in the *2006 Pilot Program Order*. For example, we clarify that eligible costs include the non-recurring costs for design, engineering, materials, and construction of fiber facilities and other broadband infrastructure; the non-recurring costs of engineering, furnishing, and installing network equipment; and the recurring and non-recurring costs of operating and maintaining the constructed network. We also clarify that ineligible costs include those costs not directly associated with network design, deployment, operations, and maintenance.

4. We provide specific guidance to the selected participants regarding how to submit existing FCC Forms to the universal service Fund Administrator, the Universal Service Administrative Company (USAC). For example, selected participants, in order to receive universal service support, must submit with the required FCC Forms detailed network costs worksheets concerning their proposed network costs, certifications demonstrating universal service support will be used for its intended purposes, and letters of agency from each participating health care provider. In order to receive reimbursement, selected applicants must also submit, consistent with existing processes and requirements, detailed invoices showing actual incurred costs of project build-out and, if applicable, network design studies. We also require that selected participants' network build-outs be completed within five years of receiving an initial funding commitment letter (FCL). As discussed below, selected participants that fail to comply with the terms of this Order and with the USAC administrative processes will be prohibited from receiving support under the Pilot Program. We also set forth data reporting requirements for selected participants where participants must submit to USAC and to the Commission quarterly reports containing data on network build-out and use of Pilot Program funds. This information will inform the Commission of the cost-effectiveness and efficacy of the different state and regional networks funded by the Pilot Program and of whether support is being used in a manner consistent with section 254 of the 1996 Act, and the Commission's rules and orders.

5. We also address various requests for waivers of Commission rules filed by applicants concerning participation in the Pilot Program. Among other things, we deny waiver requests of the Commission's rule requiring that Pilot Program selected participants competitively bid their proposed network projects. In doing so, we reaffirm that the competitive bidding process is an important safeguard for ensuring universal service funds are used wisely and efficiently by requiring the most cost-effective service providers be selected by Pilot Program participants.

6. In addition, we establish an audit and oversight mechanism for the Pilot Program to guard against waste, fraud, and abuse, and to ensure that funds disbursed through the Pilot Program are used for appropriate purposes. In particular, the Commission will conduct audits of all selected participants and, if necessary, investigations of any selected participants to determine compliance with the Pilot Program, Commission rules and orders, and section 254 of the 1996 Act. As discussed in greater detail below, because audits or investigations may provide information showing that a beneficiary or service provider failed to comply with the statute or Commission rules and orders, such proceedings can reveal instances in which Pilot Program disbursement awards were improperly distributed or used in a manner inconsistent with the Pilot Program. To the extent we find funds were not used properly, USAC or the Commission may recover such funds and the Commission may assess forfeitures or pursue other recourse.

7. Finally, selected participants shall coordinate the use of their health care networks with the Department of Health and Human Services (HHS) and, in particular, with its Centers for Disease Control and Prevention (CDC) in instances of national, regional, or local public health emergencies (*e.g.*, pandemics, bioterrorism). In such instances, where feasible, selected participants shall provide access to their supported networks to HHS, including CDC, and other public health officials. Similarly, selected participants shall use Pilot Program funding in ways that are consistent with HHS' health information technology (IT) initiatives that "provide leadership for the development and nationwide implementation of an interoperable health information technology infrastructure to improve the quality and efficiency of

health care."[5] Accordingly, where feasible, selected participants, as part of their Pilot Program network build-out projects shall: (1) use health IT systems and products that meet interoperability standards recognized by the HHS Secretary; (2) use health IT products certified by the Certification Commission for Healthcare Information Technology; (3) support the Nationwide Health Information Network (NHIN) architecture by coordinating their activities with the organizations performing NHIN trial implementations; (4) use resources available at HHS's Agency for Healthcare Research and Quality (AHRQ) National Resource Center for Health Information Technology; (5) educate themselves concerning the Pandemic and All Hazards Preparedness Act and coordinate with the HHS Assistant Secretary for Public Response as a resource for telehealth inventory and for the implementation of other preparedness and response initiatives; and (6) use resources available through CDC's Public Health Information Network (PHIN) to facilitate interoperability with public health organizations and networks.

II. BACKGROUND

A. Rural Health Care Support Mechanism

8. In the 1996 Act, Congress specifically intended that rural health care providers be provided with "an affordable rate for the services necessary for the provision of telemedicine and instruction relating to such services."[6] In 1997, the Commission implemented this statutory directive by adopting the current RHC support mechanism, funded by monies collected through the universal service fund.[7] Consistent with Congress's directive in 47 U.S.C. § 254(h)(1)(A), the Commission established the rural health care program to ensure that rural health care providers pay no more than their urban counterparts for their telecommunications needs in the provision of health care services.[8] To accomplish this, the Commission concluded that telecommunications carriers must charge eligible rural health care providers 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.[9] The Commission also adopted mechanisms to provide support for limited toll-free access to an Internet service provider.[10] Finally, the Commission adopted an annual cap of $400 million for universal service support for rural health care providers.[11] The Commission based its conclusions on analyses of the condition of the rural health care community and on the state of technology in existence at that time.[12]

9. Since 1997, the Commission has made several changes to the RHC support mechanism to increase its utility and to reflect technological changes. For example, in 1999, after determining that only a small number of rural health care providers qualified for discounts in the original funding cycle (which

[5] *See* Incentives for the Use of Health Information Technology and Establishing the Position of the National Health Information Technology Coordinator, Exec. Order No. 13335, 69 FR 24059 (April 27, 2004).

[6] *See* Joint Explanatory Statement of the Committee of Conference, 104th Cong., 2d Sess. at 133 (1996); *see also* 47 U.S.C. § 254(b)(3), (h).

[7] *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776 (1997) (*Universal Service First Report and Order*) (subsequent history omitted).

[8] *See, e.g.*, 47 U.S.C. § 254(h)(1)(A); *Universal Service First Report and Order*, 12 FCC Rcd at 9093-9161, paras. 608-749; 47 C.F.R. Part 54, Subpart G.

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

[10] *Id.*

[11] 47 C.F.R. § 54.623; *Universal Service First Report and Order*, 12 FCC Rcd at 9141, para. 705.

[12] *See Universal Service First Report and Order*, 12 FCC Rcd at 9094, n.1556 (relying on material supplied by the Advisory Committee on Telecommunications and Health Care and the Federal-State Joint Board on Universal Service).

covered the period from January 1, 1998, through June 30, 1999), the Commission reevaluated the structure of the RHC support mechanism.[13] Among other things, the Commission simplified the urban/rural rate calculation and encouraged participation by consortia.[14] The Commission also provided additional guidance regarding the types of entities that are not eligible to receive support, determining that the definition of "health care provider" does not include nursing homes, hospices, other long-term care facilities, or emergency medical service facilities.[15] The Commission declined to clarify further the definition of "health care provider" or to provide additional support for long distance telecommunications service.[16]

10. In 2002, the Commission issued a Notice of Proposed Rulemaking to review the RHC support mechanism.[17] In particular, the Commission sought comment on whether it should: clarify how the Commission treats eligible entities that also perform functions that are outside the statutory definition of "health care provider"; provide support for Internet access; or change the calculation of discounted services, including the calculation of urban and rural rates.[18] In addition, the Commission sought comment on whether and how to streamline the application process; allocate funds if demand exceeds the annual cap; modify the current competitive bidding rules; and encourage partnerships with clinics at schools and libraries.[19] The Commission sought further comment on other issues concerning the structure and operation of the RHC support mechanism, including measures to prevent waste, fraud, and abuse.[20]

11. In 2003, the Commission released the *2003 Report and Order and FNPRM* that modified its rules to improve the effectiveness of the RHC support mechanism.[21] Among other changes, the *2003 Report and Order and FNPRM*: (1) clarified that dedicated emergency departments of rural for-profit hospitals that participate in Medicare are "public" health care providers and are eligible to receive prorated rural health care support; (2) clarified that non-profit entities that function as rural health care providers on a part-time basis are eligible for prorated rural health care support; (3) revised the rules to provide a 25 percent discount off the cost of monthly Internet access for eligible rural health care providers; (4) revised the rules to allow rural health care providers to compare the urban and rural rates for functionally similar services as viewed from the perspective of the end user; (5) revised the rules to allow rural health care providers to compare rural rates to urban rates in any city with a population of at least 50,000 in the same state; and (6) revised the rules to allow rural health care providers to receive discounts for satellite services even where alternative terrestrial-based services may be available, but

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[13] *Changes to the Board of Directors of the National Exchange Carrier Association, Inc., Federal-State Joint Board on Universal Service*, CC Docket Nos. 97-21 and 96-45, Sixth Order on Reconsideration in CC Docket No. 97-21 and Fifteenth Order on Reconsideration in CC Docket No. 96-45, 14 FCC Rcd 18756, 18760-61, para. 7 (1999) (*Fifteenth Order on Reconsideration*) (noting that there were 2,500 initial applications, and only a small fraction received funding in the first funding cycle).

[14] *Fifteenth Order on Reconsideration*, 14 FCC Rcd at 18762, para. 9.

[15] *Id.* at 18786, para. 48. The Commission found that, given the specific categories of health care providers listed in section 254(h)(5)(B), if Congress had intended to include nursing homes, hospices, or other long-term care facilities, and emergency medical service facilities, it would have done so explicitly. *Id.*

[16] *Id.* at 18773, 18786, paras. 26, 48-49.

[17] *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Notice of Proposed Rulemaking, 17 FCC Rcd 7806 (2002) (*2002 NPRM*).

[18] *Id.* at 7812-7825, paras. 13-50.

[19] *Id.* at 7825-7828, paras. 51-61.

[20] *Id.* at 7826, para. 62.

[21] *See 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 Report and Order and FNPRM*).

capped such support at the amount providers would have received if they purchased functionally similar terrestrial-based alternatives.[22] These changes were implemented beginning in Funding Year 2004.[23]

12. In an accompanying Further Notice of Proposed Rulemaking, the Commission also sought comment on the definition of "rural area" for the rural health care program.[24] In 1997, the Commission adopted the definition of "rural" used by the Office of Rural Health Policy (ORHP) at that time.[25] ORHP, however, subsequently discontinued using that definition, and adopted a new definition.[26] The Commission also sought comment on whether it should also use the new definition ORHP had adopted or use a different definition.[27] The Commission also sought comment on whether additional modifications to the Commission's rules were appropriate to facilitate the provision of support to mobile rural health clinics for satellite services and whether other measures were necessary to further streamline the administrative burdens associated with applying for support.[28]

13. In 2004, the Commission released a *Second Report and Order and Further Notice of Proposed Rulemaking*, which established a new definition of "rural" for purposes of the RHC support mechanism, effective as of Funding Year 2005.[29] Under the new definition, a rural area is one that is not located within or near a large population base. Specifically, a "rural area" is an area that: (1) is entirely outside of a Core Based Statistical Area (CBSA);[30] (2) is within a CBSA that does not have any urban area with a population of 25,000 or greater; [31] or (3) is in a CBSA that contains an urban area with a population of 25,000 or greater, but is within a specific census tract[32] that itself does not contain any part

[22] *See generally id.*

[23] Funding Year 2003 for the rural health care program ended June 30, 2004, and Funding Year 2004 began July 1, 2004. Because the Commission chose not to introduce changes to the program in the middle of a funding year, the modifications to the program adopted in the *2003 Report and Order and FNPRM* were implemented beginning with Funding Year 2004. *Id.* at 24577, para. 60.

[24] *Id.* at 24578, para. 63.

[25] *Universal Service First Report and Order*, 12 FCC Rcd at 9115-9116, para 649.

[26] ORHP has adopted the Rural Urban Commuting Area (RUCA) system for rural designation, using 2000 Census data. *See* HRSA, Rural Health Policy: Geographic Eligibility for Rural Health Grant Programs *at* http://ruralhealth.hrsa.gov/funding/eligibilitytestv2.asp (last visited Nov. 15, 2007).

[27] *2003 Report and Order and FNPRM*, 18 FCC Rcd at 24578, para. 64.

[28] *Id.* at 24579-81, paras. 65-66, 69.

[29] *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 (2004) (*Second Report and Order and FNPRM*).

[30] A CBSA is a statistical geographic entity consisting of the county or counties associated with at least one core of at least 10,000 people plus adjacent counties having a high degree of social and economic integration with the core as measured through commuting ties with the counties containing the core. A core is a densely settled concentration of population, comprising either an urbanized area (of 50,000 or more population) or an urban cluster (of 10,000 to 49,999 population) defined by the Census Bureau. *See Standards for Defining Metropolitan and Micropolitan Statistical Areas*, Office of Management and Budget, 65 FR 82228, no. 249 (Dec. 27, 2000).

[31]The urbanized population is the population contained in the urban area (urbanized area or urban cluster) at the core of the CBSA, as well as all other urban areas in the CBSA. Urbanized areas and urban clusters are areas of "densely settled territory," as defined by the Census Bureau. *See* U.S. Census Bureau, 2000 Census of Population and Housing, Summary File 3: Technical Documentation, 2002, Appendix A. A list of urban areas for the 2000 Census can be found *at* http://www.census.gov/geo/www/ua/ctrlplace.html (last visited Nov. 15, 2007).

[32]Census tracts are small, relatively permanent statistical subdivisions of a county or statistically equivalent entity. Tracts in the United States, Puerto Rico and the U.S. Virgin Islands generally contain between 1,500 and 8,000 (continued....)

of a place or urban area with a population of greater than 25,000.[33] The Commission also revised its rules to expand funding for mobile rural health care services by subsidizing the difference between the rate for satellite service and the rate for an urban wireline service with a similar bandwidth.[34] Further, the Commission established June 30 as a fixed deadline for applications for support under the RHC support mechanism, and permitted rural health care providers in states that are entirely rural to receive support for advanced telecommunications and information services under section 254(h)(2)(A).[35] Finally, the Commission sought comment on whether it should increase the percentage discount that rural health care providers receive for Internet access and whether infrastructure development should be funded, as well as further modifications to the existing RHC support mechanism.[36]

B. Rural Health Care Pilot Program

14. Despite the modifications the Commission has made to the RHC support mechanism, the program has yet to fully achieve the benefits intended by the statute and the Commission. Notably, although $400 million dollars per year has been authorized for funding this program, since the program's inception in 1998, the program generally has disbursed less than 10 percent of the authorized funds each year.[37] Although there are a number of technical factors that may explain the underutilization of this important program, it has become apparent that, despite prior Commission efforts, health care providers continue to lack access to the broadband facilities needed to support the types of advanced telehealth applications, like telemedicine, that are so vital to bringing medical expertise and the advantages of modern health care technology to rural areas of the country. Without access to dedicated broadband capacity, many of these real-time telehealth applications are simply not being deployed or deployed too slowly or with minimal capabilities in rural areas.

15. In response to this problem, in September 2006, the Commission released the *2006 Pilot Program Order*.[38] This order was expressly designed to explore, from the ground up, how to best encourage the deployment of broadband facilities necessary to support the enormous benefits of telehealth and telemedicine applications.[39] This order established a two-year Pilot Program to examine how RHC support mechanism funds can be used to enhance public and non-profit health care providers' access to advanced telecommunications and information services.[40] The Commission established the Pilot Program under the authority of section 254(h)(2)(A) of the 1996 Act, which called for the Commission to establish competitively neutral rules to enhance access to advanced telecommunications and information

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people, with an optimum size of 4,000. *See* U.S. Census Bureau, 2000 Census of Population and Housing, Summary File 3: Technical Documentation, 2002, Appendix A.

[33] Places include census-designated places, consolidated cities and incorporated places. *See* U.S. Census Bureau, 2000 Census of Population and Housing, Summary File 3: Technical Documentation, 2002, Appendix A.

[34] *Second Report and Order and FNPRM*, 19 FCC Rcd at 24626-28, paras. 29-32.

[35] 47 U.S.C. § 254(h)(2)(A); 47 C.F.R. §§ 54.621, 54.623; *Second Report and Order and FNPRM*, 19 FCC Rcd at 24628-29 and 24631-34, paras. 33-34 and paras. 38-44.

[36] *Second Report and Order and FNPRM*, 19 FCC Rcd at 24635, paras. 47-53. The issues raised in the *FNPRM* remain pending.

[37] *See* USAC, Annual Report 2006 at 5, *available at* http://www.usac.org/_res/documents/about/pdf/usac-annual-report-2006.pdf (last visited Nov. 15, 2007) (*USAC 2006 Annual Report*); USAC, Annual Report 2002 at 2, *available at* http://www.usac.org/_res/documents/about/pdf/usac-annual-report-2002.pdf (last visited Nov. 15, 2007) (*USAC 2002 Annual Report*).

[38] *2006 Pilot Program Order*, 21 FCC Rcd at 11111, para. 1.

[39] *Id.*

[40] *Id.*

services for health care providers.[41] The long-term goal of the Pilot Program is to provide the Commission with a more complete and practical understanding of how to ensure the best use of the available RHC support mechanism funds to support a broadband, nationwide health care network (expressly including rural areas) so that the Commission can reform the overall RHC support mechanism.[42]

16. In the *2006 Pilot Program Order*, the Commission sought to facilitate broadband deployment to health care providers in order to bring the benefits of innovative telehealth and, in particular, telemedicine services to those areas of the country where the need for those benefits is most acute.[43] To accomplish this task, the Commission stated the Pilot Program would fund a significant portion of the costs of deploying dedicated broadband capacity that connects multiple public and non-profit health care providers, within a state or region, as well as providing the "advanced telecommunications and information services" that ride over that network.[44] The Commission specified that the Pilot Program would fund up to 85 percent of the costs incurred by the selected participants to deploy a state or regional dedicated broadband health care network and, at the applicant's discretion, to connect that network to Internet2, National LambdaRail (NLR), or the public Internet.[45] Consistent with the mandate provided in section 254(h)(2)(A) and the general principles of universal service, participation was opened to all eligible public and non-profit health care providers, but applicants were required to include in their proposed networks public and non-profit health care providers that serve rural areas.[46] The Commission also established (*via* the competitive bidding process) that the Pilot Program be technology neutral,

[41] *See* 47 U.S.C. § 254(h)(2)(A). Section 254(h)(2)(A) provides the Commission broad discretionary authority to fulfill this statutory mandate. *See Federal State Joint Board on Universal Service Schools Libraries Universal Service Support Mechanism Rural Health Care Support Mechanism Lifeline and Link-Up*, Order, 20 FCC Rcd 16883, 16899 (2005). 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 non-rural health care providers. 18 F.3d 393, 446 (5th Cir. 1999), *aff'g in part, ref'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). In reaching this conclusion, the court determined that Congress intended to allow the Commission broad authority to implement section 254(h)(2)(A) of the 1996 Act. *Id.* at 446. Pursuant to this authority the Commission adopted the *2006 Pilot Program Order* to "provide funding to support the construction of state or regional broadband networks and services provided over those networks." *2006 Pilot Program Order*, 21 FCC Rcd at 11111, para. 1.

[42] *2006 Pilot Program Order*, 21 FCC Rcd at 11113, para. 9. Upon completion of the Pilot Program, the Commission intends to issue a report detailing the results of the Pilot Program and the status of the RHC support mechanism generally, and to recommend any changes necessary to improve existing RHC support mechanism. In addition, the Commission intends to incorporate the information it gathers as part of the Pilot Program into the record of any subsequent proceeding. *Id.* at 9.

[43] *Id.* at 11111, 11113, paras. 1, 9.

[44] *Id.* at 11114, para. 10.

[45] *See id.* at 11115, para. 14; *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order on Reconsideration, 22 FCC Rcd 2555 (2007) (*Pilot Program Reconsideration Order*) (reconsidering the *2006 Pilot Program Order* to permit funding to connect a state or regional health care network to NLR or to the public Internet, in addition to Internet2). Internet2 and NLR are not-for-profit, nationwide network backbones, dedicated to educational, clinical, and research goals. *See, e.g.*, Internet 2, About Us, at http://www.internet2.edu/about/ (last visited Nov. 15, 2007) and NLR, About National LambdaRail, at http://www.nlr.net/about/ (last visited Nov. 15, 2007).

[46] *2006 Pilot Program Order*, 21 FCC Rcd at 11114, para. 10.

permitting eligible health care providers to choose any technology and provider of broadband connectivity needed to provide telehealth, including telemedicine, services.[47]

17. Applicants selected under the Pilot Program must use the funds for the purposes specified in their applications, subject to any required modifications in this Order.[48] Authorized purposes for funds awarded under the Pilot Program include the costs of deploying transmission facilities and advanced telecommunications and information services, including associated non-recurring and recurring costs, as well as conducting initial network design studies.[49] Funding for the Pilot Program was initially set at an amount not to exceed the difference between $100 million and the amount committed under the Commission's existing RHC support mechanism for the relevant funding year.[50]

18. Except as otherwise expressly specified, the Pilot Program utilizes the same program definitions as, and is intended to function within the confines of, the existing RHC support mechanism. The RHC support mechanism utilizes the statutory definition of "health care provider" established in section 254(h)(7)(b) of the 1996 Act.[51] Specifically, section 254(h)(7)(b) defines "health care provider" as:

(i) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools;
(ii) community health centers or health centers providing health care to migrants;
(iii) local health departments or agencies;
(iv) community mental health centers;
(v) non-for-profit hospitals;
(vi) rural health clinics; and
(vii) consortia of health care providers consisting of one or more entities described in clauses (i) through (vi).[52]

Accordingly, under both the existing RHC support mechanism and the Pilot Program, only eligible health care providers and consortia that include eligible health care providers may apply for and receive discounts for eligible services.[53]

19. In the *2006 Pilot Program Order*, the Commission further specified the minimum types of information applicants should include in their applications to be selected to be eligible to receive funding. Applicants were instructed to present a strategy for aggregating the specific needs of health care providers within a state or region, including providers that serve rural areas, and for leveraging existing technology

[47] *Id.* at 11114, para. 11. As discussed above, *see supra* para. 15 and note 41, the Commission established the Pilot Program under the authority of section 254(h)(2)(A) of the 1996 Act. The Commission has previously determined that section 254(e) of the 1996 Act, which provides that "only an eligible telecommunications carrier designated under section 214(e) shall be eligible to receive specific Federal universal service support," is inapplicable to section 254(h)(2). *See Universal Service First Report and Order*, 12 FCC Rcd at 9086-87, paras. 592-94. Accordingly, bidders on selected participants' proposals need not be eligible telecommunications carriers to receive Pilot Program funds if selected. *See infra* para. 119 addressing service provider eligibility.

