

## 8. Waivers

99. In the *2006 Pilot Program Order*, the Commission indicated that, after they are selected, the selected participants would work within the confines of the existing RHC support mechanism, including the requirement “to comply with the existing competitive bidding requirements, certification requirements, and other measures intended to ensure funds are used for their intended purposes.”<sup>318</sup> The Commission indicated, however, that it would waive additional program rules if such waivers are necessary for the successful operation of the Pilot Program.<sup>319</sup> After reviewing the applications and the requested rule waivers, we find that selected participants have not demonstrated good cause exists to warrant waiving certain Commission rules, including our competitive bidding rules and the rule prohibiting resale of telecommunications services or network capacity.<sup>320</sup> Among other reasons, we find requiring selected participants to comply with these rules will further the goals and principals of the *2006 Pilot Program Order* and protect against waste, fraud, and abuse.<sup>321</sup> For the reasons discussed below, however, we find good cause to waive the program application deadline and to clarify other administrative rules related to participation in the Pilot Program.

### a. Competitive Bidding

100. Pursuant to sections 54.603 and 54.615 of the Commission’s rules, each eligible health care provider must participate in a competitive bidding process and follow any additional applicable state, local, or other procurement requirements to select the most cost-effective provider of services eligible for universal service support under the RHC support mechanism.<sup>322</sup> To satisfy the competitive bidding requirements, selected participants must submit an FCC Form 465 that includes a description of the services for which the health care provider is seeking support and wait at least 28 days from the date on which this information is posted on USAC’s website before making commitments with the selected service provider.<sup>323</sup> After selecting a service provider, the participant must certify that it selected the most cost-effective method of providing service.<sup>324</sup> A selected Pilot Program participant may select a

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Commission may seek recovery of funds, assess forfeitures, or impose fines if it determines that Pilot Program support has been used in violation of Commission rules or orders, or section 254 of the 1996 Act.

<sup>318</sup> *2006 Pilot Program Order*, 21 FCC Rcd at 11117, para. 18.

<sup>319</sup> *Id.*

<sup>320</sup> Generally, the Commission’s rules may be waived for good cause shown. 47 C.F.R. § 1.3. The Commission may exercise its discretion to waive a rule where the particular facts make strict compliance inconsistent with the public interest. *Northeast Cellular Telephone Co. v. FCC*, 897 F.2d 1164, 1166 (D.C. Cir. 1990) (*Northeast Cellular*). In addition, the Commission may take into account considerations of hardship, equity, or more effective implementation of overall policy on an individual basis. *WAIT Radio v. FCC*, 418 F.2d 1153, 1159 (D.C. Cir. 1969); *Northeast Cellular*, 897 F.2d at 1166. Waiver of the Commission’s rules is therefore appropriate only if special circumstances warrant a deviation from the general rule, and such deviation will serve the public interest. *Northeast Cellular*, 897 F.2d at 1166.

<sup>321</sup> *2006 Pilot Program Order*, 21 FCC Rcd at 11117, para. 18.

<sup>322</sup> 47 C.F.R. §§ 54.603, 54.615; *see also supra* note 58 and accompanying text. The Commission previously granted a limited waiver of the rural health care program’s competitive bidding and cost-effectiveness rules to allow selected participants to pre-select Internet2 or NLR. *See 2006 Pilot Program Order*, 21 FCC Rcd at 11115, para. 14; *Pilot Program Reconsideration Order*, 22 FCC Rcd at 2555 (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). We clarify that this waiver only applies to pre-selecting Internet2 or NLR and that selected participants must follow the competitive bidding rules for all other service requests.

<sup>323</sup> 47 C.F.R. § 54.603(b).

<sup>324</sup> The most cost-effective method of providing services is defined as “the method that costs the least after consideration of the features, quality of transmission, reliability, and other factors that the health care provider (continued....)”

service provider(s) that may be part of a pre-existing contract(s), provided that the selection of the provider(s) complies with the terms of this Order, including the Commission's competitive bidding rules.<sup>325</sup> Various selected participants request a waiver of these competitive bidding requirements.<sup>326</sup> The majority of these selected participants argue that waivers are necessary because they have pre-selected their preferred service provider or would like to select service providers without the burden or uncertainty of the competitive bidding process.<sup>327</sup> Other selected participants argue that waivers are necessary because they have already contracted with service providers.<sup>328</sup> For the reasons discussed below, we do not find selected participants have demonstrated good cause exists for waiving the competitive bidding rules.

101. In establishing the competitive bidding process, the Commission determined that a competitive bidding requirement was necessary to "help minimize the support required by ensuring that rural health care providers are aware of cost-effective alternatives" and "ensure that the universal service fund is used wisely and efficiently."<sup>329</sup> The selected participants requesting waivers identify service providers they would like to provide service or those that are already providing service but give no

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deems relevant to choosing a method of providing the required health care services." 47 C.F.R. § 54.603(b)(4); see also *supra* Part III.E.4.

<sup>325</sup> See *supra* paras. 78-79, 85-87. Construction or services completed prior to compliance with the competitive bidding requirements are not eligible for Pilot Program funding. See *infra* para. 103.

<sup>326</sup> Arkansas Telehealth Network Application at 92; Bacon County Health Services Application at 6; North Country Telemedicine Project Application at 36; Rural Nebraska Healthcare Network Application at Appendix F; Rural Western and Central Maine Broadband Initiative Application at 44; Rural Wisconsin Health Cooperative Application at 5; Texas Healthcare Network Application at 16-17; Tohono O'odham Nation Department of Information Technology Application at 72; University of Mississippi Medical Center Application at 44; West Virginia Telehealth Alliance Application at 14-15. Iowa Rural Health Telecommunications Program also requested a waiver to enable it to "bid multiple hospitals, regions of Iowa or the entire state of Iowa, including fiber construction of all network electronics" and Iowa Health System seeks "some flexibility (not a waiver)" to enable it to bid on a "macro" instead of a "micro" level. Iowa Rural Health Telecommunications Program Application at 40; Iowa Health System at 15-16. To the extent these Iowa participants have requested a waiver of the Commission's competitive bidding rules, we deny their request because a waiver is not necessary to enable the Iowa participants to seek bids in the manner they specified. We direct the Iowa applicants, and all other applicants, to follow the competitive bidding process detailed *supra* Part III.E.7.

<sup>327</sup> Bacon County Health Services Application at 6 (seeking a waiver in order to receive service from ATC Broadband, LLC without going through the competitive bidding process); North Country Telemedicine Project Application at 36 (seeking a waiver to pre-select Open Access Telecommunications Network to support its telemedicine program applications); Rural Nebraska Healthcare Network Application at Appendix F (seeking a waiver in order to receive service from Mobius Communications Company without going through the competitive bidding process); Rural Western and Central Maine Broadband Initiative Application at 12 (seeking a waiver in order to receive service from Oxford Networks without going through the competitive bidding process); Rural Wisconsin Health Cooperative Application at 5 (seeking a waiver in order to receive service from Charter Communications without going through the competitive bidding process); Tohono O'odham Nation Department of Information Technology Application at 72 (seeking a waiver for certain entities, like the Indian Health Services, to provide services); West Virginia Telehealth Alliance Application at 14-15 (seeking a waiver for service providers that may already be serving certain facilities).

<sup>328</sup> Arkansas Telehealth Network Application at 92 (seeking a waiver and evergreen status for pre-existing contracts for frame relay and ATM service); University of Mississippi Medical Center Application at 44 (seeking a waiver to enable it to "allow use of E-rate eligible state master contracts"); Texas Healthcare Network Application at 16-17 (seeking a waiver for existing contracts with some vendors that would provide services needed to implement the proposed network).

<sup>329</sup> *Universal Service First Report and Order*, 12 FCC Rcd at 9134, para. 688 (citing 47 U.S.C. § 228(c)(7); 47 C.F.R. § 64.1504).

assurance that they are aware of other alternatives or that the identified providers offer the most cost-effective method of providing service. For example, Rural Nebraska Healthcare Network claims that the competitive bidding process is unnecessary because Mobius Communications Company is “uniquely positioned to bury fiber and maintain the system in western Nebraska” but does not demonstrate that Mobius is the most cost-effective choice because it does not explain whether it sought bids from, or even considered providers other than Mobius.<sup>330</sup> Similarly, Rural Wisconsin Health Cooperative requests a waiver of the competitive requirements because it has “identified Charter Communications as the optimal provider” but does not explain if it considered or is aware of other providers or why Charter Communications is superior to other potential providers. The competitive bidding requirements are not unduly burdensome because, if the service provider the selected participant identified in its application is the most cost-effective, the selected participant can select that service provider after completing the competitive bidding process; if this service provider is not the most cost-effective, then the competitive bidding process may identify more cost-effective solutions. In using the competitive bidding process, selected participants will thus have an opportunity to identify and select the most cost-effective service provider to build-out their proposed network projects. The competitive bidding requirements also will not create any unreasonable delays for selected participants because the selected participant must wait only 28 days from the date its service request is posted on USAC’s website to select the most cost-effective method of providing service.<sup>331</sup> Accordingly, we find selected participants have not demonstrated that special circumstances warrant deviation from sections 54.603 and 54.615 of the Commission’s rules.

102. Requiring all selected participants to strictly comply with the competitive bidding process is in the public interest because the competitive bidding process is vital to the Commission’s effort to ensure that universal service funds support services that satisfy the exact needs of an institution in the most cost-effective manner.<sup>332</sup> The competitive bidding requirements ensure that selected participants are aware of the most cost-effective method of providing service and ensures that universal service funds are used wisely and efficiently, thereby providing safeguards to protect against waste, fraud, and abuse. Additionally, the competitive bidding rules are consistent with section 254(h)(2)(A) of the 1996 Act because competitive bidding furthers the requirement of “competitively neutrality” by ensuring that universal service support does not disadvantage one provider over another, or unfairly favor or disfavor one technology over the other.<sup>333</sup> We find that it is in the public interest and consistent with the *2006 Pilot Program Order* to require all participants to participate in the competitive bidding process.<sup>334</sup> None of the selected participants that seek a waiver of the competitive bidding process offer persuasive evidence to the contrary. Accordingly, we do not find good cause exists to waive the Commission’s competitive bidding rules.

103. Heartland Unified Broadband Network seeks a waiver of section 54.611 of the Commission’s rules to allow it to be reimbursed for equipment that it has already ordered.<sup>335</sup> We deny this waiver as moot because, as explained above, all selected participants are required to comply with the competitive bidding requirements that require soliciting bids prior to entering into agreements with

<sup>330</sup>Rural Nebraska Healthcare Network Application at Appendix F.

<sup>331</sup> 47 C.F.R. § 54.603.

<sup>332</sup> *Federal-State Joint Board on Universal Service, Access Charge Reform, Price Cap Performance Review for Local Exchange Carriers, Transport Rate Structure and Pricing, End User Common Line Charge*, Fourth Order on Reconsideration in CC Docket No. 96-45, Report and Order CC Docket Nos. 96-45, 96-262, 94-1, 91-213, 95-72, 13 FCC Red 5318, 5425-5426, para. 185 (1997).

<sup>333</sup> 47 U.S.C. § 254(h)(2)(A).

<sup>334</sup> *2006 Pilot Program Order*, 21 FCC Red at 11117, para. 18.

<sup>335</sup> Heartland Unified Broadband Network Application at 38; 47 C.F.R. § 54.611.

providers.<sup>336</sup> We also deny this waiver because it is inconsistent with the Pilot Program goal to only fund the construction of new broadband facilities.<sup>337</sup>

104. To further prevent against waste, fraud, and abuse, we require participants to identify, when they submit their Form 465, to USAC and the Commission any consultants, service providers, or any other outside experts, whether paid or unpaid, who aided in the preparation of their Pilot Program applications.<sup>338</sup> For example, Rocky Mountain HealthNet identifies service provider participants and a consultant who helped prepare its application.<sup>339</sup> Also, Northeast HealthNet identifies a consultant who helped prepare its applications.<sup>340</sup> Identifying these consultants and outside experts could facilitate the ability of USAC, the Commission, and law enforcement officials to identify and prosecute individuals that may seek to manipulate the competitive bidding process or engage in other illegal acts.<sup>341</sup> To ensure selected participants comply with the competitive bidding requirements, they must disclose all of the types of relationships explained above.

