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

Prepared by ATC Broadband, Greg Davis, President
comments in red

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

COMMENTS ON NOTICE OF PROPOSED RULEMAKING

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I. INTRODUCTION

1. Improving America's health care and health care system is one of the most important tasks facing the nation.[1] The Commission has recognized that broadband can play an important role in the transformation of health care in the 21st century, and that access to broadband is not fully realized today in all parts of the country. In its March 16, 2010 Joint Statement on Broadband, the Commission said, "Ubiquitous and affordable broadband can unlock vast new opportunities for Americans, in communities large and small, with respect to . . . health care delivery."[2] The National Broadband Plan emphasized the importance of ensuring "sufficient connectivity for health care delivery locations."[3]

2. This Notice of Proposed Rulemaking (NPRM) proposes and seeks comment on reforms to the universal service health care support mechanism that are consistent with the recommendations set forth in the National Broadband Plan to expand the reach and use of broadband connectivity for and by public and non-profit health care providers. This greater broadband connectivity has the potential to revolutionize health care delivery by providing access to state-of-the-art Health IT solutions to over 12,000 hospitals and clinics across the nation.[4] Greater use of broadband will allow patients in medically underserved communities to receive health care locally and have access to state-of-the-art diagnostic tools typically available only in the largest and most sophisticated medical centers. Use of health-related applications delivered over broadband will not only save lives, but also cut costs by shortening average hospital stays, reducing the need for tests, and increasing administrative efficiencies. According to one study, remote patient monitoring for heart failure can save up to $6.4 billion annually through reduced hospital admissions.[5] The monetary benefits of remote monitoring of other medical conditions could be

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[1] Health care already accounts for 17% of the U.S. gross domestic product (GDP) and by 2020, it will top 20%. Ctrs. for Medicare & Medicaid Servs., National Health Expenditure Projections 2008–2018, http://www.cms.hhs.gov/NationalHealthExpendData/downloads/proj2008.pdf (last visited Jan. 21, 2010).

[2] *Joint Statement on Broadband*, GN Docket No. 10-66, Joint Statement on Broadband, FCC 10-42, para. 3 (rel. Mar. 16, 2010).

[3] Federal Communications Commission, *Connecting America: The National Broadband Plan* at 200 (rel. Mar. 16, 2010) (NBP or National Broadband Plan), *available at* http://hraunfoss.fcc.gov/edocs_public/attachmatch/DOC-296935A1.pdf. In this NPRM, we incorporate comments filed in response to the NBP Public Notice #17. *See Comment Sought on Health Care Delivery Elements of National Broadband Plan, NBP Public Notice #17*, GN Docket Nos. 09-47, 09-51, 09-137, WC Docket No. 02-60, 24 FCC Rcd 13728 (2009) (*NBP Public Notice #17*). A list of the commenters and reply commenters is included in Appendix B.

[4] As defined in the National Broadband Plan, health information technology ("health IT") refers to information-driven health practices and the technologies that enable them. National Broadband Plan at 200. Health IT includes billing and scheduling systems, e-care, electronic health records (EHRs) and telehealth and telemedicine. "E-care" refers to the electronic exchange of information – data, images and video—to aid in the practice of medicine and advance analytics. *Id.*

[5] New England Healthcare Institute, *Research Update: Remote Physiological Monitoring* (Jan. 2009), available at http://www.nehi.net/publications/36/remote_physiological_monitoring_research_update. The Veteran's Hospital System's Care Coordination/Home Telehealth Program (CCHT) for veterans with chronic conditions has resulted in a 19% reduction in hospital admissions and a 25% reduction in bed days for those who are admitted. Adam Darkins et al., *Care Coordination/Home Telehealth: The Systematic Implementation of Health Informatics, Home Telehealth, and Disease Management to Support the Care of Veteran Patients with Chronic Conditions*, 10 Telemed. & e-Health 1118, 1118 (2008), *available at* http://www.liebertonline.com/doi/pdf/10.1089/tmj.2008.0021?cookieSet=1.

exponentially larger. Live video feeds over broadband will enable intensive care physicians and nurses to monitor real-time information about critically ill patients at multiple locations around the clock. Likewise, live video feeds will enable psychiatrists and other health professionals to evaluate and treat psychosis and substance abuse at the most remote community mental health centers.[6] Disease management applications that require broadband connectivity will permit on-going consultations between patients and medical, pharmaceutical, and behavioral professionals for the treatment and management of renal and kidney diseases, asthma, hypertension, obesity, and other long-term conditions.[7]

3. In this NPRM, we seek comment on a package of reforms that would expand the use of broadband to improve the quality and delivery of health care, and address each of the major recommendations in the National Broadband Plan regarding the Commission's rural health care program. We maintain the existing funding cap of the rural health care program and propose reforms that can be implemented in a measured and fiscally prudent way to provide public and non-profit health care providers with the underlying connectivity needed to access critical health IT applications. Specifically, we propose and seek comment on the following reforms which could be implemented in funding year 2011 (July 1, 2011 to June 30, 2012):

- Building on lessons learned from the existing Rural Health Care Pilot Program, we propose to create a health infrastructure program that would support up to 85 percent of the construction costs of new regional or statewide networks to serve public and non-profit health care providers in areas of the country where broadband is unavailable or insufficient. The National Broadband Plan estimated, for instance, that 29 percent of federally funded rural health care clinics lack access even to mass-market broadband;[8] this new program would be focused on closing the connectivity gap that exists throughout the country.

- We propose to establish a health broadband services program that would subsidize 50 percent of the monthly recurring costs for access to broadband services for eligible public or non-profit rural health care providers, which should make broadband connectivity more affordable for providers operating in rural areas. This would largely benefit rural health care providers that, to date, have not participated significantly in the existing internet access program, as well as current participants in the existing Rural Health Care Pilot Program, including state and regional networks that will improve health care for more than 200 Tribes in 16 states.

- We propose to expand the Commission's interpretation of "eligible health care provider" to include acute care facilities that provide services traditionally provided at hospitals, such as skilled nursing facilities and renal dialysis centers and facilities, and administrative offices and data centers that do not share the same building as the clinical offices of a health care provider but that perform support functions critical for the provision of health care. This could expand access to broadband connectivity from roughly 9,800 eligible health care providers today to 12,000 health care providers across the country.

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[6] *See, e.g.*, Dell NBP Public Notice #17 Comments at 3 (noting that in certain emergency scenarios, health care providers would benefit from the ability to access and exchange real-time patient information to make critical care decisions).

[7] *See, e.g.*, Harris Corp NBP Public Notice #17 Comments at 6 (noting that broadband connectivity would enable disease management service providers to receive patient vital signs from multiple locations and devices, and would enable the transmission of patient information in text, audio, and video formats).

[8] *See* National Broadband Plan at 213, Exhibit 10-F.

- We seek comment on how to prioritize funding requests to the extent demand exceeds the annual $400 million funding cap.
- We seek comment on ways to enhance ongoing program evaluation and implementation of performance measures to ensure that the public realizes benefits from the investment of universal service funding to improve broadband connectivity for health care providers.
- We propose to clarify our existing recordkeeping requirements to enhance our ability to protect against waste, fraud and abuse.
- Based on more than a decade's experience, we propose to eliminate the current rule that requires that funding be offset against universal service contributions owed by participating service providers, and instead propose to allow service providers participating in the health broadband services program, the telecommunications program, and the health infrastructure program to receive rural health care funds directly from USAC.

4. We encourage input from Tribal governments on all of these issues, and specifically ask whether there are any unique circumstances in Tribal lands that would necessitate a different approach.[9] Similarly, we request comment on whether there are any unique circumstances in insular areas that would necessitate a different approach.

II. BACKGROUND

A. Rural Health Care Support Mechanism

5. Section 254(h)(1)(A) of the Communications Act of 1934, as amended by the Telecommunications Act of 1996 (the Act), directs that telecommunications carriers provide telecommunications services that are necessary for the provision of health care services in rural areas at rates that are reasonably comparable to rates in urban areas.[10] Consistent with this directive, in 1997, the Commission established the rural health care telecommunications program (referred to in this NPRM as the "*telecommunications program*") to ensure that rural health care providers pay no more than their urban counterparts for their telecommunications needs in the provision of health care services.[11] Section

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[9] For the purposes of this NPRM, we define "Tribal lands" as any federally recognized Indian tribe's reservation, pueblo or colony, including former reservations in Oklahoma, Alaska Native regions established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688), and Indian allotments. The term "Tribe" means any American Indian or Alaska Native Tribe, Band, Nation, Pueblo, Village or Community which is acknowledged by the Federal government to have a government-to-government relationship with the United States and is eligible for the programs and services established by the United States. *See Statement of Policy on Establishing a Government-to-Government Relationship with Indian Tribes*, Policy Statement, 16 FCC Rcd 4078, 4080 (2000). Thus, "Tribal lands" includes American Indian Reservations and Trust Lands, Tribal Jurisdiction Statistical Areas, Tribal Designated Statistical Areas, and Alaska Native Village Statistical Areas, as well as the communities situated on such lands. This would also include the lands of Native entities receiving Federal acknowledgement or recognition in the future. Although Native Hawaiians are not currently members of federally-recognized Tribes, we also seek comment on whether there are any unique circumstances that would warrant an alternative approach in Native Hawaiian homelands.

[10] 47 U.S.C. § 254(h)(1)(A).

[11] *See Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776, 9093-9161, paras. 608-749 (1997) (*Universal Service First Report and Order*); 47 C.F.R. Part 54, Subpart G. To accomplish this, the Commission concluded that telecommunications carriers must charge eligible rural health care providers a rate for each supported service that is no higher than the highest tariffed or publicly available (continued….)

254(h)(2)(A) directs the Commission to establish competitively neutral rules to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for public and non-profit health care providers.[12] In 2003, the Commission adopted the rural health care internet access program (referred to in this NPRM as the "*internet access program*") to provide a flat percent discount on monthly charges for access to the public Internet for rural health care providers. The discount is 50 percent for health care providers in states that are entirely rural, and 25 percent for all other rural health care providers.[13]

B. Rural Health Care Pilot Program

6. In 2007, the Commission established the Rural Health Care Pilot Program (Pilot Program) to examine ways to stimulate deployment of the broadband infrastructure necessary to support telehealth and telemedicine in those areas of the country where the need for such services is most acute.[14] This program makes available universal service funding to support up to 85 percent of the eligible costs of broadband infrastructure deployment of telehealth networks that connect rural and urban health care providers within a State or region.[15] Nationwide, 62 projects are eligible to receive up to $417 million in Pilot Program funding for telehealth networks serving 6,000 health care facilities in 42 states and three U.S. territories.[16] To receive funding commitments under the Pilot Program, health care providers must first competitively bid their networks and demonstrate, among other things, that they have selected the most cost-effective vendors.[17] Projects must also identify all eligible health care providers that will be part of the network, demonstrate their ability to fund at least fifteen percent of eligible project costs, and provide assurances that their proposed networks will be self-sustaining once established.[18]

7. Since implementing the Pilot Program, the Commission has learned valuable lessons about what has worked best in the Pilot Program and has conducted extensive outreach to ensure its success. To ensure that Pilot Program participants are able to provide the full benefits of their projects to health care consumers in the targeted areas, the Wireline Competition Bureau (Bureau) has approved successors in instances where certain projects could not continue under the Program and has extended by one year, to

(Continued from previous page)

commercial rate for a similar service in the closest city in the state with a population of 50,000 or more people, taking distance charges into account. *See* 47 C.F.R. §§ 54.604, 54.605, 54.607.

[12] 47 U.S.C. § 254(h)(2)(A).

[13] 47 C.F.R. § 54.621.

[14] *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 22 FCC Rcd 20360 (2007) (*2007 Pilot Program Selection Order*).

[15] Specifically, the Pilot Program supports up to 85 percent of the costs associated with (1) the construction of state or regional broadband networks and the advanced telecommunications and information services provided over those networks; (2) connecting to nationwide backbone providers Internet2 or National LambdaRail (NLR); and (3) connecting to the public Internet. *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20361, para. 2.

[16] To date, the Pilot Program has made funding commitments for 29 projects that will link hundreds of hospitals regionally in 24 states. Collectively, these projects are eligible to receive up to $216 million for costs associated with network deployment. 18 of the remaining projects have developed or posted requests for proposals to select vendors to build-out their broadband networks. The final 16 projects in the Pilot Program continue to prepare their requests for proposals as part of the Program's competitive bidding process.

[17] *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 21 FCC Rcd 11111, 11117, para. 18 (2006) (*2006 Pilot Program Order*).

[18] *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20383-84, 20389-90, 20399-40, paras. 49, 54, 77.

June 30, 2011, the deadline for participants to select a vendor and request funding commitments from the Universal Service Administrative Company (USAC).[19]

C. Current Funding Levels

8. The telecommunications program and the internet access program, together with the Pilot Program, are collectively referred to in this NPRM as the Rural Health Care Support Mechanism. The annual fund cap for the Rural Health Care Support Mechanism, as established by the Commission, is $400 million per funding year.[20]

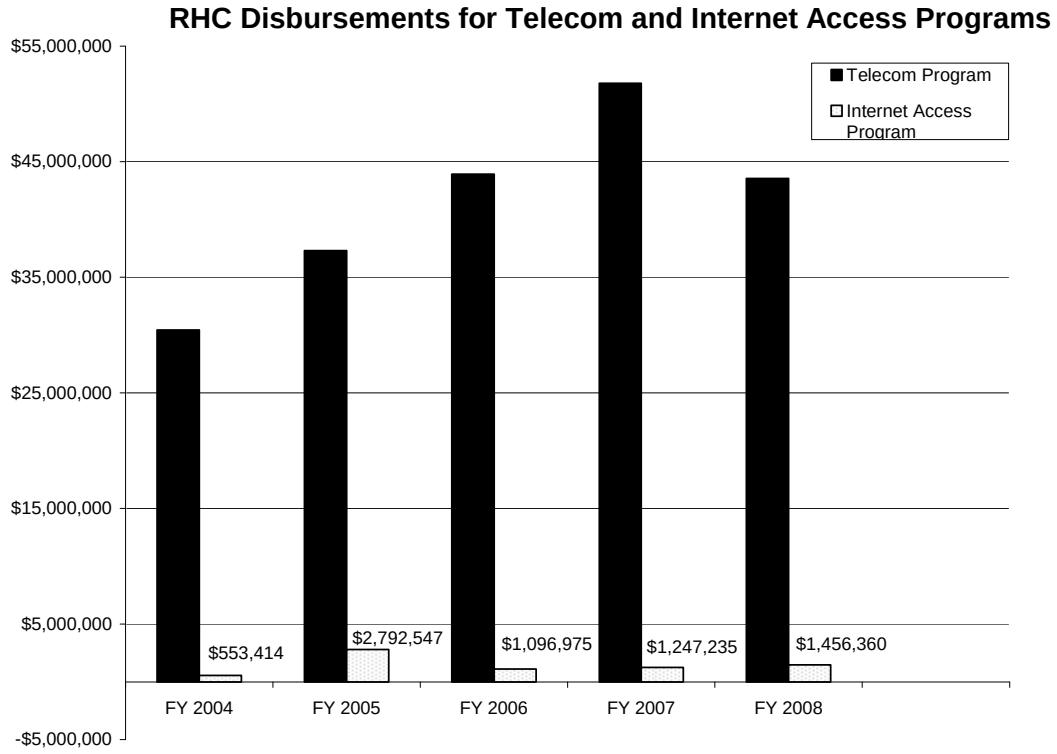
9. Historically, the Rural Health Care Support Mechanism has not been fully utilized. Out of the 9,800 health care providers eligible for support under the telecommunications program and the internet access program, only about 3,000 providers participate in these programs. As noted by the National Broadband Plan, the telecommunications and internet access programs have provided $60.7 million in support to eligible health care providers to date for funding year 2009.[21] The following chart illustrates the amount of funding disbursed to participants of the telecommunications program and the internet access program, respectively, for funding years 2004 through 2008:[22]

[19] *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 25 FCC Rcd 1423 (Wireline Comp. Bur. 2010) (*2010 Pilot Program Extension Order).*

[20] 47 C.F.R. § 54.623; *Universal Service First Report and Order*, 12 FCC Rcd at 9141, para. 705.

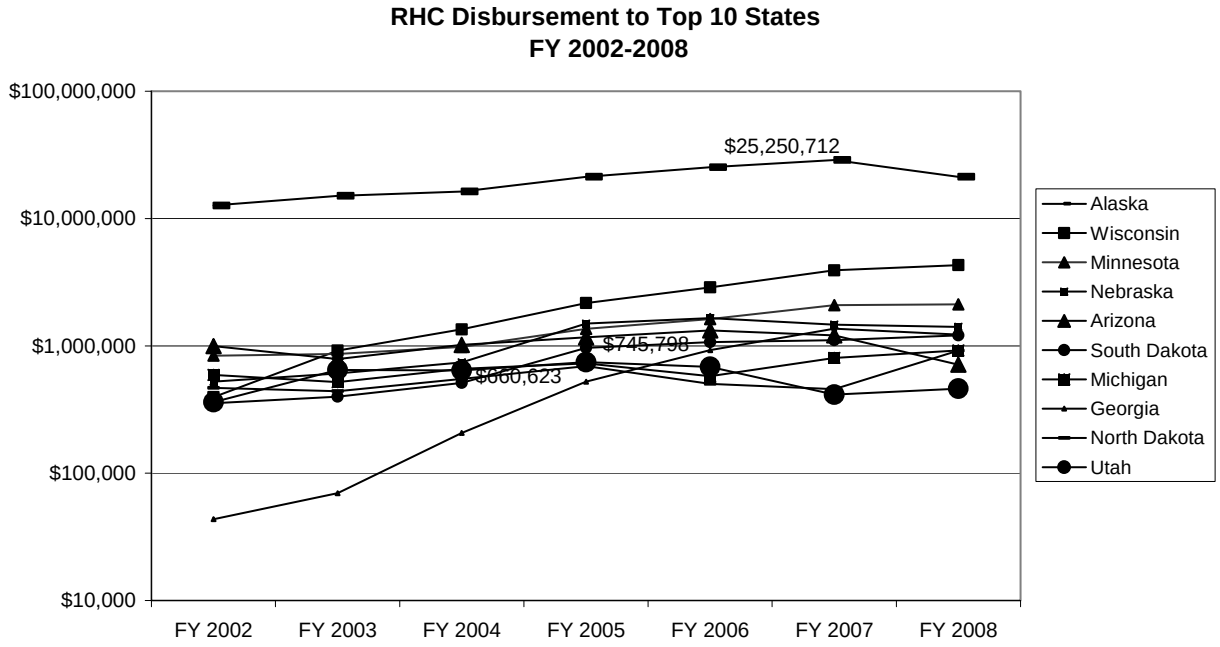
[21] National Broadband Plan at 214, Exhibit 10-G. Funding Year 2009 will end on June 30, 2010. See 47 C.F.R. § 54.623(b). However, funds may be disbursed for Funding Year 2009 after that date.

[22] The chart does not include disbursements for funding year 2009 because FY 2009 has not ended. USAC will continue to accept applications for FY 2009 RHC support through June 30, 2010.



10. Moreover, the vast majority of funding under the telecommunications program and the internet access program has been directed toward health care providers in only one state, as shown in the chart below, which depicts telecommunications and internet access program disbursements to the top ten highest state recipients for funding years 2002 through 2008:[23]

[23] *See Universal Service Monitoring Report*, CC Docket No. 98-202, Prepared for the Federal-State Joint Board on Universal Service in CC Docket No. 96-45, Table 5.2 (2009), *available at* http://hraunfoss.fcc.gov/edocs_public/attachmatch/DOC-295442A1.pdf; *Universal Service Monitoring Report*, CC Docket No. 98-202, Prepared for the Federal-State Joint Board on Universal Service in CC Docket No. 96-45, Table 5.2 (2008), *available at* http://hraunfoss.fcc.gov/edocs_public/attachmatch/DOC-287688A1.pdf; *Universal Service Monitoring Report*, CC Docket No. 98-202, Prepared for the Federal-State Joint Board on Universal Service in CC Docket No. 96-45, Table 5.2 (2007), *available at* http://hraunfoss.fcc.gov/edocs_public/attachmatch/DOC-279226A1.pdf; *Universal Service Monitoring Report*, CC Docket No. 98-202, Prepared for the Federal-State Joint Board on Universal Service in CC Docket No. 96-45, Table 5.2 (2006), *available at* http://hraunfoss.fcc.gov/edocs_public/attachmatch/DOC-269251A1.pdf; *Universal Service Monitoring Report*, CC Docket No. 98-202, Prepared for the Federal-State Joint Board on Universal Service in CC Docket No. 96-45, Table 5.2 (2005), *available at* http://hraunfoss.fcc.gov/edocs_public/attachmatch/DOC-262986A1.pdf; *Universal Service Monitoring Report*, CC Docket No. 98-202, Prepared for Federal-State Joint Board on Universal Service in CC Docket No. 96-45, Table 5.2 (2004), *available at* http://www.fcc.gov/Bureaus/Common_Carrier/Reports/FCC-State_Link/Monitor/mr04-5.pdf. We have extrapolated the disbursement data for the ten states that have received the most disbursements over the past seven funding years.



Total (FY 2002 to FY 2008)			
1. Alaska	$140,697,269	6. South Dakota	$5,613,184
2. Wisconsin	$15,952,634	7. Michigan	$4,803,001
3. Minnesota	$9,883,112	8. Georgia	$4,360,330
4. Nebraska	$7,896,677	9. North Dakota	$4,030,073
5. Arizona	$7,211,967	10. Utah	$3,955,086

III. HEALTH INFRASTRUCTURE PROGRAM

11. The National Broadband Plan stated that the Pilot Program "represents an important first step in extending broadband infrastructure to unserved and underserved areas and ensuring that health care providers in rural areas and Tribal lands are connected with sophisticated medical centers in urban areas."[24] However, the National Broadband Plan noted that, despite the efforts of the Commission to date, many health care providers remain under-connected.[25] The National Broadband Plan recommended that the Commission continue to support broadband infrastructure for health care purposes, incorporating lessons learned from the Pilot Program.[26]

12. In establishing the Pilot Program, the Commission noted that many health care providers were unable to access certain telehealth services without deployment of broadband facilities.[27] Despite

[24] National Broadband Plan at 214. The Plan suggested that the Commission continue to assist participants to ensure networks are built as quickly and effectively as possible. *Id.*

[25] *Id.*

[26] *Id.* at 215-16 (NBP Recommendation 10.7).

[27] *See 2006 Pilot Program Order*, 21 FCC Rcd at 11113, paras. 8-9.

the overwhelming interest and participation levels in the Pilot Program, the National Broadband Plan found that a large broadband connectivity gap still exists, particularly among small, rural providers. For example, the National Broadband Plan identified a broadband connectivity gap among an estimated 3,600 out of approximately 307,000 small providers.[28] 70 percent of those small providers lacking access to mass-market broadband services – approximately 2,500 providers – are located in areas that the Commission defines as rural.[29] The National Broadband Plan also found that larger physician offices (i.e., five or more physicians), larger clinics and hospitals also face broadband connectivity barriers; it noted that due to their size and health IT service needs, such health care providers cannot utilize mass-market broadband, but require dedicated Internet access (DIA) solutions.[30]

13. Consistent with our authority under section 254(h)(2)(A) of the Act,[31] we propose to create a "*health infrastructure program*" to fund up to 85 percent of eligible costs for the design, construction and deployment of dedicated broadband networks that connect public or non-profit health care providers in areas of the country where the existing broadband infrastructure is inadequate.[32] The program would provide support for the construction of state or regional broadband health care networks that can, for example, connect rural and urban health care providers, facilitate the transmission of real time video, pictures, and graphics, bridge the silos that presently isolate relevant patient data, make communications resources more robust and resilient, and maximize the efficiency and reliability of packet routing. Broadband infrastructure projects may include either new facilities or improvements to upgrade existing facilities (for example, converting a copper facility to a fiber facility capable of broadband delivery). In addition, funding may be used to support up to 85 percent of the cost of connecting health care networks to Internet2 or National LambdaRail (NLR), both of which are non-profit, nationwide backbone providers.[33]

The health infrastructure program is unnecessary. If the FCC will fund the health broadband services program at 85%, all the necessary network will be provided by service providers and all the program administration can be eliminated. Existing common carriers such as Telcos, CLECs, CATV companies and ISPs have the networks and are best positioned to build dedicated health networks. Only last mile infrastructure will be required to hospitals and other health care providers.

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[28] National Broadband Plan at 211; *see also* Public Safety Spectrum Trust NBP Public Notice #17 Comments at 5-6 (noting that there is a connectivity gap within healthcare that needs to be addressed).

[29] National Broadband Plan at 211.

[30] *Id.* at 211-13; *see* Letter from Michael McGill, Internet2, to Marlene Dortch, Secretary, Federal Communications Commission, GN Docket No. 09-51 and CC Docket No. 02-60, at 1 (filed June 25, 2010) (Internet2 June 25, 2010 *Ex Parte* Letter) (network reliability is critical to assure the availability of health records for providing care).

[31] 47 U.S.C. § 254(h)(2)(A); *see also Universal Service First Report and Order*, 12 FCC Rcd at 9109, para. 634 (the Commission concluded that it has discretionary authority to implement a program of universal service support for infrastructure development as a method to enhance access to advanced telecommunications and information services under section 254(h)(2)(A), so long as such a program is competitively neutral, technically feasible, and economically reasonable). The Pilot Program was established pursuant to section 254(h)(2)(A) to fund deployment of broadband infrastructure for telehealth and telemedicine networks. *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20361, para. 1.

[32] *See* Appendix A, 47 C.F.R. § 54.650(b).

[33] Internet2 and NLR are non-profit, nationwide network backbones, dedicated to educational, clinical, and research goals. *See, e.g.*, Internet2, *About Us*, at http://www.internet2.edu/about/ (last visited June 24, 2010) and NLR, *About National LambdaRail*, at http://www.nlr.net/about.php (last visited June 24, 2010).

A. Program Process

14. We propose an application and selection process for the health infrastructure program in which eligible health care providers may seek funding for qualified projects through a streamlined process. We seek comment on each step of the process described below. To the extent a commenter disagrees with a particular aspect of the proposed process, we ask them to identify that with specificity and propose an alternative.

15. *Initial Application Phase.* First, applicants may request consideration for funding by completing a user friendly online application available on a website to be developed and maintained by USAC.[34] Applications would be accepted during the first quarter of each funding year (July 1 to September 30). As part of this initial application phase, an applicant would be required to (1) verify that either there is no available broadband infrastructure or the existing available broadband infrastructure is insufficient for health IT needed to improve and provide health care delivery,[35] (2) provide letters of agency for each of the eligible health care providers in the applicant's proposed network, (3) include a preliminary budget and an infrastructure funding request, not in excess of the per-project caps discussed below, and (4) certify that it will comply with all program requirements if selected for funding.[36]

Sufficient broadband infrastructure should be defined as a 10 MB symmetrical fiber connection. The important thing is that the health care provider has a fiber connection to the broadband network. Ten (10) gigabit bandwidth is typical on fiber.

We serve 5 rural hospitals. They all have fiber connections. Their broadband requests are based on what they wish to pay. They can all get 1 Gigabit bandwidth but they get much less. The largest user has 30 MB and the smallest user has about 3 Mb. The problem is not infrastructure. It is cost. Subsidize the cost for small rural healthcare providers and they will get broadband quickly.

The schools and libraries program has been very successful in its objectives. ATC has built fiber WANs for 7 rural school systems. All have Gigabit fiber connections at costs between $1000 and $2000/ month per school. In fact most schools now have Gigabit Ethernet and want to upgrade their WANs to 10 Gigabit. This is possible because these rural schools receive 80% to 90 % subsidy. No infrastructure program had to be developed. No application process or project review is necessary. The schools just issued an RFP and it was built.

The proposed infrastructure program allows 3 years for arranging the paperwork and 5 years for build out. This is an unnecessary, time consuming, and expensive process. As a company involved in the pilot project we know the difficulties in moving through the process of bureaucratic approvals. This process of submitting plans and having USAC supervise and approve the project from start to finish will cause long delays and in the end will be of no value

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[34] *See* Appendix A, 47 C.F.R. § 54.650(b). Some commenters have noted that the administrative process of applying for Pilot Program funding is burdensome. *See, e.g.*, ATA NBP Public Notice #17 Comments at 18; Geisinger NBP Public Notice #17 Comments at 2; Minnesota Health Dept. NBP Public Notice #17 Comments at 4–6; Palmetto Network NBP Public Notice #17 Comments at 14-15; Oregon Health Network NBP Public Notice #17 Comments at 7, 12–13.

[35] *See infra* para. 20, proposing a minimum broadband connectivity speed for infrastructure deployment projects supported under the health infrastructure program.

[36] *See* Appendix A, 47 C.F.R. § 54.603(b)(1)(iii).

16. Project Selection Phase. We propose that applications submitted for funding be made publicly available on USAC's website.[37] Publicly available information would include the names of the parties seeking funding, their geographic location, and information filed by the applicants to corroborate that sufficient broadband infrastructure is unavailable or insufficient in their geographic location. During the second quarter of each funding year (October 1 to December 31), USAC would review all applications received during the initial application phase. We seek comment below on limiting the total number of projects that may be selected in a given year.[38] We also seek comment below on prioritization rules to be applied by USAC in the event that funding requests exceed the annual amount available under the health infrastructure program.[39] After applications have been reviewed, and prioritization rules have been applied, USAC would notify selected participants of their project eligibility status. This would normally occur during the third quarter of each funding year (January 1 to March 30). After a participant is notified of project eligibility, it may proceed with the project commitment phase per the requirements set forth below. During the project commitment phase, participants may receive funding from the health infrastructure program for a portion of the reasonable administrative expenses incurred in connection with the project, subject to certain caps as discussed further below.

16. *Project Commitment Phase.* After being selected based on their initial application, we propose that participants in the health infrastructure program would complete and submit all application materials and comply with all program requirements,[40] including: (1) 15 percent minimum contribution requirement; (2) project milestones; (3) detailed project description; (4) facilities ownership, IRU or capital lease requirements; (5) standard terms and conditions; (6) sustainability plan; (7) excess capacity disclosures; (8) vendor cost reporting requirements; (9) quarterly reporting requirements; (10) competitive bidding and vendor selection requirements; (11) completion of project; and (12) NEPA and NHPA requirements.[41] USAC would review each step of the project commitment phase to confirm the participant's compliance with all data and information requirements and compliance with program rules. USAC would conduct technical and financial review of all proposed projects to ensure that they comply with the Commission's rules. USAC may request additional information from applicants and participants if deemed necessary to substantiate, explain or clarify any materials submitted as part of the funding process

Fifthteen percent contribution is generally a good number but the subsidy should be based on the need in the area. Rural areas should receive a higher percentage subsidy.

Facilities ownership is a bad idea because a health care provider does not need to manage a fiber network and it will certainly be more expensive than buying existing fiber bandwidth from a network provider.

An IRU is a good idea because it will guarantee sustainability. In fact, we think it is the only thing that guarantees sustainability. There are problems with the IRU. In 15 years, prices and technology can change a lot. For example, 15 years ago we payed over $1000 per MB for

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[37] *See id.*, 47 C.F.R. § 54.650(c).

[38] *See infra* para. 31.

[39] *See infra* paras. 128 - 134 regarding funding limits and prioritization rules.

[40] *See* Appendix A, 47 C.F.R. § 54.650(c).

[41] *See infra* paras. 44 - 89, regarding post-application requirements for participants in the health infrastructure program.

Internet bandwidth. Now we pay less than $100/MB. An IRU is money up front for a small rural provider. In the pilot project, a ten year IRU could have cost 5 million. 15% of this is $750,000. This is $150,000 for each of the 5 hospitals. They would not have paid this. We think 15% of a 15 yr. IRU will be a significant barrier to participation.

Health care providers do not need to own their own private fiber networks. It does not make economic sense. Service providers spread the cost of their networks across many thousands or millions of customers. It will be much less expensive to purchase or lease capacity from a service provider.

Build-out Period. We propose that participants have a period of three funding years (commencing with the funding year in which the initial online application was submitted) to file all forms and supporting documents necessary to receive funding commitment letters from USAC; and a period of five years (commencing on the date on which the participant receives its first funding commitment letter for the project) in which to complete build-out.[42]

B. Provisions Applicable to Initial Application for Funding

1. Demonstrated Need for Infrastructure Funding

17. We propose that applicants under the health infrastructure program demonstrate that broadband, at the connectivity speeds defined below, is presently unavailable or insufficient for health IT needed to provide or improve health care delivery requested by the eligible health care providers seeking funding.[43] We seek comment on this proposal.

Connectivity Speed. We seek comment on setting a minimum threshold for broadband connectivity speeds under the health infrastructure program. The National Broadband Plan suggested that most businesses in the United States, including health care providers, have two choices of broadband service: mass-market, small business solutions of 4 Mbps or more, or dedicated Internet access (DIA) solutions of 10 Mbps or more.[44] Because the focus of the health infrastructure program is to fund dedicated networks, we propose setting 10 Mbps as the minimum broadband speed for infrastructure deployment supported under the health infrastructure program.[45] We seek comment on this proposal. We also seek comment on minimum levels of reliability, including physical redundancy, to support health IT services and what can be done to encourage reliability.[46] We also seek comment on the minimum quality of

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[42] *See* Appendix A, 47 C.F.R. § 54.650(e). For example: An applicant submits an initial application on July 1, 2011, and is notified of project eligibility on January 1, 2012. This applicant would have three funding years, ending on June 30, 2014, in which to complete all application materials, conduct competitive bidding, select vendors, and request funding commitment letters from USAC. If such applicant receives its first funding commitment letter for a project on July 1, 2012, it would have to complete build-out for the project by July 1, 2017.

[43] *See id.* § 54.651(a).

[44] National Broadband Plan at 211; *see* Internet2 June 25, 2010 *Ex Parte* Letter, at 2-3 (bandwidth requirements for telemedicine applications can vary from 10.8 Mbps to as high as 20.4 Mbps).

[45] *See* Appendix A, 47 C.F.R. § 54.631(e).

[46] *See* Internet2 June 25, 2010 *Ex Parte* Letter, at 1 (suggesting that funded services should include minimum standards of quality of service, including reliability, bit relay, jitter, packet dropping probability and/or bit error rate).

service standards necessary to meet health IT needs. We seek comment on whether the health infrastructure program should contain a minimum quality of service requirement.[47]

A 10 MB fiber connection is sufficient infrastructure because it can be easily upgraded. The connection needs to be fiber and not bonded T-1s.

18. The National Broadband Plan recommended that the Commission establish demonstrated-needs criteria to ensure that deployment is focused in those areas of the country where the existing broadband infrastructure is insufficient.[48] It suggested that such criteria could include: demonstration that the health care provider is located in an area where sufficient broadband is unavailable or unaffordable; or certification that the health care provider has posted for services for an extended period of time and has not received any viable proposals from qualified network vendors for such services.[49]

19. Building a dedicated broadband network involves significant effort and costs. It is important, therefore, to adopt a process that will help ensure that projects are funded only in those regions where providers cannot obtain access to broadband adequate for health care purposes due to a lack of sufficient infrastructure. Accordingly, we propose that applicants seeking funding under the health infrastructure program demonstrate that broadband adequate to meet their health care needs is unavailable or insufficient in the geographic area where health care providers are to be connected by the proposed dedicated network, by using any of the following methods:

- Provide a survey of current carrier network capabilities in the geographic area, compiled by a preparer reasonably qualified to make such surveys. The survey should provide details as to the identity and broadband capabilities of all existing carriers in the proposed network area, and discuss and justify the methodology used to make such determinations. The survey should be accompanied by a statement of the preparer's professional, educational, and business background that make the preparer qualified for conducting the survey. For example, indicate the preparer's prior experience, technical or engineering degrees, telecommunications background, and knowledge of methods typically employed to perform such surveys. In addition to the survey, the applicant would be required to provide a report detailing either that there is no available broadband infrastructure, or explaining why existing broadband infrastructure would be insufficient for health IT needed to provide or improve health care delivery requested by the health care providers that are proposing the infrastructure project.[50]

- Provide copies or linked references to recognized broadband mapping studies, such as NTIA's national broadband map, state or local broadband maps, and other mapping sources that adequately depicts the available broadband in the proposed network area.[51]

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[47] *See id.*

[48] National Broadband Plan at 215 (NBP Recommendation 10.7).

[49] *Id.*

[50] *See* Appendix A, 47 C.F.R. § 54.651(a)(1).

