FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 54

[WC Docket No. 02–60; FCC 12–150]

Rural Health Care Support Mechanism

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: In this document, the Federal Communications Commission reforms its universal service support program for health care, transitioning its existing Internet Access and Rural Health Care Pilot programs into a new, efficient Healthcare Connect Fund. This Fund will expand health care provider access to broadband, especially in rural areas, and encourage the creation of state and regional broadband health care networks. Access to broadband for medical providers saves lives while lowering health care costs and improving patient experiences.

DATES: Effective April 1, 2013, except for added §§ 54.601(b), 54.631(a) and (c), 54.632, 54.633(c), 54.634(b), 54.636, 54.639(d), 54.640(b), 54.642, 54.643, 54.645, 54.646, 54.647, 54.648(b), 54.675(d), and 54.679, and the amendments to §§ 54.603(a) and (b), 54.609(d)(2), 54.615(c), 54.619(a)(1) and (d), and 54.623(a), which contain new or modified information collection requirements that will not be effective until approved by the Office of Management and Budget. The Federal Communications Commission will publish a document in the **Federal Register** announcing the effective date for those sections.

FOR FURTHER INFORMATION CONTACT: Linda Oliver, Wireline Competition Bureau at (202) 418–1732 or TTY (202) 418–0484.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Report and Order (*Order)* in WC Docket No. 02–60, FCC 12–150, adopted December 12, 2012, and released December 21, 2012. The complete text of this document is available for inspection and copying during normal business hours in the FCC Reference Information Center, Portals II, 445 12th Street SW., Room CY–A257, Washington, DC 20554, or at the following Internet address: *http://hraunfoss.fcc.gov/edocs_public/attachmatch/FCC-12-150A1.doc.* The document may also be purchased from the Commission's duplicating contractor, Best Copy and Printing, Inc., 445 12th Street SW., Room CY–B402, Washington, DC 20554, telephone (800) 378–3160 or (202) 863–2893, facsimile (202) 863–2898, or via the Internet at *http://www.bcpiweb.com.*

I. Introduction

1. In this *Order,* the Commission reforms our universal service support programs for health care, transitioning our existing Internet Access and Rural Health Care Pilot programs into a new, efficient Healthcare Connect Fund (Fund). This Fund will expand health care provider (HCP) access to broadband, especially in rural areas, and encourage the creation of state and regional broadband health care networks. Broadband connectivity has become an essential part of 21st century medical care. Whether it is used for transmitting electronic health records, sending X-rays, MRIs, and CAT scans to specialists at a distant hospital, or for video conferencing for telemedicine or training, access to broadband for medical providers saves lives while lowering health care costs and improving patient experiences. Telemedicine can save stroke patients lasting damage, prevent premature births, and provide psychiatric treatment for patients in rural areas. Exchange of electronic health records (EHRs) avoids duplicative medical tests and errors in prescriptions, and gives doctors access to all of a patient's medical history on a moment's notice. Telehealth applications save HCPs money as well. For example, a South Carolina HCP consortium funded by the Commission's Rural Health Care (RHC) Pilot Program saved $18 million in Medicaid costs through telepsychiatry provided at hospital emergency rooms. Another Pilot project in the Midwest saved $1.2 million in patient transport costs after establishing an electronic intensive care unit (e-ICU) program.

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

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

4. In particular, like the Pilot Program, the Healthcare Connect Fund will permit HCPs to purchase services and construct their own broadband infrastructure where it is the most cost-effective option. The Healthcare Connect Fund is thus a hybrid of the separate infrastructure and services programs proposed in the Commission's July 2010 *Notice of Proposed Rulemaking* (NPRM), 75 FR 48236, August 9, 2010. The self-construction option will only be available, however, to HCPs that apply as part of consortia, which can garner economies of scale unavailable to individual providers. With these safeguards, and based on the experience of the RHC Pilot Program, we expect the self-construction option to be used only in limited circumstances, and often in combination with services purchased from commercial providers.

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

Telecommunications and Internet Access Programs.

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

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

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

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

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

II. Performance Goals and Measures

11. Clear performance goals and measures will enable the Commission to determine whether the health care universal service support mechanism is being used for its intended purpose and whether that funding is accomplishing the intended results. In the *NPRM,* the Commission recognized the importance of establishing measurable performance goals, stating that ''[i]t is critical that our efforts focus on enhancing universal service for health care providers and that support is properly targeted to achieve defined goals.'' Establishing performance goals and measures also is consistent with the Government Performance and Results Act of 1993 (GPRA), which requires federal agencies to engage in strategic planning and performance measurement. In its 2010 report, the Government Accountability Office (GAO) also emphasized that the Commission should provide the RHC support mechanism with ''a solid performance management foundation'' by ''establishing effective performance goals and measures, and planning and conducting effective program evaluations.''

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

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

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

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

15. Measurement. We will evaluate progress towards our first goal by measuring the extent to which program participants are subscribing to increasing levels of broadband service over time. We also plan to collect data about participation in the Healthcare

Connect Fund relative to the universe of eligible participants. We also will collect data about the bandwidth obtained by participants in the program, and will chart the increase over time in higher bandwidth levels. We plan to compare those bandwidth levels with the minimum bandwidth requirements recommended in the *National Broadband Plan,* March 16, 2010 and the *OBI Technical Paper,* August, 2010 to determine how HCP access to broadband evolves as technology changes and as HCPs increasingly adopt telemedicine and electronic health records. We also expect to measure the bandwidth obtained by HCPs in the different statutory categories, as that information is not administratively burdensome to collect. To the extent feasible, we also will endeavor to compare the bandwidth obtained by participants in the Commission's programs with that used by non-participants, by relying on public sources of information regarding broadband usage by the health care industry, and by comparing the bandwidth obtained by new participants in the Commission's programs with what they were using prior to joining, to the extent such data is available.

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

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

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

B. Foster Development and Deployment of Broadband Health Care Networks

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

20. Measurement. We will evaluate progress towards this second goal by measuring the extent to which eligible HCPs participating in the Healthcare Connect Fund are connected to other HCPs through broadband health care networks. We plan to collect data about the reach of broadband health care networks supported by our programs, including connections to those networks by eligible and non-eligible HCP sites. We also will measure how program participants are using their broadband connections to health care networks, including whether and to what extent HCPs are engaging in telemedicine, exchange of EHRs, participation in a health information exchange, remote training, and other telehealth applications. Access to high speed broadband health care networks should help facilitate adoption of such applications by HCPs, including those HCPs serving patients in rural areas. We direct the Bureau to work with USAC to implement the reporting requirements regarding such telehealth applications in a manner that imposes the least possible burden on participants, while enabling us to measure progress toward this goal. We also direct the Bureau to coordinate with other federal agencies to ensure that data collection minimizes the burden on HCPs, which may already be required to track similar data for other health care regulatory purposes. To the extent feasible, we also will endeavor to compare the extent to which participants in the new program are using telehealth applications to that of non-participants, relying on public sources of information regarding trends in the health care industry.

C. Maximize Cost-Effectiveness of Program

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

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

23. Second, we will measure the value delivered to HCPs with support from the Healthcare Connect Fund by tracking the prices and speed of the broadband connections supported by the program. As we found in the Pilot Program, consortium applications, in combination with competitive bidding

and other program features, lead to lower prices and higher speed broadband. As we did in the *Pilot Evaluation,* DA 12–1332, we expect to measure the prices and speed of connections obtained under the Healthcare Connect Fund to determine whether this goal has been accomplished, and will examine similar data from the Telecommunications Program. In addition, we will monitor the results of the Administrator's audits and other reports to track progress in reducing improper payments and waste, fraud and abuse.

III. Support for Broadband Connectivity

A. Overview

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

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

26. In the *NPRM,* the Commission proposed to create two separate programs: A Health Infrastructure Program and a Broadband Services Program. The former would support the construction of HCP-owned broadband networks; the latter would support the purchase of broadband services. In view of the real world experience we have gained from the Pilot Program over the intervening two years, and based on the extensive record in this docket from a broad array of affected stakeholders, we now conclude that the better approach is to adopt a single, hybrid program. The new program will support the cost of (1) broadband and other advanced services; (2) upgrading existing facilities to higher bandwidth; (3) equipment necessary to create networks of HCPs, as well as equipment necessary to receive broadband services; and (4) HCP-owned infrastructure where shown to be the most cost-effective option. The hybrid approach of the Healthcare Connect Fund provides flexibility for HCPs to create broadband networks that best meet their needs and that can most readily be put to use for innovative and effective telehealth applications, while ensuring funds are spent responsibly and efficiently. The new program will replace the current Internet Access Program and provide continuing support for Pilot Program consortia as they exhaust any remaining funding already committed under the Pilot Program. As discussed in the Implementation Timeline section, for administrative convenience, rural HCPs can continue to participate in the Internet Access Program during funding year 2013.

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

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

29. We adopt the Healthcare Connect Fund pursuant to section 254(h)(2)(A) of the Communications Act, which requires the Commission to ''establish competitively neutral rules to * * * enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for all public and nonprofit * * * health care providers.'' The Commission relied on this statutory authority when it created the Pilot Program in 2006 to support HCP-owned infrastructure and services, including Internet access services, and the Commission has broad discretion regarding how to fulfill this statutory mandate. In *Texas Office of Public Utility Counsel* v. *FCC,* the United States Court of Appeals for the Fifth Circuit upheld the Commission's authority under section 254(h)(2)(A) to provide universal service support for ''advanced services'' to both rural and non-rural HCPs.