[48] *2006 Pilot Program Order*, 21 FCC Rcd at 11115, para. 14.

[49] *Id.* at 11115-16, paras. 14-15.

[50] *Id.* at 11115, para. 12 ($100 million represents 25 percent of the total $400 million annual RHC funding cap).

[51] *Id.* at 11111, n.4.

[52] 47 U.S.C. § 254(h)(7)(b). The Commission has determined dedicated emergency departments of rural for-profit hospitals that participate in Medicare constitute rural health care clinics. *2003 Report and Order and FNPRM*, 18 FCC Rcd at 24553-55, paras. 13, 16.

[53] *See* 47 C.F.R. § 54.601(a)(1), (c)(1).

to adopt the most efficient and cost-effective means of connecting those providers.[54] The Commission stated that proposals connecting only a *de minimis* number of rural health care providers would not be considered.[55] The *2006 Pilot Program Order* also included the following eleven specific criteria which applicants were instructed to address in their applications.[56]

1) Identify the organization that will be legally and financially responsible for the conduct of activities supported by the fund;
2) Identify the goals and objectives of the proposed network;
3) Estimate the network's total costs for each year;
4) Describe how for-profit network participants will pay their fair share of the network costs;
5) Identify the source of financial support and anticipated revenues that will pay for costs not covered by the fund;
6) List the health care facilities that will be included in the network;
7) Provide the address, zip code, Rural Urban Commuting Area (RUCA) code, and phone number for each health care facility participating in the network;
8) Indicate previous experience in developing and managing telemedicine programs;
9) Provide a project management plan outlining the project's leadership and management structure, as well as its work plan, schedule, and budget;
10) Indicate how the telemedicine program will be coordinated throughout the state or region; and
11) Indicate to what extent the network will be self sustaining once established.

20. On February 6, 2007, the Commission released the *Pilot Program Reconsideration Order*.[57] In that order, the Commission allowed applicants either to pre-select Internet2 or NLR as a nationwide backbone provider,[58] or to seek competitive bids for their nationwide backbone providers through the normal competitive bidding process.[59]

21. On March 8, 2007, the Commission received OMB approval of the information collection requirements contained in the *2006 Pilot Program Order*.[60] Applications to participate in the Pilot Program for Funding Year 2006 were due no later than May 7, 2007.[61]

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[54] *2006 Pilot Program Order*, 21 FCC Rcd at 11116, para. 16.

[55] *Id.*

[56] *Id.* at 11116-17, para. 17. In addition, successful applicants were instructed to demonstrate that they have a viable strategic plan for aggregating usage among health care providers within their state or region. *Id.* at 11116, para. 16. In selecting participants for the Pilot Program, the Commission also indicated that it would consider whether an applicant has a successful track record in developing, coordinating, and implementing a successful telehealth/telemedicine program within their state or region, and the number of health care providers that are included in the proposed network, with considerable weight to applications that propose to connect the rural health care providers in a given state or region. *Id.*

[57] *Pilot Program Reconsideration Order*, 22 FCC Rcd at 2556, para. 5.

[58] The Commission waived, on its own motion, the rural health care program's competitive bidding and cost-effectiveness rules for Pilot Program applicants where an applicant proposes to pre-select Internet2 or NLR as its nationwide backbone provider. *Id.* at 2558, para. 8. The Commission did not otherwise waive its competitive bidding or cost-effectiveness rules.

[59] *Id.* at 2555, para. 1. In addition, the Commission extended the deadline for applications to the Pilot Program from 30 days after Office of Management and Budget (OMB) approval of the information collection requirements contained in the *2006 Pilot Program Order* to 60 days after OMB approval. *Id.* at 2558, para. 9.

[60] *Wireline Competition Bureau Announces OMB Approval of the Rural Health Care Pilot Program Information Collection Requirements and the Deadline for Filing Applications*, WC Docket No. 02-60, Public Notice, 22 FCC Rcd 4770 (Wireline Comp. Bur. 2007) (*OMB Public Notice*).

III. DISCUSSION

22. The *2006 Pilot Program Order* generated overwhelming interest from the health care community. We received 81 applications representing approximately 6,800 health care providers. Of these, 69 applications covering 42 states and three United States territories demonstrate the overall qualifications consistent with the goals, objectives, and other criteria outlined in the *2006 Pilot Program Order* necessary to advance telehealth and telemedicine in their areas. Specifically, they describe strategies for aggregating the specific needs of health care providers within a state or region, including providers serving rural areas; provide strategies for leveraging existing technology to adopt the most efficient and cost-effective means of connecting those providers; describe previous experience in developing and managing telemedicine programs; and detail project management plans.[62] Rather than limit participation to a select few among the 69 qualified applicants, we find that it would be in the best interests of the Pilot Program, and appropriate as a matter of universal service policy, to accommodate as many of these qualified applicants as possible.

23. Moreover, having more participants will enable us to collect more data and thus enhance our ability to critically evaluate the Pilot Program. To accommodate the 69 qualified applicants in an economically reasonable and fiscally responsible manner, including remaining well within the existing $400 million annual RHC support mechanism cap, we modify the Pilot Program to spread funding equally over a three-year period.[63] Specifically, total available support for Year One of the Pilot Program (Funding Year 2007 of the existing RHC support mechanism), Year Two (Funding Year 2008 of the existing RHC support mechanism), and Year Three (Funding Year 2009 of the existing RHC support mechanism) of the Pilot Program will be approximately $139 million per funding year. With this modification, we are thus able to select all of the 69 qualified applicants as eligible to participate in the Pilot Program. Finally, selected participants shall work with HHS and, in particular, CDC, to make the health care networks funded by the Pilot Program available for use in instances of nationwide, regional, or local public health emergencies (*e.g.*, pandemics, bioterrorism). Selected participants shall also use funding in a manner consistent with HHS's health IT initiatives.[64]

A. Overview of Applicants

24. Consistent with the Commission's goal in the *2006 Pilot Program Order* to learn from the health care community through the design of a bottom-up application process, selected participants proffered a wide array of proposals to construct new health care networks or to upgrade existing networks and network components in an efficient manner. The selected proposals range from small-scale, local networks to large-scale, statewide or multi-state networks. Examples of applicants proposing small-scale networks include Mountain States Health Alliance which seeks $54,400 to connect two rural Virginia hospitals to an existing network consisting of 11 Tennessee hospitals.[65] Rural Healthcare Consortium of Alabama seeks $232,756 to connect four critical access hospitals in rural Alabama to enable teleradiology, lab information systems, video conferencing, and secure networking with academic medical centers and universities.[66]

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[61] *Id.* at 4771.

[62] *2006 Pilot Program Order*, 21 FCC Rcd at 11116, paras. 16-17.

[63] *See* 47 C.F.R. § 54.623.

[64] *See supra* para. 7, *infra* Part III.E.6; *see also* Appendix D.

[65] Mountain States Health Alliance Application at 1.

[66] Rural Healthcare Consortium of Alabama Application at 1-3.

25. Other applicants propose networks much larger in scope. For instance, Tennessee Telehealth Network (TTN) seeks approximately $7.8 million to expand upon the existing Tennessee Information Infrastructure, a pre-existing broadband network serving state, local, and educational agencies in Tennessee.[67] Upon completion of the project, TTN's network will reach more than 440 additional health care providers throughout the state enabling it to bring the benefits of innovative telehealth, such as access to specialists in urban areas, to rural sites.[68] In addition, certain applicants plan to connect multi-state networks, such as New England Telehealth Consortium (NETC) which seeks approximately $25 million to connect 555 sites in Vermont, New Hampshire, and Maine to the Northern Crossroads network, enabling connectivity to hospitals and universities throughout New England, including Rhode Island, Massachusetts, and Connecticut.[69] NETC's resulting network would facilitate expansive telemedicine benefits, including remote trauma consultations, throughout the multi-state region.[70]

26. Numerous applicants also demonstrate the serious need to deploy broadband networks for telehealth and telemedicine services to the rural areas of the nation where the needs for these services are most acute. For example, Pacific Broadband Telehealth Demonstration Project seeks to connect Hawaii and 11 Pacific Islands to one broadband network in the region where transportation costs are extremely high and health care specialists are concentrated mainly in the region's urban centers such as Honolulu.[71]

27. Similarly, Health Care Research & Education Network convincingly demonstrates its state's need for expanded telemedicine services: North Dakota is an extremely rural state where 42 of its 53 counties include 30 percent or more residents living at or below 200 percent of the Federal Poverty Guidelines.[72] Part or all of 83 percent of North Dakota's counties are designated as health professional shortage areas,[73] and 94 percent are designated as mental health shortage areas.[74] To help alleviate these hardships, the University of North Dakota seeks to construct a high-speed data network to connect, *via* the existing state fiber network, Stagenet, its medical school's four main campus sites and clinical medical sites to five rural North Dakota health care facilities.[75] Doing so will allow for research which would greatly accelerate the ability to bring contemporary treatment options to rural areas.[76]

28. The Wyoming Telehealth Network also demonstrates the need for broadband infrastructure for health care use. In its application, it explains that Wyoming is an extremely low populous and rural

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[67] Tennessee Telehealth Network Application at 8, 12.

[68] *Id.* at 4, 6-7.

[69] New England Telehealth Consortium Application at 4.

[70] *Id.* at 15-16.

[71] Pacific Broadband Telehealth Demonstration Project Application at 1-2.

[72] *See 2007 Poverty Guidelines for the 48 Contiguous States and the District of Columbia*, 72 Fed. Reg. 3147-48 (2007). The Federal Poverty Guideline (FPG) is a measure used as an eligibility criterion for Federal programs, and is updated annually to reflect changes in the Consumer Price Index (CPI). *See id.* The FPG is currently used as a factor in the calculation for determining eligibility for the universal service low-income (Lifeline/Link-Up) program. *See Lifeline and Link-Up*, WC Docket No. 03-109, Report and Order and Further Notice of Proposed Rulemaking, 19 FCC Rcd 8302, 8308, para. 10 (2004).

[73] 42 C.F.R. § 5.2. Health professional(s) shortage area means any of the following which the Secretary determines has a shortage of health professional(s): (1) An urban or rural area (which need not conform to the geographic boundaries of a political subdivision and which is a rational area for the delivery of health services); (2) a population group; or (3) a public or nonprofit private medical facility.

[74] *See id.*

[75] Health Care Research & Education Network Application at 8, 12-23.

[76] *Id.* at 16.

state, suffering from a severe shortage of health care providers. Wyoming ranks 45th in physicians per 100,000 people, and has only 18 psychiatrists, four certified psychological practitioners, and two school psychologists statewide. Wyoming Telehealth Network's proposed network will extend the reach of health care professionals by linking the entire state's 72 hospitals, community mental health centers, and substance abuse centers, which will enable these facilities to transmit data to one another and videoconference.[77] As these and other applications demonstrate, health care providers in rural areas need access to broadband facilities for telehealth and telemedicine services to be available in rural areas.

29. Some applicants request Pilot Program funding to support build-out to tribal lands. For example, Tohono O'odham Nation Department of Information Technology (Nation) seeks funding to connect three of the Nation's remote health care facilities to Internet2 and to Arizona health care providers with existing networks to facilitate implementation of a comprehensive telemedicine program for the Nation that will enable the Nation to connect into a nationwide backbone of networks.[78] The Nation's planned dedicated broadband network will result in a comprehensive health care delivery system that reaches even its most remote geographic areas – a particularly important goal considering the Nation's extremely limited public transportation system.[79]

30. We find that the selected participants demonstrate a viable strategy for effective utilization of Pilot Program support consistent with the principles established in the *2006 Pilot Program Order*, and sufficiently set forth how their networks will meet the detailed Pilot Program criteria set forth in the *2006 Pilot Program Order*. As discussed in detail below, while we find that the selected applications overall satisfy the criteria set forth in the *2006 Pilot Program Order*, many applicants must submit additional information to USAC to ensure that fund commitments and disbursements will be consistent with section 254 of the 1996 Act, this Order, and the Commission's rules and orders.[80]

B. Scope of Pilot Program and Selected Participants

31. In the *2006 Pilot Program Order*, the Commission stated, "[o]nce we have determined funding needs of the existing program, we will fund the Pilot Program in an amount that does not exceed the difference between the amount committed under our existing program for the current year and $100 million."[81] We estimated that approximately $55-60 million would be available for the Pilot Program, based on our past experience and estimates of funding requests received under the existing program for Funding Year 2006.[82] In the *2006 Pilot Program Order*, we also established the Pilot Program as a two-year program.[83]

32. *Funding Cap.* In light of the overwhelming need for the Pilot Program funding to build-out dedicated health care network capacity to support telehealth and telemedicine, we increase the funding cap amount from that set in the *2006 Pilot Program Order* to approximately $139 million for each year of the Pilot Program. We find this modification necessary to enable the 69 qualified applicants to implement their plans to the fullest extent possible.[84] In particular, we believe this increased amount of Pilot Program funding will enable participants to fully realize the benefits to telehealth and telemedicine

[77] Wyoming Telehealth Network Application at 1, 13-16.

[78] Tohono O'odham Nation Department of Information Technology Application at 4.

[79] *Id.* at 3.

[80] *See infra* paras. 83-95.

[81] *2006 Pilot Program* Order, 21 FCC Rcd at 11115, para. 12.

[82] *Id.* at 11115, para. 12, n.17.

[83] *Id.* at 11115, para. 13, n.18

[84] We do not disturb the overall $400 million cap on the RHC support mechanism. *See* 47 C.F.R. § 54.623(a).

services by making universal service support available for significant build-out of dedicated broadband network capacity. Increased support will also provide the Commission with an RHC Pilot Program extensive enough to soundly evaluate and to serve as a basis to propose to modify the existing RHC support mechanism, all without requiring us to reject otherwise compliant applications. Although available yearly Pilot Program support is higher than we originally contemplated in the *2006 Pilot Program Order*, this amount is still well below the $400 million cap for each funding year of the existing RHC support mechanism (even when combined with the most recent disbursements under the existing RHC support mechanism of $41 million), and therefore remains well within the existing parameters of economic reasonability and fiscal responsibility.[85]

33. *Duration of Pilot Program.* To continue to maintain fiscal discipline, we modify the duration of the Pilot Program to require that commitments for the two-year program costs identified by selected participants in their applications occur over a three-year period. Funding the selected applications over a three-year period at somewhat lower levels than requested based on a two-year program will better serve goals of section 254(h)(2)(A) of the 1996 Act because it provides us with sufficient flexibility to support more expansive network build-outs, thereby significantly enhancing health care providers' access to broadband services and enabling such access to occur considerably quicker than it otherwise would.[86] Spreading commitments over a three-year period will also ensure that the Program moves forward seamlessly to facilitate uninterrupted rural telehealth/telemedicine network build-outs, while balancing the need for economic reasonableness and responsible fiscal management of the program, including by staying well within the $400 million dollar RHC mechanism cap.[87] In addition, expansion of the Pilot Program's duration, as well as increasing available aggregate support, will provide greater certainty of support to applicants that requested funding for multiple years, and will obviate the need for reapplications during the duration of the Pilot Program. Accordingly, the Pilot Program will begin in Funding Year 2007 and end in Funding Year 2009 of the existing RHC support mechanism.[88]

34. *Administration of Funding Year 2006 Funds.* In establishing the Pilot Program duration, we apply to Funding Year 2007 the moneys that USAC already collected in Funding Year 2006 for the Pilot Program. Because we did not receive approval from the OMB until March 8, 2007, only two months prior to the application deadline of May 7, 2007, and because applicants could not meet the June 30, 2007, deadline for submitting Funding Year 2006 forms to USAC, we find it impracticable to begin the Pilot Program in Funding Year 2006 as originally contemplated.[89] Consequently, we begin the USAC application, commitment, and disbursement process for the Pilot Program with Funding Year 2007. Total available support for Year One of the Pilot Program (Funding Year 2007 of the existing RHC support mechanism), Year Two (Funding Year 2008 of the existing RHC support mechanism), and Year Three

[85] *See* 47 U.S.C. § 254(h)(2)(A). *See also 2006 Pilot Program Order*, 21 FCC Rcd at 11115, para. 12; USAC, Annual Report 2006 at 4, *available at* http://www.usac.org/_res/documents/about/pdf/usac-annual-report-2006.pdf (*USAC 2006 Annual Report*) (last visited Nov. 8, 2007).

[86] *See* 47 U.S.C. § 254(h)(2)(A).

[87] *See infra* paras. 85-86, 89. 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 U.S.C. § 1341; Pub. L. No. 97-258, 96 Stat. 923 (1982); Omnibus Budget Reconciliation Act of 1990, Pub. L. No. 101-508, Title XIII, § 13213(a), 104 Stat. 1388-621 (1990). The universal service programs, however, have been exempt from the ADA since 2005, and currently are exempt until December 31, 2007 as part of a one-year exemption set forth in the Revised Continuing Appropriations Resolution of 2007, Pub. L. No. 110-5, 121 Stat. 8 (2007).

[88] The RHC funding year is from June 30 to July 1. *See* 47 C.F.R. § 54.623.

[89] *See supra* para. 21.

(Funding Year 2009 of the existing RHC support mechanism) of the Pilot Program will be approximately $139 million per Pilot Program funding year.[90]

35. *Selected Participants.* Appendix B lists each selected participant's eligible support amounts for each Pilot Program funding year. As indicated in Appendix B, selected participants' available support for each funding year of the Pilot Program is one third of the sum of their Year One and Year Two application funding requests, as calculated by the Commission.[91] We find that committing this funding over a three-year period ensures the Pilot Program remains economically reasonable and fiscally responsible while allowing selected participants to remain eligible to receive their entire eligible Year One and Year Two support as identified in their applications.[92] Although we increase available support amounts, as explained in greater detail below, selected participants may not exceed the available support for each funding year as listed in Appendix B. The selected participants also remain required to provide at least 15 percent of their network costs from other specified sources.[93] In addition, we require that selected participants' network build-outs be completed within five years of receiving an initial FCL.

36. *Priority System.* Contrary to our findings in the *2006 Pilot Program Order*, we also, on our own motion, modify the Pilot Program structure by declining to establish a funding priority system similar to the priority system provided for in the universal service schools and libraries mechanism. In the *2006 Pilot Program Order*, we found that applications for support under the existing RHC support mechanism would be funded before funding any of the projects proposed in the Pilot Program.[94] We had limited funding for the Pilot Program to the difference between the amount committed to the existing RHC support mechanism and $100 million.[95] We find it is not necessary to establish a priority system for the rural health care program because we have eliminated the $100 million cap on funding for the existing RHC support mechanism and the Pilot Program. As such, our expansion of the Pilot Program will ensure that both the applicants under the existing RHC support mechanism and those under the Pilot Program receive funding for all eligible expenses they have included in their applications.

C. Qualifications of Selected Participants

37. In the *2006 Pilot Program Order*, we instructed applicants to indicate how they plan to fully utilize a broadband network to provide health care services and to present a strategy for aggregating the specific needs of health care providers within a state or region, including providers that serve rural areas.[96] Overall, selected participants demonstrated significant need for RHC Pilot Program funding for health care broadband infrastructure and services for their identified health care facilities, and provided the Commission with sufficiently detailed proposals.[97] In their applications, each selected participant explained the goals and objectives of their proposed networks and generally addressed other criteria on

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[90] The funding total is capped by the maximum amount allowable funding for each applicant during the three-year period.

[91] Calculations are based on 85 percent of each selected participant's funding request. For selected participants that did not clearly request 85 percent funding for their total costs, we have adjusted the support level to the appropriate 85 percent level.

[92] *See* 47 U.S.C. § 254(h)(2)(A).

[93] *See infra* Part III.E.3.

[94] *See 2006 Pilot Program Order*, 21 FCC Rcd at 11115, para. 12

[95] *Id.*

[96] *Id.* at 11116, para. 16.

[97] *Id.*

which we sought information in the *2006 Pilot Program Order.*[98] In addition, each selected participant must comply with all Pilot Program administrative requirements discussed below to receive universal service support funding.[99]

38. *Network Utilization.* In the *2006 Pilot Program Order,* we set forth the network goals and objectives for applicants to meet to be considered for Pilot Program funding. In particular, we requested that applicants indicate how they will utilize dedicated broadband capacity to provide health care services.[100] Selected participants sufficiently set forth the various ways in which they would appropriately utilize a broadband network.[101] For example, Virginia Acute Stroke Telehealth Project proposes a broadband network that would focus on the continuum of care (prevention through rehabilitation) for stroke patients in rural and underserved areas of Virginia.[102] Illinois Rural HealthNet

[98] *Id.* at 11116-17, paras. 16-17. Selected participants must meet the goals and objectives they identified in their Pilot Program applications.

[99] *See infra* Part III.E.

[100] *2006 Pilot Program Order*, 21 FCC Rcd at 11116, para. 16.