[51] In the Recovery Act, Congress directed the NTIA to develop and maintain a comprehensive, interactive and searchable nationwide-inventory map that depicts the geographic extent to which broadband service capability is deployed and available from a commercial or public provider throughout each state. *See* American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, § 6001, 123 Stat. 115, 512 (2009) (codified at 47 U.S.C.A. § 1305 (West 2010)) (Recovery Act). The Recovery Act requires that the national broadband map be accessible to the public on an NTIA web site no later than February 17, 2011. Recovery Act § 6001(l). In addition, pursuant to the (continued….)

In addition to referencing such NTIA or state broadband mapping studies, the applicant would be required to provide a report detailing why existing broadband infrastructure would be insufficient to meet the needs of the eligible health care providers that are proposing the infrastructure project.[52]

- Certify that, for a continuous period of not less than six months, the health care providers in the proposed dedicated network requested broadband services under the telecommunications program or the health broadband services program, and did not receive any proposals from qualified network vendors meeting the terms of the requested services.[53] We propose six months as the minimum time period for which applicants must show that they were unable to acquire broadband services sufficient for their needs. This period would allow existing carriers to compete to provide services to the health care providers prior to any funding from the health infrastructure program. We seek comment on whether six months is a sufficient period of time. To the extent commenters propose other time periods, they should provide specific information to support their recommended time periods.[54]

Issuing RFPs to Service providers will prevent building duplicate networks. The RFPs should be done before any broadband infrastructure is started. Requesting proposals through the health broadband services program should be required before funding a broadband infrastructure project. Comparing proposals to the cost of building networks will help in eliminating waste.

20. The National Broadband Plan also suggested that health care providers could justify funding from an infrastructure program by providing a financial analysis showing that the cost of new network deployment would be significantly less expensive over a specified time period (e.g., 15-20 years) than purchasing services from an existing network carrier.[55] We seek comment on whether we should adopt such criteria, in addition to the three options proposed above, and, if so, what should be included in the financial analysis? If we require that applicants demonstrate that network deployment would be less expensive over a period of time, what period of time is appropriate? For example, should such period of time be equivalent to the useful economic life of the funded network? Should an applicant provide a net present value to demonstrate cost effectiveness? Are there other methodologies that can be included in a financial analysis to demonstrate the cost effectiveness of network deployment?

21. We invite comments on whether the above criteria are sufficient to establish that broadband is unavailable or insufficient. In addition, we invite comments on other ways in which health care providers could demonstrate, or interested stakeholders could challenge, the sufficiency of existing

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Broadband Data Improvement Act, NTIA established a State Broadband Data and Development Grant Program which grants funds for statewide initiatives to identify and track the availability and adoption of broadband services within each State. *See* Broadband Data Improvement Act, Pub. L. No. 110-385, tit. I, §§ 101-06, 122 Stat. 4096, 4096-4102 (2008) (codified at 47 U.S.C.A. §§ 1301-04) (West 2010) (BDIA); State Broadband Data and Development Program, BroadbandUSA – NTIA, http://www2.ntia.doc.gov/SBDD (last visited June 24, 2010).

[52] *See* Appendix A, 47 C.F.R. § 54.651(a)(2).

[53] See 47 C.F.R. § 54.603 for the process by which health care providers request services under the telecommunications program; *see also* Appendix A, 47 C.F.R. § 54.603. For the health infrastructure program, we propose that a method of seeking services is posting detailed RFPs. *See infra* para. 85.

[54] *See* Appendix A, 47 C.F.R. § 54.651(a)(3).

[55] National Broadband Plan at 215.

broadband infrastructure. When possible, such comments should indicate publicly available sources that could be used to determine the existence or absence of adequate broadband infrastructure.

22. All information submitted by applicants to establish that broadband is unavailable or insufficient would be subject to review and verification by USAC.

2. Letters of Agency

23. We propose that as part of the initial application phase for infrastructure projects, applicants identify (1) all eligible health care providers on whose behalf funding is being sought, and (2) the lead entity that will be responsible for completing the application process. In addition, as in the Pilot Program, we would require that the application include a Letter of Agency (LOA) from each participating health care provider, confirming that the health care provider has agreed to participate in the applicant's proposed network, and authorizing the lead entity to act as the health care provider's agent for completing the application process. Such letters of agency will serve as confirmation that the identified health care providers endorse the proposed network, and will also avoid improper duplicate support for health care providers participating in multiple networks. All such letters of agency would be delivered by the applicant as part of the initial application.[56]

24. *Consortium Applications.* We recognize that eligible health care providers may wish to obtain broadband services as part of consortia that may include other entities that are not eligible health care providers. For example, health care providers may join with state organizations, public sector (governmental) entities, and non-profit entities that are not eligible health care providers. The Pilot Program allowed state organizations, public entities and non-profits to act as administrative agents for eligible health care providers within a consortium.[57] We propose retaining this same flexibility for the health infrastructure program. Although state organizations, public entities and non-profits may not constitute eligible health care providers, they may apply on behalf of eligible health care providers as part of a consortium (e.g., as consortia leaders) to function in an administrative capacity for eligible health care providers within the consortium. In doing so, however, state organizations, public entities and non-profits would be prohibited from receiving any funding from the health infrastructure program (other than some administrative expenses, as discussed below). We propose that any discounts, funding, or other program benefits secured by a state organization, public sector (governmental) entity or non-profit entity acting as a consortium leader under the health infrastructure program would be passed on to the consortium members that are eligible health care providers.[58]

25. We also propose that in the case of a consortium, the legally and financially responsible entity that owns dedicated facilities funded by the health infrastructure program could be a state organization, public sector (governmental), or not-for profit entity acting as a fiduciary agent for eligible health care providers within such consortium. For example, a state, public (government) or non-profit entity acting as administrative agent for a consortium of eligible health care providers seeking funding for a dedicated network, could also serve as the title owner of the dedicated network. However, we propose

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[56] *See* Appendix A, 47 C.F.R. § 54.652.

[57] *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20396-97, paras. 72-73.

[58] We note that in the E-Rate context, the Commission has explicitly required state telecommunications networks that secure discounts under the universal service support mechanisms on behalf of eligible schools and libraries, or consortia that include an eligible school or library, to pass on these discounts to the eligible schools or libraries. *See* 47 C.F.R. § 54.519.

that title to the dedicated network would be held exclusively for the benefit of eligible health care providers.[59] We seek comment on the above proposals.

3. Funding Requests and Budgets

26. We propose that every applicant's initial application include a funding request, a brief project description and a detailed budget. The funding request should not exceed 85 percent of the eligible costs identified in the budget.[60] We seek comment on the proposals set forth below.

27. *Cap on Amount Funded Per Project.* We seek comment on whether there should be a cap on the total amount for which a project may seek funding. A per project cap would help ensure that multiple projects across varying unserved geographic areas will be eligible to receive funding for infrastructure. We note that nearly 90 percent of the projects in the Pilot Program had proposed budgets below $15 million. For example, we could provide that no single project would be eligible for more than $15 million in funding. We seek comment on whether $15 million, or some other figure, is the correct per project cap to use. We note that the Commission would retain authority to consider an applicant's request for waiver of the per project cap on a case-by-case basis if warranted by the particular circumstances and the public interest.

28. *Cap on Number of Projects per Year.* Further, we seek comment on whether to adopt a rule setting a maximum number of projects to be selected for funding each year. One of the lessons learned from the Pilot Program is that many applicants were ill-prepared to undertake the complex process of developing a new health care network, and consequently many required ongoing coaching and support to navigate their way through the process. A smaller number of projects will allow USAC to devote greater resources and time in ensuring their success. Also, unlike the Pilot Program, projects not selected for funding in any funding year will have opportunities to apply for funding in subsequent funding years. If the number of projects that apply and qualify for funding in any year exceeded such a cap, should priority be given to those projects that connect the greatest number of rural health care providers?[61] If we adopt a cap on the number of projects that may be funded per year, we seek comment on whether such cap should be in addition to or in lieu of a cap on the amounts funded per project.

29. *Budget.* We propose that together with the funding request, applicants submit a detailed budget that identifies all costs related to the proposed project.[62] The budget should be reasonable, and should be based on pricing information available to the applicant. All material assumptions used in preparing the budget should be noted and discussed in narrative form. The budget should separately identify the following (each subject to the limitations identified in this NPRM): (1) eligible non-recurring costs; (2) eligible administrative expenses; (3) eligible network design costs; (4) eligible maintenance costs; (5) eligible NLR or Internet2 membership fees; and (6) all costs that are necessary for completion of the project, but that are not eligible for support under the health infrastructure program. If a budget

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[59] *See infra* paras. 55 - 58 (Ownership, IRU, and Capital Lease Requirements). Entities could show they meet this requirement by providing an opinion or other documentation prepared by legal counsel.

[60] *See* Appendix A, 47 C.F.R. § 54.653.

[61] *See infra* discussion of prioritization rules beginning at para. 128.

[62] *See* Appendix A, 47 C.F.R. § 54.653(b)(1). In comparison, Pilot Program participants are required to submit budgets on line-item network costs worksheets that accompany FCC Forms 465 and 466-A. *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20399, para. 76.

line item contains both eligible and ineligible components, costs should be allocated to the extent that a clear delineation can be made between the eligible and ineligible components.[63]

30. Requiring applicants to prepare and submit a budget would ensure that the applicant has given adequate consideration to the project requirements, has undertaken a preliminary analysis of potential costs, and has identified the amount of funds that they will be required to contribute to the overall project. We seek comment on whether the Commission should require applicants to include any additional information in their preliminary budget.

31. We propose that USAC review all project budgets for compliance with program rules.[64] USAC could assist prospective applicants with tools that provide benchmark cost estimates for certain items common to all infrastructure projects. We propose allowing budgets submitted by program applicants and program participants to be made available publicly so that other prospective applicants may use such information as a basis for preparing their own budgets.[65] We seek comment on the above proposals.

4. Eligible Costs

32. *Non-Recurring Costs.* We propose that the health infrastructure program may provide support for the following non-recurring costs for the deployment of infrastructure: (1) initial network design studies (but not in excess of the cap identified below); (2) engineering, materials and construction of fiber facilities or other broadband infrastructure; and (3) the costs of engineering, furnishing (i.e., as delivered from the manufacturers), and installing network equipment.[66] We seek comment on these proposals and whether the health infrastructure program should offer support for other non-recurring infrastructure costs. [67]

33. *Network Design.* While network design would be eligible for funding, the primary focus of the health infrastructure program should be capital costs for infrastructure construction and deployment. Therefore, we propose that support for eligible network design costs be limited to $1 million per project or 15 percent of the project's eligible costs, whichever is less.[68] We seek comment on this proposal.

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[63] *See* Appendix A, 47 C.F.R. § 54.653(b)(2); *cf.* 47 C.F.R. § 54.504(g) (describing mixed eligibility services in the E-Rate program context); *see also 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20399, para. 76.

[64] *See* Appendix A, 47 C.F.R. § 54.653(b).

[65] The Commission and USAC may post this information on their respective websites for prospective applicants to review.

[66] *See* Appendix A, 47 C.F.R. § 54.654.

[67] Health infrastructure program participants would be able to seek funding under the health broadband services program or the telecommunications program to subsidize their recurring costs, to the extent these participants comply with the Commission's rules and section 254 of the Act.

[68] *See* Appendix A, 47 C.F.R. § 54.654(b). Funding commitments for the network design elements of projects in the Pilot Program are less than the caps we propose herein. For example, Alaska Native Tribal Health Consortium, has a total eligible project award of $10.4 million, and received a funding commitment for network design in the amount of $209,000 (2% of total award); Louisiana Department of Hospitals -- total eligible project award of $16 million, network design funding commitment letter for $400,000 (1.56% of total award); New England Telehealth Consortium -- total eligible project award of $25 million, network design funding commitment letter for $746,000 (2.37% of Award).

34. *Administrative Expenses*. We propose that, for the health infrastructure program only, reasonable administrative expenses incurred by participants for completing the application process may be eligible for some limited support.[69] Examples of administrative expenses are costs incurred in preparing request for proposals, negotiating with vendors, reviewing bids, etc.[70] Our experience with the Pilot Program supports the need to provide some amount of funding for administrative expenses in infrastructure projects, to support the process of designing the network and securing necessary agreements. Participants have indicated that the costs associated with infrastructure deployment can be a considerable financial burden on participants that are designing and deploying networks over vast geographic areas.[71] Allowing a portion of funding to be used for administrative expenses could enable program participants to explore more efficient, effective means of deploying broadband for the delivery of health care.[72] Accordingly, we propose that after a participant is selected for funding based on its initial application, it may request funding for up to 85 percent of the reasonable administrative expenses incurred in connection with the project.

35. Because the primary focus of the program should be to fund infrastructure and not project administration, we propose three limitations on administrative expenses. First, support for such expenses will be limited to 36 months, commencing with the month in which a participant has been notified that its project is eligible for funding. This period should be sufficient for completing the majority of program requirements, and support should not be provided beyond this period. Second, we propose that the rate of support will not exceed $100,000 per year. This amount should be sufficient for one full-time employee (or the equivalent) dedicated to project administration. Participants would be required to submit certifications and maintain records confirming the number of hours provided by one or more employees for tasks related to the health infrastructure program project, and that the administrative expense for which support is sought is not more than the reasonable costs for the amount of time such employee(s) spent on the project. Third, we propose that the aggregate amount of support a project may receive for administrative expenses shall not exceed ten percent of the total budget for the project. We act conservatively in proposing a ten percent cap, which is similar to funding limits on administrative expenses used in some Federal grant programs.[73] We seek comment on this proposal to provide limited support for administrative expenses.

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[69] *See id.* § 54.654(c).

[70] Commenters responding to the *NBP Public Notice #17*, for example, suggest that the Commission make a limited amount of funding available for administrative costs, such as staff salaries, costs incurred while making outreach to potential network members, the drafting of RFPs and supporting documentation, and expenses related to the vendor selection process. *See, e.g.*, ATA NBP Public Notice #17 Comments at 18; California Telehealth NBP Public Notice #17 Comments at 1-2; Western New York Area Health NBP Public Notice #17 Comments at 3.

[71] *See* Dale C. Alverson, M.D., Medical Director for Telehealth and Cybermedicine Research, University of New Mexico Center for Telehealth and Cybermedicine Research, Federal Communications Commission Rural Health Care Pilot Program: Lessons Learned and Opportunities for Improvement 27-28 (Sept. 15, 2009) (transcript available at http://www.broadband.gov/docs/ws_23_healthcare.pdf).

[72] *See infra* paras. 116 - 119 (eligibility of administrative offices).

[73] *See* Appendix A, 47 C.F.R. § 54.654(c). See, for example, each of the following federal grant programs that allow administrative expenses as an eligible grant cost, but not in excess of 10% of total grant amount: Ryan White HIV/Aids program administered by HRSA, (http://hab.hrsa.gov/tools/parta/parta/ptAsec2chap2.htm) (last visited June 24, 2010); Emergency Shelter Grants, administered by HUD (http://www.hud.gov/offices/cpd/homeless/programs/esg/) (last visited June 24, 2010); Household Water Well System Grant, administered by RUS (http://www.rurdev.usda.gov/rd/nofas/2006/031506hwwgp.html) (last visited June 24, 2010); and National Emergency Grants administered by US Department of Labor (http://www.doleta.gov/neg/admin_req.cfm) (last visited June 24, 2010).

36. *Maintenance Costs.* We propose allowing limited support for up to 85 percent of the reasonable, necessary and customary ongoing maintenance costs for networks funded by the health infrastructure program.[74] Such costs would include, for example, service agreements to operate and maintain dedicated broadband facilities. The primary focus of the health infrastructure program is to create a sustainable broadband infrastructure where access is presently inadequate. We seek comment on whether support for maintenance costs should be limited to a defined period of time, such as three years from completion of build-out of a project, or five years from the first funding commitment letter issued for such project (whichever period is shorter).[75] Participants should be able to demonstrate in their sustainability plans that the costs of network operations and maintenance will be sustainable after such period of support from the health infrastructure program. Service agreements for network maintenance will be subject to competitive bidding rules, and may be bid either at the time of construction of the network or at a later time. We seek comment on this proposal.

37. *National LambdaRail and Internet2.* We propose that participants may receive support for not more than 85 percent of the membership fees for connecting their networks to the dedicated nationwide backbones, Internet2 or NLR.[76] As in the Pilot Program, while we allow such connections as an eligible expense, we do not indicate that such connections are mandatory or preferred.[77] Thus, under the health infrastructure program, applicants would be free to propose the construction of state or regional dedicated networks that do not connect to a nationwide backbone. It is reasonable to allow, as an eligible expense, membership fees to connect to NLR and Internet2. As noted in the Pilot Program, both of these backbone providers are non-profit entities that already link a number of institutions such as government research institutions and academic, public and private health care providers that house significant medical expertise.[78] By connecting to either of these two dedicated national backbones, health care providers at the state and local levels could have the opportunity to benefit from advanced applications in continuing education and research.[79] While the membership fees for joining NLR or Internet2 would be an eligible cost, we do not propose allowing other recurring costs related to connecting to such backbone networks.[80] We seek comment on this proposal.

38. For the Pilot Program, the Commission provided that connections to Internet2 or NLR were not subject to the competitive bidding rules requirement.[81] For the health infrastructure program, we

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[74] *See* Appendix A, 47 C.F.R. § 54.654(d).

[75] For example, an applicant that receives its first funding commitment on July 1, 2012, and completes build-out of the project on July 1, 2013, would have until June 30, 2016 to seek funding for eligible maintenance costs. A project that receives its first funding commitment on July 1, 2012, and completes build-out of the project on January 30, 2017, would have until June 30, 2017 to seek funding for eligible maintenance costs.

[76] *See* Appendix A, 47 C.F.R. § 54.654(e).

[77] *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order on Reconsideration, 22 FCC Rcd 2555, 2556, para. 2 (2007) (*Pilot Program Reconsideration Order)*.

[78] *See id.*, 22 FCC Rcd at 2556-57, para. 5.

[79] *See 2006 Pilot Program Order*, 21 FCC Rcd at 11111, para. 2.

[80] An example of costs that we propose would not be supported by the health infrastructure program are additional fees that Internet2 members may pay to subscribe to Internet2's "Commons" videoconferencing service. This service "allows subscribing members to schedule and hold distributed working groups, classes, meetings, and conferences in support of research and education." Internet2, The Internet2 Commons, http://commons.internet2.edu/ (last visited June 24, 2010). Support for the recurring costs of obtaining dedicated broadband access services, however, would be available under the proposed health broadband services program.

[81] *See Pilot Program Reconsideration Order*, 22 FCC Rcd at 2557, para. 6.

propose that participants may either pre-select to connect with either Internet2 or NLR, and seek funding for such connection, or may (at their discretion) seek competitive bids from NLR and Internet2 through the normal competitive bidding process.[82] Allowing a participant to pre-select NLR on Internet2 should provide the participant with an opportunity to more fully develop the specific elements of its infrastructure proposal, particularly where only a specific non-profit nationwide backbone provider will fulfill the participant's network plan or meet its need to access a particular institution that is currently connected to only one nationwide network.[83] If Internet2 or NLR are pre-selected by a participant, the costs of connection to such nationwide backbone must be reasonable. We invite comment on our proposal to exempt connections to Internet2 and NLR from the competitive bidding rules in the new health infrastructure program. Regardless of whether they choose to pre-select NLR or Internet2, participants in the health infrastructure program will be subject to the Commission's audit authority. We emphasize that we retain the discretion to evaluate the activities of participants and determine on a case-by-case basis whether waste, fraud, or abuse has occurred and whether corrective action is necessary.

5. Ineligible Costs

39. *Examples of Ineligible Costs.* We propose that, for the health infrastructure program, as in the Pilot Program, ineligible costs are those costs that are not directly associated with network design, construction, or deployment of a dedicated network for eligible health care providers.[84] We seek comment on this proposal. Participants would be required to certify that support from the health infrastructure program will not be used to pay for ineligible costs. We propose that, as in the Pilot Program and consistent with the Act, the authorized purposes of the health infrastructure program would include the costs of *access* to advanced telecommunications services.[85] Ineligible costs would include (but not be limited to) the following costs, because the following costs are not directly related to access or to network design, construction or deployment:[86]

- Personnel costs (including salaries and fringe benefits), except for those costs that qualify as administrative expenses, subject to the limitations set forth in paragraphs 37 and 38 of this NPRM.
- Travel costs, except for travel costs that are reasonable and necessary for network design or deployment and that are specifically identified and justified as part of a competitive bid for a construction project.
- Legal costs.
- Training, except for basic training or instruction directly related to and required for broadband network installation and associated network operations. For example, costs

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[82] *See* Appendix A, 47 C.F.R. § 54.654(e)(2). Some commenters propose allowing participants to use backbones other than Internet2 and NLR. *See, e.g.*, AT&T NBP Public Notice #17 Comments at 1; Oregon Health Network NBP Public Notice #17 Comments at 7.

[83] *See Pilot Program Reconsideration Order*, 22 FCC Rcd at 2557-58, para. 7.

[84] *See* Appendix A, 47 C.F.R. § 54.655; *see 2007 Pilot Program Selection Order*, 22 FCC Rcd. at 20398, para. 75.

[85] *See* 47 U.S.C. § 254(h)(2)(A) (directing the Commission "to enhance, to the extent technically feasible and economically reasonable, *access to* advanced telecommunications and information services for all public and non-profit . . . health care providers . . . .") (emphasis added); *see also 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20397, para. 74 n.239.

[86] *See* Appendix A, 47 C.F.R. § 54.655(b).

for end-user training, e.g., training of health care provider personnel in the use of telemedicine applications, are ineligible.

- Program administration or technical coordination, except for those costs that qualify as administrative expenses, subject to the limitations set forth in paragraphs 37 and 38 of this NPRM.
- Inside wiring or networking equipment (e.g., video/Web conferencing equipment and wireless user devices) on health care provider premises except for equipment that terminates a carrier's or other provider's transmission facility and any router/switch that is directly connected to either the facility or the terminating equipment.
- Computers, including servers, and related hardware (e.g., printers, scanners, laptops), unless used exclusively for network management.
- Helpdesk equipment and related software, or services.
- Software, unless used for network management, maintenance, or other network operations; software development (excluding development of software that supports network management, maintenance, and other network operations); Web server hosting; and Website portal development.
- Telemedicine applications and software.
- Clinical or medical equipment.
- Electronic records management and expenses.
- Connections to ineligible network participants or sites (e.g., for-profit health care providers).
- Costs related to any share of a project that is not allocable to the dedicated healthcare network.
- Administration and marketing costs (e.g., administrative costs; supplies and materials; marketing studies, marketing activities, or outreach efforts; evaluation and feedback studies), except for those costs that qualify as eligible administrative expenses, subject to the limitations set forth in paragraphs 37 and 38 of this NPRM.
- Continuous power source.

40. *Billing and Operational Expenses.* We propose that the health infrastructure program not provide support for billing and operational expenses incurred either by a health care provider or its selected vendor.[87] An example of billing or operational costs is the expense that service providers may charge for allocating costs to each health care provider in a project's network. Because we do not require that costs be allocated in this manner, such billing and operational costs should not be eligible for support. We seek comment on this proposal.

[87] *See id.* § 54.655(c).

C. Provisions Applicable After Initial Application

1. Fifteen Percent Contribution Requirement

41. *Minimum Participant Contribution.* We propose that as one of the conditions to receiving any funding commitments from USAC, participants submit certification of the availability of funds, from eligible sources, for at least 15 percent of all eligible costs.[88] We seek comment on this proposal. The Pilot Program similarly required a 15 percent minimum contribution requirement for all eligible costs. As recognized by the National Broadband Plan, the participant contribution requirement aligns incentives and helps ensure that the health care provider values the broadband services being deployed, and makes financially prudent decisions regarding the project.[89] Ensuring that each participant has a financial stake in the project is an important part of the implementation of infrastructure projects, as well as critical to maintaining overall accountability for prudent use of finite universal service funds. We therefore propose that the health infrastructure program would pay not more than 85 percent of eligible project costs, and participants would be required to pay the remaining 15 percent of such eligible projects costs. In addition, participants would be required to pay all costs that are related to the project but that do not qualify as eligible project costs.

42. We note that the matching funds requirement for the Broadband Technology Opportunities Program (BTOP), established pursuant to the Recovery Act, is generally 20 percent of eligible costs, and that the Broadband Initiatives Program (BIP), also established pursuant to the Recovery Act, will fund 75 percent in grants and 25 percent in loans.[90] We have learned from our experience with the Pilot Program that some applicants have difficulty even meeting a 15 percent contribution requirement.[91] At the same time, one of the benefits of increasing the contribution requirement to 20 percent or higher would be that more funds would be available under the program to fund additional projects. We invite comment on whether the Commission should consider a higher level of participant contribution for health infrastructure projects. Commenters should identify whether, in light of higher levels of participant contributions in the BTOP and BIP programs, the contribution requirement for the health infrastructure program should be more than 15 percent to ensure better efficiencies and greater level of "at risk" commitment by participants to their projects.

43. *Evidence of Viable Source for 15 Percent Contribution.* We propose that, within 90 days after being notified of project selection, participants demonstrate that they have a reasonable and viable source for the minimum 15 percent contribution.[92] Many projects in the Pilot Program indicated

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[88] *See id.* 47 C.F.R. § 54.656.

[89] National Broadband Plan at 215 (NBP Recommendation 10.7).

[90] *See Broadband Initiatives Program/Broadband Technology Opportunities Program, Notice of Funds Availability and Solicitation of Applications*, 75 Fed. Reg. 3792, 3799, 3822 (Jan. 22, 2010). The Broadband Technology Opportunities Program (BTOP), established pursuant to the Recovery Act, provides grants for deploying broadband infrastructure in unserved and underserved areas of the United States. *See* Broadband USA, BTOP, http://www2.ntia.doc.gov/about (last visited June 24, 2010). The Broadband Initiatives Program (BIP), also established pursuant to the Recovery Act, provides loans, grants, and loan/grant combinations to facilitate broadband deployment in rural areas. *See* Broadband USA, BIP, http://www.broadbandusa.gov/BIPportal/index.htm (last visited June 24, 2010).

[91] For example, commenters responding to the *NBP Public Notice #17* noted that it is difficult for rural health care providers to secure funds to invest in broadband infrastructure, given the competing demands for limited resources in rural areas. *See, e.g.*, Northwest Healthcare NBP Public Notice #17 Comments at 2; St. John's Hospital NBP Public Notice #17 Comments at 2; Glacier Community, NBP Public Notice #17 Comments at 2.

[92] *See* Appendix A, 47 C.F.R. § 54.656(b).

deployment delays due to many factors, including difficulty in obtaining the minimum 15 percent contribution.[93] This, among other factors, resulted in the Bureau extending (by one year) the deadline for participants in the Pilot Program to select vendors and request funding commitments from USAC.[94] To ensure that projects are completed in a timely manner, it is important for participants in the health infrastructure program to meet a date certain by which they have secured the minimum 15 percent contribution for eligible project costs. Doing so will ensure that program funds are not indefinitely allocated to projects that cannot proceed to completion due to lack of adequate financial contribution from the participant. We therefore propose that after a participant has been notified that, based on its initial application, its project is eligible for funding, the participant have a period of 90 days to submit letters of assurances confirming funds from eligible sources to meet the 15 percent minimum contribution requirement. We seek comment on this proposal.

44. *Eligible Sources.* We propose placing limitations on the eligible sources for matching funds. Selected participants would be required to identify with specificity their source(s) of funding for the minimum 15 percent contribution of eligible network costs.[95] Only funds from an eligible source may apply towards meeting this requirement. As in the Pilot Program, eligible sources would be limited to (1) eligible health care providers; (2) state grants, funding, or appropriations; (3) federal funding, grants, loans, or appropriations (but not other universal service funding); and (4) other grant funding, including private grants. Participants who do not demonstrate that their 15 percent contribution comes from an eligible source or whose minimum 15 percent contribution is derived from an ineligible source would be denied funding by USAC. Ineligible sources would include (1) in-kind or implied contributions; (2) a local exchange carrier (LEC) or other telecom carrier, utility, contractor, consultant, or other service provider; and (3) for-profit participants.[96] Moreover, selected participants may not obtain any portion of their 15 percent contribution from any universal service support program. These limitations on eligible sources would safeguard against program manipulation, and would prevent conflicts of interest or influence from vendors and for-profit entities that may lead to waste, fraud, and abuse. We therefore propose that these limitations, which were applied to the Pilot Program, be applied to the health infrastructure program. We seek comment on the proposed list of eligible sources.

2. Project Milestones

45. To ensure that projects proceed to completion, we propose that participants submit a project schedule that identifies the following project milestones: start and end date for network design; start and end date for drafting and posting RFPs; start and end date for selecting vendors and negotiating contracts; start date for commencing construction and end date for completing construction; and target dates for each health care provider to be connected to the network and operational.[97] The project schedule should be submitted within 90 days after a participant has been notified that, based on its initial application, the project is eligible for funding.[98] The project schedule would also have to be updated at the time that quarterly reports are filed by the participants, noting which project milestones have been met and any progress or unanticipated delays in meeting other milestones.[99] We propose that in the event a project

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[93] *2010 Pilot Program Extension Order*, 25 FCC Rcd at 1423.

[94] *Id*.

[95] *See* Appendix A, 47 C.F.R. § 54.656(c)-(d).

[96] *See id.*§ 54.656(d).

[97] *See id.* § 54.657.

[98] *See id.* § 54.657(a).

[99] *See* Appendix A, 47 C.F.R. § 54.657(b).

milestone is not achieved, or there is a material deviation from the project schedule, the participant would provide an explanation in the quarterly reports. Requiring participants to establish a schedule and report on project milestones for infrastructure projects would assist USAC and the Commission in assessing a participant's progress in completing project build-out, and would reduce fraud, waste and abuse.[100] We seek comment on these proposals. We also seek comment on whether the Commission should require participants to include other information in addition to or in lieu of project milestones. Such information should serve as a way to monitor project progress.[101]

3. Detailed Project Description

46. We propose that, within 90 days after a participant is notified that its project is eligible for funding based on its initial application, the participant complete and submit a detailed project description that describes the network, identifies the proposed technology, demonstrates that the project is technically feasible and reasonably scalable, and describes each specific development phase of the project (e.g., network design phase, construction period, deployment and maintenance period).[102] We seek comment on these proposals, as described below.

47. *Technology Neutral*. While a project description must establish feasibility and scalability, we do not propose restricting the type of technology participants may use. Eligible health care providers participating in the health infrastructure program may choose any currently available technology that meets the definition of broadband as adopted for purposes of the Rural Health Care program. We seek comment on this proposal. Allowing health care providers flexibility in designing their networks furthers the "competitive neutrality" provision of section 254(h)(2) of the Act by ensuring that universal service support does not favor or disfavor one technology over another.[103] We note that the various projects in the Pilot Program employed different solutions with varying levels of broadband capacity to meet the specific needs of the health care providers participating in each network.[104]

48. *Network Coverage*. We propose that the project description should include the identity and location of all network participants, and should include a network diagram.[105] Participants would be required to indicate how they plan to fully utilize their proposed network to provide health care services, and would be required to present a strategy for aggregating the specific needs of health care providers

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[100] The Pilot Program requires participants to submit a project management plan. *2006 Pilot Program Order*, 21 FCC Rcd at 11117. The project management plan lists certain project milestones and provides tentative dates for the completion of these milestones. *Id.*. Pilot Program participants were required to provide a project management plan and schedule in their first quarterly data report. *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20433, Appendix D. In subsequent quarterly data reports, participants are required to identify those project deliverables that were achieved and those that were not achieved. *Id.*

[101] *See supra* para. 18, regarding project build-out period for participants in the health infrastructure program.

[102] *See* Appendix A, 47 C.F.R. § 54.658.

[103] 47 U.S.C. § 254(h)(2).

[104] For example, the quarterly reports filed by the Rural Wisconsin Health Cooperative Information Technology Network indicate that its network includes three hospitals that connect to a data center via 20 Mb Ethernet, DS3 or combination point-to-point connections. Rural Wisconsin Health Cooperative Information Technology Network, FCC Pilot Program Quarterly Data Report, WC Docket No. 02-60 (filed Feb. 1, 2010). In contrast, the Michigan Public Health Institute received rural health care support for the expansion of an existing tower-based wireless network and the purchase of telecommunications equipment for and upgraded network. Michigan Public Health Institute, FCC Pilot Program Quarterly Data Report, WC Docket No. 02-60 (filed April 23, 2010).

[105] *See* Appendix A, 47 C.F.R. § 54.658(b).

within a state or region, including providers that serve rural areas. The project description should also discuss whether the proposed network will connect to a national backbone, such as NLR or Internet2. Networks may be limited to a particular state or region, but participants should describe feasible ways in which such networks will connect to a national broadband network. Designing networks so that they may, where feasible, connect to a dedicated national network will allow health care providers the opportunity to benefit from advanced applications in continuing education and research and will also enhance the health care community's ability to provide a rapid and coordinated response in the event of a national crisis. We seek comment on these proposals.

49. *Service Speeds and Scalability.* We propose that the project description include a discussion of the speeds and services necessary for the particular network, and how the minimum broadband speed, proposed above, will be provided.[106] Networks should be adequately designed for the exchange of identifiable health information, and capable of meeting transmission speed requirements necessary for health care applications to be used by the health care providers. To demonstrate their broadband needs, participants would be required to explain and provide reasonable support for the type of health care providers that will use the network, the bandwidth and speed requirements for such network, and the health care services that necessitate broadband connections at the desired speeds. Participants would also be required to explain how the proposed network will be designed to meet the current broadband needs of the network members, and would be required to address whether or how the proposed network will be scalable to handle projected future demand.[107] We seek comment on these proposals.

50. *Health IT Purposes.* We propose requiring that, as part of the project description, participants specify how the dedicated broadband network will be used by eligible health care providers for health IT to improve or provide health care delivery.[108] As defined in the National Broadband Plan, "health IT" refers to information-driven health practices and the technologies that enable them.[109] Health IT includes billing and scheduling systems, e-care, electronic health records (EHRs) and telehealth and telemedicine.[110] In adopting the Pilot Program, the Commission recognized the benefits of telehealth and telemedicine.[111] We seek comment on this proposal. Consistent with the National Broadband Plan's recommendation to adopt outcome-based performance goals for the Rural Health Care program, we seek comment below on how best to monitor how participants are utilizing dedicated broadband networks to support these health IT purposes.

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[106] *See* Appendix A, 47 C.F.R. § 54.658(c); *supra* para. 20 (minimum broadband speed requirements for infrastructure projects).

[107] As referenced here, scalability refers to the ability of a system to accommodate a significant growth in the size of the system (i.e., services provided, end users served) without the need for substantial redesign.

[108] *See* Appendix A, 47 C.F.R. §§ 54.602(e), 54.658(d).

[109] National Broadband Plan at 200.

[110] "E-care" refers to the electronic exchange of information – data, images and video—to aid in the practice of medicine and advance analytics. *Id.*

[111] *See 2006 Pilot Program Order*, 21 FCC Rcd at 11111, para. 1 (noting that the pilot program would fund networks designed to bring the benefits of innovative telehealth and telemedicine services to those areas of the country where the need for such benefit is most acute). Telemedicine is the provision of medical care from a distance using telecommunications technology. *Id.* Telemedicine includes a broad set of applications using communications technologies to support long-distance clinical care, consumer and professional health-related education, public health, health administration, research and electronic health records. *Id.*

51. *Emergency Response Connectivity*. We seek comment on whether every project should be required to include ways in which the proposed network will be used in emergency response and meet disaster preparedness requirements.[112] We also seek comment on whether every project should be required to include ways in which the proposed network will provide effective and secure connectivity, and peering with other networks in order to address global public health and border issues.[113]

4. Facilities Ownership, IRU or Capital Lease Requirements

52. We propose requiring health care providers to have an ownership interest, indefeasible right of use (IRU), or capital lease interest in facilities funded by the program.[114] The Pilot Program did not restrict the form of agreement that health care providers could enter into with vendors for projects funded by that program. In some instances, Pilot Program projects opted to enter into short-term or operating leases, which placed them at greater risk and more dependent on the vendor than if they had obtained an ownership or long-term interest. For example, if a vendor becomes insolvent, a project that does not have an IRU or ownership interest could be left with a non-operational network with limited recourse.[115] Moreover, in the case of a participant that enters into a short-term or operating lease for network access, once the term of the lease expires, the participant could potentially lose access to the network. In some instances, lease arrangements may result in proposals in which vendors incur infrastructure costs and pass these costs to the health care providers as either a one-time construction charge or an amortized cost over the term of the lease. Funding from the health infrastructure program should confer optimal long-term interests in a funded network with the least amount of risk. We therefore propose that health care providers seeking funding for infrastructure projects should either: (1) own the infrastructure facilities funded by the program, (2) have an IRU for such facilities, or (3) have a capital lease.[116] We seek comment on the proposals described below.