**b. Restriction on Resale**

105. Section 254(h)(3) of the 1996 Act provides that “[t]elecommunications services and network capacity provided to a public institutional telecommunications user under this section may not be sold, resold, or otherwise transferred by such user in consideration for money or any other thing of value.”<sup>342</sup> The Commission interpreted this section to restrict the resale of any services purchased pursuant to the section 254(h) discount for services under the RHC support mechanism.<sup>343</sup> Rural Nebraska Healthcare Network seeks a waiver, if necessary, of the resale prohibition set forth in section 54.617(a) of the Commission’s rules.<sup>344</sup> Rural Nebraska Healthcare Network argues that this rule should not be interpreted to prohibit the provision of capacity to for-profit entities or to the fiber strands ownership plan detailed in its application.<sup>345</sup>

106. As an initial matter, we note that although the Commission has authority to waive regulatory requirements, it does not have authority to waive a requirement imposed by statute.<sup>346</sup>

<sup>336</sup> See *supra* Part III.E.8.f (Distributing Support), in which we address other selected participants’ requests for waiver of 47 C.F.R. § 54.611.

<sup>337</sup> 2006 Pilot Program Order, 21 FCC Rcd at 11116, para 14.

<sup>338</sup> Pilot Program participants must also retain records and make available all document and records that pertain to them, including those of contractors and consultants working on their behalf, to the Commission’s OIG, to the USF Administrator, and to their auditors. See *Comprehensive Review Report and Order*, FCC 07-150, at para. 26. We also note that sanctions, including enforcement action, are appropriate in cases of waste, fraud, and abuse. See *id.*, at para. 30.

<sup>339</sup> Rocky Mountain HealthNet Application at 4-5.

<sup>340</sup> Northeast HealthNet Application at 1 (identifying Rural Health Telecom, a division of Koxlien Communications, Inc., as a partner).

<sup>341</sup> We do not imply that any applicant has actually engaged in illegal activity that warrants prosecution.

<sup>342</sup> 47 U.S.C. § 254(h)(3).

<sup>343</sup> 47 C.F.R. § 54.617; see also *Universal Service First Report and Order*, 12 FCC Rcd at 8795, para. 33.

<sup>344</sup> Rural Nebraska Healthcare Network Application at Appendix F. 47 C.F.R. § 54.617(a).

<sup>345</sup> Rural Nebraska Healthcare Network and Mobius Communications have a fiber build-out agreement. The agreement calls for Rural Nebraska Healthcare Network to give Mobius four fiber strands of the proposed network in exchange for 15 percent of the proposed network costs and ongoing maintenance. Rural Nebraska Healthcare Network Application at Appendix F.

<sup>346</sup> *Request for Waiver by Republic County Unified School District #457 Belleville, Kansas*, CC Docket Nos. 96-45, 97-21, Order, 17 FCC Rcd 24596, 24600, para. 12 (Tel. Access Policy Div. 2002) (citing *Federal-State Joint Board* (continued....))

Although Rural Nebraska Healthcare Network couches its request as one of waiver of our rules, it is actually requesting a waiver of the statute. The implementation of rule 54.617(a) flowed directly from the plain meaning of the statute. Thus, regardless of whether we were to waive our rule, the statutory prohibition on resale would still remain. We conclude, because rule 54.617(a) is based on a statute, it cannot be waived.

107. We further note that, the prohibition on resale does not prohibit for-profit entities, paying their fair share of network costs, from participating in a selected participant's network.<sup>347</sup> Section 254(h)(3) of the 1996 Act and section 54.617(a) of the Commission's rules are not implicated when for-profit entities pay their own costs and do not receive discounts provided to eligible health care providers. A selected participant cannot sell its network capacity supported by funding under the Pilot Program but could share network capacity with an ineligible entity as long as the ineligible entity pays its fair share of network costs attributable to the portion of network capacity used.<sup>348</sup> To the extent participants connect to for-profit entities they may do so as long as they comply with section 54.617 and any other applicable Commission rules.

108. To prevent against violation of the prohibition on resale of supported services and to further prevent against waste, fraud, and abuse, we require participants to identify all for-profit or other ineligible entities, how their fair share of network costs was assessed, and proof that these entities paid or will pay for their costs. Specifically, as part of their reporting requirements in Appendix D of this Order, selected participants must: provide project contact and coordination information; identify all health care facilities included in the network; provide a network narrative; provide a diagram of the planned network indicating those facilities currently in place; identify the non-recurring and recurring costs; describe how costs have been apportioned and the sources of the funds to pay them; identify any technical or non-technical requirements or procedures necessary for ineligible entities to connect to the participant's network; provide an update on the project management plan; provide information on the network's self sustainability; and provide detail on how the supported network has advanced telemedicine benefits.<sup>349</sup>

### c. Eligibility

109. Texas Health Information Network Collaborative and Virginia Acute Stroke Telehealth Project request that the Commission expand the list of facilities eligible for support.<sup>350</sup> Section 254(h)(7)(b) of the 1996 Act defines health care providers.<sup>351</sup> The Commission adopted section 54.601 of its rules based on a plain reading of the statute.<sup>352</sup> In the *2006 Pilot Program Order*, the Commission explained that it would use the definition of health care provider found in section 54.601 of the Commission rules to determine what facilities are eligible for support.<sup>353</sup> As explained above, the

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on *Universal Service*, CC Docket No. 96-45, Memorandum Opinion and Order, 15 FCC Rcd 7170, para. 13 (1999); *Chrysler Corp. v. Brown*, 441 U.S. 281, 302 (1979).

<sup>347</sup> *2006 Pilot Program Order*, 21 FCC Rcd at 11116-17, para. 17.

<sup>348</sup> We note that such a capacity sharing arrangement is different and distinct from the relationship with Mobius Communications Company described in the Rural Nebraska Healthcare Network Application. Rural Nebraska Healthcare Network Application at Appendix F.

<sup>349</sup> See *infra* Appendix D; see also *infra* Parts IV (oversight) and V (reporting requirements).

<sup>350</sup> Texas Health Information Network Collaborative Application at 57-62 (requesting funding to connect emergency medical service providers and school clinics); Virginia Acute Stroke Telehealth Project Application at 50-51 (requesting funding for emergency medical service providers). See also *supra* note 224.

<sup>351</sup> 47 U.S.C. § 254(h)(7)(b).

<sup>352</sup> 47 C.F.R. § 54.601.

<sup>353</sup> *2006 Pilot Program Order*, 21 FCC Rcd at 11111, n.4.

Commission does not have authority to waive a requirement imposed by statute.<sup>354</sup> We conclude, because section 54.601 is based on a statutory requirement, we cannot waive section 54.601 and expand the types of health care facilities that are eligible for support under the Pilot Program.<sup>355</sup> We find however, although emergency medical service facilities themselves 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.<sup>356</sup>

**d. Service Eligibility**

110. The Missouri Telehealth Network and Iowa Health System seek a waiver of section 54.601(c) of the Commission's rules to ensure that funding under the Pilot Program is not restricted to funding available under the existing RHC support mechanism.<sup>357</sup> Section 54.601 of the Commission's rules identifies which services are supported under the existing RHC support mechanism.<sup>358</sup> Because the Pilot Program provides funding to cover the costs associated with different facilities and services than does the existing support mechanism, we find that it is necessary to waive this section of our rules. Specifically, Pilot Program funding is not limited to the provision of telecommunications services and internet access, but rather includes funding of infrastructure deployment and network design studies, as well. Accordingly, we find good cause exists to waive section 54.601(c) of the Commission's rules to enable selected participants to receive support for the eligible services described above.<sup>359</sup>

**e. Filing Deadline**

111. The deadline for receipt of Pilot Program applications was May 7, 2007.<sup>360</sup> A number of applicants filed their applications one day after the deadline on May 8, 2007.<sup>361</sup> Some of these applicants filed petitions with the Commission seeking a waiver of the May 7, 2007, filing deadline.<sup>362</sup> For

<sup>354</sup> See *supra* para. 106.

<sup>355</sup> For a discussion eligible facilities see *supra* Part III.E.1.

<sup>356</sup> See *supra* note 224; 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.

<sup>357</sup> 47 C.F.R. § 54.601.

<sup>358</sup> See *id.*

<sup>359</sup> See *supra* Part III.E.2.

<sup>360</sup> OMB Public Notice, 22 FCC Rcd at 4770.

<sup>361</sup> See Texas Health Information Collaborative Application; Texas Healthcare Network Application; Western Carolina University Application; University of Mississippi Medical Center Application; California Telehealth Network Application; Northwest Alabama Mental Health Center Application; Western New York Rural Area Health Education Application; and United Health Services Application.

<sup>362</sup> See Texas Health Information Network Collaborative Motion to Accept as Timely Filed, CC Docket No. 02-60, at 1 (filed May 9, 2007) (due to technical difficulties, its application was not accepted by the ECFS filing system until 12:02 a.m. on May 8, 2007) (Texas Health Information Network Collaborative Petition for Waiver of Filing Deadline); Western Carolina University Petition for Waiver of Deadline for Submission of Grant Application for the Rural Health Care Pilot Program, CC Docket No. 02-60, at 1 (filed May 14, 2007) (due to technical difficulties, it filed its application at 2:18 a.m. on May 8, 2007) (Western Carolina University Petition for Waiver of Filing Deadline); Western New York Rural Area Health Education Center Petition for Waiver, CC Docket No. 02-60, at 1 (filed May 24, 2007) (claims application posted on ECFS has a date stamp of May 8, 2007, but Federal Express documentation shows it was received by the Commission on May 7, 2007); and United Health Services Petition for Waiver of Deadline for Submission of Grant Application for Rural Health Care Pilot Program, CC Docket No. 02- (continued....)

example, Texas Health Information Collaborative seeks a waiver because it contends it attempted to file its application electronically before the deadline but, due to technical difficulties, its application was received at 12:02 a.m. on May 8, 2007.<sup>363</sup> Also, Western Carolina University contends it should be granted a waiver because technical difficulties prevented it from timely filing its application.<sup>364</sup>

112. We find that good cause exists to accept late filed applications because the applicants provide information and seek funding for projects that further the goals of the Pilot Program to stimulate deployment of innovative telehealth, and in particular, telemedicine services to those areas of the country where the need for those benefits is most acute.<sup>365</sup> Furthermore, the late filed applications will help further the goals of the Pilot Program because they provide the Commission with information about how to revise the existing RHC support mechanism. Accepting these applications has not caused any delay; indeed, we find it significant that none of the applicants missed the filing deadline by more than one day. Moreover, many of the late applications were mailed before the deadline but received after the deadline, while other applicants tried unsuccessfully to file their applications electronically before the deadline.<sup>366</sup> Accordingly, we waive the May 7, 2007, deadline and accept the applications filed after the deadline.<sup>367</sup>

#### f. Distributing Support

113. Section 54.611 of the Commission's rules sets forth how a telecommunications service provider may receive universal service support for providing service to an eligible health care provider.<sup>368</sup> Pursuant to section 54.611, a telecommunications carrier providing services eligible for rural health care universal support shall offset the amount eligible for support against its universal service obligation.<sup>369</sup> If the total amount of support owed to the carrier exceeds its universal service payment obligation, calculated on an annual basis, the carrier is entitled to receive the differential as a direct reimbursement.<sup>370</sup> Any reimbursement due a carrier, however, shall be made after the offset is credited against the carrier's universal service obligation.<sup>371</sup> Any reimbursement shall be submitted to a carrier no later than the first quarter of the calendar year following the year in which the costs for the services were incurred.<sup>372</sup>

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60, at 1 (filed May 17, 2007) (mailed its application on May 4, 2007, by commercial overnight mail but claims it was received on May 8, 2007, because it was sent to the FCC headquarters instead of the Commission's 9300 East Hampton Drive, Capitol Heights, MD where the Commission accepts filings sent by commercial mail) (United Health Services Petition for Waiver of Filing Deadline).