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

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

31. We conclude that non-rural HCPs may apply and receive support as part of consortia in the Healthcare Connect Fund. To ensure that program support continues to benefit rural as well as non-rural HCPs, however, we require that in each consortium, a majority of HCP sites (over 50 percent) be rural HCPs. We also adopt measures to limit the amount of funding that flows to the

largest hospitals in the country, to ensure that funding remains focused on a broad cross section of providers serving smaller communities across America.

32. Separately, we describe the services and equipment eligible for support (including services and equipment necessary for networks), and we describe the funding process, including the requirements applicable to consortia.

1. Key Benefits of a Consortium Approach

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

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

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

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

2. Eligibility To Participate in Consortia

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

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

- First, even primarily rural networks benefit from the inclusion of larger, non-rural HCPs. Pilot projects state that rural HCPs value their connections to non-rural HCPs for a number of reasons, including access to medical specialists; help in instituting telemedicine programs; leadership; administrative resources; and technical expertise. Many non-rural HCPs in the Pilot Program devoted resources to organizing consortia, preparing applications, designing networks, and preparing requests for proposal (RFPs). Had these non-rural HCPs not been eligible for support, they might not have been willing to take on a leadership role, which in turn directly enabled smaller and more rural HCPs to participate in Pilot networks. The participation of non-rural sites has also led to better prices and more broadband for participating rural HCPs, due to the greater bargaining power of consortia that include larger, non-rural sites.
- Second, the Commission's longstanding definition of ''non-rural'' HCPs encompasses a wide range of locales, ranging from large cities to small towns surrounded by rural countryside. Even within areas that are primarily rural, HCPs are likely to be located in the most populated areas. Many HCPs that are technically classified as non-rural within our rules in fact are located in relatively sparsely populated areas. For example, Orangeburg County Clinic in Holly Hill, South Carolina (population 1,277), a HCP participating in Palmetto State Providers Network's Pilot project, is characterized as non-rural. The largest cities closest to Holly Hill are Charleston, SC, and Columbia, SC, which are respectively 50 and 69 miles away from Holly Hill. Moreover, even those hospitals and clinics that are located in more densely populated

towns directly serve rural populations because they are the closest HCP for many patients who do live in the surrounding rural areas. For example, the University of Virginia Medical Center is a major referral center for many counties in rural Appalachia.

• Third, even hospitals and clinics that are located in truly urban areas are able to provide significantly improved care by joining broadband networks. The California Telehealth Network, for example, states that it ''frequently encounters urban health care providers with patient populations that are as isolated from clinical specialty care as [the] most rural health care providers,'' including urban Indian HCPs who could better serve Native populations through broadband-centered technologies such as EHRs and telemedicine. In some areas of the country, even ''urban'' communities may be hundreds of miles away from critical health care services such as Level 1 Trauma Centers, academic health centers, and children's hospitals. Like HCPs in rural areas, these ''urban'' community hospitals may serve as ''spoke'' health care facilities that access services that are available at larger hospital ''hubs.'' Eligible public and not-for-profit HCPs located in communities that are not classified as ''rural'' thus have a need for access to broadband to be able to effectively deliver health care, just as their ''rural'' counterparts do.

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

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

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

41. To protect against larger HCPs in non-rural areas joining the program merely to obtain support for pre-existing connections, we require consortium applicants to describe in their applications the goals and objectives of the proposed network and their strategy for aggregating HCP needs, and to use program support for the described purposes. We also impose a limitation on the amount of funding available to large metropolitan hospitals, while recognizing that it is unlikely in the near term that large urban hospitals will consume a disproportionate amount of funds in the Healthcare Connect Fund. We require that under the Healthcare Connect Fund, a non-rural hospital site with 400 or more licensed patient beds may receive no more than $30,000 per year in support for recurring charges and no more than $70,000 in support for nonrecurring charges every 5 years under the Fund, exclusive in both cases of costs shared by the network. For purposes of this limit, we ''grandfather'' non-rural hospitals that have received a funding commitment through a Pilot project as of the adoption date of this *Order.* We base the amount of these caps on the average charges that were supported for non-rural hospitals in the Pilot Program. The American Hospital Association (AHA) defines ''large'' hospitals as those with 400 or more staffed patient beds. We will use the AHA classification as a guide for our own definition of a ''large'' hospital, which is any non-rural hospital with 400 or more licensed patient beds. Based on our experience with the Pilot Program, it appears that the vast majority of Pilot participant hospitals have fewer than 200 beds. We do not anticipate, therefore, that the funding caps for large hospitals that we adopt here will be likely to affect most of the hospitals that are likely to join consortia in the Healthcare Connect Fund. We will monitor use of support by large hospitals closely in the new program, and if it appears that such hospitals are utilizing a disproportionate share of program funds despite our caps, we may consider more explicit prioritization rules to ensure that program dollars are targeted to the most cost-effective uses. We plan to conduct a further proceeding to examine possible approaches to prioritizing funding.

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

proceeding to expeditiously re-evaluate the participation requirement.

43. We emphasize that the limitations do *not* prevent any non-rural HCP from *participating* in a health care broadband network; entities ineligible for support may participate in networks if they pay their ''fair share'' (*i.e.* an ''undiscounted'' rate) of network costs. Non-profit entities, including non-rural HCPs, may also serve as consortium leaders even if they do not receive universal service support.

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

3. Eligibility of Grandfathered Formerly ''Rural'' Sites

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

C. A Hybrid Infrastructure and Services Approach

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

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

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

49. We adopt safeguards to ensure that the self-construction option will be exercised only where it is absolutely necessary to enable the HCPs to obtain the needed broadband connectivity. First, the HCP-owned infrastructure option may be employed only where self-construction is demonstrated to be the most cost-effective option after competitive bidding. We require USAC carefully to evaluate this showing; USAC already has experience in evaluating cost-effectiveness for large-scale projects from the Pilot Program. Consortia interested in pursuing self-construction as an option must solicit bids both for services and for construction, in the same posted Request for Proposals (submitted with Form 461), so that they will be able to show either that no vendor has bid to provides the requested services, or that the bids for self-construction were the most cost-effective option. RFPs must provide sufficient detail so that cost-effectiveness can be evaluated over the useful life of the facility, if the consortium pursues a self-construction option. We also permit HCPs that have received no bids on a services-only posting to then pursue a self-construction option through a second posting. We discuss the mechanics of the competitive bidding process and delegate to the Bureau the authority to provide administrative guidance for conducting the competitive bidding process, for the treatment of hybrid (services and construction) RFPs, excess capacity and shared costs, and other necessary guidelines for effective operation of this aspect of the Healthcare Connect Fund.

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

51. Finally, we impose a $150 million cap on the annual funds that can be allocated to up-front, non-recurring

costs, including HCP-owned infrastructure, and we require that non-recurring costs that exceed an average of $50,000 per HCP in a consortium be prorated over a minimum three-year period. These measures will help ensure that the Fund does not devote an excessive amount of support to large up-front payments for HCP self-construction, which could potentially foreclose HCPs' ability to use the Fund for monthly recurring charges for broadband services. This also addresses the comments of several parties, who suggested that providing funding for infrastructure could put undue pressure on the Fund.

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

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

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

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

56. The Montana Telecommunications Association (MTA), which represents telecommunications providers in Montana, also argues that funding HCP-owned infrastructure violates section 254(h)(3) of the Communications Act, which provides that ''[t]elecommunications service and network capacity provided to a public institutional telecommunications user under this subsection may not be sold, resold, or otherwise transferred by such user in consideration for money or any other thing of value.'' MTA's argument is unconvincing. As the Commission determined in connection with the Pilot Program, ''the prohibition on resale does not prohibit for-profit entities, paying their fair share of network costs, from participating in a selected participant's network.'' It concluded that the resale provision is ''not implicated when for-profit entities pay their own costs and do not receive discounts provided to eligible health care providers'' because only subsidized services and network capacity can be said to have been ''provided * * * under this subsection.'' The protections we adopt in this *Order* to ensure that non-eligible entities pay their fair share of the cost of health care networks they participate in will help ensure that this principle is satisfied. In 2008, the Bureau provided guidance to the Pilot projects and USAC regarding excess capacity on network facilities supported by universal service funds. We adopt similar guidelines in this *Order* for the treatment of excess capacity on HCP-owned facilities. Under those guidelines, the use of excess capacity by non-HCP entities would not violate the restrictions against sale, resale, or other transfer contained in section 254(h)(3) because HCPs would retain ownership of the excess capacity and because payments for that excess capacity may only be used to support sustainability of the network. Allowing HCPs to own network facilities when it is the most cost-effective option can yield better prices for the acquired broadband services or facilities used in the health care networks, in furtherance of the objectives of section 254(h)(2) and responsible management of universal service funds. Thus, our interpretation of section 254(h)(3) not only advances the universal service goals of section 254(h)(2), but is consistent with the restrictions on subsidies to ineligible entities incorporated in paragraphs (h)(3), (h)(4), and (h)(7)(B) of section 254.

D. Health Care Provider Contribution

57. Discussion. We adopt a requirement that all HCPs receiving support under the Healthcare Connect Fund contribute 35 percent towards the cost of all items for which they seek support, including services, equipment, and all expenses related to infrastructure and construction. A flat, uniform percentage contribution is administratively simple, predictable, and equitable, and has broad support in the record. Requiring a significant contribution will provide incentives for HCPs to choose the most cost-effective form of connectivity, design their networks efficiently, and refrain from purchasing unneeded capacity. Vendors

will also have an incentive to offer services at competitive prices, knowing that HCPs will be unwilling to increase unnecessarily their out-of-pocket expenses.

1. Use of a Uniform Contribution Percentage

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

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

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

61. Adopting a uniform contribution requirement will also help eligible HCPs to conduct better long-range planning for their broadband needs and obtain better rates. A clear, uniform rate will allow HCPs to better project anticipated support over a multi-year period, plan accordingly for their broadband services, and as appropriate, enter into multi-year contracts to take advantage of more favorable rates.