53. *Ownership or IRU*. We propose permitting facilities subject to an IRU to be funded under the health infrastructure program.[117] An IRU is an indefeasible right to use facilities for a certain period of time that is commensurate with the remaining useful life of the asset, generally 20 years. An IRU confers on the grantee the vestiges of ownership, and is customarily used in the telecommunications

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[112] *See* Internet2 June 25, 2010 *Ex Parte* Letter, at 3 ("In disaster situations, it is often the local institution that is on the front line of the response.").

[113] *See id.* at 4 ("Effective and secure International connectivity and peering with other international networks are needed as the country addresses global public health and border health issues. Examples include increasing international public health concerns, such as tuberculosis, HIV/AIDS, pandemic influenza, chem-bio terrorism, that require improved surveillance, situational awareness, consequence management, sharing data and information that would include rural sites, larger centers and national or international agencies.").

[114] *See* Appendix A, 47 C.F.R. § 54.659.

[115] *See* Michael J. Lichtenstein & Charles A. Rohe, *The Treatment of IRUs in Bankruptcy Proceedings*, 11 J. Bankr. L. & Prac. 83 (2001); Charles A. Rohe & Richard H. Agins, *Indefeasible Rights of Use in a Revived Telecommunications Industry: Revisiting the Treatment of IRUs in Bankruptcy Proceedings*, *in* Norton Annual Survey of Bankruptcy Law 333 (2008 ed.).

[116] Numerous providers of broadband service use individual dark fiber strands to provision their services. Individual strands of dark fiber are not sold via a bill of sale. Instead, it is standard practice in the telecommunications industry for a provider of broadband service to receive a long-term IRU for strands of dark fiber to correspond to the useful life of the strands. Such IRUs are often, but not always, for 20 year period. IRUs purchasers pay for the full cost of the IRU in advance, and treat the purchase of the IRU as a capital event, and the IRU as a capital asset under Generally Accepted Accounting Principles.

[117] *See* Appendix A, 47 C.F.R. § 54.659(b).

industry. It normally involves a substantial sum paid up front, generally priced as a certain amount (depending on market rates) per mile or per fiber mile. We propose that any contract that involves paying for the full cost of new construction with eligible funds should not be treated as an IRU, but simply as a construction project with assurances that the participant owns all constructed facilities. We also propose that an IRU should include maintenance of the fiber/network for the term (vendor should be responsible for maintenance and repairs); costs of maintenance and operation of associated electronics can be (and usually are) addressed in a separate service agreement. An IRU should be independent of any contract for services or electronics. Unlike a lease, an ownership interest or IRU ensures that the vestiges of network ownership will remain with the eligible health care provider members for the period of time delineated by the IRU, and that the network assets supported by universal service funds will not revert to the vendor. While IRUs are often for 20 years, we do not propose setting a fixed number of years for an IRU. Rather, the period of the IRU should be commensurate with the remaining economic life of the facility funded by the program.[118] We seek comment on this proposal.

54. *Capital Lease.* We also propose permitting capital leases to be funded under the health infrastructure program, but propose to prohibit short-term or operating leases.[119] A capital lease is a lease of a business asset which represents ownership and is reflected on the lessee's balance sheet as an asset.[120] This is in contrast to an operating lease, in which the lessee which has no ownership interest.[121] Under Generally Accepted Accounting Principles (GAAP), a lease is a capital lease if it meets one or more of the following criteria: the lease term is greater than 75 percent of the property's estimated economic life; the lease contains an option to purchase the property for less than fair market value; ownership of the property is transferred to the lessee at the end of the lease term; or the present value of the lease payments exceeds 90 percent of the fair market value of the property.[122] We propose that participants in the health infrastructure program be permitted to seek support for the cost of leasing facilities required to provide broadband service if such lease qualifies as a capital lease under GAAP. If there is doubt regarding the classification of a particular lease under GAAP, the participant may be required to provide an explanation justifying the classification of its leasing arrangement as a capital lease. We invite comment on this proposal.

55. *No Short-Term Leases*. We propose that short-term or operating leases are not eligible for funding under the health infrastructure program. Because the primary focus of the health infrastructure program is the construction and sustainability of broadband infrastructure facilities, we do not believe that short-term or operating leases are appropriate. In a short-term lease, ownership of the funded asset would revert back to the vendor at the conclusion of the term of the lease, conferring a benefit on the vendor and not the health care provider. This is inconsistent with the goal of funding infrastructure programs for the creation of sustainable, long-term dedicated broadband networks used for health care purposes. We

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[118] We note that most new dark fiber IRUs have a duration of at least 20 years (less for other types of facilities). The critical factor is that an IRU extend throughout the estimated economic life of the asset at the time of the IRU purchase.

[119] *See* Appendix A, 47 C.F.R. § 54.659(c).

[120] *See* John Huber et al., *A Leap of Faith: Jumping Into Disclosure of Accounting Issues and Thriving*, 1773 PLI Corp. L. & Practice Handbook 861, 922 (2009).

[121] *Id.*

[122] *See* Broadband USA, "BTOP/BIP Frequently Asked Questions," at 16, *available at* http://www.broadbandusa.gov/files/BIP_BTOP_FAQ_I-III.pdf (citing Accounting Standards Codification of the Financial Accounting Standards Board (FASB Codification), section 840-20, "Capital Lease") (last visited June 24, 2010).

therefore propose that short-term or operating leases are not an acceptable vehicle for deploying facilities under the health infrastructure program.[123] We invite comment on this proposal.

Historically bandwidth prices have been declining. Leases cost less every year. In this environment long term contracts are not desired.

Depreciation of Network Components. Because of the restrictions against the sale, resale, or other transfer of universal service funds contained in section 254(h)(3) of the Act, health care providers would not normally be able to dispose of equipment or other improvements funded by the health infrastructure program.[124] We seek comment on whether we should adopt rules that allow for the disposition of assets after the full economic useful life of funded projects (as determined, for example, under GAAP or as determined for tax depreciation reporting purposes). We note, however, that the full economic useful life of infrastructure projects in most instances should be ten to twenty years.[125] We also seek comment on whether the Commission should adopt rules that allow for the transfer of ownership of funded projects to subsidiaries or affiliates of the original applicants, provided that eligible health care providers continue to have a controlling beneficial ownership interest in the project.

5. Standard Terms and Conditions

56. We propose adopting requirements that construction contracts, IRUs or eligible capital leases entered into by health care providers for infrastructure projects contain certain mandatory provisions.[126] This would ensure consistency among projects, and will help health care providers to negotiate contracts that meet at least a basic level of assurance. We emphasize that such standard terms and conditions would not be a substitute for further negotiated terms that health care providers may deem necessary in their business judgment. We expect health care providers to exercise due diligence in negotiating such contracts with vendors. We seek comments on these proposed terms and conditions, and inquire whether additional or different provisions should be required.

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[123] We note that the Rural Utilities Services' Broadband Initiatives Program has similar restrictions prohibiting operating leases. *See Dep't of Agri., Rural Utils. Serv., Broadband Initiatives Program, Notice of Funds Availability and Solicitation of Applications*, 75 Fed. Reg. 3820, 3828 (Jan. 22, 2010) (noting that program funding is not available for operating leases).

[124] *See* 47 U.S.C. § 254(h)(3); 47 C.F.R. § 54.617(a); *see also 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20416, para. 107 (the Commission has determined that, under this resale restriction, a selected participant cannot sell network capacity that was supported by Pilot Program funding, but could share network capacity with an ineligible entity as long as the ineligible entity does not receive discounts provided to eligible health care providers and pays its fair share of network costs attributable to the portion of the network capacity used). The Commission also recently stated in the *May 2010 E-Rate NPRM* that it did not believe that these restrictions remain applicable when the applicant is no longer utilizing equipment purchased with E-rate funds, because the equipment is past its useful life. *Schools and Libraries Universal Support Mechanism; A National Broadband Plan for our Future*, CC Docket No. 02-6, GN Docket No. 09-51, Notice of Proposed Rulemaking, FCC 10-83, para. 90 (2010) (*May 2010 E-Rate NPRM*).

[125] *See infra*, para. 56 (determining useful economic life of infrastructure assets).

[126] *See* Appendix A, 47 C.F.R. § 54.660.

57. *Construction Contracts*. We propose that the following provisions should be included in all construction contracts:[127]

- *Work Standards*. All work shall conform to identified standards and specifications. The vendor shall not use any defective material in the performance of the work.
- *Withholding of Payments*. The health care provider may withhold money due for any portion of the work which has been rejected by the health care provider and which has not been corrected by the vendor to the reasonable satisfaction of the health care provider.
- *Defects in Work*. For a period of not less than one year after project completion, the vendor shall correct at its expense all defects and deficiencies in the work which result from (1) labor or materials furnished by the vendor, (2) workmanship, or (3) failure to follow the plans, drawings, standards, or other specifications made a part of the contract.

58. *IRU*. We propose that the following provisions should be included in all IRUs:[128]

- *Term of the Agreement*. The health care provider is granted an exclusive and irrevocable right to use the facility funded by the health infrastructure program, for the remainder of facility's useful life.
- *Beneficial Ownership Interest*. The health care provider receives beneficial title and interest or equitable title in the facilities funded by the health infrastructure program. Such title should include the right to use the facilities, the right to have access for repairs, and the right to let others use such facilities.

59. *Capital Leases*. We propose requiring that the payment structure in a capital lease should be reflective of the term of the lease. Lease payments in advance of the lease term would not be allowed. For example, in a ten year lease, we would not allow an upfront payment of the entire ten year lease period. Such prepayments present a significant risk that the vendor could default or go into bankruptcy after the pre-payment has been made, resulting in the loss of funds.[129]

60. *Provisions Applicable to all Contracts.* Whether a construction contract, an IRU, or a capital lease, we propose that all contracts should have provisions that address the following:[130]

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[127] *See id.* § 54.660(b); *cf.* 15 C.F.R. § 14.48; Office of Mgmt. & Budget, Executive Office of the President, "Uniform Administrative Requirements for Grants and Agreements with Institutions of Higher Education, Hospitals, and Other Non-Profit Organizations," OMB Circular A-110, at para. 48 (1999), *available at* http://www.whitehouse.gov/omb/rewrite/circulars/a110/a110.html (setting forth contract provisions among Federal agencies in the administration of grants to and agreements with hospitals and other non-profit organizations) (OMB Circular A-110); Dept. of Agric., Rural Utils. Serv., "Construction Contract Generating Notice and Instruction to Bidders" (2004), *available at* http://forms.sc.egov.usda.gov/efcommon/eFileServices/eForms/RUS200.PDF (requiring similar standard terms and conditions to be included in contracts for projects supported by Federal funds) (RUS Standard Form Construction Contract).

[128] *See* Appendix A, 47 C.F.R. § 54.660(c).

[129] *See id.* § 54.660(d).

[130] *See id.* § 54.660(e); *cf.* 15 C.F.R. § 14.48; OMB Circular A-110 at para. 48; RUS Standard Form Construction Contract.

- *Laws and Regulations*. The vendor shall comply with all federal, state and municipal laws, ordinances and regulations (including building and construction codes) applicable to the performance of the work.

- *Environmental Protection.* The vendor shall comply with all applicable federal, state and municipal environmental laws and regulations which relate to environmental protection, inspection and monitoring of property and environmental reporting and information requirements.

- *Performance Bonds*. For contracts in excess of $150,000, the vendor shall deliver a performance bond. For construction contracts, performance bonds should be for the construction term of the contract plus a period of not less than one year (i.e., the same period in which the health care provider may require the vendor to remedy defects in the work). For a lease or an IRU, performance bonds should be for the entire term of the agreement.

- *Indemnification*. The vendor agrees to indemnify and hold harmless the health care provider from any and all claims, actions, or causes of action to the extent the claimed loss or damages arises out of the vendor's negligent performance or nonperformance of its obligations under the contract.

6. Sustainability Reporting Requirement

61. Consistent with the recommendations of the National Broadband Plan, we propose requiring that, prior to receiving a funding commitment letter from USAC, participants submit a sustainability report demonstrating that the project is sustainable.[131] Although participants would be free to include additional information to demonstrate a project's sustainability, we propose that a sustainability plan would at a minimum address the following points:[132]

- Principal factors. Discuss each of the principal factors that were considered by the participant to demonstrate sustainability.

- Minimum Fifteen Percent Funding Contribution. Discuss the status of obtaining the minimum 15 percent contribution for eligible project costs. If project funding is dependent on appropriations or other special conditions, such conditions should be discussed.

- Projected sustainability period. Indicate a reasonable sustainability period, which is at least equal to the useful life of the funded facility. Although a sustainability period of 10 years is generally appropriate, the period of sustainability should be commensurate with the investments made from the health infrastructure program.

- Terms of Membership in the Network. Describe generally any agreements made (or to be entered into) by network members (e.g., participation agreements, memoranda of understanding, usage agreements, or other documents). Describe financial and time commitments made by proposed members of the network. If the project includes excess

[131] *See* Appendix A, 47 C.F.R. § 54.661; National Broadband Plan at 215 (NBP Recommendation 10.7).

[132] Similar sustainability factors were recommended for use in the Pilot Program, as set forth in the Pilot Program FAQs, available at http://www.fcc.gov/cgb/rural/rhcp.html#faq24 (last visited June 24, 2010).

bandwidth for growth of the network, describe how such excess bandwidth will be financed. If the network will include eligible health care providers and other network members, describe how fees for joining and using the network will be assessed.

- Ownership Structure. Explain who will own each material element of the network, and arrangements made to ensure continued use of such elements by the network members for the duration of the sustainability period.

- Sources of Future Support. If sustainability is dependent on fees to be paid by eligible health care providers, then the sustainability plan should confirm that the health care providers are committed and have the ability to pay such fees. If sustainability is dependent on fees to be paid by network members that will use the network for health care purposes, but are not eligible health care providers under the Commission's rules, then the sustainability plan should identify such entities. Alternatively, if sustainability is dependent on revenues from excess capacity not related to health care purposes, then the sustainability plan should identify the proposed users of such excess capacity. If rural health care provider members of the network qualify for continued support under the health broadband services program, this should be discussed in the sustainability plan.

- Management. Describe the management structure of the network for the duration of the sustainability period, and how management costs will be funded.

62. We seek comment on whether additional or different sustainability requirements should be included.

7. Shared Use

63. Given the nature of high capacity networks capable of supporting the health IT requirements of health care providers, it is customary to build excess capacity when deploying such networks.[133] We therefore need to resolve: (i) What capacity should properly be funded by universal service funds? (ii) Should eligible health care providers be allowed to share this excess capacity with non-eligible entities and, if so, (a) with which entities and (b) what percentage of the total cost should such non-eligible entities be required to pay?

64. We recognize that there may be cost-savings and other benefits from allowing community users to participate in infrastructure projects funded by the health infrastructure program. However, we seek to ensure that the health infrastructure program is not indirectly subsidizing unauthorized uses, and that funds are not wasted. Rules governing the sharing of this subsidized infrastructure are necessary to prevent waste, fraud and abuse, and to control the size of the disbursements, particularly given the annual limits on the health infrastructure program.

65. *Fully-Distributed and Incremental Costs.* Telecommunications networks generally provide multiple services over a shared plant. Telecommunications regulators in setting prices for telecommunications services have generally had to allocate the costs of the shared plant to the various services. Two traditional methods for assigning costs to services are to employ incremental cost or fully distributed costs. In economic theory, the term "incremental cost" refers to "the additional costs (usually expressed as a cost per unit of output) that a firm will incur as a result of expanding the output of a good

[133] For instance, a provider typically will deploy additional strands of fiber when building a fiber network because the cost of adding additional fiber to the conduit is minimal.

or service by producing an additional quantity of the good or service."[134] The term "common cost" refers to "cost that are incurred in connection with the production of multiple products or services, and remains unchanged as the relative proportion of those products or services varies. . ."[135] Where multiple services are produced by a shared plant, pricing those services on the basis of their incremental cost is unlikely to generate revenues sufficient to recover the total costs of production. Accordingly, regulators traditionally have allocated the common costs among the multiple services so as to recover the total costs of the plant. A common approach has been to adopt "fully distributed cost" (or fully allocated cost) pricing rules, which allocate costs on the basis of relative output levels, revenues or attributable costs.[136]

66. We seek comment on how to define fully distributed costs for purposes of the health infrastructure program. For instance, what allocators should we use for allocating common costs? Should we allocate costs on the basis of directly attributable costs? Or should we allocate costs based on relative capacity assigned to eligible versus ineligible users? Are there other allocators that would be more appropriate to employ?

67. We also seek comment on whether we should provide guidance on how incremental cost should be estimated. For example, should the cost of building laterals to other community institutions, the cost of electronics to light the fibers used by the other institutions, and any additional costs associated with purchasing a higher-capacity fiber cable all be deemed to be incremental costs? Should other costs be included in estimating incremental costs?

68. We seek comment on these proposed distinctions between fully-distributed costs and incremental costs, and solicit alternative proposals.

69. We propose that the health infrastructure program only support the infrastructure costs associated with the eligible health care providers' current and anticipated bandwidth requirements. To the extent that the deployed network has excess capacity and the eligible entities seek to share that excess capacity with ineligible entities, we propose that the ineligible entities should pay an appropriate portion of the costs of the network.[137] We seek comment on whether the share of costs borne by the ineligible entities should be based on incremental cost or fully-distributed cost. We seek comment on the likely proportion of network costs ineligible entities would be required to bear if we adopt an incremental cost approach. We seek comment on whether it would be administratively simpler or more appropriate to adopt a fully distributed cost approach. For example, if eligible health care providers plan to use 75 percent of the network capacity and 25 percent of the capacity is planned for use by the community, should the Commission require a showing that the ineligible users pay 25 percent of the total cost of the network?. In this example, should this 25 percent proportionate share of costs include costs associated with trenching, planning and design, obtaining rights of way, deployment, modulating equipment costs, and maintenance and operation costs?

70. In the event we adopt an incremental cost approach, should we make a bright line distinction so if ineligible users take more than a set percentage of the network's capacity, then they

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[134] *Implementation of the Local Competition Provisions in the Telecommunications Act of 1996; Interconnection between Local Exchange Carriers and Commercial Mobile Radio Service Providers,* CC Docket Nos. 96-98, 96-185, First Report and Order, 11 FCC Rcd 15499, 15844, para. 675 (1996).

[135] *Id.* at 15845, para. 676.

[136] *See, e.g.,* Daniel F. Spulber, Regulation and Markets 127-28 (1989); Alfred E. Kahn, The Economics of Regulation: Principles and Institutions 151 (1970).

[137] *See* Appendix A, 47 C.F.R. § 54.662(a).

would be required to pay a larger share based on fully-distributed costs (rather than merely incremental cost)?

71. We seek comment on which allocators we might adopt. For example, in fiber projects, should we allocate the cost of the common infrastructure on the basis of the relative number of fibers used by the health care providers compared with other users? Should we use some other measure of relative capacity or demand? Alternatively, should we allocate common costs on the basis of directly attributable costs? Are there other allocators that would be simpler to implement? Would use of a fully distributed cost allocation methodology reduce the likelihood of waste, fraud and abuse? What effect would such an approach have on the incentives of the eligible health care provider, the vendor and other potential users of the infrastructure to invest in a fiscally responsible manner in broadband networks?

72. *Protecting Against Fraud, Waste and Abuse.* We seek comment on what limitations on additional capacity for community use are necessary to protect the integrity of dedicated health care networks, and to help ensure that eligible health care providers receive the maximum benefit from infrastructure funded by universal service funds. We seek comment on what restrictions or measures we should adopt to prevent fraud, waste and abuse as a result of projects that involve dedicated health care networks and additional capacity for use by entities that are not eligible health care providers under our rules. For instance, if the Commission allows excess capacity to be shared by other community uses at incremental cost, should it require that:

- The eligible health care providers or consortium of eligible health care providers should own (or have an IRU or capital lease interest in) in all physical elements of the dedicated network that are part of the project, including any excess capacity.

- All revenues generated by the network from allowing non-eligible health care providers to use the network's excess capacity must be retained by the network to operate, maintain and support the network. This could include, for example, purchasing equipment or applications necessary for the network or the applications that run over it.

- The participant's sustainability plan must indicate reasonable assumptions for the use of excess capacity.

- Either all excess capacity will be used for the health care purposes identified in the participant's application for funding; or, if used by non-eligible entities, the users of such excess capacity will pay (to the network) a market or arm's length negotiated rate to use such excess capacity.

- Network members must have a written agreement or organizational document that specifies the members' respective rights and obligations, including access and maintenance, and reasonable (i.e., arm's length) allocation of recurring and non-recurring costs.

73. *Excess Capacity Disclosures.* If an infrastructure project includes excess capacity, we propose requiring applicants to disclose the estimated amount of excess capacity as part of its sustainability plan,[138] and to explain how they plan to allocate the cost of the network between the network members that are eligible health care providers and the members that are not eligible health care

[138] *See supra* para. 65 for a discussion of sustainability plan requirements.

providers.[139] In doing so, participants would be required to: (1) identify non-eligible users of such excess capacity and explain what proportion of the network non-recurring and recurring costs they will bear, and (2) describe all agreements made between the eligible health care providers and other participants in the network (e.g., cost allocation, facility sharing agreements, maintenance and access obligations, ownership rights). We seek comment on this proposal, and on how recipients should be required to document the required cost allocation (whether fully-distributed cost or/and incremental cost). Particularly, we seek comment on how to determine what constitutes "fully-distributed costs" in situations where there are various types of ownership interests (e.g., IRU or capital lease) proposed in this notice.

74. *Additional Capacity for Community Use.* In addition to the proposed rules above (regarding excess capacity for health care purposes), we seek comment on whether we should encourage, permit, or restrict the following categories of joint projects that include additional capacity for use by the community (not for health care purposes):[140]

- Additional capacity for use by schools and libraries;
- Additional capacity for use by governmental entities (state and local); and
- Additional capacity for use by other entities in the community, such as local non-profits, community or civic organizations, low-income residents, local businesses, anchor institutions and other residents.

75. *Priority Preferences for Projects that Include Additional Capacity for Community Use.* For each of the above types of additional capacity for community use listed in paragraph 78, we seek comments on whether projects funded by the health infrastructure program should include, restrict, or allow these types of joint or shared projects. We also invite comment on priority preference and other issues. For example:

- If we cap the number of projects per year, or if the number of projects per year under the health infrastructure program exceeds the proposed $100 million funding cap,[141] should we give special prioritization treatment to projects that plan to allow use of excess capacity by schools and libraries that are otherwise eligible for universal service funding?
- Should we give priority to projects that allow use of excess capacity by state or local government (including government offices, police, fire departments and Emergency Medical Services)?
- Should other community use be allowed or restricted?

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[139] *See* Appendix A, 47 C.F.R. § 54.661(d).

[140] *See, e.g.*, Oregon Health Network NBP Public Notice #17 Comments at 10 (noting that broadband connectivity can be achieved nationwide through an "anchor tenant" model that includes institutions such as schools, hospitals, and government); Internet2 June 25, 2010 *Ex Parte* Letter, at 3 ("Health care is critical to all areas of the US but it is not the only use of broadband resources. In fact, there are regions of the country where broadband is being analyzed as a community resource for economic development or other rationales. The aggregation of broadband demand, including health care, must be viewed positively and encouraged.").

[141] See *infra* paras. 128- 134 regarding prioritization rules; *supra* para. 31, seeking comment on a cap for the number of projects per year under the health infrastructure program.

76. *Other Considerations Regarding Additional Capacity for Community Use.* Should there be additional restrictions on the terms and conditions on which additional capacity may be made available for community use? For example, should we restrict, limit, or add specific requirements as to who should own the portion of a network dedicated for community use?

77. Should we require that additional capacity for community use be physically separated from the dedicated capacity reserved for the health care network? If so, we seek comment on how such separation may be effectuated. For example, should we require capacity to be separated by fiber strand, channel, wavelength, or by some other method?

78. Commenters should address how permitting joint projects that include additional capacity for community use would be consistent with the resale restrictions contained in section 254(h)(3) of the Act.[142] The use of such additional capacity by the community would not violate the restrictions against sale, resale or other transfer contained in section 254(h)(3) of the Act because, in such instances, health care providers would retain ownership of the additional capacity, and payments to the network for the use of such additional capacity would be retained to sustain the network. We seek comment on this analysis.

8. Vendor Cost Reporting Requirements

79. We propose requiring that health care providers obtain certain cost information from vendors.[143] We seek comment on our proposal, as detailed below. Because infrastructure projects are complex and involve a significant amount of funding, it is important that participants exercise due diligence in determining costs. To assist participants in this process, and to mitigate waste, fraud and abuse, we propose that participants in the health infrastructure program should:

- Require the vendor to certify either that: (1) The infrastructure project will only involve the construction and deployment of the dedicated healthcare network, and will not involve the construction or deployment of additional facilities or capacity that will not be part of the dedicated network; or (2) The infrastructure project will include both the construction and deployment of the dedicated network and the construction and deployment of additional facilities or capacity for uses other than the dedicated network, but: (a) the cost charged to the dedicated network will not exceed fully distributed costs given the use, quality of service, term (length of service) and other terms and conditions for use of the dedicated facility; and (b) the vendor will pay all costs related to the additional facility or capacity.[144]

- To assist the health care providers to determine sustainability of the network, require that the vendor provide a depreciation schedule showing the useful life of fixed assets.[145]

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[142] *See* 47 U.S.C. § 254(h)(3); 47 C.F.R. § 54.617(a); *see also 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20416, para. 107 ("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.").

[143] *See* Appendix A, 47 C.F.R. § 54.660(f).

[144] *See id.* § 54.660(f)(1)(b).

[145] *See id.* § 54.660(f)(2). RUS has similar depreciation record retention requirements. *See* Dept. of Agric., Rural Utils. Serv., "Rural Broadband Access Loan and Loan Guarantee Advance and Construction Procedures Guide," RUS Bulletin 1738-2, at section 1(i), *available at* http://www.usda.gov/rus/telecom/broadband/farmbill/rus-bulletin-1738-web2-6-03%20_2_.pdf.

- Require the vendor to maintain books and records that support all cost allocations.[146]

9. Quarterly Reporting Requirements

80. We propose requiring that health infrastructure program participants submit quarterly reports that provide information on the following: (1) attaining project milestones, (2) status of obtaining the 15 percent minimum match, (3) status of the competitive bidding process, (4) details on how the supported network has complied with HHS health IT guidelines or requirements, such as meaningful use, if applicable; and (6) performance measures (as described in more detail in Section IX of this NPRM).[147] We seek comment on this proposal, and on whether such reports should only be required annually or semi-annually. Such information could inform the Commission's understanding of cost-effectiveness and efficacy of the different state and regional networks funded by the program and guide future decision-making. This information should also enable the Commission to ensure that universal service funds are being used in a manner consistent with section 254 of the Act and the Commission's rules and orders.[148] In particular, collection of this information is critical to the goal of preventing waste, fraud, and abuse by ensuring that funding is flowing to its intended beneficiaries.[149] Participants should also note that submission of a quarterly report is not a substitute for seeking consent for any material modification to the original application.

10. Competitive Bidding

81. We propose that all projects funded by the health infrastructure program be subject to fair and open competitive bidding.[150] Currently, health care providers seeking support under the Rural Health Care Support Mechanism post a request for services on USAC's website for a period of at least 28 days, using FCC Form 465, which serves as a method for USAC and potential vendors to be aware of requests for services.[151] Because of the complexity of infrastructure projects, participants in the health infrastructure program should be explicitly required to prepare a detailed request for proposals (RFP) that provides sufficient information to define the scope of the project, and to distribute the RFP in a method likely to garner attention from interested venders.[152] For example, participants could (1) post a notice of the RFP in trade journals or newspaper advertisements, (2) send the RFP to known or potential service providers, (3) include the RFP on the health care provider's web page or other Internet sites, or (4) follow other customary and reasonable solicitation practices used in competitive bidding. Adding this mandatory RFP preparation and distribution requirement could increase the quality and quantity of bids received by health care providers for their network projects, and will therefore result in a more efficient use of funding under the health infrastructure program. We seek comment on whether participants also should be required to post an FCC Form 465 and note on that form that they have issued a detailed RFP. If participants using an RFP are not required to use an FCC Form 465, then the certifications that are contained in the Form 465 would be included in a substitute form.

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[146] *See* Appendix A, 47 C.F.R. § 54.660(f)(3).

[147] *See id.* § 54.663.

[148] *See* 47 U.S.C. § 254; 47 C.F.R. Part 54, Subpart G.

[149] Also, we note that selected participants will be subject to audit oversight as discussed *infra* para. 139.

[150] *See* Appendix A, 47 C.F.R. § 54.603(a).

[151] 47 C.F.R. § 54.603(a); *see* Appendix A, 47 C.F.R. § 54.603(b).

[152] *See* Appendix A, 47 C.F.R. § 54.603(b).

82. We recognize that in certain smaller projects, or in projects that are subject to mandatory, state or local procurement rules, our proposed RFP preparation and distribution requirements may not be practical or cost-effective. Accordingly, our proposed RFP requirements would not be applicable to infrastructure projects of $100,000 or less or projects that are subject to mandatory state or local procurement rules.[153] However, such projects would still be required to complete a request for services on an FCC Form 465 and post this request on USAC's webpage for a period of at least 28 days before selecting a vendor. We propose that health care providers be required to certify that each service or facility provider selected for an infrastructure project supported by the health infrastructure program is, to the best of the health care provider's knowledge, the most cost-effective service or facility provider available, as defined in our rules.[154] We seek comment on the above proposals.

11. Designation of Successor Projects

83. We propose that USAC monitor each funded participant's progress, as defined by their project milestones, and alert the Bureau in the event of any significant project delays or concerns. Similar to the Pilot Program, we propose delegating to the Bureau the authority to waive the relevant sections of Subpart G of Part 54 of the Commission's rules to the extent waiver may be necessary to the sound and efficient administration of the health infrastructure program.[155]

84. We also propose that in instances where a participant is unable to complete its project, the Bureau would have authority to designate a successor project, similar to the delegation of authority for the Pilot Program.[156] Such designation of a successor could be made upon request of the participant, or on the Bureau's own motion. The Bureau would exercise such discretion in instances where a project fails to meet a specified milestone, or a participant fails to adequately notify the Commission of modifications to the project milestone deadlines. In selecting a successor project, the Bureau would take into consideration the likelihood that the successor will be able, at a minimum, to complete the project in a manner that provides new broadband infrastructure to the identified region or area. We also propose delegating authority to the Bureau to revoke funding awarded to any selected participant making unapproved material changes to the network design plan set forth in the participant's detailed project description submitted as part of the funding application materials.[157] We seek comment on the proposals outlined above. As a final matter, we also seek comment on ways for the Bureau and USAC to improve outreach efforts in assisting projects through the Commission's administrative process.[158]

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[153] *See id.* § 54.603(b). We note that in federal procurements, a less stringent simplified acquisition procedure is used for contracts of $100,000 of less. *See* 41 U.S.C. § 403(11).

[154] *See Universal Service First Report and Order*, 12 FCC Rcd at 9134, para. 687; 47 C.F.R. § 54.615(c)(7); Appendix A, 47 C.F.R. § 54.603(c)(4).

[155] *See* Appendix A, 47 C.F.R. § 54.664(a). *See generally 2006 Pilot Program Order*, 21 FCC Rcd 11111; *Pilot Program Reconsideration Order*, 22 FCC Rcd 2555.

[156] *See* Appendix A, 47 C.F.R. § 54.664(b).

[157] *See id.* § 54.664(c).

[158] For the Pilot Program, the Bureau maintains and updates a webpage with frequently asked questions. *See* Rural Health Care Pilot Program, Frequently Asked Questions, http://www.fcc.gov/cgb/rural/rhcp.html#faqs (last visited June 24, 2010). USAC holds monthly telephonic meetings open to all Pilot Program participants, to discuss recurring issues and allow participants to seek clarification on specific areas of concern regarding program rules and requirements. In addition, USAC assigned to each Pilot Program participant a coach to guide the participant through the administrative process, and to answer any questions. The Bureau has also responded to direct inquiries from various Pilot Program participants. We anticipate that the Bureau and USAC will engage in similar outreach efforts (continued….)

12. NEPA and NHPA Requirements

85. Certain projects funded by the health infrastructure program could implicate the National Environmental Policy Act (NEPA) and the National Historic Preservation Act (NHPA).[159] If NEPA and NHPA are implicated by a particular proposed project, we invite comment on the point in the application process at which participants should be required to comply with the requirements codified in our rules.[160]

IV. HEALTH BROADBAND SERVICES PROGRAM

86. In the *2003 Rural Health Care Internet Access Order*, the Commission amended the Rural Health Care Support Mechanism to fund the recurring costs associated with Internet access for rural health care providers in two ways. First, the program subsidizes the rates paid by rural health care providers for telecommunications services to eliminate the rural/urban price difference within each state (via the telecommunications program).[161] Second, to support advanced telecommunications and information services, the program provides a 25 percent flat discount on monthly Internet access for rural health care providers and a 50 percent discount for health care providers in states that are entirely rural (via the internet access program).[162]

87. In establishing the level of support for the internet access program, the Commission concluded that a flat discount percentage of 25 percent off the cost of monthly Internet access would assist health care providers seeking to purchase Internet services, while also providing incentives for rural health care providers to make prudent economic decisions concerning their telehealth needs.[163] The Commission found that a flat discount would be easy to administer and consistent with section 254(b)(5), which requires "a specific, sufficient, and predictable mechanism . . . because it limits the amount of support that each health care provider may receive per month to a reasonable level."[164] The Commission also determined that a flat discount would lead to greater predictability and fairness among health care providers.[165] In setting the discount level at 25 percent, the Commission acted conservatively based on the belief that this amount would provide an incentive for rural health care providers to choose a level of service appropriate to their needs, ensure that demand for Internet access support would not exceed the annual funding cap, and deter wasteful expenditures.[166] The Commission stated that as it gained more

(Continued from previous page)

for the health infrastructure program.

[159] *See generally* 42 U.S.C. § 4332 (NEPA) and 16 U.S.C. § 470*f* (NHPA).

[160] *See* 47 C.F.R. § 1.1307 et seq.

[161] 47 C.F.R. § 54.609.

[162] *Id.* § 54.621(a), (c). Alternatively, eligible health care providers that cannot obtain toll-free access to an Internet service provider is entitled to receive support for 30 hours of access to an ISP per month or $180 per month in toll charge credits, whichever is less. *Id.* § 54.621(b).

[163] *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 18 FCC Rcd 24546, 24560, para. 27 (2003) (*2003 Report and Order and FNPRM*).

[164] 47 U.S.C. § 254(b)(5); *2003 Report and Order and FNPRM*, 18 FCC Rcd at 24560, para. 27.

[165] *2003 Report and Order and FNPRM*, 18 FCC Rcd at 24560, para. 27 (comparing to the E-Rate flat discount).

[166] *Id.*

experience with this aspect of the support mechanism, it would reassess the appropriateness of the 25 percent discount level.[167]

88. Noting the under-utilization of the current support mechanism, the National Broadband Plan recommended that the internet access program be replaced with a broadband services access program that expands the definition of funded services and provides greater support than the 25 percent subsidy under the current internet access program in order to better meet the health IT needs of health care providers.[168] To better encourage program participation, the National Broadband Plan also recommended that the Commission simplify the application process for the program, while also continuing to protect against potential waste, fraud and abuse in the program.[169]

A. Eligible Services

1. Recurring Costs

89. *Eligible Access and Transport Services*. Pursuant to section 254(h)(2)(A), and consistent with the recommendations made in the National Broadband Plan, we propose to replace the existing internet access program with a new "health broadband services program," which will subsidize 50 percent of an eligible rural health care provider's recurring monthly costs for any advanced telecommunications and information services that provide point-to-point broadband connectivity, including Dedicated Internet Access.[170] We seek comment on this proposal. We note that section 254(h)(2)(A) is not limited to health care providers in rural areas. We seek comment on whether an appropriate first step for expanding funding for broadband services should be to focus on rural areas, given the particular challenges that rural communities often face in obtaining access to health care. We also invite comment on whether this proposal implicates section 254(h)(1)(A),[171] and if so, how we would implement the proposed health broadband services program in light of section 254(h)(1)(A). For instance, should we require that recipients seeking funding for telecommunications services to make an election as to whether they wish to receive support under the telecommunications program or under the new proposed health broadband services program?

