required projects to submit a copy of their sustainability plan with every quarterly report.[706] Based on our experience with the Pilot Program, we conclude submission of the sustainability report on a quarterly basis is unnecessarily burdensome for applicants, and provides little useful information to the Administrator. We therefore conclude that sustainability reports for the Healthcare Connect Fund should only be required to be re-filed if there is a material change in sources of future support or management, a change that would impact projected income or expenses by the greater of 20 percent or $100,000 from the previous submission, or if the applicant submits a funding request based on a new Form 461 (*i.e.*, a new competitively bid contract). In that event, the revised sustainability report should be provided to USAC no later than the end of the relevant quarter, clearly showing (*i.e.*, by redlining or highlighting) what has changed.

4. Requests for Multi-Year Commitments

294. *Background*. The Commission currently allows for multi-year contracts in the Primary Program through the use of "evergreen" status, meaning that participants do not have to rebid the service for the life of the a contract designated as evergreen. Primary Program participants, however, are only guaranteed support for a year at a time, and must re-submit a funding request each year.[707] Because funding is not guaranteed for a multiple year period, however, HCPs may not be able to obtain the same

[705] If the number of entities to be identified is large (*e.g.*, each eligible HCP will own its end user equipment), applicants may identify such entities by reference (*e.g.*, "each eligible HCP listed in Form 462 being submitted today will own its end user equipment").

[706] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20423-24, para. 126.

[707] *See* USAC web site on evergreen contracts, *available at* http://www.universalservice.org/rhc/health-care-providers/evergreen-contracts.aspx (last visited Dec. 3, 2012).

level of cost savings that they could receive with multiple years of guaranteed funding. The Pilot Program, on the other hand, provided a lump-sum award over a three-year period, which provided projects with additional leverage in negotiating contracts.

295. In the *July 19th Public Notice*, the Bureau sought to further develop the record on issues relating to multi-year contracts, including issues relating to upfront payments.[708] Commenters unanimously supported multi-year commitments as a measure that would reduce administrative costs and increase the value of the services procured.[709]

296. *Discussion.* We will allow applicants in the Healthcare Connect Fund to receive multi-year funding commitments that cover a period of up to three funding years. The multi-year funding commitments we adopt will reduce uncertainty and administrative burden by eliminating the need for HCPs to apply every year for funding, as is required under the Primary Program, and reduce administrative expenses both for the projects and for USAC.[710] Multi-year funding commitments, prepaid leases, and IRUs also encourage term discounts and produce lower rates from vendors.[711] Multi-year commitments will also allow consortium applicants to choose HCP-constructed-and-owned infrastructure where it is the most cost-effective way to obtain broadband. Applicants receiving support for long-term capital investments whose useful life extends beyond the period of the funding commitment may be subject to additional reporting requirements to ensure that such facilities continue to be used for their intended purpose throughout their useful life. We delegate authority to the Bureau to issue administrative guidance to implement such requirements.

297. Applicants requesting a funding commitment for a multi-year funding period should indicate the years for which funding is required on Form 462 and, for consortia, with the attachment that lists the HCPs and costs for each HCP within the network. If a long-term contract covers a period of more than three years, the applicant may also have the contract designated as "evergreen" if the contract meets the criteria specified in section VI.B.6.d above, which will allow the applicant to re-apply for a funding commitment under the contract after three years without having to undergo additional competitive bidding.[712] In choosing a three-year period, we strike a balance between allowing applicants and the Fund to reap the benefits of long-term contracts, reducing administrative burdens on applicants and the Fund, and ensuring that applicants are not "locked in" to long-term contracts which may prevent them from seeking more cost-effective options when prices drop, or they choose to upgrade to higher bandwidths/newer technologies.[713] Three years is also consistent with our requirement that upfront

[708] *July 19 Public Notice*, 27 FCC Rcd at 8198, para. 11.

[709] *See, e.g.*, AHA PN Comments at 4; RWHC PN Comments at 4; MTN PN Comments at 3; CCHCS PN Comments at 5.

[710] *See* USAC Observations Letter at 4; MTN PN Comments at 3; CCHCS PN Comments at 5. Multi-year funding commitments will only be available in the Healthcare Connect Fund.

[711] *See, e.g.*, IRHN PN Comments at 14, 18 (multi-year contracts allow HCPs to lock in cost-effective pricing for high-speed broadband for multiple years, give vendors an improved business case to construct/install/upgrade fiber or other plant, and help make the business case for commercial providers to lower their standard recurring-cost pricing due to the longer-term revenue stream).

[712] *See supra* section VI.B.6.d. By having contracts designated as "evergreen," HCPs will also be able to exercise voluntary extensions without re-bidding as described above. *See id.; cf.* CHCC/RMHN PN Comments at 4; MTN Comments at 3-4.

[713] *See* RWHC PN Comments at 4; CHCC/RMHN PN Comments at 4; CCHCS PN Comments at 5; IRHN PN Comments at 14; UTN PN Comments at 4. *See also* USAC E-rate guidance for technology plans, *available at* http://www.usac.org/sl/applicants/step01/default.aspx (*last visited* Dec. 3, 2012) (recommending that in general, e-rate technology plans should not cover more than three years).

payments averaging more than $50,000/site be amortized over at least three years. Commenters generally support a three-year period as being reasonable.[714] Consistent with current rules, a multi-year funding commitment cannot extend beyond the end of the contract submitted with the request for funding. For example, if an applicant submits a two-year contract and requests a multi-year funding commitment, USAC will only issue a funding commitment for two years. Similarly, if a contract ends in the middle of the funding year, the funding commitment can only extend to the end date of the contract.

298. In the *NPRM*, the Commission proposed a $100 million cap for infrastructure projects.[715] We institute a single cap of $150 million annually that will apply to all commitments for upfront payments during the funding year, and all multi-year commitments made during a funding year.[716] This approach for the hybrid infrastructure-services program will provide greater flexibility than the $100 million cap proposed in the NPRM for infrastructure projects; it recognizes that upfront payments also can be substantial when purchasing services from a commercial provider who needs to deploy facilities to serve the HCP. This cap takes into account the need for economic reasonableness and responsible fiscal management of the program, and will help prevent large annual fluctuations in program demand. We direct USAC to process and prioritize funding requests for upfront payments and multi-year commitments on a rolling basis, similar to the process we set forth above for funding requests generally. We also direct USAC to periodically inform the public, through its web site, of the total dollar amounts subject to the $150 million cap that have been (1) requested by HCPs (2) actually committed by USAC for the funding year.[717] We may consider adjusting the cap upward if it appears a significant number of Primary Program participants are moving to the Healthcare Connect Fund. Finally, USAC may establish a filing window tailored toward funding requests subject to the $150 million cap, if necessary.[718]

299. Current Commission rules allow universal service support for state and federal taxes and surcharges assessed on eligible services.[719] We recognize that taxes and surcharges can fluctuate over a three-year commitment period. In the Pilot Program, projects were allowed to estimate taxes and surcharges over the commitment period. Similarly, in the Healthcare Connect Fund, we will take into account the year-to-year fluctuation in taxes and surcharges by allowing HCPs and consortia to estimate the expense using either current tax rates or by projecting the tax rate for the commitment period. Projected taxes and surcharges shall be limited to no higher than 110 percent of the current rate at the

[714] *See, e.g.*, NCTN PN Comments at 5; RHWC PN Comments at 4; CCHCS PN Comments at 5 (supporting a term of three to five years); SWTAG PN Comments at 11 (stating that a three-year term would allow for changes to maintenance agreements and equipment upgrades if necessary).

[715] *NPRM*, 25 FCC Rcd at 9421-22, paras. 128-31.

[716] We find that a single cap is the most easily administrable, given that some multi-year commitment requests will likely include a component for upfront payments. The Anti-Deficiency Act (ADA) prohibits the Commission from making or authorizing an expenditure or obligation that exceeds the amount available for it an appropriation or fund. 31 USC §1341. The universal service programs, however, have been exempt from the ADA since about 2005, Pub. L. No. 108-494, Title III, §§ 301-302 (Dec. 23, 2004) and currently are exempt until December 31, 2013 as part of a two-year exemption set forth in the Consolidated Appropriations Act, 2012, Pub. L. No. 112-74, § 510 (Dec. 23, 2011).

[717] We require USAC to post this information both for the $150 million cap on multi-year commitments and upfront payments, and for the overall $400 program cap. *See infra* section X.C. If an applicant signs a multi-year contract but funds are no longer available for the funding year for a multi-year commitment, the applicant may choose to simply seek a one-year funding commitment, have the contract designated as "evergreen," and apply for a multi-year funding commitment in the next funding year.

[718] *See* Appendix D, 47 C.F.R. § 54.675.

[719] 47 C.F.R. § 54.609(a).

time that the HCP or consortium files a funding request.[720] The funding commitment will be issued based on the tax and surcharge rate provided by the applicant. We note that this does not lead to an additional potential for waste, fraud, and abuse, because disbursements will be based on actual expenses, not the projections.

5. USAC Processing and Issuance of Funding Commitment Letters

300. USAC will review funding requests and, if approved, issue a funding commitment letter to the applicant. We allow applicants the opportunity to cure errors on their submissions after initial USAC review, although the responsibility to submit complete and accurate information remains at all times the sole responsibility of the applicant. In order to expedite HCPs' ability to initiate service once they have selected a service provider, we specify a timeframe for USAC's initial review of funding commitment requests. Within 21 calendar days of receipt of a complete funding commitment request, USAC will inform applicants in writing of (1) any and all ministerial or clerical errors that it identifies in the funding commitment request, along with a clear and specific explanation of how the selected participants can remedy those errors; (2) any missing, incomplete, or deficient certifications; and (3) any other deficiencies that USAC finds, including any ineligible network components or ineligible network components that are mislabeled in the funding request. If USAC needs more than 21 calendar days to complete its initial review of the funding request, it should inform the applicant in writing that it needs additional time, and provide the applicant with a date on or before which it expects to provide the information described in the prior sentence.[721] We remind applicants that this 21-day period is not a deadline for USAC to issue a funding commitment letter. Instead, it is a timeframe for USAC to check that information provided by applicants is complete and accurate, which will then allow USAC to subsequently process the funding request. If an applicant receives a notice that its funding request includes deficiencies, it will have 14 calendar days from the date of receipt of the USAC written notice to amend or re-file its funding request for the sole purpose of correcting the errors identified by USAC.[722]

301. For purposes of prioritizing funding requests, funding requests are deemed to have been filed when the applicant submits an application that is complete. If USAC identifies any errors or deficiencies during its initial 21-day review, the application is not considered to be complete until all such errors and deficiencies are corrected. Applicants may make material changes to their funding requests prior to USAC's issuance of a funding commitment letter, but will be considered, for priority purposes, to have filed their applications as of the date when a complete notice of the material change (*i.e.* without the types of errors or deficiencies identified in the prior paragraph) is submitted to USAC.

302. Upon completion of its review process, USAC will send funding commitment letter or a denial. The funding commitment letter should specify whether the contract has been deemed evergreen (if requested), and whether a multi-year commitment has been issued (and if so, the annual amount of the commitment). Applicants denied funding for errors other than ministerial or clerical errors must follow USAC's and the Commission's regular appeal procedures.[723] Applicants that do not comply with the

---

[720] *See* USAC Nov. 16 Data Letter at 4 (Pilot projects usually requested funding for a maximum of 10 percent over the current tax rate).

[721] We delegate authority to the Bureau to extend USAC's deadline to complete initial reviews based on the volume of funding requests.

[722] Applicants will be presumed to have received notice five days after such notice is postmarked by USAC. To expedite the application process, we also direct USAC to send the notice via e-mail to the applicant if the applicant has provided an e-mail address.

[723] *See* 47 C.F.R. §§ 54.719 *et seq*.

terms of this Order, section 254 of the 1996 Act, and Commission rules and orders will be denied funding in whole or in part, as appropriate.

D. Invoicing and Payment Process

303. *Background.* The Primary and Pilot Programs have different invoicing and payment procedures, through which service providers receive universal service support payments for the services they have rendered to HCPs. Although both programs require HCPs to certify that they have received contracted services from providers, the Pilot Program also requires HCPs to certify that they have already paid their 15 percent contribution to the service provider before the invoice for payment to the service provider can be submitted to USAC. The Pilot Program also requires HCPs and service providers to review and certify the accuracy of payment requests submitted to USAC.[724]

304. *Discussion.* In Healthcare Connect Fund, we adopt an invoicing procedure similar to the one currently in use by the Pilot Program. In the Pilot Program, service providers bill HCPs directly for services that they have provided. Upon receipt of a service provider's bill, the HCP creates and approves an invoice for the services it has received, certifies that the invoice is accurate and that it has paid its contribution, and sends the invoice to the service provider. The service provider then certifies the invoice's accuracy and uses it to receive payment from USAC.

305. This invoicing procedure is different from the Primary Program in two principal ways. In the Healthcare Connect Fund, as in the Pilot Program, (1) a HCP or Consortium Leader must certify to USAC that it has paid its contribution to the service provider before the invoice can be sent to USAC and the service provider can be paid, and (2) before any invoice is sent to USAC, both the HCP and service provider must certify that they have reviewed the document and that it is accurate. We believe the adoption of these requirements in the new program will help eliminate waste, fraud, and abuse by making sure that HCPs have made their required contribution to the cost of the services they receive and that the invoice accurately reflects the services an HCP is receiving and the support due to the service provider. It is permissible to certify that these steps have been taken via electronic signature of an officer, director, or other authorized employee of the Consortium Leader or HCP. All invoices must be received by the Administrator within six months of the end date of the funding commitment.

E. Contract Modifications

306. *Background.* In the 1997 *Universal Service Fourth Order on Reconsideration*, the Commission set forth the requirements applicable to contract modifications in the RHC support mechanism. We adopt the same requirements for the Healthcare Connect Fund, and briefly recap them below for applicants who are new to universal service fund programs.

307. *Discussion.* The *Universal Service Fourth Order on Reconsideration* concluded that requiring a competitive bid for every minor contract modification would place an undue burden upon eligible entities.[725] The Commission found that an eligible school, library, or rural HCP would be entitled to make minor modifications to a contract that was previously approved for funding without completing an additional competitive bid process.[726] The Commission also noted that any service provided pursuant to a minor contract modification also must be an eligible supported service as defined in the *Order* to receive support or discounts.

---

[724] For a summary of Pilot Program invoicing and payment procedures, *see* USAC RHC Pilot Program Process Overview, http://www.universalservice.org/rhcp/vendors/default.aspx/ (last visited Oct. 18, 2012).

[725] *Universal Service Fourth Order on Reconsideration*, 13 FCC Rcd at 5448, para. 224.

[726] *Id*.

308. Consistent with existing requirements, HCPs should look to state or local procurement laws to determine whether a proposed contract modification would be considered minor and therefore exempt from state or local competitive bidding processes.[727] If a proposed modification would be exempt from state or local competitive bidding requirements, the applicant likewise would not be required to undertake an additional competitive bidding process in connection with the applicant's request for discounted services under the federal universal service support mechanisms.[728] Similarly, if a proposed modification would have to be rebid under state or local competitive bidding requirements, then the applicant also would be required to comply with the Commission's competitive bidding requirements before entering into an agreement adopting the modification.[729]

309. The *Universal Service Fourth Order on Reconsideration* also addressed instances in which state and local procurement laws are silent or are otherwise inapplicable with respect to whether a proposed contract modification must be rebid under state or local competitive bidding processes. In such cases, the Commission adopted the "cardinal change" doctrine as the standard for determining whether the contract modification requires rebidding.[730] The cardinal change doctrine looks at whether the modified work is essentially the same as that for which the parties contracted.[731] A cardinal change occurs when one party affects an alteration in the work so drastic that it effectively requires the contractor to perform duties materially different from those originally bargained for.[732] In determining whether the modified work is essentially the same as that called for under the original contract, factors considered are the extent of any changes in the type of work, performance period, and cost terms as a result of the modification.[733] Ordinarily a modification falls within the scope of the original contract if potential offerors reasonably could have anticipated the modification under the changes clause of the contract.[734]

310. The cardinal change doctrine recognizes that a modification that exceeds the scope of the original contract harms disappointed bidders because it prevents those bidders from competing for what is essentially a new contract. The Commission adopted the cardinal change doctrine as the test for determining whether a proposed modification will require rebidding of the contract, absent direction on this question from state or local procurement rules, because it believed this standard reasonably applies to

---

[727] *See Universal Service Fourth Order on Reconsideration,* 13 FCC Rcd at 5448-49, para. 225.

[728] *Id*.

[729] *Id*.

[730] *See id.* at 5449, para. 226.

[731] *See Graphicdata, LLC v. U.S.*, 37 Fed.Cl. 771, 781 (Fed.Cl. 1997)*; AT&T v. WILTEL*, 1 F.3d 1201, 1205 (Fed. Cir. 1993); *Cray Research v. Dept. of Navy*, 556 F. Supp. 201, 203 (D.D.C. 1982); CAD Language Systems, 68 Comp. Gen. 376 (1989), 89-1 CPD para. 364; *Universal Service Fourth Order on Reconsideration,* 13 FCC Rcd at 5449-50, para. 227

[732] *Rumsfeld v. Freedom NY.*, Inc., 329 F.3d 1320, 1332, *adhered to on denial of reh'g en banc sub nom. Rumsfeld v. Freedom, NY, Inc.*, 346 F.3d 1359 (Fed. Cir. 2003); *Krygoski Constr. Co. v. United States*, 94 F.3d 1537, 1543 (Fed.Cir.1996).

[733] *Information Ventures, Inc.*, B-240458, Nov. 21, 1990, 90-2 CPD para. 414.

[734] *Cardinal Maint. Serv., Inc. v. United States*, 63 Fed.Cl. 98, 107(Fed. Cl. Nov. 2004); *Master Security, Inc.*, B-274990.2, Jan. 14, 1997, 97-1 CPD para. 21; *Air A-Plane Corporation v. United States*, 408 F.2d 1030, 1032-33 (Ct. Cl. 1968); *Hewlett Packard Co.*, B-245293, Dec. 23, 1991, 91-2 CPD para. 576; *Universal Service Fourth Order on Reconsideration*, 13 FCC Rcd at 5449-50, para. 227.

contracts for supported services arrived at via competitive bidding.[735] If a proposed modification is not a cardinal change, there is no requirement to undertake the competitive bidding process again.[736]

311. An eligible HCP seeking to modify a contract without undertaking a competitive bidding process should, within 30 calendar days of signing or otherwise entering into the contract modification, file a revised funding commitment request indicating the value of the proposed contract modification so that USAC can track contract performance. The HCP also must demonstrate that the modification is within the original contract's change clause or is otherwise a minor modification that is exempt from the competitive bidding process.[737] The HCP's justification for exemption from the competitive bidding process will be subject to audit and will be reviewed by USAC to determine whether the applicant's request is, in fact, a minor contract modification that is exempt from the competitive bidding process. We note that program participants make contract modifications without competitive bidding at their own risk. If a participant makes a contract modification without competitive bidding, and the modification does not qualify as minor, USAC will not allow support for the modification.

312. We emphasize that even though minor modifications will be exempt from the competitive bidding requirement, parties are not guaranteed support with respect to such modified services. A commitment of funds pursuant to an initial FCC Form 462 does not ensure that additional funds will be available to support the modified services. We conclude that this approach is reasonable and is consistent with our effort to adopt the least burdensome application process possible while maintaining the ability of USAC and the Commission to perform appropriate oversight.

F. Site and Service Substitutions

313. Based on our experience in the Pilot Program, we adopt a site and service substitution policy for participants in the Healthcare Connect Fund that is similar to that applied in the Pilot Program.[738] Consortia may make site substitutions in accordance with the policy (because individual applicants are by definition single-site, no site substitutions are allowed for individual applicants). Both individual and consortium applicants may make service substitutions in accordance with the policy.

314. As the Commission found in the Pilot Program, allowing site and service substitutions minimizes the burden on consortium participants and increases administrative efficiency by enabling HCPs to ask USAC to substitute or modify the site or service without modifying the actual commitment letter.[739] Moreover, this policy recognizes the changing broadband needs of HCPs by providing the flexibility to substitute alternative services within the constraints set forth below.[740] This policy is a more administratively efficient approach than the Primary Program, in which any modification of funding requires a new application and a new funding commitment letter for each HCP impacted.[741] In its *July 19 Public Notice*, the Bureau asked for comment on whether to adopt the Pilot Program approach to site and

---

[735] *Universal Service Fourth Order on Reconsideration*, 13 FCC Rcd at 5450, para. 228.

[736] *See, e.g., MCI Telecommunications Corp.*, B-276659.2, Sept. 29, 1997, 1997 WL 602194 (C.G.) at 9; *Universal Service Fourth Order on Reconsideration*, 13 FCC Rcd at 5450, para. 228.

[737] *Graphicdata, LLC supra, citing AT&T Communications, Inc. v. WilTel*, 1 F.3d at 1205; *Universal Service Fourth Order on Reconsideration*, 13 FCC Rcd at 5450-51, para. 229.

[738] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20401, 20405-06, paras. 80, 86; *Pilot Evaluation* 27 FCC Rcd at 9436, para. 80.

[739] *See Pilot Evaluation*, 27 FCC Rcd at 9436, para. 80.

[740] *See* RWHC PN Comments at 2; OHN PN Comments at 4; UAMS PN Comments at 4.

[741] *Pilot Evaluation*, 27 FCC Rcd at 9436, para. 80.

service substitutions in the reformed program.[742] The commenters generally supported applying the same approach in the new program.[743]

315. The Pilot Program permits site and service substitutions within a project in certain specified circumstances, in order to provide some amount of flexibility to project participants. Under the Pilot Program, a site or service substitution may be approved if (i) the substitution is provided for in the contract, within the change clause, or constitutes a minor modification, (ii) the site is an eligible HCP and the service is an eligible service under the Pilot Program, (iii) the substitution does not violate any contract provision or state or local procurement laws, and (iv) the requested change is within the scope of the controlling FCC Form 465, including any applicable Request for Proposal.[744] Once USAC has issued a funding commitment letter, support under the letter is capped at the amount provided in the letter. Therefore, support for a qualifying site and service substitution is only guaranteed if the substitution will not cause the total amount of support under the funding commitment letter to increase.[745] We adopt these same criteria for the Healthcare Connect Fund, which we include in a new rule.[746]

G. Data Collection and Reporting Requirements

316. *Background*. The Commission required Pilot projects to submit quarterly reports in order to help inform the Commission's understanding of the composition and uses of broadband health networks.[747] In the *NPRM*, the Commission proposed to collect data that would help the Commission analyze how the support in the health care support mechanism is being used, such as requiring beneficiaries to annually identify the speed of the connections and the type and frequency of telehealth applications used as a result of broadband access.[748] In addition, GAO recommended that the Commission develop a sound evaluation plan as part of the design of any new program.[749]

317. *Discussion*. Data from participants and from the Fund Administrator are essential to the Commission's ability to evaluate whether the program is meeting the performance goals adopted today

---

[742] *July 19 Public Notice*, 27 FCC Rcd at 8187-89, para. 6.

[743] *See, e.g.*, Geisinger PN Comments at 3; IRHTP PN Comments at 2; CHCC/RMHN PN Comments at 2; CCHCS PN Comments at 3; UTN PN Comments at 2.

[744] *See Universal Service Fourth Order on Reconsideration*, 13 FCC Rcd at 5450, para. 228 (adopting the "cardinal change doctrine as the test for determining whether a proposed modification will require rebidding of the contract, absent direction on this question from state or local procurement rules"); USAC Site and Service Substitution Policy, at 1, 3, *available at* http://www.universalservice.org/_res/documents/rhc-pilot-program/pdf/Site-and-Service-Substitution.pdf (last visited Dec. 19, 2012).

[745] If the requested site and service substitution causes an increase in the total amount of support under the funding commitment letter, the applicant may request an increase to the existing funding commitment letter or an additional funding commitment letter. However, a commitment of funds pursuant to an initial funding commitment letter does not ensure that additional funds will be available to support the modified services. *See Universal Service Fourth Order on Reconsideration*, 13 FCC Rcd at 5450-51, para. 229.

[746] Appendix D, 47 C.F.R. § 54.646. GCI asks that the Commission apply the site and service substitution policy to the existing RHC programs at this time. *See* GCI PN Comments at 5-6. We decline to extend this policy to the Telecommunications Program in this proceeding, which did not propose such policy changes for that program. We may consider adopting such changes for that program in the future, if they work well in the Healthcare Connect Fund.

[747] *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20423-24, para. 126.

[748] *NPRM*, 25 FCC Rcd at 9428, para. 151.

[749] GAO Report at 53.

and to measure progress toward meeting those goals.[750] We anticipate collecting the necessary data through a combination of the application process and annual reporting requirements. For consortium participants under the Healthcare Connect Fund, we require the submission of annual reports with the data specified below. Annual, rather than quarterly, reports minimize the burden on participants and the Administrator alike while still supporting performance evaluation and enabling us to protect against waste, fraud, and abuse.[751] Because we expect to be able to collect data from single applicants in the Healthcare Connect Fund on forms they already submit, we do not at this time expect that they will need to submit an annual report, unless a report is required for other reasons. To further minimize the burden on participants, we direct the Bureau to work with the Administrator to develop a simple and streamlined reporting system that integrates data collected through the application process, thereby eliminating the need to resubmit any information that has already been provided to the Administrator.[752] We agree with several commenters that to the extent feasible, USAC should collect information through automated interfaces.[753]

318. In the Healthcare Connect Fund, each consortium lead entity must file an annual report with the Administrator on or before September 30 for the preceding funding year (*i.e.*, July 1 through and including June 30).[754] Each consortium is required to file an annual report for each funding year in which it receives support from the Healthcare Connect Fund. For consortia that receive large upfront payments, the reporting requirement extends for the life of the supported facility.[755] The Administrator shall make the annual reports publicly available as soon as possible after they are filed.

319. All participants are required to provide the information necessary to ensure the Commission can assess progress towards the performance goals and measures adopted in Section III. To track progress toward the first goal, increasing access to broadband, we require participants to report the characteristics, including bandwidth and price, of the connections supported by the Healthcare Connect Fund.[756] To track progress toward the second goal, fostering broadband health care networks, we require participants to report the number and characteristics of the eligible and non-eligible sites connecting to the network.[757] We also expect participants to report whether and to what extent the supported connections are being used for telemedicine, exchange of EHRs, participation in a health information exchange, remote training, and other telehealth applications.[758] To track progress toward the third goal, maximizing

[750] *See supra* section III; *see* OHN PN Comments at 3 ("Information collection is vital to demonstrating use and value of the network and FCC/matching funding investments.").

[751] *See, e.g.*, IRHTP PN Comments at 2; UTN PN Comments at 1; HSHS PN Comments at 3-4.

[752] *See* MTN PN Comments at 2; *see also* UTN PN Comments at 1 (explaining that much of the information contained in the Pilot quarterly reports is already contained in prior filings with USAC).

[753] As one commenter put it, the "[t]he least burdensome manner of collecting this information (with the maximum reporting-out capability) is to create a uniform reporting tool with drop-downs/descriptions of use that allow USAC and the FCC to more easily report on majority trends and uses of the network and funding as a whole." OHN PN Comments at 3; *see also* ITN PN Comments at 2; WNYRAHEC PN Comments at 2-3 (suggesting the use of an online system that automatically populates information from the Network Cost Worksheet and invoices).

[754] *See* SWTAG PN Comments at 4 (suggesting that only the consortium lead entity be required to submit reports, similar to the Pilot Program).

[755] For instance, if a participant receives support to purchase a 20-year IRU, the participant is required to file annual reports for 20 years.

[756] *See supra* section III.A.

[757] *See supra* section III.B.

[758] *Id*.

the cost-effectiveness of the program, in addition to the reporting requirements under the first goal, we require that participants report the number and nature of all responsive bids received through the competitive bidding process as well as an explanation of how the winning bid was chosen, as discussed above in the section on competitive bidding requirements.[759]

320. We delegate authority to the Bureau to provide, and modify as necessary, further guidance on the reporting requirements described above, for both participants and the Administrator, to ensure the Commission has the necessary information to measure progress towards meeting the performance goals adopted in this Order. For consortium applicants, the consortium leader will be responsible for preparing and submitting these annual reports. Some of the data will already be collected through other forms that participants will submit through the funding process. We do not require non-consortium applicants to file annual reports at this time because we expect to be able to collect information through forms they already submit in connection with the application process, or if necessary, through other simplified automated interfaces. We delegate authority to the Bureau to work with USAC to accomplish these tasks, and to modify specific reporting requirements if necessary consistent with the requirements set forth in the prior paragraph.

321. We also extend the current Pilot Program reporting requirement for each Pilot project through and including the last funding year in which the project receives Pilot support, but make it an annual instead of a quarterly obligation.[760] We will also make the Pilot Program reporting requirements the same as the Healthcare Connect Fund reporting requirements and delegate to the Bureau the authority to specify whether any additional information from the quarterly report should continue to be included in the annual report that might be needed to evaluate the Pilot Program or to prevent waste, fraud, and abuse in that program.[761] As of the effective date of this Order, Pilot projects are no longer required to file quarterly reports and instead may file their first annual report on September 30, 2013. We further delegate authority to the Bureau to determine the expiration of any supplemental Pilot Program reporting requirements.

322. In specifying these reporting requirements, we have sought to simplify and streamline the requirements as much as possible, in order to minimize the burden on participants while still ensuring the funding is used for its intended purpose.[762] This furthers all of our performance goals – expanding access to broadband and fostering health care networks while maximizing the cost-effectiveness of the program. The data we collect will also help us to measure progress toward each of these goals.

VII. ADDITIONAL MEASURES TO PREVENT WASTE, FRAUD, AND ABUSE

323. In this section, we adopt additional safeguards against waste, fraud, and abuse. These are set forth in new rule section 54.648, in various rule provisions requiring certifications, and elsewhere in the rules and in this Order. The safeguards are patterned on the rules for the Telecommunications

[759] *See supra* section VI.C.3.

[760] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20423-24, paras. 126-27. The Commission required that each Pilot project submit reports on or before January 30, April 30, July 30, and October 30 for six years following the initial quarterly report due date. *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20424 para. 127. In addition, for Pilot Projects that received large upfront payments, the reporting requirement extends for the life of the supported facility.

[761] The required content of the Pilot project reports and the submission process will remain as specified in *2007 Pilot Program Selection Order*, until otherwise specified by the Bureau. *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20424, para. 126.

[762] *See supra* para. 41.; *see, e.g.*, VAST PN Reply Comments at 1 (finding "the quarterly reporting, as required by the Pilot Program, to be extremely burdensome").

Program, and incorporate many of the provisions that proved effective in the Pilot Program in making the program efficient and in safeguarding against waste, fraud, and abuse. The provisions we adopt here also take into account the comments we received in response to the *NPRM*. These safeguards are in addition to many of the requirements described above for the Healthcare Connect Fund that are also designed to protect against waste, fraud, and abuse.

324. In addition to the requirements below, we remind participants in the Healthcare Connect Fund that they will be subject to existing Commission rules governing the exclusion of certain persons from activities associated with or relating to the USF support mechanisms (the "suspension and disbarment" rules).[763] We also remind participants that all entities that are delinquent in debt owed to the Commission are be prohibited from receiving support until full payment or satisfactory arrangement to pay the delinquent debt is made, pursuant to the Commission's "red light" rule implementing the Debt Collection Improvement of 1996.[764]

A. Recordkeeping, Audits, and Certifications

325. As proposed in the *NPRM*, we apply all relevant Pilot and Telecommunications Program requirements regarding recordkeeping, audits, and certifications to participants in the Healthcare Connect Fund, as modified herein, and we recodify those requirements in a new rule section applicable to the new program.

326. *Recordkeeping*. Consistent with sections 54.619(a), (b), and (d) of our current rules, program participants and vendors in the Healthcare Connect Fund must maintain for five years certain documentation related to the purchase and delivery of services, network equipment, and participant-owned facilities funded by the program, and they will be required to produce these records upon request.[765] In particular, participants who receive support for long-term capital investments in facilities whose useful life extends beyond the period of the funding commitment shall maintain records for at least 5 years after the end of the useful life of the facility. The *NPRM* also proposed to: (1) clarify that the documents to be retained by participants and vendors must include all records related to the participant's application for, receipt of, and delivery of discounted services; and (2) mandate that vendors, upon request, produce the records kept pursuant to the Commission's recordkeeping requirement.[766] We adopt rules consistent with these proposals to enable the Commission and USAC to obtain the records necessary for effective oversight of the new Healthcare Connect Fund.

327. *Audits and Site Visits*. The Commission will continue to use the audit process to ensure there is a focused and effective system for identifying and deterring program abuse.[767] Consistent with

---

[763] The suspension and disbarment rules concern persons who have been convicted of, or have had a civil judgment against them, for attempt or commission of fraud or other offenses arising out of activities associated with the USF. *See generally* 47 C.F.R. § 54.8.

[764] *See* 47 C.F.R. § 1.1910(b). For more information on the Red Light Rule, *see* "Debt Collection Improvement Act Implementation," http://transition.fcc.gov/debt_collection/ (last visited Nov. 14, 2012).

[765] *See* 47 C.F.R. § 54.619(a)-(b), (d).

[766] *See NPRM*, 25 FCC Rcd at 9425, para. 139.

[767] USAC's audit program historically has consisted of audits by USAC's internal audit division staff as well as audits by independent auditors under contract with USAC. In addition, in the past, the Commission's Office of Inspector General (OIG) has conducted audits of USF program beneficiaries. *See* FEDERAL COMMUNICATIONS COMMISSION OFFICE OF INSPECTOR GENERAL, SEMIANNUAL REPORT TO CONGRESS, OCTOBER 1, 2009 THROUGH MARCH 31, 2010 AT 17-20, *available at* http://transition.fcc.gov/oig/SAR_March_2010_050710.pdf. In a February 12, 2010, letter to USAC, OMD directed USAC to separate its two audit objectives into distinct programs – one focused on Improper Payments Information Act ("IPIA") assessment and the second on auditing compliance with all

(continued…)

existing section 54.619(c), participants in the Healthcare Connect Fund will be subject to random audits to ensure compliance with program rules and orders.[768]

328. USAC must assess compliance with the program's requirements, including the new requirements established in this Order for recipients of RHC support. We direct USAC to review and revise the Beneficiary/Contributor Compliance Audit Program (BCAP)[769] and the Payment Quality Assurance (PQA) program[770] to take into account the changes adopted in this Order when designing procedures for recipients of funding under the Healthcare Connect Fund. We further direct USAC to submit a report to the Bureau and Office of Managing Director (OMD) within 60 days of the effective date of this Order or by May 31, 2013, whichever is later, proposing changes to the BCAP and PQA programs consistent with this Order.

329. We also direct USAC to conduct random site visits to Healthcare Connect Fund participants to ensure that support is being used for its intended purposes, or as necessary and appropriate based on USAC's review of participants' submissions to USAC. We further direct USAC to notify the Wireline Competition Bureau and the Office of the Managing Director of any site visit findings and analysis within 45 days of the site visit.

330. *Certifications*. We adopt certification requirements for the Healthcare Connect Fund that are similar to those in the existing RHC programs.[771] Participants in the Healthcare Connect Fund must

(Continued from previous page)

four USF programs. *See* Improper Payments Information Act of 2002, Pub.L.No. 107-300, 116 Stat. 2350 (2002). In addition to providing guidance on the implementation of the IPIA assessment program and compliance audit program, the letter informed USAC that OMD would assume responsibility for oversight of USAC's implementation of both programs. *See* Letter from Steven Van Roekel, Managing Director, Federal Communications Commission to Scott Barash, Acting CEO, Universal Service Administrative Company (filed Feb. 12, 2010) (FCC IPIA Letter), *available at* http://www.fcc.gov/omd/usac-letters/2010/021210-ipia.pdf.

[768] *See* 47 C.F.R. § 54.619(c).

[769] The Compliance Audit program, BCAP, was developed with the following objectives: (1) cover all four programs and contributors; (2) tailor audit type and scope to program risk elements, size of disbursement, audit timing and other specific factors; (3) keep costs reasonable in relation to overall program disbursements, amount disbursed to beneficiary being audited, and USF administrative costs; (4) spread audits throughout the year; and (5) retain capacity and capability for targeted and risk-based audits. *See* FCC IPIA Letter at 2, 4. To assist program participants, USAC has information about BCAP available on its website. *See* USAC, Understanding Audits, http://www.usac.org/rhc/about/program-integrity/audits.aspx (*last visited* Dec. 10, 2012).

[770] The Improper Payments Information Act (IPIA) assessment program (PQA) was developed with the following objectives: (1) separately cover all four USF programs; (2) measure the accuracy of the Administrator's payments to program applicants; (3) evaluate the eligibility of program applicants who have received payments; (4) include high-level testing of information obtained from program participants; and (5) tailor scope of procedures to ensure reasonable cost while meeting IPIA requirements for sample size and precision. Unlike BCAP, the PQA program does not involve audits. *See* USAC, Payment Quality Assurance (PQA) Program FAQs, *available at* http://www.usac.org/rhc/about/program-integrity/pqa.aspx. Rather, it provides for reviews specifically designed to assess estimated rates of improper payments, thereby supporting IPIA requirements. The PQA reviews measure the accuracy of USAC payments to applicants, evaluate the eligibility of program applicants, and involve high level testing of information obtained from program participants. USAC tailors the scope of procedures to ensure reasonable costs while still meeting IPIA requirements. To assist program participants, USAC has information about the PQA program available on its website. *See* USAC, Payment Quality Assurance (PQA) Program, http://www.usac.org/rhc/about/program-integrity/pqa.aspx (*last visited* Dec. 10, 2012).

[771] *See* 47 C.F.R. §§ 54.603(b), 54.615(c) (certification requirements for existing Rural Health Care programs); App. D, various rule sections (certification requirements for Healthcare Connect Program). This order does not modify certification requirements for existing Rural Health Care programs.

certify under oath to compliance with certain program requirements, including the requirements to select the most cost-effective bid and to use program support solely for purposes reasonably related to the provision of health care services or instruction.

331. For individual HCP applicants, required certifications must be provided and signed by an officer or director of the HCP, or other authorized employee of the HCP (electronic signatures are permitted). For consortium applicants, an officer, director, or other authorized employee of the Consortium Leader must sign the required certifications. USAC may not knowingly accept certifications signed by a person who is not an officer, director, or other authorized employee of the HCP or Consortium Leader.

332. Third parties may submit forms and other documentation on behalf of the applicant, including the HCP or Consortium Leader's signature and certifications, if USAC receives, prior to submission of the forms or documentation, a written, dated, and signed authorization from the relevant officer, director, or other authorized employee stating that the HCP or Consortium Leader accepts all potential liability from any errors, omissions, or misrepresentations on the forms and/or documents being submitted by the third party. We find that a HCP or Consortium Leader may not contractually reallocate responsibility for compliance with program requirements to a consultant or similar third party.