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

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

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

2. 35 Percent HCP Contribution

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

66. We base our conclusion on a number of factors. First, many state offices of rural health, which work most directly with rural HCPs, believe that a 65 percent discount is required to provide a ''realistic incentive'' for many eligible rural HCPs to participate. A 65 percent discount rate is also similar to the average effective discount rate in the Telecommunications Program, which is approximately 69 percent, excluding Alaska. The effective discount rate in the Telecommunications Program provides a reasonable proxy for the discount rate that will be sufficient to allow health care providers in rural areas, which tend to have high broadband costs, to participate in the program. The discount level we set also falls between the proposed discount levels in the *NPRM* (50 percent for the Broadband Services Program and 85 percent for the Health Infrastructure Program)—a reasonable choice given the hybrid nature of the program we adopt. A 35 percent HCP contribution is also within the range of the match required in other federal programs subsidizing broadband infrastructure. For example, the BTOP program required a 20 percent match, while the U.S. Department of Agriculture's Broadband Initiatives Program overall provided an average of 58 percent of its funding in the form of grants, with 32 percent of its funding in loans (which the recipients ultimately repay), and 10 percent recipient match.

67. We also expect that the 65 percent discount will be sufficient to induce many HCPs to participate in the Healthcare Connect Fund—both those currently in the Telecommunications Program and those that have not participated in that program before. We expect that at a 65 percent discount, eligible HCPs participating in consortia in the Healthcare Connect Fund will generally pay less ''out-of-pocket'' when

purchasing the higher bandwidth connections necessary to support telehealth applications than they would pay as individual participants in the Telecommunications Program. The Pilot Program showed that bulk buying through consortia, coupled with competitive bidding, can reduce the prices that HCPs pay for services and infrastructure through their increased buying power.

68. Other attractive features of the Healthcare Connect Fund include the lower administrative costs and the broader eligibility of services and equipment, relative to the Telecommunications Program. These factors may offset to some degree concerns regarding the size of the contribution requirement from those who advocated a lower HCP contribution. We also note that from a program efficiency perspective, the better prices negotiated by consortia in the Pilot Program, relative to the prices paid by Telecommunications Program participants, will mean that USF dollars will go further in the new program, particularly as HCPs demand the higher bandwidth and better service quality needed for telehealth applications.

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

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

71. A 65 percent discount rate will help keep demand for the overall health care universal service, including the Healthcare Connect Fund, below the $400 million cap for the foreseeable future, even as program participation expands. We estimate that there are approximately 10,000 eligible rural HCPs nationwide, of which approximately 54 percent (5,400) are participating in the RHC Telecommunications, Internet Access, or Pilot Programs. If we assume that in five years (1) the rural HCP participation rate increases from 54 percent to 75 percent, (2) the number of rural HCPs participating in the Telecommunications Program does not significantly decrease, and (3) the average annual support per HCP is $14,895 in the Healthcare Connect Fund (including support for both recurring and non-recurring costs), the projected size of the annual demand for funding (including non-rural and rural HCPs) would be approximately $235 million. We will continue to monitor the effect of the 35 percent contribution requirement on participation in the program and on the USF, and stand ready to adjust the contribution HCP requirement or establish additional prioritization rules, should it prove necessary.

3. Limits on Eligible Sources of HCP Contribution

72. Consistent with the Pilot Program, we limit the sources for HCPs' contribution (*i.e.,* the non-discounted portion) to ensure that participants pay their share of the supported expenses. Only funds from an eligible source will apply towards a participant's required contribution. In addition, consortium applicants are required to identify with specificity their source of funding for their contribution of eligible expenses in their submissions to USAC. Requiring participants to pay their share helps ensure efficiency and fiscal responsibility and helps prevent waste, fraud, and abuse.

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

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

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

76. *Future Revenues from Excess Capacity as Source of Participant Contribution.* Some consortia may find, after competitive bidding, that construction of their own facilities is the most cost-effective option. Due to the low additional cost of laying additional

fiber, some Pilot projects who chose the ''self-construction'' option found that they were able to lay more fiber than needed for their health care network and use revenues from the excess capacity as a source for their 15 percent contribution. We conclude that under the following limited circumstances, consortia in the Healthcare Connect Fund may use future revenues from excess capacity as a source for their 35 percent match.

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

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

IV. Eligible Services and Equipment

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

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

ELIGIBLE SERVICES AND EQUIPMENT

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

A. Eligible Services

80. We describe the services that will be eligible for support under the Healthcare Connect Fund. We are guided, among other considerations, by our statutory directive to enhance access to ''advanced telecommunications and information services'' in a competitively neutral fashion. We conclude that providing flexibility for HCPs to select a range of services, within certain defined limits, and in conjunction with the competitive bidding requirements we adopt, will maximize the impact of Fund dollars (and scarce HCP resources).

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

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

1. Definition of Eligible Services

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

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

The definition we adopt differs from the *NPRM* proposal in only two respects. First, because we allow all HCPs to participate in consortia and receive support (subject to the limitations on non-rural HCPs), we have removed the language referring to ''rural'' HCPs. Second, we delete the word ''broadband access'' from the definition originally proposed, to make clear that eligible services include not only broadband Internet access services, but also high-speed transmission services offered on a common carrier or non-common carrier basis that may not meet the definition of ''broadband'' that the Commission has used in other contexts. This broad definition allows HCPs to choose from a wide range of connectivity solutions, all of which enhance their access to advanced services, based on their individual health care broadband needs as available technology evolves over time; decisions will be made in the marketplace without regard to regulatory classification decisions of the connectivity solutions.

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

85. *Network Configurations.* Under the new rule, ''eligible services'' may include last mile, middle mile, or backbone services, as long as support for such services is requested and used by an eligible HCP for eligible purposes in compliance with other program rules. HCPs emphasize that they need the ability to control the design of their networks, even if the network relies on leased services. Our Pilot Program experience also indicates that HCPs are likely to tailor their funding requests based on what services are already available. For example, if a region already has a middle mile network suitable for health care use, the applicant may choose to focus its funding request on last mile facilities to connect to the middle mile or backbone network. On the other hand, if there is no pre-existing middle mile connection between the HCPs in the network, providers may choose to seek funding to lease such capacity instead. Therefore, we find that allowing flexibility in the network segments supported will best leverage prior investments by allowing maximum use of existing infrastructure.

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

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

2. Minimum Bandwidth and Service Quality Requirements

88. Discussion. We will not impose minimum bandwidth and service quality requirements for the Healthcare Connect Fund, based on the record in this proceeding. Commenters agree that HCPs need certain minimum levels of reliability, redundancy, and quality of service, but they note that the exact requirement may vary depending on the application, and that not all HCPs will have access to services that provide a specified level of reliability and quality. While our goal is to encourage HCPs to obtain broadband connections at the speeds recommended in the *National Broadband Plan,* the record indicates that in some areas of the country, HCPs face limited options in obtaining speeds of 4 Mbps or above. Commenters note that in areas where higher speed connections are not available, telemedicine networks have nevertheless been able to operate with connections at speeds less than 4 Mbps. Commenters also state that some of the smallest rural HCPs simply may not be able to afford higher bandwidth connections, even when such connections are available. These commenters express concern that a minimum bandwidth requirement could result in HCPs either (1) being forced to buy bandwidths that are not cost-effective for their circumstances; or (2) being unable to receive health care

universal service discounts (due to the cost of the required minimum-bandwidth connection). We do not wish to prevent the neediest HCPs from receiving discounts, especially if they are able to address their connectivity needs in the near term by utilizing a connection below a defined minimum. After reviewing the record, we conclude that it would be difficult to set a minimum speed requirement at this time that would not have the unintended effect of potentially precluding some HCPs from obtaining connectivity currently appropriate for their individual needs. We therefore conclude it would be premature now to set a minimum threshold speed for connections that are supported in the Healthcare Connect Fund.

89. We will continue to provide support in the Healthcare Connect Fund for services that have been historically supported through the Internet Access Program, including DSL, cable modem, and other similar forms of Internet access. We expect recipients to migrate to services over time that deliver higher capabilities. We do, however, adopt one limitation designed to ensure that the focus of the program remains on advancing access to the bandwidths that increasingly will be needed for health care purposes. No upfront payments will be eligible for funding for services that deliver less than 1.5 Mbps symmetrical (*i.e.* less than T–1 speeds), except for reasonable installation costs under $5,000. We have chosen the 1.5 Mbps threshold because HCPs have indicated that they can successfully implement telemedicine services over a 1.5 Mbps connection, if that is the only practical option. Therefore, we conclude that 1.5 Mbps is the minimum threshold at which HCPs should be able to obtain support for upfront costs for build-out or infrastructure upgrades.

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

3. Dark and Lit Fiber

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

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

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

94. As the Commission concluded in the E-rate context, we are not persuaded by arguments that entities who are not telecommunications providers, such as HCPs, ''have a poor track record making dark fiber facilities viable for their services.'' While dark fiber will not be an appropriate solution for all HCPs, Pilot projects have demonstrated that they can successfully incorporate dark fiber solutions into a regional or statewide health care network. We are also not persuaded by the argument that dark fiber solutions may not be cost-effective. HCPs will be required to undergo competitive bidding, and our actions merely ensure that HCPs have an additional option to consider during that process. If service providers can provide comparable, less expensive lit fiber alternatives, we anticipate that such providers will bid to provide services to HCPs, who are required to select the most cost-effective option. As the Commission found in the *Schools and Libraries Sixth Report and Order,* 75 FR 75393, December 3, 2010, if more providers bid to provide services, the resulting competition should better ensure that applicants—and the Fund—receive the best price for the most bandwidth.