<sup>363</sup> Texas Health Information Network Collaborative Petition for Waiver of Filing Deadline at 1.

<sup>364</sup> Western Carolina University Petition for Waiver of Filing Deadline at 1.

<sup>365</sup> 47 C.F.R. § 1.3; *see supra* note 320. To the extent that an applicant filed one day late but has not sought a waiver of the filing deadline, we hereby grant a waiver on our own motion. *See id.*

<sup>366</sup> *See, e.g.*, Texas Health Information Network Collaborative Petition for Waiver of Filing Deadline at 1; United Health Services Petition for Waiver of Filing Deadline at 1.

<sup>367</sup> We waive this request for all applicants that filed late. This waiver, however, is not an ongoing waiver. We will not consider applications that have yet to be filed. Further, we clarify that in *supra* Part III.D, we deny United Health Services' application based on a review of its application, not because it was received after the filing deadline.

<sup>368</sup> 47 C.F.R. § 54.611.

<sup>369</sup> *Id.*

<sup>370</sup> 47 C.F.R. § 54.611(b).

<sup>371</sup> 47 C.F.R. § 54.611(c).

<sup>372</sup> 47 C.F.R. § 54.611(d).

114. Some selected participants have requested a waiver of section 54.611.<sup>373</sup> These selected participants claim that a different type of distribution process is needed for the Pilot Program. For example, Rural Nebraska Healthcare Network argues that a waiver is necessary because the offset provision cannot be applied to non-telecommunications carriers and support must be distributed in a manner that allows for the build-out of the proposed networks to proceed immediately.<sup>374</sup> Similarly, the California Healthcare Network argues that section 54.611 should be waived to allow non-telecommunications carriers to receive funding under the Pilot Program and to allow "USAC to pay vendor(s) monthly based on invoiced amounts."<sup>375</sup>

115. We find good cause exists to waive section 54.611 of our rules, as described herein. We agree with those applicants that argue that a waiver is necessary for non-telecommunications carriers seeking funding. As explained above, section 254(h)(2)(A) does not limit support to only eligible telecommunications carriers.<sup>376</sup> Because the rule is drafted to apply to eligible telecommunications carriers only, we find it necessary and in the public interest to waive it for non-eligible telecommunications carriers selected to participate in the Pilot Program.<sup>377</sup>

116. We also find that good cause exists to waive this rule to permit both telecommunications carriers and non-telecommunications carriers to be distributed support in the same manner. Because section 54.611 requires USAC to reimburse carriers the first quarter of the calendar year following the year in which costs were incurred, providers receiving support under the Pilot Program could be owed millions of dollars by the time they are reimbursed in full. Such a delay in reimbursement could jeopardize the timely deployment of selected participants' broadband networks, which would be contrary to the goals of the Pilot Program to stimulate deployment of broadband infrastructure necessary to support telemedicine services to those areas of the country where the needs for those benefits is most acute.<sup>378</sup> Additionally, section 54.611 could produce an inequitable result by depriving providers of the funding flow needed to continue to perform their service contracts with selected participants because, among other things, service providers may potentially be unable to meet their payment obligations to vendors without finding other means of financial support.<sup>379</sup> Waiving section 54.611 also serves the public interest because it promotes the goals of section 254 of the 1996 Act to enhance access to advanced telecommunications and information services for health care providers.<sup>380</sup> Accordingly, we find good cause exists to waive section 54.611 and instruct all participants, service providers, and USAC to follow the support distribution method outlined in this Order.<sup>381</sup>

<sup>373</sup> California Telehealth Network Application at Appendix B; Missouri Telehealth Network Application at 11; Rural Nebraska Telehealth Network Application at Appendix F.

<sup>374</sup> Rural Nebraska Healthcare Network Application at Appendix F.

<sup>375</sup> California Telehealth Network Application at 83 (Appendix B).

<sup>376</sup> See *supra* note 41; 47 U.S.C. § 254(h)(2)(A); 47 U.S.C. § 4(i) (Commission may perform any and all acts, make such rules and regulations, and issue such orders, not inconsistent with Act, as may be necessary for its functions).

<sup>377</sup> 47 C.F.R. § 54.611.

<sup>378</sup> 2006 Pilot Program Order, 21 FCC Rcd 11111.

<sup>379</sup> *Unicom Inc. Request for Waiver of Section 54.611 of the Commission's Rules*, CC Docket No. 02-60, Order, 21 FCC Rcd 11241, 11244, para. 10 (Wireline Comp. Bur. 2006).

<sup>380</sup> 47 U.S.C. § 254(h)(2)(A).

<sup>381</sup> See *supra* Part III.E.7.

**g. Funding Year 2006 Deadline**

117. Selected participants also request that the Commission waive the Funding Year 2006 deadline.<sup>382</sup> Section 54.623(c)(3) of the Commission's rules establishes June 30 as the deadline for all required forms to be filed with USAC for the funding year that begins on the previous July 1.<sup>383</sup> Therefore, for funding year 2006, the deadline is June 30, 2007. Although participants were selected after the June 30, 2007 deadline, a waiver of section 54.623 is not necessary because, as detailed in *supra* section III.B, Funding Year 2006 Pilot Program support will be rolled over to Funding Year 2007, and Year One of the RHC Pilot Program will begin in Funding Year 2007. We therefore, find these waiver requests are moot.

**h. Other Waiver Requests**

118. As described above, the Pilot Program is broader in scope than the existing RHC support mechanism because it provides funding for up to 85 percent of eligible costs associated with the construction of dedicated broadband health care network capacity that connects health care providers in a state and region.<sup>384</sup> In contrast, the existing RHC support mechanism is designed to ensure that rural health care providers pay no more than their urban counterparts for their telecommunications needs.<sup>385</sup> Because the Pilot Program and existing RHC support mechanism support different network connections related to rural health care, many of the rules that apply to the existing program may not apply to the Pilot Program. Various participants note that the Commission's rules for the existing RHC support mechanism are either inapplicable or should be waived to achieve the goals of the Pilot Program. In particular, participants request waivers of and specific deviation from Commission rules to allow: 1) funding for services supplied by providers who are not telecommunications carriers or Internet service providers;<sup>386</sup> 2) non-rural eligible entities to directly request funding under the Pilot Program;<sup>387</sup> 3) selected participants to receive funding for services that exceed the maximum supported distance for rural health care providers and not base support on the difference between the urban and rural rate;<sup>388</sup> and 4) support to be based on actual costs, not the difference between the urban and rural rate.<sup>389</sup> We agree with these

<sup>382</sup> Heartland Unified Broadband Network Application at 37-38; Rural Nebraska Healthcare Network Application at Appendix F.

<sup>383</sup> See 47 C.F.R. § 54.623(c)(3); see also *Second Report and Order and FNPRM*, 19 FCC Rcd at 24629, para. 34.

<sup>384</sup> *2006 Pilot Program Order*, 21 FCC Rcd at 11112, para. 3.

<sup>385</sup> *Id.*

<sup>386</sup> Missouri Telehealth Network Application at 11 (seeking waiver of 47 C.F.R. § 54.601(c)); Iowa Health System at 14 (noting 47 C.F.R. § 54.601 is inconsistent with the Pilot Program to the extent it limits reimbursement to telecommunications carriers); Southern Ohio Healthcare Network Application at 33 (requesting the Commission waive any requirements that service be provided by common carriers); Texas Healthcare Network Application at 16; Utah Telehealth Network Application at 54; Rural Nebraska Healthcare Network Application at Appendix F (seeking waiver of 47 C.F.R. § 54.621).

<sup>387</sup> Heartland Unified Broadband Network Application at 37 (seeking a waiver of 47 C.F.R. §§ 54.601(b)(1)(ii)); Iowa Health System at 14 (noting 47 C.F.R. § 54.601 is inconsistent with the Pilot Program to the extent it limits reimbursement to a maximum supported distance); Missouri Telehealth Network Application at 11; Oregon Health Network Application.

<sup>388</sup> Heartland Unified Broadband Network Application at 39 (seeking waiver of 47 C.F.R. §§ 54.601(c)(1) and 54.613(a)); Rural Nebraska Healthcare Network Application at Appendix F (seeking a waiver of 47 C.F.R. § 54.625).

<sup>389</sup> California Telehealth Network Application at Appendix B (seeking waiver of 47 C.F.R. § 54.609); Iowa Health System (noting 47 C.F.R. §§ 54.605, 54.607, and 54.609 are inconsistent with the Pilot Program to the extent they limit support to the difference between the urban and rural rate); Rural Nebraska Healthcare Network Application at Appendix F (seeking a waiver of 47 C.F.R. §§ 54.605, 54.607, 54.609, 54.613).

commenters that many of these rules may be inapplicable to the Pilot Program but, to the extent any rule is inapplicable, selected participants must follow the eligibility requirements detailed in this Order and section 254 of the 1996 Act.

119. First, funding under the Pilot Program is not limited to telecommunications carriers. As discussed above,<sup>390</sup> the Commission established the Pilot Program under the authority of section 254(h)(2)(A) of the 1996 Act, which does not limit support to only eligible telecommunications carriers.<sup>391</sup> In the *2006 Pilot Program Order*, the Commission explained that eligible health care providers may choose any technology and provider of supported services and may utilize any currently available technology.<sup>392</sup> Accordingly, service providers who participate in the competitive bidding process do not need to be eligible telecommunications carriers to receive Pilot Program funds. For example, a selected participant may choose to have the network design studies done by a non-telecommunications carrier. If a service provider is not a telecommunications carrier, certain rules providing support only to telecommunications carriers are inapplicable to the extent they do not contemplate funding to non-telecommunications carriers for the purpose of the Pilot Program.<sup>393</sup>

120. Second, funding under the Pilot Program is not limited to rural health care providers. Consistent with the mandate provided in section 254(h)(2)(A) and general principles of universal service, in the *2006 Pilot Program Order*, the Commission opened participation in the Pilot Program to all eligible public and non-profit health care providers to promote the Pilot Program goal of stimulating the deployment of innovative telehealth networks that will link rural health care facilities to urban health care facilities and provide telemedicine services to rural communities.<sup>394</sup> Applicants, however, were instructed to include in their proposed networks public and non-profit health care providers that serve rural areas.<sup>395</sup> Accordingly, eligible non-rural health care providers may receive funding under the Pilot Program order. To the extent the rules that govern the existing RHC support mechanism do not contemplate funding eligible non-rural health care providers, they are inapplicable.<sup>396</sup> Non-rural eligible health care providers should follow the steps detailed *supra*, section III.E.7.

121. Third, the existing RHC support mechanism limits support to a maximum supported distance. The Pilot Program differs because it explicitly provides funding for deploying dedicated broadband capacity that connects health care providers in a state or region and does not set maximum supported distances. Specifically, the “purpose of the pilot program is to encourage health care providers to aggregate their connections needs to form a comprehensive statewide or regional dedicated health care network.”<sup>397</sup> Accordingly, to the extent distance limitation rules conflict with the goals of the Pilot Program to create state and regional networks, the rules are inapplicable.<sup>398</sup>

<sup>390</sup> See *supra* note 41.

<sup>391</sup> 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, paras. 592-94.

<sup>392</sup> *2006 Pilot Program Order*, 21 FCC Rcd at 11114, para. 11.

<sup>393</sup> See, e.g., 47 C.F.R. §§ 54.601(c), 54.611 (discussed *supra* Part III.E.8.f).

<sup>394</sup> *2006 Pilot Program Order*, 21 FCC Rcd at 11114, para. 10.

<sup>395</sup> *Id.*

<sup>396</sup> See, e.g., 47 C.F.R. §§ 54.601, 54.615(c)(2).

<sup>397</sup> *2006 Pilot Program Order*, 21 FCC Rcd at 11115, para. 16.

<sup>398</sup> See, e.g., 47 C.F.R. §§ 54.615(b), 54.625.