333. We find that our actions here will preserve the integrity of the program by protecting against wasteful or unlawful use of support.

B. Duplicative Support and Relationship to Other RHC Programs

334. *Background*. In the *NPRM*, the Commission proposed that HCPs be prohibited from receiving support for the same services under both the proposed health broadband services program and the existing RHC programs.[772] Similarly, the Commission proposed to prohibit HCPs from receiving support for the same services under either the existing programs or the reformed RHC program and any other universal service program (*i.e*., the E-rate program, the High Cost program, and the Lifeline program) or any other federal program, including, for example, federal grants, awards, or loans.[773]

335. *Discussion*. As the Commission proposed in the *NPRM*, we adopt a rule prohibiting HCPs from receiving universal service support for the same services from both the Telecommunications Program and the Healthcare Connect Fund.[774] This prohibition is necessary because, in certain instances, an HCP's selected service could be eligible for support under both the Telecommunications Program and the Healthcare Connect Fund.[775] Where this is the case, HCPs will not be permitted to "double dip" from the USF for the same connections. Applicants are prohibited from submitting a funding request for the same service in the Telecommunications Program and the Healthcare Connect Fund.[776] Further, consistent with the *NPRM*, we adopt a rule prohibiting HCPs from receiving funds for the same services

[772] *See NPRM*, 25 FCC Rcd at 9425, para. 140.

[773] *See id.*; *see also 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20422, para. 123 (clarifying that "selected participants may not receive funds for the same services under the Pilot Program and either the existing universal service programs . . . or other federal programs").

[774] Appendix D, 47 C.F.R. § 54.672. *See NPRM*, 25 FCC Rcd at 9425, para. 140.

[775] For example, under the new rules we adopt today, an HCP would be able to receive support for the urban-rural cost differential for a T-1 line under the existing Telecommunications Program or 65 percent of the cost of that same T-1 under the Healthcare Connect Fund.

[776] Similarly, during the period in which the Internet Access Program is still in effect, participants are prohibited from receiving support under both the Internet Access Program and the Healthcare Connect Fund for the same service.

under either the Telecommunications or the reformed RHC program and any other universal service program.[777] If an HCP is still receiving support under the Pilot Program, it also will be subject to this same restriction on receiving support from another FCC program for the same services.[778] Under this rule, an HCP only will be prohibited from receiving *duplicative* support for the *same* services – not from receiving *complementary* support for *different* services.

336. Our action here is consistent with the Commission's Pilot Program requirement that participants cannot receive support for the same service from both the Pilot Program and other universal service programs.[779] We believe that the prohibition on using funds from other Universal Service programs as part of the HCP's 35 percent contribution requirement is equally important in our reformed RHC program, and that it will help safeguard against wasteful and unlawful duplicative distribution of universal service support.

337. We do not believe, however, that it is necessary in the Healthcare Connect Fund to prohibit the use of federal funds from non-universal service program sources to be part of the HCP's 35 percent contribution requirement.[780] Here, the HCP contribution amount is significantly greater than in the Pilot Program (35 percent as opposed to 15 percent in the Pilot Program). While we are not aware of other sources of federal funding for HCPs that could be used towards their 35 percent contribution, we do not want to preclude the possibility that a recipient in our program could use funding from another federal agency towards its 35 percent contribution. We anticipate that even if other federal funding may be available, HCPs will still be required to secure a significant portion of the cost of broadband supported by this program through their own efforts.

338. We also do not preclude federal government entities, such as the Indian Health Service, or other Tribal entities, from receiving support under the Healthcare Connect Fund, even though their 35 percent contribution may come from federal sources, as does the balance of the budget of such entities.[781] We also do not preclude HCPs from purchasing services from entities that have received federal funds to assist in infrastructure construction, such as through the Broadband Telecommunications Opportunities Program or the Rural Utilities Service Broadband Infrastructure Program.[782] These programs are intended to develop broadband infrastructure in geographic areas that are unserved or underserved by broadband. It would defeat the value of federal investment in such facilities if we were to prohibit such entities from bidding to provide service under the Healthcare Connect Fund.

C. Recovery of Funds, Enforcement, and Debarment

339. *Recovery of Funds*. Consistent with the 2007 *Program Management Order*, Healthcare Connect Fund monies that are disbursed in violation of a Commission rule that implements the Act, or a

[777] *See NPRM*, 25 FCC Rcd at 9425, para. 140. While very few commenters address the Commission's proposal to prohibit duplicative support for RHC program participants, Broadband Principals expresses support for the prohibition. *See* Broadband Principals Comments at 16.

[778] *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20422, para. 123.

[779] *Id.*

[780] Some commenters contend that HCPs should be allowed to use support from other federal programs to make up their contribution requirement. *See, e.g.*, ATA Comments at 12; Avera Health Comments at 4.

[781] We note that the 1996 Act includes "public" – i.e. governmental – entities, as well as private, not-for-profit entities, as eligible HCPs. 47 U.S.C. 254 (H)(1)(A).

[782] *See supra* n.254.

substantive program goal, will be recovered.[783] Recovery of funds will be directed at the party or parties (including both beneficiaries and vendors) who have committed the statutory or rule violation. If more than one party shares responsibility for a statutory or rule violation, recovery actions may be initiated against both parties, and pursued until the amount is satisfied by one of the parties.[784] Failure to repay recovery amounts may subject recipients to enforcement action by the Commission, in addition to any collection action.

340. *Enforcement and Criminal Sanctions.* In the 2007 *Program Management Order*, the Commission also found that sanctions, including enforcement action, are appropriate in cases of waste, fraud, and abuse in the universal service support programs, but not in cases of clerical or ministerial errors.[785] If any participant or vendor fails to comply with Commission rules or orders, or fails to timely submit filings required by such rules or orders, the Commission has the authority to assess forfeitures for violations of such Commission rules and orders under section 503 of the Act.[786] In addition, any participant or service provider that willfully makes a false statement(s) can be punished by fine or forfeiture under sections 502 and 503 of the Communications Act, or fine or imprisonment under Title 18 of the United States Code (U.S.C.) including, but not limited to, criminal prosecution pursuant to section 1001 of Title 18 of the U.S.C.[787]

341. *Debarment.* In order to prevent fraud, and to prevent bad actors from continuing to participate in the universal service programs, section 54.8 of the Commission's rules provides that the Commission shall suspend and debar parties for conviction of, or civil judgment for, fraud or other criminal offenses arising out of activities associated with or related to the universal service support mechanisms, absent extraordinary circumstances.[788] These debarment procedures in section 54.8 will apply to the Healthcare Connect Fund, just as they do to other Commission universal service programs.

VIII. TELECOMMUNICATIONS PROGRAM REFORM

342. This Order focuses on the creation of a new, reformed health care support mechanism. As discussed above, the Healthcare Connect Fund replaces the current RHC Internet Access Program.

---

[783] *Comprehensive Review of the Universal Service Fund Management, Administration, and Oversight,* WC Docket No. 05-195 *et al.,* 22 FCC Rcd 16372, 16387-88, para. 30 (2007) (*Program Management Order*); *cf. 2007 Pilot Program Selection Order,* 22 FCC Rcd at 20423, para. 125 n.407. The recovery process is commonly referred to as a "commitment adjustment" (COMAD). The Commission has previously determined that funding commitments must be adjusted (and recovered, if already disbursed) if the disbursement of funds associated with those commitments would result in violations of a federal statute. *See Changes to the Board of Directors of the National Exchange Carrier Association, Inc., et al.,* CC Docket No. 97-21 *et al.,* 18 FCC Rcd 27090, 27092-93, para. 7 (1999).

[784] *Cf. Federal-State Joint Board on Universal Service et al.,* CC Docket No. 96-45 *et al.,* Order on Reconsideration and Fourth Report and Order, 19 FCC Rcd 15252, 15257, para. 15 (2004); *2007 Pilot Program Selection Order,* 22 FCC Rcd at 20423-24, para. 125.

[785] *Program Management Order,* 22 FCC Rcd at 16386, para. 30.

[786] 47 U.S.C. § 503; 47 C.F.R. § 1.80.

[787] 47 U.S.C. §§ 502, 503; 18 U.S.C. § 1001 *et seq.*

[788] *See* 47 C.F.R. § 54.8(c). More specifically, causes for suspension and debarment are conviction of or civil judgment for attempt or commission of criminal fraud, theft, embezzlement, forgery, bribery, falsification or destruction of records, making false statements, receiving stolen property, making false claims, obstruction of justice, and other fraud or criminal offense arising out of activities associated with or related to the schools and libraries support mechanism, the high-cost support mechanism, the rural health care support mechanism, and the low-income support mechanism.

For the time being, we maintain the current RHC Telecommunications Program, which funds the difference between the rural rate for telecommunications services and the rate paid for comparable services in urban areas.[789] In doing so, we recognize that the RHC Telecommunications Program is particularly important for extremely remote places like Alaska. However, we would expect the Healthcare Connect Fund to prove attractive to many of the HCPs that currently receive support under the Telecommunications Program, as well as to HCPs that do not currently participate in any RHC Program. Unlike the Telecommunications Program, the new program will provide a flat rate discount, a simpler application process for both single and consortium applicants, flexibility for consortia to design their networks in a cost-effective manner to best serve the needs of their communities, support for certain network-related expenses, the availability of multi-year and prepaid funding arrangements, and the option for health care provider self-construction. And most importantly, as described above, we also expect that many HCPs will be able to get higher bandwidth service for lower out-of-pocket costs under the new program. For all these reasons, we expect significant migration of HCPs out of the Telecommunications Program and into the Healthcare Connect Fund over time.

343. As the new Healthcare Connect Fund is implemented, we expect to consider whether the Telecommunications Program remains necessary, and if so whether reforms to the program are appropriate to ensure that any continuing support under that program is provided in a cost-effective manner. In doing so, we will, in particular, look at the needs of extremely remote places like Alaska. Such reforms could include changes to ensure subsidies provided under the program are set at appropriate levels, to provide greater incentives for cost-efficient purchasing by program participants, and to reduce the administrative costs of the program, both to participants and to USAC.

344. In the meantime, the current Telecommunications Program rules and procedures will continue to apply.[790] In addition, because we view our health care universal service programs as accomplishing the same overarching goals, we make the performance goals and measures adopted in this Order applicable in the Telecommunications Program as well as to the Healthcare Connect Fund.[791]

IX. PILOT PROGRAM FOR SKILLED NURSING FACILITY CONNECTIONS

345. *Background*. In the *NPRM*, the Commission sought comment on whether non-profit skilled nursing facilities (SNFs) should be considered eligible for support under the category of "not-for-profit" hospitals, citing the *National Broadband Plan* recommendations.[792] As noted in the *NPRM*, SNFs "provide some of the same post-acute services that are traditionally provided at hospitals, such as the management, observation, and evaluation of patient care."[793] The Commission also noted that many nursing facilities provide both skilled nursing services and custodial services that involve assisting patients with daily activities such as eating, clothing, bathing, etc., which are not covered by Medicare or

[789] *See* 47 U.S.C. § 254(h)(1)(A); *supra* section V.A.1.

[790] We do adopt one new rule, governing offset of universal service contributions, that applies to both the Telecommunications and Internet Access Programs as well as to the Healthcare Connect Fund. *See infra* section X.D.

[791] *See supra* section III.

[792] *NPRM*, 25 FCC Rcd at 9419-20, paras. 123-25; *see National Broadband Plan* at 216. The Commission also sought comment on whether to include renal dialysis facilities or other providers as eligible HCPs under the health care support mechanism. *NPRM*, 25 FCC Rcd at 9416, 9421, paras. 115, 126-127. As with SNFs, we do not decide here whether to include renal dialysis facilities in the Commission's health care universal service support programs.

[793] *NPRM*, 25 FCC Rcd at 9419, para. 123 (referencing HHS Centers for Medicare and Medicaid definition).

Medicaid.[794] The Commission sought comment on how to ensure that support is provided to facilities with a sufficient volume of skilled nursing patients.[795] While a number of commenters generally supported making SNFs eligible for support under the health care mechanism,[796] there was no consensus among them regarding how to ensure that funds are directed to skilled nursing activities that are comparable to hospital care.

346. *Discussion.* There is evidence that skilled nursing facilities are particularly well-suited to improve patient outcomes through greater use of broadband. By their nature, they are often remote from doctors and sophisticated laboratory and testing facilities, making the availability of EHRs and telehealth an especially valuable benefit to convalescents or patients for whom traveling to see a doctor, diagnostician, or specialist would be especially difficult. On the record before us, however, we are unable to determine how support for SNFs can be provided as part of an ongoing program in a "technically feasible and economically reasonable" manner, as required by section 254(h)(2)(A). Nor does the record currently allow us to balance the potential benefits of supporting SNFs against the potential impact on Fund demand. On this record, we reach no conclusion about whether or under what circumstances a SNF might qualify as a health care provider under the statute.[797] We find, however, that funding connections used by SNFs in working with HCPs has the potential to enhance access to advanced services and to generate the associated health care benefits, and that a limited pilot program would enable us to gain experience and information that would allow us to determine whether such funding could be provided on a permanent basis in the future.

347. We therefore conclude that it is both technically feasible and economically reasonable to launch, as an initial step, a pilot program to test how to support broadband connections for SNFs, with safeguards to ensure that the support is directed toward SNFs that are using broadband to help provide hospital-type care for those patients, and that are using those broadband connections for telehealth applications that improve the quality and efficiency of health care delivery.[798] The Skilled Nursing

---

[794] *NPRM*, 25 FCC Rcd at 9419-20, paras. 123-25. *See, e.g.*, ELGSS Comments at 1-2 (stating that hospitals and post-acute providers must work very closely together to provide great care at the lowest possible cost, but that attempting to use definitions of skilled nursing services and custodial nursing services to determine eligibility is not consistent with the rapidly changing health care environment, and the post-acute census of Medicare residents can vary greatly from facility to facility or even time of year).

[795] *See NPRM*, 75 FCC Rcd at 9420, para. 125.

[796] *See, e.g.*, HHS Comments at 12 (recommending that any Medicare certified skilled nursing facility be eligible for support); ATA Comments at 8; Avera Comments at 8; CPUC Comments at 8; CTN Comments at 26; ELGSS Comments at 1; HIEM Comments at 17; IHS Comments at 9; IRHN Comments at 18; NSTN Comments at 4; NETC Comments at 3; NTCA Comments at 9; UW Reply Comments at 1; MCT PN Reply Comments at 2.

[797] Contrary to the statement of Commissioner Pai, this is not a recognition that this pilot program might not comply with section 254, as discussed *infra* n.799.

[798] Thus, this pilot program is grounded in the Commission's responsibility under section 254(h)(2)(A) "to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for all … health care providers." Although, as noted in para. 346, we do not determine in what circumstances SNFs are or are not HCPs in their own right, we emphasize that pilot projects must "enhance . . . access to advanced telecommunications and information services for" eligible HCPs in a technically feasible and economically reasonable manner. For example, this pilot program could provide support for purchasing a connection for the exchange of information between a SNF and an eligible HCP. We direct the Bureau to approve any given application only to the extent that it demonstrates that it satisfies the statutory criteria. The program will also enable the Commission to determine how, if at all, to most efficiently construct a permanent program in the future, which itself is a technically feasible and economically reasonable way to enhance HCPs' access to advanced telecommunications and information services. Contrary to the statement of Commissioner Pai, we do not "recognize that … this program may not comply with Section 254." Section 254(h)(2)(A) does not require that funding be

(continued…)

Facilities Pilot Program (SNF Pilot) will focus on determining how we can best utilize program support to assist SNFs that are using broadband connectivity to work with eligible HCPs to optimize care for patients in SNFs through the use of EHRs, telemedicine, and other broadband-enabled health care applications.[799] We will fund up to $50 million for this purpose within the existing health care support mechanism, which remains capped at $400 million annually. We expect to implement this SNF Pilot in Funding Year 2014. We conclude that a total of $50 million may be disbursed for the SNF Pilot over a funding period not to exceed three years, which will moderate the annual impact on Fund demand.

348. We direct the Bureau to develop scoring criteria for applications for the SNF Pilot consistent with the program goals adopted in section III above, soliciting input from HHS (including IHS) and other stakeholders, and to specify other requirements for the SNF Pilot, including safeguards to ensure that funding is directed towards facilities that are engaged in the provision of skilled care comparable to what is available in a hospital or clinic. In order to maximize other Fund investments, only SNFs that do not currently have broadband services sufficient to support their intended telehealth activities are eligible to participate in the SNF Pilot. The Bureau shall give a preference to applicants that partner with existing or new consortia in the existing Pilot Program or the Healthcare Connect Fund and to SNFs located in rural areas, and will require applicants to demonstrate how proposed participation of SNFs will improve the overall provision of health care by eligible HCPs. The SNF Pilot Program will seek to collect data on a number of variables related to the broadband connections supported and their health care uses, so that at the conclusion of the SNF Pilot, the Commission can use the data gathered to determine how to proceed with regard to including SNFs in the Commission's health care support programs on a permanent basis.

349. Once the scoring criteria are developed, the Bureau shall release a Public Notice specifying the application procedures, including dates, deadlines, and other details of the application process. Except as necessary to meet the goals of the SNF Pilot, all requirements applicable to the Healthcare Connect Fund, as described in this Order, will apply to the SNF Pilot. After reviewing the applications, the Bureau then will announce the SNF Pilot participants. We delegate authority to the Bureau to implement the SNF Pilot consistent with the framework established in this Order, and specify that USAC shall disburse no more than $50 million to fund the SNF Pilot, as directed by the Bureau.[800]

350. To be eligible for funding, those seeking to participate in SNF Pilot projects must commit to robust data gathering as well as analysis and sharing of the data and to submitting an annual report. Applicants will be expected to explain what types of data they intend to gather and how they intend to gather that data. At the conclusion of the Pilot, we expect applicants to be prepared to demonstrate with objective, observable metrics the health care cost savings and/or improved quality of patient care that

(Continued from previous page)

provided only to HCPs; it requires us to establish competitively neutral rules to enhance HCPs' access to the extent technically feasible and economically reasonable. We conclude that the pilot program described here will do so, even if funds from the program are paid to SNFs that may not be eligible HCPs, because the program will be designed in a way that meets the statutory criteria (*i.e.* to enhance eligible HCP access to "advanced telecommunications and information services"). We are not yet able to conclude that it would be economically reasonable to support these connections more broadly on an ongoing or permanent basis, but we expect the pilot program to provide information to help us decide whether and under what circumstances it might.

[799] *See, e.g.*, ELGSS Comments at 3 ("One of the best ways to improve health care for rural residents, and for rural residents in skilled nursing facilities who are transferred to a rural or urban hospital is to ensure their medical records are electronically submitted from the skilled nursing facility to the hospital, and vice versa. Errors in prescription drugs, medical tests that have already been run and many other necessary pieces of information can be resolved if skilled nursing facilities also have electronic medical records.").

[800] The $50 million for the pilot is exclusive of administrative expenses for USAC to administer the program.

have been realized through greater use of broadband to provide telemedicine to treat the residents of SNFs. We authorize USAC to use administrative expenses from the Fund to perform data gathering and related functions. The Commission plans to make this data public for the benefit of all interested parties, including third parties that may use such information for their own studies and observations.

X. MISCELLANEOUS

A. Implementation Timeline

351. *Background*. Participants in the RHC Telecommunications and Internet Access Programs can request universal service support at any time during the funding year, which runs from July 1 to June 30 annually. However, before making a request, the applicant first must submit a FCC Form 465 to competitively bid for requested services.[801] The FCC Form 465 is posted on USAC's website for 28 days, after which the HCP can choose a service provider.[802] Then, having chosen a service provider, the HCP may submit its request for funding (FCC Form 466 and/or FCC Form 466-A) at any time during the funding year, covering services received during that funding year.[803]

352. *Discussion.* In this Order, we adopt for the Healthcare Connect Fund the same general funding schedule that is currently used in the Telecommunications and Internet Access Programs. Thus, applicants seeking support under the Healthcare Connect Fund may start the competitive bidding process anytime after January 1 (six months before the July 1 start of the funding year) and can submit a request for funding at any time during that funding year (*i.e.* between July 1 and June 30) for services received during that funding year.[804] This process is described in more detail in Section VI above (Funding Process).

353. For the first funding year of the Healthcare Connect Fund (FY 2013, which runs from July 1, 2013 to June 30, 2014), we adopt a schedule in which the funding for Pilot project applicants and new applicants begins at different times. The schedule for RHC Pilot project applicants will remain unchanged.[805] Starting on July 1, 2013, Pilot projects can seek universal service support under the Healthcare Connect Fund at a 65 percent discount level for existing HCP sites that have exhausted funding allocated to them as well as for new sites to be added to Pilot project networks.[806]

354. For new applicants (either current Telecommunications or Internet Access Program participants or HCPs new to the Commission's programs), the funding schedule for the Healthcare

---

[801] USAC RHC Getting Started, http://www.usac.org/rhc/about/getting-started/faqs.aspx#year (last viewed on Dec. 10, 2012) (noting USAC accepts the FCC Form 465 for posting typically beginning in late March or early April for the upcoming funding year).

[802] *Id*.

[803] *Id*.

[804] We use the term "services" here to mean any covered services, equipment, infrastructure, or other items eligible under the Healthcare Connect Fund. USAC can start receiving and processing funding requests prior to July 1, but the funding commitment can only be effective starting July 1.

[805] Throughout this section, references to "Pilot" applicants include only the existing RHC Pilot Program participants, not the SNF Pilot applicants. *See supra* section IX.

[806] Although all funding commitments now have been made under the Pilot Program, funding will continue to be disbursed to many Pilot projects for several more years. Funding disbursed under such past Pilot Program awards will continue to reflect the 15 percent contribution required of participants in that program. Once Pilot participants exhaust that funding, they may migrate to either the Healthcare Connect Fund or to the Telecommunications Program, which require different HCP contribution amounts.

Connect Fund will be different in FY 2013. For FY 2013 only, the competitive bidding process for non-Pilot Healthcare Connect Fund applicants will start in late summer 2013, with applicants eligible to receive funds starting on January 1, 2014. This six-month delay is necessary to complete administrative processes relating to the new program, including obtaining approval for new forms under the Paperwork Reduction Act. Starting in FY 2014 (July 1, 2014-June 30, 2015), all applicants will be on the same funding year schedule and will be able to request funds from USAC between July 1-June 30, after completing a competitive bidding process that may start on or after January 1. In addition, to ensure a smooth transition and to minimize the administrative burden, eligible rural HCPs may continue to receive support under the RHC Internet Access Program through the end of funding year 2013, or through June 30, 2014.[807]

355. A timeline of the funding schedule for the first year of the program for both Pilot project applicants and non-Pilot applicants appears in Figure 5 below.

Figure 5: Funding Year 2013 Implementation Timeline

<table>
<tr><th></th><th>Jan. 2013</th><th>Feb. 2013</th><th>Mar. 2013</th><th>Apr. 2013</th><th>May 2013</th><th>June 2013</th><th>July 2013</th><th>Aug. 2013</th><th>Sept. 2013</th><th>Oct. 2013</th><th>Nov. 2013</th><th>Dec. 2013</th><th>Jan. 2014</th><th>Feb. 2014</th><th>Mar. 2014</th><th>Apr. 2014</th><th>May 2014</th><th>June 2014</th></tr>
<tr><td>Pilot Project Applicants</td><td colspan="3">Pilot projects determine their service needs and prepare RFPs in accordance with reformed program rules</td><td colspan="3">Competitive bidding starts during second quarter 2013</td><td colspan="12">2013 Funding</td></tr>
<tr><td>Non-Pilot Project Applicants</td><td colspan="6">New program applicants organize themselves, determine their service needs, and prepare RFPs</td><td colspan="6">Competitive bidding starts during third quarter 2013 and continues through fourth quarter 2013</td><td colspan="6">2013 Funding</td></tr>
</table>

356. As shown in the chart, starting the competitive bidding process in summer of 2013 will give non-Pilot Healthcare Connect Fund applicants time to organize as consortia, to determine their service needs, to design RFPs, and to complete the competitive bidding process before requesting funds from USAC. The experience of Pilot Program participants suggests that it takes at least six months for consortia to organize themselves, obtain the necessary authorizations from individual health care providers, assess broadband needs for the members, and prepare RFPs.[808] Pilot experience also suggests that it can take approximately six additional months for a consortium to post the RFP, receive bids, evaluate bids properly, and negotiate a contract.[809] If funding were available July 1, 2013, new applicants would not have enough time to complete all these steps. A possible result could be poorly organized consortia and ill-considered network designs, which would be inconsistent with our overarching program goals. In order to maximize the cost-effectiveness of bulk buying and competitive bidding, it is important to allow sufficient time for needs assessment, network design, and RFP preparation, as well sufficient time to solicit a range of competitive bids, select a vendor, and negotiate a contract. Making funding available beginning January 1, 2014, will allow time for all these activities to take place and to enable applicants to create well-designed networks and to obtain cost-effective bids.

[807] Support will no longer be available under the RHC Internet Access Program for services provided on or after July 1, 2014. We are amending our rules today to remove the rules governing the Internet Access Program, but participants continuing to receive funds under that Program through June 30, 2014, will do so pursuant to the current Internet Access Program rules (including section 54.621(d) of the current rules, 47 C.F.R. § 54.621 (2012). *See also* Appendix D, 47 C.F.R. § 54.634(a).

[808] USAC Nov. 16 Data Letter at 3.

[809] *See, e.g.,* USAC Nov. 16 Data Letter at 3.

357. This funding cycle also will encourage individual HCPs to join new or existing consortia rather than applying for funding alone. We expect that some potential single HCP applicants will receive offers to join existing Pilot project networks or newly-formed consortia. We encourage this collaboration. As discussed in the *Pilot Evaluation*, consortia are able to obtain higher bandwidths, lower rates, and better service quality, and they save on administrative costs.[810] By making funding available at the same time for consortium applicants and single applicants, there will be more time for coordination and outreach between consortia applicants and their prospective members to occur. In the meantime, individual HCPs can still receive support through the Telecommunications or Internet Access Programs until they are eligible to seek funds under the Healthcare Connect Fund.

358. The same considerations do not apply to the Pilot projects. They have already completed the multi-step process of forming consortia and conducting competitive bidding. Allowing them to begin receiving funding effective July 1, 2013, will benefit both existing Pilot project HCPs and HCPs that seek to join existing Pilot projects. Allowing new sites joining existing Pilot projects to receive funds on July 1, 2013, will encourage those projects to grow and become large-scale networks. This funding schedule will also provide sites that will exhaust Pilot Program funding on or before July 1, 2013, a smooth transition into the new program. As the Commission observed in providing transitional funding to such Pilot project HCPs in the July 2012 *Bridge Funding Order*, it is important for the sustainability of these networks that they are not forced to transition twice to different RHC programs–first to the Telecommunications or Internet Access Programs and then to the Healthcare Connect Fund.[811] Without an orderly transition to the new program, some individual Pilot project HCPs could be at risk of discontinuing their participation in their respective networks.[812] This would be contrary to the goals of the Pilot Program. Providing continuing support (albeit at the discount level applicable under the Healthcare Connect Fund) will help protect the investment the Commission has already made in these networks.

359. Outreach efforts will be essential in order to maximize potential of the Healthcare Connect Fund to support broadband and thereby transform the provision of health care for both individual HCPs and consortia. We therefore direct the Bureau to work with USAC to develop and execute a range of outreach activities to make HCPs aware of the new program and to educate them about the application process. We expect the Bureau will consult with other health care regulatory agencies (such as HHS); with state, local, and Tribal governments; with organizations representing HCPs (especially rural HCPs); and with other stakeholder groups to identify the best means to publicize the new program and to identify likely beneficiaries of the new program – both HCPs already participating in RHC programs and those that are not. We direct USAC to produce and disseminate outreach materials designed to educate eligible HCPs about the new program. In addition, we direct USAC to implement a mechanism for any interested party to subscribe to an automated alert from USAC when Healthcare Connect Fund requests for services or RFPs are posted, based on available filtering criteria.

B. Pilot Program Transition Process and Requests for Additional Funds

360. The final deadline for filing requests for funding commitments in the RHC Pilot Program was June 30, 2012. As discussed in the *Pilot Evaluation*, several projects either withdrew from the program or merged with other projects, leaving 50 active Pilot projects.[813] Every one of these remaining projects met the June 30 deadline for filing funding commitment requests. USAC is likely to complete

[810] *See supra* section IV.B.1. *See also Pilot Evaluation*, 27 FCC Rcd at 9436, 9435, paras. 81, 78.

[811] *2012 Bridge Funding Order*, 27 FCC Rcd at 7911, para. 12.

[812] *Id.*

[813] *Pilot Evaluation*, 27 FCC Rcd 9405 at para. 31.

the processing of all these funding requests by the end of calendar year 2012. Projects have up to six years from the date of issuance of the initial funding commitment letter for the applicable project to complete invoicing.[814] Thus, by the latter part of calendar year 2017, all invoicing under the Pilot Program should be completed.

361. We would expect that as the Pilot projects and their member HCPs begin to exhaust Pilot funding, they will migrate as consortia into the Healthcare Connect Fund. Pilot participants are at different points in the process of implementing their networks and invoicing for the services or infrastructure in their projects. As discussed in the Commission's *Bridge Funding Order*, released in July 2012, a number of projects began to exhaust funding for some of their HCP sites in 2012, and the Commission provided continued funding for those sites pursuant to that Order.[815] Although we believe the rules we adopt in this Order should permit an easy transition for the Pilot Program participants, we delegate to the Bureau the authority to adopt any additional procedures and guidelines that may be necessary to smooth this process. As discussed above in the Implementation Timeline section, we make support under the Healthcare Connect Fund for the transitioning Pilot Program participants effective on July 1, 2013, in order to ensure that there are no gaps in support for them. We permit them to use the same forms they used in the Pilot Program to secure funding pursuant to the *Bridge Order*. Once their currently committed Pilot funds are exhausted, they will be required to provide a 35 percent contribution (not the 15 percent in the Pilot Program), and will not be eligible to receive support for anything that is not covered under the Healthcare Connect Fund.

362. Several Pilot projects filed requests for additional support, asking the Commission to use funds that were originally allocated to the Pilot Program, but were relinquished or unspent by other Pilot projects that withdrew or did not use their full awards.[816] In their requests for additional funding, these Pilot projects argued, among other things, that remaining Pilot funding should be redirected to projects that have demonstrated substantial progress with their original awards and that these additional funds would facilitate expansion of these successful projects.[817]

363. In light of our creation of the new Healthcare Connect Fund, we deny these requests for additional Pilot Program funding. First, we note that Pilot projects may now seek additional funding through the Healthcare Connect Fund, once their current awards are exhausted, so there is no reason to provide these Pilots preferential treatment over other consortia. Second, the Pilot Program was just that – a pilot, or trial, program launched to examine how the RHC program could be used to enhance HCP access to advanced services and to lay the foundation for the reformed program we adopt today.[818] It would be contrary to the limited scope of the Pilot Program to authorize additional Pilot Program support

---

[814] *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 26 FCC Rcd 6619, 6628, para. 19 (2011).

[815] *2012 Bridge Funding Order*, 27 FCC Rcd at 7911, para. 10.

[816] *See* Letter from Kim Lamb, Executive Director, OHN, to Sharon Gillett, Chief, FCC Wireline Competition Bureau, WC Docket No. 02-60 (filed Dec. 17, 2010) (OHN Letter); *see also* Letter from Eric P. Brown, President and CEO, CTN, to Sharon Gillett, Chief, FCC Wireline Competition Bureau, WC Docket No. 02-60 (filed Mar. 17, 2011); Letter from Dale C. Alverson, M.D., Project Coordinator, SWTAG, to Sharon Gillett, Chief, FCC Wireline Competition Bureau, WC Docket No. 02-60 (filed May 23, 2011) (SWTAG Letter); Letter from Kenneth L. Oakley, Ph.D., FACHE, Project Coordinator, WNYRAHEC, to Sharon Gillett, Chief, FCC Wireline Competition Bureau, WC Docket No. 02-60 (filed Mar. 4, 2011) (WNYRAHEC Letter); Letter from Frank C. Clark, Ph.D., Project Coordinator, PSPN, to Sharon Gillett, Chief, FCC Wireline Competition Bureau, WC Docket No. 02-60 (filed Mar. 16, 2011); Letter from Kipman Smith, Executive Director, HIEM, to Sharon Gillett, Chief, FCC Wireline Competition Bureau, WC Docket No. 02-60 (filed Dec. 29, 2010) (HIEM Letter).

[817] *See, e.g.*, HIEM Letter at 1; OHN Letter at 1; WNYRAHEC Letter at 1.

[818] *See 2006 Pilot Program Order*, 21 FCC Rcd at 11111-12, paras. 1, 4.

at this time. Finally, disbursement of additional Pilot Program support would be inconsistent with the Commission's 2007 directive that Pilot Program applicants that were denied funding at that time could reapply for RHC funding in the reformed program.[819] The Pilot projects requesting additional support may reapply in the reformed program, just as denied applicants may do. To grant these requesting Pilot projects additional support without requiring new applications would unfairly advantage them to the detriment of the denied Pilot applicants. Instead, we direct USAC to utilize unused Pilot Program funds for the demand associated with the Healthcare Connect Fund.

364. We also dismiss a request by the Texas Health Information Network Collaborative (TxHINC) for an extension of the June 30, 2012, Pilot Program deadline for projects to choose vendors and request funding commitment letters from USAC.[820] In its request, TxHINC explains that, due to circumstances unique to Texas, it was delayed in choosing vendors and submitting funding requests to USAC.[821] We dismiss TxHINC's request, finding it moot because TxHINC ultimately filed its request for funding commitments by the June 30, 2012 deadline.

C. Prioritization of Funding

365. *Background.* The Commission's current RHC program rules establish a procedure for allocating funds in the event that total requests for funding commitments exceed the $400 million annual RHC program cap.[822] Generally, funds are available on a first-come, first-served basis, although USAC may implement a filing period that treats all HCPs filing within the period as if their applications were simultaneously received, and if necessary, apply a pro-rata reduction in support across the board to all requests filed within the same filing period.[823] Because program demand has never approached the $400 million cap, USAC has not to date needed to implement a filing period for the purpose of applying pro-rata reductions.

366. In the *NPRM*, the Commission sought comment on whether to establish an annual cap of $100 million for support under the proposed Health Infrastructure Program, and sought comment on whether to establish criteria for prioritizing funding should the infrastructure program exceed that cap in a particular year.[824] The Commission stated that it did not believe that the proposed Health Broadband Services Program initially would exceed the amount of available funds, but sought comment on possible prioritization procedures in the event that the total requests for funding under the Telecommunications and the new programs were to exceed the Commission's established $400 million annual cap.[825]

367. *Discussion.* After consideration of the record received in response to the prioritization proposals in the *NPRM*, we will continue for the time being to apply the existing rule for addressing

---

[819] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20394, para. 69.

[820] *See* Letter from George S. Conklin, Project Coordinator, TxHINC, and Senior Vice President and CIO, CHRISTUS Health, to Marlene H. Dortch, Secretary, FCC, and Sharon Gillett, Chief, Wireline Competition Bureau, FCC, WC Docket No. 02-60 (filed March 26, 2012) (TxHINC Letter).

[821] TxHINC Letter at 1.

[822] *See* 47 C.F.R. § 54.623(a) (establishing an annual cap of $400 million on federal universal service support for HCPs). To date, the requests for support have never approached the $400 million cap in any funding year.

[823] *See* 47 C.F.R. § 54.623(c), (f).

[824] *NPRM*, 25 FCC Rcd at 9422, para. 129. In the *NPRM*, the Commission sought comment on options for prioritizing funding should the health care universal service programs reach the $400 million cap. *NPRM*, 25 FCC Rcd at 9421-9423, paras. 128-134; 47 C.F.R. § 54.623(a).

[825] *NPRM*, 25 FCC Rcd at 9421, para. 128.

situations when total requests exceed the $400 million cap.[826] Demand in this program has never come close to the $400 million annual cap, and we believe, for the reasons discussed immediately below, that we are unlikely to reach the cap in the foreseeable future. We direct USAC to periodically inform the public, through its web site, of the total dollar amounts that have been requested by HCPs, as well as the total dollar amounts that have been actually committed by USAC for the funding year. USAC should post this information for both the $150 million cap on multi-year commitments and the $400 million cap that applies to the entire rural health care support mechanism.[827] We do intend, however, to conduct further proceedings and issue an Order by the end of 2013 regarding the prioritization of support for all the RHC universal service programs. In the meantime, we will continue to rely upon, as a backstop, the approach codified in our existing rules, in the unlikely event that funding requests do reach the $400 million cap before we have established other prioritization procedures.[828]

368. We believe it is unlikely that the combined health care support programs will approach the $400 million annual cap any time soon. It will likely take a significant amount of time for new consortia to organize, identify broadband needs, prepare RFPs, conduct competitive bidding, and select vendors, and for that reason it will be at least a year before funding will begin to flow to new applicants in the program.[829] Given the Pilot Program experience, it will likely take even longer than that for many consortium applicants to be ready to seek funding under the Healthcare Connect Fund.[830] In addition, our decision to require a 35 percent participant contribution, the limitations we impose on participation by non-rural HCPs, and the $150 million cap on annual funds for upfront payments all should moderate demand for funding in the near term.[831] Finally, the pricing and other efficiencies made possible through consortium purchase of a broader array of services also should help drive down the cost of connections supported by the RHC component of the Universal Service Fund, as some Telecommunications Program participants migrate to the reformed program. For that reason, we project growth in the combined health care universal service fund to remain well under the $400 million cap over the next five years, as discussed above in the Support for Broadband section.[832] Because we lack historical demand data for the Healthcare Connect Fund, and because the new program provides support for multi-year contracts and other upfront payments, we direct the Bureau, working with OMD and with the Administrator, to project the amounts to be collected for the USF for the early period of the new program, until such time as historical data provides an adequate basis for projecting demand.[833]

---

[826] *See* 47 C.F.R. § 54.623(f). The funds for the Pilot Program have already been collected (though not all have been disbursed), so the $400 million cap will not be affected by future remaining Pilot Program disbursements.

[827] *See supra* section VI.C.4. The $400 million cap applies to funding commitments. *See Universal Service First Report and Order*, 12 FCC Rcd at 9143-44, paras. 710-713.

[828] *See* 47 C.F.R. § 54.623(f).

[829] *See supra* section X.A.

[830] USAC Nov. 16 Letter at 3; *see also supra* n.817.