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

96. We are not persuaded that allowing a HCP to purchase dark fiber from state, regional, or local government entities will negate the HCP's ability to ''maintain a fair and open competitive bidding environment'' if the HCP is ''linked'' to the governmental entity in question. We adopt requirements that prohibit potential service providers, including government entities, from also acting as either a Consortium Leader or consultant or providing other types of specified assistance to HCPs in the competitive bidding process. Allowing HCPs to lease dark fiber should increase competition among fiber providers and

ensure a more robust bidding process. HCPs still must demonstrate that the bid they choose is the most cost-effective. As the Commission stated in the E-rate context, we believe our competitive bidding rules will protect against the possibility of waste, fraud, or abuse in that context. To the extent there are violations of the competitive bidding rules, such as sharing of inside information during the competitive bidding process, USAC will adjust funding commitments or recover any disbursed funds through its normal process. As the Commission concluded in the E-rate context, our RHC rules and requirements, including the competitive bidding rules, apply to all applicants and service providers, irrespective of the entity providing the fiber network.

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

98. Eligible HCPs applying as consortia may also receive support for upfront charges associated with fiber leases or IRUs, subject to the limitations applicable to all upfront charges. An IRU or lease for dark fiber typically requires a large upfront payment, even if no new construction is required. In some cases, however, service providers may deploy new fiber facilities to serve HCPs under the lease or IRU, and may seek to recover all of part of those costs through non-recurring charges (sometimes called ''special construction charges''). Such ''build-out'' costs are eligible for support. Consistent with the general rule we adopt, we will provide support for build-out costs from an off-premises fiber network to the service provider demarcation point. We decline to provide support for such charges after the service provider demarcation point, consistent with the Commission's current policy of not supporting internal connections for HCPs.

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

100. *Maintenance Costs.* We also find that HCPs may receive support for maintenance costs associated with leases of dark or lit fiber. Only HCPs applying as consortia may receive support for upfront payments for maintenance costs.

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

102. *Eligible Providers.* The Commission has previously authorized schools and libraries to lease dark fiber, and authorizes schools and libraries to lease any fiber connectivity (not just dark fiber) from any entity, including state, municipal or regional research networks and utility companies. We will allow HCPs to lease fiber connectivity from any provider.

4. Connections to Internet2 or National LambdaRail

103. Discussion. ''Broadband Services'' in this context includes backbone services. We find that the membership fees charged by Internet2 and NLR are part of the cost of obtaining access to the backbone services provided by these organizations, and thus are eligible for support as recurring costs for broadband services. We delegate authority to the Wireline Competition Bureau to designate as an eligible expense, upon request, membership fees for other non-profit research and education networks similar to Internet2 and NLR. We further find that broadband services required to connect *to* Internet2 or NLR should be eligible for support under the Healthcare Connect Fund, as well as any broadband services obtained directly *from* Internet2 or NLR. Commenters generally support providing support for both membership fees and for the broadband services required to connect health care networks to Internet2 and NLR. In addition, some commenters believe that these networks may provide a level of service not available from commercial providers in certain situations.

104. We conclude, however, that it is appropriate to require participants to seek competitive bids from NLR and Internet2, or any other research and education network, through our standard competitive bidding process. We recognize and anticipate that in some cases, Internet2 or NLR services may be the most cost-effective solution to meet a HCP's needs. As noted by commenters, these networks can provide many benefits, and the most cost-effective solution for HCP needs may come from Internet2 or NLR. There may be instances, however, under which a more cost-effective solution is available from a commercial provider, or a non-profit provider other than Internet2 or NLR. Many commenters opposed the Commission's proposal to exempt National LambdaRail and Internet2 from competitive bidding, arguing, among other things, that such an exemption would be anti-competitive by disadvantaging other telecommunications providers. A competitive bidding requirement that applies equally to all participants will ensure that HCPs can consider possible options from all interested service providers. Because applicants must already engage in competitive bidding for all other services, we do not believe it would be overly burdensome to require applicants to also include Internet2 or NLR in their competitive bidding process. While we encourage all applicants to fully consider the benefits of connecting to non-profit research and education networks such as Internet2 and NLR, we emphasize that it is not a requirement to connect to Internet2 or NLR.

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

105. Discussion. Based on our experience with the RHC Telecommunications and Pilot Programs, we adopt a rule that provides support under the Healthcare Connect Fund for the connections and network equipment associated with off-site data centers and off-site administrative offices used by eligible HCPs for their health care purposes, subject to the conditions and restrictions. There has been significant change in how HCPs use information technology in the delivery of health care since the Commission originally adopted the rules for the Telecommunications Program that do not provide support for off-site data centers and administrative

offices. This new rule appropriately recognizes ''best practices'' in health care facility and infrastructure design and the way in which HCPs increasingly accomplish their data storage and transmission requirements. It also enables HCPs to use efficient network connections, rather than having to re-route traffic unnecessarily in order to obtain support. Many commenters pointed out the operational and network efficiency gains from this approach.

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

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

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

109. As commenters point out, HCPs often find increased efficiencies by locating administrative offices and data centers apart from the site where patient care is provided. This is especially true for groups of HCPs, including smaller HCPs, who often share administrative offices and/or data centers, to save money and pool resources. Furthermore, it does not make practical sense to distinguish administrative offices and/or data centers that are located off-site but otherwise perform the same functions as on-site facilities, and which require the same broadband connectivity to function effectively. While off-site administrative offices and off-site data centers do not provide ''hands on'' delivery of patient care, they often perform support functions that are critical to the provision of clinical care by HCPs. 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. Administrative offices also perform ministerial tasks, such as billing and collection, claims processing, and regulation compliance. Without an administrative office capable of carrying out these functions, an eligible HCP may not be able to successfully provide patient care.

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

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

112. After reviewing the record, we conclude that requiring that an eligible HCP to have majority ownership or control over an off-site administrative office or data center in order for it to be eligible for support would impose an unnecessary burden on HCPs seeking to use broadband effectively to deliver health care to their patients. Providing support for eligible expenses associated with off-site administrative offices and off-site data centers was widely endorsed by commenters, but commenters noted that there is a wide variation in the way that HCPs structure their physical facilities. For example, HHS explains that an HCP often has no ownership or control of the off-site data center hosting its health care related equipment and servers. NCTN suggests that the Commission identify ''eligible functions'' rather than evaluating ownership. The adopted rule addresses these concerns and provides eligible HCPs with the flexibility to use off-site data centers and administrative offices irrespective of ownership or control, subject to the conditions and requirements.

113. The adopted approach also accommodates a variety of arrangements for the operation of off-site administrative offices and/or off-site data centers. For instance, one commenter was concerned that the *NPRM* proposal unreasonably excluded support for the off-site administrative offices and off-site data centers owned by a public or non-profit health care system rather than by one or more eligible HCP sites. Under the rule we adopt, the network equipment and connections associated with these off-site facilities owned by public or non-profit health care systems are eligible for

support to the extent they satisfy the conditions and restrictions. Any network equipment and connections shared among a system's eligible and ineligible HCP sites may only receive support to the extent that the expenses are cost allocated according to the guidelines. We believe this approach is consistent with the intent of the statute and best balances the objectives of fiscal responsibility and increasing access to broadband connectivity to eligible HCPs.

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

114. Discussion. We will provide support for reasonable and customary installation charges for broadband services, up to an undiscounted cost of $5,000 (*i.e.,* up to $3,250 in support) per HCP location. Commenters generally agree with providing support for installation charges. ACS suggests, however, that in order to preserve funds, the Commission should limit the scope of this funding to only the most medically underserved areas (*i.e.,* those with the highest HPSA score). We conclude, however, that the better course is to limit the amount of installation charges per eligible HCP location. Because our experience with the RHC Telecommunications and Pilot Programs indicates that undiscounted installation charges are typically under $5,000 per location, we conclude that setting a cap at this level will ensure that as many HCPs can obtain the benefits of broadband connectivity as possible. HCPs who are subject to installation charges higher than this amount may seek upfront support for eligible services or equipment, if those charges independently qualify as eligible expenses (*e.g.,* upfront charges for service provider deployment of facilities, costs for HCP-constructed and owned infrastructure, network equipment, etc.).

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

115. Discussion. Eligible consortia may obtain support for upfront charges for service provider deployment of new or upgraded facilities to serve eligible HCP sites that are applying as part of the consortium, including (but not limited to) fiber facilities. Although the Pilot Program has helped thousands of HCPs to obtain broadband services, many HCPs in more remote, rural areas still lack access to broadband connections that effectively meet their needs. The Pilot Program demonstrated that many HCPs prefer not to own the physical facilities comprising their networks, but can still assemble a dedicated health care network if funds are available for service provider construction and upgrades where broadband facilities are not already available. In a number of instances, Pilot projects found that support for upfront charges for deployment of service provider facilities allowed them to find the most cost-effective services to meet their needs while obtaining the benefits of connecting to existing networks.

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

117. We adopt a rule to provide support for service provider deployment of facilities up to the ''demarcation point,'' which is the boundary between facilities owned or controlled by the service provider, and facilities owned or controlled by the customer. In other words, the demarcation point is the point at which responsibility for the connection is ''handed off'' to the customer. Thus, charges for ''curb-to-building installation'' or ''on site wiring'' are eligible if they are used to extend service provider facilities to the point where such facilities meet customer-owned terminal equipment or wiring. If the additional build-out is not owned or controlled by the service provider, it will not be eligible as service provider deployment costs. In contrast, consistent with current RHC program rules, ''inside wiring'' and ''internal connections'' are not eligible for support.