122. Fourth, the Pilot Program provides funding for up to “85% of an applicant’s costs of deploying a dedicated broadband network, including any necessary network design studies, as well as the costs of advanced telecommunications and information services that will ride over the network.”<sup>399</sup> The Commission recognized that the funding percentage under the Pilot Program exceeds the funding percentages under the existing RHC support mechanism.<sup>400</sup> Unlike the existing RHC support mechanism, the Pilot Program does not use the difference between the urban rate and the rural rate to calculate support. Accordingly, the rules for calculation of support do not apply to Pilot Program participants.<sup>401</sup>

#### 9. Other Administrative Issues

123. We also clarify that selected participants may not receive funds for the same services under the Pilot Program and either the existing universal service programs – which consist of the RHC support mechanism, the E-Rate program, the High-Cost program, and the Low Income program – or other federal programs, including, *e.g.*, federal grants, awards, or loans. For example, funds received by Pilot Program selected participants as part of their participation in the existing RHC support mechanism may not be used by selected participants to offset costs for the same services incurred as a result of participation in the Pilot Program. The Commission, the Wireline Competition Bureau (Bureau), the Enforcement Bureau, and the Office of Inspector General (OIG), maintain the authority to investigate and enforce program violations, including against selected participants who violate this prohibition, and to recover funds used for unauthorized purposes.

124. The Commission also seeks the timely and effective implementation of the three-year Pilot Program. To expedite implementation, and consistent with sections 0.91 and 0.291 of the Commission’s rules,<sup>402</sup> we delegate to the Bureau the authority to waive the relevant sections of Subpart G of Part 54 of the Commission’s rules for selected participants to the extent they prove unreasonable or inconsistent with the sound and efficient administration of the Pilot Program.<sup>403</sup> In instances where a selected participant, including a consortium, is unable to participate in the Pilot Program for the three-year term due to extenuating circumstances, a successor may be designated by the Bureau upon request.

#### IV. OVERSIGHT OF THE PILOT PROGRAM

125. We are committed to guarding against waste, fraud, and abuse, and ensuring that funds disbursed through the Pilot Program are used for appropriate purposes. In particular, each Pilot Program participant and service provider shall be subject to audit by the Commission’s OIG and, if necessary, investigated by the OIG, to determine compliance with the Pilot Program, Commission rules and orders, as well as section 254 of the 1996 Act.<sup>404</sup> The beneficiary or service provider will be required to comply fully with the OIG’s audit requirements including, but not limited to, providing full access to all accounting systems, records, reports, and source documents of itself and its employees, contractors, and other agents in addition to all other internal and external audit reports that are involved, in whole or in

<sup>399</sup> 2006 Pilot Program Order, 21 FCC Rcd at 11111-12, para. 3.

<sup>400</sup> *Id.* at 11111-12, para. 3.

<sup>401</sup> *See, e.g.*, 47 C.F.R. §§ 54.605, 54.607, 54.609, 54.613, 54.621.

<sup>402</sup> *See* 47 C.F.R. §§ 0.91, 0.291.

<sup>403</sup> *See generally* 2006 Pilot Program Order, 21 FCC Rcd 11111; *Pilot Program Reconsideration Order*, 22 FCC Rcd 2555.

<sup>404</sup> *See* 47 C.F.R. § 54.619 (giving the Commission authority to require recordkeeping and production of records for auditing from health care providers receiving support under the Rural Health Care program); *Comprehensive Review Report and Order*, FCC 07-150, at para. 26 (finding that the record retention requirement also applies to service providers that receive support for serving rural health care providers). The term service provider includes any participating subcontractors.

part, in the administration of this Pilot Program.<sup>405</sup> Such audits or investigations may provide information showing that a beneficiary or service provider failed to comply with the 1996 Act or the Commission rules, and thus may reveal instances in which Pilot Program awards were improperly distributed or used.<sup>406</sup> To the extent the Commission finds that funds were distributed and/or used improperly, the Commission will require USAC to recover such funds through its normal processes, including adjustment of support amounts by selected participants or service providers in other universal service programs from which they receive support.<sup>407</sup> If any participant or service provider fails to comply with Commission rules or orders, or fails to timely submit filings required by such rules or orders, the Commission also has the authority to assess forfeitures for violations of such Commission rules and orders. In addition, any participant or service provider that willfully makes a false statement(s) can be punished by fine or forfeiture under sections 502 and 503 of the Communications Act,<sup>408</sup> or fine or imprisonment under Title 18 of the United States Code (U.S.C.) including, but not limited to, criminal prosecution pursuant to section 1001 of Title 18 of the U.S.C.<sup>409</sup> We emphasize that we retain the discretion to evaluate the uses of monies disbursed through the RHC Pilot Program and to determine on a case-by-case basis whether waste, fraud, or abuse of program funds occurred and whether recovery is warranted. We remain committed to ensuring the integrity of the Universal Service program and will aggressively pursue instances of waste, fraud, and abuse under the Commission's procedures and in cooperation with law enforcement agencies. In doing so, we intend to use any and all enforcement measures, including criminal and civil statutory remedies, available under law.<sup>410</sup> The Commission will also monitor the use of awarded monies and develop rules and processes as necessary to ensure that funds are used in a manner consistent with the goals of this Pilot Program. Finally, we remind selected participants that nothing in this Order relieves them of their obligations to comply with other applicable federal laws and regulations.<sup>411</sup>

## V. REPORTING REQUIREMENTS

126. Upon completion of the Pilot Program, the Commission intends to issue a report detailing the results of the program, its status, and recommended changes.<sup>412</sup> In addition, the Commission intends to incorporate any information gathered as part of the Pilot Program in the record in any subsequent

<sup>405</sup> This includes presenting personnel to testify, under oath, at a deposition if requested by the Office of Inspector General.

<sup>406</sup> We also delegate authority to the Bureau to revoke funding awarded to any selected participant making unapproved material changes to the network design plan set forth in their initial Pilot Program application. We reiterate that payment may be suspended if the project appears not to be consistent with the approved network plan.

<sup>407</sup> We intend that funds disbursed in violation of a Commission rule that implements section 254 or a substantive program goal will be recovered. Sanctions, including enforcement action, are appropriate in cases of waste, fraud, and abuse, but not in cases of clerical or ministerial errors. See *Comprehensive Review Report and Order*, FCC 07-150, at para. 30.

<sup>408</sup> 47 U.S.C. §§ 502, 503(b).

<sup>409</sup> 18 U.S.C. § 1001. Further, the Commission has found that "debarment of applicants, service providers, consultants, or others who have defrauded the USF is necessary to protect the integrity of the universal service programs." *Comprehensive Review Report and Order*, FCC 07-150, at para. 32. Therefore, the Commission intends to suspend and debar parties from the Pilot Program who are convicted of or held civilly liable for the commission or attempted commission of fraud and similar offenses arising out of their participation in the Pilot Program or other universal service programs. See *id.* at paras. 31-32.

<sup>410</sup> See, e.g., 41 U.S.C. §§ 51-58 (Anti-Kickback Act of 1986); 31 U.S.C. § 3729 (False Claims Act).

<sup>411</sup> See, e.g., 42 U.S.C. §§ 1390d *et seq.*; Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191 (1996).

<sup>412</sup> See *2006 Pilot Program Order*, 21 FCC Rcd at 11114, para. 9.

proceeding to reform the RHC support mechanism.<sup>413</sup> To assist us in this task, we require selected participants to submit to USAC and the Commission quarterly reports containing data listed in Appendix D of this Order. These data will serve as a guide for further Commission action by informing the Commission's understanding of cost-effectiveness and efficacy of the different state and regional networks funded. These data will also enable the Commission to ensure universal service funds are being used in a manner consistent with section 254 of the 1996 Act, this Order, and the Commission's rules and orders.<sup>414</sup> In particular, collection of this data is critical to the goal of preventing waste, fraud, and abuse by ensuring that funding is flowing through to its intended purpose.<sup>415</sup>

127. The first quarterly report shall be due after two full quarters have passed following the effective date of this Order and shall include responsive data from the effective date of the Order to the then-most recent month.<sup>416</sup> These reports will be due on 30th day of the month beginning each quarter and include data for the prior three months. Thus, reports will be due as appropriate on January 30 (including responsive data for the prior October to December), April 30 (including responsive data for the prior January to March), July 30 (including responsive data for the prior April to June), and October 30 (including responsive data for the prior July to September).<sup>417</sup> Reports will be required for a 72-month period following the initial due date unless the Bureau extends this deadline. Quarterly reports shall also have responsive data separated by month.

128. Failure to provide the data will result in either the elimination of the selected participant from the Pilot Program, loss or reduction of support, or recovery of prior distributions. In accordance with section 54.619 of the Commission's rules, health care providers and selected participants must also keep supporting documentation for these reports for five years and present that information to the Commission or USAC upon request.<sup>418</sup>

129. This Order shall be effective upon publication in the Federal Register, subject to OMB approval for new information collection requirements. We find good cause for the Order to become effective upon publication because many of the accepted applicants' work plans are based on start dates that have already passed.<sup>419</sup> Therefore, to prevent further delay, we waive our general requirement that our rules become effective 30 days after publication in the Federal Register and instead make them effective upon publication in the Federal Register.<sup>420</sup>

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<sup>413</sup> See *id.*

<sup>414</sup> See 47 U.S.C. § 254; 47 C.F.R. Part 54, Subpart G.

<sup>415</sup> Also, we note that selected participants will be subject to audit oversight as discussed *supra* para. 125 and, as such, the Commission will evaluate the allocation methods selected by selected participants in the course of its audit activities to ensure program integrity and to ensure that providers are complying with the program's certification requirements. See 47 C.F.R. § 54.619. The certification requirements for rural health care providers are set forth at 47 C.F.R. § 54.615(c).

<sup>416</sup> For example, if the Order became effective August 15, the report would be due on April 30 of the following year and include responsive data from August 15 to March 31. The effectiveness of these reporting requirements is also subject to the information collection associated therewith receiving approval from the OMB.

<sup>417</sup> The submitted date shall be postmarked date.

<sup>418</sup> 47 C.F.R. § 54.619.

<sup>419</sup> See, e.g., Penn State Milton S. Hershey Medical Center Application at 22 (setting forth an anticipated project start date of September 1, 2007); see also University Health Systems of East Carolina Application at Appendix B (setting forth June 2007 as its target month to begin network design).

<sup>420</sup> See 47 C.F.R. § 1.427.

**VI. PROCEDURAL MATTERS****A. Paperwork Reduction Act Analysis**

130. This document contains new or modified information collection requirements subject to the Paperwork Reduction Act of 1995 (PRA), Public Law 104-13. It will be submitted to the OMB for review under Section 3507(d) of the PRA.<sup>421</sup> OMB, the general public, and other federal agencies are invited to comment on the new information collection requirements contained in this proceeding.

**VII. ORDERING CLAUSE**

131. Accordingly, IT IS ORDERED that, pursuant to the authority contained in sections 1, 4(i), 4(j), 10, 201-205, 214, 254, and 403 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151, 154(i), 154(j), 10, 201-205, 214, 254, and 403, this Order IS ADOPTED, and SHALL BECOME EFFECTIVE 30 days after release of this Order, pursuant to 47 U.S.C. § 408. The information collection contained in this Order will become effective following OMB approval.<sup>422</sup> The Commission will publish a document at a later date establishing the effective date.

FEDERAL COMMUNICATIONS COMMISSION

Marlene H. Dortch  
Secretary

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<sup>421</sup> See 44 U.S.C. § 3507(d).

<sup>422</sup> In light of the importance of these rules, the Commission is seeking emergency approval from OMB. The Commission will issue a public notice announcing the date upon which the information collection requirements set forth in this Order shall become effective following receipt of such emergency approval.