The purpose of Rural Healthcare program is to help provide telecommunications and internet services in rural areas. The program should be focused on rural areas.

90. As noted by the National Broadband Plan, when used effectively, broadband-based technologies can "help health care professionals and consumers make better decisions, become more efficient, engage in innovation, and understand both individual and public health more effectively."[172]

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[167] *Id.*

[168] National Broadband Plan at 215 (NBP Recommendation 10.6). The National Broadband Plan recommended that this funding be available for eligible entities in health professional shortage areas (HPSAs), which can be located in urban as well as rural areas. As discussed more fully below, we propose initially to provide funding to eligible entities that are deemed as "rural." We can, at a future date, consider whether to expand support to HPSAs located outside of rural areas.

[169] *Id.*

[170] *See* Appendix A, 47 C.F.R. § 54.631(a).

[171] *See* 47 U.S.C. § 254(h)(1)(A) (authorizing universal service support for the difference, if any, between the rates for telecommunications services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in corporate rural areas in that State).

[172] National Broadband Plan at 200.

Currently, the internet access program provides support equal to 25 percent of the monthly cost of Internet access reasonably related to the health care needs of rural health care providers.[173] The Commission's current rules define Internet access as "an information service that enables rural health care providers to post their own data, interact with stored data, generate new data, or communicate over the World Wide Web."[174] Under this definition, the Commission determined that Internet access provides access to the world-wide information resource of the Internet, and includes all features typically provided by Internet service providers to provide adequate functionality and performance.[175] To qualify as Internet access under the definition, the Commission further stated that transmissions must traverse the Internet in some fashion.[176]

91. Access to advanced telecommunications and information services for health care delivery is provided in a variety of ways today, and is not limited to the public Internet and the features typically provided by Internet service providers. For example, due to privacy laws and electronic health care record requirements, secure transmission of health IT data needs to occur over a private dedicated connection between health care providers. In addition, as evidenced in the networks being funded under the Pilot Program, many health care providers rely on private wide area networks to provide Health IT and access applications for the delivery of health care to rural areas.[177] Limiting funding to transmission over the public Internet therefore may inhibit access to health IT necessary to improve health care delivery. The low utilization rate of the existing internet access program suggests the narrow definition of Internet Access does not align with the needs of health care practitioners.[178]

92. We propose that the health broadband services program provide support to eligible rural health care providers for the recurring costs of access to advanced telecommunications and information services that enable rural health care providers to post their own data, interact with stored data, generate new data, or communicate over private dedicated networks or the public Internet for the provision of health IT.[179]

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[173] 47 C.F.R. § 54.621(a). Alternatively, a 50% discount on the monthly cost of advanced telecommunications and information services is available to health care providers located in states that are entirely rural. 47 C.F.R. § 54.621(c). These services must also be reasonably related to the health care needs of the facility. 47 C.F.R. § 54.621(c).

[174] This definition is codified at 47 C.F.R. § 54.601(c)(2)(i).

[175] *2003 Report and Order and FNPRM*, 18 FCC Rcd at 24559, para. 25.

[176] *See id.*

[177] See, e.g., West Virginia Telehealth Alliance, Quarterly Report for April 2010, WC Docket No. 02-60, at 4-5 (filed Apr. 30, 2010) (discussing WVTA's use of dedicated wide area networks to "to improve and establish inter-connected broadband health care networks"); Southwest Alabama Mental Health Consortium, Quarterly Report for April 2010, WC Docket No. 02-60, at 8 (filed April 29, 2010) (noting that its members "intend to lease a fiber Wide Area Network, Internet, and associated managed services to enable communications between sites and distribute Internet, and associated services to the end user level of member facilities").

[178] *See* National Broadband Plan at 211-13 (discussing the need for dedicated Internet access (DIA) solutions for medium and large providers and the price disparities for rural and Tribal providers who require DIA solutions); *see also* USF Consultants NBP Public Notice #17 Comments at 8 (noting that health care networks need a connection point for their remote facilities that are cost-effective and can provide secure connections between carriers).

[179] *See* Appendix A, 47 C.F.R. §§ 54.602(e); 54.631(c).

93. We seek comment on whether we should define a minimum level of broadband capability for purposes of providing support under the new health broadband services program.[180] The National Broadband Plan suggested that 4 Mbps downstream is the minimum necessary for a solo practitioner to support the deployment of health IT applications today and in the near future, whereas the recommended bandwidth for other health care providers is 10 Mbps for small clinics and health care providers with 2 to 4 physicians, 25 Mbps for larger clinics and health care providers with 5 or more physicians, 100 Mbps for hospitals and 1,000 Mbps for large medical centers.[181] Would 4 Mbps be an appropriate minimum for purposes of the new health broadband services program, or should we require different minimum speeds depending on the type of health care provider? Four (4) Mbps could be a sufficient minimum requirement since the health broadband services program would be used to fund broadband services without funding additional infrastructure. In contrast, for the health infrastructure program, given the use of funding specifically for broadband deployment, the minimum broadband speed should be higher.[182] We also seek comment on minimum levels of reliability, including physical redundancy, to support health IT services and what can be done to encourage reliability.[183] We also seek comment on the minimum quality of service standards necessary to meet health IT needs. We seek comment on whether the health broadband services program should contain a minimum quality of service requirement.[184]

94. *Eligible Service Providers*. In the past, we have permitted health care providers to seek discounts on "the most cost-effective form of Internet access, regardless of the platform."[185] Consistent with section 254(h)(2)(A),[186] we propose that participants in the health broadband services program may seek supported services from any type of broadband provider, as long as the participant selects the most cost-effective option to meet its health care needs.[187] We seek comment on this proposal.

95. *Limitations to Prevent Waste, Fraud, and Abuse*. To guard against the possibility of waste, fraud, and abuse in the health broadband services program, we propose that the supported services must be reasonably related to the provision of health care services by an eligible health care provider. Second, eligible health care providers that seek support for telecommunications service offerings may not also request support from the telecommunications program for the same service.[188] Lastly, all requests

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[180] *See id.* § 54.631(e); Internet2 June 25, 2010 *Ex Parte* Letter, at 2-3 (bandwidth requirements differ depending on the type of service being provided by the health care site).

[181] National Broadband Plan at 210, Exhibit 10-C.

[182] *See supra* para. 20, discussing minimum connectivity speeds for the health infrastructure program.

[183] *See* Internet2 June 25, 2010 *Ex Parte* Letter, at 1 (suggesting that funded services should include minimum standards of quality of service, including reliability, bit relay, jitter, packet dropping probability and/or bit error rate).

[184] *See id.*

[185] *2003 Report and Order and FNPRM*, 18 FCC Rcd at 24561, para. 28; *see also 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20367-68, para. 16.

[186] *See* 47 U.S.C. § 254(h)(2)(A) (requiring that the Commission establish rules that are competitively neutral).

[187] *See* Appendix A, 47 C.F.R. § 54.635; s*ee also infra* paras. 85 - 86, discussing competitive bidding requirements for the health broadband services program.

[188] *See* Appendix A, 47 C.F.R. § 54.631(d). In the Pilot Program, health care providers are prohibited from receiving funds for the same service from both the Pilot Program and other universal service or government programs. *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20422, para. 123.

for discounts under the health broadband services program would comply with our rules on competitive bidding and cost-effectiveness, as discussed below.[189] We seek comment on these proposals.

2. No Capital or Infrastructure Costs

96. The National Broadband Plan recommended that the Rural Health Care Support Mechanism maintain a distinction between subsidies for recurring costs (i.e., the monthly service price) and subsidies for other costs (e.g., infrastructure, equipment).[190] Given the proposed availability of funding for infrastructure deployment and upgrades in the health infrastructure program, we propose placing limits on the use of funding under the health broadband services program for non-recurring costs.[191] Under the internet access program, USAC allows participants to receive one-time support equal to 25 percent of the cost of Internet access installation.[192] The existing internet access program, however, does not provide support for the costs of construction or infrastructure build-out necessary for the installation of Internet access services.[193] We propose that under the health broadband services program, participants may receive a one-time support equal to 50 percent of reasonable and customary installation charges for broadband access.[194] Installation charges would be defined as charges that are normally charged by service providers to commence service, and are not charges that are based on amortization or pass through of construction or infrastructure costs. The health broadband services program would only subsidize health care providers' recurring costs – that is, the monthly price for providers' eligible services and one-time installation charges.[195] We seek comment on this proposal.

It is impossible to determine if installation and monthly charges are used for capital or infrastructure costs. Projects should be bid and proposals should be evaluated on total "Present Value" of all charges. The health care provider then gets the lowest price.

97. The National Broadband Plan recommended that "federal and state policies should facilitate demand aggregation and use of state, regional and local networks when that is the most cost-efficient solution for anchor institutions to meet their connectivity."[196] We propose that eligible health

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[189] *See infra* paras. 85 – 86.

[190] *See* National Broadband Plan at 215 (NBP Recommendations 10.6 and 10.7).

[191] *See* Appendix A, 47 C.F.R. § 54.633.

[192] *See* USAC, Rural Health Care Webpage, Frequently Asked Questions, http://usac.org/rhc/tools/frequently-asked-questions.aspx#5 (last visited June 24, 2010).

[193] *See id.*

[194] See Appendix A, 47 C.F.R. 54.633; *cf.* Minnesota Health Dept. NBP Public Notice #17 Comments at 4 (noting that equipment and installation costs can exceed the resources of rural health care providers); Rural Wisconsin Network NBP Public Notice #17 Comments at 8 (noting that rural health care providers should have access to discounts on the installation and monthly charges for telecommunications and Internet access services used for the provision of health care).

[195] Eligible, rural health care providers would be able to seek funding under the health broadband services program or the telecommunications program to subsidize their recurring costs, to the extent these participants comply with the Commission's rules and section 254 of the Act, including (but not limited to) competitive bidding requirements. In the event recurring costs are for both eligible (i.e., rural) and non-eligible (e.g., urban) health care providers. *Cf. 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20397, para. 76; 47 C.F.R. 54.504(g) (describing mixed eligibility services in the E-Rate program).

[196] National Broadband Plan at 153 (NBP Recommendation 8.20); *see, e.g.*, Intel NBP Public Notice #17 Comments at 47 (suggesting that the Commission coordinate with other Federal agencies -- such as the RUS, Commerce, HHS, FDA, VA, and HIS -- to develop community-wide public sector broadband networks, which would stimulate (continued….)

care providers should be able to receive support for the lease of dark or lit fiber to provide broadband connectivity from any provider. Under such an approach, applicants would, for instance, be able to lease dark fiber that may be owned by state, regional or local governmental entities, when that is the most cost-effective solution to their connectivity needs.

98. We recognize that in some situations service providers may deploy new facilities to serve eligible health care entities, and may seek to recover all or part of those costs through non-recurring charges when service is initiated. Consistent with policies adopted in the schools and libraries support mechanism, we propose that applicants may not seek upfront support for non-recurring charges of $500,000 or more.[197] If non-recurring charges are more than $500,000, they must be part of a multi-year contract, and must be prorated over a period of at least five years.[198] We seek comment on these proposals.

Projects should be bid and proposals should be evaluated on total Present Value of all charges. The health care provider then gets the lowest price. Higher installation charges are necessary when funds are only committed for one year. Projects need to be 3 or 5 years for any construction to be practical. Three or five year contracts are necessary for an alternative provider to be competitive with an incumbent. Mulit- year contracts need to be funded for the life of the contract.

3. Restrictions on Satellite Services

99. Section 254 directs the Commission to adopt rules that enhance access to advanced telecommunications and information services to the extent "technologically feasible and economically reasonable."[199] As noted by the National Broadband Plan, "the high fixed costs of designing, building and launching a satellite mean that satellite-based broadband is likely to be cheaper than terrestrial service only for the most expensive-to-serve areas."[200] We propose to require that a health care provider seeking

(Continued from previous page)

broadband access and value); Oregon Health Network NBP Public Notice #17 Comments at 10 (noting that the value of a broadband network is enhanced through an "anchor tenant" model that includes institutions such as schools, hospitals, and government).

[197] *See* Appendix A, 47 C.F.R. § 54.633(c); *cf.* USAC, Schools and Libraries, Wide Area Network (WAN) Fact Sheet, http://www.universalservice.org/sl/applicants/step06/wide-area-network-fact-sheet.aspx#5 (last visited June 24, 2010).

[198] In the *Brooklyn Order*, the Commission determined that where the non-recurring charge for capital investment "vastly exceeds" the monthly recurring charge, recipients may receive discounts on non-recurring charges associated with capital investment made by a service provider in an amount equal to the investment prorated over a term of at least three years. *Request for Review of the Decision of the Universal Service Administrator by Brooklyn Public Library Brooklyn, New York; Federal-State Joint Board on Universal Service; Changes to the Board of Directors of the National Exchange Carrier Association, Inc.*, CC Docket Nos. 96-45, 97-21, Order, 15 FCC Rcd 18598, 18606, para. 20 (2000) (*Brooklyn Order*). In 2003, the Commission sought comment on whether to limit the recovery of upfront charges for capital investments to no more than 25 of a funding request and whether to require amortization of non-recurring charges of more than $500,000 over at least five years. *Schools and Libraries Universal Service Support Mechanism*, CC Docket No. 02-6, Third Report and Order and Second Further Notice of Proposed Rulemaking, 18 FCC Rcd 26912, 26943, paras. 74-75 (2003).

[199] *See* 47 U.S.C. § 254(h)(2)(A) (requiring rules that are "technically feasible and economically reasonable")

[200] National Broadband Plan at 37 n.10.

support for satellite service demonstrate that it is the most cost-effective option available to meet the provider's health care needs.[201] We also propose to incorporate the rules currently governing the purchase of satellite services under the telecommunications program into the new health broadband services program.[202] Currently, eligible health care providers may seek support for rural satellite services, even if a similar terrestrial-based service is available.[203] However, discounts are capped at the amount that the provider would have received if they purchased a functionally similar terrestrial-based alternative.[204] We seek comment on these proposals.

B. Level of Support

100. The National Broadband Plan recommended that the Commission base discount levels for the health broadband services program on criteria that address such factors as lack of broadband access, lack of affordable broadband, price discrepancies for similar broadband services between health care providers, the health care provider's inability to afford broadband services, special status for health care providers in the highest Health Professional Shortage Areas (HPSAs) of the country, and special status for public or safety net institutions.[205]

The amount of subsidy should be flexible and based on how rural or poor the area. Based on our experience with the schools and libraries program, it will take more than 80% subsidy to significantly impact broadband deployment.

101. The National Broadband Plan further recommended that, to enable health care providers to afford higher bandwidth broadband services, the subsidy support amount under the health broadband services program should be greater than the 25 percent subsidy available under the internet access program.[206] In addition, the National Broadband Plan suggested that support be adjusted to better match the costs of services for disadvantaged health care providers.[207] Additionally, to encourage participation in the health broadband services program, the National Broadband Plan stated that the Commission should "simplify the application process and provide clarity on the level of support that providers can reasonably expect, while protecting against potential waste, fraud and abuse."[208]

102. We note that, on average, health care providers that applied for the urban/rural cost difference for eligible telecommunications services under the existing telecommunications program received funding commitments for a 60 percent discount on their cost of service; a significant number of

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[201] *See* Appendix A, 47 C.F.R. § 54.639. Presently, rural health care providers seeking discounts for satellite services under the telecommunications program must provide documentation to USAC listing the urban and rural rates for all terrestrial-based alternatives. 47 C.F.R. § 54.609(d)(2).

[202] 47 C.F.R. § 54.609(d).

[203] *Id.* § 54.609(d)(1).

[204] *Id*.

[205] *See* National Broadband Plan at 215 (NBP Recommendation 10.6).

[206] *Id.*; *see also* USF Consultants NBP Public Notice #17 Comments at 8 (advocating that health care providers receive an increased support amount of 50%, in order to incentivize a transition from point-to-point T-1 networks to virtual private networks).

[207] National Broadband Plan at 215 (NBP Recommendation 10.6).

[208] *Id*.

those funding commitments are for T-1 lines.[209] We do not have sufficient information at this time regarding the comparative costs of higher bandwidth services that increasingly may be used by health care providers in the future as they employ health IT applications for telehealth and e-care, nor do we have information that would enable us to develop an administratively workable affordability benchmark. Given the dearth of available information, a cautious approach could be to adopt a flat discount of 50 percent for monthly recurring costs and evaluate, after some period of time, whether such a flat discount results in increased adoption and utilization of broadband for health care purposes. We seek comment on this proposal, as discussed in this section.

103. One potential advantage of adopting a 50 percent discount is that the participating health care provider has a financial stake in paying for its selected services, thereby providing an incentive for cost-effective decision making and promoting the efficient use of universal service funding. In particular, unlike a rural/urban benchmark methodology, a flat discount requires that providers seek cost efficient solutions to their broadband needs because they have their own investment in the recurring service costs.[210] In conjunction with the competitive bidding process, a financial stake in services supported by the health broadband services program will help in keeping costs lower for the same quality services.

104. The National Broadband Plan also recommended that, to better encourage participation in the health broadband services program, the Commission should provide clarity as to the level of support that health care providers can reasonably expect to receive.[211] Not only does a 50 percent flat discount promote prudent decision-making, it provides a clear and predictable support amount,[212] thereby assisting rural health care providers in planning for their broadband needs and purchasing services.[213] Moreover, a flat rate discount is easy to administer, which should expedite the application process and reduce administrative expenses incurred by USAC.

105. We also seek input on whether affordability metrics could be incorporated into the flat rate methodology proposed above. Are there factors that could be considered under a flat rate funding mechanism that target health care providers in rural areas that still could not afford broadband access services under the 50 percent funding threshold?

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[209] *See* Letter from Universal Service Administrative Company, to Marlene H. Dortch, Secretary, Federal Communications Commission, GN Docket Nos. 09-47, 09-51, 09-137, WC Docket No. 02-60 (dated Feb. 23, 2010).

[210] Commenters responding to the NBP Public Notice #17 noted that health care providers in rural areas, in order to receive support under the telecommunications program (which supports the difference between rural and urban rates for telecommunications service in a state, may in some circumstances, have an incentive to maintain slower, more costly connections in order to receive telecommunications program support. *See, e.g.*, Rural Wisconsin Network NBP Public Notice #17 Comments at 7 (noting that if the relative costs of different type of connections in a region's urban and rural areas is not different, the health care providers in rural areas will have an incentive to choose only those services that do have a pricing difference between rural and urban services, in order to get USF support); USF Consultants NBP Public Notice #17 Comments at 5 (noting that rural health care providers "may look only at the limited number of default values for support for Frame Relay and T-I services" and limit their options to those services, as opposed to considering cable or other advanced services not typically considered telecommunications services).

[211] National Broadband Plan at 215 (NBP Recommendation 10.6).

[212] 47 U.S.C. § 254(b)(5); *see also 2003 Report and Order and FNPRM*, 18 FCC Rcd at 24560, para. 27 (noting that section 254(b)(5) requires "a specific, sufficient, and predictable mechanism . . . because it limits the amount of support that each health care provider may receive per month to a reasonable level").

[213] *2003 Report and Order and FNPRM*, 18 FCC Rcd at 24560, para. 27.

C. Competitive Bidding

106. The National Broadband Plan suggests that the Commission should evaluate the tools at its disposal, such as competitive bidding, to enhance its oversight of the Rural Health Care Support Mechanism.[214] We propose to extend the competitive bidding requirements that are currently applicable to the internet access program to the new health broadband services program. Specifically, we propose that each participant undertake a competitive bidding process by posting an FCC Form 465 prior to selecting a service provider, and certify that it considered all bids received and selected the most cost-effective bid.[215] We seek comment on this proposal. Are there changes we can make to the competitive bidding mechanism to make it more successful or efficient? Are there certain types of situations that should be exempted from the competitive bidding requirements?[216]

107. *Multi-year Contracts*. Under the current internet access program, certain service contracts have "evergreen" status, meaning that for the life of the contract, the parties do not have to rebid the service or post an FCC Form 465.[217] A health care provider covered under an evergreen contract may apply annually for Internet access support by filing only an FCC Form 466-A.[218] Conversely, a health care provider who does not have an evergreen contract is considered to have a "month-to-month, tariffed service and must post an FCC Form 465 and select the most cost-effective service and service provider each year."[219]

108. We propose to codify this practice as part of the new health broadband services program. If they choose to do so, program participants will be allowed to enter into multi-year contracts for recurring broadband services.[220] Further, we propose that multi-year contracts that are competitively bid in accordance with the Commission's rules and that are deemed to have evergreen status by USAC do not need to be re-bid each year, for the life of the contract.[221] However, consistent with current policy, all health care providers would be required to continue to request support annually by filing an FCC Form 466-A.[222] Additionally, any changes to the parties' evergreen contract, such as an extension, renewal, or the addition of services, would require the posting of a new FCC Form 465.[223] Codifying this existing

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[214] National Broadband Plan at 217 (NBP Recommendation 10.9).

[215] *See* 47 C.F.R. §§ 54.603, 54.615(a), (c), 54.637.

[216] *See, e.g.*, Oregon Health Network NBP Public Notice #17 Comments at 7 (proposing that in instances where a multi-year contract has been signed after a competitive bid process, USAC should have "a simplified process where the applicant and the telecommunications provider can indicate and attest to the fact that no change in service has occurred and that the service is still eligible for universal service discounts.").

[217] USAC, Rural Health Care Webpage, Evergreen Contracts, http://www.usac.org/rhc/health-care-providers/step04/evergreen-contracts.aspx (last visited June 24, 2010). A Form 465 must be posted, however, whenever an applicant seeks to add services, make cardinal changes, renew or extend the contract (including optional extensions. *Id.*

[218] *Id.*

[219] USAC, Rural Health Care Webpage, Glossary of Terms – Evergreen Contracts, http://www.usac.org/rhc/tools/glossary-terms-detailed.aspx (last visited June 24, 2010).

[220] *See* Appendix A, 47 C.F.R. § 54.641(a).

[221] *See id.* § 54.641(b).

[222] *See id.* § 54.641(c).

[223] *See id.* § 54.641(b); *cf.* USAC, Rural Health Care Webpage, Evergreen Contracts, http://www.usac.org/rhc/health-care-providers/step04/evergreen-contracts.aspx (last visited June 24, 2010).

practice would maintain consistency while transitioning from the existing internet access program to the new health broadband services program. Health care providers would also benefit from the opportunity to enter into long-term contracts with service providers, which may offer lower pricing than would be available on an annual basis. Moreover, the administrative obligations would be reduced for those providers who do not file a Form 465 each year.[224] We seek comment on our proposal.

109. *Opting into the Health Broadband Services Program.* Under the Pilot Program, we permitted participants to seek support for both the recurring and non-recurring costs associated with the deployment of broadband health care networks and the advanced telecommunications and information services provided over those networks.[225] When the Pilot Program ends, some participants may wish to transition to the new health broadband services program to subsidize the recurring costs formerly funded by the Pilot Program. We seek comment on whether Pilot Program participants whose original request for competitive bids included both non-recurring and recurring costs should be permitted to transition to the health broadband services program without undergoing a new competitive bidding process.

If participants have entered into multiyear contracts which continue after the pilot program then they should be transitioned to the Health Broadband program. Expired contracts should be rebid to make sure the participant gets the lowest price and to eliminate waste and fraud.

V. ELIGIBLE HEALTH CARE PROVIDERS

A. Background

110. The National Broadband Plan recommended that the Commission "re-examine [its interpretation of section 254(h)(7)(B)] in light of trends in the delivery of health care, and expand the definition of health care providers to include, where consistent with the statute, those institutions that have become integral in the delivery of care in the United States."[226]

111. The Commission previously determined that it does not have the authority to expand the list of eligible health care providers set forth in section 254(h)(7)(B).[227] This section defines "health care provider" as: (1) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (2) community health centers or health centers providing health care to migrants; (3) local health departments or agencies; (4) community mental health centers; (5) not-for-profit hospitals; (6) rural health clinics; and (7) consortia of health care providers consisting of one or more entities described in clauses (1) through (6).[228] We seek comment below on several proposals to expand the specific facilities that can be funded, consistent with the current statute. We also seek comment on

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[224] *See, e.g.*, Oregon Health Network NBP Public Notice #17 Comments at 7 (noting that health care providers with multiyear contracts should not have to reapply for support each year, as it can be a financially burdensome process for the health care provider).

[225] *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20397, para. 74.

[226] National Broadband Plan at 216 (NBP Recommendation 10.8).

[227] *2003 Report and Order and FNPRM*, 18 FCC Rcd at 24555, para. 16; *Changes to the Board of Directors of the National Exchange Carrier Association, Inc., Federal-State Joint Board on Universal Service*, CC Docket Nos. 97-21 and 96-45, Sixth Order on Reconsideration in CC Docket No. 97-21 and Fifteenth Order on Reconsideration in CC Docket No. 96-45, 14 FCC Rcd 18756, 18786, para. 48 (1999) (*Fifteenth Order on Reconsideration*); *Universal Service First Report and Order*, 12 FCC Rcd at 9118-19, paras. 655-56.

[228] 47 U.S.C. § 254(h)(7)(B).

whether there are any providers not identified below that should be eligible for support, consistent with the provisions of section 254(h)(7)(B).

B. Administrative Offices

112. Under the Commission's current rules, health care providers housing their administrative operations in off-site offices may not seek rural health care support for those offices. The National Broadband Plan recommended that the Commission expand its interpretation of eligible health care provider to allow participation in the Rural Health Care Support Mechanism by off-site administrative offices.[229] Off-site administrative offices that are owned or controlled by an eligible health care provider should have the opportunity to receive rural health care support, and, as detailed below, we propose to amend the Commission's rules to reflect this change. We seek comment on this proposal.

Of course administrative offices should be included. This is where data is possibly stored and used and there are often many other type offices in the same building.

113. There are several reasons why we think it appropriate to revisit this issue. In today's environment, while administrative offices do not provide "hands on" delivery of patient care,[230] they often perform support functions that are critical to the provision of clinical care by rural health care providers. For example, administrative offices may coordinate patient admissions and discharges, ensure quality control and patient safety, and maintain the security and completeness of patients' medical records.[231] Administrative offices also perform ministerial tasks, such as billing and collection, claims processing, and regulation compliance.[232] Without an administrative office capable of carrying out these functions, an eligible health care provider may not be able to successfully provide patient care. From the Pilot Program, we have also learned that administrative costs can be significant for rural health care providers and, in some cases, may prevent providers from adopting telemedicine at all.[233] For example, one Pilot Program participant stated in its response to the *NBP Public Notice #17* that, despite efforts to minimize costs, it had spent over $160,000 on administrative expenses in approximately two years.[234] By expanding our interpretation of section 254(h)(7)(B) to include funding for off-site administrative offices, we could help to reduce the costs of telemedicine adoption for rural providers.

114. We also recognize that there is a wide variation in the way that health care providers structure their facilities. While some providers perform both clinical and administrative functions at a single, stand-alone facility, other providers require multiple sites and choose to house their administrative and clinical operations in separate buildings. It is becoming a best practice among health care providers

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[229] National Broadband Plan at 216 (NBP Recommendation 10.8); *see also* Internet2 June 25, 2010 *Ex Parte* Letter, at 4.

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

[231] *Id.*

[232] *Id.*

[233] *See, e.g.*, Internet2 Group NBP Public Notice #17 Comments at 12; ATA NBP Public Notice #17 Comments at 18; California Telehealth NBP Public Notice #17 Comments at 1-2; Christus Health NBP Public Notice #17 Comments at 2.

[234] Western New York Area Health NBP Public Notice #17 Comments at 3.

to locate their administrative facilities off-site from the provider's primary facility.[235] To the extent that administrative offices are owned or controlled by an eligible health care provider, we propose that they should be funded as a part of the eligible health care provider under section 254(h)(7)(B).[236] It is impractical to distinguish administrative offices that are located off-site but otherwise perform the same functions as in-house administrative offices.[237] We seek comment on this proposed change.

115. If we revise our rules to indicate that off-site administrative offices may qualify as eligible health care providers, additional limitations may be needed to protect the program from waste, fraud, and abuse. First, we propose that an off-site administrative office must be at least 51 percent owned or controlled by an eligible non-profit or public health care provider listed in section 254(h)(7)(B) of the Act.[238] An off-site facility would not qualify for support, therefore, simply by entering into an outsourcing relationship with an eligible health care provider. We also seek comment on whether an off-site administrative office that is less than 51 percent owned or controlled by an eligible health care provider should be eligible for support on a pro-rated basis or should be excluded from support altogether. Second, we note that, in some cases, off-site administrative offices may serve several purposes, some of which are unrelated to health care or performed on behalf of ineligible entities. We therefore propose to allow eligible health care providers to seek support for off-site administrative offices only in those

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[235] *See* Cynthia Hayward, *Planning Flexible Health Care Facilities is no Longer Optional*, SpaceMed Trendline, Fall 2008, *available at* http://www.spacemed.com/Trendline-Flexibility.pdf (noting that flexible health care facilities are needed due to "fluctuating workloads, rapidly changing technology, staff shortages, and high turnover, and limited access to capital"); Cynthia Hayward, *Benchmarking a Hospital's Functional Layout*, SpaceMed Newsletter, Winter 2009, *available at* http://www.spacemed.com/Newsletter21.htm ("Larger office suites should be planned (on or off site) in lieu of smaller pockets of offices throughout the hospital campus. Flexible, generic office space should be planned to accommodate various department staff who do not require face-to-face contact with customers so that offices and workstations can be reassigned periodically as programs and staffing levels change."); Raj Gupta & David Marshall, *Engineers are playing a much more active role in health-care design: bringing new ideas and technologies to the process*, 33 Consulting-Specifying Engineer 30 (2005) (noting that health care providers have begun seeking engineers "to design infrastructures in such a way that each area of a hospital can be isolated in the event of future expansion").

[236] *See* Appendix A, 47 C.F.R. § 54.601(b).

[237] *See* Dale Alverson, MD, University of New Mexico Center for Telehealth and Cybermedicine Research, FCC Rural Health Care Pilot Program: Lessons Learned and Opportunities for Improvement 10 (2009), http://www.broadband.gov/docs/ws_healthcare/alverson.pdf (noting a need for consistency on issues such as the funding of eligible entities).

[238] *See* Appendix A, 47 C.F.R. § 54.601(b)(1). *See also* similar definition of control used by other agencies, *e.g.*, 42 C.F.R. § 422.354(d) (for provider-sponsored organizations under the Medicare program, "control is presumed to exist if one party, directly or indirectly, owns, controls, or holds the power to vote, or proxies for, not less than 51 percent of the voting rights or governance right of another"); 12 C.F.R. § 204.2(q) (defining an "affiliate" of a depository institution as any "corporation, association, or other organization: (1) Of which a depository institution, directly or indirectly, owns or controls either a majority of the voting shares or more than 50 percent of the number of shares voted for the election of its directors, trustees, or other persons exercising similar functions at the preceding election . . . (2) Of which control is held, directly or indirectly, through stock ownership or in any other manner, by the shareholders of a depository institution who own or control either a majority of the shares of such depository institution or more than 50 percent of the number of shares voted for the election of directors of such depository institution at the preceding election, or by trustees for the benefit of the shareholders of any such depository institution . . . . [or] (4) Which owns or controls, directly or indirectly, either a majority of the shares of capital stock of a depository institution or more than 50 percent of the number of shares voted for the election of directors, trustees, or other persons exercising similar functions or a depository at the preceding election."). We reemphasize that administrative offices, both in-house and off-site, must also be owned by or affiliated with an eligible non-profit or public health care provider. *See* 47 U.S.C. §§ 254(h)(1)(A), (h)(2)(A).

instances where the health care provider certifies that the administrative office is used primarily for performing services that are integral to the provision of health care by eligible health care providers.[239] We seek comment on these proposals.

C. Data Centers

116. Currently, off-site data centers are not eligible health care providers under the Commission's rules.[240] The National Broadband Plan recommended that the Commission expand its interpretation of "eligible health care provider" to include off-site data centers used for health care purposes and owned (directly or indirectly) by an eligible health care provider.[241] As we learned from the Pilot Program, data centers often perform functions, such as housing patient records or serving as operations centers, which are critical to the delivery of health care in rural communities. For example, the Utah Telehealth Network Pilot Program Project uses a primary and a secondary data center to deliver approximately 2,500 clinical and financial applications across wide area networks to eligible health care facilities.[242] Similarly, the Western New York Rural Area Health Education Center (Western New York Area Health) Pilot Program Project plans to "connect all participating hospitals and clinics in the rural and under-served areas over a dedicated broadband Internet Protocol network to a centralized conferencing and server core at the Western New York Area Health data center facility . . . which aggregates, and expands the primary- and secondary-care capacities of these hospitals and clinics for telemedicine, radiological imaging, and community-based health information exchange, as well as clinical collaboration, mentoring, and distance learning and education applications."[243] Commenters responding to the *NBP Public Notice #17* stressed that if the connections between the data centers and the individual network sites are not funded, information transfer will not occur and the network cannot operate, thereby inhibiting patient care.[244]

117. As health care providers rely more on advanced applications to meet the challenges of sharing, storing and retrieving electronic medical data and images, health care providers and organizations will likely need to depend more heavily on high-speed connectivity between key sites and data centers.[245] As an administrative matter, it is impractical to disallow funding to data centers that

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[239] *See* Appendix A, 47 C.F.R. § 54.601(b)(2).

[240] *See* 47 C.F.R. § 54.601(c); Rural Health Care Pilot Program, Frequently Asked Questions and Answers, FAQ #5, http://www.fcc.gov/cgb/rural/rhcp.html#faq5 (last visited June 24, 2010).

[241] National Broadband Plan at 216 (NBP Recommendation 10.8).

[242] Utah Telehealth Network, Quarterly Report for Q7, WC Docket No. 02-60, at 19 (filed Feb. 1, 2010).

[243] Western New York Rural Area Health Education Center, Quarterly Report for Q7, WC Docket No. 02-60, at 18 (filed Jan. 28, 2010).

[244] *See, e.g.,* Internet2 Group NBP Public Notice #17 at 13 ("Large health care systems frequently centralize their data centers in off-site locations. Yet data centers are being declared ineligible to receive support to connect them to their health users. The [purpose of the Pilot Program] is to build a network that will transmit electronic health information (i.e. Electronic Health Records, digital imaging, telemedicine, etc) from data centers to sites on the network. Therefore, a network cannot function without sites having electronic access to data centers on the network."); *see also* Internet2 June 25, 2010 *Ex Parte* Letter, at 4.

[245] *See, e.g., CMS Revs Up Data Centers, Awards $228M in Contracts to CDS*, HomeCare, May 5, 2007, *available at* http://homecaremag.com/news/cms-data-centers-cds-contract/ (reporting on CMS' plan to modernize its operations and lower costs by establishing enterprise data centers); Johnathon Allen, *Johns Hopkins Medical Develops Dual-Site Data Center to Support Fast Growing Digital Clinical System*, Tradeline, Apr. 8, 2009, *available at* http://www.tradelineinc.com/reports/16357D11-C699-7643-A7FC9C1DD4D1A662# (discussing the staggering amount of data that must be archived with patient records and delivered over high-speed networks that (continued….)

provide the same functions as on-site entities, but happen to be located off-site. Like off-site administrative offices, we therefore propose that off-site data centers that are owned or controlled by eligible health care providers should receive rural health care support as a part of the eligible health care provider under section 254(h)(7)(B).[246]

Offsite data centers are data centers and should be included in the broadband program.

118. As with the case of administrative offices, we note that off-site data centers can serve several purposes, some of which may be unrelated to health care or performed on behalf of ineligible entities. Many private companies, for example, offer off-site data center services that may be purchased by any member of the public.[247] In those cases, it is possible that some of the entities served are not eligible health care providers. As such, we propose to allow eligible health care providers to seek support only for off-site data centers in which the eligible health care provider has at least a 51 percent ownership or controlling interest.[248] We also seek comment on whether an off-site administrative office that is less than 51 percent owned or controlled by an eligible health care provider would be eligible for support on a pro-rated basis or should be excluded from support altogether. Additionally, because of the possibility that off-site data centers may provide services unrelated to health care or on behalf of ineligible entities, we propose to require eligible health care providers seeking support for off-site data centers to certify that the data center is used primarily for performing services that are integral to the provision of health care.[249] We seek comment on these proposals.