118. Because upfront charges for build-out costs can be significant, we limit eligibility for such upfront charges to consortium applications. Our experience of over a decade with the RHC Telecommunications Program suggests that individual HCPs are unlikely to attract multiple bids, which would constrain prices. As HCPs themselves acknowledge, and as we learned in the Pilot Program, consortium applications are more likely to attract multiple bidders, due to the more significant dollar amounts associated with larger projects. Furthermore, we anticipate that individual HCPs will benefit from participating in a consortium in numerous ways, including pooling administrative resources (*e.g.* for the competitive bidding process), and increased opportunities for cooperation with other HCPs within their state or region. Consortia seeking funding for build-out costs must apply and undergo the competitive bidding process through the consortium application process. As in the Pilot Program, an RFP that includes a build-out component need not be *limited* to such costs (for example, some HCPs included in the RFP may not need any additional build-out to be served, but rather only need discounts on recurring services). We expect HCPs to select a proposal that includes carrier build-out costs only if that proposal is the most cost-effective option. In addition, upfront charges for build-out are subject to the limitations.

B. Eligible Equipment

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

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

121. Second, support for the equipment necessary to operate and manage dedicated broadband health care networks can facilitate efficient network design. USAC states that urban centers, where most specialists are located, are natural ''hubs'' for telemedicine networks, but the cost of equipment required to serve as a hub

can be a barrier for these facilities to serve as hubs. In the Pilot Program, funding network equipment eliminated this barrier to entry. OHN explains that connecting to urban hubs can also reduce the need for rural sites to manage firewalls at their locations, which allows the rural sites to reduce equipment costs while adhering to security industry best practices and standards.

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

123. We do not express a preference for single- or multi-vendor networks here, nor do we suggest that it is always more efficient for a dedicated health broadband network to have its own NOC. For example, a network that chooses to obtain a single-vendor solution and obtain NOC service from that vendor may receive support for the NOC service as a broadband service, if that solution is the most cost-effective. Our actions simply facilitate the ability of a consortium to operate its own NOC, if that is the most cost-effective option.

124. Eligible equipment costs include the following:

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

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

C. Ineligible Costs

126. Services and equipment eligible for support under the Healthcare Connect Fund are limited to those listed in this *Order*. For administrative clarity, however, we also list the following specific examples of costs that are not supported.

1. Equipment or Services Not Directly Associated With Broadband Services

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

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

- Computers, including servers, and related hardware (*e.g.,* printers, scanners, laptops), (unless used exclusively for network management, maintenance, or other network operations);
- End user wireless devices, such as smartphones and tablets;
- Software (unless used for network management, maintenance, or other network operations);
- Software development (excluding development of software that supports network management, maintenance, and other network operations);
- Helpdesk equipment and related software, or services (unless used exclusively in support of eligible services or equipment);
- Web hosting;
- Web site portal development;
- Video/audio/web conferencing equipment or services; and
- Continuous power source.

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

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

2. Inside Wiring/Internal Connections

130. Discussion. The American Telemedicine Association requests that the Commission provide support for ''internal wiring.'' The Healthcare Connect Fund will provide support for service provider build-out to the customer demarcation point, and for network equipment necessary to make a broadband connection functional. We conclude that support is better targeted at this time toward providing broadband connectivity *to* the HCP rather than internal networks *within* HCP premises. The record does not indicate that small HCPs (such as clinics) likely will incur large expenses for inside wiring or internal connections in order to utilize their broadband connectivity. For larger institutions such as hospitals, however, the cost of providing discounts for internal connections could be substantial. Furthermore, as the Commission has acknowledged, it can be difficult to distinguish from ''internal

connections'' and ineligible computers or other peripheral equipment. In the E-rate context, the Commission relied on the congressional directive that the Fund provide connectivity all the way to *classrooms*. There is no similar statutory directive with respect to HCPs. For these reasons, we decline to provide support for inside wiring or internal connections under the Healthcare Connect Fund.

3. Administrative Expenses

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

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

133. The Commission has recognized that administrative expenses of organizing networks and applying for universal service support can be substantial. In response, we are taking steps throughout this *Order* to minimize the administrative burden of participating in the Healthcare Connect Fund. First, we put in place a streamlined application process that facilitates consortium applications, which should enable HCPs to file many fewer applications and to share the administrative costs of all aspects of participation in the program. Second, we adopt a uniform flat-rate discount to simplify the calculation of support, particularly when compared with the urban/rural differential approach of the Telecommunications Program. Third, we enable multi-year funding commitments, long-term arrangements (*e.g.,* IRUs and pre-paid leases), and the use of existing MSAs. Fourth, we expand eligibility to include all HCPs, with rules in place to ensure a reasonable balance of rural and non-rural sites within health care networks. In the Pilot Program, HCPs that did not meet our long-standing definition of ''rural'' HCPs frequently provided administrative and technical support to the consortia, thereby reducing the burden on individual HCPs. Finally, we eliminate the competitive bidding requirement for applicants seeking support for $10,000 or less of total undiscounted eligible expenses for a single year. We find that the combination of these reforms, among others, should significantly reduce the administrative burden on participants in terms of the complexity, volume, and frequency of filings, thereby addressing concerns raised by some commenters regarding the administrative burdens of participating in the program. In contrast, if we were to provide direct support for administrative expenses, it would necessitate additional and more complex application requirements, guidelines, and other administrative controls to protect such funding from waste, fraud, and abuse. This would significantly increase the administrative burden on USAC and on applicants as well.

134. We recognize that many commenters support the provision of support for administrative expenses. Some commenters suggest that the funding of reasonable administrative expenses is necessary to ensure participation in the program. However, experience with the existing programs suggests that HCPs will participate even without the program funding administrative expenses. Neither the Telecommunications nor Pilot Programs fund administrative expenses, but both programs have significant participation. The number of participating HCPs in the Telecommunications Program has grown by nearly 10 percent year-over-year for the past five years. Similarly, the Pilot Program has experienced substantial and sustained interest with just over 3,800 HCP sites receiving funding commitments. We expect that the participation in the RHC support mechanism will only increase with the implementation of the Healthcare Connect Fund and its more streamlined administrative process.

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

136. Consistent with the approach taken by the Commission in the *Pilot Program Selection Order,* 73 FR 4573, January 25, 2008, we conclude that administrative expenses will not be eligible for support under the Healthcare Connect Fund. Ineligible expenses include, but are not limited to, the following expenses:

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

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

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

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

• *Sharing with ineligible entities.* In the case of statewide or regional health care networks, it may be useful for health care purposes to have both eligible and ineligible HCPs participate in the same network, and share certain backbone or network equipment costs between all participants in the network. Having both eligible and ineligible entities contribute to shared costs may lead to lower overall costs for the eligible HCPs, and enables HCPs to benefit from connections to a greater number of other HCPs, including for-profit HCPs that are not eligible for funding under section 254 but nevertheless play an important role in the overall health care system. The Commission has previously found that the resale prohibition does not prevent Pilot Program networks from ''sharing'' facilities with for-profit entities that pay their ''fair share'' of network costs (*i.e.,* that do not receive discounts provided to eligible HCPs, but instead pay their full *pro rata* undiscounted share as determined by the portion of network capacity used).

• *Allocating cost between eligible and ineligible components.* A product or service provided under a single price may contain both eligible and ineligible components. For example, a service provider may provide a broadband internet access service (eligible) and, as a component of that service, include web hosting (ineligible). While it may be simpler to buy the eligible and ineligible components separately, in some instances it is more cost-effective for HCPs (and the Fund) to buy the components as a single product or service. In such cases, applicants may need guidance on if, and how, they should allocate costs between the eligible and ineligible components.

• *Excess capacity in fiber construction.* In the *NPRM,* the Commission noted that it is customary to build excess capacity when deploying high-capacity fiber networks, because the cost of adding additional fiber to the conduit is minimal. In the Pilot Program, the Commission found that a Pilot participant could not ''sell'' network capacity supported by Pilot funding, but could ''share'' network capacity with ineligible entities paying a fair share of network costs attributable to the portion of network capacity used. Consortia that seek support to construct and own their own fiber networks may wish to put in extra fiber strands during construction and make the excess capacity available to other users.

• *Part-time eligible HCPs.* Under current rules, entities that provide eligible health care services on a part-time basis are allowed to receive prorated support commensurate with their provision of eligible health care services. For example, if a doctor operates a non-profit rural health clinic on a non-profit basis in a rural community one day per week or during evenings in the local community center, that community center is eligible to receive prorated support, because it serves as a ''rural health clinic'' on a part-time basis.

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

• First, if the service provider charges a separate and independent price for each site, an ineligible site must pay the full undiscounted price. For example, if a consortium has negotiated certain rates that are applicable to all sites within the consortium, an ineligible HCP site must pay the full price without receiving a USF discount. Similarly, if the consortium has received a quote from the service provider for the individualized costs of serving each member of the consortium, an ineligible member must pay the full cost without receiving a USF discount.

• Second, if there is no separate and independent price for each site, the applicant must prorate the undiscounted price for the ''shared'' facility (including any supported maintenance and operating costs) between eligible and ineligible sites on a proportional fully-distributed basis, and the applicant may seek support for only the portion attributable to the eligible sites. Applicants must make this cost allocation using a method that is based on objective criteria and reasonably reflects the eligible usage of the shared facility. For example, a network may choose to divide the undiscounted price of the shared facility equally among all member sites, and require ineligible sites to pay their full share of the price. Other possible metrics, depending on the services utilized, may include time of use, number of uses, amount of capacity used, or number of fiber strands. The applicant bears the burden of demonstrating the reasonableness of the allocation method chosen.