## APPENDIX A

## List of Pilot Program Applicants

Adirondack-Champlain Telemedicine Information Network (New York) – Filed May 7, 2007

Alabama Pediatric Health Access Network (Alabama) – Filed May 7, 2007

Alabama Rural Health Network (Alabama) – Filed May 4, 2007

Alaska Native Tribal Health Consortium (Alaska) – Filed May 3, 2007

Albemarle Network Telemedicine Initiative (North Carolina) – Filed May 4, 2007

Arizona Rural Community Health Information Exchange (Arizona) – Filed May 4, 2007

Arkansas Telehealth Network (Arkansas) – Filed May 7, 2007

As One-Together for Health (Mississippi) – Filed May 7, 2007

Association of Washington Public Hospital Districts (Washington) – Filed May 7, 2007

Bacon County Health Services (Georgia) – Filed May 4, 2007

Big Bend Regional Healthcare Information Organization (Florida) – Filed May 7, 2007

California Telehealth Network (California) – Filed May 7, 2007

Colorado Health Care Connections (Colorado) – Filed May 7, 2007

Communicare (Kentucky) – Filed May 7, 2007

DCH Health System (Alabama) – Filed May 4, 2007

Erlanger Health System (Tennessee, Georgia) – Filed May 7, 2007

Frontier Access to Healthcare in Rural Montana (Montana) – Filed May 4, 2007

Geisinger Health System (Pennsylvania) – Filed May 7, 2007

Greater Minnesota Telehealth Broadband Initiative (Minnesota) – Filed May 3, 2007

Health Care Research & Education Network (North Dakota) – Filed May 7, 2007

Health Information Exchange of Montana (Montana) – Filed May 7, 2007

Heartland Unified Broadband Network (South Dakota, North Dakota, Iowa, Minnesota, Nebraska, Wyoming) – Filed May 7, 2007

Hendricks Regional Health (Indiana) – Filed May 7, 2007

Holzer Consolidated Health Systems (Ohio) – Filed May 7, 2007

Illinois Hospital Association (Illinois) – Filed May 7, 2007

Illinois Rural HealthNet Consortium (Illinois) – Filed May 2, 2007

Indiana Health Network (Indiana) – Filed May 7, 2007

Institute for Family Health (New York) – Filed May 7, 2007

Iowa Health System (Iowa) – Filed May 7, 2007

Iowa Rural Health Telecommunications Program (Iowa, Nebraska, South Dakota) – Filed May 7, 2007

Juniata Valley Network (Pennsylvania) – Filed May 7, 2007

Kansas University Medical Center (Kansas) – Filed May 7, 2007

Kentucky Behavioral Telehealth Network (Kentucky) – Filed May 7, 2007

Louisiana Department of Hospitals (Louisiana) – Filed May 7, 2007

Michigan Public Health Institute (Michigan) – Filed May 4, 2007

Missouri Telehealth Network (Missouri) – Filed May 7, 2007

Mountain States Health Alliance (Tennessee, Virginia) – Filed May 4, 2007

New England Telehealth Consortium (Maine, Vermont, New Hampshire) – Filed May 4, 2007

North Carolina Telehealth Network (North Carolina) – Filed May 7, 2007

North Country Telemedicine Project (New York) – Filed May 7, 2007

Northeast HealthNet (Pennsylvania, New York) – Filed May 7, 2007

Northeast Ohio Regional Health Information Organization (Ohio) – Filed May 7, 2007

North Link of Northern Enterprises (Vermont) – Filed May 7, 2007

Northwest Alabama Mental Health Center (Alabama) – Filed May 8, 2007

Northwestern Pennsylvania Telemedicine Initiative (Pennsylvania) – Filed May 3, 2007

OpenCape Corporation (Massachusetts) – Filed May 7, 2007

Oregon Health Network (Oregon) – Filed May 7, 2007

Pacific Broadband Telehealth Demonstration Project (Hawaii, American Samoa, Guam) –  
Filed May 7, 2007

Palmetto State Providers Network (South Carolina) – Filed May 4, 2007

Pathways Community Behavioral Healthcare, Inc. (Missouri) – Filed May 7, 2007

Penn State Milton S. Hershey Medical Center (Pennsylvania) – Filed May 7, 2007

Pennsylvania Mountains Healthcare Alliance (Pennsylvania) – Filed May 7, 2007

Pioneer Health Network (Kansas) – Filed May 7, 2007

Puerto Rico Health Department (Puerto Rico) – Filed May 7, 2007

Rocky Mountain HealthNet (Colorado) – Filed May 7, 2007

Rural Healthcare Consortium of Alabama (Alabama) – Filed May 7, 2007

Rural Nebraska Healthcare Network (Nebraska) – Filed May 7, 2007

Rural Western and Central Maine Broadband Initiative (Maine) – Filed May 7, 2007

Rural Wisconsin Health Cooperative (Wisconsin) – Filed May 3, 2007

Sanford Health Collaboration and Communication Channel (South Dakota, Iowa, Minnesota) –  
Filed May 7, 2007

Southern Ohio Healthcare Network (Ohio) – Filed May 4, 2007

Southwest Alabama Mental Health Consortium (Alabama) – Filed May 3, 2007

Southwest Telehealth Access Grid (New Mexico, Texas, Colorado) – Filed May 7, 2007

Southwestern Pennsylvania Regional Broadband Health Care Network (Pennsylvania) –  
Filed May 7, 2007

St. Joseph's Hospital (Wisconsin) – Filed May 7, 2007

Taylor Regional Hospital (Kentucky) – Filed May 7, 2007

Tennessee Telehealth Network (Tennessee) – Filed May 7, 2007

Texas Health Information Network Collaborative (Texas) – Filed May 7, 2007

Texas Healthcare Network (Texas) – Filed May 7, 2007

Tohono O'odham Nation Department of Information Technology (Arizona) – Filed May 7, 2007

United Health Services (New York, Pennsylvania) – Filed May 8, 2007

University Health Systems of East Carolina (North Carolina) – Filed May 15, 2007

University of Mississippi Medical Center (Mississippi) – Filed May 7, 2007

Utah Telehealth Network (Utah) – Filed May 8, 2007

Valley View Hospital (Colorado) – Filed May 7, 2007

Virginia Acute Stroke Telehealth Project (Virginia) – Filed May 7, 2007

West Virginia Telehealth Alliance (West Virginia, Virginia, Ohio) – Filed May 3, 2007

Western Carolina University (North Carolina) – Filed May 7, 2007

Western New York Rural Area Health Education Center (New York) – Filed May 8, 2007

World Network Institutional Services (New York) – Filed May 7, 2007

Wyoming Telehealth Network (Wyoming) – Filed May 7, 2007

## APPENDIX B

Selected Pilot Program Participants and  
Maximum Support Amounts\*

Applicant Name	State	Year 1 Support	Year 2 Support	Year 3 Support
Adirondack-Champlain Telemedicine Information Network	NY	\$2,549,434.75	\$2,549,434.75	\$2,549,434.75
Alabama Pediatric Health Access Network	AL	\$140,105.33	\$140,105.33	\$140,105.33
Alaska Native Tribal Health Consortium	AK	\$3,475,083.33	\$3,475,083.33	\$3,475,083.33
Albemarle Network Telemedicine Initiative	NC	\$527,692.00	\$527,692.00	\$527,692.00
Arizona Rural Community Health Information Exchange	AZ	\$1,412,572.68	\$1,412,572.68	\$1,412,572.68
Arkansas Telehealth Network	AR	\$1,405,896.00	\$1,405,896.00	\$1,405,896.00
As One- Together for Health	MS	\$637,654.67	\$637,654.67	\$637,654.67
Association of Washington Public Hospital Districts	WA	\$237,361.93	\$237,361.93	\$237,361.93
Bacon County Health Services, Inc.	GA	\$746,526.67	\$746,526.67	\$746,526.67
Big Bend Regional Healthcare Information Organization	FL	\$3,207,673.05	\$3,207,673.05	\$3,207,673.05
California Telehealth Network	CA	\$7,366,666.67	\$7,366,666.67	\$7,366,666.67
Colorado Health Care Connections	CO	\$1,540,518.00	\$1,540,518.00	\$1,540,518.00
Communicare	KY	\$129,058.22	\$129,058.22	\$129,058.22
DCH Health System	AL	\$64,741.67	\$64,741.67	\$64,741.67
Erlanger Health System	TN, GA	\$732,870.00	\$732,870.00	\$732,870.00
Frontier Access to Rural Healthcare in Montana (FAhRM)	MT, ID, WY	\$652,550.67	\$652,550.67	\$652,550.67
Geisinger Health System	PA	\$300,517.00	\$300,517.00	\$300,517.00
Greater Minnesota Telehealth Broadband Initiative	MN, ND	\$1,798,997.20	\$1,798,997.20	\$1,798,997.20
Health Care Research & Education Network	ND	\$95,381.33	\$95,381.33	\$95,381.33
Health Information Exchange of Montana	MT	\$4,533,333.33	\$4,533,333.33	\$4,533,333.33
Heartland Unified Broadband Network	SD, ND, IA, MN, NE, WY	\$1,593,976.93	\$1,593,976.93	\$1,593,976.93
Holzer Consolidated Health Systems	OH	\$612,000.00	\$612,000.00	\$612,000.00
Illinois Rural HealthNet Consortium	IL	\$7,021,176.00	\$7,021,176.00	\$7,021,176.00
Indiana Health Network	IN	\$5,379,423.33	\$5,379,423.33	\$5,379,423.33
Iowa Health System	IA, IL	\$2,600,910.67	\$2,600,910.67	\$2,600,910.67
Iowa Rural Health Telecommunications Program	IA, NE, SD	\$3,316,320.18	\$3,316,320.18	\$3,316,320.18
Juniata Valley Network	PA	\$1,103,349.33	\$1,103,349.33	\$1,103,349.33
Kansas University Medical Center	KS	\$1,266,100.00	\$1,266,100.00	\$1,266,100.00
Kentucky Behavioral Telehealth Network	KY	\$952,033.67	\$952,033.67	\$952,033.67
Louisiana Department of Hospitals	LA	\$5,308,423.40	\$5,308,423.40	\$5,308,423.40
Michigan Public Health Institute	MI	\$6,970,000.00	\$6,970,000.00	\$6,970,000.00
Missouri Telehealth Network	MO	\$791,535.00	\$791,535.00	\$791,535.00
Mountain States Health Alliance	TN, VA	\$31,080.00	\$31,080.00	\$31,080.00
New England Telehealth Consortium	ME, VT, NH	\$8,229,672.00	\$8,229,672.00	\$8,229,672.00