[101] Arizona Rural Community Health Information Exchange Application at 7-8; Iowa Rural Health Telecommunications Program Application at 7-8, 12-13; Northeast HealthNet Application at 4; Southwest Alabama Mental Health Consortium Application at Section B; Mountain States Health Alliance Application at 1; University Health Systems of Eastern Carolina Application at 6; University of Mississippi Medical Center Application at 2, 19; Western Carolina University Application at 4, 6; Alabama Pediatric Health Access Network Application at 5, 9, 12; Colorado Health Care Connections Application at 10; Heartland Unified Broadband Network Application at 3, 15-17; Juniata Valley Network Application at 5, 22-28; Michigan Public Health Institute Application at 3-7; Frontier Access to Healthcare in Rural Montana Application at 1; Northeast Ohio Regional Health Information Organization Application at 3, 5-6; Pacific Broadband Telehealth Demonstration Project Application at 3-13; Rural Wisconsin Health Cooperative Application at 1-3; Southwest Telehealth Access Grid Application at 6; Big Bend Regional Healthcare Information Organization Application at 3; Geisinger Health System Application at 2-3; Indiana Health Network Application at 53; Northwest Alabama Mental Health Center at 1; Oregon Health Network Application at 17-20; St. Joseph's Hospital Application at 4; Health Care Research & Education Network at 12-23; Alaska Native Tribal Health Consortium Application at 12; Bacon County Health Services Application at 1; California Telehealth Network Application at 9; Missouri Telehealth Network Application at 4, 7; New England Telehealth Consortium Application at 15-16; North Country Telemedicine Project Application at 7-8; Rocky Mountain HealthNet Application at 3; Texas Health Information Network Collaborative Application at 7; Wyoming Telehealth Network Application at 19; Adirondack-Champlain Telemedicine Information Network Application at 15-22; Association of Washington Public Hospital Districts Application at 7, 23-26; Holzer Consolidated Health Systems Application at 2, 5; North Carolina Telehealth Network Application at 3-4; Palmetto State Providers Network at 4-6; Penn State Milton S. Hershey Medical Center Application at 6-8; Rural Healthcare Consortium of Alabama Application at 1-3; Pathways Community Behavioral Healthcare, Inc. Application at 2; West Virginia Telehealth Alliance Application at 34-50; Virginia Acute Stroke Telehealth Project Application at 22, 25-29; Rural Nebraska Healthcare Network Application at 14-16, 32-35; Southern Ohio Healthcare Network Application at 3; Texas Healthcare Network Application at 11; Iowa Health System Application at 5; Rural Western and Central Maine Broadband Initiative Application at 26-28; Tennessee Telehealth Network Application at 23-24; DCH Health System Application at 2; Albemarle Network Telemedicine Initiative Application at 1; Kansas University Medical Center at 2; Western New York Rural Area Health Education Center Application at 3; Health Information Exchange of Montana Application at 5; Arkansas Telehealth Network Application at 3-4; As One-Together for Health Application at 8; Communicare Application at 12; Erlanger Health System Application at 2-3; Greater Minnesota Telehealth Broadband Initiative Application at 5, 17, 44-45; Illinois Rural HealthNet Consortium Application at Attachment 1; Kentucky Behavioral Telehealth Network Application at 5-6; Pennsylvania Mountains Healthcare Alliance Application at 8-9; Tohono O'odham Nation Department of Information Technology Application at 4; Louisiana Department of Hospitals Application at 3; Northwestern Pennsylvania Telemedicine Initiative Application at 1; Puerto Rico Health Department Application at 2-3; Sanford Health Collaboration and Communication Channel Application at 3; Utah Telehealth Network Application at 19-20.

[102] Virginia Acute Stroke Telehealth Project Application at 21-22, 25.

Consortium plans to use its network for a wide variety of telemedicine applications, including video conferencing, remote doctor-patient consultations, and telepsychiatry.[103] Pacific Broadband Telehealth Demonstration Project seeks to interconnect seven existing networks to link health care providers throughout Hawaii and the Pacific Island region.[104] The network will enable delivery of broadband telehealth and telemedicine for clinical applications, continuing medical, nursing and public health education, and electronic health records support.[105] Alaska Native Tribal Health Consortium plans to connect rural health care providers throughout Alaska to urban health centers *via* a network that will support teleradiology, electronic medical records, and telepsychiatry through video conferencing.[106]

39. Based on our review of all 81 of the applications, we find that the 69 selected participants have shown that they intend to utilize dedicated health care network capacity consistent with the goals set forth in the *2006 Pilot Program Order*. Thus, in selecting these applicants as eligible to receive funding for broadband infrastructure and services, we will advance the goals of, among other things, bringing the benefits of telehealth and telemedicine to areas where the need for these benefits is most acute; allowing patients to access critically needed specialists in a variety of practices;[107] and enhancing the health care community's ability to provide a rapid and coordinated response in the event of a national health care crisis.[108]

40. *Leveraging of Existing Technology.* In the *2006 Pilot Program Order*, we stated that applicants should leverage existing technology to adopt the most efficient and cost-effective means of connecting providers.[109] We explained that the Pilot Program would be "technically feasible" because it would not require development of any new technology, but rather would enable participants to utilize any currently available technology.[110] In general, selected participants explained how their proposed networks would leverage existing technology.[111] Examples of applicants leveraging existing technology

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[103] Illinois Rural HealthNet Consortium Application at 9.

[104] Pacific Broadband Telehealth Demonstration Project Application at 4-8.

[105] *Id.* at 3.

[106] Alaska Native Tribal Health Consortium Application at 9, 12-14.

[107] *2006 Pilot Program Order*, 21 FCC Rcd at 11111, paras. 1-2. *See, e.g.*, Virginia Acute Stroke TeleHealth Project Application at 14-16 (explaining that the differential diagnosis and treatment of a stroke within the first three hours is critical for effective patient care).

[108] *2006 Pilot Program Order*, 21 FCC Rcd at 11111, paras. 1-2. *See, e.g.*, Bacon County Health Services Application at 1-2 (noting that its goal to enhance a rapid and coordinated response by health care providers in the event of a national crisis is especially important to residents in its area, many of whom live within 10 to 50 miles of Plant Hatch, a nuclear energy plant).

[109] *2006 Pilot Program Order*, 21 FCC Rcd at 11116, para. 16.

[110] *Id.* at 11114, para. 11; *see also* 47 U.S.C. § 254(h)(2)(A).

[111] Iowa Rural Health Telecommunications Program Application at 4, 6, 8; Northeast HealthNet Application at 6; Mountain States Health Alliance Application at 1; University Health Systems of East Carolina Application at 4, 5; Western Carolina University Application at 10; Alabama Pediatric Health Access Network Application at 16; Colorado Health Care Connections Application at 7; Heartland Unified Broadband Network Application at 3, 9; Juniata Valley Network Application at 6-7, 35; Michigan Public Health Institute Application at 29-31; Frontier Access to Healthcare in Rural Montana at 13-16; Northeast Ohio Regional Health Information Organization Application at 11, 18; Pacific Broadband Telehealth Demonstration Project Application at 3-13; Rural Wisconsin Health Cooperative Application at 4; Southwest Telehealth Access Grid Application at 1, 2, 6; Big Bend Regional Healthcare Information Organization Application at 2-12; Geisinger Health System Application at 3-4; Indiana Health Network Application at 63; Oregon Health Network Application at 17-20; St. Joseph's Hospital Application at 2; Health Care Research & Education Network Application at 13-15; Alaska Native Tribal Health Consortium Application at 12; Bacon County Health Services Application at 6; Missouri Telehealth Network Application at 9; (continued....)

include the Association of Washington Public Hospital Districts, which plans to create a "network of networks" by interconnecting six existing networks to create a statewide network.[112] And Colorado Health Care Connections proposes to leverage an existing state network as the basis for a dedicated health care network for Colorado's public and non-profit health care providers.[113] The goal is to connect all 50 rural hospitals and 76 rural clinics to the state network, which in turn is connected to the major metropolitan tertiary hospitals, and Internet2 and NLR.[114]

41. *Aggregation.* In the *2006 Pilot Program Order*, we instructed applicants to provide strategies for aggregating the specific needs of health care providers, including providers that serve rural areas within a state or region.[115] In general, selected participants sufficiently explained how their proposed networks would aggregate the needs of health care providers, including rural health care providers.[116] For

(Continued from previous page)
New England Telehealth Consortium Application at 12-13; North Country Telemedicine Project Application at 13; Rocky Mountain HealthNet Application at 4; Texas Health Information Network Collaborative Application at 10; Adirondack-Champlain Telemedicine Information Network Application at 36-37; Association of Washington Public Hospital Districts Application at 28; North Carolina Telehealth Network Application at 11-12; Palmetto State Providers Network Application at 7; Penn State Milton S. Hershey Medical Center Application at 9; Rural Healthcare Consortium of Alabama Application at 3, 5; Pathways Community Behavioral Healthcare, Inc. Application at 3; West Virginia Telehealth Alliance Application at 2, Attachment 1; Virginia Acute Stroke Telehealth Project Application at 34-35; Rural Nebraska Healthcare Network Application at 28; Southern Ohio Healthcare Network Application at 4, 21; Texas Healthcare Network Application at 13; Iowa Health System Application at 5; Rural Western and Central Maine Broadband Initiative Application at 24, 47-48; Tennessee Telehealth Network Application at 8, 12; DCH Health System Application at 1-2; Kansas University Medical Center Application at 5-6; Western New York Rural Area Health Education Center Application at 4; Arkansas Telehealth Network Application at 12; As One - Together for Health Application at 12; Communicare Application at 11; Erlanger Health System Application at 4; Greater Minnesota Telehealth Broadband Initiative Application at 17-38; Illinois Rural HealthNet Consortium Application at 15; Pennsylvania Mountains Healthcare Alliance Application; Louisiana Department of Hospitals Application at 6; Northwestern Pennsylvania Telemedicine Initiative Application at 4-5; Puerto Rico Health Department Application at 7-8; Sanford Health Collaboration and Communication Channel Application at 4, Appendix C; Utah Telehealth Network Application at 27.

[112] Association of Washington Public Hospital Districts Application at 6, 28.

[113] Colorado Health Care Connections Application at 1.

[114] *Id.* at 7.

[115] *2006 Pilot Program Order*, 21 FCC Rcd at 11116, para. 16.

[116] *See id.* Arizona Rural Community Health Information Exchange Application at 3; Iowa Rural Health Telecommunications Program Application at 7-8; Northeast HealthNet Application at 7, 10; Southwest Alabama Mental Health Consortium Application at Section B; Mountain States Health Alliance Application at 1; University Health Systems of Eastern Carolina Application at 5-6; University of Mississippi Medical Center Application at 2, 4; Western Carolina University Application at 4; Alabama Pediatric Health Access Network Application at 8; Colorado Health Care Connections Application at 11-12; Heartland Unified Broadband Network Application at 3, 9; Juniata Valley Network Application at 6-7, 35; Michigan Public Health Institute Application at 27; Frontier Access to Healthcare in Rural Montana Application at 10; Northeast Ohio Regional Health Information Organization Application at 18-19; Pacific Broadband Telehealth Demonstration Project Application at 3-13; Rural Wisconsin Health Cooperative Application at 4; Southwest Telehealth Access Grid Application at 12; Big Bend Regional Healthcare Information Organization Application at 2-12; Indiana Health Network Application at 63; Oregon Health Network Application at 21-30; St. Joseph's Hospital Application at 3; Health Care Research & Education Network at 12-23; Alaska Native Tribal Health Consortium Application at 9; Bacon County Health Services Application at 3, 6; California Telehealth Network Application at 69-70; Missouri Telehealth Network Application at 3; New England Telehealth Consortium Application at 11-12; North Country Telemedicine Project Application at 4, 13; Rocky Mountain HealthNet Application at 4; Texas Health Information Network Collaborative Application at 10; Wyoming Telehealth Network Application at 1; Adirondack-Champlain Telemedicine Information Network Application at 25-26; Association of Washington Public Hospital Districts Application at 28-29; Holzer Consolidated Health Systems Application at 8; North Carolina Telehealth Network Application at 5, 8; Palmetto (continued....)

example, Palmetto State Providers Network plans to link large tertiary centers, academic medical centers, rural hospitals, community health centers, and rural office-based practices in four separate rural/underserved areas in South Carolina into a developing fiber optic statewide backbone which connects to Internet2, NLR, and the public Internet.[117] Similarly, Iowa Rural Health Telecommunications Program plans to link 100 hospitals in 57 counties in Iowa, one Nebraska hospital, and two South Dakota hospitals to a broadband network which will: facilitate timely diagnosis and initiation of appropriate treatment or transfer of patients in rural communities; facilitate rapid access to and transmission of diagnostic images and patient information between hospitals; extend and improve terrorism and disaster preparedness and response through communication network interoperability between hospitals, the Iowa Department of Public Health, and Iowa Homeland Security and Emergency Management; and enable future remote monitoring and care coordination for intensive care patients.[118]

42. *Creation of Statewide or Regional Health Care Networks and Connection to Dedicated Nationwide Backbone.* In the *2006 Pilot Program Order*, we instructed applicants to submit proposals that would facilitate the creation of state or regional networks and (optionally) connect to a nationwide broadband network. These networks should be dedicated to health care, thereby connecting public and non-profit health care providers in rural and urban locations.[119] The selected participants generally demonstrated how their proposals would result in new or expanded state or regional networks and connection to a nationwide broadband network dedicated to health care.[120] For example, Wyoming

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State Providers Network Application at 5, 7, 22, 57-58; Penn State Milton S. Hershey Medical Center Application at 6; Rural Healthcare Consortium of Alabama Application at 2; Pathways Community Behavioral Healthcare, Inc. Application at 3; West Virginia Telehealth Alliance Application at 1-2; Virginia Acute Stroke TeleHealth Project Application at 31; Rural Nebraska Healthcare Network Application at 10; Southern Ohio Healthcare Network Application at 4, 15-16; Texas Healthcare Network Application at 6; Iowa Health System Application at 6; Rural Western and Central Maine Broadband Initiative Application at 11-12, 26; Tennessee Telehealth Network Application at 30; DCH Health System Application at 3; Kansas University Medical Center Application at 5; Western New York Rural Area Health Education Center Application at 16; Health Information Exchange of Montana Application at 2, 9; Arkansas Telehealth Network Application at 32-33; Communicare Application at 7; Erlanger Health System Application at 5; Greater Minnesota Telehealth Broadband Initiative Application at 12-13; Illinois Rural HealthNet Consortium Application at 14; Pennsylvania Mountains Healthcare Alliance Application at 6-8; Tohono O'odham Nation Department of Information Technology Application at 3-4; Louisiana Department of Hospitals Application at 10-11; Northwestern Pennsylvania Telemedicine Initiative Application at 3; Puerto Rico Health Department Application at 10; Sanford Health Collaboration and Communication Channel Application at 2; Utah Telehealth Network Application at 20-24.

[117] Palmetto State Providers Network Application at 5.

[118] Iowa Rural Health Telecommunications Program Application at 7-8, 12-13.

[119] *See 2006 Pilot Program Order*, 21 FCC Rcd at 11111, 11115-16, paras. 2, 16.

[120] *See infra* paras. 83-98, explaining the USAC application process, which will require selected participants to provide, *inter alia*, detailed information on their creation of, and connection to, networks, to receive Pilot Program funds. Arizona Rural Community Health Information Exchange Application at 26; Iowa Rural Health Telecommunications Program Application at 7, 12, 14; Northeast HealthNet Application at 8; Southwest Alabama Mental Health Consortium Application at Section B; Mountain States Health Alliance Application at 1; University Health Systems of Eastern Carolina Application at 5; University of Mississippi Medical Center Application at 2; Alabama Pediatric Health Access Network Application at 9; Colorado Health Care Connections Application at 11-12; Heartland Unified Broadband Network Application at 2; Juniata Valley Network Application at 6-7, 35; Michigan Public Health Institute Application at 1, 4; Frontier Access to Healthcare in Rural Montana Application at 10, 15; Northeast Ohio Regional Health Information Organization Application at 13; Pacific Broadband Telehealth Demonstration Project Application at 1, 2, 6, 8, Appendix 1; Rural Wisconsin Health Cooperative Application at 1; Southwest Telehealth Access Grid Application at 12; Big Bend Regional Healthcare Information Organization Application at 4-10; Geisinger Health System Application at 5; Indiana Health Network Application at 63; Northwest Alabama Mental Health Center Application at 2; Oregon Health Network Application at 21-30; St. Joseph's Hospital Application at 2; Health Care Research & Exchange Network Application at 12-23; Alaska Native (continued....)

Telehealth Network will connect more than 30 hospitals and 42 community health centers, providing consortium health care professionals with access to a statewide network, and facilitating connection to Internet2 or NLR.[121] West Virginia Telehealth Alliance's proposed network will facilitate access in every region, health care market, and community in West Virginia, with particular focuses on medically underserved rural areas; health professional shortage areas; communities with high disease and chronic health condition disparities; and communities that demonstrate "readiness for deployment."[122] Southwest Alabama Mental Health Consortium plans to establish a broadband network connecting 34 mental health providers in 16 counties in Southwest Alabama, and this network will connect to Internet2 thereby creating a large regional mental health care network that has access to the national backbone.[123]

43. *Tribal Lands.* A significant number of applicants plan to use Pilot Program funds to create or expand health care networks serving tribal lands.[124] We find that network reach to tribal lands to be a positive use of Pilot Program funds; these areas traditionally have been underserved by health care facilities and reflect unique health care needs, particularly compared to non-tribal areas.[125] In addition to inadequate access to health care, tribal lands suffer from relatively low levels of access to important

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Tribal Health Consortium Application at 12; Bacon County Health Services Application at 2; California Telehealth Network Application at 12; Missouri Telehealth Network Application at 3; New England Telehealth Consortium Application at 12; North Country Telemedicine Project Application at 11; Rocky Mountain HealthNet Application at 5; Texas Health Information Network Collaborative Application at 10, 24; Wyoming Telehealth Network Application at 8-9; Adirondack-Champlain Telemedicine Information Network Application at 2; Association of Washington Public Hospital Districts Application at 6; Holzer Consolidated Health Systems Application at 2-3; North Carolina Telehealth Network Application at 5, 11; Palmetto State Providers Network Application at 22; Penn State Milton S. Hershey Medical Center Application at 6; Rural Healthcare Consortium of Alabama Application at 2-3; West Virginia Telehealth Alliance Application at Attachment 1; Virginia Acute Stroke TeleHealth Project Application at 44; Rural Nebraska Healthcare Network Application at 10; Southern Ohio Healthcare Network Application at 15-16, 21; Texas Healthcare Network Application at 12; Iowa Health System Application at 5; Rural Western and Central Maine Broadband Initiative Application at 26; Tennessee Telehealth Network Application at 18-19; Albemarle Network Telemedicine Initiative Application at 2; Kansas University Medical Center Application at 6; Western New York Rural Area Health Education Center Application at 8-9; Health Information Exchange of Montana Application at 7; Arkansas Telehealth Network Application at 10-12; As One-Together for Health Application at 4-9; Communicare Application at 7; Erlanger Health System Application at 2, 13; Greater Minnesota Telehealth Broadband Initiative Application at 10-11; Illinois Rural HealthNet Consortium Application at 15, 18; Kentucky Behavioral Telehealth Network Application at 10-11; Pennsylvania Mountains Healthcare Alliance Application at 4; Tohono O'odham Nation Department of Information Technology Application at 4; Louisiana Department of Hospitals Application at 10-12; Northwestern Pennsylvania Telemedicine Initiative Application at 2-3; Puerto Rico Health Department Application at 13; Sanford Health Collaboration and Communication Channel Application at 2; Utah Telehealth Network Application at 20-24.

[121] Wyoming Telehealth Network Application at 8-10.

[122] West Virginia Telehealth Alliance Application at 26 of Strategic Plan.

[123] Southwest Alabama Mental Health Consortium Application at Section B.

[124] *See, e.g.*, Western Carolina University Application at 10; Heartland Unified Broadband Network Application at Appendix F; Michigan Public Health Institute Application at 34-35; Southwest Telehealth Access Grid Application at 1; Oregon Health Network Application at 22; Health Care Research & Education Network Application at 10; California Telehealth Network Application at 55; Adirondack-Champlain Telemedicine Information Network Application at 10-14; Association of Washington Public Hospital Districts Application at 18-22; Rural Nebraska Healthcare Network Application at 7; Health Information Exchange of Montana Application at 8; Tohono O'odham Nation Department of Information Technology Application at 10-16; Sanford Health Collaboration and Communication Channel Application at 5; Utah Telehealth Network Application at 2, 4, 5, 7, 32.

[125] U.S. Department of Health and Human Services, Indian Health Service, Facts on Indian Health Disparities, *available at* http://info.ihs.gov/Files/DisparitiesFacts-Jan2007.doc (last visited Nov. 15, 2007).

telecommunications services. For example, Native American communities have the lowest reported levels of telephone subscribership in America.[126]

44. We find that these health care and telecommunications disparities between tribal lands and other areas of the country underscore the serious need for Pilot Program support of telemedicine and teleheath networks in tribal areas. Many selected participants plan to use Pilot Program support for networks on or near tribal lands. For example, Health Care Research & Education Network (Network) plans to construct a network that will serve a significant Native American population. According to the Network, Native Americans report being uninsured at a rate of 37.1 percent and North Dakota's Indian population is 1.5 times as likely to die of heart disease, cancer, stroke, and influenza/pneumonia as those living on non-tribal lands.[127] The Network seeks to alleviate some of these disparities through use of its planned network that will provide a link to improve educational opportunities, and will facilitate new and ongoing research in health care delivery to rural areas.[128]

45. In the first year of the Pilot Program, Western Carolina University (WCU) in collaboration with the Eastern Band of Cherokee Indians (EBCI) seeks to connect the WCU's health care facilities to health care facilities on the ECBI reservation and in outlying areas so that patients can access critically needed medical specialists in a variety of practices without leaving their homes or their communities.[129] In Year two of the Pilot Program, WCU plans to connect the United South and Eastern Tribes, Inc. (USET), a non-profit, inter-tribal organization of 24 federally recognized tribes, to its network.[130] We find that these and the other planned uses of Pilot Program funds to support network build-out to tribal lands will further our goal of bringing innovative health care services to those areas of the country with the most acute health care needs.[131]

46. *Cost Estimates.* In the *2006 Pilot Program Order* we requested that applicants provide estimates of their network's total costs for each year.[132] Selected participants provided cost estimates or budgets.[133] Several applicants provided significant cost and budget details, including Adirondack-

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[126] *See, e.g., Sacred Wind Communications, Inc. and Qwest Corporation, Joint Petition for Waiver of the Definition of "Study Area" Contained in Part 36, Appendix-Glossary of the Commission's Rules, Sacred Wind Communications, Inc., Related Waivers of Parts 36, 54, and 69 of the Communication's Rules*, CC Docket No. 96-45, Order, 21 FCC Rcd 9227, 9231 para. 9 (2006); *see also Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Memorandum Opinion and Order, and Further Notice of Proposed Rulemaking, 15 FCC Rcd 12208, 12217-18, para. 16 (2000) (amending Lifeline and Link-Up assistance rules applicable to eligible residents of tribal lands, consisting of qualifying low-income consumers living on or near reservations, as defined in 25 C.F.R. § 20.1(r), (v)); *Federal-State Joint Board on Universal Service; Promoting Deployment and Subscribership in Unserved and Underserved Areas, Including Tribal and Insular Areas*, CC Docket No. 96-45, Order and Further Notice of Proposed Rulemaking, 15 FCC Rcd 17122 (2000) (seeking additional comment on extending the enhanced Lifeline and Link-Up measures to qualifying low-income consumers living in areas near reservations to target support to the most underserved, geographically isolated, and impoverished areas that are characterized by low subscribership).