140. Because we define eligible services and equipment for the Healthcare Connect Fund broadly in this *Order,* we do not anticipate that applicants will encounter many situations in which they purchase or lease a single service or piece of equipment that includes both eligible and ineligible components. Nonetheless, we also provide guidelines herein for allocating costs when a single service or piece of equipment includes an ineligible component. Applicants seeking support for a service or equipment that includes an ineligible component must also explicitly request in their RFP that service providers should also provide pricing for a comparable service or piece of equipment that includes only eligible components. If the selected provider also submits a price for the eligible component on a stand-alone basis, the support amount is capped at the stand-alone price of the eligible component. If the service provider does not offer the eligible component on a stand-alone basis, the full price of the entire service or piece of equipment must be taken into account, without regard to the value of the ineligible components, when determining the most cost-effective bid.

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

142. Applicants must submit a written description of their allocation method(s) to USAC with their funding requests.

Allocations must be consistent with the principles. If ineligible entities participate in a network, the allocation method must be memorialized in writing, such as a formal agreement among network members, a master services contract, or for smaller consortia, a letter signed and dated by all (or each) ineligible entity and the Consortium Leader. For audit purposes, applicants must retain any documentation supporting their cost allocations for a period consistent with the recordkeeping rules.

D. Limitations on Upfront Payments

143. Discussion. Support for upfront payments can play an important part in ensuring that HCPs can efficiently obtain the broadband connections they need in a cost-effective manner. We therefore adopt a rule providing support for upfront payments, but include certain limitations to ensure the most cost-effective use of Fund support and to deter waste, fraud, and abuse. The limitations in this section apply to all non-recurring costs, other than reasonable and customary installation charges of up to $5,000. USAC reports that in both the ''Primary'' (Telecommunications and Internet Access and Pilot Programs, service providers do not typically assess ''installation charges'' in excess of $5,000 if no new build-out is required to provide a service (*i.e.,* the ''installation charge'' is entirely for the cost of ''turning on'' services over existing facilities). Therefore, we find that it is appropriate to treat installation charges of up to $5,000 as ''ordinary'' installation charges, and apply limitations only to charges above that amount.

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

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

146. Third, we impose a $150 million annual limitation on total commitments for upfront payments and multi-year commitments. We do so in order to limit major fluctuations in Fund demand, although we anticipate that the $150 million should be sufficient to meet demand for upfront payments given the other limitations we impose. Fourth, we will require that consortia prorate support requested for upfront payments over at least three years if, on average, more than $50,000 in upfront payments is requested per HCP site in the consortium. Fifth, upfront payments must be part of a multi-year contract. At $50,000 per site, $50 million per year would provide upfront support to 1,000 HCP sites. Given that total participation in the Pilot Program since 2006 has been approximately 3,900 providers to date, we believe this is an adequate level of funding to meet HCP needs in the immediate future; we can revisit this conclusion if experience under the new program proves otherwise.

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

148. Finally, consortia that seek certain types of upfront payments will be subject to additional reporting requirements and other safeguards to ensure effective use of support.

E. Eligible Service Providers

149. Discussion. We conclude that eligible service providers for the Healthcare Connect Fund shall include any provider of equipment, facilities, or services that are eligible for support under the program, provided that the HCP selects the most cost-effective option to meet its health care needs. We reiterate that eligible services may be provided through any available technology, consistent with our competitive neutrality policy. Commenters generally support a broad definition of eligible service providers, and state that allowing a wide variety of vendors will provide more competing options and thus will be more cost-effective. We note that the Pilot Program, which allowed similar flexibility, had over 120 different vendors win contracts to provide services.

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

V. Funding Process

151. USAC shall, working with the Bureau, develop the necessary application, competitive bidding, contractual, and reporting requirements for participants to implement the requirements to ensure the objectives of the program are met.

A. Pre-Application Steps

1. Creation of Consortia

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

a. Designation of a Consortium Leader

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

154. The consortium need not be a *legal* entity, although the consortium members may wish to form as a legal entity for a number of reasons. For example, if the consortium itself is to be legally and financially responsible for activities supported by the Fund (*i.e.* serve as the ''Consortium Leader''), the consortium should constitute itself as a legal entity. In addition, the consortium may wish to constitute itself as a legally recognized entity to simplify contracting with vendors (*i.e.* if the consortium is not a legal entity, each individual participant may need to sign an individual contract with the service provider, or one of the consortium members may need to enter into a master contract on behalf of all of the other members).

155. The Consortium Leader may be the consortium itself (if it is constituted as a legal entity), an eligible HCP participating in the consortium, or an ineligible state organization, public sector (governmental) entity (including a Tribal government entity), or non-profit entity. An eligible HCP may serve as the Consortium Leader and simultaneously receive support. If an ineligible entity serves as the Consortium Leader, however, the ineligible entity is prohibited from receiving support from the Healthcare Connect Fund, and the full value of any discounts, funding, or other program benefits secured by the ineligible entity must be passed on to the consortium members that are eligible HCPs.

156. Certain state organizations, public sector entities (including Tribal government entities), or non-profit entities may wish to perform multiple roles on behalf of consortia, including (1) serving as lead entities; (2) providing consulting assistance to consortia; and/or (3) serving as a service provider (vendor) of eligible services or equipment for which consortia are seeking support. Potential conflict of interest issues arise in the competitive bidding process, however, if an entity serves a dual role as both Consortium Leader/consultant *and* potential service provider. The potential conflict is that the selection of the service provider may not be fair and open but may, in fact, provide an unfair advantage to the lead entity as service provider.

157. For that reason, we conclude that state organizations, public sector entities, or non-profit entities may serve as lead entities or provide consulting assistance to consortia if they do not participate as potential vendors during the competitive bidding process. Conversely, if such entities wish to provide eligible services or equipment to consortia, they may not simultaneously serve as project leaders, and may not provide consulting or other expertise to the consortium to assist it in developing its request for services. This restriction does not prohibit eligible HCPs from conducting general due diligence to determine what services are needed and to prepare for an RFP. Part of such due diligence may involve reaching out to known service providers—including state or other public sector entities—that serve the area to determine what services are available. Nor does the restriction prevent a service provider, once selected through a fair and open competitive bidding process, from assisting an eligible HCP with implementing the purchased services.

158. We recognize that certain state governmental entities, for example, may be large enough to institute an organizational and functional separation between staff acting as service providers and staff providing application assistance. Consistent with current practice in the E-rate program, we will allow state organizations, public sector entities, or non-profit entities, if they so choose, to obtain an exemption from this prohibition by making a showing to USAC that they have set up an organizational and functional separation. This exemption, however, must be obtained before the consortium begins preparing its request for services. Examples of appropriate documentation for such a showing include organizational flow charts, budgetary codes, and supervisory administration.

159. The Consortium Leader's responsibilities include the following:

• *Legal and Financial Responsibility for Supported Activities.* The Consortium Leader is the legally and financially responsible entity for the conduct of activities supported by the Fund. By default, the Consortium Leader will be the responsible entity if audits or other investigations by USAC or the Commission reveal violations of the Act or our rules by the consortium, with the individual consortium members being jointly and severally liable if the Consortium Leader dissolves, files for bankruptcy, or otherwise fails to meet its obligations. We recognize that in some instances, a consortium may wish to have a Consortium Leader serve only in an administrative capacity and to have the consortium itself, or its individual members, retain ultimate legal and financial responsibility. Except for the responsibilities, we will allow consortia to have flexibility to allocate legal and financial responsibility as they see fit, provided that this allocation is memorialized in a formal written agreement between the affected parties (*i.e.* the Consortium Leader, and the consortium as a whole and/or its individual members), and the written agreement is submitted to USAC for approval with or prior to the Request for Services (Form 461). The agreement should clearly identify the party(ies) responsible for repayment if USAC is required, at a later date, to recover disbursements to the consortium due to violations of program rules. USAC is directed to provide, in writing by the expiration of the 28-day competitive bidding period, either approval or an explanation as to why the agreement does not provide sufficient clarity on who will be responsible for repayment. If USAC provides such comments, it shall provide the Consortium Leader with a minimum of 14 calendar days to respond. USAC is prohibited from issuing a funding commitment to the consortium until the Consortium Leader either takes on the default position as responsible entity, or provides an agreement that adequately identifies alternative responsible party(ies).

• *Point of Contact for the FCC and USAC.* The Consortium Leader is responsible for designating an individual who will be the ''Project Coordinator'' and serve as the point of contact with the Commission and USAC for all matters related to the consortium. The Consortium Leader is responsible for responding to Commission and USAC inquiries on behalf of the consortium members throughout the application, funding, invoicing, and post-invoicing period.

• *Typical Applicant Functions, Including Forms and Certifications.* The Consortium Leader is responsible for submitting program forms and required documentation and ensuring that all information and certifications submitted are true and correct. This responsibility may not contractually be allocated to another entity. The Consortium Leader may be asked during an audit or other inquiry to provide documentation that supports information and certifications

provided. The Consortium Leader must also collect and retain a Letter of Agency (LOA) from each member.

• *Competitive Bidding and Cost Allocation.* The Consortium Leader is responsible for ensuring that the competitive bidding process is fair and open and otherwise complies with Commission requirements. If costs are shared by both eligible and ineligible entities, the Consortium Leader must also ensure that costs are allocated in a manner that ensures that only eligible entities receive the benefit of program discounts.

• *Invoicing.* The Consortium Leader is responsible for the invoicing process, including certifying that the participant contribution has been paid and that the invoice is accurate.