D. Skilled Nursing Facilities

119. We propose that non-profit skilled nursing facilities be considered eligible for rural health care support under the category of "not-for-profit hospitals."[250] Skilled nursing facilities provide some of the same post-acute services that are traditionally provided at hospitals, such as the management, observation, and evaluation of patient care.[251] As noted by the National Broadband Plan, under the changing technological landscape of rural health care, services are no longer clearly divided into traditional delivery models.[252] The CDC reports that the number of acute care facilities has decreased, and services traditionally provided in hospital settings are increasingly performed at non-acute and post-

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are critical to day-to-day operations of a modern medical center); Press Release, Cisco, Healthcare Organization Lowers Costs, Increases Availability (Mar. 2010), *available at* http://www.cisco.com/en/US/solutions/collateral/ns340/ns517/ns224/case_study_c36_595476.html (pointing out that Exempla Healthcare, a non-profit community-based organization was forced to build an additional off-site data center to deal with increased storage, and network capacity requirements).

[246] *See* Appendix A, 47 C.F.R. § 54.601(c).

[247] *See, e.g.*, The Planet, Data Centers, http://www.theplanet.com/data-centers/ (last visited June 24, 2010); CoreSite: Data Centers, Collocation, Peering, http://www.coresite.com/ (last visited June 24, 2010).

[248] *See* Appendix A, 47 C.F.R. § 54.601(c)(1). All data centers, both off-site and on-campus, must be owned by or affiliated with a non-profit or public eligible health care provider to be eligible for support. *See* 47 U.S.C. §§ 254(h)(1)(A), (h)(2)(A).

[249] *See* Appendix A, 47 C.F.R. § 54.601(c)(2).

[250] *See id.* § 54.601(d).

[251] Dept. of Health & Human Servs., Ctrs. for Medicare and Medicaid Servs., "Medicare Coverage of Skilled Nursing Facility Care," at 1 (2007), *available at* http://www.medicare.gov/publications/pubs/pdf/10153.pdf.

[252] *See* National Broadband Plan at 200-02; *see also* Internet2 June 25, 2010 *Ex Parte* Letter, at 4.

acute care facilities.[253] Skilled nursing facilities are an example of this trend.[254] Specifically, due to advances in telemedicine, in many instances patients no longer need to be transferred to hospitals for treatment because they can receive the same or similar treatment at a skilled nursing facility.[255]

120. The evolution of skilled nursing facilities as a recognized provider of post acute services is demonstrated by their coverage under Medicare. Medicare covers skilled nursing care when certain conditions are met: (1) The patient enters the skilled nursing facility shortly following a hospital stay of three consecutive days or more; (2) a doctor has ordered skilled nursing care which requires the skills of professional personnel such as nurses, physical therapists, occupational therapists or speech pathologists or audiologists; and (3) the patient needs skilled care on a daily basis on an in-patient basis.[256] We propose that facilities that provide skilled nursing services that are covered by Medicare should be eligible for support as a "not-for-profit hospital" under section 254(h)(7)(B) of the Act.

121. We recognize, however, that certain facilities (such as nursing homes) may provide both skilled nursing services and custodial services. Unlike skilled nursing services, custodial services involve assisting patients with daily activities such as eating, clothing, bathing, etc., and are not services covered by Medicare.[257] It is therefore important that rural health care support be available only to those facilities with a sufficient volume of skilled nursing patients. We seek comment on how to distinguish a facility that is primarily engaged in providing skilled nursing services as opposed to facilities that are primarily engaged in providing custodial care. For example, should we allow a facility to receive support as a skilled nursing facility if: (1) it has a certificate of need to provide skilled nursing services for at least 51 percent of its total beds; [258] or (2) at least 51 percent of the facility's revenues for the last twelve months are from skilled nursing services? Alternatively, should designation as a skilled nursing facility be based on the number of patients at a facility that received skilled nursing services over a three-month period of time compared to the total number of patients at the facility for the same period of time? We invite comment on this issue. Additionally, we seek comment on whether support should be limited to skilled nursing facilities that maintain an average patient stay not exceeding 20 consecutive days, which is consistent with the Centers for Medicare and Medicaid Services (CMS) restrictions on reimbursement for skilled nursing care.[259]

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[253] William R. Jarvis, "Infection Control & Changing Health Care Delivery Systems," 7 Emerging Infectious Diseases 170 (2001), *available at* http://www.cdc.gov/ncidod/eid/vol7no2/jarvis.htm.

[254] Dept. of Health & Human Servs., Ctrs. for Medicare and Medicaid Servs., "Medicare Coverage of Skilled Nursing Facility Care," at 1 (2007), *available at* http://www.medicare.gov/publications/pubs/pdf/10153.pdf.

[255] Lanis L. Hicks, et al., "Using Telemedicine to Avoid Transfer of Rural Emergency Department Patients," 17 Journal of Rural Health 150, at 220-228 (2001).

[256] Dept. of Health & Human Servs., Ctrs. for Medicare and Medicaid Servs., "Medicare Coverage of Skilled Nursing Facility Care," at 13 (2007), *available at* http://www.medicare.gov/publications/pubs/pdf/10153.pdf.

[257] *Id.* at 1, 3.

[258] The Certificate of Need program "is a regulatory process that requires certain health care providers to obtain state approval before offering certain new or expanded services." Florida Agency for Health Care Administration, Certificate of Need (CON) Program Overview, http://ahca.myflorida.com/mchq/CON_FA/index.shtml (last visited June 24, 2010). "The CON process is intended to help ensure that new services proposed by health care providers are needed for quality patient care within a particular region or community." *Id.*

[259] The Medicare program will cover the full cost of skilled nursing services for up to 20 days. Dept. of Health & Human Servs., Ctrs. for Medicare and Medicaid Servs., "Medicare Coverage of Skilled Nursing Facility Care," at 3 (2007), *available at* http://www.medicare.gov/publications/pubs/pdf/10153.pdf. Patients requiring skilled nursing (continued….)

E. Renal Dialysis Centers and Facilities

122. Consistent with the National Broadband Plan's suggestion to examine funding those institutions that have become integral in the delivery of health care, we propose to indicate that non-profit renal dialysis centers and non-profit renal dialysis facilities may receive support as eligible health care providers under the category of not-for-profit hospitals.[260] As defined by the CMS, a renal dialysis center is "a hospital unit that is approved to furnish the full spectrum of diagnostic, therapeutic, and rehabilitative services required for the care of End Stage Renal Disease (ESRD) dialysis patients (including inpatient dialysis furnished directly or under arrangement and outpatient dialysis)."[261] More limited services are provided by a renal dialysis facility, which is "a unit that is approved to furnish dialysis service(s) directly to ESRD patients."[262]

123. Acute care provided by renal dialysis centers and renal dialysis facilities is consistent with the general schema of services traditionally provided by hospitals. We also believe that inclusion of renal dialysis centers and renal dialysis facilities is consistent with CMS's classification of these facilities.[263] Additionally, we propose that a renal dialysis center or renal dialysis facility seeking rural health care support should be required to certify that, over the 12-month period preceding the date of application for support, the facility provided life-preserving ESRD treatment to at least 51 percent of its patients. We seek comment on the above proposals.

VI. ANNUAL CAPS AND PRIORITIZATION RULES

124. The aggregate annual cap for the Rural Health Care Support Mechanism is $400 million.[264] Given that current demand under the existing program has historically been less than $70 million, we see no need to revisit the overall funding cap. We do, however, believe it would be prudent to set an initial cap for the proposed health infrastructure program (within the overall $400 million cap) to manage the portion of funding that supports new deployment as opposed to ongoing services. We propose to allocate up to $100 million for infrastructure projects under the health infrastructure program,[265] leaving at least $300 million available annually for the telecommunications program and the health broadband services program. In the existing Pilot Program, the Commission made funding commitments to 62 infrastructure projects in 42 states, which represented $139 million per year.[266] As discussed above, funding a smaller number of infrastructure projects on an annual basis, at least as we initially implement the new program, would be more administratively workable, and therefore we propose a cap of $100 million per year for infrastructure projects. As we gain more experience, the Commission can re-evaluate and make subsequent changes to the program as appropriate.

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services for 21 to 100 days are responsible for a daily copayment, and Medicare does not cover any costs for skilled nursing care beyond 100 days. *Id.*

[260] *See* Appendix A, 47 C.F.R. § 54.601(e).

[261] *See* U.S. Dept. of Health and Human Servs., Ctrs. for Medicare and Medicaid Servs., End Stage Renal Disease Facility Providers, http://www.cms.gov/CertificationandComplianc/05_DialysisProviders.asp (last visited June 24, 2010). CMS defines ESRD, in relevant part, as "that stage of renal impairment that…requires a regular course of dialysis…to maintain life." *Id.*

[262] *Id.*

[263] *See id.*

[264] 47 C.F.R. § 54.623(a).

[265] *See* Appendix A, 47 C.F.R. § 54.675(a).

[266] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20370, para. 22.

125. We seek comment on this proposal to set $100 million cap for the health infrastructure program and $300 million for the telecommunications program and the health broadband services program. Because there are limited funds available for both the health broadband services program and the health infrastructure program, we also seek comment and proposals on what funding priority rules we should apply in those instances where funding requests exceed the amount of funds available in a particular funding year.

The purpose of the program would be better carried out by allocating 100% of the 400 million to the Health Broadband Services program. Funding the health care providers and letting them purchase or lease broadband network from existing service providers will be more cost effective and efficient than the infrastructure program. The schools and libraries program has succeeded very well in deploying broadband infrastructure. USAC should not be involved in project selection or administration. The FCC pilot program accepted applications in 5/07 and we started construction June, 2010. It took three years to move thru the process with only 5 hospitals involved.

126. Initially, we do not believe that the funding requests in the health broadband services program will exceed the amount of available funds. However, in the event that USAC receives funding requests that exceed available funds, it would be necessary to allocate funding. One approach would be to apply a pro-rata deduction among all eligible health care providers, thereby reducing the amount that each health care provider receives for such funding year. Another approach would be to fund eligible health care providers based on their Health Professional Shortage Area (HPSA) score for primary care as designated by HHS.[267] For example, health care providers in areas with the highest possible HPSA score (presently, 26) would receive support first, and health care providers with scores below the highest HPSA score would receive support in descending order, until available funds are exhausted. We seek comments on alternative proposals to prioritize funding for the health broadband services program if funding limits are reached.

127. For the health infrastructure program, we seek comments on how to prioritize funding in the event projects apply and qualify for funding in any funding year that collectively exceed the proposed $100 million cap. For example, one method for prioritizing projects could be based on the following factors: (1) total number of rural health care providers in the proposed network; (2) total number of health care providers (both urban and rural) in the proposed network, and (3) the combined HPSA scores for all urban health care providers in the proposed network. Under this method, USAC would give first priority to projects that have the highest number of eligible rural health care providers, not to exceed $100 million in the aggregate and second priority to projects that have the highest number of health care providers (urban and rural). In the event projects have the same number of eligible health care providers in their proposed networks, they would be sub-ranked according to the number of rural health care providers in the proposed network. If further sub-ranking is required, projects would be ranked according to the aggregate HPSA scores of the urban health care providers in the proposed network. Other ways to prioritize projects could be to consider the relative size of the patient base or population density of the area served by the health care providers, or to consider measures such as the cost per served population or other factors that demonstrate the most cost effective use of funds. We seek comment on these or other methods that commenters may suggest for prioritizing project funding. Commenters recommending the use of one prioritization method over another should explain the basis for such prioritization, and explain how the prioritization system would work.

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[267] *See* Dep't of Health and Human Servs., Nat'l Health Resources and Servs. Admin, Shortage Designation: HPSAs, MUAs & MUPs, http://bhpr.hrsa.gov/shortage/index.htm (last visited June 24, 2010).

Rural Health care providers should receive priority because that is where broadband is most needed and that is where broadband is most scarce. Cost per rural health care provider should be a consideration. Additionally an efficiency measure such as cost per patient served is desired.

One readily available source of information to prioritize funding requests would be to use HPSA scores. HPSA scores rank urban and rural geographic areas based on the shortage of primary care health professionals.[268] HPSA designations and scores are used across the federal government to allocate resources, with more than 30 federal programs providing benefits based on HPSA designations or scoring.[269] Geographic areas are scored on a scale of 0 to 26, with 26 representing the highest professional shortage area. Scores are provided for three categories of providers: Primary Care, Mental Health and Dental.[270] The factors considered by HHS for calculating HPSA scores for a geographic area include population-to-provider ratios, population poverty rates, and travel time and distance to the nearest source of care.[271] Additional factors that influence the score include infant mortality rates and low birth weight data.[272] We seek comment on the use of HPSA scores as a component of any prioritization considerations..

128. We also seek comment on whether there are other publicly available criteria, in addition to HPSA scores, that could be used to prioritize funding. Alternatively, should we collect additional information from applicants that could be used to prioritize applications, and if so, what information should be collected in a standardized fashion for such purpose? Commenters should discuss the burden or additional reporting obligations that would be imposed on health care providers in compiling and submitting such information as part of their applications for funding.

129. We also seek comment generally on whether we should set aside some amount of funding each year that could be awarded through a competitive process that takes into account factors other than those proposed above. For instance, should the Commission set aside a defined amount of the annual $400 million funding for recipients that can demonstrate innovative uses of broadband connectivity to meet health care needs in a community?

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[268] *See id.*

[269] Gov't Accountability Office, "Health Professional Shortage Areas: Problems Remain with Primary Care Shortage Area Designation System," at 24 (2006) (GAO HPSA Report), *available at* http://www.gao.gov/new.items/d0784.pdf. For example, the National Health Service Corps Loan Repayment program recruits fully-trained primary medical, dental and mental health professionals to work in approved community-based sites in designated HPSAs. Dep't of Health and Human Servs., Nat'l Health Resources and Servs. Admin, Loan Repayment, http://nhsc.hrsa.gov/loanrepayment/ (last visited June 24, 2010). Physicians working in primary medical care and mental health HPSAs receive bonus payments for services provided under Medicare. Dep't of Health and Human Servs., Ctrs. For Medicare & Medicaid Servs., HPSA/PSA Physician Bonuses Overview, http://www.cms.hhs.gov/HPSAPSAPhysicianBonuses/ (last visited June 24, 2010). The Exchange Visitor Program, run by HHS, waives the two-year foreign residency requirement for J-1 visa physicians agreeing to deliver health care services for three years in mental health or primary care HPSAs. Dep't of Health and Human Servs., Exchange Visitor Program, http://www.globalhealth.gov/exchangevisitorprogram/ (last visited June 24, 2010). Rural Health Clinics in geographic HPSAs are eligible for special Medicare and Medicaid reimbursement. Dep't of Health and Human Servs., Rural Assistance Ctr., Rural Health Clinics, http://www.raconline.org/info_guides/clinics/rhc.php (last visited June 24, 2010).

[270] *Criteria for Determining Priorities Among Health Professional Shortage Areas*, 68 Fed. Reg. 32531, 32532 (May 30, 2003).

[271] *Id.*

[272] *Id.* Detailed ranking and weighting methodology is found in 42 C.F.R. pt. 5, Apps. A-C.

No, the amount of funding is not enough.

Offset Rule

130. The Commission has historically required contributors to federal universal service support mechanisms to treat the support received for providing services under the Rural Health Care Support Mechanism as an offset to the amount they must otherwise contribute to the universal service fund.[273] When the Commission adopted this requirement, it was construing the statutory language that authorized both the rural health care mechanism and the schools and libraries mechanism. However, the Commission ultimately implemented the offset rule as a mandatory requirement only for the Rural Health Care Support Mechanism and not for the schools and libraries mechanism.[274] Although the Commission concluded it had authority to allow direct reimbursement, it considered a mandatory offset rule for the Rural Health Care Support Mechanism to be "less vulnerable to manipulation and more easily administered and monitored."[275]

131. While the original intent of the offset rule was to prevent fraud, waste and abuse, it may no longer make sense today, particularly in light of the proposed reforms in this NPRM. The Commission has recognized that the offset rule can create inequities and inefficiencies,[276] and has modified its applicability in the past. In establishing the Pilot Program, the Commission determined that the offset rule should not apply to that program because both telecommunications carriers and non-telecommunications carriers were eligible to provide services under the program. The Commission determined it was in the public interest to distribute support to Pilot Program service providers in a neutral fashion, where neither the telecommunications carriers nor the non-telecommunications carrier would be subject to the offset rule.[277] We recognize that the offset rule could create administrative

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[273] *See* 47 C.F.R. § 54.611; *Universal Service First Report and Order*, 12 FCC Rcd at 9154–55, para. 734.

[274] *See Universal Service First Report and Order*, 12 FCC Rcd at 9154–55, para. 734. *Compare* 47 C.F.R. § 54.515 (permitting carriers providing services under the schools and libraries support mechanism to elect either an offset or a direct reimbursement), *with* 47 C.F.R. § 54.611(a) (requiring carriers to receive support in the form of an offset).

[275] *Universal Service First Report and Order*, 12 FCC Rcd at 9156, para. 737 (*citing Federal State-Joint Board on Universal Service*, CC Docket No. 96-45, Recommended Decision, 12 FCC Rcd 87, 446 (1996)).

[276] Commenters note that rural health care providers are disadvantaged by the offset rule, as they are billed for the full costs of service by the carrier, but then have to wait for reimbursement. *See, e.g.*, Minnesota Health Dept. NBP Public Notice #17 Comments at 4; Rural Wisconsin Network NBP Public Notice #17 Comments at 7-8. In the Pilot Program, however, commenters indicate that this issue is resolved, because vendors receive direct reimbursement from USAC. Rural Wisconsin Network NBP Public Notice #17 Comments at 7-8.

[277] *2007 Pilot Program Selection Order*, 22 FCC Rcd at 20419, paras. 114-16. In the *Unicom Order* and the *TeleQuality* Order, the Wireline Bureau waived the offset rule for two small carriers participating in the Rural Health Mechanism, finding that it would be more equitable to reimburse the carriers directly to best fulfill the intent of the Act and the policies of the Rural Health Care Support Mechanism. *See Request for Waiver of Section 54.611 of the Commission's Rules Telequality Communications, Inc. San Antonio, Texas; Rural Health Care Universal Service Support Mechanism*, WC Docket No. 02-60, Order, 24 FCC Rcd 10716, (Wireline Comp. Bur. 2009) (*TeleQuality Order*) (authorizing reimbursement on a bi-monthly basis); *Request for Waiver of Section 54.611 of the Commission's Rules Unicom, Inc. Anchorage, Alaska; Rural Health Care Universal Service Support Mechanism*, WC Docket No. 02-60, Order, 21 FCC Rcd at 11243 (Wireline Comp. Bur. 2006) (*Unicom Order*) (authorizing reimbursement on a quarterly basis).

difficulties in the future, if we authorize support for services provided by entities that do not contribute to the universal service fund.[278]

132. Accordingly, we propose to eliminate the offset rule for participants in the health broadband services program, the telecommunications program, and the health infrastructure program and replace it with a rule allowing service providers in the program to receive monies directly from USAC.[279] We seek comment on this proposal. Notably, the schools and libraries mechanism has an optional offset method, yet only a small percentage of service providers elect to offset their obligation against their contribution to the universal service fund. We seek comment on whether to retain the offset rule as an option for contributors that wish to utilize an offset in the context of the new programs proposed in this NPRM. We also seek comment on whether the reimbursement mechanism should be unified across all of the new rural health care programs.

VII. PROTECTING AGAINST WASTE, FRAUD, AND ABUSE

133. We propose that participants in the health infrastructure program and the health broadband services program should continue to be subject to any currently applicable rules pertaining to audits, recordkeeping, and duplicate support. We seek comment on the proposals described below.

134. With respect to audits, we propose that participants in both programs will be subject to random compliance audits to ensure compliance with program rules and orders.[280] We also propose that program participants and service providers will be required to maintain certain documentation related to the purchase and delivery of services funded by the Rural Health Care Support Mechanism, and will be required to produce those records upon request.[281] However, we propose to make the following clarifications to our recordkeeping rules: First, we propose to clarify that the documents to be retained by participants and service providers under the program should include all records related to the participant's application for, receipt of, and delivery of discounted services. Second, we propose to amend the Commission's existing rules to mandate that service providers, upon request, produce the records kept pursuant to the Commission's recordkeeping requirement.

135. Finally, we propose that health care providers may not receive funds for the same services under the health broadband services program and the telecommunications program. Similarly, we propose to prohibit participants from receiving funds for the same services under the Rural Health Care Support Mechanism and any other universal service program (i.e., the E-rate program, the High Cost program, and the Low Income program), or from any other federal program, including, for example, federal grants, awards, or loans.[282] We seek comment on these proposals.

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[278] For example, the health infrastructure program could potentially fund non-telecommunications providers who are incapable of receiving an offset because they do not contribute to the universal service fund. The health broadband services program could potentially fund unlit fiber provided by a local governmental agency.

[279] *See* Appendix A, 47 C.F.R. § 54.611.

[280] *See* 47 C.F.R. § 54.619(c).

[281] *See id.* § 54.619(a)-(b), (d).

[282] *See 2007 Pilot Program Selection Order*, 22 FCC Rcd at 20422, para. 123. This would not, however, restrict the ability of participants in the health infrastructure program to seek their 15% match from eligible sources. *See supra* para. 44.

VIII. DATA GATHERING AND PERFORMANCE MEASURES

A. Background

136. The Commission is committed to ensuring that the Rural Health Care Support Mechanism funds are used to support broadband services and infrastructure that are useful to medical facilities, health care providers, and patients. It is critical that our efforts focus on enhancing universal service for health care providers and that support is properly targeted to achieve defined goals. We seek comment on performance measures that offer objective tests of how the support is used. We also seek comment on what data should be collected to track our progress as a country in making broadband available to eligible health care providers and how we can monitor and evaluate the success of the rural health care program.

B. "Meaningful Use" Criteria

137. The National Broadband Plan recommended that the Commission align the Rural Health Care Support Mechanism with other federal government criteria intended to measure the efficient use of health IT, such as the "meaningful use" criteria being developed by HHS.[283] Meaningful use criteria are intended to encourage physicians and hospitals to use broadband services and infrastructure in a way that improves the Nation's health care delivery system. HHS is still developing and considering regulations to implement meaningful use requirements for electronic health records, but is expected to adopt final rules later this year. Initially, under the HHS requirements, health care providers will be given financial incentives if they meet the HHS definition of meaningful use of electronic health records. In 2015, full Medicare and Medicaid support will be conditioned on compliance with meaningful use requirements, and health care providers will receive reduced Medicare or Medicaid reimbursement if they do not meet the requirements of meaningful use.

138. The National Broadband Plan suggested that the Commission should condition receipt of rural health care support on providers' compliance with the HHS meaningful use requirements after a certain period of time, such as three years. We recognize that any new compliance obligations may impose burdens on health care providers, and that these burdens may be more significant for rural providers. At the same time, the goals reflected in the HHS meaningful use requirements are important, and there may be benefits both to providers and the federal government in aligning policies to the extent feasible. We seek comment on whether and how the Commission could align its performance measures with HHS's meaningful use criteria. We also seek comment on whether there are other federal criteria that we should consider adopting.

139. We seek comment on whether, assuming full implementation of meaningful use requirements in 2015, recipients of funding from the Rural Health Care Support Mechanism should be required to document their compliance with meaningful use requirements as a condition of receiving support. What would be the practical and operational implications of such a requirement? We note that,

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[283] *See* National Broadband Plan at 216 (NBP Recommendation 10.9). The Recovery Act provides Medicare and Medicaid incentive payments to eligible providers, such as physicians and hospitals, to increase the adoption of electronic health records (EHRs). To receive the incentive payments, providers must demonstrate "meaningful use" of a certified EHR. Building upon the work done by the HIT Policy Committee, the Centers for Medicare & Medicaid Services (CMS), along with the Office of the National Coordinator for Health Information Technology (ONC), are developing a proposed rule that provides greater detail on the incentive program and proposes a definition of meaningful use. *See* Press Release, HHS, Important First Step to Expand the Use of Information Technology to Improve the Health and Care of Every American (June 16, 2009), *available at* http://www.hhs.gov/news/ press/2009pres/06/20090616a.html.

under HHS' draft proposed regulations, meaningful use will be certified at the individual physician level (with the exception of hospitals), while our program provides support to a variety of eligible entities that do not necessarily include physician offices (such as post-secondary educational institutions offering health care instruction, local health departments, community health centers, community mental health centers and rural health clinics). If the Commission were to adopt a meaningful use requirement, how should we evaluate whether the health care entity has satisfied meaningful use? We also seek comment on what should be the remedy for failure to meet such a requirement, if adopted? For instance, if a health care provider is required to comply with HHS meaningful use regulations as of 2015, should the Commission reduce or eliminate rural health care support if the entity has not achieved the HHS meaningful use standard by 2018?

C. Other Performance Measures

140. To measure the impact of our universal service programs, it is important for participants in the health broadband services program and the health infrastructure program to have measurable performance goals to demonstrate how they are using the federal support to take advantage of broadband capabilities for medical services or support. The Commission therefore seeks comment on what generally-applicable performance criteria the Commission should adopt. For example, the Commission could adopt criteria regarding consistency or frequency of use of broadband services for record-keeping, remote monitoring, or remote consultation on complex or non-routine medical issues. We seek comment on these and other possible criteria by which to measure performance.[284] We also seek comment on whether the Commission should employ existing industry standards or metrics, such as the American Telemedicine Association's Standards and Guidelines for Teledermatology, Telemental Health and Telepathology,[285] as part of the Commission's performance measure criteria. Are there other existing metrics that would be suitable for measuring accomplishments related to the Rural Health Care Support Mechanism?

141. We also recognize there are a wide variety of eligible entities that may obtain support from the proposed health broadband services program and the health infrastructure program, and therefore there may be a need for some flexibility in performance measures to reflect the many potential uses and varying needs of program beneficiaries. Therefore, we seek comment on whether to require each program beneficiary to identify more specific performance measures. For example, the Commission might require all beneficiaries to report on progress of bringing services online, and the individual recipient would identify a specific timeline and report on whether it met the timeline. The Commission might require beneficiaries to identify particular goals, such as increasing network speed or reliability, and the beneficiary would identify the specific goal and report on whether the goal was accomplished. We seek comment on this proposal. We seek comment on how this process should work. For example,

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[284] Several commenters responding to the NBP Public Notice #17 suggest performance measures that could be used by the Commission to measure the impact of the rural health care program. *See, e.g.*, Geisinger NBP Public Notice #17 Comments at 2; WellDoc NBP Public Notice #17 Comments at 7; Penn. Mountains Healthcare et al. NBP Public Notice #17 Comments at 7.

[285] The Standards and Guidelines Committee of the American Telemedicine Association (ATA), "provides guidance in the following: identifying, overseeing, and assisting work groups that would be charged with developing individual standards and guidelines and recommending the relative priority for each specific area to the Board of Directors, reviewing existing telemedicine/telehealth standards documents that have been developed by other groups and acting on this information as appropriate, maintaining documents of telemedicine/telehealth terminology, guidance and policies that provide instructions and a framework for incorporation into specific standards that will be developed by work groups." *See* http://www.americantelemed.org/i4a/pages/index.cfm?pageid=3311 (last visited June 24, 2010).

we might require a beneficiary to submit specific performance measures within 60 days of notification that its application for support has been approved. We also seek comment on whether the Commission should have the opportunity to reject or propose modifications to the individualized performance measurements that beneficiaries submit.

142. We seek comment on the frequency of assessing performance and how often the beneficiary should report on performance. For example, should performance measures be made annually or more frequently? Should ongoing support be conditioned wholly or partly on demonstrated satisfaction of performance standards? We also seek comment on what, if any, additional information the report should contain, such as an explanation for any failure to meet performance goals or the opportunity to propose revisions to the performance measurements.

D. Data Gathering and Analysis

143. *Health Care Broadband Status Report and Testing Mechanisms*. The National Broadband Plan recommended that the Commission periodically publish a health care broadband status report that discusses the state of health care broadband connectivity, reviews health IT industry trends, describes government programs and makes reform recommendations.[286] Further, the National Broadband Plan suggested that the Commission should work in conjunction with HHS (which has experience in evaluating the effectiveness of clinical programs) to measure and assess the impact that the health broadband services program and the health infrastructure program have on health care and health IT.[287] For example, the National Broadband Plan suggested that the Commission could conduct the following tests:

- Determine how health care providers that receive Rural Health Care Support for broadband, differ in the utilization of e-care from health care providers that do not receive program support;
- Assess the impact of changing the level of broadband subsidies to a targeted community and determine if there is an increased use of broadband and health IT as a result of such subsidies;
- Explore whether expanding the Rural Health Care Support Mechanism to include funding for training would lead to better broadband utilization and improved care; and
- Evaluate the impact the Rural Health Care Support Mechanism is having on vulnerable populations, such as the elderly, racial and ethnic minorities, or low-income rural and urban communities, to understand whether targeted efforts would be more effective.[288]

144. The National Broadband Plan suggested that in order to ensure sufficient support for these tests, the Commission should allocate a portion of the Rural Health Care Support Mechanism (*e.g.*, $5 million) for a testing program that funds innovative ideas for evaluating the existing broadband efforts or improve upon them in the future.[289] We seek comment on the recommendation to allocate a portion of

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[286] National Broadband Plan at 217 (NBP Recommendation 10.11).

[287] *Id.*

[288] *Id.*

[289] *Id.*

the rural health care funding for running trials of and evaluating innovative concepts, and if so, what amount should be set aside for that purpose?

145. We seek comment on whether and how to develop the periodic broadband status reports and testing mechanisms suggested by the National Broadband Plan. In particular, we are interested in suggestions for how to evaluate objectively the impact of the Rural Health Care Support Mechanism and how we can direct support to make greatest use of limited resources. We also seek comment on whether to create a working group to develop recommendations for the direction of the Rural Health Care Support Mechanism, and if so, who should participate in such a group and how should it be structured?

146. We also propose to collect data that will help the Commission analyze how the support is being used, such as requiring beneficiaries to annually identify the speed of the connections supported by the Rural Health Care Support Mechanism and the type and frequency of utilization of telehealth or telemedicine applications as a result of broadband access.[290] This data could assist the Commission in its ongoing oversight over this program and help the Commission determine how beneficiaries are using broadband services to improve the provision of medical services or support. We seek comment on this proposal. We also seek comment on the services or applications that should be included.

IX. PROCEDURAL MATTERS

147. The proposed rules are attached as Appendix A. In addition to the changes discussed above, the proposed rules include non-substantive changes to the rules applicable to the telecommunications program. We seek comment on such changes.

A. Initial Paperwork Reduction Act Analysis

148. This document contains proposed new information collection requirements. The Commission, as part of its continuing effort to reduce paperwork burdens, invites the general public and the Office of Management and Budget (OMB) to comment on the information collection requirements contained in this document, as required by the Paperwork Reduction Act of 1995.[291] In addition, pursuant to the Small Business Paperwork Relief Act of 2002,[292] we seek specific comment on how we might "further reduce the information collection burden for small business concerns with fewer than 25 employees."[293]

B. Initial Regulatory Flexibility Analysis

149. As required by the Regulatory Flexibility Act of 1980, the Commission has prepared an Initial Regulatory Flexibility Analysis (IRFA) of the possible significant economic impact on small entities of the policies and rules addressed in this document.[294] The IRFA is set forth in Appendix C. Written public comments are requested on this IRFA. Comments must be identified as responses to the IRFA and must be filed by the deadlines for comments on the Notice provided on or before the dates indicated on the first page of this Notice.

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[290] *See* Appendix A, 47 C.F.R. § 54.677.

[291] Pub. L. No. 104-13.

[292] Pub. L. No. 107-198.

[293] *See* 44 U.S.C. § 3506(c)(4).

[294] *See* 5 U.S.C. § 603.

C. *Ex Parte* Presentations

150. The rulemaking this Notice initiates shall be treated as a "permit-but-disclose" proceeding in accordance with the Commission's *ex parte* rules.[295] Persons making oral *ex parte* presentations are reminded that memoranda summarizing the presentations must contain summaries of the substance of the presentations and not merely a listing of the subjects discussed. More than a one- or two-sentence description of the views and arguments presented generally is required.[296] Other requirements pertaining to oral and written presentations are set forth in section 1.1206(b) of the Commission's rules.[297]

D. Comment Filing Procedures

151. We invite comment on the issues and questions set forth in the NPRM and IRFA contained herein. Pursuant to sections 1.415 and 1.419 of the Commission's rules,[298] interested parties may file comments on this NPRM within 30 days after publication in the Federal Register and may file reply comments within 45 days after publication in the Federal Register. **All filings related to this NPRM must refer to WC Docket No. 02-60.** Comments and reply comments may be filed using: (1) the Commission's Electronic Comment Filing System (ECFS), (2) the Federal Government's eRulemaking Portal, or (3) by filing paper copies. *See Electronic Filing of Documents in Rulemaking Proceedings*, 63 FR 24121 (1998).

- *Electronic Filers:* Comments may be filed electronically using the Internet by accessing the ECFS: http://fjallfoss.fcc.gov/ecfs2/ or the Federal eRulemaking Portal: http://www.regulations.gov.

- *Paper Filers:* Parties who choose to file by paper must file an original and four copies of each filing. If more than one docket or rulemaking number appears in the caption of this proceeding, filers must submit two additional copies for each additional docket or rulemaking number. Filings can be sent by hand or messenger delivery, by commercial overnight courier, or by first-class or overnight U.S. Postal Service mail. All filings must be addressed to the Commission's Secretary, Office of the Secretary, Federal Communications Commission.

    - All hand-delivered or messenger-delivered paper filings for the Commission's Secretary must be delivered to FCC Headquarters at 445 12th St., SW, Room TW-A325, Washington, DC 20554. The filing hours are 8:00 a.m. to 7:00 p.m. All hand deliveries must be held together with rubber bands or fasteners. Any envelopes must be disposed of before entering the building.

    - Commercial overnight mail (other than U.S. Postal Service Express Mail and Priority Mail) must be sent to 9300 East Hampton Drive, Capitol Heights, MD 20743. U.S. Postal Service first-class, Express, and Priority mail must be addressed to 445 12th Street, SW, Washington DC 20554.

    - In addition, one copy of each paper filing must be sent to each of the following: (i) The Commission's duplicating contractor, Best Copy and Printing, Inc., 445 12th Street, SW.,

[295] 47 C.F.R. §§ 1.1200-1.1216.

[296] 47 C.F.R. § 1.1206(b)(2).

[297] *Id.*§ 1.1206(b).

[298] 47 C.F.R. §§ 1.415, 1.419.

Room CY–B402, Washington, DC 20554; Web site: www.bcpiweb.com; phone: 1–800–378–3160; (ii) Ernesto Beckford, Telecommunications, Telecommunications Access Policy Division, Wireline Competition Bureau, 445 12th Street, SW., Room 5–A312, Washington, DC 20554; e-mail: Ernesto.Beckford@fcc.gov; and (iii) Charles Tyler, Telecommunications, Access Policy Division, Wireline Competition Bureau, 445 12th Street, SW., Room 5–A452, Washington, DC 20554, e-main: Charles.Tyler@fcc.gov.

People with Disabilities: To request materials in accessible formats for people with disabilities (braille, large print, electronic files, audio format), send an e-mail to fcc504@fcc.gov or call the Consumer & Governmental Affairs Bureau at 202-418-0530 (voice), 202-418-0432 (tty).

Filings and comments are also available for public inspection and copying during regular business hours at the FCC Reference Information Center, Portals II, 445 12th Street, S.W., Room CY-A257, Washington, D.C., 20554. Copies may also be purchased from the Commission's duplicating contractor, BCPI, 445 12th Street, S.W., Room CY-B402, Washington, D.C. 20554. Customers may contact BCPI through its website: www.bcpiweb.com, by e-mail at fcc@bcpiweb.com, by telephone at (202) 488-5300 or (800) 378-3160, or by facsimile at (202) 488-5563.

152. Comments and reply comments must include a short and concise summary of the substantive arguments raised in the pleading. Comments and reply comments must also comply with section 1.49 and all other applicable sections of the Commission's rules.[299] We direct all interested parties to include the name of the filing party and the date of the filing on each page of their comments and reply comments. All parties are encouraged to utilize a table of contents, regardless of the length of their submission. We also strongly encourage parties to track the organization set forth in the NPRM in order to facilitate our internal review process.

153. For further information, contact Ernesto Beckford at (202) 418-1523 in the Telecommunications Access Policy Division, Wireline Competition Bureau.

X. ORDERING CLAUSES

154. Accordingly, IT IS ORDERED that, pursuant to sections 1, 2, 4(i)–(j), 201(b), 254, 257, 303(r), and 503 of the Communications Act of 1934, as amended, and section 706 of the Telecommunications Act of 1996, as amended, 47 U.S.C. §§ 151, 152, 154(i)–(j), 201(b), 254, 257, 303(r), 503, 1302, this Notice of Proposed Rulemaking IS ADOPTED.