[127] Health Care Research & Education Network Application at 8.

[128] *Id.*

[129] Western Carolina University Application at 3, 10.

[130] Western Carolina University Application at 10-11.

[131] *2006 Pilot Program Order*, 21 FCC Rcd at 11111, para. 1.

[132] *Id.* at 11111-12, 11116-17, paras. 3, 17.

[133] Arizona Rural Community Health Information Exchange Application at 13, 15; Iowa Rural Health Telecommunications Program Application at 15; Northeast HealthNet Application at 10-11; Southwest Alabama Mental Health Consortium Application at Section D; Mountain States Health Alliance Application at 1, 6, 8; University Health Systems of Eastern Carolina Application at 7, 16; University of Mississippi Medical Center (continued....)

Champlain Telemedicine Information Network whose budget includes a clear and detailed analysis of network costs, including, *e.g.*, cost per foot of fiber, cost of a pole installation, number of feet of fiber, and number of poles where fiber is installed.[134] Alaska Native Tribal Health Consortium provides detailed cost estimates for each phase of its network, including deployment and services, and provides significant information about its revenue stream, operating expenses, and maintenance for five years.[135] Although we find selected participants have satisfied this criterion, to ensure support is used for eligible costs, as part of the USAC application process, applicants must submit detailed network costs worksheets.[136]

47. *Fair Share.* To prevent improper distribution of Pilot Program funds, in the *2006 Pilot Program Order,* we instructed applicants to describe how for-profit network participants will pay their fair share of the network and other costs.[137] In general, selected participants provided significant

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Application at 45, 19; Western Carolina University Application at 8; Alabama Pediatric Health Access Network Application at 37-38; Colorado Health Care Connections Application at 13; Heartland Unified Broadband Network Application at 30-32; Juniata Valley Network Application at 50; Michigan Public Health Institute Application at 63-65; Frontier Access to Healthcare in Rural Montana Application at 38; Northeast Ohio Regional Health Information Organization Application at 51-55; Pacific Broadband Telehealth Demonstration Project Application at Appendix 2; Rural Wisconsin Health Cooperative Application at 6; Southwest Telehealth Access Grid Application at 40; Big Bend Regional Healthcare Information Organization Application at 13; Geisinger Health System Application at 4; Indiana Health Network Application at 4-5; Northwest Alabama Mental Health Center Application at 2; Oregon Health Network Application at 37; St. Joseph's Hospital Application at 4; Health Care Research & Education Network Application at 23-24; Alaska Native Tribal Health Consortium Application at 19; Bacon County Health Services Application at 9; California Telehealth Network Application at 22-23; Missouri Telehealth Network Application at 7; New England Telehealth Consortium Application at 18, 37; North Country Telemedicine Project Application at 15, 16; Rocky Mountain HealthNet Application at 7; Texas Health Information Network Collaborative Application at 16; Wyoming Telehealth Network Application at 11; Adirondack-Champlain Telemedicine Information Network Application at 5; Association of Washington Public Hospital Districts Application at 15, 17; Holzer Consolidated Health Systems Application at 12; North Carolina Telehealth Network Application at 13-14; Palmetto State Providers Network Application at 27; Penn State Milton S. Hershey Medical Center Application at 9-10; Rural Healthcare Consortium of Alabama Application at 6; Pathways Community Behavioral Healthcare, Inc. Application at 1, 3; West Virginia Telehealth Alliance Application at Appendix 2; Virginia Acute Stroke TeleHealth Project Application at 77; Rural Nebraska Healthcare Network Application at 37; Southern Ohio Healthcare Network Application at 25; Texas Healthcare Network Application at 12; Iowa Health System Application at 5; Rural Western and Central Maine Broadband Initiative Application at 24; Tennessee Telehealth Network Application at 25; DCH Health System Application at 4; Albemarle Network Telemedicine Initiative Application at 2; Kansas University Medical Center Application at 8, 16; Western New York Rural Area Health Education Center Application at 18; Health Information Exchange of Montana Application at 13; Arkansas Telehealth Network Application at 56-58; As One-Together for Health Application at 12; Cómmunicare Application at 23; Erlanger Health System Application at 12; Greater Minnesota Telehealth Broadband Initiative Application at 2; Illinois Rural HealthNet Consortium Application at 30; Kentucky Behavioral Telehealth Network Application at 18-21; Pennsylvania Mountains Healthcare Alliance Application at 3; Tohono O'odham Nation Department of Information Technology Application at Appendix B; Louisiana Department of Hospitals Application at 14; Northwestern Pennsylvania Telemedicine Initiative Application at 11; Puerto Rico Health Department Application at 13, Appendix F; Sanford Health Collaboration and Communication Channel Application at 4, 10; Utah Telehealth Network Application at 3, 47.

[134] Adirondack-Champlain Telemedicine Information Network Application at 5-9.

[135] Alaska Native Tribal Health Consortium Application at 19, 50.

[136] Below, we provide selected participants with an illustrative format for identifying all of the information that should be included in their budgets. *See infra* at Appendix F.

[137] *2006 Pilot Program Order*, 21 FCC Rcd at 11116-17, para. 17.

assurances that for-profit participants will be responsible for all of their network costs.[138] For instance, Northeast HealthNet states that its proposed network does not include for-profit entities and that, if for-profit entities are added to its network, they would be invoiced separately for each service item and USAC would receive invoice documentation that reflects only eligible rural health care providers.[139] Similarly, TTN notes that although it will not include for-profit participants in the first two years, for-profits will later be allowed to join and will be required to pay 100 percent of their actual costs.[140]

48. *Funding Source.* In the *2006 Pilot Program Order*, we instructed applicants to identify their source of financial support and anticipated revenues that will pay for costs not covered by the fund.[141] Generally, selected participants identified their source or sources of support for costs not covered by the Pilot Program.[142] For example, University Health Systems of Eastern Carolina states that it, the

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[138] Arizona Rural Community Health Information Exchange Application at 18; Iowa Rural Health Telecommunications Program Application at 19; Northeast HealthNet Application at 11; Mountain States Health Alliance Application at 6; University Health Systems of Eastern Carolina Application at 7; University of Mississippi Medical Center Application at Attachment to p. 45; Western Carolina University Application at 9; Heartland Unified Broadband Network Application at 20, 34; Juniata Valley Network Application at 36; Michigan Public Health Institute Application at 24; Frontier Access to Healthcare in Rural Montana Application at 16; Northeast Ohio Regional Health Information Organization Application at 7-8; Pacific Broadband Telehealth Demonstration Project Application at 14; Rural Wisconsin Health Cooperative Application at 6; Big Bend Regional Healthcare Information Organization Application at 4; Geisinger Health System Application at 4; Indiana Health Network Application at 70; Northwest Alabama Mental Health Center Application at 2; Oregon Health Network Application at 92; St. Joseph's Hospital Application at 4; Health Care Research & Education Network Application at 25; Alaska Native Tribal Health Consortium Application at 13; Bacon County Health Services Application at 2; California Telehealth Network Application at 24; Missouri Telehealth Network Application at 4; New England Telehealth Consortium Application at 18; North Country Telemedicine Project Application at 17; Rocky Mountain HealthNet Application at 2, 7; Texas Health Information Network Collaborative Application at 26; Wyoming Telehealth Network Application at 11; Adirondack-Champlain Telemedicine Information Network Application at 9; Association of Washington Public Hospital Districts Application at 16; Holzer Consolidated Health Systems Application at 6; North Carolina Telehealth Network Application at 15; Palmetto State Providers Network Application at 9, 23; Penn State Milton S. Hershey Medical Center Application at 10; Rural Healthcare Consortium of Alabama Application at 3; Pathways Community Behavioral Healthcare, Inc. Application at 3; West Virginia Telehealth Alliance Application at 8-9; Virginia Acute Stroke TeleHealth Project Application at 53; Rural Nebraska Healthcare Network Application at 37; Southern Ohio Healthcare Network Application at 23-24; Texas Healthcare Network Application at 17; Iowa Health System Application at 6; Rural Western and Central Maine Broadband Initiative Application at 45-46; Tennessee Telehealth Network Application at 26; Albemarle Network Telemedicine Initiative Application at 2; Arkansas Telehealth Network Application at 54; As One-Together for Health Application at 13; Communicare Application at 24; Erlanger Health System Application at 5; Greater Minnesota Telehealth Broadband Initiative Application at 2; Illinois Rural HealthNet Consortium Application at 30; Tohono O'odham Nation Department of Information Technology Application at 18; Louisiana Department of Hospitals Application at 24; Northwestern Pennsylvania Telemedicine Initiative Application at 4; Puerto Rico Health Department Application at 13; Sanford Health Collaboration and Communication Channel Application at 4; Utah Telehealth Network Application at 50.

[139] Northeast HealthNet Application at 11.

[140] Tennessee TeleHealth Network Application at 26.

[141] *2006 Pilot Program Order*, 21 FCC Rcd at 11116-17, para. 17. To preserve the integrity of the Pilot Program, we will continue to require selected participants to indicate how for-profit participants pay their fare share of network costs. Accordingly, selected participants must submit this information to USAC as part of their detailed line-item network costs worksheet submission and Pilot Program Participants Quarterly Data Reports. *See* Appendices D, F; *see also* Part III.E.3, *infra* (describing eligible funding sources).

[142] Arizona Rural Community Health Information Exchange Application at 14; Iowa Rural Health Telecommunications Program Application at 19; Northeast HealthNet Application at 11; Southwest Alabama Mental Health Consortium Application at Section F; Mountain States Health Alliance Application at 7; University (continued....)

participating health care providers, and the North Carolina Office of Rural Health will provide funding for their network costs not supported by Pilot Program funds.[143] And, Wyoming Telehealth Network has received a commitment from the Wyoming Department of Public Health and Terrorism Preparedness Program to fund the Network's costs not covered by the Program.[144]

49. *85 Percent Funding.* We also stated in the *2006 Pilot Program Order* that no more than 85 percent of their costs incurred by a participant will be funded to deploy a state or regional dedicated broadband health care network, and to connect that network to NLR, Internet2, or the public Internet.[145] In general, selected participants demonstrated their commitment to seeking no more than 85 percent of their network costs from the Pilot Program.[146] Michigan Public Health Institute, for example, explains

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Health Systems of Eastern Carolina Application at 7, Appendixes A, B, C, D; Western Carolina University Application at 9; Alabama Pediatric Health Access Network Application at 6, 9; Colorado Health Care Connections Application at 17; Heartland Unified Broadband Network Application at 34, Appendix D; Juniata Valley Network Application at 55; Michigan Public Health Institute Application at 61-62; Frontier Access to Healthcare in Rural Montana Application at 17, Letters of Commitment; Northeast Ohio Regional Health Information Organization Application at 7, 52-54; Pacific Broadband Telehealth Demonstration Project Application at 14; Rural Wisconsin Health Cooperative Application at 6; Southwest Telehealth Access Grid Application at Appendix 5; Big Bend Regional Healthcare Information Organization Application at 14-15; Indiana Health Network Application at 68; Northwest Alabama Mental Health Center Application at 3; Oregon Health Network Application at 86; St. Joseph's Hospital Application at 5; Health Care Research & Education Network Application at 25; Alaska Native Tribal Health Consortium Application at 23; Bacon County Health Services Application at 8; California Telehealth Network Application at 26; Missouri Telehealth Network Application at 5, 14, Attachment C; New England Telehealth Consortium Application at 19, Appendix C; North Country Telemedicine Project Application at 13; Rocky Mountain HealthNet Application at 2, 8; Texas Health Information Network Collaborative Application at 17; Wyoming Telehealth Network Application at 11; Adirondack-Champlain Telemedicine Information Network Application at 8; Association of Washington Public Hospital Districts Application at 15; Holzer Consolidated Health Systems Application at 7; North Carolina Telehealth Network Application at 15; Palmetto State Providers Network Application at 8; Penn State Milton S. Hershey Medical Center Application at 10; Rural Healthcare Consortium of Alabama Application at 3-4; Pathways Community Behavioral Healthcare, Inc. Application at 3; West Virginia Telehealth Alliance Application at 9; Virginia Acute Stroke TeleHealth Project Application at 1; Rural Nebraska Healthcare Network Application at 30, 37-38; Southern Ohio Healthcare Network Application at 14; Texas Healthcare Network Application at 17; Iowa Health System Application at 7; Rural Western and Central Maine Broadband Initiative Application at 13; Tennessee Telehealth Network Application at 8, 25-26; Albemarle Network Telemedicine Initiative Application at 14; Kansas University Medical Center Application at 9; Western New York Rural Area Health Education Center Application at 22; Arkansas Telehealth Network Application at 13-14; As One-Together for Health Application at 14; Communicare Application at 24; Erlanger Health System Application at 1; Greater Minnesota Telehealth Broadband Initiative Application at 2; Pennsylvania Mountains Healthcare Alliance Application at 12; Tohono O'odham Nation Department of Information Technology Application at Appendix D; Utah Telehealth Network Application at 49; Sanford Health Collaboration and Communication Channel Application at 4; Puerto Rico Department of Health Application at 13; Louisiana Department of Hospitals Application at 10, 14.

[143] University Health Systems of Eastern Carolina Application at 7.

[144] Wyoming Telehealth Network Application at 11.

[145] *2006 Pilot Program Order*, 21 FCC Rcd at 11116-17, para. 14; *Pilot Program Reconsideration Order*, 22 FCC Rcd at 2556, para. 5.

[146] Arizona Rural Community Health Information Exchange Application at 15; Iowa Rural Health Telecommunications Program Application at 15, 12-13; Northeast HealthNet Application at 11; Southwest Alabama Mental Health Consortium Application at Section F; Mountain States Health Alliance Application at 8-9; University Health Systems of Eastern Carolina Application at Appendix C; University of Mississippi Medical Center Application at Attachment to p. 45; Western Carolina University Application at 9; Colorado Health Care Connections Application at 17-18; Heartland Unified Broadband Network Application at Appendix D; Juniata Valley Network Application at 50, 55; Michigan Public Health Institute Application at 61-62; Frontier Access to Healthcare in Rural Montana Application at 17; Northeast Ohio Regional Health Information Organization (continued....)

that the Michigan Legislature has appropriated funds to cover a portion of its 15 percent share of costs.[147] California Telehealth Network stated that it will receive its 15 percent share from the California Emerging Technology Fund, which is operated by the California Public Utility Commission.[148] Iowa Health System states that it plans to fund approximately 39 percent of the total cost of extending its existing fiber backbone to 78 rural sites.[149]

50. Included Facilities. With respect to health care facilities, we directed applicants in the *2006 Pilot Program Order*: (1) to list the health care facilities that will be included in their networks;[150] and (2) to demonstrate that they will connect more than a *de minimis* number of rural health care providers in their networks.[151] All selected participants satisfied this request by providing the names and details of facilities to be included and by proposing to connect more than a *de minimis* number of rural health care facilities.[152] Although some proposals include only a few rural health care providers, relative to the total number of facilities to be included in these networks, and recognizing the significant benefits these networks will confer on their rural populations, we find these small numbers of rural health care providers are more than *de minimis* when viewed in context. For example, Erlanger Health System's proposed network in Tennessee and Georgia includes five rural health care providers out of a total of 11

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Application at 7, 9-10, 52; Pacific Broadband Telehealth Demonstration Project Application at 14; Rural Wisconsin Health Cooperative Application at 6; Southwest Telehealth Access Grid Application at Appendix 5; Big Bend Regional Healthcare Information Organization Application at 4; Geisinger Health System Application at 4; Indiana Health Network Application at 4-5; Northwest Alabama Mental Health Center Application at 3; Oregon Health Network Application at 8; St. Joseph's Hospital Application at 3; Health Care Research & Education Network Application at 25; Alaska Native Tribal Health Consortium Application at 23; Bacon County Health Services Application at 8-10; California Telehealth Network Application at 26; Missouri Telehealth Network Application at 15; New England Telehealth Consortium Application at 37; North Country Telemedicine Project Application at 14-16; Texas Health Information Network Collaborative Application at 17; Wyoming Telehealth Network Application at 11; Adirondack-Champlain Telemedicine Information Network Application at 5; Association of Washington Public Hospital Districts Application at 15, 17; North Carolina Telehealth Network Application at 15; Palmetto State Providers Network Application at 26-27; Penn State Milton S. Hershey Medical Center Application at 10, Appendix C; Rural Healthcare Consortium of Alabama Application at 3; Pathways Community Behavioral Healthcare, Inc. Application at 3; West Virginia Telehealth Alliance Application at 8-9; Virginia Acute Stroke Telehealth Project Application at 5, 52, 55; Rural Nebraska Healthcare Network Application at 37-39; Southern Ohio Healthcare Network Application at 25; Texas Healthcare Network Application at 17; Iowa Health System Application at 7; Rural Western and Central Maine Application at 12; Tennessee Telehealth Network Application at 26; DCH Health System Application at 4; Albemarle Network Telemedicine Initiative Application at 2; Western New York Rural Area Health Education Center Application at 21; Health Information Exchange of Montana Application at 34; Arkansas Telehealth Network Application at 54; As One-Together for Health Application at 12; Erlanger Health System Application at 12; Greater Minnesota Telehealth Broadband Initiative Application at 2; Illinois Rural HealthNet Consortium Application at 30-31; Kentucky Behavioral Telehealth Network Application at 18-21; Pennsylvania Mountains Healthcare Alliance Application at 3; Tohono O'odham Nation Department of Information Technology Application at 8-9; Louisiana Department of Hospitals Application at 14; Northwestern Pennsylvania Telemedicine Initiative Application at 5; Puerto Rico Health Department Application at 12-13; Sanford Health Collaboration and Communication Channel Application at 4; Utah Telehealth Network Application at 3, 49.

[147] Michigan Public Health Institute Application at 61.

[148] California Telehealth Network Application at 26, 108.

[149] Iowa Health System Application at 6.

[150] *2006 Pilot Program Order*, 21 FCC Rcd at 11116-17, para. 17.

[151] *Id.* at 11116, para. 16.

[152] *See* list of selected participants at Appendix B.

facilities,[153] and Puerto Rico Health Department's proposed network includes six rural health care providers out of a total of 52 facilities.[154] Considering the total number of health care providers to be included in these proposed networks, we find that the number of rural health care providers is more than *de minimis.*

51. *Prior Experience.* To help ensure sufficient skill and competency of Pilot Program participants, in the *2006 Pilot Program Order* we asked whether applicants had previous experience in developing and managing telemedicine programs,[155] and specifically whether applicants had successful track records in developing, coordinating, and implementing telehealth/telemedicine programs within their states or regions.[156] In general, selected participants exhibited experience with telehealth/telemedicine programs, and some exhibited significant, impressive experience in this area.[157] Notably, University Health Systems of Eastern Carolina has been recognized as one of the nation's "100 Most Wired Healthcare Organizations" five of the previous six years by *Hospitals and Health Networks*

[153] Erlanger Health System Application at 8.

[154] Puerto Rico Health Department Application at 13-20.

[155] *2006 Pilot Program Order*, 21 FCC Rcd at 11116-17, para. 17.

[156] *Id.* at 11116, para. 16.

[157] Arizona Rural Community Health Information Exchange Application at 19-20; Iowa Rural Health Telecommunications Program Application at 8, 11, 26-28; Southwest Alabama Mental Health Consortium Application at Section H; Mountain States Health Alliance Application at 7; University Health Systems of Eastern Carolina Application at 2, 5; University of Mississippi Medical Center Application at 8-18; Western Carolina University Application at 4; Alabama Pediatric Health Access Network Application at 6; Colorado Health Care Connections Application at 20-23; Heartland Unified Broadband Network Application at 9; Juniata Valley Network Application at 59-60; Michigan Public Health Institute Application at 69-70; Frontier Access to Healthcare in Rural Montana Application at 18-19, 22, 26, 29; Northeast Ohio Regional Health Information Organization Application at 16-17; Pacific Broadband Telehealth Demonstration Project Application at 19-20; Rural Wisconsin Health Cooperative Application at 8-10; Southwest Telehealth Access Grid Application at 27-32; Big Bend Regional Healthcare Information Organization Application at 21-22; Geisinger Health System Application at 8; Indiana Health Network Application at 29; Northwest Alabama Mental Health Center Application at 4; Oregon Health Network Application at 95; St. Joseph's Hospital Application at 6; Health Care Research & Education Network Application at 25-26; Alaska Native Tribal Health Consortium Application at 5, 8; Bacon County Health Services Application at 5; California Telehealth Network Application at 48-49; Missouri Telehealth Network Application at 3, 6-7, 9, 14; New England Telehealth Consortium Application at 21-23; North Country Telemedicine Project Application at 26; Rocky Mountain HealthNet Application at 23; Texas Health Information Network Collaborative Application at 41; Wyoming Telehealth Network Application at 6, 16-17; Adirondack-Champlain Telemedicine Information Network Application at 15-22; Association of Washington Public Hospital Districts Application at 23-26; Holzer Consolidated Health Systems Application at 9-10; North Carolina Telehealth Network Application at 22; Palmetto State Providers Network Application at 17-18; Penn State Milton S. Hershey Medical Center Application at 18-19; West Virginia Telehealth Alliance Application at 34-50 of Strategic Plan; Virginia Acute Stroke Telehealth Project Application at 5; Rural Nebraska Healthcare Network Application at 41-42; Southern Ohio Healthcare Network Application at 3, 17-18; Texas Healthcare Network Application at 19; Iowa Health System Application at 9; Rural Western and Central Maine Application at 24-25; Tennessee Telehealth Network Application at 13-17; DCH Health System Application at 1; Albemarle Network Telemedicine Initiative Application at 12-13; Kansas University Medical Center Application at 12-13; Western New York Rural Area Health Education Center Application at 26; Health Information Exchange of Montana Application at 24; Arkansas Telehealth Network Application at 17-22; Erlanger Health System Application at 10-11; Greater Minnesota Telehealth Broadband Initiative Application at 17-23; Illinois Rural HealthNet Consortium Application at 19; Kentucky Behavioral Telehealth Network Application at 11-13; Pennsylvania Mountains Healthcare Alliance Application at 16-17; Tohono O'odham Nation Department of Information Technology Application at 19; Louisiana Department of Hospitals Application at 5-6; Northwestern Pennsylvania Telemedicine Initiative Application at 6-7; Puerto Rico Health Department Application at 9-10; Sanford Health Collaboration and Communication Channel Application at 7; Utah Telehealth Network Application at 49, 51-52.

magazine, and connects regional hospitals *via* a high-speed fiber-optic network enabling telemedicine, teleradiology and telehealth services.[158] University of Mississippi Medical Center's TelEmergency program already provides real-time medical care to patients in rural emergency departments utilizing specially-trained nurse practitioners linked with their collaborating physicians.[159] We find this experience, and the experiences cited in other applications, will further the goals of the *2006 Pilot Program Order* by ensuring that applicants have the necessary experience to successfully implement telemedicine/telehealth programs within their states or regions.[160]

52. *Project Management.* To ensure proper network oversight and implementation, in the *2006 Pilot Program Order*, we instructed applicants to provide project management plans which outline leadership and management structures, work plans, schedules, and budgets.[161] Selected participants provided project management plans that demonstrate a strong commitment to the success of their proposed networks.[162] For example, Southwest Alabama Mental Health Consortium sets forth a detailed

[158] University Health Systems of Eastern Carolina Application at 2.