Applicant Name	State	Year 1 Support	Year 2 Support	Year 3 Support
North Carolina Telehealth Network	NC	\$2,007,995.00	\$2,007,995.00	\$2,007,995.00
North Country Telemedicine Project	NY	\$661,666.33	\$661,666.33	\$661,666.33
Northeast HealthNet	PA, NY	\$566,780.00	\$566,780.00	\$566,780.00
Northeast Ohio Regional Health Information Organization	OH	\$3,762,066.67	\$3,762,066.67	\$3,762,066.67
Northwest Alabama Mental Health Center	AL	\$127,216.67	\$127,216.67	\$127,216.67
Northwestern Pennsylvania Telemedicine Initiative	PA	\$117,389.82	\$117,389.82	\$117,389.82
Oregon Health Network	OR	\$6,727,541.67	\$6,727,541.67	\$6,727,541.67
Pacific Broadband Telehealth Demonstration Project	HI, AS, GU	\$1,622,654.33	\$1,622,654.33	\$1,622,654.33
Palmetto State Providers Network	SC	\$2,648,316.67	\$2,648,316.67	\$2,648,316.67
Pathways Community Behavioral Healthcare, Inc.	MO	\$153,000.00	\$153,000.00	\$153,000.00
Penn State Milton S. Hershey Medical Center	PA	\$298,160.70	\$298,160.70	\$298,160.70
Pennsylvania Mountains Healthcare Alliance	PA	\$393,334.67	\$393,334.67	\$393,334.67
Puerto Rico Health Department	PR	\$2,458,006.15	\$2,458,006.15	\$2,458,006.15
Rocky Mountain HealthNet	CO, MT	\$1,688,100.00	\$1,688,100.00	\$1,688,100.00
Rural Healthcare Consortium of Alabama	AL	\$77,585.33	\$77,585.33	\$77,585.33
Rural Nebraska Healthcare Network	NE	\$6,418,980.67	\$6,418,980.67	\$6,418,980.67
Rural Western and Central Maine Broadband Initiative	ME	\$1,200,442.00	\$1,200,442.00	\$1,200,442.00
Rural Wisconsin Health Cooperative	WI	\$531,118.33	\$531,118.33	\$531,118.33
Sanford Health Collaboration and Communication Channel	SD, IA, MN	\$270,717.35	\$270,717.35	\$270,717.35
Southern Ohio Healthcare Network	OH	\$4,643,139.00	\$4,643,139.00	\$4,643,139.00
Southwest Alabama Mental Health Consortium	AL	\$837,263.13	\$837,263.13	\$837,263.13
Southwest Telehealth Access Grid	NM, TX, CO	\$5,187,060.33	\$5,187,060.33	\$5,187,060.33
St. Joseph's Hospital	WI	\$218,400.00	\$218,400.00	\$218,400.00
Tennessee Telehealth Network	TN, KY, IN, AR, MS	\$2,666,037.00	\$2,666,037.00	\$2,666,037.00
Texas Health Information Network Collaborative	TX	\$3,680,698.53	\$3,680,698.53	\$3,680,698.53
Texas Healthcare Network	TX	\$1,629,733.33	\$1,629,733.33	\$1,629,733.33
Tohono O'odham Nation Department of Information Technology	AZ	\$142,091.67	\$142,091.67	\$142,091.67
University Health Systems of Eastern Carolina	NC	\$320,313.00	\$320,313.00	\$320,313.00
University of Mississippi Medical Center	MS	\$1,306,106.30	\$1,306,106.30	\$1,306,106.30
Utah Telehealth Network	UT, ID	\$3,015,319.75	\$3,015,319.75	\$3,015,319.75
Virginia Acute Stroke Telehealth Project	VA	\$900,425.33	\$900,425.33	\$900,425.33
Western Carolina University	NC	\$1,198,763.33	\$1,198,763.33	\$1,198,763.33
West Virginia Telehealth Alliance	WV, VA, OH	\$2,798,710.00	\$2,798,710.00	\$2,798,710.00
Western New York Rural Area Health Education Center	NY	\$1,993,816.67	\$1,993,816.67	\$1,993,816.67
Wyoming Telehealth Network	WY	\$259,588.33	\$259,588.33	\$259,588.33
<b>Totals</b>		<b>\$139,259,173.08</b>	<b>\$139,259,173.08</b>	<b>\$139,259,173.08</b>

\* Selected participants 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. See 47 C.F.R. § 1.1910(b).

**APPENDIX C****Denied Pilot Program Applications**

Alabama Rural Health Network (Alabama) – Filed May 4, 2007  
Hendricks Regional Health (Indiana) – Filed May 7, 2007  
Illinois Hospital Association (Illinois) – Filed May 7, 2007  
Institute for Family Health (New York) – Filed May 7, 2007  
North Link of Northern Enterprises (Vermont) – Filed May 7, 2007  
OpenCape Corporation (Massachusetts) – Filed May 7, 2007  
Pioneer Health Network (Kansas) – Filed May 7, 2007  
Southwestern Pennsylvania Regional Broadband Health Care Network (Pennsylvania) – Filed May 7, 2007  
Taylor Regional Hospital (Kentucky) – Filed May 7, 2007  
United Health Services (New York and Pennsylvania) – Filed May 15, 2007  
Valley View Hospital (Colorado) – Filed May 4, 2007  
World Network Institutional Services (New York) – Filed May 7, 2007

## APPENDIX D

## Pilot Program Participants Quarterly Data Reports

1. Project Contact and Coordination Information
  - a. Identify the project leader(s) and respective business affiliations.
  - b. Provide a complete address for postal delivery and the telephone, fax, and e-mail address for the responsible administrative official.
  - c. Identify the organization that is legally and financially responsible for the conduct of activities supported by the award.
  - d. Explain how project is being coordinated throughout the state or region.
2. Identify all health care facilities included in the network.
  - a. Provide address (including county), zip code, Rural Urban Commuting Area (RUCA) code (including primary and secondary), six-digit census tract, and phone number for each health care facility participating in the network.
  - b. For each participating institution, indicate whether it is:
    - i. Public or non-public;
    - ii. Not-for-profit or for-profit;
    - iii. An eligible health care provider or ineligible health-care provider with an explanation of why the health care facility is eligible under section 254 of the 1996 Act and the Commission's rules or a description of the type of ineligible health care provider entity.
3. Network Narrative: In the first quarterly report following the completion of the competitive bidding process and the selection of vendors, the selected participant must submit an updated technical description of the communications network that it intends to implement, which takes into account the results its network design studies and negotiations with its vendors. This technical description should provide, where applicable:
  - a. Brief description of the backbone network of the dedicated health care network, *e.g.*, MPLS network, carrier-provided VPN, a SONET ring;
  - b. Explanation of how health care provider sites will connect to (or access) the network, including the access technologies/services and transmission speeds;
  - c. Explanation of how and where the network will connect to a national backbone such as NLR or Internet2;
  - d. Number of miles of fiber construction, and whether the fiber is buried or aerial;
  - e. Special systems or services for network management or maintenance (if applicable) and where such systems reside or are based.
4. List of Connected Health Care Providers: Provide information below for all eligible and non-eligible health care provider sites that, as of the close of the most recent reporting period, are connected to the network and operational.
  - a. Health care provider site;
  - b. Eligible provider (Yes/No);
  - c. Type of network connection (*e.g.*, fiber, copper, wireless);
  - d. How connection is provided (*e.g.*, carrier-provided service; self-constructed; leased facility);
  - e. Service and/or speed of connection (*e.g.*, DS1, DS3, DSL, OC3, Metro Ethernet (10 Mbps));
  - f. Gateway to NLR, Internet2, or the Public Internet (Yes/No);



9. Provide detail on whether network is or will become self sustaining. Selected participants should provide an explanation of how network is self sustaining.
10. Provide detail on how the supported network has advanced telemedicine benefits:
  - a. Explain how the supported network has achieved the goals and objectives outlined in selected participant's Pilot Program application;
  - b. Explain how the supported network has brought 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;
  - c. Explain how the supported network has allowed patients access to critically needed medical specialists in a variety of practices without leaving their homes or communities;
  - d. Explain how the supported network has allowed health care providers access to government research institutions, and/or academic, public, and private health care institutions that are repositories of medical expertise and information;
  - e. Explain how the supported network has allowed health care professional to monitor critically ill patients at multiple locations around the clock, provide access to advanced applications in continuing education and research, and/or enhanced the health care community's ability to provide a rapid and coordinated response in the event of a national crisis.
11. Provide detail on how the supported network has complied with HHS health IT initiatives:
  - a. Explain how the supported network has used health IT systems and products that meet interoperability standards recognized by the HHS Secretary;
  - b. Explain how the supported network has used health IT products certified by the Certification Commission for Healthcare Information Technology;
  - c. Explain how the supported network has supported the Nationwide Health Information Network (NHIN) architecture by coordinating activities with organizations performing NHIN trial implementations;
  - d. Explain how the supported network has used resources available at HHS's Agency for Healthcare Research and Quality (AHRQ) National Resource Center for Health Information Technology;
  - e. Explain how the selected participant has educated themselves concerning the Pandemic and All Hazards Preparedness Act and coordinated 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
  - f. Explain how the supported network has used resources available through HHS's Centers for Disease Control and Prevention (CDC) Public Health Information Network (PHIN) to facilitate interoperability with public health and emergency organizations.
12. Explain how the selected participants coordinated in 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, explain how selected participants provided access to their supported networks to HHS, including CDC, and other public health officials.

APPENDIX E

FCC Form 465 Spreadsheet







APPENDIX F

FCC Form 466-A Spreadsheet









APPENDIX G

FCC Form 466-A Network Costs Worksheet

Rural Health Care Program  
 FCC Form 466-A Network Cost Worksheet

XYZ Health Care Systems (fill in selected  
 participant name here)

Year 1 Network Cost Worksheet								
(Line)	Category	Itemized Components (Description)	Number of Items	Cost per Item	Comments	Eligible Cost? (Y/N)	Explanation of Eligibility	Total Costs (100%)
1	Network Design							
2	Recurring							
3								
4								
5	Recurring Subtotal							
6								
7	Non-recurring							
8								
9								
10	Non-recurring Subtotal							
11	Category Total							
12								
13	Network Equipment, including Engineering and Installation							
14	Recurring							
15								
16								
17	Recurring Subtotal							
18								
19	Non-recurring							
20								
21								
22	Non-recurring Subtotal							
23	Category Total							
24								
25	Infrastructure/Outside Plant							
26	- Engineering							
27	Recurring							
28								
29								
30	Recurring Subtotal							
31								
32	Non-recurring							
33								
34								
35	Non-recurring Subtotal							
36	Sub-Category Total							
37								
38	- Construction							
39	Recurring							
40								
41								
42	Recurring Subtotal							
43								
44	Non-recurring							
45								
46								
47	Non-recurring Subtotal							
48	Sub-Category Total							
49	Category Total							
50								
51	Internet 2/NLR/Internet Connection							
52	Recurring							
53								
54								
55	Recurring Subtotal							
56								
57	Non-recurring							
58								
59								
60	Non-Recurring Subtotal							
61	Category Total							
62								
63	Leased/Tariffed facilities or services							
64	Recurring							
65								
66								
67	Recurring Subtotal							
68								
69	Non-recurring							

Rural Health Care Program  
 FCC Form 466-A Network Cost Worksheet

XYZ Health Care Systems (fill in selected participant name here)

(Line)	Category	Total Non-Eligible Costs	Total Eligible Costs	RHC Pilot Program Funding Request (maximum 85% of eligible costs)	Participant Contribution for Eligible Network Costs (minimum 15%)	Source of Participant Funds	Is This an Eligible Source? (Yes/No/ In Part)	Funding Amount Approved in Pilot Program Award Order
1	Network Design							
2	Recurring							
3								
4								
5	Recurring Subtotal							
6								
7	Non-recurring							
8								
9								
10	Non-recurring Subtotal							
11	Category Total							
12								
13	Network Equipment, including Engineering and Installation							
14	Recurring							
15								
16								
17	Recurring Subtotal							
18								
19	Non-recurring							
20								
21								
22	Non-recurring Subtotal							
23	Category Total							
24								
25	Infrastructure/Outside Plant							
26	- Engineering							
27	Recurring							
28								
29								
30	Recurring Subtotal							
31								
32	Non-recurring							
33								
34								
35	Non-recurring Subtotal							
36	Sub-Category Total							
37								
38	- Construction							
39	Recurring							
40								
41								
42	Recurring Subtotal							
43								
44	Non-recurring							
45								
46								
47	Non-recurring Subtotal							
48	Sub-Category Total							
49	Category Total							
50								
51	Internet 2/NLR/Internet Connection							
52	Recurring							
53								
54								
55	Recurring Subtotal							
56								
57	Non-recurring							
58								
59								
60	Non-Recurring Subtotal							
61	Category Total							
62								
63	Leased/Tariffed facilities or services							
64	Recurring							
65								
66								
67	Recurring Subtotal							
68								
69	Non-recurring							

Rural Health Care Program  
 FCC Form 466-A Network Cost Worksheet

Year 1 Network Cost Worksheet								
(Line)	Category	Itemized Components (Description)	Number of Items	Cost per Item	Comments	Eligible Cost? (Y/N)	Explanation of Eligibility	Total Costs (100%)
70								
71								
72		Non-recurring Subtotal						
73		Category Total						
74								
75		Network Management /Maintenance/ Operations Costs (not captured elsewhere)						
76		Recurring						
77								
78								
79		Recurring Subtotal						
80								
81		Non-recurring						
82								
83		Non-recurring Subtotal						
84		Category Total						
85								
86		Other (specify)						
87		Recurring						
88								
89								
90		Recurring Subtotal						
91								
92		Non-recurring						
93								
94								
95		Non-recurring Subtotal						
96		Category Total						
97								
98								
99		Total Recurring						
100		Total Non-recurring						
101		Total						

(1) Please provide a separate breakout for aerial and buried fiber construction, the budgeted unit cost per mile for each, and the number of miles (to at least the 10th of a mile) to be constructed.