[831] Because we have put in place a cap on upfront payments, we do not believe it is necessary to adopt a separate cap on HCP-owned infrastructure, as proposed in the *NPRM*. 25 FCC Rcd at 9422, para. 129. In addition, given the experience of the Pilot Program, where most HCPs chose services over self-construction, we would not expect demand for HCP-owned infrastructure in the Healthcare Connect Fund to be so great as to require prioritization rules to be put in place now. *See Pilot Evaluation*, 27 FCC Rcd at 9443, para. 91.

[832] *See supra* para. 67.

[833] *See* 47 C.F.R. §§ 54.709(b), 54.709(a)(3).

D. Offset Rule

369. *Background*. The E-rate program allows service providers to be reimbursed for services in one of two ways: either as an offset to their obligation to contribute to universal service support, or through direct reimbursement drawn from universal service support mechanisms. E-rate service providers elect the preferred method in January of each year.[834] For the Telecommunications and Internet Access Programs, however, the Commission requires carriers to use the offset option.[835] A carrier in those programs may only receive direct reimbursement if the total amount of support owed exceeds the carrier's total universal service obligation, calculated on an annual basis. USAC has until the end of the first quarter of the calendar year following the year in which costs were incurred (and any applicable offset applied) to provide the direct reimbursement to the carrier.[836] This means that a Fund contributor may be required to wait over a year before it is reimbursed for services provided to HCPs. The Commission waived the offset rule for the Pilot Program, however, enabling both "telecommunications carriers" and "non-telecommunications carriers" to receive direct reimbursement for discounts provided to Pilot Program participants.[837]

370. In the *NPRM*, the Commission explained that, despite its intended benefits, the offset rule can create inequities and inefficiencies.[838] Based on the offset rule's shortcomings, the Commission proposed to eliminate the rule for participants in the Broadband Services Program (now part of the Healthcare Connect Fund) and the existing RHC program, and replace it with a rule allowing service providers to receive direct reimbursement from USAC.[839] The Commission also sought comment on whether to retain the offset rule as an option for contributors who wish to utilize this method.[840]

---

[834] 47 C.F.R. § 54.515.

[835] *See* 47 C.F.R. § 54.611*; see also Universal Service First Report and Order*, 12 FCC Rcd at 9154–55, para. 734. In adopting this requirement, the Commission construed the statutory language that authorized both the Rural Health Care mechanism and the E-rate mechanism. Ultimately, the Commission implemented the offset rule as a requirement only for the RHC program and not for the E-rate. *See Universal Service First Report and Order*, 12 FCC Rcd at 9154–55, para. 734. *Compare* 47 C.F.R. § 54.515 (permitting carriers providing services under E-rate to elect either an offset or a direct reimbursement), *with* 47 C.F.R. § 54.611(a) (requiring RHC program carriers to receive support in the form of an offset). Although the Commission concluded that it had authority to allow carriers to receive direct reimbursement from USAC, it deemed a mandatory offset rule for the RHC Program to be "less vulnerable to manipulation and more easily administered and monitored." *Universal Service First Report and Order*, 12 FCC Rcd at 9156, para. 737 (*citing Federal State-Joint Board on Universal Service*, CC Docket No. 96-45, Recommended Decision, 12 FCC Rcd 87, 446, para. 716 (1996)).

[836] 47 C.F.R. § 54.611(d).

[837] *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20419, paras. 114-16. The Commission determined that offset should not be mandatory in the Pilot Program because both telecommunications carriers and non-telecommunications carriers were eligible to provide services under the program. *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20419, para. 116.

[838] *NPRM*, 25 FCC Rcd at 9424, para. 136. Under the offset rule, service providers are not reimbursed until the annual rural health care offset occurs, which often means that HCPs must pay the full cost for services and wait for a refund from the service provider once the service provider receives the offset. *See* 47 C.F.R. § 54.611; *NPRM*, 25 FCC at 9424, para. 136 n.276. The Commission also noted that USF contributors are subject to the offset rule, whereas non-contributors, by definition, cannot receive an offset (and thus must receive direct reimbursement). *Id.* at para. 136 n.278.

[839] *NPRM*, 25 FCC Rcd at 9424, para. 137.

[840] *Id.*

371. *Discussion.* While the original intent of the offset rule was to prevent waste, fraud, and abuse, we find that mandatory application of the rule is no longer necessary or advisable. Our action here is not the first instance in which the Commission has recognized the shortcomings of the offset rule. Indeed, the Bureau has waived the offset rule in several instances because strict application of the rule would have jeopardized the precarious finances and operations of some small, rural HCPs and their service providers.[841] Further, service providers who are not required to contribute to the Fund already receive direct reimbursement. Based on the wide variety of vendors participating in the Pilot Program, we believe that direct reimbursement encouraged extensive bidding on RFPs in the Pilot Program.[842] Likewise, we expect that enabling carriers to elect direct reimbursement in the Healthcare Connect Fund will encourage many more vendors to bid on RFPs than if offset was mandatory, because they will not have to wait to receive reimbursement until they can offset their universal service contribution amount.

372. In light of the shortcomings of the offset rule discussed above, and in consideration of the relevant comments, we revise section 54.611 of the Commission's rules to eliminate mandatory application of the offset procedure. Commenters unanimously support having the option of direct reimbursement, arguing, among other things, that the offset requirement is obsolete, outdated, and administratively burdensome, and that it delays payment to carriers.[843] We will permit USF contributors in the Telecommunications Program and the Healthcare Connect Fund to elect whether to treat the amount eligible for support as an offset against their universal service contribution obligation, or to receive direct reimbursement from USAC.[844] We adopt a new rule for the Healthcare Connect Fund and the Telecommunications Program to effectuate this approach.[845]

---

[841] *See Request for Waiver of Section 54.611 of the Commission's Rules by Action Communications, Inc*., WC Docket No. 02-6, Order, 25 FCC Rcd 8031 (Wireline Comp. Bur. 2010) (authorizing direct reimbursement on a monthly basis); *see also Request for Waiver by TeleQuality Communications, Inc*., WC Docket No. 02-6, Order, 24 FCC Rcd 10716 (Wireline Comp. Bur. 2009) (authorizing direct reimbursement on a bi-monthly basis); *see also Request for Waiver by Unicom, Inc*., WC Docket No. 02-6, Order, 21 FCC Rcd 11240 (Wireline Comp. Bur. 2006) (authorizing direct reimbursement on a quarterly basis).

[842] *See Pilot Evaluation*, 27 FCC Rcd at 9467-68, App. D, List of Winning Vendors; *see also* section VI.B.1..

[843] *See, e.g.*, AHA Comments at 5 (supporting proposal to receive payment for services directly from the Fund because it would further simplify funding mechanisms); AT&T Comments at 11 (noting that direct funding from USAC would remove additional, time-consuming step of having the project coordinator review and approve the invoice); GCI Comments at 21 (stating that the offset rule is "obsolete" and fully supporting its elimination); CTN Comments at 28 (calling the offset rule "outdated" and not technology neutral); Fort Drum Regional Health Planning Organization Comments at 7 (noting that it "supports removal of the offset rule"); Avera Health Comments at 12 (requesting that the Commission modify the reimbursement process going forward to mirror that of the Pilot Program so that carriers are "reimbursed by USAC directly for specific services rendered, as is the case with the E-Rate and other Commission programs"); Charter Communications Comments at 17 (citing delay in payment to carriers).

[844] Until it expires, participants in the Internet Access Program also qualify for the new offset rule. Consistent with the modifications to the offset rule adopted herein, we grant the petitions for waiver of section 54.611 of the rules filed by Network Services Solutions, L.L.C. (NSS), and Richmond Connections, Inc. (Richmond Connections), and direct USAC, no later than 10 days calendar days from release of this Order, to initiate bi-monthly rural health care support disbursements to NSS and Richmond Connections. We dismiss as moot NSS's and Richmond Connections' companion petitions for expedited stays. *See Wireline Competition Bureau Seeks Comment on Network Services Solutions, L.L.C., Petition for Waiver of Certain Rural Health Care Program Rules and Emergency Petition for Expedited Stay*, WC Docket No. 02-60, Public Notice, 27 FCC Rcd 8946 (Wireline Comp. Bur. 2012); Petition for Waiver and Emergency Request for Expedited Stay and/or Special Relief of Network Services Solutions, L.L.C, WC Docket No. 02-60 (filed Jun. 18, 2012); *Comment Sought on Richmond Connections, Inc., Request for Waiver of the Commission's Rural Health Care Program Rules and Emergency Petition for Expedited Stay Pending Commission Review*, WC Docket No. 02-60, Public Notice, 26 FCC Rcd 10247 (Wireline Comp. Bur. 2011);

(continued…)

373. We note that, while commenters unanimously support direct reimbursement, they do not agree on whether to maintain offset as an option. TeleQuality recommends that service providers be given an offset option.[846] Several other commenters do not directly advocate for an offset option but implicitly support it in their support of our proposed rule which includes an offset option.[847] Conversely, a few commenters seek elimination of offset even as an option, with Charter Communications asking the Commission to "formalize its recognition of the deficiencies of the offset rule by eliminating it in the new RHC programs."[848] While we recognize the deficiencies of mandatory offset, we conclude it is appropriate to maintain offset as an option because it affords flexibility to carriers that deem offset simpler or otherwise more beneficial than direct reimbursement. Further, while carriers such as Charter and GCI prefer, and likely will choose, direct reimbursement, an offset option will not disadvantage them in any way.[849] Finally, our revised rule is consistent with the choice available in the E-rate program, in which service providers may opt to use the offset method or receive direct reimbursement from USAC.[850]

374. Also as we do in the E-rate program, each January we will require service providers to elect the method by which they will be reimbursed, and require that they remain subject to this method for the duration of the calendar year using Form 498, as is the case in the E-rate program.[851] Form 498 will need to be revised to accommodate such elections in the health care support mechanism, and the revised form is unlikely to be approved by OMB under the Paperwork Reduction Act prior to January 31, 2013. Therefore, once revised Form 498 is available, we direct the Bureau to announce via public notice a 30-day window for service providers to make their offset/direct reimbursement election for the health care support mechanism for 2013.[852] To the extent that a service provider fails to remit its monthly universal service obligation, however, any support owed to it under the Healthcare Connect Fund or the Telecommunications Program will automatically be applied as an offset to the service provider's annual universal service obligation.[853]

(Continued from previous page)

Petition for Waiver and Emergency Request for Expedited Stay and/or Special Relief of Richmond Connections, Inc., WC Docket No. 02-60 (filed Jul. 7, 2011).

[845] *See* Appendix D, 47 C.F.R. § 54.679.

[846] TeleQuality Comments at 6.

[847] *See, e.g.*, NETC Comments at 4; AHA Comments at 5; USF Consultants Comments at 3.

[848] *See* Charter Communications Comments at 18; *see also* GCI Comments at 21; Fort Drum Regional Health Planning Organization Comments at 7.

[849] *See* Charter Communications Comments at 18; *see also* GCI Comments at 21.

[850] *See* 47 C.F.R. § 54.515 (permitting carriers providing services under E-rate to elect either an offset or a direct reimbursement).

[851] *See* 47 C.F.R. § 54.515(a); *see also Changes to the Board of Directors of the National Exchange Carrier Association, Inc.*, Second Report and Order and Third Order on Reconsideration, CC Docket No. 97-21, *Federal-State Joint Board on Universal Service*, Sixth Order on Reconsideration, CC Docket No. 96-45, 13 FCC Rcd 22908, 22918, para. 18 (1998) (*Universal Service Sixth Order on Reconsideration*) (noting that it "may be costly and administratively burdensome if USAC is asked to alter on a frequent basis the method by which a carrier is reimbursed" and "therefore requir[ing] carriers that are owed support under the universal service support mechanism for schools and libraries to elect on an annual basis the method by which they will receive payment").

[852] We note that, as in the Internet Access Program, vendors that elect direct reimbursement can receive monthly reimbursement payments.

[853] *See* 47 C.F.R. § 54.515(a); *see also Universal Service Sixth Order on Reconsideration*, 13 FCC Rcd at 22919, para. 19 (finding that, "to the extent that a carrier is in arrears on its universal service obligations, it has already

(continued…)

E. Delegation to Revise Rules

375. Given the complexities associated with modifying existing rules as well as other reforms adopted in this Order, we delegate authority to the Bureau to make any further rule revisions as necessary to ensure the reforms adopted in this Order are reflected in the rules.[854] This includes correcting any conflicts between the new and or revised rules and existing rules as well as addressing any omissions or oversights. If any such rule changes are warranted, the Bureau shall be responsible for such change. We note that any entity that disagrees with a rule change made on delegated authority will have the opportunity to file an Application for Review by the full Commission.[855]

XI. PROCEDURAL MATTERS

A. Paperwork Reduction Act

376. This Order contains new information collection requirements subject to the Paperwork Reduction Act of 1995 (PRA), Public Law 104-13. It will be submitted to the Office of Management and Budget (OMB) for review under Section 3507(d) of the PRA. OMB, the general public, and other Federal agencies are invited to comment on the new or modified information collection requirements contained in this proceeding. In addition, we note that pursuant to the Small Business Paperwork Relief Act of 2002, Public Law 107-198, *see* 44 U.S.C. 3506(c)(4), we previously sought specific comment on how the Commission might further reduce the information collection burden for small business concerns with fewer than 25 employees. We describe the impacts that might affect small businesses, which include most businesses with fewer than 25 employees, in the Final Regulatory Flexibility Analysis in Appendix C.

B. Congressional Review Act

377. The Commission will send a copy of this Order to Congress and the Government Accountability Office pursuant to the Congressional Review Act.[856]

C. Final Regulatory Flexibility Analysis

378. The Regulatory Flexibility Act (RFA)[857] requires that an agency prepare a regulatory flexibility analysis for notice and comment rulemakings, unless the agency certifies that "the rule will not, if promulgated, have a significant economic impact on a substantial number of small entities."[858] Accordingly, we have prepared a Final Regulatory Flexibility Analysis concerning the possible impact of the rule changes contained in the Order on small entities. The Final Regulatory Flexibility Analysis is set forth in Appendix C.

(Continued from previous page)

effectively chosen an offset method of compensation" and "requiring the use of an offsetting procedure . . . for a carrier that fails to make timely contributions serves the public interest by ensuring an appropriate universal service fund and minimizing the need for costly and time-consuming enforcement actions").

[854] *See* 47 U.S.C. § 155(c)(1).

[855] *See* 47 U.S.C. § 155(c)(4).

[856] *See* 5 U.S.C. § 801(a)(1)(A).

[857] *See* 5 U.S.C. § 601–612. The RFA has been amended by the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA), Pub. L. No. 104-121, Title II, 110 Stat. 857 (1996).

[858] 5 U.S.C. § 605(b).

XII. ORDERING CLAUSES

379. Accordingly, IT IS ORDERED that, pursuant to sections 1, 2, 4(i)–(j), 201(b), and 254 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151, 152, 154(i)–(j), 201(b), and 254, this Report and Order IS ADOPTED.

380. IT IS FURTHER ORDERED that Part 54 of the Commission's rules, 47 C.F.R. Part 54, is AMENDED as set forth in Appendix D, and such rules shall be effective thirty (30) days after publication of the text or summary thereof in the Federal Register, except for those rules and requirements that involve Paperwork Reduction Act burdens, which shall become effective immediately upon announcement in the Federal Register of OMB approval and of effective dates of such rules.

381. IT IS FURTHER ORDERED that pursuant to 5 U.S.C. § 801(a)(1)(A), the Commission SHALL SEND a copy of this Report and Order to Congress and to the Government Accountability Office pursuant to the Congressional Review Act.

382. IT IS FURTHER ORDERED that the Commission's Consumer and Governmental Affairs Bureau, Reference Information Center, SHALL SEND a copy of this Report and Order, including the Final Regulatory Flexibility Analysis, to the Chief Counsel for Advocacy of the Small Business Administration.

383. IT IS FURTHER ORDERED that, pursuant to the authority contained in sections 1-4 and 254 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151-154 and 254, the requests for additional Rural Health Care Pilot Program funding filed by Oregon Health Network, California Telehealth Network, Southwest Telehealth Access Grid, Western New York Rural Area Health Education Center, Inc., Palmetto State Providers Network, and Health Information Exchange of Montana ARE DENIED.

384. IT IS FURTHER ORDERED that, pursuant to the authority contained in sections 1-4 and 254 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151-154 and 254, the request for an extension of the June 30, 2012, Rural Health Care Pilot Program deadline filed by the Texas Health Information Network Collaborative IS DISMISSED AS MOOT.

385. IT IS FURTHER ORDERED that, pursuant to the authority contained in sections 1-4 and 254 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151-154 and 254, the requests for waiver of 47 C.F.R. § 54.611 of the Commission's rules filed by Network Services Solutions, L.L.C., and Richmond Connections, Inc., ARE GRANTED.

386. IT IS FURTHER ORDERED that, pursuant to the authority contained in sections 1-4 and 254 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151-154 and 254, USAC SHALL MAKE an initial reimbursement payment to Network Services Solutions, L.L.C., and Richmond Connections, Inc., no later than 10 calendar days from release of this Order as described herein.

387. IT IS FURTHER ORDERED that, pursuant to the authority contained in sections 1-4 and 254 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151-154 and 254, the requests for stay of enforcement of 47 C.F.R. § 54.611 of the Commission's rules filed by Network Services Solutions, L.L.C., and Richmond Connections, Inc., ARE DISMISSED AS MOOT.

FEDERAL COMMUNICATIONS COMMISSION

Marlene H. Dortch
Secretary

APPENDIX A

Summary of Funding Process

Pre-Application Steps

	Individual Applicants	Consortium Applicants
Organize Consortia	N/A	• Identify an entity or organization that will be the lead entity – "Consortium Leader" • Identify all HCPs who will make up the consortium. • Each Consortium Leader must secure necessary authorizations through a Letter of Agency from each HCP seeking to participate that is independent of the Consortium Leader
Determination of HCP Eligibility (Form 460)	✓	✓
Preparation for Competitive Bidding • If not covered by a competitive bidding exemption, develop appropriate evaluation criteria for selecting the winning bid *before* submitting a request for services to USAC to initiate competitive bidding	✓	✓
Sources for Undiscounted Portion of Costs • Begin identifying possible sources for the 35% of undiscounted costs	✓	✓
Obtain FCC Registration Number	✓	Consortia applicants may obtain a single FRN for the consortium as a whole.

Competitive Bidding

	Individual Applicants	Consortium Applicants
Ensure Fair & Open Competitive Bidding Process	✓	✓
Requests for Proposals • Only required if applicant meets certain conditions	Required to issue RFP under applicable state or local procurement rules or regulations	• Seek more than $100,000 in program support in a funding year; *or* • Seek support for HCP-constructed infrastructure; *or* • Required to issue RFP under applicable state or local procurement rules or regulations
USAC Posting of Request for Services • Applicants subject to competitive bidding must submit new FCC Form 461 & accompanying documentation to USAC	✓	Consortia must additionally provide: • Network planning documents, including project management plan, work plan, schedule, and budget • Letters of Agency from members
28 Day Posting Requirement • Applicants must wait at least 28 days from the date that their Form 461 is posted on USAC's website before making a commitment with a service provider	✓	✓
Exemptions to Competitive Bidding Process • Annual undiscounted cost ≤ $10,000 • Government Master Service Agreements • MSAs Approved under Pilot Program or Healthcare Connect Fund • Evergreen Contracts • Contracts Negotiated under E-Rate	✓	✓

Funding Commitment from USAC

	Individual Applicants	Consortium Applicants
Required Documentation for Applicants • Form 462 • Competitive bidding documentation • Cost allocation documentation (if applicable)	✓	Consortia must additionally submit: • Listing of participating HCPs and all of their relevant information, including cost information • Revised project management plan, work plan, schedule, and budget, as necessary • Evidence of viable source for 35% contribution • Consortia who seek funding for long-term capital expenses must submit a sustainability plan
Requests for Multi-Year Commitments	✓	✓

Post-Commitment Steps

	Individual Applicants	Consortium Applicants
Invoicing and Payment Process	✓	✓
Contract Modifications	✓	✓
Site and Service Substitutions	✓	✓

APPENDIX B

Assessment of Broadband Needs of Health Care Providers

TABLE OF CONTENTS

Heading Paragraph #

A. Background 2
B. Need Based on Telehealth Application 6
1. Bandwidth, File Size, and Service Quality 6
2. Telemedicine Applications 13
3. Electronic Health Records 16
4. Image Transfer 19
5. Cumulative Effect of Multiple Applications 20
C. Need Based on Health Care Provider Size and Type 21
D. Resources to Purchase Broadband 23
E. Future Needs of Health Care Providers 28
F. Conclusion 34

1. In this Appendix, we undertake an assessment of health care provider (HCP) needs for broadband capability in light of the current and future state of telemedicine, telehealth, and health care information technology (Health IT).1 Such an assessment is a useful step in determining the appropriate level and type of support the Commission should provide in the new program. The U.S. Government Accountability Office (GAO) also has recommended that the Commission undertake a needs assessment before adopting reforms to the Rural Health Care (RHC) program.2 We evaluate the broadband needs of HCPs by examining the telehealth applications adopted by the providers. Our assessment includes a consideration of various bandwidth-intensive telemedicine applications, the need to store and forward electronic health records (EHRs), the transmission of images and high capacity data, as well as other uses. We also consider the needs of HCPs by looking at the size and type of the various providers, the availability of broadband services, and the future needs of HCPs.

[1] There do not appear to be consistent, settled definitions of the terms "telemedicine," "telehealth," or "Heath IT" across all agencies and health care-related groups. As used in the *National Broadband Plan,* the term "Health IT" encompasses a large group of broadband-enabled solutions that have the potential to improve health care outcomes, while controlling costs and extending the reach of health care professionals. *National Broadband Plan* at 199. In this *Needs Assessment*, the term "telehealth" is used to encompass the full range of health care-related applications over broadband, similar to the way the term "Health IT" was used in the *National Broadband Plan*. These would include telemedicine; exchange of electronic health records (EHRs); collection of data through Health Information Exchanges and other entities; exchange of large image files (*e.g.* X-ray, Magnetic Resonance Images (MRIs), and Computerized Tomography (CT) scans); and the use of real-time videoconferencing and other video applications for a wide range of telemedicine, consultation, training, and other health care purposes. We use the term "telemedicine" in the way it is defined by the American Telemedicine Association: "the use of medical information exchanged from one site to another via electronic communications to improve patients' health status." American Telemedicine Association, http://www.americantelemed.org/i4a/pages/index.cfm?pageid=3333 (last visited June 5, 2012).

[2] U.S. Gov't Accountability Office, FCC's Performance Management Weaknesses Could Jeopardize Proposed Reforms of the Rural Health Care Program, GAO 11-27, at 21 (Nov. 2010) (*GAO Report*), *available at* http://www.gao.gov/products/GAO-11-27. For background on the Commission's Pilot, Telecommunications, and Internet Access Rural Health Care Programs, *see Pilot Evaluation*, 27 FCC Rcd at 9394-97, paras. 8-16.

A. Background

2. The March 2010 National Broadband Plan included a preliminary analysis of health care broadband needs.[3] It identified a broadband connectivity gap for rural HCPs and suggested reforms to the RHC program that could provide greater access to broadband in rural areas.[4] In August 2010, Commission staff issued the *Omnibus Broadband Initiative (OBI) Health Care Technical Paper*, which further analyzed HCP connectivity requirements, available options, and barriers to obtaining sufficient broadband.[5]

3. The *OBI Health Care Technical Paper* found that HCPs typically need three things from their broadband services: (1) bandwidth adequate to support the number and types of applications used, with two popular applications being video consultations and transfer of high-resolution medical images; (2) service quality (*i.e.* reliability, latency level, packet loss and jitter), certain levels of which are required, for example, to support real-time, interactive video consultations; and (3) security, which is required to allow HCPs to comply with Health Insurance Portability and Accountability Act (HIPAA) security requirements for health information.[6] The paper concluded that the broadband needs of an individual HCP are driven by the particular telemedicine applications that it employs and the type and size of the health care delivery setting.[7] The technologies each type of provider uses and the number of concurrent applications to be supported depend on the size and clinical practices of different institutions, which translate into minimum actual broadband requirements.[8]

4. In November 2010, the GAO recommended that the Commission assess the telecommunications needs of rural HCPs in order to guide the evolution of the RHC Program.[9] GAO stated that the primary purpose of a needs assessment is to identify needed services that are lacking, (*i.e.*, telecommunications services for rural HCPs, relative to some generally accepted standard).[10] GAO stated that a needs assessment could provide useful information to help Commission officials determine how many HCPs actually need services, ascertain why some rural HCPs are not participating in the current RHC programs, and better ensure that programmatic changes achieve the intended results.[11]

5. This needs assessment describes and analyzes the current and future HCP needs for broadband to perform the wide range of applications that fall within the umbrella of telehealth or Health

---

[3] Federal Communications Commission, Connecting America: The National Broadband Plan, at 200 (rel. Mar. 16, 2010) (*National Broadband Plan*).

[4] *Id.* at 209. The *National Broadband Plan* observed that relatively little has been published on aggregate broadband demands of HCPs. *Id.* This is due to a number of challenges, such as pricing data that is often proprietary and which fluctuates widely, and the existence of inconsistent and often overlapping category classifications. *Id.*

[5] Federal Communications Commission, Health Care Broadband in America: Early Analysis and a Path Forward (Aug. 2010) (*Omnibus Broadband Initiative (OBI) Health Care Technical Paper* or *OBI Paper*), *available at* http://download.broadband.gov/plan/fcc-omnibus-broadband-initiative-(obi)-working-reports-series-technical-paper-health-care-broadband-in-america.pdf.

[6] *See generally OBI Health Care Technical Paper;* Health Insurance Portability and Accountability Act of 1996 (HIPAA), 42 U.S.C. §§ 300gg *et seq*.

[7] *OBI Health Care Technical Paper* at 5-7.

[8] *Id.* at 7.

[9] *GAO Report* at 21.

[10] *Id.* at 21.

[11] *Id.* at 23-27.

IT.[12] It builds on the *National Broadband Plan* and *OBI Health Care Technical Paper*. It also relies upon (1) information gathered through the Pilot and the RHC Telecommunications and Internet Access Programs; (2) the Wireline Competition Bureau Staff Report on the Pilot Program (the *Pilot Evaluation*):[13] (3) observations provided by the Universal Service Administrative Company (USAC), the Administrator of the RHC Program; (4) outreach meetings with Pilot projects, government agencies, and organizations representing HCPs; and (5) other information in the record and in public sources.[14] We also rely on comments filed in response to the *July 19 Public Notice*, in which the Bureau asked a series of specific questions regarding HCP broadband needs.[15]

B. Need Based on Telehealth Application

1. Bandwidth, File Size, and Service Quality

6. The bandwidth required by a HCP generally depends upon the types of telehealth applications it intends to adopt, in addition to the HCP's other uses for bandwidth (such as e-mail, phone, and data communications). The *OBI Health Care Technical Paper* sets forth estimates of the bandwidth required for each type of telehealth application– including the various types of telemedicine, exchange of medical images, exchange of EHRs, and use of video for consultation and training purposes.[16] The data file sizes associated with these applications vary widely. For example, the *OBI Paper* determined that a standard patient chart might be 5 MB, an X-Ray 10MB, a Magnetic Resonance Image (MRI) 45 MB, a Positron Emission Tomography (PET) scan 200 MB, and a 64-slice Computerized Tomography (CT) scan 3,000 MB.[17] Of course, the larger the files, the greater the need for bandwidth, in order to avoid a slowdown in the transmission times. Real-time video transmission, especially if high-definition (HD), requires a great deal of bandwidth as well. Service quality needs also vary by type of application, and can be quite significant, as discussed in more detail below.[18]

7. In addition to providing estimates of typical data file sizes, the *OBI* Paper describes the differences in transmission time for each file size, based on the bandwidth of the connection used (and assuming no other traffic). Thus, transmitting a 45 MB MRI would take 6 minutes over a 1 Mbps connection (assuming no other traffic at the time), but only 5 seconds over a 72 Mbps connection.[19]

---

[12] *See* Report and Order, *supra* n. 1.

[13] The Commission's Wireline Competition Bureau Staff prepared a Report regarding its Rural Health Care Pilot Program, released in August 2012, which provides background on the Commission's Rural Health Care Programs. *Wireline Competition Bureau Interim Evaluation of Rural Health Care Pilot Program Staff Report***,** WC Docket No. 02-60, Staff Report, 27 FCC Rcd 9387, 9394-9440, paras. 8-22 (2012) (*Pilot Evaluation*).

[14] Letter from Craig Davis, Vice President, Rural Health Care Division, USAC, to Sharon Gillett, Chief, WCB, Federal Communications Commission, WC Docket No. 02-60 (filed Apr. 12, 2012) (USAC April 12, 2012 Letter). For a list of *ex parte* filings from outreach and other calls or meetings with outside entities, *see Pilot Evaluation*, 27 FCC Rcd at 9469, Appendix E.

[15] *Wireline Competition Bureau Seeks Further Comment on Issues in the Rural Health Care Reform Proceeding*, WC Docket No. 02-60, Public Notice, 27 FCC Rcd 8185, 8201-02, para. 12 (Wireline Comp. Bur. 2012) (*July 19 Public Notice).*

[16] *OBI Health Care Technical Paper* at 5-6 (Exhibits A, B); *see also National Broadband Plan* at 209-11.

[17] *OBI Health Care Technical Paper* at 5; *see also National Broadband Plan* at 210.

[18] *OBI Health Care Technical Paper at 5.*

[19] *Id.* at 5.

According to the *OBI* paper, the bandwidth requirement to achieve full functionality of these applications varies widely by the type of telehealth application, as depicted in the chart below.[20]

Health IT Bandwidth Requirements[21]

Text-Only EHR	Remote Monitoring	Basic email + Web browsing	SD Video Conferencing	HD Video Conferencing	Image Transfer (PACS)
.025 Mbps	.5 Mbps	1.0 Mbps	2.0 Mbps	>10 Mbps	100 Mbps

8. USAC also provides useful observations about bandwidth needs for particular telehealth applications. USAC provided the results of its discussions with six telehealth subject matter experts, some of whom are directly involved with one of the RHC Pilot projects.[22] USAC notes that video conferencing applications (especially high resolution) and transmission of large medical images consume the greatest bandwidth.[23] The experts that USAC interviewed stated that while the optimal bandwidth needs for the transmission of HD video consultation averages 22 Mbps, the typical bandwidth dedicated by HCPs to HD video conferencing is only about 8.1 Mbps.[24] For non-HD video conferencing, these experts stated that the optimal bandwidth is around 14 Mbps, with a typical dedicated bandwidth ranging from .4-10 Mbps.[25]

9. The commenters responding to the *July 19 Public Notice* also provided information about bandwidth needs.[26] For example, OHN explains that a minimum speed of 10 Mbps symmetrical is necessary to support the majority of telehealth applications, but emphasizes that larger facilities utilizing multiple concurrent technologies and connections may require upwards of 100 Mbps.[27] It adds that two-way video consults require between 1 and 4 Mbps, depending on the protocol used, and that bandwidth requirements are significantly higher when HD services are used.[28] OHN cautions that, while bandwidth needs continue to decline on a per-application basis, the number of applications in use and the number of concurrent video calls continue to increase at rates disproportionate to the small reductions in bandwidth

[20] *Id.* at 5.

[21] *Id.*

[22] USAC April 12, 2012 Letter at 1-2, App. A.

[23] *Id.* at 3.

[24] *Id.*

[25] *Id.*

[26] IRHTP PN Comments at 3; UTN PN Comments at 5; Geisinger PN Comments at 5-6; CTN PN Comments at 13-14; OHN PN Comments at 12-14; SWTAG PN Comments at 13-15; WNYRAHEC PN Comments at 8-9; RWHC PN Comments at 4; GCI PN Comments at 13, Att. 1 at 4; IRHN PN Comments at 4, 24-26; CHCC/RMHN PN Comments at 5; AHA PN Comments at 2, 5; MiCTA at 7; HSHS PN Comments at 7.

[27] OHN PN Comments at 12; *see also* Geisinger PN Comments at 5 (within Geisinger's system, major clinics are slowly being upgraded from 100 Mbps to gigabit connectivity). Geisinger states that the increase is being driven by specialties such as radiology and cardiology offering services at community clinics in order to reduce patients' need to travel. *Id*. at 5.

[28] OHN PN Comments at 13.

needs within individual applications.[29] Accordingly, OHN concludes that HCP bandwidth needs will continue to rise.[30]

10. Similarly, SWTAG asserts that "telemedicine is dynamically changing with new technologies and expanding applications" and "high definition video, large image files, genomic data, and multipoint connectivity will likely require increased bandwidth."[31] SWTAG therefore concludes that "[c]onnections of over 100 megabits or even Gigabit connections are feasible bandwidth needs in the not too distant future.[32] The Illinois Rural Health Network (IRHN) states that the growth curve for broadband needs associated with telemedicine is difficult to overstate, because "the number of medical procedures that can be digitized and performed remotely will continue to expand."[33]

11. With respect to specific applications, Geisinger explains that, using its relatively "bandwidth friendly" PACS system, it needs 1.5 Mbps for small X-rays files and a minimum of 10 Mbps (ideally 50 Mbps) for high-resolution X-rays requiring real-time radiologist involvement.[34] Also addressing teleradiology needs, RWHC explains that it uses a shared PACS system with 20 Mbps connections but notes that it is "functional but not optimal."[35] RWHC therefore asserts that "100 Mbps would be sufficient and 1 GB would be optimal."[36]

12. Quality-of-service metrics are also crucial to health IT utilization.[37] Applications that integrate real-time image manipulation and real-time two-way video will stimulate demand for more and better broadband because these applications have specific requirements for network speed, latency, and jitter.[38] Many commenters indicated that the telehealth applications they currently use and that they plan to use in the future will demand broadband connections with such high service quality requirements.[39] Certain remote monitoring technologies also may require very low latency in order to pass through high priority events like alarms.[40] Electronic health record exchange can require increased bandwidth and reliability, particularly when the EHR system is remotely hosted, as discussed further below.[41] The *National Broadband Plan* and the *OBI Technical Paper* also recognized and identified the particular

---

[29] *Id.* at 14.

[30] *Id.*

[31] SWTAG PN Comments at 13.

[32] *Id.*

[33] IRHN PN Comments at 25.

[34] Geisinger PN Comments at 5.

[35] RWHC PN Comments at 4.

[36] *Id.*

[37] *National Broadband Plan* at 211; *OBI Health Care Technical Paper* at 7, Exhibit D.

[38] *National Broadband Plan* at 211

[39] *See, e.g.*, Geisinger PN Comments at 6-7; RWHC PN Comments at 5; CHCC/RMHN PN Comments at 5; IRHN PN Comments at 27; MiCTA PN Comments at 7; OHN PN Comments at 15; UTN PN Comments at 6; SWTAG PN Comments at 15-16; HSHS PN Comments at 8; WNYRAHEC PN Comments at 9.

[40] *OBI Health Care Technical Paper* at 7 and Exhibit D.

[41] *See, e.g.*, Geisinger PN Comments at 6; ANTHC PN Comments at App. 1, p. 7. The Oregon Health Network (OHN) also states that the quality of the circuit (and not just the bandwidth) will play a pivotal role in the usability of the circuit as security requirements increase to keep pace with EHR sharing, telehealth applications, and attendant HIPAA requirements. OHN PN Comments at 15.

broadband service quality needs that are associated with telehealth applications.[42] The USAC April 12, 2012 Letter also concluded that EHR systems have high reliability requirements.[43] SWTAG believes that although service quality features such as dedicated connections, redundancy, low latency, and lack of jitter may initially increase costs, "they actually could increase demand and use through demonstrated value, thus eventually lowering cost though improved quality of the encounters, higher volume and expanding applications to achieve an economy of scale and investment by a broader spectrum of service providers."[44]

2. Telemedicine Applications

13. Telemedicine may be the greatest driver of need for broadband capacity generally and for higher bandwidth and higher quality of service specifically, at least in the short term.[45] Tele-radiology, one of the most well-established forms of telemedicine, relies upon rapid and accurate transmission of very large imaging files. Other telemedicine applications require the transmission of high-resolution images or scans (as for tele-dermatology and tele-stroke). Many telemedicine applications require the use of real-time two-way video transmission, including tele-psychiatry, tele-OB/GYN, and tele-stroke. Other applications require transmission of smaller size data files, but they still require rapid transmission of information and high service quality (for example, remote monitoring in a tele-ICU context).

14. Not only do telemedicine applications require high capacity bandwidth, they also require high levels of service quality, as pointed out by many commenters in response to the *July 19 Public Notice*.[46] These applications have little tolerance for latency or other reliability issues (such as dropped connections, jitter and packet loss).[47] Real-time video telemedicine consults in particular require low-latency, reliable connections (connections that do not cause video interruptions or degraded quality) in addition to relatively high bandwidth. Such high quality connections can be critical to the quality of medical care delivered. For example, to build patient trust and to accurately diagnose a patient's condition through tele-psychiatry, it is important that there be no interruption in the video transmission and that the picture quality be good.[48] Similarly, in tele-stroke, a distant neurologist must be able to carefully observe a patient's movements and facial expressions via high-quality video connections, as well as be able to receive and view large CT files very quickly, in order to confirm the existence of a stroke.[49] Stroke-limiting medication must be administered within hours of the event, but has the

---

[42] *OBI Health Care Technical Paper* at 7; *National Broadband Plan* at 209-11.

[43] *See* USAC April 12, 2012 Letter at 1.

[44] SWTAG PN Comments at 15.

[45] *See* USAC April 12, 2012 Letter at 1; IRHN PN Comments at 25; ATA PN Comments at 2; SWTAG PN Comments at 13-14.

[46] *See, e.g.*, Geisinger PN Comments at 6-7; RHWC PN Comments at 5; CHCC/RMHN PN Comments at 5; IRHN PN Comments at 27; MiCTA PN Comments at 7; OHN PN Comments at 15; UTN PN Comments at 6; SWTAG PN Comments at 15-16; HSHS PN Comments at 8; WNYRAHEC PN Comments at 9.

[47] *See, e.g.*, *OBI Health Care Technical Paper* at 5, *USAC April 12, 2012 Letter* at 1.

[48] *See* Letter from Linda L. Oliver, Attorney Advisor, Federal Communications Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 (filed April 12, 2012) at 1 (Summary of *ex parte* call with Hill Country Community Mental Health and Developmental Disabilities Centers and National Ass'n for Rural Mental Health) (NARMH April 12 *Ex Parte* Letter).