[159] University of Mississippi Medical Center Application at 8-18.

[160] *See 2006 Pilot Program Order*, 21 FCC Rcd at 11116, para. 16.

[161] *Id.* at 11116-17, para. 17. We note that all selected participants must provide detailed project management plans as part of their Pilot Program Participants Quarterly Data Reports submitted to USAC. *See* Appendix D.

[162] Arizona Rural Community Health Information Exchange Application at 13, 15, 21-22; Iowa Rural Health Telecommunications Program Application at 15, 30, 35-38; Northeast HealthNet Application at 3, 14, 16; Southwest Alabama Mental Health Consortium Application at Section I; Mountain States Health Alliance Application at 6-8; University Health Systems of Eastern Carolina Application at 2, Appendixes A, B, C, D; University of Mississippi Medical Center Application at 4, 42-45; Western Carolina University Application at 8, 33-35; Alabama Pediatric Health Access Network Application at 27-30; Colorado Health Care Connections Application at 24-25; Heartland Unified Broadband Network Application at 18-19; Juniata Valley Network Application at 43; Michigan Public Health Institute Application at 52-53, 69; Frontier Access to Healthcare in Rural Montana Application at 31; Northeast Ohio Regional Health Information Organization Application at 22; Pacific Broadband Telehealth Demonstration Project Application at 20-21; Rural Wisconsin Health Cooperative Application at 10; Southwest Telehealth Access Grid Application at 34, Appendix 4; Big Bend Regional Healthcare Information Organization Application at 26; Geisinger Health System Application at 8-9; Indiana Health Network Application at 4, 5, 47-53, 62, 82, 120-129; Northwest Alabama Mental Health Center Application at 4-7; Oregon Health Network Application at 74-85; St. Joseph's Hospital Application at 6; Health Care Research & Education Network Application at 26-29; Alaska Native Tribal Health Consortium Application at 1, 12-14, 50; Bacon County Health Services Application at 5-6; California Telehealth Network Application at 50-51; Missouri Telehealth Network Application at 9-10, 12, 15; New England Telehealth Consortium Application at 30-31; North Country Telemedicine Project Application at 28, 31; Rocky Mountain HealthNet Application at 23-24; Texas Health Information Network Collaborative Application at 19, 42-44; Wyoming Telehealth Network Application at 19, 21-23; Adirondack-Champlain Telemedicine Information Network Application at 5, 24-25; Association of Washington Public Hospital Districts Application at 27-43; Holzer Consolidated Health Systems Application at 6, 10-12; North Carolina Telehealth Network Application at 23-35; Palmetto State Providers Network Application at 19-25; Penn State Milton S. Hershey Medical Center Application at 21-22; Rural Healthcare Consortium of Alabama Application at 4-5; Pathways Community Behavioral Healthcare, Inc. Application at 5; West Virginia Telehealth Alliance Application at 11-13, 28-29 of Strategic Plan, Appendix 2; Virginia Acute Stroke TeleHealth Project Application at 68-72; Rural Nebraska Healthcare Network Application at Exhibit C; Southern Ohio Healthcare Network Application at 28; Texas Healthcare Network Application at 19-20; Iowa Health System Application at 9; Rural Western and Central Maine Application at 40-42; Tennessee Telehealth Network Application at 43-44, 47-48, Attachment D; DCH Health System Application at 3-4; Albemarle Network Telemedicine Initiative Application at 15-18; Kansas University Medical Center Application at 13-16; Western New York Area Rural Health Education Center Application at 19, 28-30; Health Information Exchange of Montana Application at 27-30; Arkansas Telehealth Network Application at 23-28; As One-Together for Health Application at 46-50; Communicare Application at 25-26; Erlanger Health System Application at 4; Greater Minnesota Telehealth Broadband Initiative Application at 47; Illinois Rural HealthNet Consortium Application at 115, Attachment 5; Kentucky Behavioral Telehealth Network (continued....)

management structure, budget, and schedule, and its work plan provides for: establishment of a legal partnership; selection of a service provider based on Commission requirements; installation of WAN and connection to Internet2; monthly project assessment meetings; implementation of telehealth and telemedicine services; implementation evaluation; and project continuation to achieve goals and objectives.[163] Missouri Telehealth Network describes in detail the program manager's responsibilities; provides a month-by-month project timeline; and lists specific funding amounts requested for network costs, equipment, connections, and operation.[164]

53. *Coordination.* To ensure efficiencies and avoid duplication of efforts or network facilities, in the *2006 Pilot Program Order*, we instructed applicants to indicate how their proposed telemedicine program will be coordinated throughout the state or region.[165] In general, selected participants sufficiently described such coordination.[166] Notably, NETC members represent 57 hospitals, three

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Application at 14-19; Pennsylvania Mountains Healthcare Alliance Application at 19; Tohono O'odham Nation Department of Information Technology Application at 20-22; Louisiana Department of Hospitals Application at 4-5, 12-14; Northwestern Pennsylvania Telemedicine Initiative Application at 7-11; Puerto Rico Health Department Application at 5, 11-13, Appendix F; Sanford Health Collaboration and Communication Channel Application at 8-10; Utah Telehealth Network Application at 31, 35-38, 46-47.

[163] Southwest Alabama Mental Health Consortium Application at Sections D, I.

[164] Missouri Telehealth Network Application at 9-10, 15.

[165] *2006 Pilot Program Order*, 21 FCC Rcd at 11116-17, para. 17.

[166] Arizona Rural Community Health Information Exchange Application at 6; Iowa Rural Health Telecommunications Program Application at 38; Southwest Alabama Mental Health Consortium Application at Section J; Mountain States Health Alliance Application at 5-6; University Health Systems of Eastern Carolina Application at 2; University of Mississippi Medical Center Application at Cover Letter; Western Carolina University at 35; Alabama Pediatric Health Access Network Application at 7-8; Colorado Health Care Connections Application at 30; Heartland Unified Broadband Network Application at 36-37; Juniata Valley Network Application at 57; Michigan Public Health Institute Application at 43; Frontier Access to Healthcare in Rural Montana Application at 36-37; Northeast Ohio Regional Health Information Organization Application at 32-38; Pacific Broadband Telehealth Demonstration Project Application at 27; Rural Wisconsin Health Cooperative Application at 15; Southwest Telehealth Access Grid Application at 15; Big Bend Regional Healthcare Information Organization Application at 35; Geisinger Health System Application at 6; Indiana Health Network Application at 72; Northwest Alabama Mental Health Center Application at 7; Oregon Health Network Application at 57-65; St. Joseph's Hospital Application at 6; Health Care Research & Education Network Application at 32; Alaska Native Tribal Health Consortium Application at 12; Bacon County Health Services Application at 6-7; California Telehealth Network Application at 61; Missouri Telehealth Network Application at 12-13; New England Telehealth Consortium Application at 37; North Country Telemedicine Project Application at 33; Texas Health Information Network Collaborative Application at 3, 43; Wyoming Telehealth Network Application at 19; Adirondack-Champlain Telemedicine Information Network Application at 26; Association of Washington Public Hospital Districts Application at 11, 13, 27, 45; Holzer Consolidated Health Systems Application at 12-13; North Carolina Telehealth Network Application at 37; Palmetto State Providers Network Application at 26; Penn State Milton S. Hershey Medical Center Application at 23; Rural Healthcare Consortium of Alabama Application at 4-5; West Virginia Telehealth Alliance Application at 12; Virginia Acute Stroke TeleHealth Project Application at 45-47; Rural Nebraska Healthcare Network Application at 43-44; Southern Ohio Healthcare Network Application at 17-18; Texas Healthcare Network Application at 24; Rural Western and Central Maine Broadband Initiative Application at 15; Tennessee Telehealth Network Application at 45; DCH Health System Application at 4; Albemarle Network Telemedicine Initiative Application at 3; Kansas University Medical Center Application at 17; Health Information Exchange of Montana Application at 33; As One-Together for Health Application at 50-52; Communicare Application at 27; Erlanger Health System Application at 14; Greater Minnesota Telehealth Broadband Initiative Application at 48; Illinois Rural HealthNet Consortium Application at 25; Kentucky Behavioral Telehealth Network Application at 20; Tohono O'odham Nation Department of Information Technology Application at 23; Louisiana Department of Hospitals Application at 10-12; Northwestern Pennsylvania Telemedicine Initiative Application at 7-8; Puerto Rico Health Department Application at 5, 10; Sanford Health Collaboration and Communication Channel Application at 1, 8; Utah Telehealth Network Application at 5-6.

universities, 57 behavioral health sites, eight correctional facilities' clinics, 81 federally qualified health care centers, six health education sites, and two health research sites throughout Maine, Vermont and New Hampshire.[167] Each NETC member, through its representation on the NETC Board of Directors, will be able to provide input into critical NETC decisions including network implementation priority among the various sites and telemedicine programs implemented as a result of this network.[168] According to NETC, all members have agreed in writing that an Executive Committee will facilitate efficient management of the organization between meetings of the full Board.[169] Rural Nebraska Healthcare Network (RNHN), a non-profit membership organization consisting of nine local hospitals and their associated clinics in the Panhandle of Nebraska, has coordinated health care efforts in the Panhandle since 1996. RNHN plans to utilize and enhance its existing regional coordination for programs and services by employing a system of Regional Leadership Teams that will draft regional priorities and be responsible for communication between all participants.[170] The Regional Leadership Teams also will coordinate with the Board of Directors which includes the Chief Executive Officer of each member hospital.[171]

54. *Self Sustainability.* A primary goal of the Pilot Program is to ensure the long-term success of rural health care networks and to prevent wasteful allocation of limited universal service funds. Accordingly, in the *2006 Pilot Program Order*, we sought assurances from applicants that their proposed networks will be self sustaining once established.[172] Generally, selected participants provided sufficient evidence that their proposed networks will be self sustaining by the completion of the Pilot Program.[173]

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[167] New England Telehealth Consortium Application at 11-12.

[168] *Id.* at 37-38.

[169] *Id.* at 11.

[170] Rural Nebraska Healthcare Network Application at 44.

[171] *Id.* at 43.

[172] *2006 Pilot Program Order*, 21 FCC Rcd at 11116-17, para. 17. To the extent a network is not self sustainable once established, that may be an indicia of non-compliance with the terms of this Order and may be considered as part of any Pilot Program audits and oversight. *See infra* Part IV.

[173] Arizona Rural Community Health Information Exchange Application at 27-28; Iowa Rural Health Telecommunications Program Application at 39; Northeast HealthNet Application at 16-17; Southwest Alabama Mental Health Consortium Application at Section K; Mountain States Health Alliance Application at 1, 6; University Health Systems of Eastern Carolina Application at 10; University of Mississippi Medical Center Application at 44; Western Carolina University Application at 39; Alabama Pediatric Health Access Network Application at 34-35; Colorado Health Care Connections Application at 31-32; Heartland Unified Broadband Network Application at 34-36; Juniata Valley Network Application at 56; Michigan Public Health Institute Application at 24; Frontier Access to Healthcare in Rural Montana Application at 37; Pacific Broadband Telehealth Demonstration Project Application at 27; Rural Wisconsin Health Cooperative Application at 15-16; Southwest Telehealth Access Grid Application at 53; Big Bend Regional Healthcare Information Organization Application at 35-39; Geisinger Health System Application at 6; Indiana Health Network Application at 67-68; Northwest Alabama Mental Health Center Application at 7-8; Oregon Health Network Application at 90-91; St. Joseph's Hospital Application at 6; Health Care Research & Education Network Application at 32; Alaska Native Tribal Health Consortium Application at 50; Bacon County Health Services Application at 8; California Telehealth Network Application at 62-64; Missouri Telehealth Network Application at 14; New England Telehealth Consortium Application at 38; North Country Telemedicine Project Application at 34; Texas Health Information Network Collaborative Application at 27-28; Wyoming Telehealth Network Application at 22-23; Adirondack-Champlain Telemedicine Information Network Application at 9, 26-27, 30; Association of Washington Public Hospital Districts Application at 47-48; Holzer Consolidated Health Systems Application at 13; North Carolina Telehealth Network Application at 37; Palmetto State Providers Network Application at 26; Penn State Milton S. Hershey Medical Center Application at 24; Rural Healthcare Consortium of Alabama Application at 7; West Virginia Telehealth Alliance Application at 9, 12; Virginia Acute Stroke Telehealth Project Application at 45-47; (continued....)

For example, Heartland Unified Broadband Network identifies three possible scenarios for network sustainability for Year Three and beyond, including: reliance on the existing RHC support mechanism; reliance on fees from network partners; and reduction (not elimination) of bandwidth should full funding be unavailable.[174] Wyoming Telehealth Network envisions some ongoing costs covered by the existing RHC support mechanism or state funding, and plans to use as a model Nebraska's statewide telehealth network which is supported through a combination of existing RHC support mechanism, state funding through the Nebraska universal service program, and minimal consortium fees.[175]

55. *USAC Application Process.* As described in detail above, we find that selected participants have sufficiently set forth how they will meet the overall Pilot Program's goals and objectives, and how their networks will meet the detailed Program criteria set forth in the *2006 Pilot Program Order.* Although we find that the selected applications overall satisfy the criteria set forth in the *2006 Pilot Program Order*, additional information will be needed from many applicants to ensure funds are disbursed and used consistent with section 254 of the 1996 Act, this Order, and the Commission's rules and orders. Accordingly, as described more fully below, each selected participant will be required to comply with this Order, and to thoroughly and clearly provide all necessary information with its forms and other data through the USAC administrative process.[176] These additional requirements will ensure that Pilot Program funds are appropriately disbursed and will prevent, to the extent possible, waste, fraud, and abuse.[177]

D. Denied Applications

56. In this section, we deny 12 applications listed in Appendix C because these applicants do not demonstrate that they overall satisfy the goals, objectives, and other criteria of the *2006 Pilot Program Order*. Unlike the applications selected for participation above, the 12 applications we deny either have substantial deficiencies across the range of criteria established in the *2006 Pilot Program Order* or seek funding for costs that are well beyond the scope of the *2006 Pilot Program Order*. Accordingly, as explained below, we find that these applications do not warrant participation in the Rural Health Care Pilot Program.[178]

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Rural Nebraska Healthcare Network Application at 45; Southern Ohio Healthcare Network Application at 32; Texas Healthcare Network Application at 6; Iowa Health System Application at 11; Rural Western and Central Maine Broadband Initiative Application at 45-46; Tennessee Telehealth Network Application at 7, 27; DCH Health System Application at 4-5; Albemarle Network Telemedicine Initiative Application at 20; Kansas University Medical Center Application at 17; Western New York Area Rural Health Education Center Application at 46; Health Information Exchange of Montana Application at 31, 34; Arkansas Telehealth Network Application at 35; Communicare Application at 28; Erlanger Health System Application at 15; Illinois Rural HealthNet Consortium Application at 33; Kentucky Behavioral Telehealth Network Application at 21; Pennsylvania Mountains Healthcare Alliance Application at 21; Tohono O'odham Nation Department of Information Technology Application at 23; Louisiana Department of Hospitals Application at 11, 14; Northwestern Pennsylvania Telemedicine Initiative Application at 4; Puerto Rico Health Department Application at 4, 13; Sanford Health Collaboration and Communication Channel Application at 11; Utah Telehealth Network Application at 49, 50.

[174] Heartland Unified Broadband Network Application at 34-35.

[175] Wyoming Telehealth Network Application at 22-23.

[176] *See infra* Part III.E.

[177] *See id.*

[178] Applicants not selected to participate in the Pilot Program may still apply to the existing RHC support mechanism *via* the existing USAC process. *See, e.g., 2003 Report and Order and FNPRM*, 18 FCC Rcd at 24557-62, paras. 22-29 (providing a 25 percent discount off the cost of monthly Internet access for eligible health care providers under section 254(h)(2)(A)). Under section 254(h)(2)(A) of the 1996 Act, rural health care providers in states that are entirely rural can receive support equal to 50 percent of the monthly cost of advanced telecommunications and information services. 47 U.S.C. § 254(h)(2)(a); *see Second Report and Order and FNPRM*, (continued....)

57. *OpenCape Corporation Application.* OpenCape fails to satisfy the goals and objectives of the *2006 Pilot Program Order* because, among other things, its application seeks support focused not for a network dedicated to telehealth, but instead for a network for use by public schools, community colleges, and commercial firms.[179] OpenCape's application is also deficient because it fails to provide adequate details of it costs.[180] For example, the budget provided with OpenCape's application provides information on tasks it will perform, but does not provide costs associated with those tasks. For instance, OpenCape states that it will perform a wireless engineering study and a topography study, but does not provide the costs associated with these studies.[181] In addition, OpenCape does not adequately identify its source of the financial support and anticipated revenues that will pay for costs not covered by the Pilot Program, but instead merely indicates that it will pursue grants, donations and earmarks for capital funding of the full implementation.[182] Not only does this show that OpenCape does not presently know who will pay for its share of the costs, we cannot even determine from the application whether its expectations to obtain funding are realistic because OpenCape provides little to no evidence of its ability to secure funding from these sources. Rather, OpenCape merely explains that its federal and state legislative delegations generally (but not for its specific Pilot Program application) have shown an interest in expanding access to underserved regions of Massachusetts.[183] Accordingly, we deny Open Cape's request to participate in the Pilot Program.

58. *North Link of Northern Enterprises, Inc. Application.* North Link of Northern Enterprises, Inc. (North Link of Northern Enterprises) seeks $2.5 million in funding for a project generally described as connecting eight hospitals and medical centers to the regional fiber optic backbone to promote the use of a photo archiving system (PAS), virtual intensive care units, and teleconferencing.[184] However, beyond the vague description of the project, North Link of Northern Enterprises does not provide sufficient information to determine how the project will advance the goals of the *2006 Pilot Program Order*. Notably, like OpenCape's application, North Link of Northern Enterprises fails to provide budget information that would permit us to assess whether the application comports with program requirements including, in particular, whether the funding request is for eligible services. Additionally, the work plan submitted by North Link of Northern Enterprises fails to provide specific details on the phases of construction anticipated by Northern Enterprises. Instead, the work plan merely states that Phase I, which consists of laying 75 miles of the 400 miles of fiber optics, will begin June 4, 2007, with the balance of the project completed by 2009.[185] We therefore deny North Link of Northern Enterprises request for Pilot

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19 FCC Rcd at 24631-34, paras. 38-44.

[179] In fact, in the application, health care is only mentioned once and the letters of support and funding in the OpenCape application appear to be limited to school districts, community colleges, and the towns that would be served by the network. *Id.* at 23. To the extent OpenCape seeks funding for schools, it may do so through the universal service support mechanism for schools and libraries (E-Rate program). Information on that program is available *at* http://www.universalservice.org/sl/ (last visited July 19, 2007). Significantly, none of the seven members of the proposed board is affiliated with a health care provider; none of the 41 entities listed as supporting the network is a health care provider; and none of the six entities providing funds to cover the 15 percent minimum funding contribution is a health care provider. The seven board members primarily come from education backgrounds. OpenCape Corporation Application at 20-23.

[180] *Id.* at 18.

[181] *Id.* at 16-18.

[182] *Id.* at 18.

[183] *Id.* at 18.

[184] North Link of Northern Enterprise Application at 1-2.

[185] *Id.* at 4.

Program participation because it does not demonstrate it is qualified to be eligible for its broad request for funding.

59. *Illinois Hospital Association Application.* We also deny the application of Illinois Hospital Association because it seeks funding primarily for costs that are beyond the scope of the Pilot Program. In particular, Illinois Hospital Association states that it seeks over $800,000 for its proposed project to provide greater access to the existing state broadband network, Illinois Century Network, for rural health care providers to promote the use of telehealth and telemedicine throughout the state.[186] The funding, however, is primarily for staff support and customer premises equipment, which are outside the scope of the Pilot Program.[187] Thus, we deny this application for participation in the Pilot Program. We note, however, that the Illinois Rural HealthNet Consortium and the Iowa Health System will be participants in the Pilot Program and will offer services in Illinois.[188] We also note that the two main proposed recipients in Illinois Hospital Association's application, University of Illinois College of Medicine at Rockford and Southern Illinois School of Medicine, are also included in Illinois Rural HealthNet Consortium's application.[189]

60. *Institute for Family Health Application.* Similarly, the Institute for Family Health in New York seeks $2.4 million in funding for its proposed network that would extend its current electronic health records (EHR) and practice management system from its New York City-based urban network to rural health centers throughout the Mid-Hudson Valley region.[190] Of the requested Pilot Program funding, over 75 percent is for costs that are beyond the scope of the Pilot Program, including customer premises equipment such as personal computers and server hardware, personnel costs, and $1.5 million in funding for software licenses.[191] Accordingly, we decline to select Institute for Family Health to participate in the Pilot Program.

61. *Valley View Hospital Application.* The Valley View Hospital in Colorado's application also fails to qualify for participation in the Pilot Program because it seeks funding primarily for ineligible Pilot Program costs. Specifically, Valley View Hospital seeks $195,000 in funding for the rental of an RP-7 robotic system, which is a tele-operated, mobile robotic system that enables remote presence.[192] As stated above, the Pilot Program funding will promote the utilization of dedicated broadband capacity to provide

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[186] Illinois Hospital Association Application at 5. *See Pilot Program Order*, 21 FCC Rcd at 11114, paras. 11, 15; *see also* Rural Health Care Pilot Program: FAQ's *at* http://www.fcc.gov/cgb/rural/rhcp.html#faq7 (stating that these broadband costs include network design studies, transmission facilities, recurring and non-recurring costs associated with advanced telecommunications and information services, and costs of connecting the regional or state networks to Internet2 and NLR) (last visited Nov. 15, 2007).