• *Recordkeeping, Site Visits, and Audits.* The Consortium Leader is also responsible for compliance with the Commission's recordkeeping requirements, and coordinating site visits and audits for all consortium members.

b. Participating Health Care Providers

160. Next, the consortium should identify all HCPs who will participate. The Consortium Leader will need to provide this information to USAC in order to request program support. We intend for eligible HCPs to have broad flexibility in organizing consortia according to their health care needs. For example, a consortium may be a pre-existing organization formed for reasons unrelated to universal service support *(e.g.* a regional telemedicine network, a statewide health information exchange), or a group newly formed for the purpose of applying for Healthcare Connect Fund support. Consortium members may be affiliated (formally or informally) or unaffiliated. Ineligible HCPs may participate in consortia, although they are not eligible to receive support and must pay full cost (fair share) for all services received through the consortium.

c. Letters of Agency

161. Discussion. The letter of agency requirement helps ensure that participating entities are eligible to receive support, and that the HCPs have given the project leaders the necessary authorization to act on their behalf. After considering our experience in the Pilot Program, and reviewing the comments filed regarding letters of agency, we conclude that each Consortium Leader must secure the necessary authorizations through an LOA from each HCP seeking to participate in the applicant's network that is *independent* of the Consortium Leader. LOAs are not required for those participating HCP sites that are owned or otherwise controlled by the Consortium Leader (and thus are not ''independent''). Similarly, one LOA is sufficient for multiple HCP sites that are owned or otherwise controlled by a single consortium member.

162. We adopt an approach that creates a two-step process of LOAs: in the first step, a Consortium Leader must obtain LOAs from members to seek bids for services, and in the second step, the Leader must obtain LOAs to apply for funding from the program. This two-step approach addresses an issue that arose in the Pilot Program, where some prospective member HCPs were reluctant to provide LOAs that would commit them to participate in a consortium network before they knew the pricing of services from prospective bidders. Under the Healthcare Connect Fund, we require that each Consortium Leader secure authorization, the required certifications, and any supporting documentation from each consortium member (i) to submit the request for services on its behalf (Form 461) and prepare and post the request for proposal on behalf of the member for purposes of the Healthcare Connect Fund and (ii) to submit the funding request (Form 462) and manage invoicing and payments, on behalf of the member. The first authorization is required prior to the submission of the request for services (Form 461), while the second authorization is only required prior to the submission of the request for funding (Form 462). An applicant may either secure both required authorizations upfront or secure each authorization as needed. Consortium Leaders may also obtain authorization, the required certifications, and any supporting documentation from each member to submit Form 460, if needed, to certify the member's eligibility to participate in the Healthcare Connect Fund. If the Consortium Leader does not obtain such authorization for a given member, that member will have to submit its own Form 460. In addition, we delegate authority to the Bureau to develop model language for the LOA required for each authorization.

163. In addition to the necessary authorizations, the LOA must include, at a minimum, the name of the entity filing the application (*i.e.,* lead applicant or consortium leader); name of the entity authorizing the filing of the application (*i.e.,* the participating HCP/consortium member); the physical location of the HCP/consortium member site(s); the relationship of each site seeking support to the lead entity filing the application; the specific timeframe the LOA covers; the signature, title and contact information (including phone number, mailing address, and email address) of an official who is authorized to act on behalf of the HCP/consortium member; signature date; and the type of services covered by the LOA. For HCPs located on Tribal lands, if the health care facility is a contract facility that is run solely by a Tribal Nation, the appropriate Tribal leader, such as the Tribal Chairperson, President, or Governor, or Chief, shall also sign the LOA, unless the health care responsibilities have been duly delegated to another Tribal government representative. In all instances, electronic signatures are permissible.

164. The approach we adopt addresses many of the concerns expressed by commenters, while still ensuring applicants have the necessary authority to act on behalf of their members. Some commenters correctly point out that under the Pilot Program, an HCP was often reluctant or unable to execute an LOA that required the HCP to agree to participate in a network before accurate pricing was available. Other commenters stressed that requiring LOAs as part of the Form 465 submission was a net benefit because it enabled the project to ''vet'' the eligibility of interested HCPs at the outset of the application process. We conclude that the adopted approach provides flexibility to allow consortium applicants to tailor the LOA process to meet the needs of their members, within the necessary constraints.

2. Determination of Health Care Provider Eligibility

165. Discussion. Consistent with other measures we adopt to improve the efficiency and operation of the Healthcare Connect Fund, we institute a new process for obtaining faster eligibility determinations from USAC by permitting HCPs to submit Form 460 at any time during the funding year to certify to the eligibility of particular sites. By separating the eligibility determination from the competitive bidding process, we provide HCPs with the option of receiving an eligibility determination before they move forward with preparing an application for funding. HCPs who have previously received an eligibility determination from USAC (*i.e.* HCPs who already participate in the existing rural health care programs) are not required to submit a Form 460 prior to submission of a Form 461. All HCPs, however, are required to submit an updated Form 460 within 30 days of a material change, such as a change in the HCP's name, site

location, contact information or eligible entity type, or for non-rural hospitals, an increase in the number of licensed patient beds such that the hospital goes from having fewer than 400 licensed beds to 400 or more licensed beds.

166. For each HCP listed, applicants will be required to provide the HCP's address and contact information, identify the eligible HCP type, provide an address for each physical location that will receive supported connectivity, provide a brief explanation for why the HCP is eligible under the Act and the Commission's rules and orders, and certify to the accuracy of this information under penalty of perjury. Consortium leaders should obtain supporting information and/or documents to support eligibility for each HCP when they collect LOAs; leaders also may be asked for this information during an audit or investigation. USAC should notify each applicant of its determination (or whether it needs additional time to process the form) within 30 days of receipt of Form 460. We caution applicants that it is their obligation to submit accurate information and certifications regarding their eligibility. Because HCP eligibility is limited by the Act, the Commission does not have discretion to waive eligibility requirements, and must recover any support erroneously disbursed to ineligible entities. We direct USAC to assign a unique identifying number to each HCP location in order to facilitate tracking of the location throughout the application process.

3. Technology Planning

167. Discussion. We encourage all applicants to carefully evaluate their connectivity needs before submitting an application. We decline at this time to require applicants in the Healthcare Connect Fund to submit technology plans with their requests for service, but we may re-evaluate this decision in the future based on experience with the new program. Our goal is reduce administrative burdens and delay associated with participating in the Healthcare Connect Fund, especially for the HCPs with the fewest resources and greatest need to participate.

168. The record indicates that HCPs are a diverse group with a diverse set of needs. Our intent, consistent with precedent, is to allow HCPs to identify their specific broadband needs, which, together with the competitive bidding requirements and the required HCP 35 percent contribution, will help ensure that universal services funds are used most cost-effectively. We recognize that the amount of planning required will vary depending on a number of factors, such as the HCP's size and planned utilization of health IT, and that the amount of IT expertise and other resources available for formal planning will vary widely between different types of HCPs. In the planning process, applicants may wish to consider questions such as the following:

- What applications do we plan to use over our broadband connection (*e.g.* exchange of EHRs, videoconferencing, image transfers, and other forms of telehealth or telemedicine)? How do these applications fit into our overall strategy to improve care and/or generate cost savings? How many users do we need to support for each application?
- What broadband services do we need to support the planned applications and users?
- Do we have a plan to train our staff to use the applications?
- Do we have the necessary IT resources to deploy the broadband services and applications?
- Have we considered the benefits and drawbacks of short-term versus multi-year contracts (*e.g.* cost savings in long-term contracts versus potential decreases in prices, technology advances, and termination fees)?
- How will we pay for the undiscounted portion of supported services and equipment, and any unsupported costs?
- Should we consider joining with other HCPs to apply as a consortium? If a consortium, should we include other HCPs?
- What resources are available to help us?

169. We encourage prospective applicants to consult available resources, including those previously published by the Commission and resources available through HHS, in conducting their technology planning.

4. Preparation for Competitive Bidding

170. Discussion. The Commission has defined ''cost-effective'' for purposes of the existing RHC support mechanism as ''the method that costs the least after consideration of the features, quality of transmission, reliability, and other factors that the HCP deems relevant to * * * choosing a method of providing the required health care services.'' The Commission does not require HCPs to use the lowest-cost technology because factors other than cost, such as reliability and quality, may be relevant to fulfill their health care needs. Furthermore, initially higher cost options may prove to be lower in the long-run, by providing useful benefits to telemedicine in terms of future medical and technological developments and maintenance. Therefore, unlike the E-rate program, the RHC program does not require participants to consider price as *the* primary factor in selecting a service provider. Instead, applicants identify the factors relevant for health care purposes, and then select the lowest price bid that satisfies those considerations. We conclude that continuing this approach is appropriate for the Healthcare Connect Fund.

171. Applicants must develop appropriate evaluation criteria for selecting the winning bid *before* submitting a request for services to USAC to initiate competitive bidding. The evaluation criteria should be based on the Commission's definition of ''cost-effective,'' and include the most important criteria needed to provide health care, as determined by the applicant. For smaller applicants (*e.g.* those requesting support for recurring monthly costs for a single T–1 line), criteria such as bandwidth, quality of transmission, reliability, previous experience with the service provider, and technical support are likely to be sufficient. For more complex projects (including projects that involve designing or constructing a new network or building upon an existing network), additional relevant non-cost factors may include prior experience, including past performance; personnel qualifications, including technical excellence; management capability, including solicitation compliance; and environmental objectives (if appropriate).

172. Typically, an applicant will develop a scoring matrix, or a list of weighted evaluation criteria, that it will use in evaluating bids. Once the applicant has developed its evaluation criteria, it should assign a weight to each in order of importance. No single factor may receive a weight that is greater than price. For example, if the HCP assigns a weight of 40 percent to cost, other factors must receive a weight of 40 percent or less individually (with the total weight equaling 100%). Each bid received should be scored against the determined criteria, ensuring they are all evaluated equally. All applicants who are not exempt from competitive bidding will be required to submit bid evaluation documentation with their funding requests.