[49] *See, e.g.*, Letter from Linda L. Oliver, Attorney Advisor, Federal Communications Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 at 2 (filed Jan. 17, 2012) (ONC Jan. 17 *Ex Parte* Letter) (explaining that when the emergency room of a rural hospital is able to quickly transmit a CT scan of a patient's head to a neurologist in an urban hospital, the rural hospital can prevent permanent stroke

(continued…)

capability of greatly improving outcomes for patients and thus for saving a great deal in long-term health care costs.[50]

15. A number of Pilot projects provide tele-psychiatry and tele-stroke applications, as well as many other telemedicine applications that require high bandwidth and high levels of service quality, as detailed in the *Pilot Evaluation*.[51] As discussed there, Pilot Program participants generally were able to obtain the needed service quality and reliability through the consortium-based competitive bidding process.[52]

3. Electronic Health Records

16. Electronic health records may also prove to be a driver of bandwidth and service quality needs now and in the future. At this time, EHRs generally speaking are relatively small files and thus require relatively little bandwidth to transmit to another HCP.[53] Also, HCPs are only required to exchange a relatively small amount of information in order to qualify for Stage One Meaningful Use incentive payments.[54] The *USAC April 12, 2012 Letter* suggests that although the optimal bandwidth needs for the transmission of EHRs can range from 1.5 Mbps to 50 Mbps, the typical bandwidth dedicated to EHRs by HCPs is only 7.6 Mbps.[55]

17. Bandwidth requirements for exchange of EHRs may increase significantly in the near future, however, for several reasons. First, HCPs may decide to embed larger files within EHRs (such as X-rays, MRIs, CAT scans, or even videos), thus changing the size of EHR files.[56] The Illinois Rural HealthNet projects that the "growth curve" in this regard will be "exponential."[57] Second, in order to participate in health information exchanges, HCPs may need the capability to transmit large amounts of data.[58] Third, the rules governing Stage Two Meaningful Use require providers to demonstrate a greater degree of actual exchange of EHRs than the Stage One rules, and such exchange may require a degree of broadband capability that not all HCPs currently possess.[59] The rules, which were recently released by the Center for

(Continued from previous page)

damage by administering preventative medicine in a timely fashion, but where only a T-1 connection is available, transmission of the CT scan could take 25 minutes, and the delay could have serious consequences for the patient); *Pilot Evaluation*, 27 FCC Rcd at 9437, para. 83 (Pilot projects were able to obtain better quality of service and reliability through the consortium-based competitive bidding process).

[50] Bart M. Demaerschalk, *Telemedicine or Telephone Consultation in Patients with Acute Stroke*, Current Neurology and Neuroscience Reports, Vol. 11: No. 1, 43 (2011)

[51] *Pilot Evaluation*, 27 FCC Rcd at 9413-14, paras. 44-45.

[52] *Id.*, 27 FCC Rcd at 9437, 9445-46, paras. 83, 94-95.

[53] *OBI Health Care Technical Paper* at 5; NARMH April 12 *Ex Parte* Letter at 2.

[54] *See* http://www.healthit.gov/providers-professionals/how-attain-meaningful-use (last visited Dec. 18, 2012).

[55] USAC April 12, 2012 Letter at App. A.

[56] *See, e.g.*, OHN PN Comments at 14; RWHC PN Comments at 4-5; IRHN PN Comments at 26; SWTAG PN Comments at 14; Geisinger PN Comments at 6.

[57] IRHN PN Comments at 26.

[58] *See, e.g.*, UTN PN Comments at 5; CHCC/RMHN PN Comments at 5; AAP PN Comments at 1; SWTAG PN Comments at 14.

[59] *See* Centers for Medicare and Medicaid Services, Details for: CMS Medicare and Medicaid EHR Incentive Programs: Stage 2 Final Rule (Aug. 23, 2012), *available at*

(continued…)

Medicare and Medicaid Services (CMS) and the Office of the National Coordinator for Health IT within the Department of Health and Human Services (ONC), include exemptions for those providers that lack the broadband capability needed to meet the Stage Two requirements.[60] Stage Three rules may require an even greater degree of EHR exchange and thus greater bandwidth.[61] Even if exemptions for HCPs that lack sufficient bandwidth continue to be included in CMS/ONC rules, there are still strong policy reasons to ensure that HCPs have the broadband required to exchange EHRs and thus participate in improving the quality and coordination of care for their patients.

18. In addition, best practices for EHR systems are evolving from on-site storage of EHRs to remote or "cloud-based" storage, where records back-up systems are located in locations that are remote from the HCP site or in the Internet "cloud."[62] A "cloud-based" EHR system allows for the easy exchange of records among HCPs, and also between HCPs and laboratories or Health Information Exchanges (HIEs).[63] They often cost less than office-based EHRs because they do not require small HCPs to invest in software or EHR infrastructure, and they thus distribute costs among multiple parties.[64] They also require less on-site maintenance.[65] Rural HCPs are especially likely to adopt such EHR solutions.[66] Geisinger states that it is likely that many rural physician practices and rural community hospitals will use an electronic medical record hosted off-site, because EMR implementation is expensive.[67] Remotely hosted solutions also may require both higher bandwidth connections and increased levels of redundancy.[68] The Oregon Health Network (OHN) observes that the quality of the circuit (and not just the bandwidth) will play a pivotal role in the usability of the circuit as security

(Continued from previous page)

https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4440&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date; CHCC/RMHN PN Comments at 5; SWTAG PN Comments at 15.

[60] *See* Centers for Medicare and Medicaid Services, Details for: CMS Medicare and Medicaid HER Incentive Programs: Stage 2 Final Rule (Aug. 23, 2012), *available at* https://www.cms.gov/apps/media/press/factsheet.asp?Counter=4440&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays=3500&srchOpt=0&srchData=&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year=&desc=&cboOrder=date.

[61] Department of Health and Human Services, EHR Incentives & Certification: How to Obtain Meaningful Use, *available at* http://www.healthit.gov/providers-professionals/how-attain-meaningful-use (stating that criteria to focus on in Stage 3 will include access to comprehensive patient data through patient centered HIE).

[62] *See AHA PN Comments at* 5; *see also* Letter from Linda L. Oliver, Attorney Advisor, Federal Communications Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 at 2 (filed Jan. 6, 2012) (ONC Jan. 6 *Ex Parte* Letter).

[63] *ONC* Jan. 6 *Ex Parte* Letter at 2.

[64] *See*, *e.g.*, AHA PN Comments at 5.

[65] *See* WNYRAHEC PN Comments at 8-9; ATA PN Comments at 5.

[66] *See*, *e.g.*, AHA PN Comments at 5; Geisinger PN Comments at 6; *see also* Ken Terry, *Cloud-Based EHRs, Telemed to Come to Rural Colorado*, InformationWeek, May 29, 2012, *available at* http://www.informationweek.com/news/healthcare/EMR/240000979 (*last visited* Nov. 21, 2012).

[67] Geisinger PN Comments at 6.

[68] *See*, *e.g.*, ATA PN Comments at 5; USAC April 12, 2012 Letter at 1. According to Geisinger, using an off-site EMR increases bandwidth and reliability requirements. A minimum of 10 Mbps at physician practices and a minimum of 100 Mbps for a community hospital can be adequate to support the EMR itself. Geisinger PN Comments at 6.

requirements increase to keep pace with EHR sharing, telehealth applications, and attendant HIPAA requirements.[69]

4. Image Transfer

19. The electronic transmission of images (including radiological images) and similar clinical data has been used increasingly by a number of medical personnel, including dermatologists and radiologists. Store-and-forward technology, which "stores" a patient record and "forwards" to a provider for further review, also supports ongoing patient monitoring and management of key medical indicators. The speed with which a large image can be transmitted can make a significant difference in the speed with which a radiologist can make a diagnosis, which may in turn affect the quality of care received by a patient in a rural area where there is no radiologist.[70] The Illinois Rural HealthNet provides a table that compares transmission times for a 64-slice CT scan over various bandwidth connections in its network. Over a T-1 (1.5 Mbps) connection, the transmission would take over four and a half hours; over a 100 Mbps connection, it would take only five minutes.[71] The increased use of "Picture Archiving and Communication System" or PACS, a medical imaging technology that enables images to be filed, stored, transmitted, and retrieved digitally, may also lead to greater demands for bandwidth to transmit and access large medical image files.[72] The *USAC April 12, 2012 Letter* showed that although the optimal bandwidth needs for the transmission of large data files can range up to 100 Mbps, the typical bandwidth dedicated by HCPs to image transfer is only about 9 Mbps.[73]

5. Cumulative Effect of Multiple Applications

20. Finally, HCPs observe that telehealth applications are cumulative in their demands for broadband capacity.[74] The need for bandwidth has increased as HCPs deploy additional and multiple telemedicine and telehealth applications. These applications are added on top of existing need for bandwidth to conduct HCP health care operations, which must continue uninterrupted (such as e-mail, accessing records, billing activities, and other data transmissions).[75] In addition, HCPs are increasingly using videoconferencing to train health care personnel in remote locations, which uses a significant amount of bandwidth.[76] When HCPs adopt new telemedicine applications, other activities can get

---

[69] OHN PN Comments at 15.

[70] While store-and-forward technology enables large images to be transmitted at night, when there are fewer demands for bandwidth, reliance upon such delayed transmission can have negative clinical implications. *See* IRHN PN Comments at 24 (observing that rapid consultation with radiologist can eliminate the need for patients to return to the hospital for diagnosis).

[71] IRHN PN Comments at 24.

[72] *See generally* OHN PN Comments at 13-14; Geisinger PN Comments at 5.

[73] USAC April 12, 2012 Letter at 3.

[74] *See, e.g.*, GCI PN Comments at 13-14; IRHN PN Comments at 25; OHN PN Comments at 14.

[75] Letter from Christianna Lewis Barnhart, Attorney Advisor, Federal Communications Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 at 1 (filed Dec. 21, 2011) (National Rural Health Ass'n (NRHA) Dec. 21 *Ex Parte* Letter) (noting that voice, video, and data use the same lines, which creates a greater need for broadband capability as telemedicine applications are increasingly deployed by rural HCPs).

[76] *Pilot Evaluation*, 27 FCC Rcd at 9425, 9431, 9433-34, 9438, 9439, paras. 63, 71, 74, 86, 89; *see also, e.g.*, NRHRC *Ex Parte* Letter at 1; USAC Mar.16 Site Visit Reports at 11 (describing PSPN provision of remote training for medical personnel); IRHN PN Comments at 26; UTN PN Comments at 5; SWTAG PN Comments at 15; WNYRAHEC PN Comments at 9.

bumped (for example, e-mail traffic slows). HCPs also report having difficulty ensuring the prioritization of the telemedicine applications over other competing uses for the broadband connections when bandwidth is inadequate to accommodate all their varying health care needs.

C. Need Based on Health Care Provider Size and Type

21. The precise bandwidth required by a particular provider will vary depending on other factors. The 2010 *National Broadband Plan* and *OBI Health Care Technical Paper* explored this issue and reached some general conclusions. The *National Broadband Plan* concluded that smaller providers generally can achieve satisfactory health IT adoption with mass-market packages of at least 4 Mbps for single physician practices and 10 Mbps for two-to-four physician practices.[77] The *OBI Health Care Technical Paper* concluded that a typical rural health clinic with five practitioners should have at least 10 Mbps, while hospitals should have at least 100 Mbps.[78] Eligible HCPs types that fit into this category include rural health clinics, community health centers, and community mental health centers. In contrast, most larger practices will require "Dedicated Internet Access" (DIA) above T-1 or bonded T-1 levels (*i.e.*, greater than 1.5 Mbps), because of their size and service offerings.[79] These enterprise solutions have several characteristics that make them a better choice for HCPs: higher bandwidths; broader and stricter Service Level Agreements (SLAs) that can include minimum service quality guarantees; security through various means, including a dedicated connection and/or software-based solutions; and the ability to allocate bandwidth levels and prioritize certain types of traffic according to HCP needs.[80] The *National Broadband Plan* found that the key connectivity consideration for smaller providers is whether or not they can access mass-market solutions of sufficient bandwidth.[81] It observed that as long as HCPs are located within the mass-market broadband infrastructure, they are likely to have a more convenient and less expensive option than the Dedicated Internet Access necessary for their larger peers.[82]

22. In the Pilot Program, a wide range of HCP types and sizes participated in consortia.[83] The bandwidth connections purchased by individual HCPs within the Pilot Program consortia often varied by the size and type of HCP, as shown in the *Pilot Evaluation*.[84] The consortium purchasing approach, uniform level of discount funding, the competitive bidding process, and flexible approaches to funding, all have helped Pilot Program HCPs purchase greater bandwidth than participants in the RHC Telecommunications Program.[85] As of January 2012, three-quarters of Pilot Program HCPs opted for connections of 3 Mbps or more, with nearly 60 percent obtaining commitments for at least 10 Mbps.[86] In

[77] *National Broadband Plan* at 211.

[78] *OBI Health Care Technical Paper* at 6.

[79] *Id.* at 8.

[80] *Id.*

[81] *Id.* at 9.

[82] *Id.* at 8-9, *National Broadband Plan* at 211.

[83] *Pilot Evaluation*, 27 FCC Rcd at 9408-13, paras. 36-43.

[84] *Id.* at 9422, para. 55 and Figure 14, showing bandwidth used by various types of HCP, according to bandwidth categories used in *National Broadband Plan.*

[85] *Id.* at 9408-13, paras. 36-43.

[86] *Id.* at 9421, para. 54.

contrast, the vast majority of HCPs in the RHC Telecommunications Program purchase circuits of less than 3 Mbps.[87]

D. Resources to Purchase Broadband

23. Many times the problem is not availability of broadband but rather the resources of the HCP to purchase broadband connections. Although many rural HCPs are interested in using technology to implement telemedicine and telehealth, budgetary constraints often limit their ability to do so.[88] Many of the Pilot projects and organizations representing rural HCPs state that HCPs in rural areas often operate on a very thin margin, and some operate at a loss.[89] Some state that even in urban areas, HCPs face financial challenges.[90] As one example of financial challenges facing HCPs, the Arkansas Hospital Association found in its 2008 Annual Report that "Arkansas's hospitals only cleared 26 cents a day in 2007 (a statistic which predated the recent economic downturn)."[91]

24. In addition to budgetary challenges, HCPs in rural areas often pay more for broadband services.[92] Participants in this proceeding have noted that prices for communications services often are higher in rural areas, due in part to the greater distance of the customer's premises from a service provider's network, and in part due to the relatively small number of potential customers that can share the costs in rural areas.[93] According to the *OBI Paper*, which did not focus only on rural HCPs, the major barrier for medium and large providers is not access, but price.[94] It found that while DIA offerings generally are available, DIA pricing depends on factors such as capacity, type and length of the

---

[87] *See id.* at 9421, para. 54 and Figures 13(a) and 13(b).

[88] *See, e.g.*, NRHA Dec. 21 *Ex Parte* Letter at 1.

[89] *Pilot Evaluation* at 9442, 9449-9451, paras. 90, 104-107; Letter from Linda L. Oliver, Attorney Advisor, Federal Communications Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 (filed Mar. 16, 2012) at 1 (Pilot Conference Call Mar. 16 *Ex Parte* Letter (ARCHIE *et al.*)) (even with USF discounts, the cost of broadband connections creates challenges for rural HCPs, whose operating margins are very thin); Letter from Chin Yoo, Attorney Advisor, Federal Communications Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 (filed Dec. 27, 2011) at 2 (NRHRC Dec. 27 *Ex Parte* Letter) (many critical access hospitals and small rural hospitals are experiencing negative margins and facing increased difficulties in accessing capital); Letter from Linda L. Oliver, Attorney Advisor, Federal Communications Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 (filed Mar. 29, 2012) at 2 (John Gale Mar. 29 *Ex Parte* Letter).

[90] *See Pilot Evaluation*, 27 FCC Rcd at 9443, para. 90; Pilot Conference Call Mar. 13 *Ex Parte* Letter (PMHA *et al.*) at 3 (summarizing call with five Pilot project representatives, who stated in relevant part that due to the current economic environment, budgets are tight for urban HCPs, and it may be difficult for urban HCPs to continue to provide support to rural HCPs in their networks if they are ineligible to receive RHC program funding themselves); Letter from W. Roger Poston II, Palmetto State Providers Network, to Christianna Lewis Barnhart, Attorney Advisor, Federal Communications Commission, WC Docket No. 02-60 (filed Feb. 23, 2012) at 1 (PSPN Feb. 23 *Ex Parte* Letter) (stating that urban hospitals, which serve as "consulting" sites for rural hospitals in telemedicine, are often as hard-pressed for available funding as the rural hospitals and cannot bear the non-discounted costs of participation in the networks, and without their participation, vital links in the chain of health care are missing).

[91] University of Arkansas Medical Center NPRM Comments at 7-8 and n.6.

[92] *See, e.g.*, *OBI Health Care Technical Paper* at 10.

[93] *See, e.g.*, ONC Jan. 17 *Ex Parte* Letter at 1; Pilot Conference Call Mar. 13 *Ex Parte* (PMHA *et al.*) letter at 3; Pilot Conference Call Mar. 26 *Ex Parte* Letter (AEN *et al.*) at 1

[94] *OBI Health Care Technical Paper* at 10.

connection, type of service provider, type of facility used, and geography.[95] Within DIA service offerings, prices jump substantially between T1 connections (1.5 Mbps) and higher levels of service such as DS3s (45 Mbps).[96] As a result, according to the *OBI Paper*, providers who purchase DIA solutions often buy connections that are too slow to meet their health IT needs.[97] In fact, surveys show that the majority of Critical Access Hospitals (CAHs) are using T-1 high-capacity access or DSL.[98] In the *Pilot Evaluation*, the data showed that the Pilot Program funding and consortium-based approach enabled HCPs to purchase higher bandwidth connections than in the existing RHC programs, without having to pay significantly more.[99]

25. While the data on high-capacity connectivity and its associated price for HCPs nationwide is limited, the Commission does have considerable data from the HCPs it has funded through the existing RHC program and the Pilot Program. The focus of the Pilot Program was to encourage HCPs to obtain access to broadband connections. As discussed in the *Pilot Evaluation*, the data show that HCPs have used the Pilot funding to obtain high bandwidth leased connections, with 80 percent purchasing connections above 3 Mbps and 69 percent purchasing 10 Mbps or greater connections.[100] In the Telecommunications Program, the vast majority of connections are relatively low bandwidth connections (approximately 80 percent are 3 Mbps or less).[101] As explained in the *Pilot Evaluation*, these differences in bandwidth purchased can be attributed partly to the difference in the discount level and the way it is calculated for the two programs.[102] But the Pilot Program's focus on consortium applications, bulk buying, and competitive bidding also helped make higher bandwidth connections available at a lower price point per megabit.[103]

26. Finally, in addition to bandwidth, HCPs often need a high degree of reliability, service quality, and redundancy for telehealth applications, as discussed above.[104] The greater the level of service quality required for the telehealth applications, the more expensive the broadband.[105]

27. In the Telecommunications Program, HCPs have stated that they would not be able to provide telemedicine services without the support of the program for their telecommunications connections.[106] The Pilot Program also enabled many HCPs to obtain higher bandwidth connections at greater service quality than typically is the case in the Telecommunications Program, let alone without RHC program support. According to a 2010 survey conducted by the Government Accountability Office, nearly all Pilot participants indicated that their project would "definitely" or "probably" have entities that obtain

[95] *National Broadband Plan* at 211.

[96] *OBI Health Care Technical Paper* at 10, *see also* NRHRC Dec. 27 *Ex Parte* Letter at 2.

[97] *OBI Health Care Technical Paper* at 10; *see also* ONC Jan. 17 *Ex Parte* Letter at 2.

[98] NRHRC Dec. 27 *Ex Parte* Letter, Attachments at 5.

[99] *Pilot Evaluation*, 27 FCC Rcd at 9422-25 paras. 57-61.

[100] *See id.* at 9406, Figure 4.

[101] *See id.* at 9407, Figure 5.

[102] *See id.* at 9422-25, paras. 57-61.

[103] *Id.* at 9422-25, 9436-37, paras. 57-62, 81-83.

[104] *See supra* para. 12; ONC Jan. 6 *Ex Parte* Letter at 1.

[105] *See* ONC Jan. 6 *Ex Parte* Letter at 1; *National Broadband Plan* at 211.

[106] GCI Oct. 1 *Ex Parte* Letter at 2; UVA June 8 *Ex Parte* Letter.

telecommunications or Internet services that would be unaffordable without the project.[107] The Pilot Evaluation also documents the higher bandwidth connections that participants were able to obtain.[108]

E. Future Needs of Health Care Providers

28. Over the next 10 years, the role of telehealth and Health IT will grow even more prominent as technologies including telemedicine, EHRs, and mobile health technologies become more critical to expanding access to health care, lowering costs and reforming reimbursement incentives.[109] As explained by the Southwest Telehealth Access Grid (SWTAG), a Pilot project, broadband needs will increase as access to telemedicine services becomes an expected standard of care, improving health outcomes, avoiding unnecessary variations in care, providing better continuity of comprehensive care through, and avoiding complications and need for transport.[110]

29. Although some delivery settings currently can function at lower connectivity and quality, those levels are straining under increasing demand and may be unable to support needs likely to emerge in the near future.[111] As demand for real-time video capability grows for both large hospitals and small rural health clinics, and specialties such as dermatology and psychiatry expand, so will the need for greater broadband capacity.[112] Just one new clinical application or user can tip the balance of speed such that all users see an unacceptable degradation in performance.[113]

30. There are a wide range of requirements to support EHRs and medical imaging, which will increase over the next decade as new technologies, such as 3D imaging, become more prevalent.[114] In addition, applications that integrate real-time image manipulation and live video will stimulate demand for more and better broadband because these applications have specific requirements for network speed, delay and jitter.[115] Increased rates of EHR adoption and exchange also will increase demand for secure, redundant connections, especially when HCPs adopt cloud-based solutions.[116]

31. The Office of the National Coordinator at the Department of Health and Human Services (HHS) believes that higher bandwidth connections may help HCPs achieve meaningful use of EHRs in

---

[107] *GAO Report* at 43 (55 of 57 respondents indicated that if they are able to accomplish their Pilot project goals, their project "definitely" or "probably" will have entities that obtain telecommunications or Internet services that would otherwise be unaffordable).

[108] *Pilot Evaluation*, 27 FCC Rcd at 9422-9434, paras. 57-62, 63-75.

[109] *OBI Health Care Technical Paper* at 5. S*ee* ONC Jan 6. *Ex Parte* Letter at 1 (stating that research suggests that only 30 percent of visits actually require the physical presence of the patient with the doctor).

[110] SWTAG PN Comments at 14.

[111] *National Broadband Plan* at 211. As noted in the *Pilot Evaluation*, the majority of connections in the Primary Program are T-1 (1.5 Mbps) circuits or bonded T-1 circuits. These bandwidths can only support a limited amount of telehealth applications.

[112] NRHA Dec. 21 *Ex Parte* Letter at 1.

[113] USAC April 12, 2012 Letter at 1.

[114] *National Broadband Plan* at 209.

[115] *Id.* at 211.

[116] *See e.g.*, AHA PN Comments at 5 (stating that Cloud-based solutions can be deployed only if the broadband available in rural areas is reliable and affordable, has built-in redundancy, and is sufficient to handle large amounts of data at rapid speeds).

the future.[117] It also notes that HCP needs for communications services are increasing as technologies and capabilities change over time.[118] It suggests that any requirements of a reformed program focus on desired outcomes, such as increasing robust health information exchange among rural health care providers and enabling rural Americans to benefit from access to health care powered by health IT applications, including telehealth, mobile health, and electronic health record technology.[119] HHS also acknowledges the need for a high degree of reliability, service quality, and redundancy for telehealth applications, and believes HCPs will need to obtain Service Level Agreements and Quality of Service guarantees,[120] especially for time-sensitive telehealth applications.[121]

32. The American Telemedicine Association (ATA) has also identified a number of chronic disease telemedicine applications that require high capacity connectivity. These include social media promoting health, mobile cardiovascular and diabetes tools, extended care visits, tele-stroke and home telehealth.[122] The ATA believes these applications will be in the next wave of telemedicine applications, although a number of barriers inhibit the adoption readiness of each telemedicine application to a different degree.[123]

33. It is hard to predict the pace of adoption of telemedicine over the coming years, despite the many proven health care availability, quality, and cost benefits associated with telemedicine. While the cost and availability of broadband connectivity is one factor affecting the pace of adoption of telemedicine, there are many other factors that may pose more significant obstacles. These include lack of reimbursement for services, state licensing requirements, credentialing requirements, lack of technical expertise, lack of patient or physician acceptance, and the need for standards.[124] These substantial

---

[117] *See* Letter from Michael J. Jacobs, Legal Advisor to Chief, Wireline Competition Bureau, Federal Communications Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, WC Docket No. 02-60 at 1 (filed Nov. 16, 2012) (ONC Nov. 16 *Ex Parte* Letter).

[118] *Id*.

[119] *Id*.

[120] ONC Jan. 6 *Ex Parte* Letter at 1.

[121] ONC Jan. 17 *Ex Parte* Letter at 2.

[122] Erin Bartolini & Nicholas McNeill, *Getting to Value: Eleven Chronic Disease Technologies to Watch*, New England Health Institute, 3-5 (June 2012) (NEHI Paper), *available at* http://www.nehi.net/publications/72/getting_to_value_eleven_chronic_disease_technologies_to_watch.

[123] *Id.* at 3.

[124] *See, e.g.*, ATA PN Comments at 2; AAP at PN Comments 2; NRHRC Dec. 27 *Ex Parte* Letter at 2 (noting that the "lack of reimbursement is the biggest obstacle to the deployment of telemedicine services"); NRHA Dec. 21 *Ex Parte* Letter at 1 ("budget limitations and the shortage of technology personnel" limit adoption of telemedicine in rural areas); NRHRC Dec. 27 *Ex Parte* Letter at 1 and attachments (describing the shortage in health IT workforce in rural areas. *See also* NEHI Paper at 1; Bart M. Demaerschalk, *Telemedicine or Telephone Consultation in Patients with Acute Stroke*, Current Neurology and Neuroscience Reports, Vol. 11: No. 1, 43 (2011) (noting that major barriers to telemedicine adoption include inadequate reimbursement rates, licensing restrictions, lack of reliable internet connectivity, and poor understanding of technology, among others); Rural Maryland Council, *Final Report of the December 2010 Maryland Telehealth and Telemedicine Roundtable* (Jan. 2011), *available at* http://www.rural.state.md.us/Roundtables/Telehealth_2010/THTM_Roundtable_FINAL_Jan2011.pdf (last visited June 15, 2012) (concluding that four major barriers to telehealth implementation exist within Maryland: inadequate funding and reimbursement, a lack of state coordination and oversight efforts, broadband limitations, and legal impediments such as licensing).

barriers to widespread adoption of telemedicine may fall over time, but the pace at which they will disappear depends on factors outside the Commission's control.

F. Conclusion

34. HCPs generally need symmetrical broadband connections of high quality in order to engage in telemedicine and to adopt many other telehealth applications. The bandwidth needed by a particular provider will vary by the telehealth applications it chooses to implement, and by the size and nature of its practice. Low latency, high reliability, and low jitter and packet loss are important elements of service quality for many telehealth applications.

35. These bandwidth and service quality needs will continue to grow in the future, as telemedicine and other telehealth applications are deployed more widely, although it is difficult to predict the pace at which these needs will grow. Many factors will affect the rates of adoption of telemedicine, including reimbursement policies, equipment cost, patient and doctor acceptance, medical licensure requirements, and spread of telemedicine standards and technical expertise. Similarly, it is difficult to predict the rate at which other bandwidth-intensive telehealth needs will change (for example, the rate of adoption of remote-hosted EHR solutions and exchange of high capacity medical images, and the use of videoconferencing to train remote health care personnel).

APPENDIX C

Final Regulatory Flexibility Analysis

1. As required by the Regulatory Flexibility Act of 1980, as amended (RFA),[1] an Initial Regulatory Flexibility Analysis (IRFA) was incorporated in the 2010 *Notice of Proposed Rulemaking*.[2] The Commission sought written public comment on the proposals in the *NPRM*, including comment on the IRFA. This present Final Regulatory Flexibility Analysis (FRFA) conforms to the RFA.[3]

A. Need for, and Objectives of, the Order

2. The Commission is required by section 254 of the Communications Act of 1934, as amended, to promulgate rules to implement the universal service provisions of section 254.[4] On May 8, 1997, the Commission adopted rules that reformed its system of universal service support mechanisms so that universal service is preserved and advanced as markets move toward competition.[5] Among other programs, the Commission adopted a program to provide discounted telecommunications services to public or non-profit health care providers (HCPs) that serve persons in rural areas.[6] The changing technological landscape in rural health care over the past decade has prompted us to propose a new structure for the rural health care universal service support mechanism.[7]

3. In this Order, we reform the Rural Health Care (RHC) Support Mechanism and adopt the Healthcare Connect Fund to expand HCP access to high-speed broadband capability and broadband health care networks, improving the quality and reducing the cost of health care throughout America, particularly in rural areas. Additionally, we adopt a pilot program to be implemented in 2014 to test how to support broadband connections for skilled nursing facilities (SNF Pilot).

4. Building on recommendations from the Staff Evaluation of the Pilot Program and comments received in response to the Commission's 2010 *Notice of Proposed Rulemaking*[8] and the *July 19 Public Notice*,[9] the reforms adopted in this Order build on the substantial impact the RHC program has on improving broadband connectivity to HCPs. Broadband connectivity generates a number of benefits and cost savings for HCPs. First, telemedicine enables patients in rural areas to access specialists and can improve the speed and enhance the quality of health care everywhere. Second, connectivity enables the

---

[1] *See* 5 U.S.C. § 603. The RFA, *see* 5 U.S.C. § 601 – 612, has been amended by the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA), Pub. L. No. 104-121, Title II, 110 Stat. 857 (1996).

[2] *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Notice of Proposed Rulemaking, 25 FCC Rcd 9371, 9462, Appendix C (2010) (*NPRM*).

[3] *See* 5 U.S.C. § 604

[4] 47 U.S.C. § 254.

[5] *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776, 9118-19, paras. 655-56 (1997) (*Universal Service First Report and Order*).

[6] *See id.*

[7] *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 19 FCC Rcd 24613, 24615-24616, paras. 5-8 (2004) (*Second Report and Order and Further Notice*).

[8] *NPRM*, 25 FCC Rcd 9371 (2010).

[9] *Wireline Competition Bureau Seeks Further Comment on Issues in the Rural Health Care Reform Proceeding*, WC Docket No. 02-60, Public Notice, 27 FCC Rcd 8185 (Wireline Comp. Bur. 2012) (*July 19 Public Notice*).

exchange of electronic health records, which is likely to become more widespread as more providers adopt "meaningful use" of such records. Third, connectivity enables the exchange of large medical images (such as MRIs and CT scans), which can improve the speed and quality of diagnosis and treatment. Fourth, connectivity enables remote health care personnel to be trained *via* videoconference and to exchange other technical and medical expertise. Fifth, these "telehealth" applications have the potential to greatly reduce the cost of providing health care, for example by reducing length of stay or saving on patient transport costs. Finally, telemedicine can help rural HCPs keep and treat patients locally, thus enhancing revenue streams and helping rural providers to keep their doors open.

B. Summary of Significant Issues Raised by Public Comments in Response to the IRFA

5. No comments were filed in response to the IFRA attached to the *NPRM*. Notwithstanding the foregoing, some general comments discussing the impact of the proposed rules on small businesses were submitted in response to the *NPRM* and the *July 19 Public Notice*.

6. Several commenters expressed concern that administrative and reporting requirements for the new program might be too burdensome for small HCPs.[10] Many commenters suggested abandoning quarterly reporting requirements in favor of annual or semi-annual reporting to reduce administrative burdens.[11] Several commenters asked for a common reporting format, and requested that reporting requirements not be too onerous.[12] OHN recommended that the Commission authorize electronic signatures for all processes, especially the invoice approval process; permit electronic document submission; permit electronic administrative linkage into FCC/USAC project tracking systems; and support web-based electronic survey and reporting tools to gather, present, and compare data.[13] Some commenters also expressed concern that imposing detailed technical requirements on health services infrastructure projects might "discourage investment in broadband infrastructure projects and even foreclose the use of certain technologies."[14]

7. Responses to the *NPRM* and *July 19 Public Notice* also emphasized a streamlined approach to the competitive bidding requirements through the use of consortium applications and multiyear contracts.[15] For example, one commenter stated that consortium applications would take the administrative burden off small HCPs who do not have the time or resources to apply for funds.[16] However, one of the Pilot Projects, PSPN, noted that a mandated multi-year contract for at least 5 years could be burdensome to service providers.[17]

---

[10] *See, e.g.*, VAST PN Comments at 1.

[11] *See*, *e.g.*, AHA Comments at 4; GCI Comments at 15; RNHN Comments at 13; Charter Comments at 14; Fort Drum Comments at 2, 6; Motorola Comments at 3; MTN PN Comments at 2; HSHS PN Comments at 4; VAST PN Reply at 1.

[12] *See*, *e.g.*, AHA PN Comments at 1; Avera Health Comments at 3; PSPN Comments at 16; Comcast Reply Comments at 7; CHCC/RMHN PN Comments at 2.

[13] OHN Comments at 20-22.

[14] Motorola Comments at 3.

[15] ATA Comments at 9; Internet 2 Reply Comments at 1,3; IRHN Comments at 17; NETC Comments at 7; NSTN Comments at 6; UVA Comments at 6; MTN PN Comments at 3; CCHCS PN Comments at 5; AHA PN Comments at 4.

[16] Geisinger PN Comments at 2.

[17] PSPN Comments at 20.

8. Finally, one commenter specifically recommended that the Commission encourage participation from small and women-owned businesses by reducing or waiving matching contributions requirements for non-profit small and women-owned businesses acting as consortium leaders; streamlining administrative reporting requirements; and increasing the performance bond minimum requirement for contracts of $300,000 or higher from the $150,000 floor.[18] In making the determinations reflected in the Order, we have considered the impact of our actions on small entities.

C. Description and Estimate of the Number of Small Entities to Which Rules Will Apply

9. The RFA directs agencies to provide a description of, and, where feasible, an estimate of, the number of small entities that may be affected by the rules adopted herein.[19] The RFA generally defines the term "small entity" as having the same meaning as the terms "small business," "small organization," and "small governmental jurisdiction."[20] In addition, the term "small business" has the same meaning as the term "small business concern" under the Small Business Act.[21] A "small business concern" is one which: (1) is independently owned and operated; (2) is not dominant in its field of operation; and (3) satisfies any additional criteria established by the Small Business Administration (SBA).[22] In 2009, there were 27.5 million businesses in the United States, according to SBA Office of Advocacy estimates.[23] The latest available Census data show that there were 5.9 million firms with employees in 2008 and 21.4 million without employees in 2008. Small firms with fewer than 500 employees represent 99.9 percent of the total (employers and non-employers), as the most recent data show there were 18,469 large businesses in 2008.[24]

10. Small entities potentially affected by the reforms adopted herein include eligible non-profit and public health care providers and the eligible service providers offering them services, including telecommunications service providers, Internet Service Providers (ISPs), and vendors of the services and equipment used for dedicated broadband networks.

1. Health Care Entities

11. As noted earlier, non-profit businesses and small governmental units are considered "small entities" within the RFA. In addition, we note that census categories and associated generic SBA small business size categories provide the following descriptions of small entities. The broad category of Ambulatory Health Care Services consists of further categories and the following SBA small business size standards. The categories of small business providers with annual receipts of $7 million or less consists of: Offices of Dentists; Offices of Chiropractors; Offices of Optometrists; Offices of Mental Health Practitioners (except Physicians); Offices of Physical, Occupational and Speech Therapists and

[18] MTG Comments at 9-10.

[19] 5 U.S.C. § 604(a)(3).

[20] 5 U.S.C. § 601.6.

[21] 5 U.S.C. § 601(3) (incorporating by reference the definition of "small-business concern" in the Small Business Act, 15 U.S.C. § 632). Pursuant to 5 U.S.C. § 601(3), the statutory definition of a small business applies "unless an agency, after consultation with the Office of Advocacy of the Small Business Administration and after opportunity for public comment, establishes one or more definitions of such term which are appropriate to the activities of the agency and publishes such definition(s) in the Federal Register."

[22] 15 U.S.C. § 632.

[23] Office of Advocacy estimates based on data from the U.S. Dept. of Commerce, Census Bureau, and trends from the U.S. Dept. of Labor, Bureau of Labor Statistics, Business Employment Dynamics.

[24] Office of Advocacy estimates based on data from the U.S. Dept. of Commerce, Census Bureau, and trends from the U.S. Dept. of Labor, Bureau of Labor Statistics, Business Employment Dynamics.

Audiologists; Offices of Podiatrists; Offices of All Other Miscellaneous Health Practitioners; and Ambulance Services.[25] The category of such providers with $10 million or less in annual receipts consists of: Offices of Physicians (except Mental Health Specialists); Family Planning Centers; Outpatient Mental Health and Substance Abuse Centers; Health Maintenance Organization Medical Centers; Freestanding Ambulatory Surgical and Emergency Centers; All Other Outpatient Care Centers, Blood and Organ Banks; and All Other Miscellaneous Ambulatory Health Care Services.[26] The category of such providers with $13.5 million or less in annual receipts consists of: Medical Laboratories; Diagnostic Imaging Centers; and Home Health Care Services.[27] The category of Ambulatory Health Care Services providers with $34.5 million or less in annual receipts consists of Kidney Dialysis Centers.[28] For all of these Ambulatory Health Care Service Providers, census data indicate that there are a combined total of 368,143 firms that operated for all of 2002.[29] Of these, 356,829 had receipts for that year of less than $5 million.[30] In addition, an additional 6,498 firms had annual receipts of $5 million to $9.99 million; and additional 3,337 firms had receipts of $10 million to $24.99 million; and an additional 865 had receipts of $25 million to $49.99 million.[31] We therefore estimate that virtually all Ambulatory Health Care Services providers are small, given SBA's size categories. We note, however, that our rules affect non-profit and public health care providers, and many of the providers noted above would not be considered "public" or "non-profit."

12. The broad category of Hospitals consists of the following categories, with an SBA small business size standard of annual receipts of $34.5 million or less: General Medical and Surgical Hospitals, Psychiatric and Substance Abuse Hospitals; and Specialty (Except Psychiatric and Substance Abuse) Hospitals.[32] For these health care providers, census data indicate that there is a combined total of 3,800 firms that operated for all of 2002, of which 1,651 had revenues of less than $25 million, and an additional 627 firms had annual receipts of $25 million to $49.99 million.[33] We therefore estimate that most Hospitals are small, given SBA's size categories.