[187] Illinois Hospital Association Application at 32-33. *See infra* paras. 74-75; *see also 2006 Pilot Program Order*, 21 FCC Rcd at 11115-16, paras. 14-15.

[188] Illinois Hospital Association Application at 32-33.

[189] *See* Illinois Rural HealthNet Consortium Application at 75.

[190] Letter from Neil S. Calman, M.D., CEO & President, Institute for Urban Family Health, to the Commission's Secretary, Federal Communications Commission, dated May 4, 2007 (this letter accompanied the application). *See* Institute for Family Health Application at 3-5. We note that Adirondack-Champlain Telemedicine Information Network, North Country Telemedicine Project, Northeast HealthNet, and Western New York Rural Area Health Education Center will be participants in the Pilot Program and will offer services in New York. *See* Appendix B for list of selected participants.

[191] *Id.* at 6-11.

[192] *See generally* Valley View Hospital Application. Colorado Health Care Connections, Rocky Mountain HealthNet, and Southwest Telehealth Access Grid will be participants in the Pilot Program and will offer services in Colorado.

health care services.[193] Valley View Hospital, however, seeks funding not for network design or build-out, but for medical equipment, which is specifically excluded from funding.[194] We find, therefore, that participation in the Pilot Program by Valley View Hospital is not appropriate.

62. *Alabama Rural Health Network.* The application submitted by the Alabama Department of Economic and Community Affairs (Alabama Rural Health Network) also seeks funding for ineligible Pilot Program costs.[195] In particular, Alabama Rural Health Network seeks $91,275 in funding, of which $45,000 is for a category simply labeled "contractual." The rest of the funding is divided amongst personnel costs, travel, "fringe benefits," and "indirect costs."[196] None of these costs are eligible costs for which Alabama Rural Health Network could receive reimbursement.[197] Further, none of those costs appear to be associated with network design or deployment of infrastructure. Instead, Alabama Rural Health Network's application appears to be seeking funding for a survey it will conduct of the state's hospitals to determine their needs, and an evaluation of the state's broadband providers to determine their capabilities.[198] These deficiencies in Alabama Rural Health Network's proposal warrant its exclusion from participation in the Pilot Program.

63. *Pioneer Health Network Application.* Pioneer Health Network's application states that it seeks to develop a health information system focusing on health information technology (such as patient level health and quality information exchange and establishing a health information environment that emphasizes security and privacy of patient data and that leverages technologies that are enhanced by the evolving interoperability standards) as opposed to telehealth and telemedicine applications.[199] Beyond this general description, Pioneer Health Network does not provide any details concerning its proposal except to indicate the project involves software applications, as opposed to network infrastructure (which the applicant states will largely be provided by the existing statewide backbone).[200] Because the Pilot Program does not fund medical software applications, we decline to find Pioneer Health Network eligible for funding.

64. *Taylor Regional Hospital Application.* Taylor Regional Hospital's application is so vague in providing overall details about how it qualifies for participation in the Pilot Program that we deny its application. In particular, Taylor Regional Hospital's application fails to specify the amount of funding it seeks, specifying only that its proposed project would cost $7,200 per year.[201] In addition, Taylor Regional Hospital fails to provide any detail supporting its costs for us to determine whether these costs are associated with network design or network costs.[202] Moreover, Taylor Regional Hospital does not identify the health care providers it seeks to connect. Instead, Taylor Regional Hospital states that the facilities that will be included in the network are "Taylor Regional Hospital and all the affiliates

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[193] *2006 Pilot Program Order*, 21 FCC Rcd at 11116, para. 16.

[194] *See infra* paras. 74-75; *see also 2006 Pilot Program Order*, 21 FCC Rcd at 11115-16, paras. 14-15.

[195] *See* Alabama Rural Health Network Application.

[196] *Id.* at 2.

[197] *See infra* paras. 74-75; *see also 2006 Pilot Program Order*, 21 FCC Rcd at 11115-16, paras. 14-15.

[198] Alabama Rural Health Network Application at 2.

[199] *See* Pioneer Health Network Application at 2.

[200] *Id.* at 5-9, 48.

[201] Taylor Regional Hospital Application at 3.

[202] Taylor Regional Hospital's stated objective is to use the funding to enhance its imaging distribution system, community-wide scheduling system, and its Laboratory Information System. *Id.* at 2. It is unclear from the application whether such enhancements would require network upgrades or whether they are software application upgrades, which would be ineligible for support.

associated with [it]."[203] This omission on the part of Taylor Regional Hospital makes it impossible, among other things, to determine whether there will be a *de minimis* number of the rural health care providers; identify network configuration; and to ensure that the proposed project is consistent with the goals, objectives, and other criteria of the *2006 Pilot Program Order*.[204] Thus, we deny this application.

65. *United Health Services Application*. Similarly, United Health Services of New York (United Health Services) provides such inadequate detail of its network costs that it does not merit further participation in the Pilot Program. Notably, United Health Services provides no budget, but instead merely lists its monthly connectivity costs,[205] without specifying whether the costs would support an existing network or construction of a new network.[206] In addition, its application fails to include financial data or to detail in any meaningful way its proposed network build-out and costs. Consequently, we find Pilot Program participation by United Health Services would not be consistent with the *2006 Pilot Program Order*.[207]

66. *World Network Institutional Services Application*. World Network Institutional Services (WNIS) also fails to detail its costs or almost any other aspect of its proposal in its cursory four-page application to adequately assess its qualifications for participation in the Pilot Program.[208] WNIS seeks $100 million in funding but fails to provide a budget breaking out its cost estimates.[209] Additionally, WNIS does not provide any detail as to which health care facilities it would include in its network, preventing us, among other things, from determining whether the network would serve more than a *de minimis* number of rural health care providers.[210] Rather, WNIS states that a list will be provided in "later correspondence" (which was never provided).[211] Further, WNIS fails to provide specific information on how it will pay for its portion of the costs of the network. Instead, WNIS offers that its financial support will come from "advertisers and users."[212] Based on these deficiencies and the overall vagueness of the application, we decline to include WNIS as a participant in the Pilot Program.

67. *Hendricks Regional Health Application*. Hendricks Regional Health (Hendricks), like WNIS, fails to provide a work plan that sufficiently details the management/leadership structure, work plan, or budget. In particular, Hendricks provides no budget information in its application. The only estimate in its application is for the per mile cost of deploying the fiber optic cable it seeks, which is $50,000 per mile for approximately 58 miles. And, even this information is not accompanied by any specific detail or documentation. We also have concerns about the work plan presented by Hendricks. Instead of providing detailed information, Hendricks provides a vague timeline with no additional information to

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[203] *See id.* at 3.

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

[205] United Health Services Application at 3-5.

[206] *See 2006 Pilot Program Order*, 21 FCC Rcd at 11116, para. 17 (stating applicants should provide a budget). We note that United Health Services does include a management and work plan and schedule. *See* United Health Services Application at 10. However, without a budget, we are not able to identify how it intends to allocate the funding for each phase of the plan.

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

[208] *See generally* World Network Institutional Services Application.

[209] *See id. See 2006 Pilot Program Order*, 21 FCC Rcd at 11116, para. 17 (stating applicant should identify the source of financial support).

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

[211] *See* World Network Institutional Services Application at 1.

[212] *Id.*

support its assumptions on deployment of the fiber optic cable.[213] Like Taylor, United Health Services, and WNIS, the deficiencies in Hendricks's application do not warrant its participation in the Pilot Program.

68. *Southwest Pennsylvania Regional Broadband Health Care Network Application.* Similarly, the application submitted by Southwest Pennsylvania Regional Broadband Health Care Consortium (Southwest Pennsylvania Regional Broadband Health Care Network) fails to provide information that sufficiently details its work plan or budget. Specifically, Southwest Pennsylvania Regional Broadband Health Care Network offers a budget that fails to provide any line-item details. Rather, Southwest Pennsylvania Regional Broadband Health Care Network indicates that it intends to build 180 miles of fiber optic cable[214] and states that it will need $7.2 million in funding to do so.[215] Southwest Pennsylvania Regional Broadband Health Care Network provides no detail on how it arrived at this figure or what it includes. Southwest Pennsylvania Regional Broadband Health Care Network also provides no information regarding the on-going cost of operating its network. Because there are no details in its budget, we are also not able to determine what network equipment Southwest Pennsylvania Regional Broadband Health Care Network intends to purchase. Additionally, Southwest Pennsylvania Regional Broadband Health Care Network fails to document its funding sources. It, instead, lists the facilities that would join the network and assigns an annual cost of $5,456.95 to each facility for five years without providing detail on where the entities will get the additional money or providing letters of support from these entities.[216] Moreover, like Hendricks, Southwest Pennsylvania Regional Broadband Health Care Network's work plan represents nothing more than a timeline.[217] Finally, we note that of the 99 facilities listed in its application, only five are eligible rural health care providers.[218] Given the amount of funding requested, the lack of financial and other detail needed to justify funding, and the small percentage of rural health care providers that will be connected, we find Pilot Program participation would not be consistent with the *2006 Pilot Program Order*.[219]

69. Finally, as noted above, in the *2006 Pilot Program Order*, one of the purposes of the Pilot Program was to encourage health care providers to aggregate their connection needs to form a comprehensive statewide or regional dedicated health care network.[220] The applications that we are approving in this Order have fulfilled that purpose and together will cover 42 states and three United States territories. We encourage those eligible health care providers that are part of the denied applications to pursue ways to be included in the approved consortia in their states or regions.[221] We also encourage the rural health care facilities in the denied applications to contact USAC to discuss their possible participation in the existing RHC support mechanism. In addition, after three years, we intend to revisit our rules and determine how to improve the current program. We encourage the denied applicants to participate in any subsequent proceedings and reapply at that time.

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[213] Hendricks Regional Health at 5.

[214] *See* Southwest Pennsylvania Regional Broadband Health Care Network Application at 4.

[215] *Id.* at 9.

[216] *See id.* at 13-15.

[217] *Id.* at 24.

[218] *Id.* at 17-19.

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

[220] *Id.*

[221] *See infra* para. 86.

E. Pilot Program Administration

70. In this section, we discuss several issues related to the effective administration of the Pilot Program. We first provide clarification regarding what entities are eligible health care providers for purposes of the Pilot Program, which services are eligible and ineligible for Pilot Program support, and which sources of funding are eligible and ineligible for selected participants' 15 percent minimum funding contribution. We also provide specific guidance concerning selected participants' compliance with the submission of program forms to the USAC. For example, in order to receive universal service support, selected participants must submit with the required FCC Forms, detailed worksheets concerning their proposed network costs, certifications demonstrating universal service support will be used for its intended purposes, letters of agency from each participating health care provider, detailed invoices showing actual incurred costs of project build-out and, if applicable, network design studies. As discussed below, selected participants that fail to comply with these procedures and the other program requirements we discuss here will be prohibited from receiving support under the Pilot Program. Finally, we address various requests for waiver of Commission rules filed by applicants. Among other things, we deny waiver requests of the Commission's rule requiring that Pilot Program selected participants competitively bid their proposed network projects.[222] In doing so, we reaffirm that the competitive bidding process remains an important safeguard to ensuring universal service support is used wisely and efficiently ensuring that the most cost-effective service providers are selected by selected participants, and we discuss the factors on which selected participants should rely in making their cost-effectiveness determinations in the competitive bidding process.

1. Eligible Health Care Providers

71. As stated above, the existing RHC support mechanism utilizes the statutory definition of "health care provider" established in section 254(h)(7)(b) of the 1996 Act.[223] Excluded from the list of eligible health care providers are nursing homes, hospices, other long-term care facilities, and emergency medical service facilities.[224] Additionally, pharmacies are excluded from the definition of health care providers.[225] Accordingly, under the RHC Pilot Program, only eligible health care providers and consortia that include eligible health care providers may apply for and receive discounts.[226] Additionally, applicants, as well as individual health care facilities included in an application, that have been convicted of a felony, indicted, suspended, or debarred from award of federal or state contracts, or are not in compliance with FCC rules and requirements shall not be eligible for discounts under the Pilot Program.[227] To the extent that the applications we select herein contain ineligible health care providers, such providers may participate but must be treated by the applicant and by USAC as if the providers were for-profit entities and therefore are ineligible to receive any support associated with their portion of the

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[222] *See* 47 C.F.R. §§ 54.603, 54.615.

[223] *2006 Pilot Program Order*, 21 FCC Rcd at 11111, n.4. The Commission has determined dedicated emergency departments of rural for-profit hospitals that participate in Medicare constitute rural health care clinics. *2003 Report and Order and FNPRM*, 18 FCC Rcd at 24553-55, paras. 13, 16.

[224] *See supra* para. 9. Although emergency medical service facilities are not eligible providers for purposes of the RHC Pilot Program, Pilot Program funds may be used to support costs of connecting emergency medical service facilities to eligible health care providers to the extent that the emergency medical services facility is part of the eligible health care provider. *See* 47 U.S.C. § 254(c)(3) (the "Commission may designate additional services for such support mechanisms for . . . health care providers for purposes of subsection (h)"). *See also supra* Part III.E.8.c; Virginia Acute Stroke Telehealth Project Application at 48-50; Texas Health Information Network Collaborative Application at 62-63.

[225] *See 2006 Pilot Program Order*, 21 FCC Rcd at 11111, n.4; *see also* 47 U.S.C. § 254(h)(7)(B).

[226] 47 C.F.R. § 54.601(a)(1), (c)(1).

[227] *See, e.g.*, 47 C.F.R. § 54.521.

Pilot Program network. Further, selected participants or individual health care facilities that are part of the network of a selected participant that are delinquent in debt owed to the Commission shall be prohibited from receiving universal service Pilot Program support until full payment or satisfactory arrangement to pay the delinquent debt(s) is made.[228] Also, selected participants or individual health care facilities included in the network of a selected participant that are barred by the General Services Administration (GSA) from receiving federal contracts, subcontracts, and certain types of federal assistance shall be prohibited from receiving universal service Pilot Program support until the GSA determines that they are eligible for federal contracts, subcontracts, and certain types of federal assistance.[229]

72. *Participation of State Organizations and Entities as Consortia Members.* State organizations and entities may apply for funding on behalf of consortia members, but cannot themselves receive funding for services under the Pilot Program unless they satisfy the statutory definition of health care provider under section 254(h)(7)(b) of the 1996 Act.[230] Notably, the Commission previously determined that the term "health care provider" should be interpreted narrowly and, in the past, excluded potential entities from the eligible health care provider definition when not explicitly included in the statutory definition by Congress.[231] Despite the limitations of section 254(h)(7)(b), however, the Commission's rules allow eligible health care providers to join consortia with other eligible health care providers; with schools, libraries, and library consortia eligible under Subpart F of 47 C.F.R. Part 54; and with public sector (governmental) entities to order telecommunications services.[232] As state organizations or entities constitute "public sector (governmental) entities," they may join consortia under our rules.[233]

73. Therefore, although state organizations and entities do not constitute eligible health care providers, we find they may apply on behalf of eligible health care providers as part of a consortium (*e.g.*, as consortia leaders) to function, for example, in an administrative capacity for eligible health care providers within the consortium. In doing so, however, state organizations and entities are prohibited

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[228] *See* 47 C.F.R. § 1.1910(b).

[229] *See* General Services Administration, Excluded Parties List System at http://www.epls.gov (last visited Nov. 15, 2007).

[230] In addition, state organizations or entities that provide eligible service offerings are eligible to be selected as a service provider by a Pilot Program selected participant through the competitive bidding processes. *See Universal Service First Report and Order*, 12 FCC Rcd at 9086-87, paras. 592-94 (finding that section 254(e) of the 1996 Act, which provides that "only an eligible telecommunications carrier designated under section 214(e) shall be eligible to receive specific Federal universal service support," is inapplicable to section 254(h)(2)); *c.f.* 47 C.F.R. § 54.500(l) (defining "state telecommunications network," for purposes of the E-rate program, as including "a state government entity that provides, using its own facilities, . . . telecommunications offerings to . . . schools, libraries, and rural health care providers" that are eligible for universal service support).

[231] *Fifteenth Order on Reconsideration*, 14 FCC Rcd at 18785-86, paras. 47-49. The Commission found that, given the specific categories of health care providers listed in section 254(h)(5)(B), if Congress had intended to include nursing homes, hospices, other long term care facilities, and emergency medical services facilities, it would have done so explicitly. *Fifteenth Order on Reconsideration*, 14 FCC Rcd at 18786, para. 48. Although the Commission later amended part of its determination and further defined "public health care provider" to include dedicated emergency departments of rural for-profit hospitals that participate in Medicare, the Commission again declined to expand the definition of health care provider to include nursing homes, hospices, and other long term care facilities. *2003 Report and Order*, 18 FCC Rcd at 24553, 24555, paras. 13, 16. The Commission further determined that such dedicated emergency departments in for-profit rural hospitals constitute "rural health clinics." *Id.* at 24554, para. 14.

[232] 47 C.F.R. § 54.601(b) (emphasis added).

[233] We find this to be consistent with Commission precedent addressing universal service support generally. *See, e.g.*, 47 C.F.R. § 54.501(d) (defining "public sector (governmental entities)" for the E-Rate program as including, but not limited to, *state* colleges and *state* universities, *state* educational broadcasters, counties, and municipalities (emphasis added)).

from receiving any funding from the Pilot Program.[234] In addition, we also find that, like state entities, other not-for-profit ineligible entities may apply on behalf of eligible health care providers as part of a consortium (*e.g.*, as consortia leaders), and otherwise function in an administrative capacity for eligible health care providers within the consortium.[235] Like state organizations and entities, these not-for-profit entities are prohibited from receiving any funding from the Pilot Program.

2. Rural Health Care Pilot Program Network Components Eligible and Ineligible for Support

74. In the *2006 Pilot Program Order*, the Commission stated that funding provided under the Pilot Program would be used to support the costs of constructing dedicated broadband networks that connect health care providers in a state or region,[236] and that connect such state and regional networks to the public Internet, Internet2, or NLR.[237] The Commission further explained that eligible costs include those for initial network design studies,[238] and for deploying transmission facilities and providing access to advanced telecommunications and information services, including non-recurring and recurring costs.[239] In light of the many applications we received seeking funding and the wide range of network and related

[234] We note that in the E-Rate context, the Commission has explicitly required state telecommunications networks that secure discounts under the universal service support mechanisms on behalf of eligible schools and libraries, or consortia that include an eligible school or library, to pass on these discounts to the eligible schools or libraries. *See* 47 C.F.R. § 54.519. We clarify here and make explicit that any discounts, funding, or other program benefits secured by a state entity or organization or other ineligible entity functioning as a consortium leader under the Pilot Program must be passed on to consortia members that are eligible health care providers.

[235] *See, e.g.*, Iowa Rural Health Telecommunications Program Application at 40-41 (proposing to use the Iowa Hospital Association to function in an administrative capacity for eligible health care provider consortium members); Association of Washington Public Hospital Districts Application at 3, 13 (proposing the Association of Washington Public Hospital Districts, a non-profit organization established to provide services to Washington's public hospitals, as the lead applicant, which will function as the administrator for the telehealth project and network); West Virginia Telehealth Alliance Application at 1 (stating that WVTA has been chartered as a West Virginia tax-exempt non-profit corporation to represent the consortium of eligible health care organization, and administer the project for the consortium).

[236] *See 2006 Pilot Program Order*, 21 FCC Rcd at 11114, para. 10.

[237] *See id.* at 11115, para. 14; *Pilot Program Reconsideration Order*, 22 FCC Rcd at 2556, para. 5.

[238] The Commission stated in the *2006 Pilot Program Order* that it would fund necessary network design studies for selected participants, as these studies would enhance access to advanced telecommunications and information services by enabling applicants to determine how best to deploy an efficient network that includes multiple locations and various technologies. *See 2006 Pilot Program Order*, 21 FCC Rcd at 11111, 11116, paras. 3, 15. Several applicants requested funding for network design studies. For example, Kentucky Behavioral Telehealth Network proposes to complete a network design study in Year One, and in Year Two build out the designed network to link the existing statewide network of regional behavioral health providers with rural health care providers to improve access to a full range of medical care. Kentucky Behavioral Telehealth Network Application at 5, 18-21. And, Penn State Milton S. Hershey Medical Center plans in Year One to connect several rural hospitals to the Medical Center and to conduct a comprehensive inventory and capacity analysis of additional facilities it seeks to add in Year Two. Penn State Milton S. Hershey Medical Center Application at 6, Appendix C. For purposes of the Pilot Program, we clarify that funding for network design studies includes costs paid to a consultant to analyze both technical and non-technical requirements and develop feasible network designs based on the analyses.

[239] *See 2006 Pilot Program Order*, 21 FCC Rcd at 11115-16, paras. 14-15. We note that in the *2006 Pilot Program Order*, the Commission stated that authorized purposes include the costs of "advanced telecommunications and information services." *Id.* at 11112, 11115, paras. 3, 14. We clarify here that, consistent with the Act, authorized purposes include the costs of *access to* advanced telecommunications services. *See* 47 U.S.C. § 254(h)(2)(A) (directing the Commission "to enhance, to the extent technically feasible and economically reasonable, *access to* advanced telecommunications and information services for all public and non-profit . . . health care providers . . . .") (emphasis added).

components for which support is sought, we further clarify the services eligible and ineligible for support to ensure that the Pilot Program operates to facilitate the goals of the *2006 Pilot Program Order*. We thus clarify that eligible non-recurring costs include those for design, engineering, materials and construction of fiber facilities or other broadband infrastructure, and the costs of engineering, furnishing (*i.e.*, as delivered from the manufacturer), and installing network equipment. Recurring and non-recurring costs of operating and maintaining the constructed network are also eligible once the network is operational.[240] Further, to the extent that a selected participant subscribes to carrier-provided transmission services (*e.g.*, SONET, DS3s) in lieu of deploying its own broadband network and access to advanced telecommunications and information services, the costs for subscribing to such facilities and services are also eligible.