Rural Health Care Program  
 FCC Form 466-A Network Cost Worksheet

(Line)	Category	Total Non-Eligible Costs	Total Eligible Costs	RHC Pilot Program Funding Request (maximum 85% of eligible costs)	Participant Contribution for Eligible Network Costs (minimum 15%)	Source of Participant Funds	Is This an Eligible Source? (Yes/No/ In Part)	Funding Amount Approved in Pilot Program Award Order
70								
71								
72	Non-recurring Subtotal							
73	Category Total							
74								
75	Network Management /Maintenance/ Operations Costs (not captured elsewhere)							
76	Recurring							
77								
78								
79	Recurring Subtotal							
80								
81	Non-recurring							
82								
83	Non-recurring Subtotal							
84	Category Total							
85								
86	Other (specify)							
87	Recurring							
88								
89								
90	Recurring Subtotal							
91								
92	Non-recurring							
93								
94								
95	Non-recurring Subtotal							
96	Category Total							
97								
98								
99	Total Recurring							
100	Total Non-recurring							
101	Total							

**STATEMENT OF  
CHAIRMAN KEVIN J. MARTIN**

*Re: In the Matter of Rural Health Care Support Mechanism, WC Docket No. 02-60*

I am pleased the Commission adopts today's Order making funding available for the deployment broadband healthcare networks across the country. Through this Order, the Commission dedicates more than 400 million dollars over 3 years to the construction of broadband networks for state-wide and regional healthcare networks reaching over 6,000 facilities in 42 states and 3 U.S. territories, all connected to a national broadband network.

Since becoming Chairman, I have made broadband deployment the Commission's top priority. Broadband technology is a key driver of economic growth. The ability to share increasing amounts of information at greater and greater speeds, increases productivity, facilitates interstate commerce, and helps drive innovation. But perhaps most important, broadband has the potential to affect almost every aspect of our lives – from where and when we work to how we educate our children. In particular, it is increasingly changing the way healthcare is delivered and received.

Broadband infrastructure for healthcare is particularly critical to those living in rural areas where access to medical services can be limited. I can appreciate the tremendous capability of broadband to improve peoples' quality of life and healthcare in rural America. Telemedicine programs around the nation enable patients to receive medical care in a wide variety of areas, including pediatrics, dermatology, psychiatry, cardiology, and radiology, without even leaving their homes or communities. This may not seem like a big deal to those of us who need only drive a couple miles to visit our local doctor or dentist. But, it can mean everything to those patients who don't have that luxury or who don't have access to healthcare at all.

A dedicated national broadband healthcare network will also facilitate the President's goal of implementing electronic medical records nationwide. Electronic medical records will improve the healthcare treatment Americans receive by, among other things: ensuring that appropriate medical information is available; reducing medical errors; reducing health care costs, and; improving the coordination among health care facilities.

In order to receive the benefits of telemedicine, electronic health care records, and other healthcare benefits, health providers must have access to underlying broadband infrastructure. Without this underlying infrastructure, efforts to implement these advances in health care cannot succeed.

It is my vision to see every healthcare facility in the nation connected to each other with broadband. This is especially important in rural areas of the nation that may lack the breadth of medical expertise available in urban areas. To make such connectivity a reality, we need to continue to encourage the deployment of broadband facilities that connect networks of rural and non-rural public and not-for-profit healthcare providers

within a state or region – as well as connect such state-wide or regional healthcare networks to each other across the nation.

As we evaluated the pilot program, it became even more clear to me how well this program aligns with the goals that the Department of Health and Human Services and the health community is working to achieve. That is why it is important that organizations participating in the pilot program use their resources to build networks consistent with the health IT initiatives being promoted by HHS. This includes the implementation of interoperable health IT systems and the use of certified health IT products. Additionally, participants will coordinate with HHS and CDC during public health emergencies, such as pandemics or bioterrorism events.

Through the Commission's Rural Healthcare Pilot Program, I am hoping to establish the basic building blocks of a digitally connected health system – regional and state-wide broadband networks, all connected to a national backbone. I look forward to learning from this pilot program how we can ensure that all Americans, including those in the most remote areas of the country, receive first-rate medical care.

**STATEMENT OF  
COMMISSIONER MICHAEL J. COPPS**

*Re: In the Matter of Rural Health Care Support Mechanism, WC Docket No. 02-60*

Since I came to the Commission, I have been pushing for more proactive programs to put our rural health care dollars to work bringing advanced telecommunications to health care facilities in towns and villages across America. I have visited numerous such facilities, and I quickly came to understand both their plight and their potential. Their plight is lack of dollars to develop and deploy rural health communications, lack of partners, lack of sufficient personnel, and lack of a real helping hand from the federal government. Their potential is to improve health care in often less-than-affluent communities and to enhance public safety by connecting health care providers, first responders and rural citizens everywhere.

The Commission is finally tapping into the long underutilized Universal Service system's rural health care support mechanism to tackle these challenges. We today approve the disbursement of more than \$400 million over the next three years to approved health care providers who plan to build a broadband infrastructure that will connect over 6,000 facilities in 42 states and 3 U.S. territories. I am enormously pleased to support this Order, and I want to commend Chairman Martin and all my colleagues for their leadership in developing and bringing this important pilot program to reality.

It is sad but true that rural America lags the rest of the country in access to first-rate health care. That's bad news for so prosperous a nation as ours. This pilot program creatively pushes the envelope in an effort to spur the development of tele-medicine programs to better serve rural America. Having seen first-hand the difference that tele-medicine and tele-health can have on the well-being of our citizens who live hundreds of miles from the nearest hospital and are injured or just need to cure a child's ear infection, tele-medicine can be life-altering, and sometimes even life-saving. We also know that if a health catastrophe visited many of our rural areas today, our rural health care system would not generally be equipped to deal with it. Anyone who believes that terrorists, for example, are only going to focus on urban America is engaged in wrong and potentially fatal reasoning.

So I welcome and enthusiastically support this important initiative, believing it has the very real potential to kick-start badly needed rural-health infrastructure building. Once these pilot programs are under-way, monitoring them becomes critical. I will be doing everything I can to work with the Bureau and my colleagues to make sure we learn the lessons we need to learn and then develop permanent programs to bring these capabilities and services to the many rural communities that are not part of this pilot program. Today we make a good and noble start – but it is a beginning only, and much remains to be done to integrate our rural health care facilities and providers into our nationwide health care system.

**STATEMENT OF  
COMMISSIONER JONATHAN S. ADELSTEIN**

*Re: In the Matter of Rural Health Care Support Mechanism, WC Docket No. 02-60*

Broadband facilities are having a profound effect on the way that we deliver medical care. We are only beginning to envision the potential benefits available from new telecommunications technology. This Order represents an important milestone in the Commission's efforts to explore ways to maximize these benefits.

Through this Order, we are selecting sixty-nine worthy applicants to participate in our Rural Health Care Pilot Program. By expanding the Federal Universal Service Rural Health Care program to fund the construction of broadband infrastructure to connect rural health care providers, we enable local healthcare providers to deliver dramatic benefits for their communities.

Indeed, with advances in broadband and digital imaging, health care providers are increasingly able to send medical records, CAT scans, and other lab results to specialists in distant locations. Connecting our health care providers can also play a critical role in promoting continuing education through distance learning for our health care professionals, and is vital to our efforts to respond to disasters, natural and man-made. As we have seen repeatedly in the past few years, our communications systems are a critical factor in our ability to respond quickly and in a coordinated fashion. For rural residents, telemedicine can bridge distances that might otherwise be unaffordable or physically impractical to cross. They may be the only viable link to vital diagnostic services and specialized care for many patients, and they hold great potential for remote monitoring and home healthcare.

I have repeatedly supported efforts to improve the connectivity of rural health care providers and enhance the Rural Health Care program, which is crucial to the sustainability of many telemedicine programs. Without universal service, the high cost of telemedicine services might put them out of reach of many small communities. I commend Chairman Martin, my colleagues and the Bureau for their efforts to develop this Pilot Program, and I look forward to the continued advancement of the Rural Health Care program and to the results of the projects selected in this Order.

**STATEMENT OF  
COMMISSIONER DEBORAH TAYLOR TATE**

*Re: In the Matter of Rural Health Care Support Mechanism, WC Docket No. 02-60*

At Congress' direction, the Commission implemented a Rural Health Care support mechanism supported within the Universal Service Fund, which provides reduced rates to rural health care providers for their telecommunications and Internet services. Although this rural health care support program has been in place for nearly 10 years, unfortunately, it has been greatly underutilized.

I therefore was extremely supportive when the Chairman proposed that the Commission establish a Rural Health Care Pilot Program (Pilot Program) to examine how Rural Health Care support mechanism funds can be used to enhance public and non-profit health care providers' access to advanced telecommunications and information services. The response was overwhelming. The Commission received 81 applications representing approximately 6,800 health care facilities from 43 states and three United States territories.

I am very pleased by our decision today to select 69 applicants for participation in the Pilot Program. These applicants are selected because their overall qualifications are consistent with the goals of the Pilot Program to stimulate deployment of the broadband infrastructure necessary to support innovative telehealth and, in particular, telemedicine services to those areas of the country where the need for those benefits is most acute.

I am especially proud to see three projects from my home state of Tennessee receive funding- Erlanger Health System, Mountain States Health Alliance, and the Tennessee Telehealth Network. Tennessee continues to be in the forefront on extending telemedicine- and the incredible opportunities that it provides- to all of its citizens.

I am committed to taking whatever steps possible to foster access to a healthcare network that brings 21<sup>st</sup> century medicine to every corner of the nation. It has been my vision that one day all healthcare facilities in the nation are connected to each other with broadband facilities so that pioneering communities, physicians, and hospitals can show that health care can be transformed by technology no matter where a patient lives. Among other benefits, broadband connectivity among healthcare providers will assist the President's goal of implementing electronic medical records nationwide. Moreover, broadband connectivity and the ability to share information among healthcare providers would also likely assist in addressing a national crisis, whether terrorist, natural or a pandemic flu outbreak.

It has been exciting for me to see first-hand how new medical technologies—when combined with broadband—can enable everything from remote surgery in the mountains of Appalachia to telepsychiatry and teledentistry in remote parts of Alaska. I have witnessed first-hand how the technology at both a research hospital and our most remote communities serves as the bridge not only to improve people's access to

healthcare, but also to narrow the miles between doctor and patient, improve administrative efficiencies, and reduce the cost to the patient and our healthcare systems. These benefits pertain, of course, to people in rural and remote parts of our country who will benefit from the access to specialists and research that, until recently, was often only available in urban or research centers. I look forward to visiting some of these new and innovative projects which literally enable innovations in technology to improve and enhance the lives of real people and especially those who live in rural areas of this great country.

**STATEMENT  
COMMISSIONER ROBERT M. McDOWELL**

*Re: In the Matter of Rural Health Care Support Mechanism, WC Docket No. 02-60*

The response to our call for applications to participate in the Rural Health Care Pilot Program in September 2006 was heartening. The applications demonstrated the need for enhanced access to the most current and advanced health care information and services in rural areas throughout the nation. I am pleased that we are granting 69 of the applications. Our action will speed the development of regional, state and national broadband networks dedicated to health care. We are carrying out the Congressional mandate that the Commission improve the availability of advanced telecommunications and information services for rural health care providers. This program also increases support for rural areas in time of public health emergencies, such as pandemics and bioterrorism attacks. At the same time, we are imposing safeguards to assure that the rural health care funds are used for their intended purposes. I look forward to seeing increased telemedicine and telehealth services in rural areas as a result of our action today.

*Administrator's Decision on Rural Health Care Program Appeal*

Via Electronic and Certified Mail

January 27, 2016

Mr. Anthony Crandell  
Access Integration Specialists  
501 North Walnut Street  
Lamoni, Iowa 50140

Re: Appeals of Independent Auditor's Report on Iowa Rural Health Telecommunications Program's Compliance with Rural Health Care Pilot Program Rules (USAC Audit No. RH2013PP018) and of USAC's Commitment Adjustment Letters for Funding Requests (FRNs) 41446 and 63145

Dear Mr. Crandell:

The Universal Service Administrative Company (USAC) has completed its evaluation of the July 6, 2015 letter of appeal that Laura Philips submitted on behalf of Iowa Rural Health Telecommunications Program (IRHTP) and the July 6, 2015 letter of appeal that Adam Zenor submitted on behalf of Access Integration Specialists (AIS).<sup>1</sup> The appeals request that USAC reconsider the audit finding<sup>2</sup> and rescind the commitment adjustment (COMAD) letter<sup>3</sup> for the above-referenced FRNs for the federal Universal Service Rural Health Care Pilot Program (RHC Pilot Program). The audit finding and appeals concern whether IRHTP complied with Federal Communications Commission (FCC) competitive bidding rules for the RHC Pilot Program with respect to the above-referenced FRNs.