13. The broad category of Nursing and Residential Care Facilities consists, *inter alia*, of the category of Skilled Nursing Facilities, with a small business size standard of annual receipts of $13.5 million or less.[34] For these businesses, census data indicate that there were a total of 16,479 firms that

[25] 13 C.F.R. § 121.201, North American Industry Classification System (NAICS) Codes 621210, 621310, 621320, 621330, 621340, 621391, 621399, 621910.

[26] 13 C.F.R. § 121.201, NAICS Codes 621111, 621112, 621410, 621420, 621491, 621493, 621498, 621991, 621999.

[27] 13 C.F.R. § 121.201, NAICS Codes 621511, 621512, 621610.

[28] 13 C.F.R. § 121.201, NAICS Code 621492.

[29] U.S. Census Bureau, 2002 Economic Census, Subject Series: Health Care and Social Assistance, "Establishment and Firm Size (Including Legal Form of Organization," Table 4, NAICS code 621 (issued Nov. 2005) (*2002 Health Care Data*).

[30] *Id*.

[31] *Id*.

[32] 13 C.F.R. § 121.201, NAICS Codes 622110, 622210, 622310.

[33] *2002 Health Care Data*., NAIS Codes 622110, 622210, 622310.

[34] 13 C.F.R. § 121.201, NAICS Code 623110.

operated for all of 2002.[35] All of these firms had annual receipts of below $1 million. We therefore estimate that such firms are small, given SBA's size standard.

14. The broad category of Social Assistance consists, *inter alia*, of the category of Emergency and Other Relief Services, with a small business size standard of annual receipts of $7 million or less.[36] For these health care providers, census data indicate that there were a total of 55 firms that operated for all of 2002.[37] All of these firms had annual receipts of below $1 million.[38] We therefore estimate that all such firms are small, given SBA's size standard.

2. Providers of Telecommunications and Other Services

A. Telecommunications Service Providers

15. *Wired Telecommunications Carriers.* The SBA has developed a small business size standard for Wired Telecommunications Carriers, which consists of all such companies having 1,500 or fewer employees.[39] According to Census Bureau data for 2007, there were a total of 3,188 firms in this category that operated for the entire year.[40] Of this total, 3144 firms employed 999 or fewer employees, and 44 firms employed 1000 employees or more.[41] Thus, under this size standard, the majority of firms can be considered small entities that may be affected by rules adopted pursuant to the Order.

16. *Incumbent Local Exchange Carriers (LECs).* Neither the Commission nor the SBA has developed a size standard for small businesses specifically applicable to local exchange services. The closest applicable size standard under SBA rules is for Wired Telecommunications Carriers. Under that size standard, such a business is small if it has 1,500 or fewer employees.[42] According to Commission data, 1,307 carriers reported that they were incumbent local exchange service providers.[43] Of these carriers, an estimated 1,006 have 1,500 or fewer employees and 301 have more than 1,500 employees.[44] Consequently, the Commission estimates that most providers of local exchange service are small entities that may be affected by rules adopted pursuant to the Notice.

17. We have included small incumbent LECs in this present RFA analysis. As noted above, a "small business" under the RFA is one that, *inter alia*, meets the pertinent small business size standard

---

[35] U.S. Census Bureau, 2002 Economic Census, Subject Series: Nursing and Residential Care Facilities at 1 *available at* http://www.census.gov/prod/ec02/ec0262i03.pdf (last viewed Dec. 18, 2012).

[36] 13 C.F.R. § 121.201, NAICS Code 624230.

[37] *2002 Health Care Data*, NAICS Code 624230.

[38] *Id*.

[39] 13 C.F.R. § 121.201, NAICS code 517110.

[40] U.S. Census Bureau, 2007 Economic Census Report, Subject Series: Information, Sector 51, "Establishment and Firm Size: Employment Size of Firms for the United States: 2007 NAICS," at NAICS Code 174, *available at* http://factfinder.census.gov/servlet/IBQTable?_bm=y&-geo_id=&-fds_name=EC0700A1&-ds_name=EC0751SSSZ2&-_lang=en (2007 Economic Census Report Employment Size of Firms).

[41] *See id*.

[42] 13 C.F.R. § 121.201, NAICS code 517110.

[43] *See* Trends in Telephone Service, Federal Communications Commission, Wireline Competition Bureau, Industry Analysis and Technology Division at Table 5.3 (Sept. 2010), *available at* http://www.fcc.gov/reports/trends-telephony-service-2010 (Trends in Telephone Service).

[44] *See id*.

(e.g., a telephone communications business having 1,500 or fewer employees), and "is not dominant in its field of operation."[45] The SBA's Office of Advocacy contends that, for RFA purposes, small incumbent LECs are not dominant in their field of operation because any such dominance is not "national" in scope.[46] We have therefore included small incumbent LECs in this RFA analysis, although we emphasize that this RFA action has no effect on Commission analyses and determinations in other, non-RFA contexts.

18. Competitive Local Exchange Carriers (competitive LECs), Competitive Access Providers (CAPs), Shared-Tenant Service Providers, and Other Local Service Providers. Neither the Commission nor the SBA has developed a small business size standard specifically for these service providers. The closest applicable size standard under SBA rules is for Wired Telecommunications Carriers. Under that size standard, such a business is small if it has 1,500 or fewer employees.[47] According to Commission data, 1,442 carriers reported that they were engaged in the provision of either competitive local exchange services or competitive access provider services.[48] Of these carriers, an estimated 1,256 have 1,500 or fewer employees and 186 have more than 1,500 employees.[49] In addition, 17 carriers have reported that they are Shared-Tenant Service Providers, and all 17 are estimated to have 1,500 or fewer employees.[50] In addition, 72 carriers have reported that they are Other Local Service Providers.[51] Of these 72 carriers, an estimated 70 have 1,500 or fewer employees and two have more than 1,500 employees.[52] Consequently, the Commission estimates that most providers of competitive local exchange service, competitive access providers, Shared-Tenant Service Providers, and Other Local Service Providers are small entities that may be affected by rules adopted pursuant to the Order.

19. *Interexchange Carriers*. Neither the Commission nor the SBA has developed a size standard for small businesses specifically applicable to interexchange services. The closest applicable size standard under SBA rules is for Wired Telecommunications Carriers. Under that size standard, such a business is small if it has 1,500 or fewer employees.[53] According to Commission data, 359 companies reported that their primary telecommunications service activity was the provision of interexchange services.[54] Of these companies, an estimated 317 have 1,500 or fewer employees and 42 have more than 1,500 employees.[55] Consequently, the Commission estimates that the majority of interexchange service providers are small entities that may be affected by rules adopted pursuant to the Order.

---

[45] 5 U.S.C. § 601(3).

[46] *See* Letter from Jere W. Glover, SBA, to William E. Kennard, Chairman, FCC (May 27, 1999). The Small Business Act contains a definition of "small business concern," which the RFA incorporates into its own definition of "small business." *See* 15 U.S.C. § 632(a); *see also* 5 U.S.C. § 601(3). SBA regulations interpret "small business concern" to include the concept of dominance on a national basis. *See* 13 C.F.R. § 121.102(b).

[47] *See* 13 C.F.R. § 121.201, NAICS code 517110.

[48] *See* Trends in Telephone Service at Table 5.3.

[49] *See id*.

[50] *See id*.

[51] *See id*.

[52] *See id*.

[53] *See* 13 C.F.R. § 121.201, NAICS code 517110.

[54] *See* Trends in Telephone Service at Table 5.3.

[55] *See id*.

20. *Wireless Telecommunications Carriers (except Satellite)*. Since 2007, the SBA has recognized wireless firms within this new, broad, economic census category.[56] Prior to that time, such firms were within the now-superseded categories of "Paging" and "Cellular and Other Wireless Telecommunications."[57] Under the present and prior categories, the SBA has deemed a wireless business to be small if it has 1,500 or fewer employees.[58] For this category, census data for 2007 show that there were 1,383 firms that operated for the entire year.[59] Of this total, 1,368 firms employed 999 or fewer employees and 15 employed 1000 employees or more.[60] Similarly, according to Commission data, 413 carriers reported that they were engaged in the provision of wireless telephony, including cellular service, Personal Communications Service (PCS), and Specialized Mobile Radio (SMR) Telephony services.[61] Of these, an estimated 261 have 1,500 or fewer employees and 152 have more than 1,500 employees.[62] Consequently, the Commission estimates that approximately half or more of these firms can be considered small. Thus, using available data, we estimate that the majority of wireless firms can be considered small entities that may be affected by the rules adopted pursuant to the Order.

21. *Wireless Telephony*. Wireless telephony includes cellular, personal communications services, and specialized mobile radio telephony carriers. As noted, the SBA has developed a small business size standard for Wireless Telecommunications Carriers (except Satellite).[63] Under the SBA small business size standard, a business is small if it has 1,500 or fewer employees.[64] According to the *2008 Trends Report*, 434 carriers reported that they were engaged in wireless telephony.[65] Of these, an estimated 222 have 1,500 or fewer employees and 212 have more than 1,500 employees.[66] We have estimated that 222 of these are small under the SBA small business size standard.

22. *Satellite Telecommunications and All Other Telecommunications*. Since 2007, the SBA has recognized satellite firms within this revised category, with a small business size standard of $15 million.[67] The most current Census Bureau data are from the economic census of 2007, and we will use those figures to gauge the prevalence of small businesses in this category. Those size standards are for the two census categories of "Satellite Telecommunications" and "Other Telecommunications." Under

---

[56] *See* 13 C.F.R. § 121.201, NAICS code 517210.

[57] U.S. Census Bureau, 2002 NAICS Definitions, "517211 – Paging," *available at* http://www.census.gov/epcd/naics02/def/NDEF517.HTM; U.S. Census Bureau, 2002 NAICS Definitions, "517212 – Cellular and Other Wireless Telecommunications," *available at* http://www.census.gov/epcd/naics02/def/NDEF517.HTM.

[58] 13 C.F.R. § 121.201, NAICS code 517210. The now-superseded, pre-2007 C.F.R. citations were 13 C.F.R. § 121.201, NAICS codes 517211 and 517212 (referring to the 2002 NAICS).

[59] U.S. Census Bureau, Subject Series: Information, Table 5, "Establishment and Firm Size: Employment Size of Firms for the United States: 2007 NAICS Code 517210" (issued Nov. 2010).

[60] *Id*. Available census data do not provide a more precise estimate of the number of firms that have employment of 1,500 or fewer employees; the largest category provided is for firms with "100 employees or more."

[61] *See* Trends in Telephone Service at Table 5.3.

[62] *See id*.

[63] 13 C.F.R. § 121.201, NAICS code 517210.

[64] *Id*.

[65] *See* Trends in Telephone Service at Table 5.3.

[66] *Id*.

[67] *See* 13 C.F.R. § 121.201, NAICS code 517410.

the "Satellite Telecommunications" category, a business is considered small if it had $15 million or less in average annual receipts.[68] Under the "Other Telecommunications" category, a business is considered small if it had $25 million or less in average annual receipts.[69]

23. The first category of Satellite Telecommunications "comprises establishments primarily engaged in providing point-to-point telecommunications services to other establishments in the telecommunications and broadcasting industries by forwarding and receiving communications signals via a system of satellites or reselling satellite telecommunications."[70] For this category, Census Bureau data for 2007 show that there were a total of 512 firms that operated for the entire year.[71] Of this total, 464 firms had annual receipts of under $10 million, and 18 firms had receipts of $10 million to $24,999,999.[72] Consequently, we estimate that the majority of Satellite Telecommunications firms are small entities that might be affected by rules adopted pursuant to the Order.

24. The second category of Other Telecommunications "primarily engaged in providing specialized telecommunications services, such as satellite tracking, communications telemetry, and radar station operation. This industry also includes establishments primarily engaged in providing satellite terminal stations and associated facilities connected with one or more terrestrial systems and capable of transmitting telecommunications to, and receiving telecommunications from, satellite systems. Establishments providing Internet services or voice over Internet protocol (VoIP) services via client-supplied telecommunications connections are also included in this industry."[73] For this category, Census Bureau data for 2007 show that there were a total of 2,383 firms that operated for the entire year.[74] Of this total, 2,346 firms had annual receipts of under $25 million.[75] Consequently, we estimate that the majority of Other Telecommunications firms are small entities that might be affected by our action.

B. Internet Service Providers

25. *Internet Service Providers.* Since 2007, these services have been defined within the broad economic census category of Wired Telecommunications Carriers; that category is defined as follows: "This industry comprises establishments primarily engaged in operating and/or providing access to transmission facilities and infrastructure that they own and/or lease for the transmission of voice, data, text, sound, and video using wired telecommunications networks. Transmission facilities may be based on a single technology or a combination of technologies."[76] The SBA has developed a small business size standard of 1,500 or fewer employees.[77] According to Census Bureau data from 2007, there were 3,188

---

[68] *Id*.

[69] *See* 13 C.F.R. § 121.201, NAICS code 517919.

[70] U.S. Census Bureau, 2007 NAICS Definitions, "517410 – Satellite Telecommunications."

[71] *See* 13 C.F.R. § 121.201, NAICS code 517410.

[72] *See id*. An additional 38 firms had annual receipts of $25 million or more.

[73] U.S. Census Bureau, 2007 NAICS Definitions, "517919 Other Telecommunications," *available at* http://www.census.gov/naics/2007/def/ND517919.HTM.

[74] *See* 13 C.F.R. § 121.201, NAICS code 517919.

[75] U.S. Census Bureau, 2007 Economic Census, Subject Series: Information, Table 5, "Establishment and Firm Size: Employment Size of Firms for the United States: 2007, NAICS Code 517919" (issued Nov. 2010).

[76] U.S. Census Bureau, 2007 NAICS Definitions, "517110 Wired Telecommunications Carriers" (partial definition) *available at* http://www.census.gov/naics/2007/def/ND517110.HTM#N517110.

[77] 13 C.F.R. § 121.201, NAICS code 517110.

firms in this category, total, that operated for the entire year.[78] Of this total, 3,144 firms had employment of 999 or fewer employees, and 44 firms had employment of 1000 employees or more.[79] Consequently, we estimate that the majority of these firms are small entities that may be affected by rules adopted pursuant to this Order.

26. *Data Processing, Hosting, and Related Services.* Entities in this category "primarily … provid[e] infrastructure for hosting or data processing services."[80] The SBA has developed a small business size standard for this category; that size standard is $25 million or less in average annual receipts.[81] According to Census Bureau data for 2007, there were 8,060 firms in this category that operated for the entire year.[82] Of these, 7,744 had annual receipts of under $24,999,999.[83] Consequently, we estimate that the majority of these firms are small entities that may be affected by rules adopted pursuant to the Order.

27. *All Other Information Services.* The Census Bureau defines this industry as including "establishments primarily engaged in providing other information services (except news syndicates, libraries, archives, Internet publishing and broadcasting, and Web search portals)."[84] Our action pertains to interconnected VoIP services, which could be provided by entities that provide other services such as email, online gaming, web browsing, video conferencing, instant messaging, and other, similar IP-enabled services. The SBA has developed a small business size standard for this category; that size standard is $7.0 million or less in average annual receipts.[85] According to Census Bureau data for 2007, there were 367 firms in this category that operated for the entire year.[86] Of these, 334 had annual receipts of under $5.0 million, and an additional 11 firms had receipts of between $5 million and $9,999,999. Consequently, we estimate that the majority of these firms are small entities that may be affected by rules adopted pursuant to the Order.

C. Vendors and Equipment Manufacturers

28. *Vendors for Infrastructure Development or "Network Buildout" Construction.* The Commission has not developed a small business size standard specifically directed toward manufacturers of network facilities. The closest applicable definition of a small entity are the size standards under the

[78] U.S. Census Bureau, 2007 Economic Census, Subject Series: Information, Table 5, "Establishment and Firm Size: Employment Size of Firms for the United States: 2007, NAICS Code 517919" (issued Nov. 2010).

[79] *See id.*

[80] U.S. Census Bureau, 2007 Economic Census, Subject Series: Information, Table 5, "Establishment and Firm Size: Employment Size of Firms for the United States: 2007", NAICS code 519130" (issued Nov. 2010).

[81] *Id.*

[82] U.S. Census Bureau, 2007 NAICS Definitions, "518210 Data Processing, Hosting, and Related Services," *available at* http://www.naics.com/2007/def/NDEF518.HTM.

[83] *See* 13 C.F.R. § 121.201, NAICS code 518210.

[84] U.S. Census Bureau, 2007 Economic Census, Subject Series: Information, Table 4, "Establishment and Firm Size: Receipts Size of Firms for the United States: 2007", NAICS code 519130" (issued Nov. 2010).

[85] *Id.*

[86] U.S. Census Bureau, 2007 NAICS Definitions, "519190 All Other Information Services," *available at* http://www.census.gov/naics/2007/def/ND519190.HTM.

SBA rules applicable to manufacturers of "Radio and Television Broadcasting and Communications Equipment" (RTB) and "Other Communications Equipment."[87]

29. *Telephone Apparatus Manufacturing*. The Census Bureau defines this category as follows: "This industry comprises *establishments* primarily engaged in manufacturing wire telephone and data communications equipment. These products may be standalone or board-level components of a larger system. Examples of products made by these establishments are central office switching equipment, cordless telephones (except cellular), PBX equipment, telephones, telephone answering machines, LAN modems, multi-user modems, and other data communications equipment, such as bridges, routers, and gateways."[88] The SBA has developed a small business size standard for Telephone Apparatus Manufacturing, which is: all such firms having 1,000 or fewer employees.[89] According to Census Bureau data for 2002, there were a total of 518 establishments in this category that operated for the entire year.[90] Of this total, 511 had employment of under 1,000, and an additional 7 had employment of 1,000 to 2,499.[91] Thus, under this size standard, the majority of firms can be considered small.

30. *Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing* The Census Bureau defines this category as follows: "This industry comprises establishments primarily engaged in manufacturing radio and television broadcast and wireless communications equipment. Examples of products made by these establishments are: transmitting and receiving antennas, cable television equipment, GPS equipment, pagers, cellular phones, mobile communications equipment, and radio and television studio and broadcasting equipment."[92] The SBA has developed a small business size standard for Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing, which is: all such firms having 750 or fewer employees.[93] According to Census Bureau data for 2002, there were a total of 1,041 establishments in this category that operated for the entire year.[94] Of this total, 1,010 had employment of under 500, and an additional 13 had employment of 500 to 999.[95] Thus, under this size standard, the majority of firms can be considered small.

---

[87] 13 C.F.R. § 121.201, NAICS Codes 334220, 334290.

[88] U.S. Census Bureau, 2002 NAICS Definitions, "334210 Telephone Apparatus Manufacturing"; http://www.census.gov/epcd/naics02/def/NDEF334.HTM#N3342.

[89] 13 C.F.R. § 121.201, NAICS code 334210.

[90] U.S. Census Bureau, American FactFinder, 2002 Economic Census, Industry Series, Industry Statistics by Employment Size, NAICS code 334210 (released May 26, 2005); http://factfinder.census.gov. The number of "establishments" is a less helpful indicator of small business prevalence in this context than would be the number of "firms" or "companies," because the latter take into account the concept of common ownership or control. Any single physical location for an entity is an establishment, even though that location may be owned by a different establishment. Thus, the numbers given may reflect inflated numbers of businesses in this category, including the numbers of small businesses. In this category, the Census breaks-out data for firms or companies only to give the total number of such entities for 2002, which was 450.

[91] *Id*. An additional four establishments had employment of 2,500 or more.

[92] U.S. Census Bureau, 2002 NAICS Definitions, "334220 Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing"; http://www.census.gov/epcd/naics02/def/NDEF334.HTM#N3342.

[93] 13 C.F.R. § 121.201, NAICS code 334220.

[94] U.S. Census Bureau, American FactFinder, 2002 Economic Census, Industry Series, Industry Statistics by Employment Size, NAICS code 334220 (released May 26, 2005); http://factfinder.census.gov. The number of "establishments" is a less helpful indicator of small business prevalence in this context than would be the number of "firms" or "companies," because the latter take into account the concept of common ownership or control. Any single physical location for an entity is an establishment, even though that location may be owned by a different

(continued…)

31. *Other Communications Equipment Manufacturing*. The Census Bureau defines this category as follows: "This industry comprises establishments primarily engaged in manufacturing communications equipment (except telephone apparatus, and radio and television broadcast, and wireless communications equipment)."[96] The SBA has developed a small business size standard for Other Communications Equipment Manufacturing, which is: all such firms having 750 or fewer employees.[97] According to Census Bureau data for 2002, there were a total of 503 establishments in this category that operated for the entire year.[98] Of this total, 493 had employment of under 500, and an additional 7 had employment of 500 to 999.[99] Thus, under this size standard, the majority of firms can be considered small.

D. Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements for Small Entities

32. The reporting and recordkeeping requirements in this Order could have an impact on both small and large entities. However, even though the impact may be more financially burdensome for smaller entities, the Commission believes the impact of such requirements is outweighed by the benefit of providing the additional support necessary to make broadband available for HCPs to provide health care to rural and remote areas, and to make broadband rates for public and non-profit HCPs lower. Further, these requirements are necessary to ensure that the statutory goals of section 254 of the Telecommunications Act of 1996 are met without waste, fraud, or abuse.

33. *Eligibility Determination*. For each HCP listed, applicants will be required to provide the HCP's address and contact information; identify the eligible HCP type; provide an address for each physical location that will receive supported connectivity; provide a brief explanation for why the HCP is eligible under the Act and the Commission's rules and orders; and certify to the accuracy of this information under penalty of perjury.[100]

(Continued from previous page)

establishment. Thus, the numbers given may reflect inflated numbers of businesses in this category, including the numbers of small businesses. In this category, the Census breaks out data for firms or companies only to give the total number of such entities for 2002, which was 929.

[95] *Id*. An additional 18 establishments had employment of 1,000 or more.

[96] U.S. Census Bureau, 2002 NAICS Definitions, "334290 Other Communications Equipment Manufacturing"; http://www.census.gov/epcd/naics02/def/NDEF334.HTM#N3342.

[97] 13 C.F.R. § 121.201, NAICS code 334290.

[98] U.S. Census Bureau, American FactFinder, 2002 Economic Census, Industry Series, Industry Statistics by Employment Size, NAICS code 334290 (released May 26, 2005); http://factfinder.census.gov. The number of "establishments" is a less helpful indicator of small business prevalence in this context than would be the number of "firms" or "companies," because the latter take into account the concept of common ownership or control. Any single physical location for an entity is an establishment, even though that location may be owned by a different establishment. Thus, the numbers given may reflect inflated numbers of businesses in this category, including the numbers of small businesses. In this category, the Census breaks-out data for firms or companies only to give the total number of such entities for 2002, which was 471.

[99] *Id*. An additional three establishments had employment of 1,000 or more.

[100] HCPs with questions regarding their eligibility for the program may wish to contact USAC for additional guidance in advance of filing the form. For community mental health centers, USAC requires applicants to complete an additional check-off form listing the services offered at the facility. *See* USAC Community Mental Health Center Certification, *available at*

(continued…)

34. Consortium Leaders should obtain supporting information and/or documents to support eligibility for each HCP when they collect LOAs.[101] Consortium applicants must also submit documentation regarding network planning as part of the application process, although the Commission will monitor experience under the new rule, and may make adjustments in the future, if necessary, to ensure that this requirement is minimally burdensome while creating appropriate incentives for applicants to make thoughtful, cost-effective purchases. Applicants in the Healthcare Connect Fund are not required to submit technology plans with their requests for service, but the Commission may re-evaluate this decision in the future based on experience with the new program.

35. *Process for initiating competitive bidding for requested services.* Applicants must develop appropriate evaluation criteria for selecting the winning bid *before* submitting a request for services to USAC to initiate competitive bidding. The evaluation criteria should be based on the Commission's definition of "cost-effective," and include the most important criteria needed to provide health care, as determined by the applicant. Applicants should also begin to identify possible sources for the 35% of undiscounted costs.

36. Applicants subject to competitive bidding must submit new FCC Form 461 and supporting documentation to the Universal Service Administrative Company (USAC). On Form 461, applicants must provide basic information regarding the HCP(s) on the application (including contact information for potential bidders); a brief description of the desired services; and certifications designed to ensure compliance with program rules and minimize waste, fraud, and abuse.

37. Applicants must supplement their Form 461 with a Request for Proposals (RFP) on USAC's website in the following instances: (1) consortium applications that seek more than $100,000 in program support in a funding year; (2) applicants who are required to issue an RFP under applicable state or local procurement rules or regulations; and (3) consortium applications that seek support for infrastructure (*i.e.* HCP-owned facilities) as well as services.[102] In addition, any applicant is free to post an RFP.

38. Applicants also are required to submit the following documents, which will not be publicly posted by USAC.

- Form 460. Applicants should submit Form 460 to certify to the eligibility of HCP(s) listed on the application, if they have not previously done so.[103]
- Letters of Agency for Consortium Applicants. Consortium applicants should submit letters of agency demonstrating that the Consortium Leader is authorized to submit Forms 460, 461,

(Continued from previous page)

http://www.universalservice.org/_res/documents/rhc/pdf/forms/2012/CMHC-Certification.pdf (last visited Dec. 3, 2012).

[101] Consortium Leaders may be asked for this information during an audit or investigation.

[102] *Schools and Libraries Universal Service Support Mechanism, A National Broadband Plan for Our Future*, CC Docket No. 02-6 *et al.*, Sixth Report and Order, 25 FCC Rcd 18762, 18799, para. 86, n.248 (2010) (*Schools and Libraries Sixth Report and Order)* (explaining that, for FCC purposes, a "request for quotes" is the same thing as a "request for services"); *see* OHN PN Comments at 11-12 (stating that, in some instances, a simpler "Request for Quotes" as opposed to a full-fledged RFP may be more suitable). Pursuant to requirements set forth elsewhere in this Order, applicants seeking support for dark fiber must include modulating equipment and other related expenses in the same RFP. Applications that include a self-construction option must allow for the submission of bids to provide the requested services as leased services.

[103] Report and Order, *supra*, section VI.A.2.

and 462, as applicable, including required certifications and any supporting materials, on behalf of each participating HCP in the consortium.[104]

- Declaration of Assistance. As in the Pilot Program, all applicants must identify, through a Declaration of Assistance, any consultants, service providers, or any other outside experts, whether paid or unpaid, who aided in the preparation of their applications.[105] The Declaration of Assistance must be filed with the Form 461.[106] Identifying these consultants and outside experts facilitates the ability of USAC, the Commission, and law enforcement officials to identify and prosecute individuals who may seek to defraud the program or engage in other illegal acts. To ensure participants comply with the competitive bidding requirements, they must disclose all of the types of relationships explained above.[107]

39. Finally, all applicants subject to competitive bidding must certify to USAC that the services and/or infrastructure selected are, to the best of the applicant's knowledge, the most cost-effective option available.[108] Applicants must submit documentation to USAC to support their certifications, including a copy of each bid received (winning, losing, and disqualified), the bid evaluation criteria, and any other related documents, such as bid evaluation sheets; a list of people who evaluated bids (along with their title/role/relationship to the applicant organization); memos, board minutes, or similar documents related to the vendor selection/award; copies of notices to winners; and any correspondence with service providers during the bidding/evaluation/award phase of the process. Bid evaluation documents need not be in a certain format, but the level of documentation should be appropriate for the scale and scope of the services for which support is requested.

40. *Reporting Requirements.* Data from participants and USAC are essential to the Commission's ability to evaluate whether the program is meeting its performance goals, and to measure progress toward meeting those goals.[109] In the Healthcare Connect Program, each consortium lead entity must file an annual report with USAC on or before July 30 for the preceding funding year (*i.e.*, July 1 through and including June 30).[110] Individual HCP applicants do not have to fine annual reports, however.

41. *Recordkeeping*. Consistent with sections 54.619(a), (b), and (d) of the Commission's current rules, participants and service providers in the Healthcare Connect Fund must maintain certain documentation related to the purchase and delivery of services funded by the RHC programs, and will be required to produce these records upon request.[111]

42. The *NPRM* also proposed to: (1) clarify that the documents to be retained by participants and service providers must include all records related to the participant's application for, receipt of, and

[104] Report and Order, *supra*, section VI.A.1.c.

[105] *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 22 FCC Rcd 20360, 20415, para. 104 (2007) (*2007 Pilot Program Selection Order)*.

[106] *See* Appendix D, 47 C.F.R. § 54.642(e)(3).

[107] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20415, para. 104.

[108] *See Universal Service First Report and Order*, 12 FCC Rcd at 9134, para. 687.

[109] Report and Order, *supra*, section III; *see* OHN PN Comments at 3 ("Information collection is vital to demonstrating use and value of the network and FCC/matching funding investments.").

[110] *See* SWTAG PN Comments at 4 (suggesting that only the consortium lead entity be required to submit reports, similar to the Pilot Program).

[111] *See* 47 C.F.R. § 54.619(a)-(b), (d).

delivery of discounted services; and (2) amend the existing rules to mandate that service providers, upon request, produce the records kept pursuant to the Commission's recordkeeping requirement.[112] The Order adopts rules consistent with these proposals to enable the Commission and USAC to obtain the records necessary for effective oversight of the RHC programs

43. *Certifications*. Consistent with sections 54.603(b) and 54.615(c) of the current rules, participants in the Healthcare Connect Fund must certify under oath to compliance with certain program requirements, including the requirements to select the most cost-effective bid and to use program support solely for purposes reasonably related to the provision of health care services or instruction.[113] For individual HCP applicants, required certifications must be provided and signed by an officer or director of the HCP, or other authorized employee of the HCP (electronic signatures are permitted). For consortium applicants, an officer, director, or other authorized employee of the Consortium Leader must sign the required certifications.

44. *Vendors SPIN Requirement.* All vendors participating in the Healthcare Connect Fund must obtain a Service Provider Identification Number (SPIN) by submitting an FCC Form 498.[114] The SPIN is a unique number assigned to each service provider by USAC, and serves as USAC's tool to ensure that support is directed to the correct service provider. SPINs must be assigned before USAC can authorize support payments. Therefore, all service providers submitting bids to provide services to selected participants will need to complete and submit a Form 498 to USAC for review and approval if selected by a participant before funding commitments can be made. [115]

45. *Skilled Nursing Facility (SNF) Pilot*. SNF Pilot applicants must demonstrate how proposed participation of SNFs will improve the overall provision of health care by eligible HCPs. SNF Pilot applicants and participants must submit data on a number of variables (to be determined by the Bureau at a later date) related to the broadband connections supported and their health care uses, so that at the conclusion of the SNF Pilot, the Commission can use the data gathered to determine how to proceed with regard to including SNFs in the Commission's health care support programs on a permanent basis. SNF Pilot applicants also must commit to robust data gathering and analysis, and to submission of an annual report. Applicants must explain what types of data they intend to gather and how they intend to gather that data. At the conclusion of the Pilot, participants must demonstrate the health care cost savings and/or improved quality of patient care that have been realized through greater use of broadband to provide telemedicine to treat the residents of SNFs.

---

[112] *See NPRM*, 25 FCC Rcd at 9425, para. 139.

[113] *See* 47 C.F.R. §§ 54.603(b), 54.615(c).

[114] To obtain a new SPIN, a service provider must complete and file with USAC a Form 498 (Service Provider Identification and Contact Information). Complete instructions on filing Form 498 are available on USAC's web site at http://www.usac.org/sp/about/498/default.aspx. *See* USAC, Obtain a Service Provider Identification Number, *available at* http://www.usac.org/sp/about/498/obtain-spin.aspx (last visited Dec. 17, 2012). HCPs need not obtain a SPIN unless they are also the service provider (*e.g.*, self-provisioning the network). We note that non-telecommunications service providers may apply for and receive a SPIN. In Block 13 of the Form 498, a SPIN applicant may characterize itself as an NTP ("Non-Traditional Provider"), or "a Company that does not provide telecommunications services." *See* FCC Form 498, Block 13, http://www.usac.org/sp/about/498/obtain-spin.aspx

(last visited Dec. 13, 2012); FCC Form 498 Instructions at 15, *available at* http://www.usac.org/_res/documents/cont/pdf/forms/2012/form-498-fy2012-instructions.pdf (last visited Dec.. 13, 2012).

[115] Only service providers that have not already been assigned a SPIN by USAC will need to complete and submit a Form 498. Form 498 can be found on the USAC website on its forms page, http://www.usac.org/_res/documents/cont/pdf/forms/2012/form-498-fy2012.pdf / (last visited Dec.17, 2012).

E. Steps Taken to Minimize the Significant Economic Impact on Small Entities, and Significant Alternatives Considered

46. The FRFA requires an agency to describe any significant alternatives that it has considered in developing its approach, which may include the following four alternatives (among others): "(1) the establishment of differing compliance or reporting requirements or timetables that take into account the resources available to small entities; (2) the clarification, consolidation, or simplification of compliance and reporting requirements under the rule for such small entities; (3) the use of performance rather than design standards; and (4) an exemption from coverage of the rule, or any part thereof, for such small entities."[116] Accordingly, we have taken the following steps to minimize the impact on small entities.

47. *Consortium approach.* Consistent with support from commenters, the Order adopts a streamlined application process that facilitates consortium applications, which should enable HCPs to file many fewer applications and to share the administrative costs of all aspects of participation in the program.[117] Each consortium must file only one application, instead of each individual HCP filing separate applications. Applying as a consortium is simpler, cheaper, and more efficient for small HCPs. Under the consortium approach adopted in this Order, the expenses associated with planning the network, applying for funding, issuing RFPs, contracting with service providers, and invoicing are shared among a number of providers. This should help ensure that applicants, including small entities, will not be deterred from applying for support due to administrative burdens.

48. *Flat-Rate Discount.* In order to encourage participation in the Healthcare Connect Fund and relieve planning uncertainties for smaller entities, the Order adopts a flat-rate discount of 65 percent, clearly identifying the level of support that providers can reasonably expect to receive. By adopting a flat-rate discount, the Commission provides a clear and predictable support amount, thereby helping eligible HCPs to plan for their broadband needs. This approach is also less complex and easier to administer, which should expedite the application process and reduce administrative expenses for small entities.

49. *Competitive Bidding Exemptions.* While competitive bidding is essential to the program, it is not without administrative costs to participants. In three situations, exempting funding requests from competitive bidding strikes a common-sense balance between efficient use of program funds and reducing regulatory costs. First, based on our experience in the existing RHC programs, it will be more administratively efficient to exempt applicants seeking support for relatively small amounts. The threshold for this exemption is $10,000 or less in total annual undiscounted costs (which, with a 35 percent minimum applicant contribution, results in a maximum of $6,500 annually in Fund support). Second, if an applicant is required by federal, state or local law or regulations to purchase services from a master service agreement negotiated by a governmental entity on its behalf, and the master service agreement was awarded pursuant to applicable federal, state, Tribal, or local competitive bidding processes, the applicant is not required to re-undergo competitive bidding. Third, applicants who wish to request support under the Healthcare Connect Fund while utilizing contracts previously approved by USAC (under the Pilot Program, the RHC Telecommunications or Internet Access Programs, or the E-rate program) may do so without undergoing additional competitive bidding, as long as they do not request duplicative support for the same service and otherwise comply with all Healthcare Connect Fund requirements. In addition, consistent with current RHC program policies, applicants who receive evergreen status or multi-year commitments under the Healthcare Connect Fund are exempt from

[116] 5 U.S.C. § 603(c)(1) – (c)(4).

[117] *See, e.g.*, Geisinger PN Comments at 2, Report and Order, *supra*, section VI.

competitive bidding for the duration of the contract.[118] Applicants who are exempt from competitive bidding can proceed directly to submitting a funding commitment request.[119]

50. *Evergreen Contracts.* The existing RHC program allows "evergreen" contracts, meaning that for the life of a multi-year contract deemed evergreen by USAC, HCPs need not annually rebid the service or post an FCC Form 465.[120] As stated in the *NPRM*, codification of existing evergreen procedures likely will benefit participating HCPs by affording them: (1) lower prices due to longer contract terms; and (2) reduced administrative burdens due to fewer required Form 465s.[121] Commenters supported the *NPRM*'s proposal to codify the Commission's existing evergreen procedures, arguing, among other things, that the evergreen procedures significantly reduce HCPs' administrative and financial burdens.[122] The Order also makes one change to the existing evergreen policy to allow participants to exercise voluntary options to extend an evergreen contract without undergoing additional competitive bidding, subject to certain limitations.

51. *Multi-year funding commitments:* Applicants may receive multi-year funding commitments that cover a period of up to three funding years. The multi-year funding commitments will reduce uncertainty and administrative burden by eliminating the need for HCPs to apply every year for funding, as is required under the existing RHC Telecommunications and Internet Access Programs, and reduce administrative expenses both for the projects and for USAC. [123] Multi-year funding commitments, prepaid leases, and IRUs also encourage term discounts and produce lower rates from vendors. The funding of HCP-constructed-and-owned infrastructure has allowed Pilot projects to choose this option where it is the most cost-effective way to obtain broadband.

52. *Annual Reporting Requirement:* Participants in the Healthcare Connect Fund must submit reports on an annual basis, consistent with suggestions from commenters to minimize the burdens of reporting requirements.[124] Submitting annual, rather than quarterly reports, as required in the Pilot Program, will minimize the burden on participants and USAC alike while still supporting performance evaluation and enabling the Commission to evaluate the prevention of waste, fraud, and abuse.[125] Because the Commission expects to be able to collect data from individual applicants in the Healthcare Connect Fund on forms they already submit, individual applicants are not required to submit annual

---

[118] *See* Report and Order, *supra*, section VI.C.

[119] *See* Report and Order, *supra*, section VI.B.

[120] USAC, Rural Health Care Webpage, Evergreen Contracts, http://www.usac.org/rhc/health-care-providers/evergreen-contracts.aspx (last visited Oct. 10, 2012). *Id*. Applicants with multi-year contracts without evergreen status still must file the FCC Form 465 and participate in competitive bidding each year.

[121] *See NPRM*, 25 FCC Rcd at 9414-15, para. 112.

[122] *See, e.g.*, OHN NBP Public Notice #17 Comments at 7 (noting that HCPs with multi-year contracts should not have to reapply for support each year as it can be a financially burdensome process); *see also* CTN NPRM Comments at 25; Marshfield NPRM Reply Comments at 5-6; NSTN NPRM Comments at 6; UAMS NPRM Comments at 8-9.

[123] *See* Letter from Craig Davis, Vice President, Rural Health Care Division, Universal Service Administrative Company, to Sharon Gillett, Chief, Wireline Competition Bureau, Federal Communications Commission, WC Docket No. 02-60 at 4 (filed Mar. 14, 2012) (USAC Observations Letter).