75. Ineligible costs include costs that are not directly associated with network design, deployment, operations and maintenance. These ineligible costs include, but are not limited to:

- Personnel costs (including salaries and fringe benefits), except for those personnel directly engaged in 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.
- 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, *e.g.*, training of health care provider personnel in the use of telemedicine applications, are ineligible.
- Program administration or technical coordination that involves anything other than the design, engineering, operations, installation, or construction of the network.
- Inside wiring or networking equipment (*e.g.*, video/Web conferencing equipment and wireless user devices) on health care provider premises 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.
- Computers, including servers, and related hardware (*e.g.*, printers, scanners, laptops) unless used exclusively for network management.
- Helpdesk equipment and related software, or services.
- 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); Web server hosting; and Website/Portal development.
- Telemedicine applications and software; clinical or medical equipment.
- Electronic Records management and expenses.
- Connections to ineligible network participants or sites (*e.g.*, for-profit health care providers) and network costs apportioned to ineligible network participants.[241]

[240] These functions are often collectively referred to as "operation" or "network management."

[241] *See supra* Part III.E.1 for a discussion of ineligible entities.

- Administration and marketing costs (*e.g.*, administrative costs; supplies and materials (except as part of network installation/construction); marketing studies, marketing activities, or outreach efforts; evaluation and feedback studies).

76. USAC may only fund eligible costs as described in this Order and is prohibited from funding ineligible costs or providing funding to ineligible participants. We require, as discussed below, Pilot Program participants to identify and detail all ineligible costs, including costs apportioned to for-profit and other ineligible network participants or sites, in their line-item network costs worksheets submitted to USAC with FCC Forms 465 and 466-A, and to clearly demonstrate that Pilot Program support amounts will not be used to fund ineligible costs.[242] 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.[243]

3. Eligible Sources for 15 Percent of Non-Funded Costs

77. We find that selected participants' minimum 15 percent contribution of eligible network costs must be funded by an eligible source as described in this Order. Selected participants are required to identify with specificity their source of funding for the minimum 15 percent contribution of eligible network costs in their submissions to USAC, as discussed below.[244] In order to ensure that the Pilot Program operates consistent with the goals and objectives of the *2006 Pilot Program Order* and that funds are used to the benefit of public and non-profit health care providers, we place limitations on from what source selected participants may derive their minimum 15 percent contribution of eligible network costs. Only funds from an eligible source will apply towards selected participants' required 15 percent minimum contribution. Eligible sources include the applicant or eligible health care provider participants; state grants, funding, or appropriations; federal funding, grants, loans, or appropriations except for RHC funding; and other grant funding, including private grants. We stress that participants who do not demonstrate that their 15 percent contribution comes from an eligible source or whose minimum 15 percent funding contribution is derived from an ineligible source will be denied funding by USAC. Ineligible sources include in-kind or implied contributions; a local exchange carrier (LEC) or other telecom carrier, utility, contractor, consultant, or other service provider; and for-profit participants. Moreover, selected participants may not obtain any portion of their 15 percent contribution from the existing RHC support mechanism. We find that these limitations on sources are necessary to ensure that participating health care providers adequately invest in their network projects to ensure efficiency in both cost and design and to assume some minimal level of risk. Requiring participants to have a vested interest in the approved network project safeguards against program manipulation and protects against waste, fraud, and abuse. We recognize that some selected participants identified improper sources for

[242] We note that some applicants sought waivers of the *2006 Pilot Program Order*, if necessary, for certain costs. *See, e.g.*, Association of Washington Public Hospital Districts Application at 41; Southern Ohio Healthcare Network Application at 33. To the extent that these costs constitute ineligible costs, as described in this Order, selected participants may not request or receive Pilot Program funds to support these costs. *See supra* paras. 74-76. Accordingly, we deny these applicants' requests to expand the scope of funding available under the *2006 Pilot Program Order*.

[243] *C.f.* 47 C.F.R. § 54.504(g) (describing mixed eligibility services in the E-Rate program context).

[244] *See infra* para. 90. We emphasize that selected participants' 15 percent contributions must go towards *eligible* network costs only, as described in this Order. *See supra* paras. 74-76.

their participant contribution in their Pilot Program applications; however, we allow those selected participants to amend their project proposals in their submissions to USAC solely for the purpose of coming into compliance with the requirements of this Order.[245] Applicants so amending their applications are prohibited from using this opportunity to increase in any way the amount of support they are seeking.

4. Cost-Effectiveness

78. Consistent with existing rules and requirements, selected participants must comply with the competitive bidding process to select a service provider for their proposed projects.[246] As part of this requirement, we reiterate that each selected participant is required to certify to USAC that the service provider it chooses is, to the best of the applicant's knowledge, the most cost-effective service or facility provider available.[247] 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 health care provider deems relevant to . . . choosing a method of providing the required health care services."[248] In selecting the most cost-effective bid, in addition to price, we require selected participants to consider non-cost evaluation factors that include prior experience, including past performance; personnel qualifications, including technical excellence; management capability, including solicitation compliance; and environmental objectives (if appropriate).[249] The Commission has previously concluded 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.[250] Because designing and constructing a new network or building upon an existing network represents a substantial undertaking that requires technical expertise, training, and skills of a different level than those services supported by the existing RHC support mechanism, we make consideration of these factors mandatory for selected participants.

79. The existing RHC support mechanism, unlike the schools and libraries universal service support (E-Rate) program, does not require participants to consider price as the primary factor in selecting

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[245] *See, e.g.*, Adirondack-Champlain Telemedicine Information Network Application at 8 (including the provision of in-kind leases as part of its 15 percent contribution); Erlanger Health System Application at 5-7 (stating that Chattanooga Electric Power Board will fund 15 percent or more of network costs); Kansas University Medical Center Application at 9 (stating that part of its contribution will be an in-kind or implied contribution as part of the state Kan-Ed network); Rural Nebraska Healthcare Network Application at 37 (proposing that Mobius Communications will contribute the 15 percent contribution); Rural Western and Central Maine Broadband Initiative Application at 5 (proposing that Oxford, a for-profit regional broadband provider, would fund 15 percent of network costs); North Carolina Telehealth Network Application at 15 (proposing that a yet-to-be-determined contractor/vendor will pay the majority of the 15 percent contribution).

[246] *See* 47 C.F.R. § 54.603.

[247] *See Universal Service First Report and Order*, 12 FCC Rcd at 9134, para. 687.

[248] 47 C.F.R. § 54.615(c)(7).

[249] The Commission has permitted participants in the existing RHC support mechanism 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.

[250] *See 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*); *see also* 47 C.F.R. §§ 54.504(b)(2)(vii), 54.511(a).

service providers.[251] The Commission has stated that applicants to the RHC support mechanism 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 telemedicine needs.[252] This rationale remains appropriate for the Pilot Program. Thus, selected participants are not required to select the lowest bid offered, and need not consider price as the sole primary factor in selecting bids for construction of their broadband networks and the services provided over those networks. The applications selected for participation in the Pilot Program serve a variety of telemedicine and telehealth needs and entail complex network design, as well as infrastructure planning and construction. In developing a telemedicine network infrastructure, selected participants may find non-cost factors to be as or more important than price. For example, selected participants may find technical excellence and personnel qualifications particularly relevant in determining how to best meet their health care and telemedicine needs. Requiring applicants to use the lowest cost technology available could result in selected participants being relegated to using obsolete or soon-to-be retired technology. In addition, 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. Thus, we do not require selected participants to make price the sole primary factor in bid selection, but it must be a primary factor.

5. Network Modifications

80. Selected participants shall follow the network design plan outlined in their applications. Nevertheless, we recognize that selected participants may find it necessary or desirable to modify the network design plans set forth in their Pilot Program applications. For example, less expensive network components that may be available since applications were compiled may permit selected participants to acquire higher capacity at lower prices. Alternatively, selected participants may be able to add health care providers to their network within the available maximum support amounts.[253] Therefore, to the extent a selected participant wishes to upgrade, replace technology, or add eligible health care providers to its proposed network prior to commencing and completing the competitive bidding process, it may receive support to do so as long as that support does not exceed the maximum available support amount listed in Appendix B of this Order and the support is used for eligible expenses.[254] However, once a service provider is selected and an FCL is issued by USAC,[255] selected participants' support will be capped at the FCL amount, and the selected participant may only modify the network within that support amount. Any modifications that would increase the amount of support needed above the maximum available support amount for the selected participant in this Order will not be funded by the Pilot Program. After the issuance of the FCL, selected participants must complete the project for which funding is awarded.

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[251] *Compare Universal Service First Report and Order*, 12 FCC Rcd at 9134, para. 687, *with 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 26406, 26429, para. 50 (2003) (*Ysleta Order*) *and* 47 C.F.R. § 54.504(b)(2)(vii).

[252] *See 2003 Report and Order and FNPRM*, 18 FCC Rcd at 24576, para. 58.

[253] Although network modifications may deviate from a selected participant's initial application, to the extent a modification results in a supported network only connecting a *de minimis* number of rural health care providers, the modification may result in adjustment of available support or denial of participation in the Pilot Program for a selected participant.

[254] We also note that selected participants, including health care provider consortium members, may decline to participate in the Pilot Program, if they choose, subject to the restrictions noted in this Order. *See, e.g.*, Iowa Rural Health Telecommunications Program at 40-41 (requesting a waiver, if necessary, to allow hospitals to opt out if Pilot Program funds are not awarded at the 85 percent level or if actual construction costs exceed estimated costs).

[255] *See infra* para. 93.

6. Public Safety and Coordination for Emergencies

81. In 2004, the President issued an Executive Order calling for the development and implementation of a national interoperable health information technology infrastructure.[256] A key element of this plan is the NHIN initiative which promotes a "network of networks," where state and regional health information exchanges and other networks that provide health information services work together, through common architecture (services, standards, and requirements), processes and policies to securely exchange information. In response to the Pilot Program, HHS has identified ways the Pilot Program and the NHIN can advance the provision of critical patient information to clinicians at the point of care to enable vital links for disaster preparedness and emergency response, improve healthcare, population health, and prevention of illness and disease.[257]

82. We agree with HHS that the Pilot Program can advance the goals of the NHIN initiative. Accordingly, selected participants shall use Pilot Program funding in ways to ensure their funded projects are consistent with HHS's health IT initiatives in several areas: health IT standards; certification of EHRs, personal health records (PHRs), and networks; the NHIN architecture; the National Resource for Health Information Technology; and the PHIN.[258] In particular, where feasible, selected participants shall: (1) use health IT systems and products that meet interoperability standards recognized by the HHS Secretary;[259] (2) use health IT products certified by the Certification Commission for Healthcare Information Technology; [260] (3) support the NHIN architecture[261] by coordinating activities with the organizations performing NHIN trial implementations; [262] (4) use resources available at HHS's AHRQ National Resource Center for Health Information Technology;[263] (5) educate themselves concerning the Pandemic and All Hazards Preparedness Act and coordinate with the HHS Assistant Secretary for Public Response as a resource for telehealth inventory and for the implementation of other preparedness and response initiatives; and (6) use resources available through HHS's CDC PHIN to facilitate interoperability with public health and emergency organizations.[264] In addition, as part of the Pilot

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[256] *See supra* para. 7; *see also* Appendix D.

[257] Letter from Robert M. Kolodner, MD, National Coordinator for Health Information Technology, to Chairman Kevin J. Martin, FCC, dated Aug. 17, 2007 (HHS NHIN Initiative Letter).

[258] HHS NHIN Initiative Letter at 1.

[259] *See* Promoting Quality and Efficient Health Care in Federal Government Administered or Sponsored Health Care Programs, Exec. Order No. 13410, 71 FR 51089 (Aug. 22, 2006); *see also* HHS, Health Information Technology, http://www.hhs.gov/healthit/standards/recognition (last visited Nov. 8, 2007); HHS, Health Information Technology, http://www.hhs.gov/healthit/standards/activities (last visited Nov. 8, 2007).

[260] *See* HHS, Health Information Technology, http://www.hhs.gov/healthit/certification/background (last visited Nov. 8, 2007); *see also* HHS, Health Information Technology, http://www.hhs.gov/healthit/certification/cchit (last visited Nov. 8, 2007).

[261] HHS's Office of the National Coordinator for Health Information Technology is promoting the NHIN as a "network of networks," built out of state and regional health information exchanges and other networks to support the exchange of health information by connecting these networks, and the systems they connect. *See* HHS, Health Information Technology, http://www.hhs.gov/healthit/healthnetwork/background (last visited Nov. 15, 2007).

[262] Organizations performing NHIN trial implementations will participate in an NHIN cooperative "to further specify the interfaces and transactions they will need to interoperate for core services and breakth[r]ough/priority areas and to test their ability to work together in a cooperative interoperability testing event." *See* HHS, Health Information Technology, http://www.hhs.gov/healthit/healthnetwork/trial (last visited Nov. 15, 2007).

[263] The AHRQ's National Resource Center provides technical assistance and is committed to advancing the national goal of modernizing health care through the best and most effective use of IT. *See* AHRQ, National Resource Center or Health Information Technology, http://www.healthit.ahrq.gov (last visited Nov. 15, 2007).

[264] *See* CDC, Public Health Information Network, http://www.cdc.gov/phin (last visited Nov. 15, 2007). PHIN is "a (continued....)

Program quarterly reporting requirements, selected participants shall inform the Commission whether or how they have complied with these initiatives. We find that expecting selected participants to comply with these HHS initiatives likely will result in more secure, efficient, effective, and coordinated use of Pilot Program funding and the supported networks. Finally, selected participants shall coordinate in the use of their health care networks with HHS and, in particular, with CDC in instances of national, regional, or local public health emergencies (*e.g.*, pandemics, bioterrorism).[265] In such instances, where feasible, selected participants shall provide access to their supported networks to HHS, including CDC, and other public health officials.

7. Forms and Related Program Requirements

83. Selected participants are required to follow the normal RHC support mechanism procedures.[266] Under the current program, to obtain discounted telecommunications services, applicants must file certain forms with USAC.[267] First, applicants file FCC Form 465 with USAC to make a bona fide request for supported services.[268] FCC Form 465 is the means by which an applicant requests bids for supported services and certifies to USAC that the applicant is eligible to benefit from the RHC support mechanism.[269] USAC posts the completed FCC Form 465 on its website and an applicant must wait at least 28 days from the date on which its FCC Form 465 is posted on USAC's website before making commitments with the selected service provider(s).[270] Next, after the 28 days have expired, an applicant

(Continued from previous page)
national initiative to improve the capacity of public health to use and exchange information electronically." PHIN promotes the use of standards and defines functional and technical requirements. *See* CDC, Public Health Information Network, http://www.cdc.gov/phin/about.html (last visited Nov. 15, 2007).

[265] These requirements are in addition to the authority of HHS, including CDC, to coordinate with selected participants consistent with their existing strategic goals and initiatives.

[266] *See 2006 Pilot Program Order*, 21 FCC Rcd at 11115, para. 13 & n.19. USAC currently provides funds directly to the telecommunications service providers, not to the applicant. *See* 47 U.S.C. § 254(h)(1)(A) ("A telecommunications carrier providing service . . . shall be entitled to . . . an amount . . . ."); *see also* FCC Form 466 Instructions at 1, *available at* http://www.usac.org/_res/documents/rhc/pdf/forms/form-466-FY2007-instructions.pdf (last visited Nov. 8, 2007) ("HCPs cannot receive support directly from the Universal Service Fund. Rather, HCPs may receive the benefit of reduced rates for telecommunications service from their selected telecommunications carriers, who will be compensated for the reduced rates by the Universal Service Rural Health Care Support Mechanism."). We remind selected participants and service providers that universal service support received by service providers must be distributed to or credited against the portion of the project approved for eligible health care providers only. In instances where credits cannot be issued to a service provider, selected participants may receive payment directly from USAC, provided the selected participant complies with the administrative requirements in this Order.

[267] We note that all selected participants must obtain FCC registration numbers (FRNs). An FRN is a 10-digit number that is assigned to a business or individual registering with the FCC. This unique FRN is used to identify the registrant's business dealings with the FCC. Selected participants may obtain an FRN through the Commission's website, *at* https://fjallfoss.fcc.gov/coresWeb/publicHome.do. Selected participants may obtain a single FRN for the entire application or consortium (*i.e.*, each health care provider does not need a separate FRN).

[268] *See* 47 C.F.R. § 54.603(b); *see also* FCC Form 465 Instructions, *available at* http://www.usac.org/_res/documents/rhc/pdf/forms/form-465-FY2007-instructions.pdf (last visited Nov. 8, 2007). We note that for this Pilot Program, the term service provider as used in the forms and in this Order refers to any eligible provider of equipment, facilities, or services.

[269] *See* 47 C.F.R. § 54.603(b)(3); *see also* FCC Form 465 Instructions, *available at* http://www.usac.org/_res/documents/rhc/pdf/forms/form-465-FY2007-instructions.pdf (last visited Nov. 8, 2007).

[270] *See* 47 C.F.R. § 54.603(b)(3).

submits FCC Form 466 and/or 466-A.[271] These forms are used to indicate the type(s) of service ordered by the applicant, the cost of the ordered service, information about the service provider(s), and the terms of the service agreement(s).[272] Each applicant must certify, on the FCC Form 466 and 466-A, that the applicant has selected the most cost-effective method of providing the selected service(s).[273] FCC Form 467 is the next and final form an applicant submits.[274] FCC Form 467 is used by the applicant to notify USAC that the service provider has begun providing the supported service.[275] An applicant must submit one FCC Form 467 for each FCC Form 466 and or 466-A that the applicant submitted to USAC.[276] FCC Form 467 is also used to notify USAC when the applicant has discontinued the service or if the service was or will not be turned on during the funding year.[277]

84. We recognize that due to the unique structure of the Pilot Program, selected participants may have difficulty in preparing the required RHC forms to be submitted to USAC. We therefore find it necessary to provide guidance regarding how these forms should be completed to minimize the possibility of unintentional error on the part of selected participants. We also take this opportunity to provide further guidance on Pilot Program requirements and additional data that must be submitted with the FCC RHC forms. In addition, we direct USAC to conduct a targeted outreach program to educate and inform selected participants on the Pilot Program administrative process, including the various filing requirements and deadlines, in order to minimize the possibility of making inadvertent ministerial, or clerical errors in completing the required forms.[278]

85. *FCC Form 465 Process*. To ensure a fair and transparent bidding process, we direct selected participants to clearly identify, on form line 29 (description of Applicant's telecommunications/Internet needs) of the FCC Form 465, the bids the applicant is requesting for the network it intends to construct under the three-year Pilot Program.[279] For selected participants seeking funding in the first year of the Pilot Program (Funding Year 2007), they should indicate that Funding Year 2007 is the year for which they are seeking support in Line 26 of the FCC Form 465. Selected participants should also indicate if

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[271] *See* FCC Form 466 Instructions, *available at* http://www.usac.org/_res/documents/rhc/pdf/forms/form-466-FY2007-instructions.pdf (last visited Nov. 8, 2007); FCC Form 466-A Instructions, *available at* http://www.usac.org/_res/documents/rhc/pdf/forms/form-466-A-FY2007-instructions.pdf (last visited Nov. 8, 2007).

[272] *Id.*

[273] *See* 47 C.F.R. § 54.615(c)(7).

[274] *See* FCC Form 467 Instructions, *available at* http://www.usac.org/_res/documents/rhc/pdf/forms/form-467-FY2007-instructions.pdf (last visited Nov. 8, 2007).

[275] *See id.*

[276] *See id.*

[277] *See id.* We remind selected participants that all health care providers participating in the RHC Pilot Program must maintain documentation of their purchases of service for five years from the end of the funding year, which must include, among other things, records of allocations for consortia and entities that engage in eligible and ineligible activities. *See* 47 C.F.R. § 54.619. Upon request, beneficiaries must make available all documents and records that pertain to them, including those of contractors and consultants working on their behalf, to the Commission's Office of Inspector General, to USAC, and to their auditors. *See Comprehensive Review of the Universal Service Fund Management, Administration, and Oversight*, WC Docket Nos. 05-195, 02-60, 03-109, CC Docket Nos. 96-45, 02-6, 97-21, Report and Order, 22 FCC Rcd 16372, 16385, at para. 26 (2007) (*Comprehensive Review Report and Order*). This record retention requirement also applies to service providers that receive support for serving rural health care providers. *Id.*

[278] *See infra* paras. 95-97.

[279] We reiterate that selected participants cannot receive support that exceeds the amount designated in Appendix B.

they will be seeking funding for Year Two (Funding Year 2008) and/or Year Three (Funding Year 2009) of the Pilot Program in Line 29 of FCC Form 465 in their filings in Year One.[280]

86. Selected participants are not required to submit multiple FCC Forms 465 for each participating health care provider, although they may choose to do so.[281] Specifically, for purposes of administrative efficiency, selected participants may submit one master FCC Form 465, provided the information contained in the FCC Form 465 identifies each eligible health care provider participating in the Pilot Program and is included in an attached Excel or Excel compatible spreadsheet.[282] Appendix E of this Order provides a spreadsheet for selected participants.[283] We also require selected participants to provide a brief explanation for each health care provider participating in the network, identifying why each health care provider is eligible under section 254 of the 1996 Act and the Commission's rules and orders. This information should be included in an attachment to the FCC Form 465 submitted to USAC.[284] Selected participants that anticipate competitively bidding out their entire approved network project need only submit FCC Form 465 and the attached spreadsheet in Year One (or the first year they intend to competitively bid the project). Selected participants that anticipate competitively bidding their network project each Funding Year of the Pilot Program (*e.g.*, Year One, Year Two, and Year Three) shall submit a new FCC Form 465 within the appropriate Funding Year window(s) and requisite attachments for each stage.[285] To the extent that a selected participant seeks to add, remove, or substitute a health care provider in its proposed network after a funding commitment has been made by USAC,[286] the selected participant must file an amended FCC Form 465 Attachment providing any new FCC Form 465 information in order to allow USAC to determine its statutory eligibility.[287] We note, however, once USAC has issued a FCL, program support for the relevant Pilot Program Funding Year is capped at that

[280] Selected participants should also indicate the Year(s) for which each health care provider is seeking funding in the FCC Form 465 attached spreadsheet, discussed further below.

[281] We note that vendors or service providers participating in the competitive bid process are prohibited from assisting with or filling out a selected participants' FCC Form 465.