[299] *See* 47 C.F.R. § 1.49.

155. IT IS FURTHER ORDERED that the Commission's Consumer and Governmental Affairs Bureau, Reference Information Center, SHALL SEND a copy of this Notice of Proposed Rulemaking, including the Initial Regulatory Flexibility Analysis, to the Chief Counsel for Advocacy of the Small Business Administration.

FEDERAL COMMUNICATIONS COMMISSION

Marlene H. Dortch
Secretary

APPENDIX A

Proposed Rules

For the reasons discussed in the preamble, the Federal Communications Commission proposes to amend 47 C.F.R. Part 54, Subpart G, as follows:

PART 54—UNIVERSAL SERVICE

Subpart G—Universal Service Support for Health Care Providers

1. The authority citation continues to read as follows:

Authority: 47 U.S.C. 151, 154(i), 201, 205, 214, and 254 unless otherwise noted.

2. After giving effect to the amendments proposed herein, the un-numbered index for Subpart G would read as follows:

DEFINED TERMS AND ELIGIBILITY

§ 54.600 Index of defined terms.
§ 54.601 Eligibility.
§ 54.602 Eligible services.
§ 54.603 Competitive bid and certification requirements.

TELECOMMUNICATIONS PROGRAM

§ 54.604 Telecommunications services.
§ 54.605 Determining the urban rate.
§ 54.607 Determining the rural rate.
§ 54.609 Calculating support.
§ 54.611 Election to offset support against annual USF contribution.
§ 54.613 Limitations on supported services for rural health care providers.
§ 54.615 Obtaining services.
§ 54.625 Support for services beyond the maximum supported distance for rural health care providers.

HEALTH BROADBAND SERVICES PROGRAM

§54.631 Eligible services.
§54.633 Installation charges and other non-recurring costs.
§54.635 Eligible service providers.
§54.637 Competitive bidding requirements.
§54.639 Restrictions on satellite services.
§54.641 Multi-year contracts.

HEALTH INFRASTRUCTURE PROGRAM

§54.650 Obtaining support.
§54.651 Demonstrated need for infrastructure funding.
§54.652 Letters of agency.
§54.653 Funding requests and budgets.
.§54.654 Eligible costs.
§54.655 Ineligible costs.
§54.656 Minimum participant contribution requirement.
§54.657 Project milestones.
§54.658 Detailed project description.
§54.659 Facilities ownership, IRU or capital lease.
§54.660 Standard terms and conditions.
§54.661 Sustainability.
§54.662 Excess capacity.

§54.663 Quarterly reporting requirements.
§54.664 Designation of successor projects.
GENERAL PROVISIONS
§ 54.671 Resale.
§ 54.673 Audits and recordkeeping.
§ 54.675 Cap.
§ 54.677 Data gathering.

3. Add an undesignated centered heading above the first section of Subpart G, to read as follows:

DEFINED TERMS AND ELIGIBILITY

4. Add Section 54.600, to read as follows:

§ 54.600 Index of defined terms.

The following definitions apply to this subpart.

(a) *Administrative office* is defined in § 54.601.

(b) *Broadband access services* is defined in § 54.631(b).

(c) *Capital lease* (for purposes of the health infrastructure program) is defined in § 54.659(c).

(d) *Data centers* is defined in § 54.601(c).

(e) *Eligible sources* (for purposes of the health infrastructure program) is defined in § 54.656(c).

(f) *Evergreen status* or *evergreen contract* (for purposes of the health broadband services program) is defined in § 54.641(b).

(g) *Excess capacity* (for purposes of the health infrastructure program) is defined in § 54.662.

(h) *HCP consortium leader* is defined in § 54.652(c).

(i) *Health broadband services program* is defined in § 54.602(c).

(j) *Health care provider* is defined in § 54.601(a)(2).

(k) *Health infrastructure program* is defined in § 54.602 (b).

(l) *Health IT* is defined in § 54.658(d)(2).

(m) *Ineligible costs* (for purposes of the health infrastructure program) is defined in § 54.655(a).

(n) *Ineligible sources* (for purposes of the health infrastructure program) is defined in § 54.656(d).

(o) *Installation charges* is defined in § 54.633.

(p) *IRU* (for purposes of the health infrastructure program) is defined in § 54.659(b).

(q) *Maximum supported distance* (for purposes of the telecommunications program) is defined in § 54.625(a).

(r) *Minimum broadband speed* for purposes of the health infrastructure program is defined in § 54.651(c), and for purposes of the health broadband services program is defined in § 54.631(e).

(s) *Minimum contribution* (for purposes of the health infrastructure program) is defined in § 54.656(a).

(t) *NTIA* is defined in § 54.651(a)(2).

(u) *Renal dialysis centers* is defined in § 54.601(e).

(v) *Renal dialysis facilities* is defined in § 54.601(e).

(w) *Rural health care provider* is defined in § 54.601(a)(3).

(x) *Rural rate* (for purposes of the telecommunications program) is defined in §§ 54.607(a) and 54.607(b).

(y) *Selected participants* (for purposes of the health infrastructure program) is defined in § 54.650(c)(2).

(z) *Skilled nursing facilities* is defined in § 54.601(d).

(aa) *Standard urban distance* or *SUD* (for purposes of the telecommunications program) is defined in § 54.605(c).

(bb) *Telecommunications program* is defined in § 54.602 (a).

(cc) *Urban rate* (for purposes of the telecommunications program) is defined in §§ 54.605(a) and 54.605(b).

5. Amend Section 54.601 to revise paragraph (a), redesignate current paragraph (b) as paragraph (f), remove current paragraphs (c) and (d), add new paragraphs (b), (c), (d) and (e), and reprint the heading of redesignated paragraph (f), to read as follows

§ 54.601 Eligibility.

(a) *Eligible health care providers.*

(1) Only an entity that is either a public or non-profit health care provider, as defined in this section, shall be eligible to receive supported services under this subpart.

(2) For purposes of this subpart, a "health care provider" is any public or non-profit:

(i) * * *

(ii) * * *

(iii) * * *

(iv) * * *

(v) * * *

(vi) * * *

(vii) * * *

(3) *Rural health care providers.* For purposes of this subpart, a "rural health care provider" is an eligible health care provider located in a rural area, as that term is defined for purposes of the rural health care universal service support mechanism in § 54.5 of this part.

(i) * * *

(ii) * * *

(4) *Per location determination.* Each separate site or location of a health care provider shall be considered an individual health care provider for purposes of calculating and limiting support under this subpart.

(b) *Administrative offices.* As used in this subpart, an "administrative office" means a facility that does not provide hands-on delivery of patient care, but performs support functions that are critical to the provision of clinical care by eligible health care providers. Administrative offices qualify as part of an eligible health care provider if they are located on the main campus of an eligible health care provider listed in paragraph (a) of this section, or they are located off-site and comply with the following provisions:

(1) The off-site administrative office is at least 51 percent owned or controlled by an eligible health care provider listed in paragraph (a) of this section. For purposes of this paragraph, "control" of an administrative office is presumed to exist if one or more eligible health care providers listed in paragraph (a) of this section, directly or indirectly, own, control, or hold the power to vote or proxies for at least 51 percent of the voting rights or governance right of the entity that owns the administrative offices.

(2) Eligible health care providers seeking support for off-site administrative offices must certify that the administrative office is used primarily for performing services that are integral to the eligible health care provider's provision of health care.

(c) *Data centers.* As used in this subpart, a "data center" means a facility that serves as a centralized repository for the storage, management, and dissemination of an eligible health care provider's computer systems, associated components, and data. Data centers qualify as part of an eligible health care provider if they are located on the main campus of an eligible health care provider listed in paragraph (a) of this section, or they are located off-site and comply with the following provisions:

(1) The off-site data center is at least 51 percent owned or controlled by an eligible health care provider listed in paragraph (a) of this section. For purposes of this paragraph, "control" of a data center is presumed to exist if one or more eligible health care providers listed in paragraph (a) of this section, directly or indirectly, own, control, or hold the power to vote or proxies for at least 51 percent of the voting rights or governance right of the entity that owns the data center.

(2) Eligible health care providers seeking support for off-site data centers must certify that the data center is used primarily for performing services that are integral to the eligible health care provider's provision of health care.

(d) *Skilled nursing facilities.* As used in this subpart, a "skilled nursing facility" means a facility that primarily provides post-acute services that are traditionally provided at not-for-profit hospitals, including the management, observation, and evaluation of patient care. Public or non-profit skilled nursing facilities qualify as eligible health care providers as not-for-profit hospitals under paragraph (a)(5) of this section, provided that the facility primarily provides (for at least 51 percent of its total beds) services that are recognized as skilled nursing care by the Centers for Medicare and Medicaid Services.

(e) *Renal dialysis centers and facilities.* As used in this subpart, a "renal dialysis center" means a hospital unit that is approved by the Centers for Medicare and Medicaid Services (CMS) to furnish the full spectrum of diagnostic, therapeutic, and rehabilitative services required for the care of End Stage Renal Disease (ESRD) dialysis patients (including both inpatient and outpatient dialysis services). As used in this subpart, a "renal dialysis facility" is a unit that is approved by CMS to furnish dialysis services directly to ESRD patients. Public or non-profit renal dialysis centers or facilities qualify as eligible health care providers as not-for-profit hospitals under paragraph (a)(5) of this section, provided that the facility or center seeking support certifies that, over the 12-month period preceding the date of application for support, the facility or center provided life preserving ESRD treatment to at least 51 percent of its patients.

(f) *Consortia*

(1) *** * ***

(2) * * *

6. Add Section 54.602, to read as follows:

§ 54.602 Eligible services.

(a) *Telecommunications program.* Rural health care providers may request support for the difference, if any, between the urban and rural rates for telecommunications services, subject to the provisions and limitations beginning at § 54.604. This support is referred to as the "telecommunications program."

(b) *Health infrastructure program.* Eligible health care providers may request support for broadband infrastructure, subject to the provisions and limitations beginning at § 54.650. This support is referred to as the "health infrastructure program".

(c) *Health broadband services program.* Rural health care providers may request support for the recurring costs for broadband access services, subject to the provisions and limitations beginning at § 54.631. This support is referred to as the "health broadband services program."

(d) *Allocation of discounts.* An eligible health care provider that engages in eligible and ineligible activities or that collocates with an entity that provides ineligible services shall allocate eligible and ineligible activities in order to receive a prorated discount (or prorated support) for eligible activities. Health care providers shall choose a method of cost allocation that is based on objective criteria and reasonably reflects the eligible usage of the facilities.

(e) *Health care purposes.* Telecommunications and broadband access services for which eligible health care providers receive support from the telecommunications program, the health infrastructure program or the health broadband services program, must be reasonably related to the provision of health care services by the eligible health care provider.

7. Amend Section 54.603 to revise the section heading, revise paragraph (a), redesignate current paragraph (b) as paragraph (c), add a new paragraph (b), and revise redesignated paragraph (c), to read as follows:

§ 54.603 Competitive bid and certification requirements.

(a) *Competitive bidding requirements*. Each eligible health care provider shall participate in a competitive bidding process pursuant to the requirements established in this section and any additional and applicable state, local, or other procurement requirements to select the

telecommunications carriers or other services providers that will provide it services eligible for universal service support under this subpart.

(b) *Additional bidding requirements for health infrastructure program*. In addition to the requirements in paragraph (a) of this section, eligible health care providers seeking support from the health infrastructure program for projects of $100,000 or more that are not subject to mandatory state or local procurement rules, must (prior to selecting a service provider) prepare a detailed request for proposal (RFP) that provides sufficient information to define the scope of the project. Such RFP must be distributed in a method likely to garner attention from interested service providers. Examples include: (1) post a notice of the RFP in trade journals or newspaper advertisements, (2) send the RFP to known or potential service providers, (3) include the RFP on the health care provider's web page or other Internet sites, or (4) follow other customary and reasonable solicitation practices used in competitive bidding for infrastructure projects.

(c) *Posting of FCC Form 465; health care provider certification requirements.*

(1) An eligible health care provider seeking to receive services eligible for universal service support under this subpart (whether under the telecommunications program, the health broadband services program, or the health infrastructure program) shall submit a completed FCC Form 465 to the Administrator. FCC Form 465 shall be signed by the person authorized to order telecommunications or information services for the health care provider and shall include, at a minimum, that person's certification under oath that:

(i) The requester is a public or not-for-profit entity that falls within one of the categories set forth in the definition of health care provider, listed in § 54.601(a), 54.601((b) or 54.601(c);

(ii) The requester is physically located in a rural area, unless the health care provider is requesting services eligible for support under the health infrastructure program;

(iii) If the requestor is seeking services eligible for support under the health infrastructure program, that the requester has complied with the initial application requirements listed in § 54.650(b);

(iv) * * *

(v) * * *

(vi) * * *; and

(vii) The requester is required to comply with the performance measures listed in § 54.677.

(2) The Administrator shall post each FCC Form 465 that it receives from an eligible health care provider on its Rural Health Care Division website designated for this purpose.

(3) After posting an eligible health care provider's FCC Form 465 on the Rural Health Care Division website, the Administrator shall send confirmation of the posting to the entity requesting services. The health care provider shall wait at least 28 days from the date on which its FCC Form 465 is posted on the website before selecting a service provider(s). The confirmation from the Administrator shall include the date after which the requester may sign a contract with its chosen service provider(s).

(4) *Selecting a service provider*. In selecting a service provider for services eligible for universal service support under this subpart, a health care provider shall consider all bids submitted by

service providers and select the most cost-effective alternative. After selecting a service provider for services eligible for support under this subpart: (i) The health care provider shall certify to the Administrator that the health care provider is selecting the most cost-effective method of providing the requested service or services, where the most cost-effective method of providing a service is defined as the method that costs the least after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems relevant to choosing a method of providing the required health care services; and (ii) The health care provider shall submit to the Administrator paper copies of the responses or bids received in response to the requested services.

8. Add an undesignated centered heading above Section 54.604, to read as follows:

TELECOMMUNICATIONS PROGRAM

9. Amend Section 54.604 to revise the section heading, add a new paragraph (a), redesignate current paragraph (a) as paragraph (b), revise redesignated paragraph (b), and redesignate current paragraphs (b) and (c) as paragraphs (c) and (d) respectively, to read as follows:

§ 54.604 Telecommunications services.

(a) *Telecommunications services.* Any telecommunications service that is the subject of a properly completed bona fide request by a rural health care provider shall be eligible for universal service support for the difference, if any, between the urban rate and the rural rate, subject to the limitations described in this paragraph. The length of a supported telecommunications service under the telecommunications program may not exceed the distance between the health care provider and the point farthest from that provider on the jurisdictional boundary of the largest city in a state as defined in § 54.625(a).

(b) *Existing contracts.* A signed contract for services eligible for telecommunications program support pursuant to this subpart between an eligible health care provider as defined under § 54.601 and a telecommunications carrier shall be exempt from the competitive bid requirements set forth in § 54.603(a) as follows:

(1) * * *

(c) * * *

(d) * * *

10. Amend Section 54.605 to revise paragraphs (a) and (c), to read as follows:

§ 54.605 Determining the urban rate.

(a) If a rural health care provider requests support for an eligible service to be funded from the telecommunications program that is to be provided over a distance that is less than or equal to the standard urban distance, as defined in paragraph (c) of this section, for the state in which it is located, the "urban rate" for that service shall be a rate no higher than the highest tariffed or publicly-available rate charged to a commercial customer for a functionally similar service in any city with a population of 50,000 or more in that state, calculated as if it were provided between two points within the city.

(b) * * *

(c) The ''standard urban distance''(or "SUD") for a state is the average of the longest diameters of all cities with a population of 50,000 or more within the state.

(d) * * *

11. Amend Section 54.609 to revise paragraphs (a), (d) and (e), to read as follows:

§ 54.609 Calculating support.

(a) For a public or non-profit rural health care provider, the amount of universal service support provided for an eligible service to be funded from the telecommunications program shall be the difference, if any, between the urban rate and the rural rate charged for the service, as defined herein. In addition, all reasonable charges that are incurred by taking such services, such as state and federal taxes shall be eligible for universal service support. Charges for termination liability, penalty surcharges, and other charges not included in the cost of taking such service shall not be covered by the universal service support mechanisms. Rural health care providers may choose one of the following two support options.

(1) * * *

(i) * * *

(ii) * * *

(iii) * * *

(iv) A telecommunications carrier that provides telecommunications service to a rural health care provider participating in an eligible health care consortium, and the consortium must establish the actual distance-based charges for the health care provider's portion of the shared telecommunications services.

(2) * * *

(3) *Base rate support-consortium.* A telecommunications carrier that provides telecommunications service to a rural health care provider participating in an eligible health care consortium, and the consortium must establish the applicable rural base rates for telecommunications service for the health care provider's portion of the shared telecommunications services, as well as the applicable urban base rates for the telecommunications service.

(b) * * *

(c) * * *

(d) *Satellite services.*

(1) Rural public and non-profit health care providers may receive support for rural satellite services under the telecommunications program, even when another functionally similar terrestrial-based service is available in that rural area. Support for satellite services shall be capped at the amount the rural health care provider would have received if they purchased a functionally similar terrestrial-based alternative.

(2) Rural health care providers seeking support from the telecommunications program for satellite services shall provide to the Administrator with the Form 466, documentation of the urban and rural rates for the terrestrial-based alternatives.

(3) * * *

(e) *Mobile rural health care providers—*

(1) *Calculation of support* The support amount allowed under the telecommunications program for satellite services provided to mobile rural health care providers is calculated by comparing the rate for the satellite service to the rate for an urban wireline service with a similar bandwidth. Discounts for satellite services shall not be capped at an amount of a functionally similar wireline alternative. Where the mobile rural health care provider provides service in more than one state, the calculation shall be based on the urban areas in each state, proportional to the number of locations served in each state.

(2) * * *

12. Amend Section 54.611 to revise the section heading, revise paragraph (a), redesignate current paragraph (b) as paragraph (c), remove current paragraph (c), add new paragraph (b), revise redesignated paragraph (c), and revise paragraph (d), to read as follows:

§ 54.611 Election to offset support against annual USF contribution.

(a) A telecommunications carrier providing services eligible for telecommunications program support under this subpart to eligible health care providers may, at the election of the carrier: (i) treat the amount eligible for support under this subpart as an offset against the carrier's universal service support obligation for the year in which the costs for providing eligible services were incurred; or (ii) receive direct reimbursement from the Administrator for that amount.

(b) Carriers shall elect in January of each year the method by which they will be reimbursed and shall remain subject to that method for the duration of the calendar year. Any support amount that is owed a carrier that fails to remit its monthly universal service contribution obligation, however, shall first be applied as an offset to that carrier's contribution obligation. Such a carrier shall remain subject to the offsetting method for the remainder of the calendar year in which it failed to remit their monthly universal service obligation. A carrier that continues to be in arrears on its universal service contribution obligations at the end of a calendar year shall remain subject to the offsetting method for the next calendar year.

(c) If a telecommunications carrier providing services eligible for support from the telecommunications program elects to treat that support amount as an offset against the carrier's universal service contribution obligation and the total amount of support owed to the carrier exceeds its universal service obligation, calculated on an annual basis, the carrier shall receive a direct reimbursement in the amount of the difference. Any such reimbursement due a carrier shall be provided to that carrier

no later than the end of the first quarter of the calendar year following the year in which the costs were incurred and the offset against the carrier's universal service obligation was applied.

13. Amend paragraph (b) of Section 54.611, to read as follows:

§ 54.613 Limitations on supported services for rural health care providers.

(a) * * *

(b) This section shall not affect a rural health care provider's ability to obtain services supported under the health broadband services program or the health infrastructure program, provided that eligible health care providers that seek support for bundled services that include basic telecommunications service supported under the health broadband services program may not also request support from the telecommunications program for the same basic telecommunications service.

14. Amend Section 54.615 to revise paragraphs (b) and (c), to read as follows:

§ 54.615 Obtaining services.

(a) * * *

(b) *Receiving supported rate.* Upon receiving a bona fide request, as defined in paragraph (c) of this section, from a rural health care provider for a telecommunications service eligible for support under the telecommunications program, a telecommunications carrier shall provide the service at a rate no higher than the urban rate, as defined in § 54.605, subject to the limitations set forth in this Subpart.

(c) *Bona fide request.* In order to receive services eligible for support under the telecommunications program, an eligible health care provider must submit a request for services to the telecommunications carrier, signed by an authorized officer of the health care provider, and shall include that person's certification under oath that:

(1) * * *

(2) The requester is physically located in a rural area; or, if the requester is a mobile rural health care provider requesting services under § 54.609(e), that the requester has certified that it is serving eligible rural areas

(3) Deleted;

(4) * * *

(5) * * *

(6) * * *

(7) * * *

(d) * * *

15. Redesignate Section 54.617 [Resale] as Section 54.671.

16. Redesignate Section 54.619 [Audits and recordkeeping] as Section 54.673.

17. Remove Section 54.621[Access to advanced telecommunications and information services].

18. Redesignate Section 54.623 [Cap] as Section 54.675.

19. Amend Section 54.625 to revise the section heading and revise paragraphs (a), (b) and (c), to read as follows:

§ 54.625 Support for telecommunications services beyond the maximum supported distance for rural health care providers.

(a) The maximum support distance for the telecommunications program is the distance from the health care provider to the farthest point on the jurisdictional boundary of the city in that state with the largest population, as calculated by the Administrator.

(b) An eligible rural health care provider may purchase an eligible telecommunications service supported under the telecommunications program that is provided over a distance that exceeds the maximum supported distance.

(c) If an eligible rural health care provider purchases an eligible telecommunications service supported under the telecommunications program that exceeds the maximum supported distance, the health care provider must pay the applicable rural rate for the distance that such service is carried beyond the maximum supported distance.

20. Add an undesignated centered heading below Section 54.625, to read as follows:

HEALTH BROADBAND SERVICES PROGRAM

21. Add Section 54.631, to read as follows:

§ 54.631 Eligible services.

(a) *Recurring costs for broadband access services.* Subject to the provisions of sections 54.631 through 54.641, rural health care providers may request support from the health broadband services program for 50 percent of the recurring monthly costs for broadband access services at the minimum broadband speeds defined below.

(b) For purposes of this subpart, “broadband access service” is any advanced telecommunications or information service that enables rural health care providers to post their own data, interact with stored data, generate new data, or communicate over private dedicated networks or the public Internet for the provision of health IT.

(c) Eligible health care providers that seek support from the health broadband services program for broadband access services must certify that such services are reasonably related to the provision of health IT for the delivery of health care services by the eligible health care provider.

(d) Eligible health care providers that seek support under the health broadband services program for telecommunications services may not also request support from the telecommunications program for the same service.

(e) For purposes of the health broadband services program, “minimum broadband speed” means 4 Mbps.

22. Add Section 54.633, to read as follows:

§ 54.633 Installation charges and other non-recurring costs.

(a) Rural health care providers may request one-time support from the health broadband services program for 50 percent of the reasonable and customary installation charges for broadband access

services. "Installation charges" are defined as charges that are normally charged by service providers to commence service, and are not charges that are based on an amortization of construction or infrastructure costs.

(b) Except as provided in paragraph (c) of this section, no universal service support is available under the health broadband services program for the non-recurring costs associated with the construction or deployment of broadband infrastructure.

(c) Rural health care providers may not seek support for non-recurring charges of $500,000 or more. If non-recurring charges are more than $500,000, they must be part of a multi-year contract, and must be prorated over a period of at least five years.

23. Add Section 54.635, to read as follows:

§ 54.635 Eligible service providers.

Broadband access services may be provided by a telecommunications carrier or other qualified broadband access service provider, provided that the health care provider selects the most cost effective option to meet its health care needs in accordance with § 54.603.

24. Add Section 54.637, to read as follows:

§ 54.637 Competitive bidding requirements.

Rural health care providers seeking broadband access services to be supported by the health broadband services program must comply with the competitive bidding and certification requirements set forth in § 54.603.

25. Add Section 54.639, to read as follows:

§ 54.639 Restrictions on satellite services.

(a) Rural health care providers may seek support for rural satellite-based broadband access services under the health broadband services program, even when another functionally similar terrestrial-based service is available in the rural area, subject to the provisions of this section.

(b) Support for satellite services will be capped at the amount of support the eligible health care provider would be eligible to receive under the health broadband services program if it had purchased such service from a functionally similar terrestrial-based alternative.

(c) Where an eligible health care provider seeks a more expensive satellite-based service when a less expensive terrestrial-based alternative is available, the health care provider will be responsible for the difference between the satellite-based service and the terrestrial-based alternative.

(d) An eligible health care provider seeking support for satellite service must submit documentation to the Administrator demonstrating that satellite service is the most cost-effective option available to meet the provider's health care needs at the same time information is submitted pursuant to section 54.603(c)(4).

26. Add Section 54.641, to read as follows:

§ 54.641 Multi-year contracts.

(a) Participants in the health broadband services program are permitted to enter into multi-year contracts for recurring broadband access services, but may not receive funding commitments from the Administrator for more than one funding year at a time.

(b) Multi-year contracts entered into by a rural health care provider after complying with the competitive bid requirements of § 54.603, are deemed to have "evergreen" status. Health care providers do not have to rebid for services during the term of a multi-year contract with evergreen status However, health care providers may not add services to a multi-year contract or extend the term of a multi-year contract and retain "evergreen" status. Such modifications to a multi-year contract are deemed a new request for services, and require that the health care provider rebid the services in compliance with the provisions of § 54.603 and select the most cost-effective service provider.

(c) All program participants, including those covered by evergreen contracts, must submit a request for support each funding year to continue receiving funding from the health broadband services program for recurring broadband access services. Requests for support each funding year are subject to the program funding and prioritization rules set forth in § 54.675. Rural health care providers with multi-year contracts do not have a priority preference over other rural health care providers seeking support from the health broadband services program in any funding year.

27. Add an undesignated centered heading below Section 54.641, to read as follows:

HEALTH INFRASTRUCTURE PROGRAM

28. Add Section 54.650, to read as follows:

§ 54.650 Obtaining support

(a) Subject to the provisions in Sections 54.650 through 54.664, eligible health care providers may request universal service support to fund up to 85 percent of eligible costs for the design, construction and deployment of dedicated broadband networks that connect public or non-profit health care providers in areas of the country where there is no available broadband infrastructure or the existing broadband infrastructure is insufficient for health IT needed to improve and provide health care delivery. Broadband infrastructure projects may include either new facilities or improvements to upgrade existing facilities (for example, converting a copper facility to a fiber facility capable of broadband delivery). In addition, funding may be used to support up to 85 percent of the cost of connecting health care networks to Internet2 or National LambdaRail.

(b) *Initial application phase.* Eligible health care providers may apply for funding under the health infrastructure program by submitting an application to the Administrator. Applications will be accepted during the first quarter of each funding year (July 1 to September 30). As part of this initial application phase, an applicant will be required

(1) either (a) to verify that there is no available broadband infrastructure; or (b) to demonstrate, pursuant to section 54.651, that the existing broadband infrastructure is insufficient for health IT needed to improve and provide health care delivery;

(2) to provide letters of agency, as set forth in section 54.652, for each of the eligible health care providers in the applicant's proposed network, and identify the lead entity that will be responsible for completing the application process;

(3) to include a preliminary budget and an infrastructure funding request as set forth in section 54.653; and

(4) to certify that it will comply with all program requirements if selected for funding.

(c) *Project selection phase.*

(1) Applications submitted for funding will be made publicly available on the Administrator's website.

(2) After applications have been reviewed, the Administrator will notify those applicants whose projects have been selected in that funding year as eligible to participate in the program ("selected participants"). After a selected participant is notified of project eligibility, it may proceed with the project commitment phase as set forth in paragraph (d) of this section.

(3) Health care providers whose projects are not selected for funding in any funding year, may apply for funding in subsequent funding years.

(d) *Project commitment phase.* Selected participants must complete and submit all additional materials and comply with all program requirements as set forth in sections 54.656 - 54.663. The Administrator may request additional information from applicants and selected participants if necessary to substantiate, explain or clarify any materials submitted as part of the funding process.

(e) *Build-out period.* All projects funded by the health infrastructure program must be subject to fair and open competitive bidding, as provided in § 54.603. The Administrator will review all applications and additional information provided by selected participants to confirm compliance with the program rules. The Administrator will issue funding commitment letters for projects after a selected participant has completed all requirements and selected a service provider. Selected participants have a period of three funding years, commencing with the funding year in which the initial online application was submitted pursuant to § 54.650(b), to file all forms and supporting documents necessary to receive funding commitment letters from the Administrator. Selected participants have a period of five funding years, commencing with the funding year on which the selected participant receives its first funding commitment letter for the project, in which to complete build-out.

29. Add Section 54.651, to read as follows:

§ 54.651 Demonstrated need for infrastructure funding.

(a) Pursuant to § 54.650, applicants seeking funding under the health infrastructure program must demonstrate that broadband at the minimum broadband speed, as defined in paragraph (c) of this section, is unavailable or insufficient in the geographic area where the eligible health care providers are to be connected by the proposed dedicated network, by using any of the following methods:

(1) *Survey method.* Provide a survey of current carrier network capabilities in the geographic area, compiled by a preparer qualified to make such surveys.

(i) The survey must provide details as to the identity and broadband capabilities of all existing carriers in the proposed network area, and discuss and justify the methodology used to make such determinations.

(ii) The survey must be accompanied by a statement of the preparer's professional, educational, and business background that make the preparer qualified for conducting the survey. The statement should include the preparer's prior experience, technical or engineering degrees, telecommunications background, and knowledge of methods typically employed to perform such surveys.

(iii) The applicant must also provide a report detailing either that there is no available broadband infrastructure, or explaining why existing broadband infrastructure would be insufficient for

health IT needed to provide or improve health care delivery by the eligible health care providers that are proposing the infrastructure project.

(2) *Broadband mapping method.*

(i) Provide copies or linked references to recognized broadband mapping studies, such as the National Telecommunications and Information Administration ("NTIA") national broadband map, state or local broadband maps, and other mapping sources that adequately depict the available broadband in the proposed network area.

(ii) The applicant must also provide a report detailing why existing broadband infrastructure would be insufficient for health IT needed to provide or improve health care delivery by the by the eligible health care providers that are proposing the infrastructure project.

(3) *Certification method.* Certify that, for a continuous period of not less than six months, the health care providers that will participate in the proposed dedicated network requested broadband access services under the telecommunications program or the health broadband services program, at connectivity speeds of not less than the minimum broadband speed, and did not receive any proposals from network service providers meeting the terms of the requested services.

(b) All information submitted by applicants to establish that broadband is unavailable or insufficient will be subject to review and verification by the Administrator.

(c) For purposes of the health infrastructure program, "minimum broadband speed" means 10 Mbps.

30. Add Section 54.652, to read as follows:

§ 54.652 Letters of agency.

(a) Pursuant to section 54.650, applicants must identify (1) all eligible health care providers on whose behalf funding is being sought, and (2) the lead entity that will be responsible for completing the application process.

(b) The initial application must include a letter of agency from each participating eligible health care provider, confirming that the health care provider has agreed to participate in the applicant's proposed network, and authorizing the lead entity to act as the health care provider's agent for completing the application process.

(c) As used in this section, "HCP consortium leaders" means state organizations, public entities and non-profits that are not eligible health care providers but that serve in an administrative capacity for eligible health care providers within a consortium. HCP consortium leaders may apply for funding under the health infrastructure program, on behalf of eligible health care providers. In doing so, however, HCP consortium leaders may not receive any funding from the health infrastructure program except as provided in § 54.654(c). The full value of any discounts, funding, or other program benefits under the health infrastructure program that are secured by an HCP consortium leader must be passed on to the eligible health care providers that are members of the consortium.

31. Add Section 54.653, to read as follows:

§ 54.653 Funding requests and budgets.

(a) Every applicant's initial application must include a funding request, a brief project description, and a detailed budget that identifies all costs related to the proposed project. The funding request may not exceed 85 percent of the eligible costs identified in the budget.

(b) *Budget requirements.*

(1) The budget must be reasonable, and must be based on general pricing information available to the applicant from third parties. All material assumptions used in preparing the budget must be noted and discussed in narrative form. The budget must separately identify the following:

(i) eligible non-recurring costs, subject to the limitations set forth in § 54.654(a);

(ii) eligible network design costs, subject to the limitations set forth in § 54.654(b);

(iii) eligible administrative expenses, subject to the limitations set forth in § 54.654(c);

(iv) eligible maintenance costs, subject to the limitations set forth in § 54.654(d);

(v) eligible NLR or Internet2 membership fees, subject to the limitations set forth in § 54.654(e); and

(vi) all costs that are necessary for completion of the project, but that are not eligible for support under the health infrastructure program.

(2) If a budget line item contains both eligible and ineligible components, costs should be allocated between the eligible and ineligible components.

(3) Budgets submitted by applicants and selected participants may be made publicly available by the Administrator so that other prospective applicants may use such information as a basis for preparing their own budgets.

32. Add Section 54.654, to read as follows:

§ 54.654 Eligible costs.

(a) *Non-recurring costs.* The health infrastructure program may provide support for the following non-recurring costs for the deployment of infrastructure: (1) initial network design studies not in excess of the cap identified in § 54.654(b); (2) engineering, materials and construction of fiber facilities or other broadband infrastructure; and (3) the costs of engineering, furnishing (i.e., as delivered from the manufacturers), and installing network equipment.

(b) *Network design.* Network design costs are limited to $1 million per project or 15 percent of the project's eligible costs, whichever is less.

(c) *Administrative expenses.* Selected participants may request funding under the health infrastructure program for up to 85 percent of the reasonable administrative expenses incurred in connection with infrastructure projects. Selected participants must submit certifications and maintain records confirming the number of hours provided by one or more employees for tasks related to the health infrastructure program project and that the administrative expense for which support is sought is not more than the reasonable costs for the amount of time such employee(s) spent on the project. Administrative expenses are subject to the following limitations:

(1) Support for such expenses will be limited to 36 months, commencing with the month in which a selected participant has been notified by the Administrator that the selected participant's project is eligible for funding.

(2) The rate of support will not exceed $100,000 per year.

(3) The aggregate amount of support a project may receive for administrative expenses shall not exceed 10 percent of the total proposed budget for the project.

(d) *Maintenance costs.* Selected participants may request funding for up to 85 percent of the reasonable, necessary and customary ongoing maintenance costs for networks funded by the health infrastructure program, subject to the following limitations:

(1) Support for maintenance costs shall be limited to a period of five years from the first funding commitment letter issued for such project.

(2) Selected participants must demonstrate in their sustainability plans, as described in § 54.661, that the costs of network operations and maintenance will be sustainable after such period of support from the health infrastructure program.

(3) Service agreements for network maintenance will be subject to the competitive bidding rules set forth in § 54.603, and may be bid either at the time of construction of the network or at a later time.

(e) *National LambdaRail and Internet2.*

(1) Selected participants may request funding under the health infrastructure program for up to 85 percent of the membership fees for connecting their networks to the dedicated nationwide backbones offered by Internet2 or National LambdaRail, or their successors.

(2) Selected participants may either pre-select to connect with either Internet2 or National LambdaRail, and seek funding for such connection, or may (at their discretion) seek competitive bids from National LambdaRail and Internet2 through the normal competitive bidding process. If Internet2 or National LambdaRail are pre-selected by a selected participant, the costs of connection to such nationwide backbone must be reasonable.

33. Add Section 54.655, to read as follows:

§ 54.655 Ineligible costs.

(a) *Certification that funds will not be used to pay for ineligible costs.* The authorized purposes of the health infrastructure program include the costs of *access* to advanced telecommunications services. For purposes of the health infrastructure program, "ineligible costs" are those costs that are not directly related to access or are not directly associated with network design, construction, or deployment of a dedicated network for eligible health care providers. Selected participants are required to certify that support from the health infrastructure program will not be used to pay for ineligible costs.

(b) *Examples of ineligible costs.* Examples of ineligible costs include but are not limited to:

(1) Personnel costs, including salaries and fringe benefits, except for those costs that qualify as administrative expenses, subject to the limitations set forth in § 54.654(c).

(2) Travel costs, except for travel costs that are reasonable and necessary for network design or deployment and that are specifically identified and justified as part of a competitive bid for a construction project.

(3) Legal costs.

(4) Training, except for basic training or instruction directly related to and required for broadband network installation and associated network operations. For example, costs for training health care provider personnel in the use of telemedicine applications are ineligible.

(5) Program administration or technical coordination, except for those costs that qualify as administrative expenses, subject to the limitations set forth in § 54.654(c).