[124] *See, e.g.*, AHA Comments at 4; GCI Comments at 15; RNHN Comments at 13; Charter Comments at 14; Fort Drum Comments at 2, 6; Motorola Comments at 3; MTN PN Comments at 2; HSHS PN Comments at 4; VAST PN Reply at 1.

[125] *See, e.g.*, IRHTP PN Comments at 2; UTN PN Comments at 1; HSHS PN Comments at 3-4.

reports unless a report is required for other reasons. To further minimize the burden on participants, the Order delegates authority to the Bureau to work with USAC to develop a simple and streamlined reporting system that leverages data collected through the application process, eliminating the need to resubmit any information that has already been provided to USAC.[126]

53. *Sustainability plans for applicants that build their own infrastructure.* In the *NPRM*, the Commission proposed to require sustainability plans similar to those required in the Pilot Program for HCPs who intended to have an ownership interest, indefeasible right of use, or capital lease interest in supported facilities. The Pilot Program required projects to submit a copy of their sustainability plan with every quarterly report.[127] Based on the Pilot Program, the Commission concludes that submission of sustainability reports on a quarterly basis is unnecessarily burdensome for applicants, and provides little useful information to USAC. Accordingly, sustainability reports for the Healthcare Connect Fund are only required to be re-filed if there is a material change that would impact projected income or expenses by the greater of 20 percent or $100,000 from the previous submission, or if the applicant submits a funding request based on a new Form 461 (*i.e.*, a new competitively bid contract). In such an event, the revised sustainability report must be provided to USAC no later than the end of the relevant quarter, clearly showing (*i.e.* by redlining or highlighting) what has changed.

54. *Skilled Nursing Facility Pilot Requirements*. Participants in the SNF Pilot must submit data on a number of variables; gather and analyze data; submit annual reports; and, at the conclusion of the Pilot, demonstrate the health care cost savings and/or improved quality of patient care that have been realized through greater use of broadband. While these requirements may impact small entities, we have determined that the benefits of these requirements – namely, preserving program integrity and ensuring cost-effectiveness – outweigh any costs. Specifically, we do not believe that these requirements will have significant impact on small entities for two reasons. First, the SNF is a voluntary pilot program and, as such, entities may choose whether to apply. Second, the Bureau will give preference to applicants that partner with existing or new consortia in the existing Pilot Program or the Healthcare Connect Fund. Small SNFs joining consortia should experience minimal reporting burdens as these consortia typically have the leadership and expertise to effectively assist their members with administrative requirements.

55. **Report to Congress:** The Commission will send a copy of the Order, including this FRFA, in a report to be sent to Congress pursuant to the Congressional Review Act.[128] In addition, the Commission will send a copy of the Order, including this FRFA, to the Chief Counsel for Advocacy of the SBA. A copy of the Order (and FRFA summaries thereof) will also be published in the Federal Register.

[126] *See* MTN PN Comments at 2; *see also* UTN PN Comments at 1 (explaining that much of the information contained in the Pilot quarterly reports is already contained in prior filings with USAC).

[127] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20444-45, para. 126.

[128] *See* 5 U.S.C. § 604(b).

APPENDIX D

Final Rules

For the reasons discussed in the preamble, the Federal Communications Commission amends 47 C.F.R. Part 54, Subpart G, as follows:

PART 54—UNIVERSAL SERVICE

Subpart A – General Information

1. Amend § 54.5, to delete the definition of "rural area" for the health care universal service support mechanism, to read as follows:

§ 54.5 Terms and definitions.

*** * ***

Rural area. For purposes of the schools and libraries universal support mechanism, a "rural area" is a nonmetropolitan county or county equivalent, as defined in the Office of Management and Budget's (OMB) Revised Standards for Defining Metropolitan Areas in the 1990s and identifiable from the most recent Metropolitan Statistical Area (MSA) list released by OMB, or any contiguous non-urban Census Tract or Block Numbered Area within an MSA–listed metropolitan county identified in the most recent Goldsmith Modification published by the Office of Rural Health Policy of the U.S. Department of Health and Human Services.

*** * ***

Subpart G – Universal Service Support for Health Care Providers

2. The authority citation continues to read as follows:

Authority: 47 U.S.C. 151, 154(i), 201, 205, 214, and 254 unless otherwise noted.

3. After giving effect to the amendments herein, the un-numbered index for Subpart G reads as follows:

DEFINED TERMS AND ELIGIBILITY

§ 54.600 Terms and definitions.
§ 54.601 Health care provider eligibility.
§ 54.602 Health care support mechanism.

TELECOMMUNICATIONS PROGRAM

§ 54.603 Competitive bidding requirements.
§ 54.604 Telecommunications services.
§ 54.605 Determining the urban rate.
§ 54.607 Determining the rural rate.
§ 54.609 Calculating support.
§ 54.613 Limitations on supported services for rural health care providers.
§ 54.615 Obtaining services.
§ 54.619 Audits and recordkeeping.
§ 54.625 Support for services beyond the maximum supported distance for rural health care providers.

HEALTHCARE CONNECT FUND

§ 54.630 Eligible recipients.
§ 54.631 Designation of consortium leader.
§ 54.632 Letters of agency (LOA).
§ 54.633 Health care provider contribution.
§ 54.634 Eligible services.
§ 54.635 Eligible equipment.
§ 54.636 Eligible participant-constructed and owned network facilities for consortium applicants.
§ 54.637 Off-site data centers and off-site administrative offices.
§ 54.638 Upfront payments.
§ 54.639 Ineligible expenses.
§ 54.640 Eligible vendors.
§ 54.642 Competitive bidding requirement and exemptions.
§ 54.643 Funding commitments.
§ 54.644 Multi-year commitments.
§ 54.645 Payment process.
§ 54.646 Site and service substitutions.
§ 54.647 Data collection and reporting.
§ 54.648 Audits and recordkeeping.
§ 54.649 Certifications.

GENERAL PROVISIONS

§ 54.671 Resale.
§ 54.672 Duplicate support.
§ 54.675 Cap.
§ 54.679 Election to offset support against annual universal service fund contribution.
§ 54.680 Validity of electronic signatures.

4. Add an undesignated centered heading above the first section of Subpart G, to read as follows:

DEFINED TERMS AND ELIGIBILITY

5. Add Section 54.600, to read as follows:

§ 54.600 Terms and definitions.

As used in this subpart, the following terms shall be defined as follows:

(a) *Health care provider*. A "health care provider" is any:

(1) Post-secondary educational institution offering health care instruction, including a teaching hospital or medical school;

(2) Community health center or health center providing health care to migrants;

(3) Local health department or agency;

(4) Community mental health center;

(5) Not-for-profit hospital;

(6) Rural health clinic; or

(7) Consortium of health care providers consisting of one or more entities described in paragraphs (a)(1) through (a)(6) of this section.

(b) *Rural area*.

(1) A "rural area" is an area that is entirely outside of a Core Based Statistical Area; is within a Core Based Statistical Area that does not have any Urban Area with a population of 25,000 or greater; or is in a Core Based Statistical Area that contains an Urban Area with a population of 25,000 or greater, but is within a specific census tract that itself does not contain any part of a Place or Urban Area with a population of greater than 25,000. For purposes of this rule, "Core Based Statistical Area," "Urban Area," and "Place" are as identified by the Census Bureau.

(2) Notwithstanding the above definition of "rural area," any health care provider that is located in a "rural area" under the definition used by the Commission prior to July 1, 2005, and received a funding commitment from the rural health care program prior to July 1, 2005, is eligible for support under this subpart.

(c) *Rural health care provider*. A "rural health care provider" is an eligible health care provider site located in a rural area.

6. Amend Section 54.601 to revise paragraph (a) and add new paragraph (b), to read as follows:

§ 54.601 Health care provider eligibility.

(a) *Eligible health care providers*.

(1) Only an entity that is either a public or non-profit health care provider, as defined in this subpart, shall be eligible to receive support under this subpart.

(2) Each separate site or location of a health care provider shall be considered an individual health care provider for purposes of calculating and limiting support under this subpart.

(b) *Determination of health care provider eligibility for the Healthcare Connect Fund.* Health care providers in the Healthcare Connect Fund may certify to the eligibility of particular sites at any time prior to, or concurrently with, filing a request for services to initiate competitive bidding for the site. Applicants who utilize a competitive bidding exemption must provide eligibility information for the site to the Administrator prior to, or concurrently with, filing a request for funding for the site. Health care providers must also notify the Administrator within 30 days of a change in the health care provider's name, site location, contact information, or eligible entity type.

7. Add Section 54.602, to read as follows:

§ 54.602 Health care support mechanism.

(a) *Telecommunications Program.* Rural health care providers may request support for the difference, if any, between the urban and rural rates for telecommunications services, subject to the provisions and limitations set forth in sections 54.600 through 54.625 and sections 54.671 through 54.680. This support is referred to as the "Telecommunications Program."

(b) *Healthcare Connect Fund.* Eligible health care providers may request support for eligible services, equipment, and infrastructure, subject to the provisions and limitations set forth in sections 54.600

through 54.602 and sections 54.630 through 54.680. This support is referred to as the "Healthcare Connect Fund."

(c) *Allocation of discounts.* An eligible health care provider that engages in both eligible and ineligible activities or that collocates with an ineligible entity shall allocate eligible and ineligible activities in order to receive prorated support for the eligible activities only. Health care providers shall choose a method of cost allocation that is based on objective criteria and reasonably reflects the eligible usage of the facilities.

(d) *Health care purposes.* Services for which eligible health care providers receive support from the Telecommunications Program or the Healthcare Connect Fund must be reasonably related to the provision of health care services or instruction that the health care provider is legally authorized to provide under the law in the state in which such health care services or instruction are provided.

8. Add an undesignated centered heading above Section 54.603, to read as follows:

TELECOMMUNICATIONS PROGRAM

9. Amend Section 54.603 to revise the section heading and paragraphs (a) and (b), to read as follows:

§ 54.603 Competitive bidding and certification requirements.

(a) *Competitive bidding requirement.* To select the telecommunications carriers that will provide services eligible for universal service support to it under the Telecommunications Program, each eligible health care provider shall participate in a competitive bidding process pursuant to the requirements established in this section and any additional and applicable state, Tribal, local, or other procurement requirements.

(b) *Posting of FCC Form 465*.

(1) An eligible health care provider seeking to receive telecommunications services eligible for universal service support under the Telecommunications Program shall submit a completed FCC Form 465 to the Administrator. FCC Form 465 shall be signed by the person authorized to order telecommunications services for the health care provider and shall include, at a minimum, that person's certification under oath that:

(i) The requester is a public or non-profit entity that falls within one of the seven categories set forth in the definition of health care provider, listed in § 54.600(a);

(ii) The requester is physically located in a rural area;

(iii) Deleted.

(iv) * * *

(v) * * *

(vi) * * *

(2) * * *

(3) * * *

(4) * * *

(5) * * *

10. Amend Section 54.604 to revise the section heading, add paragraphs (a) and (b), redesignate paragraph (a) as paragraph (c), revise redesignated paragraph (c), and redesignate paragraphs (b) and (c) as paragraphs (d) and (e) respectively, to read as follows:

§ 54.604 Consortia, telecommunications services, and existing contracts.

(a) *Consortia.*

(1) Under the Telecommunications Program, an eligible health care provider may join a consortium with other eligible health care providers; with schools, libraries, and library consortia eligible under Subpart F; and with public sector (governmental) entities to order telecommunications services. With one exception, eligible health care providers participating in consortia with ineligible private sector members shall not be eligible for supported services under this subpart. 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.

(2) For consortia, universal service support under the Telecommunications Program shall apply only to the portion of eligible services used by an eligible health care provider.

(b) *Telecommunications Services.* Any telecommunications service that is the subject of a properly completed bona fide request by a rural health care provider shall be eligible for universal service support, subject to the limitations described in this paragraph. The length of a supported telecommunications service may not exceed the distance between the health care provider and the point farthest from that provider on the jurisdictional boundary of the largest city in a state as defined in § 54.625(a).

(c) *Existing contracts.* A signed contract for services eligible for Telecommunications Program support pursuant to this subpart between an eligible health care provider as defined under § 54.600 and a telecommunications carrier shall be exempt from the competitive bid requirements set forth in § 54.603(a) as follows:

(1) * * *

(d) * * *

(e) * * *

11. Amend Section 54.605 to revise paragraphs (a), to read as follows:

§ 54.605 Determining the urban rate.

(a) If a rural health care provider requests support for an eligible service to be funded from the Telecommunications Program that is to be provided over a distance that is less than or equal to the "standard urban distance," as defined in paragraph (c) of this section, for the state in which it is located, the "urban rate" for that service shall be a rate no higher than the highest tariffed or publicly-available rate charged to a commercial customer for a functionally similar service in any city with a population of 50,000 or more in that state, calculated as if it were provided between two points within the city.

(b) * * *

(c) * * *

(d) * * *

12. Amend Section 54.609 to revise paragraphs (a), (d) and (e), to read as follows:

§ 54.609 Calculating support.

(a) The amount of universal service support provided for an eligible service to be funded from the Telecommunications Program shall be the difference, if any, between the urban rate and the rural rate charged for the service, as defined herein. In addition, all reasonable charges that are incurred by taking such services, such as state and federal taxes shall be eligible for universal service support. Charges for termination liability, penalty surcharges, and other charges not included in the cost of taking such service shall not be covered by the universal service support mechanisms. Under the Telecommunications Program, rural health care providers may choose one of the following two support options.

(1) * * *

(i) * * *

(ii) * * *

(iii) * * *

(iv) A telecommunications carrier that provides telecommunications service to a rural health care provider participating in an eligible health care consortium, and the consortium must establish the actual distance-based charges for the health care provider's portion of the shared telecommunications services.

(2) * * *

(3) Base rate support-consortium. A telecommunications carrier that provides telecommunications service to a rural health care provider participating in an eligible health care consortium, and the consortium must establish the applicable rural base rates for telecommunications service for the health care provider's portion of the shared telecommunications services, as well as the applicable urban base rates for the telecommunications service.

(b) * * *

(c) * * *

(d) *Satellite services.*

(1) Rural public and non-profit health care providers may receive support for rural satellite services under the Telecommunications Program, even when another functionally similar terrestrial-based service is available in that rural area. Support for satellite services shall be capped at the amount the rural health care provider would have received if they purchased a functionally similar terrestrial-based alternative.

(2) Rural health care providers seeking support from the Telecommunications Program for

satellite services shall provide to the Administrator with the Form 466, documentation of the urban and rural rates for the terrestrial-based alternatives.

(3) * * *

(e) *Mobile rural health care providers—*

(1) *Calculation of support* The support amount allowed under the Telecommunications Program for satellite services provided to mobile rural health care providers is calculated by comparing the rate for the satellite service to the rate for an urban wireline service with a similar bandwidth. Support for satellite services shall not be capped at an amount of a functionally similar wireline alternative. Where the mobile rural health care provider provides service in more than one state, the calculation shall be based on the urban areas in each state, proportional to the number of locations served in each state.

(2) * * *

13. Redesignate § 54.611 [Offset Election] as § 54.679.

14. Amend Section 54.613 to delete paragraph (b), to read as follows:

§ 54.613 Limitations on supported services for rural health care providers.

(a) * * *

(b) Deleted.

15. Amend Section 54.615 to revise paragraphs (b) and (c), to read as follows:

§ 54.615 Obtaining services.

(a) * * *

(b) *Receiving supported rate.* Upon receiving a bona fide request, as defined in paragraph (c) of this section, from a rural health care provider for a telecommunications service that is eligible for support under the Telecommunications Program, a telecommunications carrier shall provide the service at a rate no higher than the urban rate, as defined in § 54.605, subject to the limitations applicable to the Telecommunications Program.

(c) *Bona fide request.* In order to receive services eligible for support under the Telecommunications Program, an eligible health care provider must submit a request for services to the telecommunications carrier, signed by an authorized officer of the health care provider, and shall include that person's certification under oath that:

(1) * * *

(2) The requester is physically located in a rural area, or if the requester is a mobile rural health care provider requesting services under § 54.609(e), that the requester has certified that it is serving eligible rural areas;

(3) Deleted;

(4) * * *

(5) * * *

(6) * * *

(7) * * *

(d) * * *

16. Redesignate Section 54.617 [Resale] as Section 54.671.

17. Amend Section 54.619 paragraphs (a) and (d), to read as follows:

§ 54.619 Audits and recordkeeping.

(a) *Health care providers.*

(1) Health care providers shall maintain for their purchases of services supported under the Telecommunications Program documentation for five years from the end of the funding year sufficient to establish compliance with all rules in this subpart. Documentation must include, among other things, records of allocations for consortia and entities that engage in eligible and ineligible activities, if applicable. Mobile rural health care providers shall maintain annual logs indicating: The date and locations of each clinic stop; and the number of patients served at each such clinic stop.

(2) * * *

(b) * * *

(c) * * *

(d) *Service providers.* Service providers shall retain documents related to the delivery of discounted services under the Telecommunications Program for at least 5 years after the last day of the delivery of discounted services. Any other document that demonstrates compliance with the statutory or regulatory requirements for the rural health care mechanism shall be retained as well.

18. Remove Section 54.621 [Access to advanced telecommunications and information services].

19. Amend Section 54.623 to revise the section heading, redesignate paragraphs (a)-(c) and (f) as Section 54.675, redesignate paragraph (d) as paragraph (a), redesignate paragraph (e) as paragraph (b), and revise redesignated paragraphs (a) and (b), to read as follows:

§ 54.623 Annual filing and funding commitment requirement.

(a) *Annual filing requirement.* Health care providers seeking support under the Telecommunications Program shall file new funding requests for each funding year.

(b) *Long term contracts.* Under the Telecommunications Program, if health care providers enter into long term contracts for eligible services, the Administrator shall only commit funds to cover the portion of such a long term contract scheduled to be delivered during the funding year for which universal service support is sought.

20. Amend Section 54.625 to revise the section heading and revise paragraphs (a), (b) and (c), to read as follows:

§ 54.625 Support for telecommunications services beyond the maximum supported distance for rural health care providers.

(a) The maximum support distance for the Telecommunications Program is the distance from the health care provider to the farthest point on the jurisdictional boundary of the city in that state with the largest population, as calculated by the Administrator.

(b) An eligible rural health care provider may purchase an eligible telecommunications service supported under the Telecommunications Program that is provided over a distance that exceeds the maximum supported distance.

(c) If an eligible rural health care provider purchases an eligible telecommunications service supported under the Telecommunications Program that exceeds the maximum supported distance, the health care provider must pay the applicable rural rate for the distance that such service is carried beyond the maximum supported distance.

21. Add an undesignated centered heading below Section 54.625, to read as follows:

HEALTHCARE CONNECT FUND

22. Add Section 54.630, to read as follows:

§ 54.630 Eligible recipients.

(a) *Rural health care provider site – individual and consortium*. Under the Healthcare Connect Fund, an eligible rural health care provider may receive universal service support by applying individually or through a consortium. For purposes of the Healthcare Connect Fund, a "consortium" is a group of two or more health care provider sites that request support through a single application. Consortia may include health care providers who are not eligible for support under the Healthcare Connect Fund, but such health care providers cannot receive support for their expenses and must participate pursuant to the cost allocation guidelines in § 54.639(d).

(b) *Limitation on participation of non-rural health care provider sites in a consortium*. An eligible non-rural health care provider site may receive universal service support only as part of a consortium that includes more than 50 percent eligible rural health care provider sites.

(c) *Limitation on large non-rural hospitals*. Each eligible non-rural public or non-profit hospital site with 400 or more licensed patient beds may receive no more than $30,000 per year in Healthcare Connect Fund support for eligible recurring charges and no more than $70,000 in Healthcare Connect Fund support every 5 years for eligible nonrecurring charges, exclusive in both cases of costs shared by the network.

23. Add Section 54.631, to read as follows:

§ 54.631 Designation of Consortium Leader.

(a) *Identifying a Consortium Leader*. Each consortium seeking support from the Healthcare Connect Fund must identify an entity or organization that will be the lead entity (the "Consortium Leader").

(b) *Consortium Leader eligibility*. The Consortium Leader may be the consortium itself (if it is a distinct legal entity); an eligible health care provider participating in the consortium; or a state organization,

public sector (governmental) entity (including a Tribal government entity), or non-profit entity that is ineligible for Healthcare Connect Fund support. Ineligible state organizations, public sector entities, or non-profit entities may serve as Consortium Leaders or provide consulting assistance to consortia only if they do not participate as potential vendors during the competitive bidding process. An ineligible entity that serves as the Consortium Leader must pass on the full value of any discounts, funding, or other program benefits secured to the consortium members that are eligible health care providers.

(c) *Consortium Leader responsibilities*. The Consortium Leader's responsibilities include the following:

(1) *Legal and financial responsibility for supported activities*. The Consortium Leader is the legally and financially responsible entity for the activities supported by the Healthcare Connect Fund. By default, the Consortium Leader is the responsible entity if audits or other investigations by Administrator or the Commission reveal violations of the Act or Commission rules, with individual consortium members being jointly and severally liable if the Consortium Leader dissolves, files for bankruptcy, or otherwise fails to meet its obligations. Except for the responsibilities specifically described in paragraphs (2) to (6) below, consortia may allocate legal and financial responsibility as they see fit, provided that this allocation is memorialized in a formal written agreement between the affected parties (*i.e*., the Consortium Leader, and the consortium as a whole and/or its individual members), and the written agreement is submitted to the Administrator for approval with or prior to the Request for Services. Any such agreement must clearly identify the party(ies) responsible for repayment if the Administrator is required, at a later date, to recover disbursements to the consortium due to violations of program rules.

(2) *Point of contact for the FCC and Administrator*. The Consortium Leader is responsible for designating an individual who will be the "Project Coordinator" and serve as the point of contact with the Commission and the Administrator for all matters related to the consortium. The Consortium Leader is responsible for responding to Commission and Administrator inquiries on behalf of the consortium members throughout the application, funding, invoicing, and post-invoicing period.

(3) *Typical applicant functions, including forms and certifications*. The Consortium Leader is responsible for submitting program forms and required documentation and ensuring that all information and certifications submitted are true and correct. The Consortium Leader must also collect and retain a Letter of Agency (LOA) from each member, pursuant to § 54.632.

(4) *Competitive bidding and cost allocation*. The Consortium Leader is responsible for ensuring that the competitive bidding process is fair and open and otherwise complies with Commission requirements. If costs are shared by both eligible and ineligible entities, the Consortium Leader must ensure that costs are allocated in a manner that ensures that only eligible entities receive the benefit of program discounts.

(5) *Invoicing*. The Consortium Leader is responsible for notifying the Administrator when supported services have commenced and for submitting invoices to the Administrator.

(6) *Recordkeeping, site visits, and audits*. The Consortium Leader is also responsible for compliance with the Commission's recordkeeping requirements and for coordinating site visits and audits for all consortium members.

24. Add Section 54.632, to read as follows:

§ 54.632 Letters of agency (LOA).

(a) *Authorizations*. Under the Healthcare Connect Fund, the Consortium Leader must obtain the following authorizations.

(1) Prior to the submission of the request for services, the Consortium Leader must obtain authorization, the necessary certifications, and any supporting documentation from each consortium member to permit the Consortium Leader to submit the request for services and prepare and post the request for proposal on behalf of the member.

(2) Prior to the submission of the funding request, the Consortium Leader must secure authorization, the necessary certifications, and any supporting documentation from each consortium member to permit the Consortium Leader to submit the funding request and manage invoicing and payments on behalf of the member.

(b) *Optional two-step process*. The Consortium Leader may secure both required authorizations from each consortium member in either a single LOA or in two separate LOAs.

(c) *Required Information in LOA.*

(1) An LOA must include, at a minimum, the name of the entity filing the application (*i.e.*, lead applicant or Consortium Leader); name of the entity authorizing the filing of the application (*i.e.*, the participating health care provider/consortium member); the physical location of the health care provider/consortium member site(s); the relationship of each site seeking support to the lead entity filing the application; the specific timeframe the LOA covers; the signature, title and contact information (including phone number, mailing address, and email address) of an official who is authorized to act on behalf of the health care provider/consortium member; signature date; and the type of services covered by the LOA.

(2) For HCPs located on Tribal lands, if the health care facility is a contract facility that is run solely by the tribe, the appropriate tribal leader, such as the tribal chairperson, president, or governor, shall also sign the LOA, unless the health care responsibilities have been duly delegated to another tribal government representative.

25. Add Section 54.633, to read as follows:

§ 54.633 Health care provider contribution.

(a) *Health care provider contribution*. All health care providers receiving support under the Healthcare Connect Fund shall receive a 65 percent discount on the cost of eligible expenses and shall be required to contribute 35 percent of the total cost of all eligible expenses.

(b) *Limits on eligible sources of health care provider contribution*. Only funds from eligible sources may be applied toward the health care provider's required contribution.

(1) Eligible sources include the applicant or eligible health care provider participants; state grants, funding, or appropriations; federal funding, grants, loans, or appropriations except for other federal universal service funding; Tribal government funding; and other grant funding, including private grants.

(2) Ineligible sources include (but are not limited to) in-kind or implied contributions from health care providers; direct payments from vendors or other service providers, including contractors and consultants to such entities; and for-profit entities.

(c) *Disclosure of health care provider contribution source*. Prior to receiving support, applicants are required to identify with specificity their sources of funding for their contribution of eligible expenses.

(d) *Future revenues from excess capacity as source of health care provider contribution*. A consortium applicant that receives support for participant-owned network facilities under § 54.636 may use future revenues from excess capacity as a source for the required health care provider contribution, subject to the following limitations.

(1) The consortium's selection criteria and evaluation for "cost-effectiveness" pursuant to § 54.642 cannot provide a preference to bidders that offer to construct excess capacity.

(2) The applicant must pay the full amount of the additional costs for excess capacity facilities that will not be part of the supported health care network.

(3) The additional cost of constructing excess capacity facilities may not count toward a health care provider's required contribution.

(4) The inclusion of excess capacity facilities cannot increase the funded cost of the dedicated health care network in any way.

(5) An eligible health care provider (typically the consortium, although it may be an individual health care provider participating in the consortium) must retain ownership of the excess capacity facilities. It may make the facilities available to third parties only under an indefeasible right of use (IRU) or lease arrangement. The lease or IRU between the participant and the third party must be an arm's length transaction. To ensure that this is an arm's length transaction, neither the vendor that installs the excess capacity facilities nor its affiliate is eligible to enter into an IRU or lease with the participant.

(6) Any amount prepaid for use of the excess capacity facilities (IRU or lease) must be placed in an escrow account. The participant can then use the escrow account as an eligible source of funds for the participant's 35 percent contribution to the project.

(7) All revenues from use of the excess capacity facilities by the third party must be used for the health care provider contribution or for sustainability of the health care network supported by the Healthcare Connect Fund. Network costs that may be funded with any additional revenues that remain include administration, equipment, software, legal fees, or other costs not covered by the Healthcare Connect Fund, as long as they are relevant to sustaining the network.

26. Add Section 54.634, to read as follows:

§ 54.634 Eligible services.

(a) *Eligible services.* Subject to the provisions of sections 54.600 through 54.602 and sections 54.630 through 54.680, eligible health care providers may request support from the Healthcare Connect Fund for any advanced telecommunications or information service that enables health care providers to post their own data, interact with stored data, generate new data, or communicate, by providing connectivity over private dedicated networks or the public Internet for the provision of health information technology.

(b) *Eligibility of dark fiber*. A consortium of eligible health care providers may receive support for "dark" fiber where the customer, not the vendor, provides the modulating electronics, subject to the following limitations:

(1) Support for recurring charges associated with dark fiber is only available once the dark fiber is "lit" and actually being used by the health care provider. Support for non-recurring charges for dark fiber is only available for fiber lit within the same funding year, but applicants may receive up to a one-year extension to light fiber if they provide documentation to the Administrator that construction was unavoidably delayed due to weather or other reasons.

(2) Requests for proposals (RFPs) that solicit dark fiber solutions must also solicit proposals to provide the needed services over lit fiber over a time period comparable to the duration of the dark fiber lease or indefeasible right of use.

(3) If an applicant intends to request support for equipment and maintenance costs associated with lighting and operating dark fiber, it must include such elements in the same RFP as the dark fiber so that the Administrator can review all costs associated with the fiber when determining whether the applicant chose the most cost-effective bid.

(c) *Dark and lit fiber maintenance costs*.

(1) Both individual and consortium applicants may receive support for recurring maintenance costs associated with leases of dark or lit fiber.

(2) Consortium applicants may receive support for upfront payments for maintenance costs associated with leases of dark or lit fiber, subject to the limitations in § 54.638.

(d) *Reasonable and customary installation charges*. Eligible health care providers may obtain support for reasonable and customary installation charges for eligible services, up to an undiscounted cost of $5,000 per eligible site.

(e) *Upfront charges for vendor deployment of new or upgraded facilities*.

(1) Participants may obtain support for upfront charges for vendor deployment of new or upgraded facilities to serve eligible sites.

(2) Support is available to extend vendor deployment of facilities up to the "demarcation point," which is the boundary between facilities owned or controlled by the vendor, and facilities owned or controlled by the customer.

27. Add Section 54.635, to read as follows:

§ 54.635 Eligible equipment.

(a) Both individual and consortium applicants may receive support for network equipment necessary to make functional an eligible service that is supported under the Healthcare Connect Fund.

(b) Consortium applicants may also receive support for network equipment necessary to manage, control, or maintain an eligible service or a dedicated health care broadband network. Support for network equipment is not available for networks that are not dedicated to health care.

(c) Network equipment eligible for support includes the following:

(1) Equipment that terminates a carrier's or other provider's transmission facility and any router/switch that is directly connected to either the facility or the terminating equipment. This includes equipment required to light dark fiber, or equipment necessary to connect dedicated health care broadband networks or individual health care providers to middle mile or backbone networks;

(2) Computers, including servers, and related hardware (e.g. printers, scanners, laptops) that are used exclusively for network management;

(3) Software used for network management, maintenance, or other network operations, and development of software that supports network management, maintenance, and other network operations;

(4) Costs of engineering, furnishing (*i.e*. as delivered from the manufacturer), and installing network equipment; and

(5) Equipment that is a necessary part of health care provider-owned network facilities.

(d) *Additional Limitations*. Support for network equipment is limited to equipment (i) purchased or leased by a Consortium Leader or eligible health care provider and (ii) used for health care purposes.

28. Add Section 54.636, to read as follows:

§ 54.636 Eligible participant-constructed and owned network facilities for consortium applicants.

(a) Subject to the funding limitations under §§ 54.675 and 54.638 and the following restrictions, consortium applicants may receive support for network facilities that will be constructed and owned by the consortium (if the consortium is an eligible health care provider) or eligible health care providers within the consortium.

(1) Consortia seeking support to construct and own network facilities are required to solicit bids for both (i) services provided over third-party networks and (ii) construction of participant-owned network facilities, in the same request for proposals. Requests for proposals must provide sufficient detail so that cost-effectiveness can be evaluated over the useful life of the proposed network facility to be constructed.

(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, pursuant to § 54.642.

29. Add Section 54.637, to read as follows:

§ 54.637 Off-site data centers and off-site administrative offices.

(a) The connections and network equipment associated with off-site data centers and off-site administrative offices used by eligible health care providers for their health care purposes are eligible for support under the Healthcare Connect Fund, subject to the conditions and restrictions set forth in subsection (b).

(1) An "off-site administrative office" is a facility that does not provide hands-on delivery of patient care, but performs administrative support functions that are critical to the provision of clinical care by eligible health care providers.

(2) An "off-site data center" is a facility that serves as a centralized repository for the storage, management, and dissemination of an eligible health care provider's computer systems, associated components, and data, including (but not limited to) electronic health records.

(b) *Conditions and Restrictions.* The following conditions and restrictions apply to support provided under this sections.

(1) Connections eligible for support are only those that are between:

(i) eligible health care provider sites and off-site data centers or off-site administrative offices,

(ii) two off-site data centers,

(iii) two off-site administrative offices,

(iv) an off-site data center and the public Internet or another network,

(v) an off-site administrative office and the public Internet or another network, or

(vi) an off-site administrative office and an off-site data center.

(2) The supported connections and network equipment must be used solely for health care purposes.

(3) The supported connections and network equipment must be purchased by an eligible health care provider or a public or non-profit health care system that owns and operates eligible health care provider sites.

(4) If traffic associated with one or more ineligible health care provider sites is carried by the supported connection and/or network equipment, the ineligible health care provider sites must allocate the cost of that connection and/or equipment between eligible and ineligible sites, consistent with the "fair share" principles set forth in § 54.639(d).

30. Add Section 54.638, to read as follows:

§ 54.638 Upfront payments.

(a) Upfront payments include all non-recurring costs for services, equipment, or facilities, other than reasonable and customary installation charges of up to $5,000.

(b) The following limitations apply to all upfront payments:

(1) Upfront payments associated with services providing a bandwidth of less than 1.5 Mbps (symmetrical) are not eligible for support.

(2) Only consortium applicants are eligible for support for upfront payments.

(c) The following limitations apply if a consortium makes a request for support for upfront payments that exceeds, on average, $50,000 per eligible site in the consortium:

(1) The support for the upfront payments must be prorated over at least three years.

(2) The upfront payments must be part of a multi-year contract.

31. Add Section 54.639, to read as follows:

§ 54.639 Ineligible expenses.

(a) *Equipment or services not directly associated with eligible services*. Expenses associated with equipment or services that are not necessary to make an eligible service functional, or to manage, control, or maintain an eligible service or a dedicated health care broadband network are ineligible for support.

NOTE TO PARAGRAPH (a): The following are examples of ineligible expenses.

(1) Costs associated with general computing, software, applications, and Internet content development are not supported, including the following:
   (i) Computers, including servers, and related hardware (*e.g.*, printers, scanners, laptops), unless used exclusively for network management, maintenance, or other network operations;
   (ii) End user wireless devices, such as smartphones and tablets;
   (iii) Software, unless used for network management, maintenance, or other network operations;
   (iv) Software development (excluding development of software that supports network management, maintenance, and other network operations);
   (v) Helpdesk equipment and related software, or services, unless used exclusively in support of eligible services or equipment;
   (vi) Web server hosting;
   (vii) Website portal development;
   (viii) Video/audio/web conferencing equipment or services; and
   (ix) Continuous power source.
(2) Costs associated with medical equipment (hardware and software), and other general health care provider expenses are not supported, including the following:
   (i) Clinical or medical equipment;
   (ii) Telemedicine equipment, applications, and software;
   (iii) Training for use of telemedicine equipment;
   (iv) Electronic medical records systems; and
   (v) Electronic records management and expenses.

(b) *Inside wiring/ internal connections*. Expenses associated with inside wiring or internal connections are ineligible for support under the Healthcare Connect Fund.

(c) *Administrative expenses*. Administrative expenses are not eligible for support under the Healthcare Connect Fund.

NOTE TO PARAGRAPH (c): Ineligible administrative expenses include, but not limited to, the following expenses:

(1) Personnel costs (including salaries and fringe benefits), except for personnel expenses in a consortium application that directly relate to designing, engineering, installing, constructing, and managing a dedicated broadband network. Ineligible costs of this category include, for example, personnel to perform program management and coordination, program administration, and marketing;
(2) Travel costs, except for travel costs that are reasonable and necessary for network design or deployment and that are specifically identified and justified as part of a competitive bid for a construction project;
(3) Legal costs;
(4) Training, except for basic training or instruction directly related to and required for broadband network installation and associated network operations;
(5) Program administration or technical coordination (*e.g.*, preparing application materials, obtaining letters of agency, preparing request for proposals, negotiating with vendors, reviewing bids, and working with the Administrator) that involves anything other than the design, engineering, operations, installation, or construction of the network;

(6) Administration and marketing costs (*e.g.*, administrative costs; supplies and materials, except as part of network installation/construction; marketing studies, marketing activities, or outreach to potential network members; evaluation and feedback studies);
(7) Billing expenses (*e.g.*, expense that vendors may charge for allocating costs to each health care provider in a network);
(8) Helpdesk expenses (*e.g.*, equipment and related software, or services); and
(9) Technical support services that provide more than basic maintenance.

(d) *Cost allocation for ineligible sites, services, or equipment*.

(1) *Ineligible sites*. Eligible health care provider sites may share expenses with ineligible sites, as long as the ineligible sites pay their fair share of the expenses. An applicant may seek support for only the portion of a shared eligible expense attributable to eligible health care provider sites. To receive support, the applicant must ensure that ineligible sites pay their fair share of the expense. The fair share is determined as follows:

(i) If the vendor charges a separate and independent price for each site, an ineligible site must pay the full undiscounted price.

(ii) If there is no separate and independent price for each site, the applicant must prorate the undiscounted price for the "shared" service, equipment, or facility between eligible and ineligible sites on a proportional fully-distributed basis. Applicants must make this cost allocation using a method that is based on objective criteria and reasonably reflects the eligible usage of the shared service, equipment, or facility. The applicant bears the burden of demonstrating the reasonableness of the allocation method chosen.

(2) *Ineligible components of a single service or piece of equipment*. Applicants seeking support for a service or piece of equipment that includes an ineligible component must explicitly request in their requests for proposals that vendors include pricing for a comparable service or piece of equipment that is comprised of only eligible components. If the selected provider also submits a price for the eligible component on a stand-alone basis, the support amount is calculated based on the stand-alone price of the eligible component on a stand-alone basis. If the vendor does not offer the eligible component on a stand-alone basis, the full price of the entire service or piece of equipment must be taken into account, without regard to the value of the ineligible components, when determining the most cost-effective bid.

(3) *Written description*. Applicants must submit a written description of their allocation method(s) to the Administrator with their funding requests.

(4) *Written agreement*. If ineligible entities participate in a network, the allocation method must be memorialized in writing, such as a formal agreement among network members, a master services contract, or for smaller consortia, a letter signed and dated by all (or each) ineligible entity and the Consortium Leader.

32. Add Section 54.640, to read as follows:

§ 54.640 Eligible vendors.

(a) *Eligibility*. For purposes of the Healthcare Connect Fund, eligible vendors shall include any provider of equipment, facilities, or services that are eligible for support under Healthcare Connect Fund.

(b) *Obligation to assist health care providers*. Vendors in the Healthcare Connect Fund must certify, as a condition of receiving support, that they will provide to health care providers, on a timely basis, all

information and documents regarding supported equipment, facilities, or services that are necessary for the health care provider to submit required forms or respond to Commission or Administrator inquiries. The Administrator may withhold disbursements for the vendor if the vendor, after written notice from the Administrator, fails to comply with this requirement.

33. Add Section 54.642, to read as follows:

§ 54.642 Competitive bidding requirement and exemptions.