[282] Requiring the filing of a separate FCC Form 465 for each health care provider location would result in thousands of FCC Forms 465 being filed with USAC, creating a substantial administrative burden for both USAC and the selected participants. By contrast, in permitting selected participants to file a single FCC Form 465 per application with an attachment detailing all participating health care providers, the Commission intends to ease the administrative burden on both USAC and selected participants. Permitting selected participants to submit a single FCC Form 465 will also allow USAC to confirm that all participating entities identified are statutorily eligible health care providers, while also providing USAC the flexibility to adjust support if any participating health care providers are found to be statutorily ineligible using a single form.

[283] *See* Appendix E. We note also that Southern Ohio Healthcare Network requests a waiver of the number of locations permitted per FCC Form 465. Southern Ohio Healthcare Network Application at 33. Because we permit selected participants to submit a single master FCC Form 465 with attachment that identifies each eligible health care provider participating, we deny this waiver request as moot.

[284] We note also that FCC Form 465 requires applicants to certify that the health care provider is located in a rural area. As described above, *supra* para. 16, the Pilot Program is open to all eligible public and non-profit health care providers. Therefore, we clarify that a participating non-rural eligible health care provider need not certify that it is located in a rural area. Consistent with USAC procedures, electronic signatures are permissible for purposes of the FCC Form 465 attachment.

[285] Selected participants whose network projects include both an initial network design study and network construction based on that initial network design study are required to competitively bid the network construction portion of the project separate from the initial network design study.

[286] *See supra* para. 80.

[287] As explained in further detail below, in addition to filing an amended FCC Form 465 Attachment providing the health care provider information, selected participants must also file an amended FCC Form 466-A.

amount.[288] In addition, along with its FCC Form 465 and related spreadsheet, each selected participant must also submit a copy of the most recent record version of its application previously submitted to the Commission as of the release date of this Order (as modified by, or consistent with, this Order, if applicable). Selected participants must also provide sufficient information to define the scope of the project and network costs to enable an effective competitive bidding process. We note that selected participants may not pre-qualify service providers for the competitive bidding process.

87. Finally, we require each applicant to include with its FCC Form 465 a Letter of Agency (LOA) from each participating health care facility to authorize the lead project coordinator to act on its behalf, to demonstrate that each health care provider has agreed to participate in the selected participant's network,[289] and to avoid improper duplicate support for health care providers participating in multiple networks.[290] We note that a number of selected participants have included health care provider participants in their networks that are also participating in another selected participant's proposed network.[291] Although we do not prohibit a health care provider from participating in more than one selected participant's supported project, it is prohibited from receiving support for the same or similar services. Specifically, network costs for participation in one project must be separate and distinct from network costs resulting from participation in any other project.

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[288] *See supra* para. 80.

[289] *See* Letter from Douglas D. Orvis II, Bingham McCutchen LLP, Counsel to Iowa Health System, to Marlene Dortch, Secretary, FCC, WC Docket No. 02-60, at 5-6 & n.5 (dated Aug. 7, 2007) (Iowa Health System Aug. 7, 2007 *Ex Parte*) (explaining that Iowa Health System did not have the opportunity to obtain a binding commitment from each of the 78 health care providers it identified in its application, but that it had obtained an informal commitment from at least 40 of the listed hospitals and facilities).

[290] The Commission has affirmed USAC's requirement that an applicant applying as a consortium in the E-Rate program must submit an LOA from each of its members expressly authorizing the applicant to submit an applicant on its behalf. *See Request for Review of the Decision of the Universal Service Administrator by Project Interconnect, Brooklyn Park, Minnesota, Federal-State Joint Board on Universal Service, Changes to the Board of Directors of the National Exchange Carrier Association*, File Nos. SLD-146858, 146854, CC Docket Nos. 96-45, 97-21, Order, 16 FCC Rcd 13655, 13658, para. 8 (Common Car. Bur. 2001). LOAs should 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 relationship of the facility to the lead entity filing the application; the specific timeframe the LOA covers; the signature, title and contact information (including phone number, physical 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. *See generally* USAC, Letter of Agency, *at* http://www.usac.org/sl/tools/reference/letters-of-agency.aspx (last visited Nov. 15, 2007). For health care providers located on tribal lands, LOAs must also be signed by the appropriate management representative of the health care facility. In most cases, this will be the director of the facility. If the 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.

[291] *Compare, e.g.*, Iowa Health System Application at Ex. 2 *with* Iowa Rural Health Telecommunications Program Application at 20-21; Rocky Mountain HealthNet Application at 8-22 *with* Colorado Health Care Connections Application at 33-34; Illinois Hospital Association Application at 16-38 *with* Illinois Rural HealthNet Consortium Application at Attach. 7; Frontier Access to Rural Healthcare in Montana Application at 18 and Attached List of Facilities *with* Wyoming Telehealth Network Application at 13-15; Wyoming Telehealth Network Application at 13-15 *with* Heartland Unified Broadband Network Application at App. B; Heartland Unified Broadband Network Application at App. B *with* Greater Minnesota Telehealth Broadband Initiative Application at 17-42; Texas Healthcare Network Application at 29 *with* Texas Health Information Collaborative Application at 28-34; Tennessee Telehealth Network Application at Attach. E *with* Mountain States Health Alliance at 1, 8; Tennessee Telehealth Network Application at Attach. E *with* Erlanger Health System Application at 8-10; Southern Ohio Healthcare Network Application at 34-35 *with* Holzer Consolidated Health Systems Application at 7-8; As One-Together for Health Application at 14-44 *with* University of Mississippi Medical Center Application at 20 and App. 5.

88. *SPIN Requirement.* All service providers that participate in the RHC Pilot Program are required to have a Service Provider Identification Number (SPIN).[292] 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.[293]

89. *FCC Form 466-A Process.* Selected participants should submit an FCC Form 466-A to indicate the type(s) of network construction ordered, the cost of the ordered network construction, information about the service provider(s), and the terms of the service agreements.[294] Selected participants are not required to submit multiple FCC Forms 466-A for each participating health care provider location, although they may choose to do so. Specifically, for purposes of administrative efficiency, selected participants may submit one master FCC Form 466-A, provided the information contained in the FCC Form 466-A identifies the location of each health care provider participating in the Pilot Program and is included in an attached Excel or Excel compatible spreadsheet. Appendix F of this Order provides a spreadsheet for selected participants.[295] Selected participants seeking funding for Year One of the Pilot Program (Funding Year 2007) should indicate this in Line 16.[296] Selected participants seeking funding for Year Two (Funding Year 2008) and/or Year Three (Funding Year 2009) of the Pilot Program should indicate the applicable Funding Years in their description in Box 17. In addition, on Line 18 of FCC Form 466-A, upon request, selected participants should provide documentation to allow

[292] 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. To obtain a new SPIN, a service provider must complete and file with USAC a Form 498 (Service Provider Identification and Contact Information). *See* USAC, Obtain a Service Provider Identification Number, *available at* http://www.usac.org/fund-administration/recipients/obtain-service-provider-id/obtain-service-provider-id.aspx (last visited Nov. 15, 2007). Health care providers need not obtain a SPIN unless they are also the service provider (*e.g.*, self-provisioning the network). We note that Iowa Health System states that USAC Form 498 may not apply to the Pilot Program to the extent it assumes the provider is a telecommunications carrier or ISP, and only for certain services. *See* Iowa Health System Application at 15-16. Although Iowa Health System later clarified that its request was only to identify an implementation issue and not request a waiver of the competitive bidding rules, *see* Iowa Health System Aug. 7, 2007 *Ex Parte* at 4, to the extent that this request can be construed as a request for a waiver of the Commission's rules pertaining to Form 498, we deny the request because a waiver is not necessary to enable non-telecommunications service providers to 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, *available at* http://www.universalservice.org/_res/documents/fund-administration/pdf/form-498-fy2006.pdf (last visited Nov. 8, 2007); FCC Form 498 Instructions at 15, *available at* http://www.universalservice.org/_res/documents/fund-administration/pdf/form-498-fy2006-instructions.pdf (last visited Nov. 8, 2007).

[293] 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/fund-administration/forms/ (last visited Nov. 8, 2007).

[294] To the extent a selected participant files an FCC Form 466 instead of an FCC Form 466-A, USAC may permit the selected participant to amend its filing by submitting an FCC Form 466-A to replace the FCC Form 466. We note that although the title of this Form is "Internet Services Funding Request and Certification Form," selected participants should use the FCC Form 466-A for all eligible funding requests under the Pilot Program because it is suitable for Pilot Program purposes.

[295] Consistent with USAC procedures, electronic signatures are permissible for purposes of the FCC Form 466-A attachment.

[296] For selected participants that seek to receive support under Year One of the Pilot Program, the due date is June 30, 2008, consistent with Commission rules. Thereafter, the due date for each year of the Pilot Program corresponds with the existing RHC support mechanism deadline. Thus, the FCC Form 466-A is due on June 30, and the FCC Form 465 is due 28 days prior, on June 2.

USAC to clearly identify allocated eligible costs related to the provision of services for each health care provider.

90. Along with its FCC Form 466-A, a selected participant must submit to USAC a copy of the contracts or service agreements with the selected service provider(s). Selected participants shall also include a detailed line-item network costs worksheet that includes a breakdown of total network costs (both eligible and ineligible costs).[297] Selected participants' network costs worksheet submissions shall demonstrate how ineligible (*e.g.*, for-profit) participants will pay their fair share of network costs. Selected participants shall identify these costs with specificity in their network costs worksheet submissions. USAC may reject line-item worksheets that lack sufficient specificity to determine that costs are eligible under this Order or the 1996 Act.[298] Selected participants shall also identify in their network costs worksheet Pilot Program the applicable maximum funding amounts pursuant to this Order. In addition, each selected participant must identify with specificity its source of funding for its 15 percent minimum funding contribution of eligible network costs in its line-item network costs worksheet submitted to USAC. A network costs worksheet for submission to USAC is attached to this Order at Appendix G. Selected participants must use this worksheet when submitting their funding requests to USAC.

91. A selected participant requesting funds for a multi-year contract (*e.g.*, Year One and Year Two, or Year One, Two, and Three) should indicate this in its initial network costs worksheet submissions. Although a selected participant may utilize a multi-year contract, USAC may commit funding for only a single year in that year's FCL for the participant, *i.e.*, USAC shall issue a separate FCL upon receiving the FCC Form 466-A and related attachments on an annual basis for the applicable funding year. A participant using a multi-year contract is not required to re-bid the contract in subsequent Pilot Program funding years, but it must submit a network costs worksheet and FCC Form 466-A to USAC for commitment approval for each funding year it participates in the Pilot Program. A selected participant who seeks funding for a multi-year agreement may only modify its network (including adding, deleting, or substituting health care providers) to the extent that funding does not exceed the funding year amount listed in the selected participant's initial network costs worksheet for the applicable funding year.

92. Selected participants alternatively may choose to competitively bid their projects in phases (*e.g.*, Year One – network design study; Year Two – network construction and installation) for each year that they participate in the Pilot Program, in which case selected participants shall submit FCC Forms 465 and 466-A and the requisite attachments, as described in this Order, for each year they participate. Selected participants that elect to request funding for a single year (*e.g.*, Year One), but intend to request funding for additional Pilot Program Years (*e.g.*, Year Two or Year Three) should submit a detailed line-item network costs worksheet for the additional Pilot Program Years for which it intends to request funding in Year One.[299]

93. We require selected participants and participating service providers (once selected through the competitive bidding process) to file a certification with their FCC Form 466-A with the Commission and with USAC stating that all federal RHC Pilot Program support provided to selected participants and participating service providers will be used only for the eligible Pilot Program purposes for which the support is intended, as described in this Order, and consistent with related Commission orders, section

[297] Selected participants choosing to submit multiple FCC Forms 466-A need only submit one master network costs worksheet.

[298] *See infra* para. 96.

[299] In order to request funding for Year Two or Year Three, the selected participant must have identified the Year Two and Year Three costs in its original application to the Commission.

254(h)(2)(A) of the 1996 Act, and Part 54.601 *et seq.* of the Commission's rules.[300] Pilot Program support amounts shall only be committed by USAC to the extent that the requisite certification has been filed. The certification must be filed with both the Office of the Secretary of the Commission,[301] clearly referencing WC Docket No. 02-60, and with USAC in the form of a sworn affidavit executed by a corporate officer attesting to the use of the Pilot Program support for the approved Pilot Program purposes for which support is intended. Failure to certify will result in suspension of processing of the selected participant's forms and support. Upon receipt and approval of a selected participant's FCC Form 466-A and related attachments, as discussed above, USAC will then issue a FCL for each Pilot Program funding year.[302]

94. *FCC Form 467 Process.* We also find that it is necessary to provide selected participants with guidance regarding how to fill out FCC Form 467 for reimbursement. In the third box of Block 3 on FCC Form 467, selected participants are asked to indicate, among other things, whether "service was not (or will not be) turned on during the funding year."[303] Selected participants should leave the third box of Block 4 blank. Instead, we direct selected participants to notify USAC and the Commission, in writing, when the approved network project has been initiated within 45 calendar days of initiation.[304] If the selected participant's network build-out has not been initiated within six months of the FCL sent by USAC to the selected participant and service provider(s) approving funding, the selected participant must notify USAC and the Commission within 30 days thereafter explaining when it anticipates that the approved network project will be initiated. Upon receipt and approval of a selected participant's FCC Form 467, USAC will then issue a Health Care Provider Support Schedule to the health care provider and the service provider.[305] Selected participants must complete build-out of the networks funded by this Pilot Program within five years from the date of the initial FCL, after which the funding commitments made in this Order will no longer be available.[306] To the extent that a Pilot Program participant fails to

[300] For selected participants, certifications shall be filed by the lead applicant, as well as the legally and financially responsible organization, if not the same entity.

[301] Selected participants and participating service providers must also send a courtesy copy of their certifications to Antoinette Stevens, (202) 418-7387, antoinette.stevens@fcc.gov in the Telecommunications Access Policy Division, Wireline Competition Bureau, Federal Communications Commission, 445 12th Street, S.W., Washington, D.C. 20554.

[302] USAC shall also provide the lead project coordinator with a copy of an FCL concerning any funding request for which it is the lead project coordinator.

[303] *See* FCC Form 467.

[304] Selected participants must file a copy of this notice with the Commission in WC Docket No. 02-60. Selected participants must also send a courtesy copy of this notification to Antoinette Stevens, (202) 418-7387, antoinette.stevens@fcc.gov in the Telecommunications Access Policy Division, Wireline Competition Bureau, Federal Communications Commission, 445 12th Street, S.W., Washington, D.C. 20554.

[305] The purpose of the support schedule is to provide a detailed report of the approved service(s) and support information for each health care provider and service provider. The service provider uses the support schedule to determine how much credit the health care provider will receive each month. Once the service provider receives the schedule, the provider must start applying program discounts to the health care provider during the next possible billing cycle based on the schedule. *See* USAC, Step 8: Receive Support Schedule, *at* http://www.usac.org/rhc/health-care-providers/step08/additional-information-support-schedule.aspx (last visited Nov. 15, 2007).

[306] It is appropriate to allow five years for selected participants to build out their Pilot Program networks. Unlike the E-Rate program and the existing RHC support mechanism which does not have deadlines for submitting invoices to USAC, the Pilot Program, in keeping with its limited scope, imposes a five-year invoicing deadline. We find this time period sufficient for network build-outs. Further, selected participants may not receive any Pilot Program support after the expiration of the invoice deadline, which is five years from receipt of their initial FCL for all Pilot Program funding years. *See supra* paras. 4, 35.

meet this build-out deadline, the Commission intends also to require the applicant repay any Pilot Program funds already disbursed. In addition, selected participants shall also notify the Commission and USAC in writing upon completion of the pilot project construction and network build-out.[307]

95. *USAC Outreach*. In addition to the filing requirements discussed above, each selected participant shall provide to USAC within 14 calendar days of the effective date of this Order the name, mailing address, e-mail address, and telephone number of the lead project coordinator for the Pilot Program project or consortium. Within 30 days of the effective date of this Order, USAC shall conduct an initial coordination meeting with selected participants. USAC shall further conduct a targeted outreach program to educate and inform selected participants on the Pilot Program administrative process, including various filing requirements and deadlines, in order to minimize the possibility of selected participants making inadvertent ministerial, or clerical errors in completing the required forms. We also direct USAC to notify selected participants when each funding year begins. We expect that these outreach and educational efforts will assist selected participants in meeting the Pilot Program's requirements. Further, we believe such an outreach program will increase awareness of the filing rules and procedures and will improve the overall efficacy of the Pilot Program. We also encourage selected participants to contact USAC with questions prior to filing their FCC forms. The direction we provide USAC will not lessen or preclude any of its review procedures. Indeed, we retain our commitment to detecting and deterring potential instances of waste, fraud, and abuse by ensuring that USAC scrutinizes Pilot Program submissions and takes steps to educate selected participants in a manner that fosters appropriate Pilot Program participation.[308]

96. As part of its outreach program, USAC shall also conduct educational efforts to inform selected participants of which network components are eligible for RHC Pilot Program support in order to better assist selected participants in meeting the Pilot Program's requirements.[309] When USAC has reason to believe that a selected participant's funding request includes ineligible network components or ineligible health care providers, USAC shall: (1) inform the selected participant promptly in writing of the deficiencies in its funding request, and (2) permit the selected participant 14 calendar days from the date of receipt of notice in writing by USAC to revise its funding request to remove the ineligible network components or facilities for which Pilot Program funding is sought or allow the selected participant to provide additional documentation to show why the components or facilities are eligible. To the extent a selected participant does not remove ineligible network components or facilities from the funding request, USAC must deny funding for those components or facilities. The 14-day period should provide sufficient time for selected participants to modify their funding requests to remove ineligible services.

97. Selected participants must submit complete and accurate information to USAC as part of the application and review process. Selected participants, however, will be provided the opportunity to cure ministerial and clerical errors on their FCC Forms and accompanying data submitted to USAC pertaining to the Pilot Program.[310] USAC shall inform selected participants within 14 calendar days in writing of any and all ministerial or clerical errors that it identifies in a selected participant's FCC Forms, along with a clear and specific explanation of how the selected participants can remedy those errors. USAC shall also inform selected participants within this same 14 calendar days in writing of any missing or

[307] Selected participants must file a copy of this notice with the Commission in WC Docket No. 02-60. Selected participants must also send a courtesy copy of this notification to Antoinette Stevens, (202) 418-7387, antoinette.stevens@fcc.gov in the Telecommunications Access Policy Division, Wireline Competition Bureau, Federal Communications Commission, 445 12th Street, S.W., Washington, D.C. 20554.

[308] *See infra* para. 125.

[309] *See supra* paras. 74-76.

[310] *See generally Request for Review of the Decision of the Universal Service Administrator by Bishop Perry Middle School, Schools and Libraries Universal Service Support Mechanism, et al.*, CC Docket No. 02-6, Order, 21 FCC Rcd 5316, 5326, para. 23 (2006).

incomplete certifications.[311] Selected participants shall have 14 calendar days from the date of receipt of notice in writing by USAC to amend or re-file their FCC Forms for the sole purpose of correcting the ministerial or clerical errors identified by USAC.[312] Selected participants denied funding for errors other than ministerial or clerical errors are instructed to follow USAC's and the Commission's regular appeal procedures.[313] Selected participants that do not comply with the 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.

98. *Disbursement of Pilot Program Funds.* USAC will disburse Pilot Program funds based on monthly submissions (*i.e.*, invoices) of actual incurred eligible expenses.[314] Service providers are only permitted to invoice USAC for eligible services apportioned to eligible health care provider network participants. Service providers shall submit detailed invoices to USAC on a monthly basis for actual incurred costs. This invoice process will permit disbursement of funds to ensure that the selected participants' network projects proceed, while allowing USAC and the Commission to monitor expenditures in order to ensure compliance with the Pilot Program and prevent waste, fraud, and abuse.[315] We direct USAC to modify its current sample "RHCD Service Provider Invoice" for purposes of the Pilot Program to ensure consistency with this Order. In doing so, USAC shall ensure that invoices reflect total incurred eligible costs, including those eligible costs for which selected participants will be responsible, to enable USAC to adjust disbursements to service providers to 85 percent or less of eligible incurred costs. All invoices shall also be approved by the lead project coordinator authorized to act on behalf the health care provider(s), confirming the network build-out or services related to the itemized costs were received by each participating health care provider. The lead project coordinator shall also confirm and demonstrate to USAC that the selected participant's 15 percent minimum funding contribution has been provided to the service provider for each invoice. Further, we expect USAC to review data submitted by Pilot Program participants to ensure that participants' data submissions[316] are consistent with invoices submitted as well as to ensure that network deployments are proceeding according to the approved dedicated network plans. Finally, we direct USAC to conduct random site visits to selected participants to ensure support is being used for its intended purposes, as well as to conduct site visits as necessary and appropriate based on USAC's review of the selected participants' data submissions.[317]

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[311] Selected participants will be presumed to have received notice five days after such notice is postmarked by USAC. USAC shall, however, continue to work beyond the 14 days with selected participants attempting in good faith to provide documentation.

[312] Selected participants shall not be permitted to make material changes to their applications.

[313] *See* 47 C.F.R. §§ 54.719 *et seq.*

[314] We note that several applicants requested that awarded funds be distributed in a specified manner, departing from established USAC procedures. *See, e.g.*, Adirondack-Champlain Telemedicine Information Network Application at 23; Iowa Rural Health Telecommunications Program Application at 40; Kansas University Medical Center Application at 19; Southern Ohio Healthcare Network Application at 33; Utah Telehealth Network Application at 54; West Virginia Telehealth Alliance Application at 15. For the reasons explained herein, Pilot Program funds will be distributed as described in this Order.

[315] USAC shall respond to service provider invoices in accordance with its current invoicing payment plan. USAC follows a bi-monthly invoicing cycle. Invoices received from the 1st through the 15th of the month will be processed by the 20th of the month. Invoices received from the 16th through the 31st of the month will be processed by the 5th of the following month. *See* USAC, Step 8: Receive Support Schedule, *available at* http://www.usac.org/rhc/service-providers/step08/ (last visited Nov. 15, 2007).

[316] *See infra* Part V.

[317] If funding is disbursed to any service provider and the approved network project is abandoned or left incomplete, we permit USAC to pursue recovery of funds from the selected participant's financially and legally responsible organization, eligible health care providers, or service provider, as appropriate. In addition, as discussed *infra*, the (continued....)