<sup>1</sup> Letter from Laura Philips, counsel for IRHTP, to USAC (July 6, 2015) (*IRHTP Appeal*); Letter from Adam Zenor, counsel for AIS, to USAC (July 6, 2015) (*AIS Appeal*).

<sup>2</sup> Independent Auditor's Report on Iowa Rural Health Telecommunications Program's Compliance with Rural Health Care Pilot Program Rules (USAC Audit No. RH2013PP018) (Sept. 5, 2014) (*Audit Report*).

<sup>3</sup> Letter from USAC to AIS (May 6, 2015). USAC is required to rescind funding commitments in full or in part, and seek recovery of funds disbursed not in compliance with FCC rules. See *In the Matter of Comprehensive Review of the Universal Service Fund Management, Administration and Oversight, et al.*, WC Docket Nos. 05-195, *et al.*, Report and Order, FCC 07-150, 22 FCC Rcd 16372, 16386, ¶ 30 (2007) ("Consistent with our conclusion regarding the schools and libraries program, funds disbursed from the high-cost, low-income, and rural health care support mechanisms in violation of a Commission rule that implements the statute or a substantive program goal should be recovered."). See also *In the Matter of Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, FCC 07-198, 22 FCC Rcd 20360, 20423, ¶ 125 (2007) (*Pilot Program Order*) (explaining that USAC must recover funds when it is determined that a participant or service provider did not comply with FCC rules and/or funds were distributed or used improperly).

Decision Summary

USAC has reviewed the appeals, supporting documentation, and the facts related to this matter, and determined that IRHTP and AIS have not demonstrated that IRHTP's competitive bidding process for the above-referenced FRNs complied with the FCC's competitive bidding rules. Specifically, IRHTP's competitive bidding processes for the above-referenced FRNs did not ensure that one service provider was not disadvantaged over another, and also may have discouraged prospective bidders. In addition, IRHTP's written disclosures to USAC for the above-referenced FRNs did not include the information required under the FCC's written disclosure requirements.

Based on the provided documents, AIS' owner and principal associate, Tony Crandell, performed work for IRHTP to implement and execute the IRHTP, including developing IRHTP's first RFP for quality assurance inspection services for its outside fiber plant ("inspection services") which did not result in a contract award, and several other IRHTP RFPs. IRHTP screened Mr. Crandell from IRHTP's two subsequent RFPs for scaled-back inspection services, and AIS ultimately competed for and was awarded contracts to provide those services. However, as a result of Mr. Crandell's work to execute and implement the IRHTP, AIS had access to information that was potentially relevant to prospective bidders for the scaled-back inspection services, including information concerning IRHTP's needs for inspection services, the bids that IRHTP received for its first RFP for inspection services, IRHTP's fiber plant to be inspected, IRHTP's budget, and IRHTP's general competitive and vendor selection processes. The documents do not indicate that other prospective bidders had access to this same information. Therefore, IRHTP's competitive bidding processes for FRNs 41446 and 63145 did not ensure that one service provider was not disadvantaged over another as required by FCC rules. In addition, the fact that Mr. Crandell executed and implemented the IRHTP (including working on IRHTP's first RFP for inspection services) and also competed to provide the scaled-back inspection services may have discouraged some prospective bidders from submitting bids.

Further IRHTP did not comply with the FCC's written disclosure requirements for the RHC Pilot Program because IRHTP's written disclosures to USAC for the requested scaled-back inspection services from AIS did not indicate that Mr. Crandell worked on IRHTP's first RFP for inspection services. IRHTP's provision of incomplete information in its original written disclosures to USAC for the above-referenced FRNs hindered USAC's competitive bidding review. Accordingly, the fact that IRHTP disclosed this information during the audit, did not remedy IRHTP's non-compliance with the FCC's written disclosure requirements. Further, USAC is not authorized to waive the FCC's written disclosure requirements.

Based on our analysis, as discussed below, USAC is unable to grant the appeals with respect to the audit finding and the requests to rescind the COMAD letter for the above-referenced FRNs.

### Appeal Decision Explanation

#### A. Background

As explained by IRHTP, IRHTP did not have the required technical expertise on its staff to develop IRHTP's RFPs or select vendors for the supported services and equipment for the RHC Pilot Program. As a result, IRHTP relied upon Anthony Crandell (the sole proprietor and principal associate of service provider AIS, and also an independent contractor to service provider Iowa Communications Network (ICN)) and staff from service provider ICN (primarily David Swanson) to implement and execute the IRHTP.<sup>4</sup> Mr. Crandell's work for IRHTP included developing and participating in the vendor selection process for IRHTP's 2008 RFP for inspection services (for which IRHTP elected not to award a contract), and IRHTP's RFPs for network and site electronics, outside fiber plant, Meshed Ethernet services and broadband lit services.<sup>5</sup> In 2009 and 2012, AIS competed for and was awarded contracts to provide scaled-back inspection services to IRHTP for the above-referenced FRNs.<sup>6</sup>

#### B. FCC Competitive Bidding Rules

RHC Pilot Program participants are required to competitively bid for eligible services and equipment, and select the most cost-effective provider of the eligible services based on their evaluation factors.<sup>7</sup> Participants submit the FCC Form 465 to initiate the competitive bidding process.<sup>8</sup> FCC rules provide that "vendors or service providers participating in the competitive bid process are prohibited from assisting with or filling out a selected participant's FCC Form 465."<sup>9</sup> To ensure compliance with the competitive bidding

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<sup>4</sup> See, e.g., AIS Appeal at 4 ("[Mr. Crandell's] expertise was requested by IRHTP in carrying out the RHC Pilot Program in Iowa...Mr. Crandell was able to assist IRHTP Project Coordinator, Art Spies, in making sure the RFPs covered all necessary services for creating the new healthcare network intended by the RHC Pilot Project."); Affidavit of Tony Crandell at 2-3, ¶¶ 13, 14 (June 29, 2015) (*Crandell Affidavit*) ("[M]y technical expertise and assistance was requested and I assisted Art Spies, Project Coordinator for IRHTP, with drafting and evaluating the following Requests for Proposal (RFPs)...I was the drafter for the above-identified RFPs"); Affidavit of Scott Curtis at 2, 4, ¶¶ 15, 44 (July 6, 2015) (*Curtis Affidavit*) ("Mr. Crandell was recruited by IRHTP to provide his independent technical expertise on the drafting and evaluating of certain RFPs." and "IRHTP has no in house technical experience in the drafting of Requests for Proposals ('RFPs') for communications connectivity or services. Thus, for the Outside Fiber RFP, IRHTP sought the assistance of Mr. Crandell, who had substantial technical experience, and Mr. Crandell participated in drafting the IRHTP Outside Fiber RFP."); Memorandums from Art Spies, IRHTP, to USAC auditors at 1 (Mar. 13, 2014 and May 12, 2014) (identifying the IRHTP RFPs for which Mr. Crandell performed work).

<sup>5</sup> See Memoranda from Art Spies, IRHTP, to USAC auditors at 1 (Mar. 13, 2014 and May 12, 2014) (identifying the IRHTP RFPs for which Mr. Crandell performed work); *Crandell Affidavit* at 2-3, ¶¶ 13, 14 (indicating same).

<sup>6</sup> See, e.g., *Crandell Affidavit*, at 3-5, ¶¶ 18-20, 34-36, Memorandum from Art Spies, IRHTP, to IRHTP Steering Committee at 1 (Sept. 16, 2009); Memorandum from Art Spies, to USAC and FCC, at 1 (June 21, 2012).

<sup>7</sup> See *Pilot Program Order*, 22 FCC Rcd at 20412, 20414, ¶¶ 100, 102; 47 C.F.R. §§ 54.603 and 54.615 (2008-11).  
<sup>8</sup> 47 C.F.R. §54.603(b)(1) (2008-11).

<sup>9</sup> *Pilot Program Order*, 22 FCC Rcd at 20405, ¶ 86, n. 281. See also USAC website at <http://www.usac.org/rhcp/vendors/step03/> ("Vendors or service providers participating in the competitive bid process are prohibited from assisting with or filling out a selected participants' service request (e.g., FCC Form 465

requirements, the FCC requires participants to “identify, when they submit their Form 465, to USAC and the Commission any consultants, service providers, or other outside experts, whether paid or unpaid, who aided in the preparation of their Pilot Program applications....they must disclose *all* of the types of relationships explained above.”<sup>10</sup> The FCC further explained that “[i]dentifying these consultants and outside experts could facilitate the ability of USAC, the Commission, and law enforcement officials to identify and prosecute individuals that may seek to manipulate the competitive bidding process or engage in other illegal activities.”<sup>11</sup> USAC is not authorized to waive the FCC’s competitive bidding rules.<sup>12</sup> Participants that do not comply with the *Pilot Program Order* requirements, including USAC administrative processes, are prohibited from receiving RHC Pilot Program support.<sup>13</sup>

In the *Pilot Program Order*, the Commission denied multiple requests, including one by IRHTP, to waive the FCC’s competitive bidding requirements for the RHC Pilot Program.<sup>14</sup> In denying the waiver requests, the Commission affirmed “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....”<sup>15</sup> The Commission also explained that competitive bidding “ensure[s] that universal service support does not disadvantage one provider over another, or unfairly favor one technology over the other.”<sup>16</sup> The Commission concluded that “it is in the public interest and consistent with the 2006 Pilot Program Order to require all participants to participate in the competitive bidding process. None of the selected participants that seek a waiver of the competitive bidding rules offer persuasive evidence to the contrary.”<sup>17</sup>

C. IRHTP Did Not Comply With the FCC’s Competitive Bidding Rules

1. *IRHTP’s Competitive Bidding Processes for FRNs 41446 and 63145 Did Not Ensure that One Service Provider Was Not Disadvantaged Over Another and May Have Discouraged Prospective Bidders*

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and related materials.”).

<sup>10</sup> *Pilot Program Order*, 22 FCC Rcd at 20415, ¶ 104 (emphasis added).

<sup>11</sup> *Id.*

<sup>12</sup> See generally, 47 C.F.R. § 54.702(c) (2008) (“[USAC] may not make policy, interpret unclear provisions of the statute or rules, or interpret the intent of Congress.”), § 1.3 (“The provisions of this chapter may be suspended, revoked, amended, or waived for good cause shown, in whole or in part, at any time by the Commission, subject to the provisions of the Administrative Procedures Act and the provisions of this chapter.”).

<sup>13</sup> See *Pilot Program Order*, 22 FCC Rcd at 20362, ¶ 4.

<sup>14</sup> See *id.* at 20395, 20413-14, ¶¶ 70, 100-101, n. 326. Some of the participants sought a waiver because they had already identified a service provider as the “optimal provider” or that was “uniquely positioned to bury fiber and maintain the system” in their location. *Id.* at 20414, ¶ 101. The FCC concluded that these circumstances did not warrant a waiver because there was “no assurance that [the participants requesting waivers] are aware of other alternatives or that the identified providers offer the most cost-effective method of providing service.” *Id.*

<sup>15</sup> *Pilot Program Order*, 22 FCC Rcd at 20395, ¶ 70. See also *id.* at 20414, ¶ 102.

<sup>16</sup> *Id.* at 20414, ¶ 102. See also FCC Frequently Asked Questions and Answers for RHC Pilot Program, available at <http://www.fcc.gov/encyclopedia/rural-health-care-pilot-program#faq18>.

<sup>17</sup> *Pilot Program Order*, 22 FCC Rcd at 20414, ¶ 102.