(a) *Competitive bidding requirement.* All applicants are required to engage in a competitive bidding process for supported services, facilities, or equipment consistent with the requirements set forth in this subpart, unless they qualify for one or more of the exemptions in paragraph (h) below. In addition, applicants may engage in competitive bidding even if they qualify for an exemption. Applicants who utilize a competitive bidding exemption may proceed directly to filing a funding request as described in § 54.643.

(b) *Fair and open process*.

(1) All entities participating in the Healthcare Connect Fund must conduct a fair and open competitive bidding process, consistent with all applicable requirements.

(2) Vendors who intend to bid to provide supported services, equipment, or facilities to a health care provider may not simultaneously help the health care provider choose a winning bid. Any vendor who submits a bid, and any individual or entity that has a financial interest in such a vendor, is prohibited from:

(i) preparing, signing or submitting an applicant's request for services;

(ii) serving as the Consortium Leader or other point of contact on behalf of applicant(s);

(iii) being involved in setting bid evaluation criteria; or

(iv) participating in the bid evaluation or vendor selection process (except in their role as potential vendors).

(3) All potential bidders must have access to the same information and must be treated in the same manner.

(4) All applicants and vendors must comply with any applicable state, Tribal, or local competitive bidding requirements. The competitive bidding requirements in this section apply in addition to state, Tribal, and local competitive bidding requirements and are not intended to preempt such state, Tribal, or local requirements.

(c) *Cost-effective*. For purposes of the Healthcare Connect Fund, "cost-effective" is defined as the method that costs the least after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems relevant to choosing a method of providing the required health care services.

(d) *Bid evaluation criteria*. Applicants must develop weighted evaluation criteria (*e.g.*, scoring matrix) that demonstrate how the applicant will choose the most "cost-effective" bid before submitting a Request for Services. Price must be a primary factor, but need not be the only primary factor. A non-price factor can receive an equal weight to price, but may not receive a greater weight than price.

(e) *Request for Services.* Applicants must submit the following documents to the Administrator in order to initiate competitive bidding.

(1) *Form 461, including certifications.* The applicant must provide the following certifications as part of the request for services.

(i) The person signing the application is authorized to submit the application on behalf of the applicant and has examined the form and all attachments, and to the best of his or her knowledge, information, and belief, all statements of fact contained therein are true.

(ii) The applicant has followed any applicable state, Tribal, or local procurement rules.

(iii) All Healthcare Connect Fund support will be used solely for purposes reasonably related to the provision of health care service or instruction that the HCP is legally authorized to provide under the law of the state in which the services are provided and will not be sold, resold, or transferred in consideration for money or any other thing of value.

(iv) The applicant satisfies all of the requirements under section 254 of the Act and applicable Commission rules.

(v) The applicant has reviewed all applicable requirements for the program and will comply with those requirements.

(2) *Bid evaluation criteria*. Requirements for bid evaluation criteria are described in paragraph (d) above.

(3) *Declaration of assistance.* All applicants must submit a "Declaration of Assistance" with their Request for Services. In the Declaration of Assistance, applicants must identify each and every consultant, vendor, and other outside expert, whether paid or unpaid, who aided in the preparation of their applications.

(4) *Request for proposal (if applicable).*

(i) Any applicant may use a request for proposals (RFP). Applicants who use an RFP must submit the RFP and any additional relevant bidding information to the Administrator with Form 461.

(ii) An applicant must submit an RFP (1) if it is required to issue an RFP under applicable state, Tribal, or local procurement rules or regulations; (2) if the applicant is a consortium seeking more than $100,000 in program support during the funding year, including applications that seek more than $100,000 in program support for a multi-year commitment; or (3) if the applicant is a consortium seeking support for participant-constructed and owned network facilities.

(iii) *RFP requirements.*

(1) An RFP must provide sufficient information to enable an effective competitive bidding process, including describing the health care provider's service needs and defining the scope of the project and network costs (if applicable).

(2) An RFP must specify the period during which bids will be accepted.

(3) An RFP must include the bid evaluation criteria described in paragraph (d) above, and solicit sufficient information so that the criteria can be applied effectively.

(4) Consortium applicants seeking support for long-term capital investments whose useful life extends beyond the period of the funding commitment (*e.g.*, facilities constructed and owned by the applicant, fiber indefeasible rights of use) must seek bids in the same RFP from vendors who propose to meet those needs via services provided over vendor-owned facilities, for a time period comparable to the life of the proposed capital investment.

(5) Applicants may prepare RFPs in any manner that complies with the rules in this subpart and any applicable state, Tribal, or local procurement rules or regulations.

(5) *Additional requirements for consortium applicants.*

(i) *Network Plan*. Consortium applicants must submit a narrative describing specific elements of their network plan with their Request for Services. Consortia applicants are required to use program support for the purposes described in their narrative. The required elements of the narrative include:

(1) Goals and objectives of the network;

(2) Strategy for aggregating the specific needs of health care providers (including providers that serve rural areas) within a state or region;

(3) Strategy for leveraging existing technology to adopt the most efficient and cost effective means of connecting those providers;

(4) How the supported network will be used to improve or provide health care delivery;

(5) Any previous experience in developing and managing health information technology (including telemedicine) programs; and

(6) A project management plan outlining the project's leadership and management structure, and a work plan, schedule, and budget.

(ii) *Letters of agency.* Consortium applicants must submit letters of agency pursuant to § 54.632.

(f) *Public posting by the Administrator*. The Administrator shall post on its web site the following competitive bidding documents, as applicable:

(1) Form 461,

(2) Bid evaluation criteria,

(3) Request for proposal, and

(4) Network plan.

(g) *28-day waiting period*. After posting the documents described in paragraph (f) above on its web site, the Administrator shall send confirmation of the posting to the applicant. The applicant shall wait at least 28 days from the date on which its competitive bidding documents are posted on the web site before selecting and committing to a vendor.

(1) *Selection of the most "cost-effective" bid and contract negotiation*. Each applicant subject to competitive bidding is required to certify to the Administrator that the selected bid is, to the best of the applicant's knowledge, the most cost-effective option available. Applicants are required to submit the documentation listed in § 54.643 below to support their certifications.

(2) Applicants who plan to request evergreen status under § 54.642(h)(4)(ii) must enter into a contract that identifies both parties, is signed and dated by the health care provider or Consortium Leader after the 28-day waiting period expires, and specifies the type, term, and cost of service.

(h) *Exemptions to competitive bidding requirements*.

(1) *Annual undiscounted cost of $10,000 or less*. An applicant that seeks support for $10,000 or less of total undiscounted eligible expenses for a single year is exempt from the competitive bidding requirements under this section, if the term of the contract is one year or less.

(2) *Government Master Service Agreement (MSA)*. Eligible health care providers that seek support for services and equipment purchased from MSAs negotiated by federal, state, Tribal, or local government entities on behalf of such health care providers and others, if such MSAs were awarded pursuant to applicable federal, state, Tribal, or local competitive bidding requirements, are exempt from the competitive bidding requirements under this section.

(3) *Master Service Agreements approved under the Pilot Program or Healthcare Connect Fund*. A eligible health care provider site may opt into an existing MSA approved under the Pilot Program or Healthcare Connect Fund and seek support for services and equipment purchased from the MSA without triggering the competitive bidding requirements under this section, if the MSA was developed and negotiated in response to an RFP that specifically solicited proposals that included a mechanism for adding additional sites to the MSA.

(4) *Evergreen contracts*.

(i) Subject to the provisions in § 54.644, the Administrator may designate a multi-year contract as "evergreen," which means that the service(s) covered by the contract need not be re-bid during the contract term.

(ii) A contract entered into by a health care provider or consortium as a result of competitive bidding may be designated as evergreen if it meets all of the following requirements: (1) is signed by the individual health care provider or consortium lead entity; (2) specifies the service type, bandwidth and quantity; (3) specifies the term of the contract; (4) specifies the cost of services to be provided; and (5) includes the physical location or other identifying information of the health care provider sites purchasing from the contract.

(iii) Participants may exercise voluntary options to extend an evergreen contract without undergoing additional competitive bidding, if (1) the voluntary extension(s) is memorialized in the evergreen contract; (2) the decision to extend the contract occurs before the participant files its funding request for the funding year when the contract would otherwise expire; and (3) the voluntary extension(s) do not exceed five years in the aggregate.

(5) *Schools and libraries program master contracts*. Subject to the provisions in sections 54.500(g), 54.501(c)(1), and 54.503, an eligible health care provider in a consortium with participants in the schools and libraries universal service support program and a party to the consortium's existing contract is exempt from the Healthcare Connect Fund competitive bidding requirements if the contract was approved in the schools and libraries universal service support program as a master

contract. The health care provider must comply with all Healthcare Connect Fund rules and procedures except for those applicable to competitive bidding.

34. Add Section 54.643, to read as follows:

§ 54.643 Funding commitments.

(a) Once a vendor is selected, applicants must submit a "Funding Request" (and supporting documentation) to provide information about the services, equipment, or facilities selected and certify that the services selected were the most cost-effective option of the offers received. The following information should be submitted to the Administrator with the Funding Request.

(1) *Request for funding*. The applicant shall submit a request for funding (Form 462) to identify the service(s), equipment, or facilities; rates; vendor(s); and date(s) of vendor selection.

(2) *Certifications*. The applicant must provide the following certifications as part of the request for funding:

(i) The person signing the application is authorized to submit the application on behalf of the applicant and has examined the form and all attachments, and to the best of his or her knowledge, information, and belief, all statements of fact contained therein are true.

(ii) Each vendor selected is, to the best of the applicant's knowledge, information and belief, the most cost-effective vendor available, as defined in § 54.642(c).

(iii) All Healthcare Connect Fund support will be used only for eligible health care purposes.

(iv) The applicant is not requesting support for the same service from both the Telecommunications Program and the Healthcare Connect Fund.

(v) The applicant satisfies all of the requirements under section 254 of the Act and applicable Commission rules, and understands that any letter from the Administrator that erroneously commits funds for the benefit of the applicant may be subject to rescission.

(vi) The applicant has reviewed all applicable requirements for the program and will comply with those requirements.

(vii) The applicant will maintain complete billing records for the service for five years.

(3) *Contracts or other documentation*. All applicants must submit a contract or other documentation that clearly identifies (1) the vendor(s) selected and the health care provider(s) who will receive the services, equipment, or facilities; (2) the service, bandwidth, and costs for which support is being requested; and (3) the term of the service agreement(s) if applicable (*i.e.*, if services are not being provided on a month-to-month basis). For services, equipment, or facilities provided under contract, the applicant must submit a copy of the contract signed and dated (after the Allowable Contract Selection Date) by the individual health care provider or Consortium Leader. If the service, equipment, or facilities are not being provided under contract, the applicant must submit a bill, service offer, letter, or similar document from the vendor that provides the required information.

(4) *Competitive bidding documents*. Applicants must submit documentation to support their certifications that they have selected the most cost-effective option, including a copy of each bid received (winning, losing, and disqualified), the bid evaluation criteria, and the following

documents (as applicable): bid evaluation sheets; a list of people who evaluated bids (along with their title/role/relationship to the applicant organization); memos, board minutes, or similar documents related to the vendor selection/award; copies of notices to winners; and any correspondence with vendors during the bidding/evaluation/award phase of the process. Applicants who claim a competitive bidding exemption must submit relevant documentation to allow the Administrator to verify that the applicant is eligible for the claimed exemption.

(5) *Cost allocation for ineligible entities or components*. Pursuant to § 54.639(d)(3)-(4), where applicable, applicants must submit a description of how costs will be allocated for ineligible entities or components, as well as any agreements that memorialize such arrangements with ineligible entities.

(6) *Additional documentation for consortium applicants*. A consortium applicant must also submit the following:

(i) Any revisions to the network plan submitted with the Request for Services pursuant to § 54.642(e)(5)(i), as necessary. If not previously submitted, the consortium should provide a narrative description of how the network will be managed, including all administrative aspects of the network, including but not limited to invoicing, contractual matters, and network operations. If the consortium is required to provide a sustainability plan as set forth in § 54.643(a)(6)(iv), the revised budget should include the budgetary factors discussed in the sustainability plan requirements.

(ii) A list of participating health care providers and all of their relevant information, including eligible (and ineligible, if applicable) cost information for each participating health care provider.

(iii) Evidence of a viable source for the undiscounted portion of supported costs.

(iv) *Sustainability plans for applicants requesting support for long-term capital expenses*. Consortia that seek funding to construct and own their own facilities or obtain indefeasible right of use or capital lease interests are required to submit a sustainability plan with their funding requests demonstrating how they intend to maintain and operate the facilities that are supported over the relevant time period. Applicants may incorporate by reference other portions of their applications (*e.g.*, project management plan, budget). The sustainability plan must, at a minimum, address the following points:

(1) *Projected sustainability period*. Indicate the sustainability period, which at a minimum is equal to the useful life of the funded facility. The consortium's budget must show projected income and expenses (*i.e.*, for maintenance) for the project at the aggregate level, for the sustainability period.

(2) *Principal factors.* Discuss each of the principal factors that were considered by the participant to demonstrate sustainability. This discussion must include all factors that show that the proposed network will be sustainable for the entire sustainability period. Any factor that will have a monetary impact on the network must be reflected in the applicant's budget.

(3) *Terms of membership in the network*. Describe generally any agreements made (or to be entered into) by network members (*e.g.*, participation agreements, memoranda of understanding, usage agreements, or other similar agreements). The sustainability plan must also describe, as applicable: (1) financial and time commitments made by proposed

members of the network; (2) if the project includes excess bandwidth for growth of the network, describe how such excess bandwidth will be financed; and (3) if the network will include ineligible health care providers and other network members, describe how fees for joining and using the network will be assessed.

(4) *Ownership structure*. Explain who will own each material element of the network (*e.g.*, fiber constructed, network equipment, end user equipment). For purposes of this subsection, "ownership" includes an indefeasible right of use interest. Applicants must clearly identify the legal entity that will own each material element. Applicants must also describe any arrangements made to ensure continued use of such elements by the network members for the duration of the sustainability period.

(5) *Sources of future support*. Describe other sources of future funding, including fees to be paid by eligible health care providers and/or non-eligible entities.

(6) *Management*. Describe the management structure of the network for the duration of the sustainability period. The applicant's budget must describe how management costs will be funded.

(v) *Material change to sustainability plan*. A consortium that is required to file a sustainability plan must maintain its accuracy. If there is a material change to a required sustainability plan that would impact projected income or expenses by more than 20 percent or $100,000 from the previous submission, or if the applicant submits a funding request based on a new Form 462 (*i.e.*, a new competitively bid contract), the consortium is required to re-file its sustainability plan. In the event of a material change, the applicant must provide the Administrator with the revised sustainability plan no later than the end of the relevant quarter, clearly showing (*i.e.*, by redlining or highlighting) what has changed.

35. Add Section 54.644, to read as follows:

§ 54.644 Multi-year commitments.

(a) Participants in the Healthcare Connect Fund are permitted to enter into multi-year contracts for eligible expenses and may receive funding commitments from the Administrator for a period that covers up to three funding years.

(b) If a long-term contract covers a period of more than three years, the applicant may also have the contract designated as "evergreen" under § 54.642(h)(4) which will allow the applicant to re-apply for a funding commitment under the contract after three years without having to undergo additional competitive bidding.

36. Add Section 54.645, to read as follows:

§ 54.645 Payment process.

(a) The Consortium Leader (or health care provider, if participating individually) must certify to the Administrator that it has paid its contribution to the vendor before the invoice can be sent to Administrator and the vendor can be paid.

(b) Before the Administrator may process and pay an invoice, both the Consortium Leader (or health care provider, if participating individually) and the vendor must certify that they have reviewed the document and that it is accurate. All invoices must be received by the Administrator within six months of the end date of the funding commitment.

37. Add Section 54.646, to read as follows:

§ 54.646 Site and service substitutions.

(a) A Consortium Leader (or health care provider, if participating individually) may request a site or service substitution if:

(1) the substitution is provided for in the contract, within the change clause, or constitutes a minor modification,

(2) the site is an eligible health care provider and the service is an eligible service under the Healthcare Connect Fund,

(3) the substitution does not violate any contract provision or state, Tribal, or local procurement laws, and

(4) the requested change is within the scope of the controlling request for services, including any applicable request for proposal used in the competitive bidding process.

(b) Support for a qualifying site and service substitution will be provided to the extent the substitution does not cause the total amount of support under the applicable funding commitment to increase.

38. Add Section 54.647, to read as follows:

§ 54.647 Data Collection and Reporting.

(a) Each consortium lead entity must file an annual report with the Administrator on or before September 30 for the preceding funding year, with the information and in the form specified by the Wireline Competition Bureau.

(b) Each consortium is required to file an annual report for each funding year in which it receives support from the Healthcare Connect Fund.

(c) For consortia that receive large upfront payments, the reporting requirement extends for the life of the supported facility.

39. Add Section 54.648, to read as follows:

§ 54.648 Audits and recordkeeping.

(a) *Random audits*. Participants shall be subject to random compliance audits and other investigations to ensure compliance with program rules and orders.

(b) *Recordkeeping*.

(1) Participants, including Consortium Leaders and health care providers, shall maintain records to document compliance with program rules and orders for at least 5 years after the last day of service delivered in a particular funding year. Participants who receive support for long-term capital investments in facilities whose useful life extends beyond the period of the funding commitment shall maintain records for at least 5 years after the end of the useful life of the facility. Participants shall maintain asset and inventory records of supported network equipment to verify the actual location of such equipment for a period of 5 years after purchase.

(2) Vendors shall retain records related to the delivery of supported services, facilities, or equipment to document compliance with program rules and orders for at least 5 years after the last day of the delivery of supported services, equipment, or facilities in a particular funding year.

(3) Both participants and vendors shall produce such records at the request of the Commission, any auditor appointed by the Administrator or the Commission, or of any other state or federal agency with jurisdiction.

40. Add Section 54.649, to read as follows:

§ 54.649 Certifications.

For individual health care provider applicants, required certifications must be provided and signed by an officer or director of the health care provider, or other authorized employee of the health care provider. For consortium applicants, an officer, director, or other authorized employee of the Consortium Leader must sign the required certifications. Pursuant to § 54.680, electronic signatures are permitted for all required certifications.

41. Add an undesignated centered heading below Section 54.649, to read as follows:

GENERAL PROVISIONS

42. Amend redesignated Section 54.671 by revising paragraph (b), to read as follows:

§ 54.671 Resale.

(a) * * *

(b) *Permissible fees.* The prohibition on resale set forth in paragraph (a) of this section shall not prohibit a health care provider from charging normal fees for health care services, including instruction related to services purchased with support provided under this subpart.

43. Add Section 54.672, to read as follows:

§ 54.672 Duplicate support.

(a) Eligible health care providers that seek support under the Healthcare Connect Fund for telecommunications services may not also request support from the Telecommunications Program for the same services.

(b) Eligible health care providers that seek support under the Telecommunications Program or the Healthcare Connect Fund may not also request support from any other universal service program for the same expenses.

44. Amend redesignated Section 54.675 by revising paragraphs (a), (c), (d), (e), and (f), to read as follows:

§ 54.675 Cap.

(a) *Amount of the annual cap.* The aggregate annual cap on federal universal service support for health care providers shall be $400 million per funding year, of which up to $150 million per funding year will be available to support upfront payments and multi-year commitments under the Healthcare Connect Fund.

(b) * * *

(c) *Requests.* Funds shall be available as follows:

(1) * * *

(2) For the Telecommunications Program and the Healthcare Connect Fund, the Administrator shall implement a filing window period that treats all eligible health care providers filing within the window period as if their applications were simultaneously received.

(3) * * *

(4) The deadline to submit a funding commitment request under the Telecommunications Program and the Healthcare Connect Fund is June 30 for the funding year that begins on the previous July 1.

(d) *Annual filing requirement.* Health care providers shall file new funding requests for each funding year, except for health care providers who have received a multi-year funding commitment under § 54.644.

(e) *Long-term contracts.* If health care providers enter into long-term contracts for eligible services, the Administrator shall only commit funds to cover the portion of such a long-term contract scheduled to be delivered during the funding year for which universal service support is sought, except for multi-year funding commitments as described in § 54.644.

(f) *Pro-rata reductions for Telecommunications Program support.* The Administrator shall act in accordance with this section when a filing window period for the Telecommunications Program and the Healthcare Connect Fund, as described in paragraph (c)(2) of this section, is in effect. When a filing window period described in paragraph (c)(2) of this section closes, the Administrator shall calculate the total demand for Telecommunications Program and Healthcare Connect Fund support submitted by all applicants during the filing window period. If the total demand during a filing window period exceeds the total remaining support available for the funding year, the Administrator shall take the following steps:

(1) The Administrator shall divide the total remaining funds available for the funding year by the total amount of Telecommunications Program and Healthcare Connect Fund support requested by each applicant that has filed during the window period, to produce a pro-rata factor.

(2) The Administrator shall calculate the amount of Telecommunications Program and Healthcare Connect Fund support requested by each applicant that has filed during the filing window.

(3) The Administrator shall multiply the pro-rata factor by the total dollar amount requested by each applicant filing during the window period. Administrator shall then commit funds to each applicant for Telecommunications Program and Healthcare Connect Fund support consistent with this calculation.

45. Amend redesignated section 54.679 by revising the section heading, and revising the rule to read as follows:

§ 54.679 Election to offset support against annual universal service fund contribution.

(a) A service provider that contributes to the universal service support mechanisms under subpart H of this section and also provides services eligible for support under this subpart to eligible health care providers may, at the election of the contributor: (i) treat the amount eligible for support under this subpart as an offset against the contributor's universal service support obligation for the year in which

the costs for providing eligible services were incurred; or (ii) receive direct reimbursement from the Administrator for that amount.

(b) Service providers that are contributors shall elect in January of each year the method by which they will be reimbursed and shall remain subject to that method for the duration of the calendar year. Any support amount that is owed a service provider that fails to remit its monthly universal service contribution obligation, however, shall first be applied as an offset to that contributor's contribution obligation. Such a service provider shall remain subject to the offsetting method for the remainder of the calendar year in which it failed to remit its monthly universal service obligation. A service provider that continues to be in arrears on its universal service contribution obligations at the end of a calendar year shall remain subject to the offsetting method for the next calendar year.

(c) If a service provider providing services eligible for support under this subpart elects to treat that support amount as an offset against its universal service contribution obligation and the total amount of support owed exceeds its universal service obligation, calculated on an annual basis, the service provider shall receive a direct reimbursement in the amount of the difference. Any such reimbursement due a service provider shall be provided by the Administrator no later than the end of the first quarter of the calendar year following the year in which the costs were incurred and the offset against the contributor's universal service obligation was applied.

46. Add Section 54.680, to read as follows:

§ 54.680 Validity of Electronic Signatures.

(a) For the purposes of this subpart, an electronic signature (defined by the Electronic Signatures in Global and National Commerce Act, as an electronic sound, symbol, or process, attached to or logically associated with a contract or other record and executed or adopted by a person with the intent to sign the record) has the same legal effect as a written signature.

(b) For the purposes of this subpart, an electronic record (defined by the Electronic Signatures in Global and National Commerce Act, as a contract or other record created, generated, sent, communicated, received, or stored by electronic means) constitutes a record.

APPENDIX E

Forms

FCC Form **460**

Approval by OMB XXXX—XXXX
Estimated time per response: XXX

Rural Health Care (RHC) Universal Service
Eligibility and Registration Form

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.

Block 1: General Information		
1 Date Submitted:		
2 Applying to:	○ Determine eligibility of an HCP site ○ Determine eligibility of Consortium ○ Register an off-site data center	○ Register an ineligible site ○ Register an off-site administrative office
2a If applying as an off-site data center, list all sites (eligible and ineligible) that will use the services of this data center.		
2b If applying as an off-site administrative office, list all sites (eligible and ineligible) that will use the services of this administrative office.		

Block 2: Physical Location		
Enter the actual physical location of the HCP site.		
3 HCP Number	4 Name of Site	
5 FCC Registration Number (FCC RN)	6 Site Contact Name	
7 Address Line 1		
8 Address Line 2		9 County
10 GeoLocation (optional)		
11 City	12 State	13 Zip Code
14 Phone Ext.	15 Email	

Block 3: Consortium Information		
16 HCP Number		
17 Name of Consortium		
18 Is the Consortium a legal entity? ○ Yes ○ No If yes, Consortium FCC RN:		
19 Consortium has a written agreement allocating legal and financial responsibility. ○ Yes ○ No		
If yes, submit the agreement to USAC. If no, see instructions regarding the default entity that bears legal and financial responsibility for the consortium's activities in connection with the Healthcare Connect Fund.		
20 Consortium Leader Type: ○ The Consortium ○ An eligible HCP participating in the Consortium HCP Number: _____	○ Ineligible State organization ○ Ineligible public sector (government) entity ○ Ineligible non-profit entity	
21 Consortium Leader Contact Information	22 Name of Consortium Leader	
Consortium applicants are required to have a Letter of Agency from each participating HCP that authorizes the Consortium to file forms on the HCP's behalf. Attach a Letter of Agency for each participating HCP.		
23 List participating HCPs (eligible/ineligible)	24 HCP Number	

Block 4: Contact Information		
25 Primary Account Holder/Project Coordinator Name		
26 Employer		
27 Address Line 1		○ Same as Physical Location
28 Address Line 2		
29 City	30 State	31 Zip Code
32 Phone # Ext.	33 Email	
34 Application Contact/Assistant Project Coordinator Name		
35 Employer		
36 Address Line 1		○ Same as Primary Account Holder Address
37 Address Line 2		
38 City	39 State	40 Zip Code
41 Phone # Ext.	42 Email	

Block 5: Eligibility Information (HCP must be public or non-profit health care provider)
43 Select the organization type from Column A that best describes the organization
○ **A.** Community health center or health center providing health care to migrants
○ **B.** Community mental health center
○ **C.** Local health department/agency
○ **D.** Non-profit hospital
○ **E.** Part-time eligible entity located in an ineligible facility
○ **F.** Post-secondary educational Institution offering health care instruction, teaching hospital, or medical school
○ **G1.** Rural health clinic
G2. Is this a mobile rural health care provider? ☐ Yes ☐ No
○ **H.** Dedicated ER of rural, for-profit hospital
○ **I.** Consortium of the above
44 Provide a brief explanation of why this site qualifies as the organization type selected above:

Block 6: Additional Information	
45 Non-Profit Tax ID:	46 Employer ID Number:
47 [HHS Unique Identifier:]	
48 If a Non-Profit Hospital, is this a Critical Access Hospital?	☐ Yes ☐ No
49 If a Non-Profit Hospital, how many licensed hospital beds are at the site?	_____
50 Is the site located on Tribal Lands or serve primarily Tribal populations?	☐ Yes ☐ No
51 [Reserved]	52 [Reserved]

Block 7: Certifications and Signatures	
53 ☐ I certify that I am authorized to submit this request on behalf of the site or consortium and that to the best of my knowledge, information and belief, all responses contained herein are true.	
54 ☐ If applying as an individual health care provider site, I certify that the health care provider is a non-profit or public entity and that the site is located in a FCC designated rural area, or is grandfathered rural pursuant to 47 C.F.R. Sec. 54.600(b)(2).	
55 ☐ If applying as a consortium, I certify that the eligible health care providers participating in the consortium are non-profit or public entities.	
56 ☐ I understand that all documentation associated with this form must be retained for a period of five years.	
57 ☐ If applying as a consortium, I understand I must obtain letters of agency from each consortium member that grants me the authority to complete, sign, and submit all forms for the funding year(s) for which support is sought.	
58 Signature	59 Date
60 Printed Name of Authorized Person	
61 Title/Position of Authorized Person	
62 Phone Ext.	63 Email
64 Employer	65 Employer's FCC RN

Persons willfully making false statements on this form can be punished by fine or forfeiture under the Communications Act, 47 U.S.C. Secs. 502, 503(b), or fine or imprisonment under Title 18 of the United States Code, 18 U.S.C. Sec. 1001.

FCC NOTICE FOR INDIVIDUALS REQUIRED BY THE PRIVACY ACT AND THE PAPERWORK REDUCTION ACT
Part 3 of the Commission's Rules authorize the FCC to request the information on this form. The purpose of the information is to determine your eligibility for certification as a health care provider. The information will be used by the Universal Service Administrative Company and/or the staff of the Federal Communications Commission, to evaluate this form, to provide information for enforcement and rulemaking proceedings and to maintain a current inventory of applicants, health care providers, billed entities, and service providers. No authorization can be granted unless all information requested is provided. Failure to provide all requested information will delay the processing of the application or result in the application being returned without

FCC Form 460

action. Information requested by this form will be available for public inspection. Your response is required to obtain the requested authorization.

The public reporting for this collection of information is estimated to average X hours per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the required data, and completing and reviewing the collection of information. If you have any comments on this burden estimate, or how we can improve the collection and reduce the burden it causes you, please write to the Federal Communications Commission, AMD-PERM, Paperwork Reduction Act Project (3060-0804), Washington, DC 20554. We will also accept your comments regarding the Paperwork Reduction Act aspects of this collection via the Internet if you send them to pra@fcc.gov. PLEASE DO NOT SEND YOUR RESPONSE TO THIS ADDRESS.

Remember - You are not required to respond to a collection of information sponsored by the Federal government, and the government may not conduct or sponsor this collection, unless it displays a currently valid OMB control number or if we fail to provide you with this notice. This collection has been assigned an OMB control number of 3060-0804.

THE FOREGOING NOTICE IS REQUIRED BY THE PRIVACY ACT OF 1974, PUBLIC LAW 93-579, DECEMBER 31, 1974, 5 U.S.C. 552a(e)(3) AND THE PAPEWORK REDUCTION ACT OF 1995, PUBLIC LAW 104-13, OCTOBER 1, 1995, 44 U.S.C. SECTION 3507.

FCC Form 460

FCC Form
461

Approval by OMB XXXX—XXXX
Estimated time per response: XXX

Rural Health Care (RHC) Universal Service
Healthcare Connect Fund
Request for Services and Certifications

USAC Internal Use Only	
FCC Form 461 Application Number:	FCC Form 460 Number:
Posting Start Date:	Posting End Date:
Allowable Contract Selection Date (ACSD):	Form 461 Friendly Name:

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.

Block 1: General Information

1 Funding Year	2 HCP Number	
3 HCP Name/Consortium Name		
4 Address Line 1		
5 Address Line 2	6 County	
7 City	8 State	9 Zip Code

Block 2: Individual HCP Site Request for Services

10 ☐ Applicant has prepared and is submitting an RFP with this form.
☐ Applicant has not and will not prepare an RFP.

11 Number of Days RFP Posted
Number of days USAC should post RFP: _____ Posting end date: _____

12 Category of Service Requested (check all applicable)
☐ Network Equipment
☐ Leased/Tariffed Facilities or Services

12a Select requested capabilities (select all that apply)

☐ Large image file transmission	☐ Interface/edge device	☐ Video conferencing
☐ Backup/redundancy	☐ Live data transmission and monitoring	☐ Voice
☐ Internet access	☐ Mobile unit communications	
☐ Electronic medical records/Patient billing	☐ Store and forward consultations	

12b Reserved

13 Contact for Request for Services:
a. ○ Same as HCP Physical Location Contact ○ Same as HCP Primary Account Holder ○ Other
b. If other, provide full contact information:

Contact Name	Organization Name
Contact Name Title	
Phone #	Email

Block 3: Consortium Application Request for Services

14 Participating Entities (list all sites (eligible and ineligible) participating in this competitive bid request)

HCP Number:	HCP Number:
HCP Number:	HCP Number:

15 ☐ Applicant has prepared and is submitting an RFP with this form. If selected, complete 15a.
☐ Applicant has not and will not prepare an RFP.

15a Applicant is submitting an RFP because:
☐ It is seeking more than $100,000 in program support ☐ Of state, Tribal, or local procurement rules
☐ It is seeking support for infrastructure ☐ The applicant has elected to use an RFP

16 Number of Days Posted

Number of days USAC should post RFP: _____ Posting end date: _____

17 Category of Service Requested

- ☐ Network Design
- ☐ Network Equipment
- ☐ Infrastructure/Outside Plant
- ☐ Leased/Tariffed Facilities or Services
- ☐ Network Management/Maintenance/Operations Cost (not captured elsewhere)

17a If requesting only Infrastructure/Outside Plant, has the Consortium previously requested Leased/Tariffed Facilities or Services?

○ Yes. If yes, provide FCC Form 461 Posting Number ○ No

18 Description of Services Requested (Required to provide a summary of RFP if submitting one)

_____

_____

19 Contact for Request for Services:

a. ○ Same as Project Coordinator ○ Same as Assistant Project Coordinator ○ Other

b. If other, provide full contact information:

Contact Name	Organization Name
Contact Name Title	
Phone #	Email

Block 4: Declaration of Assistance

20 Did anyone other than employees of the HCP or consortium listed in Block 1, or employees of the HCPs listed in Block 3 assist in the completion of this application?

○ Yes ○ No

Organization Type:

List all individuals who aided in the preparation of this application (Form, RFP, Bid Evaluation, and Network Plan).

a. Name (First, Middle Initial, Last)	b. Organization Type	
c. Title/Role	d. Employer	
e. Address Line 1		
f. Address Line 2		
g. City	h. State	i. Zip Code

Block 5: Bid Evaluation

22 Select selection criteria (and weights assigned to each) that will be used to evaluate bids received as a result of this request for services. Attach supplemental information (if necessary).

Criteria	Weight
a.	
b.	
c.	

Block 6: Additional Documentation

23 List all supporting documentation (RFP, Network Plan, etc) that is required to be submitted with this form.

Type of Documentation
a.
b.
c.

Block 7: Certifications

24 ☐ The person signing the application is authorized to submit the application on behalf of the applicant and has examined the form and all attachments, and to the best of his or her knowledge, information, and belief, all statements of fact contained therein are true.

25 ☐ I certify that the applicant has followed any applicable state, Tribal, or local procurement rules.

FCC Form 461

Block 7: Certifications	
26 ☐	I certify that the supported connections, infrastructure and/or equipment associated with this request for funding will be used solely for purposes reasonably related to the provision of health care service or instruction, and that the health care provider or consortium is legally authorized to provide under the law of the state in which the services were provided and will not be sold, resold, or transferred in consideration for money or any other thing of value.
27 ☐	I certify that the applicant satisfies all of the requirements under section 254 of the Act and applicable Commission rules.
28 ☐	I certify that the applicant has reviewed all applicable requirements for the program and will comply with those requirements.
29 ☐	I understand all documentation that is part of this form must be kept for a period of five years (including a copy of the signed 461, any bids/contracts resulting from the 461 posting, scoring sheet, and other information that was used in the decision-making process) from the last day of the funding year.
30 Signature	31 Date (mm/dd/yyyy)
32 Printed Name of Authorized Person	
33 Title/Position of Authorized Person	
34 Phone #	35 Email
36 Employer	37 Employer's FCC RN

Persons willfully making false statements on this form can be punished by fine or forfeiture under the Communications Act, 47 U.S.C. Secs. 502, 503(b), or fine or imprisonment under Title 18 of the United States Code, 18 U.S.C. Sec. 1001.

FCC NOTICE FOR INDIVIDUALS REQUIRED BY THE PRIVACY ACT AND THE PAPERWORK REDUCTION ACT
Part 3 of the Commission's Rules authorize the FCC to request the information on this form. The purpose of the information is to determine your eligibility for certification as a health care provider. The information will be used by the Universal Service Administrative Company and/or the staff of the Federal Communications Commission, to evaluate this form, to provide information for enforcement and rulemaking proceedings and to maintain a current inventory of applicants, health care providers, billed entities, and service providers. No authorization can be granted unless all information requested is provided. Failure to provide all requested information will delay the processing of the application or result in the application being returned without action. Information requested by this form will be available for public inspection. Your response is required to obtain the requested authorization.

The public reporting for this collection of information is estimated to average X hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the required data, and completing and reviewing the collection of information. If you have any comments on this burden estimate, or how we can improve the collection and reduce the burden it causes you, please write to the Federal Communications Commission, AMD-PERM, Paperwork Reduction Act Project (3060-0804), Washington, DC 20554. We will also accept your comments regarding the Paperwork Reduction Act aspects of this collection via the Internet if you send them to pra@fcc.gov. PLEASE DO NOT
SEND YOUR RESPONSE TO THIS ADDRESS.

Remember - You are not required to respond to a collection of information sponsored by the Federal government, and the government may not conduct or sponsor this collection, unless it displays a currently valid OMB control number or if we fail to provide you with this notice. This collection has been assigned an OMB control number of 3060-0804.

THE FOREGOING NOTICE IS REQUIRED BY THE PRIVACY ACT OF 1974, PUBLIC LAW 93-579, DECEMBER 31, 1974, 5 U.S.C. 552a(e)(3) AND THE PAPEWORK REDUCTION ACT OF 1995, PUBLIC LAW 104-13, OCTOBER 1, 1995, 44 U.S.C. SECTION 3507.

FCC Form 461

FCC Form
462

Approval by OMB XXXX-XXXX
Estimated time per response: XXX

Rural Health Care (RHC) Universal Service
Healthcare Connect Fund
Funding Request Form

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.

Block 1: General Information	
1 Funding Year _____	2 Funding Request Number (FRN):
3 HCP Number:	4 HCP Name/Consortium Name:

Block 2: Competitive Bidding Information
5 FCC Form 461 Application Number:
6 Allowable Contract Selection Date (ACSD):
7 Number of vendors who bid:
8 Applicant's request is exempt from competitive bidding. ☐ Evergreen Contract Evergreen Contract ID: Friendly Name:
☐ The annual cost of services received is equal to or less than $10,000
☐ Applicant is purchasing services from a Government Master Services Agreement
☐ Applicant is purchasing services from a master contract negotiated through the E-rate Program

Block 3: Service Provider Information		
9 Service provider identification number (SPIN):		
10 Service provider name:	11 Service provider contact information:	
12 Address Line 2		
13 Address Line 2	14 County	
15 City	16 State	17 Zip Code
18 Phone	19 Email	

Block 4: Type of Funding Request
20 ☐ Individual HCP, single service ☐ Individual HCP, multiple services ☐ Consortium Application

Block 5: Single Service Request for Funding	
21 Category of Service	22 Service Type
23 Bandwidth	23a Is this service symmetrical? ○ Yes ○ No If no, what is the upload bandwidth _____. What is the download bandwidth _____.
24 Circuit ID (optional)	
25 Percentage of service used for provision of health care (eligible usage)	
26 Does the Service Type include both eligible and ineligible components? ○ Yes ○ No If yes, what percentage is eligible? _____	
27 Billing Account Number (BAN)	28 Date contract signed/circuit end location
29 Expected service start date	30 Contract expiration date (write N/A if month-to-month)
31 Circuit start location	32 Circuit end location
33 Monthly rate	34 Source of HCP contribution
35 One-time installation charge	36 Is this a multi-year funding request? ○ Yes ○ No
37 Number of months requested	Multi-year commitments cannot exceed 36 months of funding and may not extend beyond the expiration date of an Evergreen Contract.