(6) Inside wiring or networking equipment, e.g., video/Web conferencing equipment and wireless user devices, on health care provider premises, except for equipment that terminates a carrier's or other provider's transmission facility and any router/switch that is directly connected to either the facility or the terminating equipment.

(7) Computers, including servers, and related hardware, e.g., printers, scanners, laptops, unless used exclusively for network management.

(8) Helpdesk equipment and related software, or services.

(9) Software, unless used for network management, maintenance, or other network operations; software development, excluding development of software that supports network management, maintenance, and other network operations; Web server hosting; and Website portal development.

(10) Telemedicine applications and software.

(11) Clinical or medical equipment.

(12) Electronic records management and expenses.

(13) Connections to ineligible network participants or sites, e.g., for-profit health care providers.

(14) Costs related to any share of a project that is not allocable to the dedicated health care network.

(15) Administration and marketing costs, e.g., administrative costs; supplies and materials; marketing studies, marketing activities, or outreach efforts; evaluation and feedback studies, except for those costs that qualify as eligible administrative expenses, subject to the limitations set forth in § 54.654(c).

(16) Continuous power source.

(c) *Billing and operational expenses.* The health infrastructure program will not provide support for billing and operational expenses incurred either by a health care provider or its selected vendor. An example of billing or operational costs is the expense that service providers may charge for allocating costs to each health care provider in a project's network.

34. Add Section 54.656, to read as follows:

§ 54.656 Minimum participant contribution requirement.

(a) *Minimum participant contribution.* The health infrastructure program will not pay more than 85 percent of eligible project costs, and selected participants are required to pay the remaining amount of all eligible project costs (the "minimum contribution"). Selected participants are required to pay all costs that are related to the project but that do not qualify as eligible project costs. Selected participants must demonstrate that their minimum contribution requirement will be met from an eligible source to receive funding from the health infrastructure program.

(b) *Evidence of eligible sources for minimum participant contribution.* Within 90 days after a selected participant has been notified that its project is eligible for funding, the selected participant must submit to the Administrator letters of assurances: (1) confirming funds from eligible sources to meet the minimum contribution requirement, and (2) identifying with specificity the eligible sources of funding.

(c) *Eligible sources.* The following are "eligible sources" for meeting the minimum contribution:

(1) eligible health care providers;

(2) state grants, funding, or appropriations;

(3) federal funding, grants, loans, or appropriations, but not other universal service funding; and

(4) other grant funding, including private grants, but not grants from ineligible sources.

(d) *Ineligible sources.* The following are examples of "ineligible sources" for meeting the minimum contribution:

(1) in-kind or implied contributions;

(2) a local exchange carrier (LEC) or other telecom carrier, utility, contractor, consultant, or other service provider;

(3) for-profit participants; and

(4) any other universal service support program.

35. Add Section 54.657, to read as follows:

§ 54.657 Project milestones.

(a) *Project schedule.* Within 90 days after a selected participant has been notified that its project is eligible for funding, the selected participant must submit to the Administrator a project schedule that identifies the following project milestones:

(1) start and end date for network design;

(2) start and end date for drafting and posting RFPs;

(3) start and end date for selecting vendors and negotiating contracts;

(4) start date for commencing construction and end date for completing construction; and

(5) target dates for each health care provider to be connected to the network and operational.

(b) *Quarterly updates.* Each selected participant must submit to the Administrator, on a quarterly basis, an update of the selected participant's project schedule, noting which project milestones have been met and any progress or unanticipated delays in meeting other milestones. In the event a project milestone is not achieved, or there is a material deviation from the project schedule, the selected participant must provide an explanation in the project schedule update.

36. Add Section 54.658, to read as follows:

§ 54.658 Detailed project description.

(a) *Project description.* Within 90 days after a selected participant has been notified that its project is eligible for funding, the selected participant must submit to the Administrator a detailed project description that describes the network, identifies the proposed technology, demonstrates that the project is technically feasible and reasonably scalable, and describes each specific development phase of the project (e.g., network design phase, construction period, deployment and maintenance period).

(b) *Network coverage.*

(1) The project description must include the identity and location of all network participants, and a network diagram.

(2) The project description must indicate how selected participants plan to fully utilize their proposed network to provide health care services, and must present a strategy for aggregating the specific needs of health care providers within a state or region, including providers that serve rural areas. Networks may be limited to a particular state or region, but selected participants should describe feasible ways in which such networks will connect to a national broadband network. The project description should discuss whether the proposed network will connect to a national backbone, such as National LambdaRail or Internet2.

(c) *Service speeds and scalability.*

(1) The project description must include a discussion of the speeds and services necessary for the particular network, and how the minimum broadband speed, as defined in § 54.651(c), will be provided.

(2) Networks must be designed for the exchange of identifiable health information, and capable of meeting transmission speed requirements necessary for health care applications to be used by the health care providers. To demonstrate their broadband needs, selected participants are required to explain and provide reasonable support for the type of health care providers that will use the network, the bandwidth and speed requirements for such network, and the health care services that necessitate broadband connections at the desired speeds.

(3) The project description must explain how the proposed network will be designed to meet the current broadband needs of the network members, and must address whether or how the proposed network will be scalable to handle projected future demand. As referenced here, scalability refers to the ability of a system to accommodate a significant growth in the size of the system (i.e., services provided, end users served) without the need for substantial redesign.

(d) *Health IT purposes.*

(1) The project description must specify how the dedicated broadband network will be used by eligible health care providers for health IT to improve or provide health care delivery.

(2) For purposes of this subpart, “health IT” is defined as information-driven health practices and the technologies that enable them. Health IT includes billing and scheduling systems, e-care, electronic health records (EHRs) and telehealth and telemedicine.

37. Add Section 54.659, to read as follows:

§ 54.659 Facilities ownership, IRU or capital lease.

(a) Health care providers seeking funding for infrastructure projects under the health infrastructure program must:

(1) own the infrastructure facilities funded by the program,

(2) have an IRU for such facilities, or

(3) have a capital lease.

(b) *IRU.* An "IRU" is an indefeasible right to use facilities for a certain period of time that is commensurate with the remaining useful life of the asset. An IRU confers on the grantee the vestiges of ownership, and is customarily used in the telecommunications industry. An IRU may include maintenance of the fiber/network for the term, where vendor is responsible for maintenance and repairs. An IRU must be independent of any contract for services or electronics. Costs of maintenance and operation of associated electronics can be (and usually are) addressed in a separate service agreement.

(c) *Capital lease.* A capital lease is a lease of a business asset which represents ownership and is reflected on the lessee's balance sheet as an asset, and meets one or more of the following criteria: the lease term is greater than 75 percent of the property's estimated economic life; the lease contains an option to purchase the property for less than fair market value; ownership of the property is transferred to the lessee at the end of the lease term; or the present value of the lease payments exceeds 90 percent of the fair market value of the property. If there is doubt regarding a selected participant's classification of a particular lease as a capital lease, the selected participant may be required to provide an explanation justifying the classification of its leasing arrangement as a capital lease.

38. Add Section 54.660, to read as follows:

§ 54.660 Standard terms and conditions.

(a) Construction contracts, IRUs or eligible capital leases entered into by health care providers for infrastructure projects receiving support from the health infrastructure program must contain the provisions set forth in this section.

(b) *Construction contracts.* The following provisions must be included in all construction contracts:

(1) *Work standards.* All work shall conform to identified standards and specifications. The vendor shall not use any defective material in the performance of the work.

(2) *Withholding of payments.* The health care provider may withhold money due for any portion of the work which has been rejected by the health care provider and which has not been corrected by the service provider to the reasonable satisfaction of the health care provider.

(3) *Defects in work.* For a period of not less than one year after project completion, the service provider shall correct at its expense all defects and deficiencies in the work which result from: (i) labor or materials furnished by the service provider, (ii) workmanship, or (iii) failure to follow the plans, drawings, standards, or other specifications made a part of the contract.

(c) *IRUs.* The following provisions must be included in all construction IRUs:

(1) *Term of the agreement.* The health care provider is granted an exclusive and irrevocable right to use the facility funded by the health infrastructure program, for the remainder of facility's useful life.

(2) *Beneficial ownership interest.* The health care provider receives beneficial title and interest or equitable title in the facilities funded by the health infrastructure program. Such title should

include the right to use the facilities, the right to have access for repairs, and the right to let others use such facilities.

(d) *Capital leases.* The payment structure in a capital lease must be reflective of the term of the lease. Leases may not provide for payments in advance of the lease term. For example, a ten year lease may not provide for an upfront payment of the entire ten year lease period.

(e) *Provisions applicable to all contracts.* Any construction contract, IRU or capital lease for projects receiving support from the health infrastructure program must include provisions as follows:

(1) *Laws and regulations.* The service provider shall comply with all federal, state and municipal laws, ordinances and regulations (including building and construction codes) applicable to the performance of the work.

(2) *Environmental protection.* The service provider shall comply with all applicable federal, state and municipal environmental laws and regulations which relate to environmental protection, inspection and monitoring of property and environmental reporting and information requirements.

(3) *Performance bonds.* For contracts in excess of $150,000, the service provider shall deliver a performance bond. For construction contracts, performance bonds must be for the construction term of the contract plus a period of not less than one year (i.e., the same period in which the health care provider may require the service provider to remedy defects in the work). For a lease or an IRU, performance bonds should be for the entire term of the agreement.

(4) *Indemnification.* The service provider agrees to indemnify and hold harmless the health care provider from any and all claims, actions, or causes of action to the extent the claimed loss or damages arises out of the service provider's negligent performance or nonperformance of its obligations under the contract.

(f) *Service provider reporting requirements.* Selected participants in the health infrastructure program must, at or prior to the time of selecting a service provider:

(1) Require the service provider to certify either that:

(a) The infrastructure project will only involve the construction and deployment of the dedicated health care network, and will not involve the construction or deployment of additional facilities or capacity that will not be part of the dedicated network; or

(b) The infrastructure project will include both the construction and deployment of the dedicated network and the construction and deployment of additional facilities or capacity for uses other than the dedicated network, but: (i) the cost charged to the dedicated network will not exceed fully distributed costs given the use, quality of service, term (length of service) and other terms and conditions for use of the dedicated facility; and (ii) the service provider will pay all costs related to the additional facility or capacity.

(2) Require the service provider to provide a depreciation schedule showing the useful life of fixed assets to assist the health care providers in determining their network sustainability.

(3) Require the service provider to maintain books and records that support all cost allocations.

39. Add Section 54.661, to read as follows:

§ 54.661 Sustainability.

Prior to receiving funding for infrastructure projects under the health infrastructure program, each selected participant must submit to the Administrator a sustainability report demonstrating that its project is sustainable. Although each selected participant may include additional information to demonstrate a project is sustainable, every sustainability plan is required to address, at a minimum, the following points:

(a) *Principal factors*. Discuss each of the principal factors that were considered by the selected participant to demonstrate sustainability.

(b) *Minimum contribution requirement*. Discuss the status of obtaining the minimum contribution for eligible project costs. If project funding is dependent on appropriations or other special conditions, such conditions should be discussed.

(c) *Projected sustainability period*. Indicate a reasonable sustainability period, which is at least equal to the useful life of the funded facility. Although a sustainability period of 10 years is generally appropriate, the period of sustainability should be commensurate with the investments made from the health infrastructure program.

(d) *Terms of membership in the network*. Describe generally any agreements made (or to be entered into) by network members, e.g., participation agreements, memoranda of understanding, usage agreements, or other documents. Describe financial and time commitments made by proposed members of the network. If the project includes excess bandwidth for growth of the network, describe how such excess bandwidth will be financed. If the network will include eligible health care providers and other network members, describe how fees for joining and using the network will be assessed.

(e) *Ownership structure.*

(1) Explain who will own each material element of the network, and arrangements made to ensure continued use of such elements by the network members for the duration of the sustainability period.

(2) In the case of a consortium, the legally and financially responsible entity designated to own facilities funded by the health infrastructure program can be a state organization, public sector (governmental) or not-for profit entity acting as a fiduciary agent for eligible health care providers within such consortium. However, title to the dedicated network must be held exclusively for the benefit of eligible health care providers.

(f) *Sources of future support*. If sustainability is dependent on fees to be paid by eligible health care providers, then the sustainability plan must confirm that the health care providers are committed and have the ability to pay such fees. If sustainability is dependent on fees to be paid by network members that will use the network for health care purposes, but are not eligible health care providers under the Commission's rules, then the sustainability plan must identify such entities. Alternatively, if sustainability is dependent on revenues from excess capacity not related to health care purposes, then the sustainability plan must identify the proposed users of such excess capacity. If rural health care provider members of the network qualify for continued support under the health broadband services program, this should be discussed in the sustainability plan.

(g) *Management*. Describe the management structure of the network for the duration of the sustainability period, and how management costs will be funded.

(h) *Excess capacity disclosures.* If an infrastructure project includes excess capacity, as part of its sustainability plan the selected participant must disclose the estimated amount of excess capacity and explain how it plans to allocate the cost of the network between the network members that are eligible

health care providers and the members that are not eligible health care providers. In doing so, selected participants are required to: (1) identify non-eligible users of such excess capacity and explain what proportion of the network non-recurring and recurring costs they will bear, and (2) describe all agreements made between the eligible health care providers and other participants in the network (e.g., cost allocation, facility sharing agreements, maintenance and access obligations, ownership rights).

40. Add Section 54.662, to read as follows:

§ 54.662 Excess capacity.

(a) The health infrastructure program will only provide funds for the infrastructure costs associated with the eligible health care providers' current and anticipated bandwidth requirements. To the extent that a deployed network has excess capacity and the eligible health care providers seek to share that excess capacity with ineligible entities, the ineligible entities must pay an appropriate portion of the costs of the network.

41. Add Section 54.663, to read as follows:

§ 54.663 Quarterly reporting requirements.

(a) Selected participants in the health infrastructure program must submit quarterly reports that provide information on the following: (1) attaining project milestones; (2) status of meeting the minimum contribution requirement; (3) status of the competitive bidding process; (4) details on how the supported network has complied with HHS health IT guidelines or requirements, such as meaningful use, if applicable; and (5) performance measures, as described in § 54.677.

(b) Such reports must be filed with the Administrator and the Commission on a quarterly basis, at such times as determined by the Administrator.

42. Add Section 54.664, to read as follows:

§ 54.664 Designation of successor projects.

(a) The Bureau may waive the relevant sections of Subpart G of Part 54 of the Commission's rules to the extent waiver may be necessary to the sound and efficient administration of the health infrastructure program.

(b) In instances where a selected participant is unable to complete its project, the Bureau has authority to designate a successor project. Such designation of a successor can be made upon request of the selected participant, or on the Bureau's own motion. The Bureau may exercise such discretion in instances where a project fails to meet a specified milestone, or a selected participant fails to adequately notify the Commission of modifications to the project milestone deadlines. In selecting a successor project, the Bureau may take into consideration the likelihood that the successor will be able, at a minimum, to complete the project in a manner that provides new broadband infrastructure to the identified region or area.

(c) The Bureau may revoke funding awarded to any selected participant making unapproved material changes to the network design plan set forth in the selected participant's detailed project description submitted as part of the funding application materials.

43. Add an undesignated centered heading below Section 54.664, to read as follows:

GENERAL PROVISIONS

44. Amend redesignated Section 54.671 by revising paragraph (b), to read as follows:

§ 54.671 Resale.

(a) * * *

(b) *Permissible fees.* The prohibition on resale set forth in paragraph (a) of this section shall not prohibit a health care provider from charging normal fees for health care services, including instruction related to such services rendered via telecommunications or broadband access services purchased under this subpart.

45. Amend redesignated Section 54.673 by revising paragraph (d), to read as follows:

§ 54.673 Audits and recordkeeping.

(a) * * *

(b) * * *

(c) * * *

(d) *Service providers.* Telecommunications and other service providers delivering services supported by the telecommunications program, the health broadband services program or the health infrastructure program, shall retain documents related to the delivery of any discounted or supported services for at least 5 years after the last day of the delivery of such discounted or supported services. Any other document that demonstrates compliance with the statutory or regulatory requirements for the rural health care mechanism shall be retained as well.

46. Amend redesignated Section 54.675 by revising paragraphs (a), (c) and (f), to read as follows:

§ 54.675 Cap.

(a) *Amount of the annual cap.* The aggregate annual cap on federal universal service support for health care providers shall be $400 million per funding year, of which up to $100 million per funding year will be available for the health infrastructure program, and the remainder shall be available for the telecommunications program and the health broadband services program.

(b) * * *

(c) *Requests.* Funds shall be available as follows:

(1) * * *

(2) For the telecommunications program and the health broadband services program, the Administrator shall implement a filing window period that treats all rural health care providers filing within the window period as if their applications were simultaneously received.

(3) For the health infrastructure program, the filing window period for applications will be the first quarter of each funding year (July 1 to September 30). The Administrator will treat all applications received during such window period as if they were simultaneously received.

(4) The deadline for all required forms to receive funding under the telecommunications program and the health broadband services program is June 30 for the funding year that begins on the previous July 1.

(5) For applicants selected to participate in the health infrastructure program based on their initial online application, the deadline to file all forms and supporting documents necessary to receive funding commitment letters from the Administrator is three funding years, commencing on July 1 of the funding year in which the initial online application is submitted pursuant to § 54.650(b) and ending 36 months (on June 30) after that. Selected participants have a period of five funding years (commencing with the funding year on which the selected participant receives its first funding commitment letter for the project) in which to complete build-out.

(d) * * *

(e) * * *

(f) *Pro-rata reductions for telecommunications program support.* The Administrator shall act in accordance with this section when a filing window period for the telecommunications program and the health broadband services program, as described in paragraph (c)(3) of this section, is in effect. When a filing window period described in paragraph (c)(3) of this section closes, the Administrator shall calculate the total demand for telecommunications program and health broadband services program support submitted by all applicants during the filing window period. If the total demand during a filing window period exceeds the total remaining support available for the funding year, the Administrator shall take the following steps:

(1) The Administrator shall divide the total remaining funds available for the funding year by the total amount of telecommunications program support requested by each applicant that has filed during the window period, to produce a pro-rata factor.

(2) The Administrator shall calculate the amount of telecommunications program support requested by each applicant that has filed during the filing window.

(3) The Administrator shall multiply the pro-rata factor by the total telecommunications program dollar amount requested by each applicant filing during the window period. Administrator shall then commit funds to each applicant for telecommunications program support consistent with this calculation.

47. Add Section 54.677, to read as follows:

§ 54.677 Data gathering.

(a) Health care providers receiving support under the health broadband services program and the health infrastructure program will be required to annually identify the speed of the connection supported by such funds, and the type and frequency of utilization of health IT applications as a result of broadband access. Such annual report shall be in a form to be prescribed by the Commission.

APPENDIX B

List of Commenters

Health Care Delivery Elements of National Broadband Plan
NBP Public Notice #17

GN Docket Nos. 09-47, 09-51, 09-137
WC Docket No. 02-60

Comments	Abbreviation	Date Filed
Alcatel-Lucent	Alcatel-Lucent	December 4, 2009
American Academy of Pediatrics	AAP	December 4, 2009
American Telemedicine Association	ATA	December 3, 2009
Arnett Development Group	Arnett	December 4, 2009
Ascension Health	Ascension	December 4, 2009
AT&T Inc.	AT&T	December 4, 2009
Boston Public Health Commission	Boston Public Health	December 4, 2009
California Telehealth Initiative	California Telehealth	December 3, 2009
Center for Democracy and Technology	CDT	December 4, 2009
Christus Health	Christus Health	December 4, 2009
CTIA	CTIA	December 4, 2009

Comments	Abbreviation	Date Filed
Dell Inc.	Dell	December 4, 2009
Entra Health Systems	Entra Health	December 4, 2009
GE Healthcare	GE	December 4, 2009
Geisinger Health System	Geisinger	December 4, 2009
Glacier Community Health Center, Inc.	Glacier Community	December 30, 2009
GreatCall, Inc.	GreatCall	December 4, 2009
Harris Corporation	Harris Corp	December 4, 2009
Health IT Now Coalition	Health IT Now	December 7, 2009
Health Network Group Organized by Internet2	Internet2 Group	December 2, 2009
Health Information Exchange of Montana	Health Montana	December 26, 2009
Indian Health Service	IHS	December 4, 2009
Inmarsat	Inmarsat	December 4, 2009
Intel	Intel	December 16, 2009 January 15, 2010 January 21, 2010
Internet2	Internet2	December 4, 2009

Comments	Abbreviation	Date Filed
International Association of Fire Chiefs	IAFC	December 4, 2009
LifeWatch Services, Inc.	LifeWatch	December 4, 2009
Minnesota Department of Health	Minnesota Health Dept.	December 4, 2009
Montana Telecommunications Association	Montana Telecom. Assoc.	January 11, 2010
National EMS Management Association	Nat'l EMS Management Assoc.	November 25, 2009
National Association of State Emergency Medical Services Officials	NASEMSO	December 3, 2009
National Health IT Collaborative for the Underserved	Health IT Collaborative	December 4, 2009
Northwest Healthcare	Northwest Healthcare	December 30, 2009
National Telecommunications Cooperative Association	NTCA	December 10, 2009
Pennsylvania Mountains Healthcare Alliance, Sting Communications, and University of Pittsburgh Medical Center	Penn. Mountains Healthcare	December 4, 2009
Palmetto State Providers Network	Palmetto Network	November 24, 2009
Public Safety Spectrum Trust	PSST	December 4, 2009
Qualcomm Incorporated	Qualcomm	December 4, 2009

Comments	Abbreviation	Date Filed
Rural Wisconsin Health Cooperative Information Technology Network	Rural Wisconsin Network	November 30, 2009
Siemens Enterprise Communications, Inc.	Siemens	December 4, 2009
St. John's Lutheran Hospital	St. John's Hospital	December 30, 2009
State of New York	New York	December 4, 2009
Telehealth Alliance of Oregon and the Oregon Health Network	Oregon Health Network	December 4, 2009
tw Telecom	TWTC	December 23, 2009
UnitedHealth Group	UnitedHealth	December 4, 2009
USF Consultants	USF Consultants	December 7, 2009
WellDoc	WellDoc	December 3, 2009
Western New York Rural Area Health Education Center	Western New York Area Health	December 4, 2009
West Wireless Health Institute	West Wireless Health	December 4, 2009

APPENDIX C

Initial Regulatory Flexibility Analysis

1. Pursuant to the Regulatory Flexibility Act ("RFA")[1], the Commission has prepared this Initial Regulatory Flexibility Analysis ("IRFA") of the possible significant economic impact on small entities by the policies and rules proposed in this Notice of Proposed Rulemaking. Written public comments are requested on this IRFA. Comments must be identified as responses to the IRFA and must be filed on or before the dates indicated on the first page of this NPRM. The Commission will send a copy of the NPRM, including the IRFA, to the Chief Counsel for Advocacy of the Small Business Administration.[2] In addition, the NPRM and IRFA (or summaries thereof) will be published in the Federal Register.[3]

A. Need for, and Objectives of, the Notice for Proposed Rulemaking:

2. The Commission is required by section 254 of the Communications Act of 1934, as amended, to promulgate rules to implement the universal service provisions of section 254.[4] On May 8, 1997, the Commission adopted rules that reformed its system of universal service support mechanisms so that universal service is preserved and advanced as markets move toward competition.[5] Among other programs, the Commission adopted a program to provide discounted telecommunications services to public or non-profit health care providers that serve persons in rural areas.[6] The changing technological landscape in rural health care over the past decade has prompted us to propose a new structure for the rural health care universal service support mechanism.[7]

3. In this NPRM, we seek comment on a package of potential reforms to the rural health care program that could be implemented in funding year 2011 (July 1, 2011 – June 30, 2012). The proposed reforms include: (1) establishing a broadband infrastructure program (the "health infrastructure program") that would support up to 85 percent of the construction costs of new regional or statewide networks to serve public and non-profit health care providers in areas of the country where broadband is unavailable or insufficient; (2) establishing a broadband services access program (the "health broadband services program") that would subsidize 50 percent of the monthly recurring costs for access to broadband services for eligible public or non-profit rural health care providers, which should make broadband connectivity more affordable for providers operating in rural areas.; (3) expanding the Commission's interpretation of "eligible health care provider" to include acute care facilities that provide services traditionally provided at hospitals, such as skilled nursing facilities and renal dialysis centers and facilities, and administrative offices and data centers that do not share the same building as the clinical offices of a health care provider but that perform support functions critical for the provision of health care; (4) clarifying our existing recordkeeping requirements to enhance our ability to protect against

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[1] 5 U.S.C. § 603. The RFA, 5 U.S.C. §§ 601-612 has been amended by the Contract With America Advancement Act of 1996, Public Law No. 104-121, 110 Stat. 847 (1996) ("CWAAA"). Title II of the CWAAA is the Small Business Regulatory Enforcement Fairness Act of 1996 ("SBREFA").

[2] 5 U.S.C. § 603(a).

[3] *Id.*

[4] 47 U.S.C. § 254.

[5] *1997 Universal Service Order*, 12 FCC Rcd at 9118-19, paras. 655-56.

[6] *See id.*

[7] *See Second Report and Order*, paras. 5-8.

waste, fraud and abuse; and (5) eliminating the current rule that requires that funding be offset against universal service contributions owed by participating service providers, and instead propose to allow service providers participating in the health broadband services program, the telecommunications program, and the health infrastructure program to receive rural health care funds directly from USAC.

B. Legal Basis:

4. This *Notice of Proposed Rulemaking*, including publication of proposed rules, is authorized under sections 1, 2, 4(i)–(j), 201(b), 254, 257, 303(r), and 503 of the Communications Act of 1934, as amended, and section 706 of the Telecommunications Act of 1996, as amended, 47 U.S.C. §§ 151, 152, 154(i)–(j), 201(b), 254, 257, 303(r), 503, 1302.[8]

C. Description and Estimate of the Number of Small Entities To Which Rules Will Apply:

5. The RFA directs agencies to provide a description of and, where feasible, an estimate of the number of small entities that may be affected by the proposed rules, if adopted.[9] The RFA generally defines the term "small entity" as having the same meaning as the terms "small business," "small organization," and "small governmental jurisdiction."[10] In addition, the term "small business" has the same meaning as the term "small business concern" under the Small Business Act.[11] A small business concern is one that: (1) is independently owned and operated; (2) is not dominant in its field of operation; and (3) satisfies any additional criteria established by the SBA.[12] Nationwide, there are a total of approximately 29.6 million small businesses, according to the SBA.[13] A "small organization" is generally "any not-for-profit enterprise which is independently owned and operated and is not dominant in its field."[14] Nationwide, as of 2002, there were approximately 1.6 million small organizations.[15] The term "small governmental jurisdiction" is defined generally as "governments of cities, towns, townships, villages, school districts, or special districts, with a population of less than fifty thousand."[16] Census Bureau data for 2002 indicate that there were 87,525 local governmental jurisdictions in the United States.[17] We estimate that, of this total, 84,377 entities were "small governmental jurisdictions."[18] Thus, we estimate that most governmental jurisdictions are small.

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[8] 47 U.S.C. §§ 151, 152, 154(i)–(j), 201(b), 254, 257, 303(r), 503, 1302.

[9] 5 U.S.C. § 603(b)(3).

[10] 5 U.S.C. § 601(6).

[11] 5 U.S.C. § 601(3) (incorporating by reference the definition of "small business concern" in 15 U.S.C. § 632). Pursuant to the RFA, the statutory definition of a small business applies "unless an agency, after consultation with the Office of Advocacy of the Small Business Administration and after opportunity for public comment, establishes one or more definitions of such term which are appropriate to the activities of the agency and publishes such definition(s) in the Federal Register." 5 U.S.C. § 601(3).

[12] Small Business Act, 15 U.S.C. § 632.

[13] *See* SBA, Office of Advocacy, "Frequently Asked Questions," http://web.sba.gov/faqs/faqindex.cfm?areaID=24 (revised Sept. 2009).

[14] 5 U.S.C. § 601(4).

[15] Independent Sector, The New Nonprofit Almanac & Desk Reference (2002).

[16] 5 U.S.C. § 601(5).

[17] U.S. Census Bureau, Statistical Abstract of the United States: 2006, Section 8, page 272, Table 415.

6. Small entities potentially affected by the proposals herein include eligible rural non-profit and public health care providers and the eligible service providers offering them services, including telecommunications service providers, Internet Service Providers (ISPs), and vendors of the services and equipment used for dedicated broadband networks.[19]

a. Rural Health Care Providers

7. Section 254(h)(5)(B) of the Act defines the term "health care provider" and sets forth seven categories of health care providers eligible to receive universal service support.[20] In addition, non-profit entities that act as "health care providers" on a part-time basis are eligible to receive prorated support and we have no ability to quantify how many potential eligible applicants fall into this category.

8. As noted earlier, non-profit businesses and small governmental units are considered "small entities" within the RFA. In addition, we note that census categories and associated generic SBA small business size categories provide the following descriptions of small entities. The broad category of Ambulatory Health Care Services consists of further categories and the following SBA small business size standards. The categories of small business providers with annual receipts of $7 million or less consists of: Offices of Dentists; Offices of Chiropractors; Offices of Optometrists; Offices of Mental Health Practitioners (except Physicians); Offices of Physical, Occupational and Speech Therapists and Audiologists; Offices of Podiatrists; Offices of All Other Miscellaneous Health Practitioners; and Ambulance Services.[21] The category of such providers with $10 million or less in annual receipts consists of: Offices of Physicians (except Mental Health Specialists); Family Planning Centers; Outpatient Mental Health and Substance Abuse Centers; Health Maintenance Organization Medical Centers; Freestanding Ambulatory Surgical and Emergency Centers; All Other Outpatient Care Centers, Blood and Organ Banks; and All Other Miscellaneous Ambulatory Health Care Services.[22] The category of such providers with $13.5 million or less in annual receipts consists of: Medical Laboratories; Diagnostic Imaging Centers; and Home Health Care Services.[23] The category of Ambulatory Health Care Services providers with $34.5 million or less in annual receipts consists of Kidney Dialysis Centers.[24] For all of these Ambulatory Health Care Service Providers, census data indicate that there is a combined total of 368,143 firms that operated for all of 2002.[25] Of these, 356,829 had receipts for that year of less than $5 million.[26] In addition, an additional 6,498 firms had annual receipts of $5 million to $9.99

(Continued from previous page)

[18] We assume that the villages, school districts, and special districts are small, and total 48,558. *See* U.S. Census Bureau, Statistical Abstract of the United States: 2006, section 8, page 273, Table 417. For 2002, Census Bureau data indicate that the total number of county, municipal, and township governments nationwide was 38,967, of which 35,819 were small. *Id.*

[19] 47 C.F.R. §§ 54.601, 54.621.

[20] *See* 47 U.S.C. § 254(h)(5)(B).

[21] 13 C.F.R. § 121.201, North American Industry Classification System (NAICS) Codes 621210, 621310, 621320, 621330, 621340, 621391, 621399, 621910.

[22] 13 C.F.R. § 121.201, NAICS Codes 621111, 621112, 621410, 621420, 621491, 621493, 621498, 621991, 621999.

[23] 13 C.F.R. § 121.201, NAICS Codes 621511, 621512, 621610.

[24] 13 C.F.R. § 121.201, NAICS Code 621492.

[25] U.S. Census Bureau, 2002 Economic Census, Subject Series: Health Care and Social Assistance, "Establishment and Firm Size (Including Legal Form of Organization," Table 4, NAICS code 621 (issued Nov. 2005) (*2002 Health Care Data*).

[26] *Id*.

million; and additional 3,337 firms had receipts of $10 million to $24.99 million; and an additional 865 had receipts of $25 million to $49.99 million.[27] We therefore estimate that virtually all Ambulatory Health Care Services providers are small, given SBA's size categories. We note, however, that our rules affect non-profit and public healthcare providers, and many of the providers noted above would not be considered "public" or "non-profit." In addition, we have no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

9. The broad category of Hospitals consists of the following categories, with an SBA small business size standard of annual receipts of $34.5 million or less: General Medical and Surgical Hospitals, Psychiatric and Substance Abuse Hospitals; and Specialty (Except Psychiatric and Substance Abuse) Hospitals.[28] For these health care providers, census data indicate that there is a combined total of 3,800 firms that operated for all of 2002, of which 1,651 had revenues of less than $25 million, and an additional 627 firms had annual receipts of $25 million to $49.99 million.[29] We therefore estimate that most Hospitals are small, given SBA's size categories. In addition, we have no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

10. The broad category of Social Assistance consists, *inter alia*, of the category of Emergency and Other Relief Services, with a small business size standard of annual receipts of $7 million or less.[30] For these health care providers, census data indicate that there was a total of 55 firms that operated for all of 2002.[31] All of these firms had annual receipts of below $1 million.[32] We therefore estimate that all such firms are small, given SBA's size standard. In addition, we have no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

b. Providers of Telecommunications and Other Services

Telecommunications Service Providers

11. *Incumbent Local Exchange Carriers (LECs).* Neither the Commission nor the SBA has developed a size standard for small incumbent local exchange services. The closest size standard under SBA rules is for Wired Telecommunications Carriers. Under that size standard, such a business is small if it has 1,500 or fewer employees.[33] According to Commission data, 1,311 incumbent carriers reported that they were engaged in the provision of local exchange services.[34] Of these 1,311 carriers, an estimated 1,024 have 1,500 or fewer employees and 287 have more than 1,500 employees.[35] Thus, under this category and associated small business size standard, we estimate that the majority of entities are small.

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[27] *Id*.

[28] 13 C.F.R. § 121.201, NAICS Codes 622110, 622210, 622310.

[29] 2002 Health Care Data.

[30] 13 C.F.R. § 121.201, NAICS Code 624230.

[31] 2002 Health Care Data, NAICS Code 624230.

[32] *Id*.

[33] 13 C.F.R. § 121.201, NAICS code 517110.

[34] FCC, Wireline Competition Bureau, Industry Analysis and Technology Division, "Trends in Telephone Service" at Table 5.5, Page 5-5 (August 2008) (*2008 Trends Report*) (using data that is current as of Nov. 1, 2006).

[35] *Id.*

12. We have included small incumbent local exchange carriers in this RFA analysis. A "small business" under the RFA is one that, *inter alia*, meets the pertinent small business size standard (*e.g.*, a telephone communications business having 1,500 or fewer employees), and "is not dominant in its field of operation."[36] The SBA's Office of Advocacy contends that, for RFA purposes, small incumbent local exchange carriers are not dominant in their field of operation because any such dominance is not "national" in scope.[37] We have therefore included small incumbent carriers in this RFA analysis, although we emphasize that this RFA action has no effect on the Commission's analyses and determinations in other, non-RFA contexts.

13. *Interexchange Carriers*. Neither the Commission nor the SBA has developed a definition of small entities specifically applicable to providers of interexchange services (IXCs). The closest applicable definition under the SBA rules is for wired telecommunications carriers.[38] This provides that a wired telecommunications carrier is a small entity if it employs no more than 1,500 employees.[39] According to the Commission's *2008 Trends Report*, 300 companies reported that they were engaged in the provision of interexchange services.[40] Of these 300 IXCs, an estimated 268 have 1,500 or few employees and 32 have more than 1,500 employees.[41] Consequently, the Commission estimates that most providers of interexchange services are small businesses.

14. *Competitive Access Providers*. Neither the Commission nor the SBA has developed a definition of small entities specifically applicable to competitive access services providers (CAPs). The closest applicable definition under the SBA rules is for wired telecommunications carriers.[42] This provides that a wired telecommunications carrier is a small entity if it employs no more than 1,500 employees.[43] According to the *2008 Trends Report*, 1,005 CAPs and competitive local exchange carriers (competitive LECs) reported that they were engaged in the provision of competitive local exchange services.[44] Of these 1,005 CAPs and competitive LECs, an estimated 918 have 1,500 or few employees and 87 have more than 1,500 employees.[45] Consequently, the Commission estimates that most providers of competitive exchange services are small businesses.

15. *Wireless Telecommunications Carriers (except Satellite)*. Since 2007, the Census Bureau has placed wireless firms within this new, broad, economic census category.[46] Prior to that time, such

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[36] 5 U.S.C. § 601(3).

[37] *See* Letter from Jere W. Glover, Chief Counsel for Advocacy, SBA, to William E. Kennard, Chairman, FCC, dated May 27, 1999. The Small Business Act contains a definition of "small business concern," which the RFA incorporates into its own definition of "small business." *See* U.S.C. § 632(a) (Small Business Act); 5 U.S.C. § 601(3) (RFA). SBA regulations interpret "small business concern" to include the concept of dominance on a national basis. 13 C.F.R. § 121.102(b).

[38] 13 C.F.R. § 121.201, NAICS code 517110.