38 This contract contains a Service Level Agreement. ○ Yes ○ No If yes, provide the following information concerning the SLA in the contract: a. Latency: b. Jitter: d. Packet Loss: d. Reliability:	
Block 6: Multi Service and Consortium Requests for Funding (attach Network Cost Worksheet)	
39 Total cost for eligible monthly recurring service	
40 Total cost for eligible non-recurring service	
Block 7: Additional Documentation	
41 List all supporting documentation (Competitive bids, Contract, etc.) that is required to be submitted with this form. Type of Documentation a. b. c.	
Block 8: Additional Information	
42 Election for Invoice Initiation: ☐ Applicant will request that service provider initiate invoicing process ☐ Applicant will initiate invoicing process	
43 I certify that financial information including, but not limited to, pricing, bids, and contract terms, is confidential and the public disclosure of such information would likely cause substantial harm to the competitive position of the associated parties. I request nondisclosure of this information contained in or submitted with this form pursuant to section 0.459 of the Commission's rules. ○ Yes ○ No	
Block 9: Certifications	
44 ☐ I certify that I am authorized to submit this request on behalf of the health care provider or consortium, and that I have examined this form and attachments and to the best of my knowledge, information, and belief, all statements of fact contained herein are true.	
45 ☐ I certify that the health care provider or consortium has considered all bids received and selected the most cost-effective method of providing the requested services. The "most cost-effective service" is defined as the "method that costs the least after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems relevant to choosing a method of providing the required health care services." 47 C.F.R. Sec. 54.642(c).	
46 ☐ I certify that all Healthcare Connect Fund support will be used only for the eligible program purposes for which support is intended.	
47 ☐ I certify that the health care provider or consortium is not requesting support for the same service from both the Telecommunications Program and the Healthcare Connect Fund.	
48 ☐ I certify that the health care provider or consortium satisfies all of the requirements under Section 254 of the Telecommunications Act of 1996, as amended, and applicable Commission rules, and understand that any letter from the Administrator that erroneously commits funds for the benefit of the applicant may be subject to recission.	
49 ☐ I certify that I have reviewed all applicable requirements for the program and will comply with those requirements.	
50 ☐ I certify that all documentation associated with this application including all bids, contracts, scoring matrices, and other information associated with the competitive bidding process, and all billing records for services received must be retained for a period of five years pursuant to 47 C.F.R. Sec. 54.648.	
51 Signature	52 Date
53 Printed Name of Authorized Person	
54 Title/Position of Authorized Person	
55 Phone Ext.	56 Email
57 Employer of Authorized Person	58 Employer's FCC RN

FCC Form 462

Persons willfully making false statements on this form can be punished by fine or forfeiture under the Communications Act, 47 U.S.C. Secs. 502, 503(b), or fine or imprisonment under Title 18 of the United States Code, 18 U.S.C. Sec. 1001.

FCC NOTICE FOR INDIVIDUALS REQUIRED BY THE PRIVACY ACT AND THE PAPERWORK REDUCTION ACT
Part 3 of the Commission's Rules authorize the FCC to request the information on this form. The purpose of the information is to determine your eligibility for certification as a health care provider. The information will be used by the Universal Service Administrative Company and/or the staff of the Federal Communications Commission, to evaluate this form, to provide information for enforcement and rulemaking proceedings and to maintain a current inventory of applicants, health care providers, billed entities, and service providers. No authorization can be granted unless all information requested is provided. Failure to provide all requested information will delay the processing of the application or result in the application being returned without action. Information requested by this form will be available for public inspection. Your response is required to obtain the requested authorization.

The public reporting for this collection of information is estimated to average X hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the required data, and completing and reviewing the collection of information. If you have any comments on this burden estimate, or how we can improve the collection and reduce the burden it causes you, please write to the Federal Communications Commission, AMD-PERM, Paperwork Reduction Act Project (3060-0804), Washington, DC 20554. We will also accept your comments regarding the Paperwork Reduction Act aspects of this collection via the Internet if you send them to pra@fcc.gov. PLEASE DO NOT
SEND YOUR RESPONSE TO THIS ADDRESS.

Remember - You are not required to respond to a collection of information sponsored by the Federal government, and the government may not conduct or sponsor this collection, unless it displays a currently valid OMB control number or if we fail to provide you with this notice. This collection has been assigned an OMB control number of 3060-0804.

THE FOREGOING NOTICE IS REQUIRED BY THE PRIVACY ACT OF 1974, PUBLIC LAW 93-579, DECEMBER 31, 1974, 5 U.S.C. 552a(e)(3) AND THE PAPEWORK REDUCTION ACT OF 1995, PUBLIC LAW 104-13, OCTOBER 1, 1995, 44 U.S.C. SECTION 3507.

FCC Form 462

Rural Health Care (RHC) Universal Service
Healthcare Connect Fund
Network Cost Worksheet (attach, if required, to form 462)

HCP Information	HCP Number																								
	HCP Name																								
Contract Information	Date Contract Signed/Carrier Selected																								
	Contract Expiration Date																								
	Billing Account Number																								
Quality of Service Requirements (if available)	Service Level Agreement?																								
	Latency																								
	Jitter																								
	Packet Loss																								
	Reliability																								
Circuit Information	Circuit ID (optional)																								
	Expected Service Start Date																								
	Circuit Start Location																								
	Circuit End Location																								
Services Received Information	Category of Service																								
	Service Type																								
	Bandwdith																								
	Is this Service Symmetrical?																								
	Upload Bandwidth																								
	Download Bandwidth																								
Financial Information	Quantity of Items																								
	Is this a Recurring Expense?																								
	Cost Per Quantity																								
	Explanation of Service Received																								
	Percentage of Service Type Eligible																								
	Percentage of Service Used for Provision of Healthcare																								
	Source of HCP Contribution																								
Multi-Year Funding Information (not to exceed 36 months)	Do you wish to receive a multi-year commitment?																								
	Quantity of Months																								

FCC Form 463
Rural Health Care (RHC) Universal Service
USAC Invoice and Request for Disbursement

Approval by OMB XXXX-XXXX
Estimated time per response: XXX

Funding Request Number		**RHC Invoice Number**	
Funding Year		**SPIN**	
HCP Number		**Service Provider Name**	
HCP Name/Consortium Name		**Total Invoice Amount**	

						Items Requested				**USAC Internal Use Only**		
FRN ID	**HCP Number**	**HCP Name**	**Category of Service**	**Service Type**	**Bandwidth**	**Installation Date of Service**	**Billing Period Start Date**	**Billing Period End Date**	**Total Actual Cost**	**Percent of Service Eligible**	**Total Eligible Actual Cost**	**USF Support Amount to be paid (65%)**

Request for Confidentiality

I certify that financial information including, but not limited to, pricing, bids and contract terms, is confidential and the public disclosure of such information would likely cause substantial harm to the competitive position of the associated parties. I request nondisclosure of this information contained in or submitted with this form pursuant to section 0.459 of the Commission's rules. _____ Yes _____ No

Service Provider Certification

I certify that I am an authorized representative of the above-named service provider, that I have examined the information provided in the Rural Health Care Healthcare Connect Fund Invoice, and to the best of my knowledge, information and belief, all costs contained in this invoice are true and correct and represent actual incurred costs for components (services) received by the health care providers(s) listed above.

Signature : _____ **Date** : _____
Name : _____ **Phone** : _____ **Email** : _____

Health Care Provider/Consortium Certification

I certify that I have examined the information provided in the Rural Health Care Healthcare Connect Fund Invoice, and to the best of my knowledge, information and belief, the health care provider or consortium has received the related services itemized on this invoice.

I certify under penalty of perjury that the 35 percent minimum funding contribution for each item on this invoice required by the Healthcare Connect Fund rules was funded by eligible sources as defined in the rules and has been provided to the service provider listed above.

Signature : _____ Date : _____
Name : Phone : Email :

Persons willfully making false statements on this form can be punished by fine or forfeiture under the Communications Act, 47 U.S.C. Secs. 502, 503(b), or fine or imprisonment under Title 18 of the United States Code, 18 U.S.C. Sec. 1001.

FCC NOTICE FOR INDIVIDUALS REQUIRED BY THE PRIVACY ACT AND THE PAPERWORK REDUCTION ACT

Part 3 of the Commission's Rules authorize the FCC to request the information on this form. The purpose of the information is to determine your eligibility for certification as a health care provider. The information will be used by the Universal Service Administrative Company and/or the staff of the Federal Communications Commission, to evaluate this form, to provide information for enforcement and rulemaking proceedings and to maintain a current inventory of applicants, health care providers, billed entities, and service providers. No authorization can be granted unless all information requested is provided. Failure to provide all requested information will delay the processing of the application or result in the application being returned without action. Information requested by this form will be available for public inspection. Your response is required to obtain the requested authorization.

The public reporting for this collection of information is estimated to average X hours per response, including the time for reviewing instructions, searching

existing data sources, gathering and maintaining the required data, and completing and reviewing the collection of information. If you have any comments on this burden estimate, or how we can improve the collection and reduce the burden it causes you, please write to the Federal Communications Commission, AMD-PERM, Paperwork Reduction Act Project (3060-0804), Washington, DC 20554. We will also accept your comments regarding the Paperwork Reduction Act aspects of this collection via the Internet if you send them to pra@fcc.gov. PLEASE DO NOT SEND YOUR RESPONSE TO THIS ADDRESS.

Remember - You are not required to respond to a collection of information sponsored by the Federal government, and the government may not conduct or sponsor this collection, unless it displays a currently valid OMB control number or if we fail to provide you with this notice. This collection has been assigned an OMB control number of 3060-0804.

THE FOREGOING NOTICE IS REQUIRED BY THE PRIVACY ACT OF 1974, PUBLIC LAW 93-579, DECEMBER 31, 1974, 5 U.S.C. 552a(e)(3) AND THE PAPEWORK REDUCTION ACT OF 1995, PUBLIC LAW 104-13, OCTOBER 1, 1995, 44 U.S.C. SECTION 3507.

APPENDIX F

List of Commenters

Comments on July 15, 2012 NPRM

Commenter	Abbreviation/Short Name
Advanced Regional Communications Cooperative	ARCC
Alaska Communications Systems	ACS
American Academy of Home Care Physicians	AAHCP
American Hospital Association	AHA
American Telemedicine Association	ATA
Arizona Rural Health Office	ARHO
AT&T	AT&T
ATC Broadband	ATC
Avera Health	Avera
Benton Foundation	Benton
Broadband Principals	Broadband Principals
California Hospital Association	CHA
California Public Utilities Commission	CPUC
California Telehealth Network	CTN
Centerstone Research Institute	CRI
Charter Communications, Inc.	Charter
Colorado Health Care Connections & Rocky Mountain HealthNet	CHCC/RMHN
Eastern Montana Telemedicine Network	EMTN
Evangelical Lutheran Good Samaritan Society	ELGSS
Fort Drum Regional Health Planning Organization	FDRHPO
Geisinger Health System	Geisinger
General Communications Inc.	GCI
Health Information Exchange of Montana	HIEM
Healthsense, Inc.	Healthsense
Illinois Rural HealthNet	IRHN
Immarsat, Inc.	Immarsat
Internet2 Ad Hoc Health Group	Internet2
Iowa Health System	IHS
Long Term and Post Acute Care Collaborative of Associations	LTPACCA
Mike Knutson	Mike Knutson
Modern Technologies Group, AirCom Consultants, and Quality Tower Services, Ltd.	MTG
Montana Independent Telecommunications Systems	MITS
Montana Telecommunications Association	MTA
Motorola, Inc.	Motorola
National Association of Black Owned Broadcasters	NABOB
National Association of State EMS Officials	NASEO
National LambdaRail	NLR
National Rural Health Association	NRHA
National Telecommunications Cooperative Association	NTCA
Nebraska Statewide Telehealth Network	NSTN
New England Telehealth Consortium	NETC
North Carolina Telehealth Network (David Kirby)	NCTN

Oregon Association of Hospitals and Health Systems	OAHHS
Oregon Health Network and Telehealth Alliance of Oregon	OHN
Palmetto State Providers Network	PSPN
Paul Amendt	Paul Amendt
PEM Filings, LLC	PEM
Qualcomm, Inc.	Qualcomm
Qwest Communications	Qwest
Rural Nebraska Health Care Network	RNHN
Rural Wisconsin Health Cooperative Information Technology Network	RWHC
Southwest Alabama Community Mental Health	SWAMH
Telecommunications Industry Association	TIA
TeleQuality Communications	TeleQuality
Texas Health Information Network Collaborative	TxHINC
United States Department of Health and Human Services	HHS
University of Arkansas for Medical Sciences	UAMS
University of Hawaii Telecommunications and Information Policy Group	UHTIPG
University of Virginia Office of Telemedicine	UVA
USF Consultants	USF Consultants
Utah Telehealth Network	UTN
Verizon and Verizon Wireless	Verizon
Virginia Telehealth Network	VTN
Washington Rural Health Association	WRHA
West Wireless Health Institute	WWHI

Reply Comments on July 15, 2012 NPRM

Commenter	Abbreviation/Short Name
Advocates for EMS	AEMS
American Telemedicine Association	ATA
Association of Public Safety Communications Officials Int'l	APCO
AT&T	AT&T
CenturyLink	CenturyLink
Charter Communications, Inc.	Charter
Chippewa Valley Hospital	Chippewa
Colorado Rural Health Center	CRHC
Comcast	Comcast
Continua Health Alliance	Continua
General Communications, Inc.	GCI
Geisinger Health System	Geisinger
Georgia State Office of Rural Health	GSORH
Hawaiian Telecom	HT
Health Information Exchange of Montana	HIEM
Health IT Now Coalition	HITNC
Horizon Telecom	Horizon
Hughes Network Systems	HNS
Illinois Critical Access Hospital Network	ICAHN
International Association of Chiefs of Police	IACP
International Association of Fire Chiefs	IAFC
Internet2 Ad Hoc Health Group	Internet2
Iowa EMS Association	IEMSA

Iowa State Office of Rural Health	ISORH
Kansas EMS Association	KEMSA
Kentucky Office of Rural Health	KORH
Marshfield Clinic	Marshfield
Michigan Department of Community Health	MDCH
Modern Technologies Group, AirCom Consultants, and Quality Tower Services Ltd	MTG
Montana Telecommunications Association	MTA
National Association of Emergency Medical Technicians	NAEMT
National Association of EMS Physicians	NAEMSP
National Association of Telecommunications Offices and Advisors	NATOA
National EMS Management Association	NEMSMA
National LambdaRail	NLR
National Organization of State Offices of Rural Health	NOSORH
National Sheriffs' Association	NSA
New Hampshire Department of Health and Human Services	NHDHHS
North Arkansas Regional Medical Center EMS	NARMC
North Carolina Office of Rural Health and Community Care	NCORHCC
National Telecommunications Cooperative Association	NTCA
Oklahoma Ambulance Association	OAA
Oklahoma EMT Association	OEMTA
Rhode Island Office of Primary Care and Rural Health	RIOPCRH
Ripon Medical Center	Ripon
Rural Nebraska Health Care Network	RNHN
South Carolina Office of Rural Health	SCORH
Sprint Nextel	Sprint
Texas Statewide Telephone Cooperative	TSTC
USF Consultants	USF Consultants
UW Health Partners – Watertown Regional Medical Center	UW
ViaSat and WildBlue	ViaSat
Virginia Telehealth Network	VTN
West Virginia Department of Rural Health and Recruitment	WVDRHR

Comments on July 19, 2012 Public Notice

Commenter	Abbreviation/Short Name
Alaska Communications Systems	ACS
American Academy of Pediatrics	AAP
American Hospital Association	AHA
American Telemedicine Association (Jonathan Linkous)	ATA
California Telehealth Network	CTN
CDCR California Correctional Health Care Services	CCHCS
Colorado Health Care Connections and Rocky Mountain HealthNet	CHCC/RMHN
Geisinger Health System	Geisinger
General Communication, Inc.	GCI
Health Information Exchange of Montana	HIEM
Illinois Rural HealthNet	IRHN
Indiana Telehealth Network (Don Kelso)	ITN
Iowa Rural Health Telecommunications Program	IRHTP
MiCTA (Gary Green)	MiCTA
Missouri Telehealth Network	MTN
Montana Telecommunications Association	MTA
National Telecommunications Cooperative Association	NTCA
North Carolina TeleHealth Network	NCTN
Oregon Health Network	OHN
Rural Wisconsin Health Cooperative (Louis Wenzlow)	RWHC
Southwest Telehealth Access Grid	SWTAG
St. Joseph's Hospital/Hospital Sisters Health System	HSHS
Telecommunications Industry Association	TIA
The University of Arkansas for Medical Sciences	UAMS
United Way Worldwide and United Ways of California	United Way
USF Consultants	USF Consultants
Utah Telehealth Network	UTN
Western New York Rural Area Health Education Center	WNYRAHEC

Reply Comments on July 19, 2012 Public Notice

Commenter	Abbreviation/Short Name
California Broadband Council	CBC
California Emerging Technology Fund	CETF
California Hospital Association	CHA
California Rural Indian Health Board	CRIHB
Charter Communications, Inc.	Charter
Eastern Plumas Health Care	EPHC
General Communication, Inc.	GCI
Health Information Exchange of Montana	HIEM
Manchester Community Technologies, Inc.	MCT
Nevada Hospital Association	NHA
New England Telehealth Consortium	NETC
Rural Nebraska Healthcare Network	RNHN
UC Davis (Michael Minear)	UC Davis
Virginia Acute Stroke Telehealth Network	VAST

STATEMENT OF
CHAIRMAN JULIUS GENACHOWSKI

Re: *Rural Health Care Support Mechanism*, WC Docket No. 02-60.

Earlier this year, I visited Barton Memorial Hospital, part of the path-breaking California Telehealth Network, to see first-hand how FCC Universal Service funding has improved health care for people in the area. At Barton, doctors and nurses are using broadband to enable remote examination through a live IP video feed and a relatively inexpensive telemedicine cart. Patients in rural El Dorado County are now being treated by specialists as far away as San Francisco, San Diego, Irvine, and Reno. And Barton has expanded its remote services to include cardiology, infectious disease, neurology and other specialties for which there are no specialists at Barton.

So patients who before had to travel many miles and many hours, or forgo diagnosis or care, can now have access to experts while staying in their home town.

This is transformational, and it's hardly the only example in our pilot program. In Florence, South Carolina, high-risk expectant mothers used to travel 168 miles to see a doctor. If the doctor drove there, he or she only had time to see each patient for 3 minutes. Now, unnecessary travel is eliminated and the doctor sees patients for an average of 30 minutes during each tele-consult. In Jefferson County, Iowa, patients used to have to wait 3 to 4 hours to have a radiology scan read. Now, it only takes half an hour. In North Carolina, the turnaround time for diagnosing communicable disease outbreaks has gone from 5 to 10 days, to 24 to 48 hours. These are cases where speed can be literally life-or-death.

And here's another important learning from our pilot program: telemedicine simultaneously drives down costs. In South Dakota, e-ICU services have saved eight hospitals over $1.2 million in patient transfer costs over just 30 months. In upstate New York, a network of about 50 providers expect $9 million in cost savings from providing cardiology, trauma, mental health, neurology and respiratory services over their broadband connections.

Broadband can revolutionize healthcare in our country, with powerful potential to improve quality of care for patients, while saving billions of dollars. But we'll only realize the full benefits of this incredible technical revolution if we get all our hospitals and clinics connected. The new Healthcare Connect program will expand the Commission's health care broadband initiative from pilot to program. It will allow thousands of new providers across the country to share in the benefits of connectivity and dramatically cut costs for both hospitals and USF. These are transformational changes that build on our major reforms across our universal service system.

For years, the FCC's primary healthcare program has made it much more difficult than it should be for hospitals serving rural patients to get high bandwidth connections of the kind that are needed for modern telemedicine. It does this in two ways: by limiting funding to telecommunications services, and by creating a complex discount formula that makes it hard for consortia to effectively bargain for the lowest cost service. So even where hospitals can get broadband connections under the program, they are often incredibly expensive, both for the hospital and for USF. Today's reform builds on the success of the Pilot program, and especially the model of state and regional health networks. Using this model, the new Healthcare Connect Fund will finally allow hospitals across the country to get broadband, while driving down costs.

In fact, based on the results in the Pilot program, we expect Healthcare Connect will bring thousands of new providers across the country into the program, and allow thousands of others to upgrade their connections. These providers offer lifesaving care to rural communities and small towns.

And Healthcare Connect could cut the costs of connections –for both providers and the Fund – in half. As we've done in reforming and modernizing all of our Universal Service programs, we've stayed true to our commitment to fiscal responsibility, maintaining the current overall program budget of $400 million, while increasing the program's impact within this limit.

Just as today's reform builds on the success of the existing pilot program, today we launch a new $50 million pilot to evaluate bringing skilled nursing facilities skilled nursing facilities into the Healthcare Connect program. These facilities allow skilled nursing staff to treat, manage, observe, and evaluate patients, many of whom have been recently discharged from the hospital. Skilled nursing facilities stand to benefit tremendously from participation in healthcare networks: nurses say that having the broadband connection is a "godsend" and it's like having the urban doctor "in the room" with them as they care for a patient.

And helping these nurses helps patients and saves money: patients can be discharged earlier from the hospital as they are recovering from injury or illness and get more focused care, closer to home. If they hit a bump on the road to recovery, they can be quickly evaluated for further care. So a patient who is recovering from open heart surgery in rural Virginia and develops an infection can have it diagnosed from afar. Or a resident in a facility in a small town in Kansas or Montana that develops a persistent cough can have chest X-rays sent to a doctor in a nearby hospital. And these consultations can save an ambulance trip or an emergency room visit, avoiding further complications.

We're starting with a rigorous, competitive trial because including these providers in the programs does raise some tricky issues. This is a fiscally responsible, data driven way to proceed, and we move ahead on completely solid legal ground. But it's vital that we do proceed so that we can harness the opportunities of broadband for health care as quickly as possible.

So yes, we're leaning forward here – but that's what it will to ensure that the broadband revolution doesn't bypass rural and low income Americans. It's the right choice and I thank Commissioners Clyburn and Rosenworcel for their support.

Let me also briefly address the idea of a "contingency plan" in case we hit the $400 million program cap. The staff's careful analysis makes clear that we're very unlikely to hit this cap within the next five years. But just in case, we've said we'll complete a rulemaking on this issue next year, well before any need could possibly arise, or any of the parade of horribles some have speculated about could occur.

I want to thank the team of the Wireline Bureau for their excellent, data intensive review of the healthcare pilot, and their careful, creative work to translate that review into the permanent Healthcare Connect Fund. Working on this program is especially challenging because it requires the team to develop an expertise not just in broadband, but also in healthcare. Linda Oliver and her team did a fantastic job.

When we said in the Broadband Plan that we were going to tackle Universal Service reform not just for schools and libraries, or for low-income Americans, or rural Americans, or Healthcare Providers and their patients – but for all of these groups, there were few who thought this Commission could get it done. Working together, we have. I'm grateful to each of my colleagues - and a special thanks to Commissioners McDowell and Clyburn who have been through, and made substantial contributions to, each of the reforms. People all across America are the beneficiaries of this vital and collaborative work.

Our staff has been amazing. Zac Katz, the FCC's Chief of Staff, has also been through each of the reforms, and this work reached a true level of excellence thanks to the two Bureau Chiefs, Sharon Gillett

and Julie Veach, and Michael Steffen in my office. I want to acknowledge one other person who deserves particular recognition for this achievement. The substantive and inspirational leader of this soup to nuts effort, scrutinizing and honing every sentence and every rule in all the orders, has been Carol Mattey. Today Carol completes the USF Grand Slam – a Steffi Graf level achievement. Carol, you are a model public servant, and the American people who ultimately benefit from our programs are better off for your service. Congratulations and thank you.

STATEMENT OF
COMMISSIONER ROBERT M. McDOWELL
APPROVING IN PART, CONCURRING IN PART, DISSENTING IN PART

Re: *Rural Health Care Support Mechanism,* WC Docket No. 02-60.

While the rural health care program is the smallest of the four Universal Service Fund (USF) programs, its size certainly does not diminish its value. The program has enabled the health care community to improve and expand services offered to patients in the most remote parts of our country.

I travelled to Alaska during my first few weeks as an FCC commissioner. I flew to the far ends of the Alaskan frontier to learn more about the health and communications challenges facing Alaska Natives and the telecommunications carriers that endeavor to serve them. I saw how medical images from the most remote corners of Alaska were transmitted to specialists in Anchorage. I learned how using telehealth technology can actually save money because, in many instances, having that technology close at hand means the patient can avoid flying hundreds of miles to a hospital. And, at other times, the patient may not be able to fly at all due to "white outs" or other extreme weather conditions.

Regarding Alaska, I am encouraged that these reforms do not undermine the current Rural Health Care Telecommunications Program which has proven to have been a success story and a critical component of health care service in that part of the country. In fact, this order specifically recognizes the importance of that particular program for places like Alaska.

Unfortunately, not all parts of rural America have been able to benefit from the current rural health care program as successfully as in Alaska. As such, I support the Commission's reform efforts today which originated from lessons learned after the Commission's tireless analysis of the FCC's pilot program that I supported several years ago. For example, we are embracing the valuable benefits that can flow from health care providers working together to create consortia which can spark a virtuous cycle of investment and opportunity. Our action today will promote efficiencies in the system and ensure that taxpayers' funds are being used wisely. Additionally, it is fiscally responsible for the Commission to require a thirty-five percent contribution from participants. These comprehensive reform efforts will hopefully encourage participation throughout rural America.

I have, however, raised concerns that the new program only requires that a "majority" of consortia members be rural. While some rural health care participants may benefit by using the experts and specialists that non-rural participants can offer as members of a consortia, simply requiring a "majority" of the members to be rural is insufficient. The intended focus of this USF program should be for *rural* America, that is, parts of the country that typically are far from hospitals. Although I had hoped for a higher minimum threshold, I appreciate the fact that the order includes language that the Commission expects that the percentage of participants will be on average higher than 51 percent and, if not, the Commission commits to commencing a proceeding to reevaluate the percentage.

Additionally, I am pleased that the Commission maintains the $400 million annual spending cap, but I am not convinced that the annual demand will stay below the cap in the foreseeable future, as projected in this order. As such it would have been more prudent for the Commission to include in this order a contingency plan to allocate priorities if the program does approach the spending cap. Due to these concerns, I concur in part.

Finally, without questioning the importance and value of skilled nursing facilities, I respectfully dissent from the portion of the order that establishes a pilot program to include these facilities as eligible entities. It is not fiscally prudent for the Commission to launch a new pilot program without first waiting

to see how our overall reforms will affect the demand for the program. Furthermore, I am disappointed that the Commission's record does not indicate whether ongoing support of skilled nursing facilities could be accomplished in a manner that is "technically feasible and economically reasonable,"[1] as the statute requires. We certainly shouldn't be laying the foundation for inflating the program before assessing the effect of the other reforms we adopt today.

In sum, I appreciate the Chairman's leadership on guiding these reforms through the process. And, I thank the dedicated staff in the Wireline Competition Bureau who have spent countless hours analyzing the successes and failures of the prior rural health care program and pilot in an effort to assemble reforms that are designed to enhance health care in rural America in a way that will be fiscally responsible and administratively feasible. I look forward to continue working with my colleagues on these issues as this order is implemented.

[1] 47 U.S.C. § 254(h)(2)(A).

STATEMENT OF
COMMISSIONER MIGNON L. CLYBURN

Re*:* *Rural Health Care Support Mechanism*, WC Docket No. 02-60.

Today's Order to create the Healthcare Connect Fund is a momentous event—one in the making since the Commission voted a Further Notice just over two years ago. Before I discuss its importance for consumers, I must first acknowledge the significance of the vote itself: this marks the fourth time, under the leadership of Chairman Genachowski that the FCC has voted to reform a Universal Service Fund program, as recommended by the National Broadband Plan. We have now implemented significant reforms for every program in the Fund, and what this means for us all, is that now each program is better equipped, to serve Americans in today's broadband world. Mr. Chairman, congratulations. Well done. And I am proud to support your Order.

The Chairman assembled an incredible team in this reform effort, so I must also acknowledge Zac Katz, Michael Steffen, and the rest of the team including Julie Veach, who became Bureau Chief this summer and hit the ground running, and Carol Mattey, her Deputy, who has been intimately involved with reforming each USF program since the drafting phase of the National Broadband Plan. Carol's dedication to the universal service principles espoused by the Act, is second to none. Of course, she has a team of people in the Telecommunications Access Policy Division, led by Trent Harkrader and assisted by Linda Oliver, who have been diligently assessing and improving upon the Rural Healthcare Pilot Program. The Rural Healthcare team prepared a well written report this summer on the Pilot Program, then applied the lessons learned from it, as reflected in today's Order. Implementing the USF reforms we already have undertaken is a significant task, so I am especially grateful that you continued to work on this program as well. That commitment will help ensure that rural Americans have better access to healthcare, through the Fund, which is an important goal for our nation.

Many of you know that I am from South Carolina, and in addition, I have had the privilege to visit other rural states since joining this Commission. I've seen first-hand how rural healthcare networks can make a difference in our citizens' lives. Through the Palmetto State Providers Network back home, an at-risk expectant mother can now receive quality prenatal care, without having to travel a long distance, at great expense, missing work and pay. A head injury patient in rural Montana, can now have his CT scan read in minutes, averting a several hundred mile trip to Kalispell in an ambulance, saving time, money and more importantly his life. And in Barrow, Alaska, that person needing psychiatric care, will be in a better position to have her needs met, without leaving familiar surroundings. Our record is full of examples of the important benefits rural healthcare networks provide, the lives that have been saved, and the significant out of pocket and Medicaid and health insurance costs that have been avoided.

So yes, I say momentous. Today's Order *is* momentous. We are moving forward in supporting new broadband networks and services, recognizing that we should build on the successes of the consortia formed in the Pilot Program. We are avoiding wasteful spending, by requiring that competitive bids be solicited for both broadband services and infrastructure, and that participants must choose the most cost effective option. Moreover, through the provisioning of a 65 percent discount for both services and infrastructure, the program will not advantage one type of support over the other. This reformed framework encourages consortia to realize the many benefits they offer, such as faster broadband speeds at lower costs, but it will not punish single site needs. We are permitting both consortia and single site entities to apply, and we have struck the right balance of encouraging consortia with a mix of rural and urban, by requiring that more than 50 percent of the consortia must be rural.

Our staff has taken great care, to make the Rural Healthcare Connect Fund simple for participants as well as for USAC, the Fund's administrator. Clear rules have been put forth to advance our objectives,

of increasing health care providers access to broadband in rural areas, and fostering the development of health care broadband networks, while increasing program efficiency. But the good news does not stop there.

Because they always are planning ahead, staff is proposing a skilled nursing facilities pilot program, to determine whether such facilities, should be eligible under the permanent program. It is believed that if supported, this type of program will afford optimal care for patients, who are too sick to stay at home, but not ill enough for a hospital admission. Broadband is especially useful for these facilities, as it permits a doctor to be virtually present, and offers patients and their families' increased peace of mind. As we have seen from the Commission's earlier Pilot Program, we learn a great deal from those pilots, before implementing changes to our programs. Thus, I fully support the Chairman's plan, to implement a time-limited pilot, for skilled nursing facilities.

Finally, staff has put together a thoughtful outreach plan, to inform healthcare facilities, of the Healthcare Connect Fund in order to help promote the benefits this new program. It is important, as we implement modifications to our programs and offer new opportunities, that we do our part, to inform the public, about these modifications. We've seen success in other recently reformed programs, such as Lifeline, when we put great care in providing information to the public, working with our sister agencies in the federal government, and with other state and local government entities, in addition to distributing details of the changes to affected industries and those who represent them.

We are living longer, playing harder; working, residing and vacationing in places that, not so long ago, seemed out of reach. On top of and as a result of these trends, with our healthcare bills rising, and the demand of electronic health records becoming the norm, broadband has the greatest potential to aid us in realizing the optimal efficiencies in healthcare service delivery in even the most remote areas of this nation. With the implementation of the Healthcare Connect Fund, facilities in rural, currently underserved communities will now have opportunities to obtain desired broadband services, allowing for better healthcare to their areas. I am pleased to support this Order which gives expanded and deserved critical services to rural America.

STATEMENT OF
COMMISSIONER JESSICA ROSENWORCEL

Re*:* *Rural Health Care Support Mechanism*, WC Docket No. 02-60.

Like some of my colleagues, I have had the chance to see the power of telemedicine up close and at work. I have watched as pediatric surgeons in California share their expertise via video with patients many miles away. I have seen how village clinics in rural Alaska use broadband to provide first-class care to patients in some of this country's most remote communities. These experiences amaze because they can challenge our traditional notions of health care. They can collapse distance and time; enhance the quality of care; improve outcomes; and lower costs.

Today's Report and Order seizes this transformative power by updating our rural health care universal service mechanism with a new Healthcare Connect Fund. The Commission's existing universal service rural health care programs have had some success, but I believe they are also due for a check-up. After all, good programs do not thrive without continuous attention and care, and I am hopeful that today's order will position this program for doing even more good in the days ahead.

I am optimistic. Because in critical part, today's decision addresses three key recommendations made by the Government Accountability Office in its 2010 assessment of the agency's universal service rural health care programs. This is important.

First, the Commission evaluated its Pilot Program and assessed the communications needs of rural health care providers. To this end, the new program encourages applications by consortia that include both urban and rural health care providers, fostering higher capacity services at lower cost.

Second, the Commission coordinated with both the Department of Health and Human Services and Universal Service Administrative Company in crafting the Healthcare Connect Fund. In addition, we set the stage for additional coordination going forward. The ability to draw regularly on experts in program administration, telemedicine, and telehealth is essential.

Third, the Commission has put in place clear performance goals and measures to ensure that this program will do what it is intended to do: increase broadband access for health care providers and support the deployment of health care networks in a cost-effective manner.

This is good governance and good medicine. It has my full support. Thank you to the Wireline Competition Bureau for its efforts.

STATEMENT OF
COMMISSIONER AJIT PAI
APPROVING IN PART AND DISSENTING IN PART

Re: *Rural Health Care Support Mechanism*, WC Docket No. 02-60.

When I was growing up, I remember my father getting up early in the morning to drive from our hometown of Parsons 45 minutes west in order to provide medical care in the town of Independence. On another day, he would drive 45 minutes north to do the same in the town of Chanute. Other towns were on his itinerary as well. In most cases, he was the only specialist residents of those towns would ever have a chance to see. When I think of how far he went, literally and figuratively, to deliver health care to people in Southeast Kansas, it makes me appreciate the power of today's communications services all the more. With a broadband connection, we can improve health care and reduce substantially the burdens on doctors and patients alike in rural Kansas and many other places.

This background, together with our careful analysis of lessons learned from the 2006 rural health care pilot program, explains why I support the vast majority of today's item, including all of the reforms that create the Healthcare Connect Fund. I am especially pleased that a majority of participants in this program must be rural health care providers. Connecting country clinics to facilities in big cities like Wichita and Kansas City will enhance the services that all Americans receive in their hometowns and ensure that people have access to advanced medicine and health care services no matter where they live.

Similarly, I believe today's order strikes an appropriate balance in several other respects. The uniform discount we adopt should provide ample incentive for eligible providers to join a consortium and participate. The significant contribution we require from participants aligns their incentives with those of universal service contributors. The option to construct facilities gives health care providers a competitive alternative. And the safeguards we adopt ensure that existing broadband network operators will have a full and fair opportunity to compete for that business.

There are two parts of today's item, unfortunately, where I part ways with my colleagues. The first part involves the Skilled Nursing Facility Pilot Program. The order recognizes that, "on this record," this program may not comply with Section 254 of the Communications Act. That provision directs us to support "health care providers,"[1] and yet the order reaches "no conclusion about whether or under what circumstances a [skilled nursing facility] might qualify as a health care provider under the statute."[2] It's also fair to say that we have not had the chance to assess how the reforms we implement today will work

[1] 47 U.S.C. § 254(h)(2)(A).

[2] *Report and Order*, para. 346. A post-adoption footnote now directs the Bureau to "approve any given application only to the extent that it demonstrates that it satisfies the statutory criteria," *i.e.*, the application must show that funding skilled nursing facilities will "enhance eligible [health care provider] access to 'advanced telecommunications and information services.'" *Id*. at n.798. I welcome the news that the statutory criteria will now play a factor in the administration of the Pilot Program. But this direction is wholly unhelpful. Skilled nursing facilities do not offer "advanced telecommunications and information services" any more than banks or grocery stores do. I therefore do not see how funding skilled nursing facilities could "enhance" the access of an eligible health care provider to such services; indeed, the sparse explanation contained in the item would appear to justify also including in the rural health care program banks, grocery stores, or *any* entity that could be connected to a health care provider. To be sure, including a skilled nursing facility in the program could be authorized by the statute if it were itself an eligible health care provider—but that, of course, is precisely the question the Commission cannot answer "on this record."

on the ground and how much the new Healthcare Connect Fund will cost. Nonetheless, the order instructs the Bureau to set up the Pilot Program—without specifying any rules or giving much guidance. In my view, it is a mistake to go forward with this program before the full Commission figures out the basics, namely how the program will work and whether it complies with the Communications Act.

The second part involves the rural health care program's budget caps. The order defers hard decisions about enforcing these caps. This leaves in place the current first-come-first-served system. As a result, everyone who submits an application will get fully funded—until one day, they won't. Once we hit the cap, rural health care providers that long relied on the Telecommunications Program to span the breadth of Kansas or Alaska will be cut off, without forewarning or prioritization. Pilot program sites that have incorporated telemedicine into their practices will go offline. The Commission quickly abandoned this approach in the E-Rate program, and I do not think leaving that work for a later day serves health care providers who are starting their investment plans now.

Finally, I would be remiss not to thank the staff of Telecommunications Access Policy Division of the Wireline Competition Bureau for developing the reforms we adopt today: Christi Barnhart, Soumitra Das, Chas Eberle, Trent Harkrader, Beth McCarthy, Avis Mitchell, Linda Oliver, Michelle Schaefer, Geoff Waldau, Mark Walker, and Chin Yoo. These experts dug through the Code of Federal Regulations to find the 46 amendments to our rules (spanning 29 pages) needed to put the Healthcare Connect Fund in place. They also reviewed over twelve hundred filings since the Notice of Proposed Rulemaking and scrubbed over a thousand footnotes in the item. They remind us all that being a public servant is about *service*, and I thank you all for serving so adeptly.