[39] *Id.*

[40] *2008 Trends Report*, Table 5.3, page 5-5.

[41] *Id.*

[42] 13 C.F.R. § 121.201, NAICS code 517110.

[43] *Id.*

[44] *2008 Trends Report*, Table 5.3, page 5-5.

[45] *Id.*

[46] U.S. Census Bureau, 2007 NAICS Definitions, "517210 Wireless Telecommunications Categories (Except Satellite)"; http://www.census.gov/naics/2007/def/ND517210.HTM#N517210.

firms were within the now-superseded categories of "Paging" and "Cellular and Other Wireless Telecommunications."[47] Under the present and prior categories, the SBA has deemed a wireless business to be small if it has 1,500 or fewer employees.[48] Because Census Bureau data are not yet available for the new category, we will estimate small business prevalence using the prior categories and associated data. For the category of Paging, data for 2002 show that there were 807 firms that operated for the entire year.[49] Of this total, 804 firms had employment of 999 or fewer employees, and three firms had employment of 1,000 employees or more.[50] For the category of Cellular and Other Wireless Telecommunications, data for 2002 show that there were 1,397 firms that operated for the entire year.[51] Of this total, 1,378 firms had employment of 999 or fewer employees, and 19 firms had employment of 1,000 employees or more.[52] Thus, we estimate that the majority of wireless firms are small.

16. *Wireless Telephony*. Wireless telephony includes cellular, personal communications services, and specialized mobile radio telephony carriers. As noted, the SBA has developed a small business size standard for Wireless Telecommunications Carriers (except Satellite).[53] Under the SBA small business size standard, a business is small if it has 1,500 or fewer employees.[54] According to the *2008 Trends Report*, 434 carriers reported that they were engaged in wireless telephony.[55] Of these, an estimated 222 have 1,500 or fewer employees and 212 have more than 1,500 employees.[56] We have estimated that 222 of these are small under the SBA small business size standard.

17. *Satellite Telecommunications and All Other Telecommunications*. These two economic census categories address the satellite industry. The first category has a small business size standard of $15 million or less in average annual receipts, under SBA rules.[57] The second has a size standard of $25 million or less in annual receipts.[58] The most current Census Bureau data in this context, however, are

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[47] U.S. Census Bureau, 2002 NAICS Definitions, "517211 Paging"; http://www.census.gov/epcd/naics02/def/NDEF517.HTM; U.S. Census Bureau, 2002 NAICS Definitions, "517212 Cellular and Other Wireless Telecommunications"; http://www.census.gov/epcd/naics02/def/NDEF517.HTM.

[48] 13 C.F.R. § 121.201, NAICS code 517210 (2007 NAICS). The now-superseded, pre-2007 C.F.R. citations were 13 C.F.R. § 121.201, NAICS codes 517211 and 517212 (referring to the 2002 NAICS).

[49] U.S. Census Bureau, 2002 Economic Census, Subject Series: Information, "Establishment and Firm Size (Including Legal Form of Organization," Table 5, NAICS code 517211 (issued Nov. 2005).

[50] *Id.* The census data do not provide a more precise estimate of the number of firms that have employment of 1,500 or fewer employees; the largest category provided is for firms with "1000 employees or more."

[51] U.S. Census Bureau, 2002 Economic Census, Subject Series: Information, "Establishment and Firm Size (Including Legal Form of Organization," Table 5, NAICS code 517212 (issued Nov. 2005).

[52] *Id.* The census data do not provide a more precise estimate of the number of firms that have employment of 1,500 or fewer employees; the largest category provided is for firms with "1000 employees or more."

[53] 13 C.F.R. § 121.201, NAICS code 517210.

[54] *Id*.

[55] "Trends in Telephone Service" at Table 5.3.

[56] "Trends in Telephone Service" at Table 5.3.

[57] 13 C.F.R. § 121.201, NAICS code 517410.

[58] 13 C.F.R. § 121.201, NAICS code 517919.

from the (last) economic census of 2002, and we will use those figures to gauge the prevalence of small businesses in these categories.[59]

18. The category of Satellite Telecommunications "comprises establishments primarily engaged in providing telecommunications services to other establishments in the telecommunications and broadcasting industries by forwarding and receiving communications signals via a system of satellites or reselling satellite telecommunications.[60] For this category, Census Bureau data for 2002 show that there were a total of 371 firms that operated for the entire year.[61] Of this total, 307 firms had annual receipts of under $10 million, and 26 firms had receipts of $10 million to $24,999,999.[62] Consequently, we estimate that the majority of Satellite Telecommunications firms are small entities that might be affected by our action.

19. The second category of All Other Telecommunications comprises, *inter alia*, "establishments primarily engaged in providing specialized telecommunications services, such as satellite tracking, communications telemetry, and radar station operation. This industry also includes establishments primarily engaged in providing satellite terminal stations and associated facilities connected with one or more terrestrial systems and capable of transmitting telecommunications to, and receiving telecommunications from, satellite systems."[63] For this category, Census Bureau data for 2002 show that there were a total of 332 firms that operated for the entire year.[64] Of this total, 303 firms had annual receipts of under $10 million and 15 firms had annual receipts of $10 million to $24,999,999.[65] Consequently, we estimate that the majority of All Other Telecommunications firms are small entities that might be affected by our action.

Internet Service Providers

20. The 2007 Economic Census places these firms, whose services might include voice over Internet protocol (VoIP), in either of two categories, depending on whether the service is provided over the provider's own telecommunications facilities (*e.g.*, cable and DSL ISPs), or over client-supplied telecommunications connections (*e.g.*, dial-up ISPs). The former are within the category of Wired Telecommunications Carriers,[66] which has an SBA small business size standard of 1,500 or fewer employees.[67] The latter are within the category of All Other Telecommunications,[68] which has a size

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[59] 13 C.F.R. § 121.201, NAICS codes 517410 and 517910 (2002)

[60] U.S. Census Bureau, 2007 NAICS Definitions, "517410 Satellite Telecommunications"; http://www.census.gov/naics/2007/def/ND517410.HTM.

[61] U.S. Census Bureau, 2002 Economic Census, Subject Series: Information, "Establishment and Firm Size (Including Legal Form of Organization)," Table 4, NAICS code 517410 (issued Nov. 2005).

[62] *Id*. An additional 38 firms had annual receipts of $25 million or more.

[63] U.S. Census Bureau, 2007 NAICS Definitions, "517919 All Other Telecommunications"; http://www.census.gov/naics/2007/def/ND517919.HTM#N517919.

[64] U.S. Census Bureau, 2002 Economic Census, Subject Series: Information, "Establishment and Firm Size (Including Legal Form of Organization)," Table 4, NAICS code 517910 (issued Nov. 2005).

[65] *Id*. An additional 14 firms had annual receipts of $25 million or more.

[66] U.S. Census Bureau, 2007 NAICS Definitions, "517110 Wired Telecommunications Carriers"; http://www.census.gov/naics/2007/def/ND517110.HTM#N517110.

[67] 13 C.F.R. § 121.201, NAICS code 517110 (updated for inflation in 2008).

standard of annual receipts of $25 million or less.[69] The most current Census Bureau data for all such firms, however, are the 2002 data for the previous census category called Internet Service Providers.[70] That category had a small business size standard of $21 million or less in annual receipts, which was revised in late 2005 to $23 million. The 2002 data show that there were 2,529 such firms that operated for the entire year.[71] Of those, 2,437 firms had annual receipts of under $10 million, and an additional 47 firms had receipts of between $10 million and $24, 999,999.[72] Consequently, we estimate that the majority of ISP firms are small entities.

Vendors and Equipment Manufacturers

21. *Vendors of Infrastructure Development or "Network Buildout."* The Commission has not developed a small business size standard specifically directed toward manufacturers of network facilities. The closest applicable definition of a small entity are the size standards under the SBA rules applicable to manufacturers of "Radio and Television Broadcasting and Communications Equipment" (RTB) and "Other Communications Equipment."[73]

22. *Telephone Apparatus Manufacturing*. The Census Bureau defines this category as follows: "This industry comprises establishments primarily engaged in manufacturing wire telephone and data communications equipment. These products may be standalone or board-level components of a larger system. Examples of products made by these establishments are central office switching equipment, cordless telephones (except cellular), PBX equipment, telephones, telephone answering machines, LAN modems, multi-user modems, and other data communications equipment, such as bridges, routers, and gateways."[74] The SBA has developed a small business size standard for Telephone Apparatus Manufacturing, which is: all such firms having 1,000 or fewer employees.[75] According to Census Bureau data for 2002, there were a total of 518 establishments in this category that operated for the entire year.[76] Of this total, 511 had employment of under 1,000, and an additional 7 had employment

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[68] U.S. Census Bureau, 2007 NAICS Definitions, "517919 All Other Telecommunications"; http://www.census.gov/naics/2007/def/ND517919.HTM#N517919.

[69] 13 C.F.R. § 121.201, NAICS code 517919 (updated for inflation in 2008).

[70] U.S. Census Bureau, "2002 NAICS Definitions: 518111 Internet Service Providers"; http://www.census.gov/epcd/naics02/def/NDEF518.HTM.

[71] U.S. Census Bureau, 2002 Economic Census, Subject Series: Information, "Establishment and Firm Size (Including Legal Form of Organization)," Table 4, NAICS code 518111 (issued Nov. 2005).

[72] An additional 45 firms had receipts of $25 million or more.

[73] 13 C.F.R. § 121.201, NAICS Codes 334220, 334290.

[74] U.S. Census Bureau, 2002 NAICS Definitions, "334210 Telephone Apparatus Manufacturing"; http://www.census.gov/epcd/naics02/def/NDEF334.HTM#N3342.

[75] 13 C.F.R. § 121.201, NAICS code 334210.

[76] U.S. Census Bureau, American FactFinder, 2002 Economic Census, Industry Series, Industry Statistics by Employment Size, NAICS code 334210 (released May 26, 2005); http://factfinder.census.gov. The number of "establishments" is a less helpful indicator of small business prevalence in this context than would be the number of "firms" or "companies," because the latter take into account the concept of common ownership or control. Any single physical location for an entity is an establishment, even though that location may be owned by a different establishment. Thus, the numbers given may reflect inflated numbers of businesses in this category, including the numbers of small businesses. In this (continued….)

of 1,000 to 2,499.[77] Thus, under this size standard, the majority of firms can be considered small.

23. *Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing.* The Census Bureau defines this category as follows: "This industry comprises establishments primarily engaged in manufacturing radio and television broadcast and wireless communications equipment. Examples of products made by these establishments are: transmitting and receiving antennas, cable television equipment, GPS equipment, pagers, cellular phones, mobile communications equipment, and radio and television studio and broadcasting equipment."[78] The SBA has developed a small business size standard for Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing, which is: all such firms having 750 or fewer employees.[79] According to Census Bureau data for 2002, there were a total of 1,041 establishments in this category that operated for the entire year.[80] Of this total, 1,010 had employment of under 500, and an additional 13 had employment of 500 to 999.[81] Thus, under this size standard, the majority of firms can be considered small.

24. *Other Communications Equipment Manufacturing.* The Census Bureau defines this category as follows: "This industry comprises establishments primarily engaged in manufacturing communications equipment (except telephone apparatus, and radio and television broadcast, and wireless communications equipment)."[82] The SBA has developed a small business size standard for Other Communications Equipment Manufacturing, which is: all such firms having 750 or fewer employees.[83] According to Census Bureau data for 2002, there were a total of 503 establishments in this category that operated for the entire year.[84] Of this total, 493 had employment of under 500, and an additional 7 had

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category, the Census breaks-out data for firms or companies only to give the total number of such entities for 2002, which was 450.

[77] *Id*. An additional 4 establishments had employment of 2,500 or more.

[78] U.S. Census Bureau, 2002 NAICS Definitions, "334220 Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing"; http://www.census.gov/epcd/naics02/def/NDEF334.HTM#N3342.

[79] 13 C.F.R. § 121.201, NAICS code 334220.

[80] U.S. Census Bureau, American FactFinder, 2002 Economic Census, Industry Series, Industry Statistics by Employment Size, NAICS code 334220 (released May 26, 2005); http://factfinder.census.gov. The number of "establishments" is a less helpful indicator of small business prevalence in this context than would be the number of "firms" or "companies," because the latter take into account the concept of common ownership or control. Any single physical location for an entity is an establishment, even though that location may be owned by a different establishment. Thus, the numbers given may reflect inflated numbers of businesses in this category, including the numbers of small businesses. In this category, the Census breaks-out data for firms or companies only to give the total number of such entities for 2002, which was 929.

[81] *Id*. An additional 18 establishments had employment of 1,000 or more.

[82] U.S. Census Bureau, 2002 NAICS Definitions, "334290 Other Communications Equipment Manufacturing"; http://www.census.gov/epcd/naics02/def/NDEF334.HTM#N3342.

[83] 13 C.F.R. § 121.201, NAICS code 334290.

employment of 500 to 999.[85] Thus, under this size standard, the majority of firms can be considered small.

D. Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements

25. The reporting and recordkeeping requirements in this *NPRM* could have an impact on both small and large entities. However, even though the impact may be more financially burdensome for smaller entities, the Commission believes the impact of such requirements is outweighed by the benefit of providing the additional support necessary to make broadband available for rural health care providers to provide health care to rural and remote areas, and to make broadband access rates for public and non-profit rural health care providers affordable. Further, these requirements are necessary to ensure that the statutory goals of section 254 of the Telecommunications Act of 1996 are met without waste, fraud, or abuse.

26. We propose an application and selection process for the health infrastructure program in which eligible health care providers may seek funding for qualified projects through a streamlined process. We seek comment on each step of the process described below. To the extent commenters disagree with a particular aspect of the proposed process, we ask them to identify that with specificity and propose an alternative.

27. Initial Application Phase. First, applicants may request consideration for funding by completing a user friendly online application available on a website to be developed and maintained by USAC. Applications would be accepted during the first quarter of each funding year (July 1 to September 30). As part of this initial application phase, an applicant would be required to (1) verify that either there is no available broadband infrastructure or the existing available broadband infrastructure is insufficient for health IT needed to improve and provide health care delivery, (2) provide letters of agency for each of the eligible health care providers in the applicant's proposed network, (3) include a preliminary budget and an infrastructure funding request, not in excess of the per-project caps discussed below, and (4) certify that it will comply with all program requirements if selected for funding.

28. Project Selection Phase. We propose that applications submitted for funding be made publicly available on USAC's website. Publicly available information would include the names of the parties seeking funding, their geographic location, and information filed by the applicants to corroborate that sufficient broadband infrastructure is unavailable or insufficient in their geographic location. During the second quarter of each funding year (October 1 to December 31), USAC would review all applications received during the initial application phase. After applications have been reviewed, and prioritization rules have been applied, USAC would notify selected participants of their project eligibility status. This would normally occur during the third quarter of each funding year (January 1 to March 30).

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[84] U.S. Census Bureau, American FactFinder, 2002 Economic Census, Industry Series, Industry Statistics by Employment Size, NAICS code 334290 (released May 26, 2005); http://factfinder.census.gov. The number of "establishments" is a less helpful indicator of small business prevalence in this context than would be the number of "firms" or "companies," because the latter take into account the concept of common ownership or control. Any single physical location for an entity is an establishment, even though that location may be owned by a different establishment. Thus, the numbers given may reflect inflated numbers of businesses in this category, including the numbers of small businesses. In this category, the Census breaks-out data for firms or companies only to give the total number of such entities for 2002, which was 471.

[85] *Id*. An additional 3 establishments had employment of 1,000 or more.

After a participant is notified of project eligibility, it may proceed with the project commitment phase per the requirements set forth below. During the project commitment phase, participants may receive funding from the health infrastructure program for a portion of the reasonable administrative expenses incurred in connection with the project, subject to certain caps.

29. Project Commitment Phase. Within 90 days after a participant in the health infrastructure program is notified that, based on its initial application, the participant's project is eligible for funding, the participants would complete and submit all application materials and comply with all program requirements, including the following: (1) certification of the availability of funds for not less than 15 percent of all eligible costs;; (2) a project schedule; and (3) a detailed project description. The project schedule would identify key milestones that the project will accomplish and the date that the tasks would be achieved. The detailed project description would describe the network, identify the proposed technology, demonstrates that the project is technically feasible and reasonably scalable, and describe each specific development phase of the project (e.g., network design phase, construction period, deployment, maintenance period).

30. In addition, prior to receiving a funding commitment letter from USAC, participants would be required to submit a sustainability report demonstrating that the costs of network operations and maintenance will be sustainable after such period of support from the health infrastructure program. If an infrastructure project includes bandwidth that may be used by entities that are not eligible health care providers, the Commission will consider the extra bandwidth to be excess capacity and would require the participant to file excess capacity disclosures. The Commission would require the excess capacity disclosures to: (1) identify users of the excess capacity and delineate how they are paying for their portion of the costs, and (2) describe generally agreements made between the health care network portion of the project and the community use portion of the project (e.g., cost allocation, sharing agreements, maintenance and access, ownership).

31. We also propose adopting a rule that would require health care providers to obtain certain cost information from vendors. Vendors would be required to make certain certifications with respect to the construction and deployment of the dedicated network. They would also be required to provide participants with a depreciation schedule showing the useful life of fixed assets, as well as maintain books and records that support all cost allocations.

32. USAC would review each step of the project commitment phase to confirm the participant's compliance with all data and information requirements and compliance with program rules. USAC would conduct technical and financial review of all proposed projects to ensure that they comply with the Commission's rules. USAC may request additional information from applicants and participants if deemed necessary to substantiate, explain or clarify any materials submitted as part of the funding process.

33. Health infrastructure program participants would be required to submit quarterly reports that provide information regarding the following: (1) attaining project milestones, (2) status of obtaining 15 percent minimum match, (3) status of the competitive bidding process, (4) details on how the supported network has complied with HHS health IT initiatives, and (6) performance measures. The project milestones would be updated at the time that quarterly reports are filed by the participants, noting which project milestones have been met and any delays or progress in meeting other milestones. We believe that requiring participants in the health infrastructure program to establish a schedule and report on project milestones will assist USAC and the Commission in assessing a participant's progress in completing project buildout, and will reduce waste, fraud, and abuse.

34. We also propose several reporting and recordkeeping requirements for the health broadband services program and the health infrastructure program. We propose that health care providers that receive support under the health broadband services program or the health infrastructure program

would be required to complete a certification that identifies the speed of any connection supported by the Rural Health Care Support Mechanism. They would also indicate, as a result of broadband access, the type of health IT applications they were using and the frequency with which they used they used the applications. We also propose the retention of the existing competitive bidding requirements for both programs, because we believe that competitive bidding has been successful regarding the prevention of waste, fraud, and abuse in the Rural Health Care Support Mechanism

35. Finally, the current rules establish a five year document retention period for health care providers. The Commission recommends that it adopt the same requirement for service providers and non-telecommunications carriers. The Commission believes that it should clarify that the documents would include all records related to the application for, receipt and delivery of discounted services. The Commission also seeks comment on whether it should adopt any additional rules regarding record keeping requirements.

E. Steps Taken to Minimize Significant Economic Impact on Small Entities, and Significant Alternatives Considered

36. The RFA requires an agency to describe any significant alternatives that it has considered in reaching its approach, which may include the following four alternatives, among others: (1) the establishment of differing compliance or reporting requirements or timetables that take into account the resources available to small entities; (2) the clarification, consolidation, or simplification of compliance or reporting requirements under the rule for small entities; (3) the use of performance, rather than design, standards; and (4) an exemption from coverage of the rule, or any part thereof, for small entities.[86]

37. In this NPRM, we make a number of proposals that may have an economic impact on small entities that participate in the universal service support mechanism for rural health care providers. Specifically, as addressed above, we seek comment on: (1) establishing a broadband infrastructure program (the "health infrastructure program") for eligible health care providers; (2) establishing a broadband services access program (the "health broadband services program") for eligible health care providers; (3) expanding the number of entities eligible for discounts by broadening the interpretation of the definition of eligible health care providers to include off-site data centers and administrative offices, as well as skilled nursing facilities and renal dialysis centers; and (4) establishing performance measures for eligible health care providers receiving broadband support. If adopted, these proposals will change the size of the overall pool of eligible applicants that may receive universal service support under the Rural Health Care Support Mechanism, as well as affect the amount of support that eligible entities may receive.

38. In seeking to minimize the burdens imposed on small entities where doing so does not compromise the goals of the universal service mechanism, we have invited comment on how these proposals might be made less burdensome for small entities. We again invite commenters to discuss the benefits of such changes on small entities and whether these benefits are outweighed by resulting costs to rural health care providers that might also be small entities. We anticipate that the record will reflect whether the overall benefits of such programmatic changes would outweigh the burdens on small entities, and if so, suggest alternative ways in which the Commission could lessen the overall burdens on small entities. We encourage small entities to comment.

39. We have taken the following steps to minimize the impact on small entities. First, to ease the administrative burden on applicants, we propose an approach that simplifies the application process

[86] 5 U.S.C. § 603.

for rural health care providers. We believe that this will help ensure that applicants, including small entities, will not be deterred from applying for support due to administrative burdens. Applicants for support from the health infrastructure program may choose between three methods in order to demonstrate the need requirement for infrastructure funding. An applicant may choose a method that would not require preparation by a third party. We also propose that participants in the health infrastructure program may receive funding for a portion of their administrative expenses in order to ease the financial burden of compliance with the various reporting requirements associated with participation in the health infrastructure program.

40. We also recognize that participants in the health infrastructure program, particularly smaller projects, or projects that are subject to mandatory, state or local procurement rules, may find the proposed RFP preparation and distribution requirements to be overly burdensome. Accordingly, we have included an exception for such projects that would exclude infrastructure projects of $100,000 or less or projects that are subject to mandatory, state or local procurement rules. However, such projects would still be required to complete a request for services on a Form 465 and posting this request on USAC's webpage for a period of at least 28 days before selecting a vendor.

41. Next, in order to encourage participation in the health broadband services program, we propose a simplified application process that clearly identifies the level of support that providers can reasonably expect to receive.[87] The proposed 50 percent flat discount promotes prudent business decisions thereby assisting rural health care providers in planning for their health-IT needs.[88] Moreover, a flat rate discount is easy to administer and consistent with section 254(b)(5),[89] which requires "a specific, sufficient, and predictable mechanism . . . because it limits the amount of support that each health care provider may receive per month to a reasonable level."[90]

42. We propose to simplify the forms process used in the application process.

F. Federal Rules that May Duplicate, or Conflict with Proposed Rules:

43. None.

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[87] NBP at 215.

[88] *2003 Report and Order and FNPRM*, 18 FCC Rcd at 24560, para. 27.

[89] 47 U.S.C. § 254(b)(5).

[90] 47 U.S.C. § 254(b)(5); *2003 Report and Order and FNPRM*, 18 FCC Rcd at 24560, para. 27.

STATEMENT OF
CHAIRMAN JULIUS GENACHOWSKI

Re: *Rural Health Care Universal Service Support Mechanism*, WC Docket No. 02-60

What we do at the Commission every day is important. Typically it's not a matter of life or death. This is.

In the 21st century, high quality health care depends on broadband connectivity. But today, too many clinics and hospitals lack affordable access to broadband connectivity adequate to handle basic telehealth tasks, like transmitting an x-ray, MRI, or other electronic medical records, or consulting remotely with a doctor. In fact, nearly thirty percent of federally funded rural health care clinics don't have secure and reliable broadband services. These are clinics at the farthest reaches of the United States, and in the center; in small town Appalachia, in the great Northwest plains, in the vast deserts of the Southwest, and in virtually every region of our country. In some areas, the numbers are even lower than the distressingly low average. Only eight percent of Indian Health Service Centers even have access to the broadband they would need to deliver advanced health care to their patients.

To achieve the goals of a 21st century health care system, including telemedicine and utilizing electronic medical records, to deliver better health care more broadly, and to lower the costs of our medical system, we need to ensure that hospitals and clinics have the technology tools and connectivity they need. Today, we are introducing a new and transformed rural health care connectivity program that would expand investment in broadband for medically underserved communities across the country. The program would give patients in rural areas access to state-of-the-art diagnostic tools now typically available only in the largest and most sophisticated medical centers. This program has the potential to do for rural health care providers and patients what the enormously successful E-Rate program has done for schools and students.

This program builds on the foundation of the existing rural health care pilot program and the lessons learned from recent pilots to extend infrastructure in rural America, like the Iowa Health System, California Telehealth Network, Oregon Health Network, Health Information Exchange of Montana, and West Virginia Telehealth Alliance. It also brings together many important voices in the health care ecosystem, including clinics and hospitals, doctors and patients, broadband service providers, medical and technology experts, entrepreneurs, and investors looking to support and unleash innovation in this important area.

The program's investment in broadband connectivity would not only improve care, but also significantly reduce health care costs – potentially saving billions of dollars. It would spur private investment in networks as well as innovative health-related applications, and would create jobs that range from building infrastructure to developing and implementing health IT solutions. Without increasing the projected size of the overall universal service fund, this program would invest up to $400 million annually to enable doctors, nurses, hospitals, and clinics to deliver world-class health care to patients, no matter where they live. The program would have a real impact on communities across the country, including up to 12,000 hospitals, clinics, and other rural health care providers – a twenty percent increase over the current program. It would help connect a limited supply of specialists to a growing patient base that needs their expertise, and make it easier for people to get the treatment they need – be it emergency care, chronic condition treatment and management, or wellness promotion.

These technological breakthroughs have a real impact on patients, their families, and our broader health care system. For instance, with telemedicine, patients don't have to travel long distances to receive care, jeopardizing their jobs and the jobs of their family members. Without the obstacles of distance, they are also more likely to keep appointments and complete treatments. People shouldn't have to choose

between their jobs and their health. Broadband-powered telehealth can turn what today is a painful choice into a false choice – achieving better care, and lowering overall medical costs.

The results of telemedicine have been remarkable. Broadband enables remote screening and counseling for diabetics and heart patients, remote monitoring of babies in neo-natal intensive care units, and much more. I recently learned about a teenager in rural North Dakota who was in a semi-conscious state after a serious car accident. The closest hospital with expertise to treat her was more than 100 miles away. But the local hospital was able to use broadband to access the expertise necessary to save her life. In Massachusetts, a woman suffering a stroke was treated via video link by a stroke specialist 75 miles away at Mass General. Without the specialist's consult, the woman wouldn't have received a life-saving drug and made a full recovery. In another case, a young boy with a painful skin condition couldn't get the treatment he needed from a local physician. A dermatologist at a distant hospital was able to diagnose him over broadband, helping him get the treatment he needed to relieve his suffering. Recently, I spoke with doctors in Hawaii and California who've used broadband-enabled telemedicine to reduce long-distance chemotherapy visits by 90%, and save the sight of newborns through remote diagnostics.

This program is a critical step in fulfilling the vision of the National Broadband Plan. It establishes a fiscally prudent program to invest in infrastructure for health care connectivity, without increasing costs to consumers, and makes an expanded range of broadband services more affordable. It would stimulate additional private investment and innovation in both broadband and health IT. By requiring that participants secure matching funds for both infrastructure and services, we are forging a public-private partnership to act in a smart and fiscally responsible way. And by expanding the market for health-related technologies and applications, we will promote innovation and private investment. With the help of all participants in this process, we intend to design and implement this program with the best ideas to drive real results and greater efficiency.

The proposed reforms would not only improve health care, but also reduce the costs of care, yielding a substantial return on investment. Implementing an electronic health records system could save our nation over $500 billion over 15 years, but a functioning EHR system requires broadband connectivity. Remote monitoring of chronic conditions saves tens of billions more each year by enabling doctors to identify health problems early, thereby avoiding hospital readmissions and shortening average hospital stays. To help monitor the return on our investment, today's Notice suggests developing performance measures to ensure that the funds supporting broadband connectivity are used in a manner that produces quantifiable benefits.

In addition to today's action, we will be taking another important step later this month to help unleash investment and innovation in health-related devices by increasing the predictability and speed of regulatory approvals. We are collaborating with the Food and Drug Administration to better understand the future of wireless health technology and to promote investment and innovation is this strongly promising area.

I look forward to working with my colleagues to launch a health care program for the 21st century, and I thank the staff for their hard work on today's item.

STATEMENT OF
COMMISSIONER MICHAEL J. COPPS

Re: *Rural Health Care Support Mechanism;* WC Docket No. 02-60

Once again, I am pleased to see an item on the agenda that takes another step toward achieving the goals of the National Broadband Plan. Since I came to the Commission, I have pointed out the unfortunate truth that rural America lags behind the rest of the country when it comes to access to first-rate health care. That's bad news for such a prosperous nation as ours. To help remedy this, I have encouraged the Commission to be more proactive in putting the Universal Service Fund's rural health care dollars to work by bringing advanced telecommunications to health care facilities across America. I have seen first hand the difference that telemedicine and telehealth can make in improving the quality of life in rural communities by providing patients in remote areas with access to services that would otherwise have been unavailable. Now, in areas that have the funding and knowhow to access and use it, telecommunications infrastructure provides access to desperately needed services such as patient-diagnostic services, patient follow-up care, educational offerings for rural health care professionals, and the dissemination of all sorts of critical health-related information, to name a few. When it comes to the well-being of our citizens who live hundreds of miles from the nearest hospital and are in need of medical care, telemedicine can be life altering, and sometimes life-saving.

So, I am happy to support today's item, which seeks to move forward with the National Broadband Plan's vision of expanding the reach and use of broadband connectivity to and by health care providers. We've known for some time that the existing rural health care program has not been living up to its potential. With a set-aside of $400 million per year, we disburse less than twenty percent of that amount—sometimes far less than that—annually. In 2007, the Commission established the Rural Health Care Pilot Program, which has been an eye-opening experience for the Commission, showing us first-hand the need for a health infrastructure support program and demonstrating what we need to do to make such a program work. To date, the Pilot Program has made funding commitments of up to $216 million for 29 projects that will link hundreds of hospitals regionally in 24 states. An additional 36 projects are under review. This is a good start, but we have a long way to go to meet the infrastructure needs of health care facilities in rural areas.

In the NPRM, we seek comment on creating a permanent fund for the build-out of much-needed health infrastructure in rural areas. It poses many questions in an effort to cover all the bases, from expanding the list of eligible recipients, to awarding support to applicants with the most efficient proposals, to providing safeguards against waste, fraud and abuse, and everything in between. In addition, we seek comment on reform of the existing health care fund to provide support where needed for access to telecommunications and broadband services. We must keep in mind that the basic task is to get a high speed, high capacity broadband network to these institutions—and we must make sure this process is accessible to eligible applicants. As we have learned from our current Rural Health Care Program and the Pilot Program, any such program needs outreach and a user-friendly application process. The Rural Health Care Program is as strong as the community that knows about it. And, while any funding program must seek to deter waste, fraud and abuse, the complexity of the process must not deter worthy applicants. I recognize that this is no easy task, and I appreciate today's detailed inquiry. I have high hopes that the Notice brings forth a fully developed record from a broad spectrum of interested parties, and I am pleased that the item specifically encouraged input from Tribal governments.

Access to healthcare is so vitally important—this program deserves to be empowered so that, at the very least, healthcare providers can have access to the health IT services available, and patients can get the health care they need, no matter where they are in this great country. I thank my colleagues for their support of the Rural Health Care Program, and I want to express my gratitude to the Bureau for its hard work on this item. I look forward to moving forward to actions that will make this a hugely successful program.

STATEMENT OF
COMMISSIONER ROBERT M. McDOWELL

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

In establishing the Rural Health Care Program, Congress recognized the importance of rural America having access to advanced healthcare just like urban America, and it envisioned that this program could help. During my travels as a Commissioner, I have witnessed first-hand some of the tremendous benefits that telemedicine has provided to rural America especially in areas of Alaska that are not even connected to the road system let alone a health care system. Although the Rural Health Care Program has been successful in some parts of the country, more Americans could stand to benefit from it. As such, I commend the Chairman for initiating this Notice of Proposed Rulemaking (NPRM) which seeks comment on various ideas to reform the program.

Thankfully, allocations for the Rural Health Care Program have never reached the Commission-imposed $400 million annual cap. With fiscal restraint in mind, the reform ideas outlined in this NPRM identify ways to bring the program's benefits to a greater number of rural Americans. In reality, however, if these reforms are implemented, we could face increased demand on the overall Universal Service Fund. As such, I am pleased that the Commission is highlighting our intention to retain the $400 million spending cap.

Additionally, I would be remiss if I did not reiterate my strong desire that the Commission identify and finalize reforms that provide savings in other areas of the Universal Service Fund. It is critical that the Commission undertake this examination in a comprehensive manner so that any reforms that we may implement in the rural health care arena do not simply result in runaway growth of the overall Universal Service Fund.

This is not the first time that the FCC has made reforms to the program. Most recently, the Commission established the Rural Health Care Pilot Program which both Commissioner Copps and I supported along with all of our colleagues in 2006. While the pilot program has shown some success, it did experience some bumps along the way. As such, I support our effort to build on the lessons we have learned from that experience. For example, the pilot program required a fifteen percent match to all eligible costs. We learned, however, that some participants had difficulty obtaining the funds for the match requirement. To avoid this type of situation in the future, we propose that receipt of infrastructure funds be conditioned upon certification of the availability of matching funds.

Finally, I cannot underscore enough that we need to always remember Congress' original intent in establishing this program under Section 254 of the Act. Congress' mandate was for us to ensure that rural parts of our nation are connected to medical assistance. Some parts of rural America simply do not have any access to health care, period - no doctors, no nurses, no technicians. To be fiscally responsible, we need to be mindful in this proceeding, and in future proceedings, that this program's mission is critically important to rural America and Congress did not intend for it to be expanded to fulfill other goals.

In conclusion, I commend Sharon Gillett, Carol Mattey, Tom Buckley, Ernesto Beckford, and the many other Bureau staff for their diligence and hard work on this challenging but important initiative. I look forward to reviewing the record and working with all of my colleagues and stakeholders in pursuit of fiscally prudent reforms that also ensure that rural America continues to benefit from this program.

STATEMENT OF
COMMISSIONER MIGNON L. CLYBURN

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

I just returned from a trip to the "Great Land", where I had an incredible opportunity to see first-hand, how USF policies that promote rural health care are making a difference in the lives of Alaskans. Through telemedicine, those who live in remote areas can receive care that was either previously out of reach, or would have otherwise required them to travel hundreds of miles, most often by aircraft, which is unbelievably expensive, and often requires multiple days of work, and school to be missed. Not only can our broadband policies help in delivering much needed health care to hard-to-serve areas, they also can save consumers both time and money.

As the National Broadband Plan recognizes, and as discussed in this Notice, our policies can do more to promote better health care throughout our nation, and improve even more lives in rural America. This Notice is a very good start, and I am pleased that it specifically requests input from Tribal governments and insular areas. There are certain geographic areas in this great nation, that may require us to consider a different approach to address the unique needs found in those areas. As my trip to Alaska illustrates, our nation is vast and diverse, and "one size" does not necessarily fit all.

I look forward to engaging with interested parties on the issues raised in this Notice, so that we can implement rural health care mechanisms that will benefit the most Americans.

STATEMENT OF
COMMISSIONER MEREDITH A. BAKER

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

Of the many programs we manage, the Rural Health Care support mechanism is one where we can vividly see how it can have a real impact on the lives of consumers, in this case patients. It has already been instrumental in bringing state-of-the-art health care to remote areas where that was previously impossible. Many of us have been privileged to see first hand the way the Rural Health Care program has helped bridge critical health care gaps posed by unique geographic and economic challenges. My sense of how meaningful rural clinics are to their communities was shaped in large part by my visit to see the Bristol Bay Area Health Corporation in Alaska—a system that now serves 34 villages and relies on communications technologies to bring quality health services to the tribes of Bristol Bay.

Telemedicine, and networks to support it, will become even more important as all aspects of our lives, including health care, become increasingly dependent upon and integrated with the Internet. This program, however, has been significantly underutilized since its inception. The projected funding level of $214 million for this year is well below the program's cap. I hope commenters in this proceeding will help us build on the work of the National Broadband Plan and draw on the lessons learned from the Pilot Program. We need to update the Rural Health Care program to ensure that all Americans have access to health care services and benefit from advances in medicine even if they live in rural and remote areas of the nation.

At the same time, I think it is prudent to move forward with reforms to this program under the existing $400 million cap. I think it makes sense to figure out how to use the money allocated for this program better and more efficiently, with appropriate accountability measures, to achieve better outcomes for communities and patients without simply throwing more money at the problem.

I look forward to working on this with the Chairman and my fellow Commissioners in the months to come and I offer my thanks to the Bureau for your work on this item.