5. Source(s) for Undiscounted Portion of Costs

173. Although applicants are not required to submit documentation regarding sources for the undiscounted portion of costs until they complete the competitive bidding process, they should begin identifying possible

sources for their 35 percent as early as possible. This is especially important for larger consortia that intend to undertake high-dollar projects. In the Pilot Program, many projects experienced delays due, in part, to difficulty in obtaining the required contribution.

6. FCC Registration Number (FRN)

174. All applicants must obtain FCC registration numbers (FRNs), if they do not have one already. An FRN is a 10-digit number that is assigned to a business or individual registering with the FCC, and is used to uniquely identify the business or individual in all of its transactions with the FCC. Obtaining an FRN is a quick, online process that can typically be completed in a manner of minutes through the Commission's Web site. Consortium applicants may obtain a single FRN for the consortium as a whole, if desired (*i.e.* instead of requiring each participating HCP to obtain a separate FRN).

B. Competitive Bidding

175. Discussion. Competitive bidding remains a fundamental pillar supporting our goals for the Healthcare Connect Fund, as it will allow HCPs to obtain lower rates (thereby increasing access to broadband) and increase program efficiency. The outlines of the competitive bidding process for the new program will remain the same as our existing programs: All HCPs will submit a request for services for posting by USAC, wait at least 28 days before selecting a service provider, and select the most cost-effective bid. In addition, in some circumstances, applicants will be required to prepare a formal request for proposals as well.

176. While competitive bidding is essential to the program, we acknowledge that it is not without administrative costs to participants and to the Fund. We conclude that in three situations, exempting funding requests from competitive bidding in the Healthcare Connect Fund will strike a common-sense balance between efficient use of program funds and reducing regulatory costs. First, based on our experience with the Telecommunications and Internet Access Programs, we find that it will be more administratively efficient to exempt applicants seeking support for relatively small amounts. The threshold for this exemption is $10,000 or less in total annual undiscounted costs (which, with a 35 percent applicant contribution, results in a maximum of $6,500 annually in Fund support). Second, if an applicant is purchasing services from a master service agreement negotiated by a governmental entity on its behalf, and the master service agreement was awarded pursuant to applicable federal, state, Tribal, or local competitive bidding processes, the applicant is not required to re-undergo competitive bidding. Third, we conclude that applicants who wish to request support under the Healthcare Connect Fund while utilizing contracts previously endorsed by USAC (Master Services Agreements under the Pilot Program or the Healthcare Connect Fund, or evergreen contracts in any of the health care programs, or master contracts the E-rate program) may do so without undergoing additional competitive bidding, as long as they do not request duplicative support for the same service and otherwise comply with all program requirements. In addition, consistent with current RHC program policies, applicants who receive evergreen status or multi-year commitments under the Healthcare Connect Fund are exempt from competitive bidding for the duration of the contract. Applicants who are exempt from competitive bidding can proceed directly to submitting a funding commitment request.

1. ''Fair and Open'' Competitive Bidding Process

177. Discussion. Unless they qualify for one of the competitive bidding exemptions, all entities participating in the Healthcare Connect Fund must conduct a fair and open competitive bidding process prior to submitting a request for funding Form 462. Although it is not possible to anticipate all possible factual circumstances that may arise during the process, we set forth here three basic principles and some specific guidance that should help applicants comply with this requirement.

178. First, service providers who intend to bid should not also simultaneously help the HCP choose a winning bidder. More specifically, service providers who submit bids are prohibited from (1) preparing, signing or submitting an applicant's Form 461 documents; (2) serving as Consortium Leaders or other points of contact on behalf of applicants; (3) being involved in setting bid evaluation criteria; or (4) participating in the bid evaluation or vendor selection process (except in their role as potential vendors). Consultants, other third-party experts, or applicant employees who have an ownership interest, sales commission arrangement, or other financial stake with respect to a bidding service provider are also prohibited from performing any of the four functions on behalf of the applicant. All applicants must submit a ''Declaration of Assistance'' with their request for services (Form 461) to help the Commission and USAC identify third parties who assisted in the preparation of the applications.

179. Second, all potential bidders and service providers must have access to the same information and must be treated in the same manner. Any additions or modifications to the documents submitted to, and posted by, USAC must be made available to all potential service providers at the same time and using a uniform method. We direct USAC to facilitate this process by allowing applicants to submit any additions or modifications to USAC, for posting on the same Web page as the originally posted documents.

180. Finally, as is the case in the Telecommunications, Internet Access, and Pilot Programs, all applicants and service providers must comply with any applicable state or local competitive bidding requirements. The Commission's requirements apply in addition to, and are not intended to preempt, such requirements.

2. Requests for Proposals

181. Discussion. We will require submission of RFPs with Form 461 for (1) applicants who are required to issue an RFP under applicable state, Tribal, or local procurement rules or regulations; (2) consortium applications that seek more than $100,000 in program support in a funding year; and (3) consortium applications that seek support for infrastructure (*i.e.* HCP-owned facilities) as well as services. Applicants who seek support for long-term capital investments, such as HCP-constructed infrastructure or fiber IRUs, must also seek bids in the same RFP from vendors who propose to meet those needs via services provided over vendor-owned facilities, for a time period comparable to the life of the proposed capital investment. This is to allow USAC to determine if the option chosen is the most cost-effective. In addition, any applicant is free submit an RFP to USAC for posting, but all applicants who utilize an RFP in conjunction with their competitive bidding process must submit the RFP to USAC for posting and provide USAC with any subsequent changes to the RFP. We conclude that our requirement strikes a reasonable balance between ensuring larger consortia and the Fund benefit from the cost savings resulting from the RFP process, while limiting the administrative burden on individual HCPs and smaller consortia.

182. Applicants who have or intend to issue an RFP must submit a copy of the RFP with their request for services. We recognize that a consortium may not know the exact cost of the project until after it completes the competitive bidding process and selects a vendor. If a consortium chooses to forego an RFP, however, its support will be capped at $100,000.

183. The Commission does not specify requirements for RFPs in the current RHC program, and USAC does not approve RFPs. Therefore, applicants may prepare RFPs in any manner that complies with program rules and any applicable state, Tribal, or local procurement rules or regulations. The RFP, however, should provide sufficient information to enable an effective competitive bidding process, including describing the HCP's service needs and defining the scope of the project and network costs (if applicable). The RFP should also specify the period during which bids will be accepted. The RFP should also include the scoring criteria that will be used to evaluate bids for cost-effectiveness, in accordance with the requirements and solicit sufficient information so that the criteria can be applied effectively. A short, simple RFP may be appropriate for smaller consortia, or for consortia whose needs are less complex. We note that consortia may choose to submit single or multiple requests for services (and multiple RFPs), depending on the structure that makes most sense for the particular project.

3. USAC Posting of Request for Services

184. Discussion. Applicants subject to competitive bidding must submit new FCC Form 461 and supporting documentation to USAC. The purpose of these documents is to provide sufficient information on the requested services to enable an effective competitive bidding process to take place and to enable USAC to obtain certifications and other information necessary to prevent waste, fraud, and abuse.

185. Documents to be submitted to USAC with the ''request for services'' include the following:

• *Form 461.* Applicants should submit Form 461, the ''request for services,'' to provide information about the services for which they are seeking support. On Form 461, applicants will provide basic information regarding the HCP(s) on the application (including contact information for potential bidders), a brief description of the desired services, and certifications designed to ensure compliance with program rules and minimize waste, fraud, and abuse. An applicant must certify under penalty of perjury that (1) it is authorized to submit the request and that all statements of fact in the application are true to the best of the signatory's knowledge; (2) it has followed any applicable state or local procurement rules; (3) the supported services and/or equipment will be used solely for purposes reasonably related to the provision of health care service or instruction that the HCP is legally authorized to provide under the law of the state in which the services are provided and will not be sold, resold, or transferred in consideration for money or any other thing of value; and (4) the HCP or consortium satisfies all program requirements and will abide by all such requirements. Applicants not using an RFP should provide on Form 461 sufficient information regarding the desired services to enable an effective competitive bidding process, including, at a minimum, a summary of their service needs, the dates for service (including whether the contract is potentially for multiple years), and the dates of the bid evaluation period. Consortium Leaders should provide the required information on behalf of all participating HCPs.

• Applicants who include a particular service provider's name, brand, product or service on Form 461 or in the RFP must also use the words ''or equivalent'' in the description, in order to avoid the appearance that the applicant has pre-selected the named service provider or intends to give the service provider preference in the bidding process. In addition, an applicant may wish to describe its needs in general terms (*e.g.,* ''need to transmit data and medical images'' rather than requesting a specific service or bandwidth), because the applicant may not be aware of all potential service providers in its market. Using general terms can allow an applicant to avoid inadvertently excluding a lower-cost bid from a service provider using a newer technology.

• *Bid Evaluation Criteria.* The requirements for bid evaluation criteria are discussed.

• *Request for Proposal.* Certain applicants *must* use an RFP in the competitive bidding process, and any applicant *may* use an RFP. Applicants who use an RFP should submit it (along with any other relevant bidding information) as an attachment to Form 461.

• *Network Planning for Consortia.* Consortium applicants must submit a narrative attachment with Form 461 that includes the following information:

(1) Goals and objectives of the proposed network;

(2) Strategy for aggregating the specific needs of HCPs (including providers that serve rural areas) within a state or region;

(3) Strategy for leveraging existing technology to adopt the most efficient and cost effective means of connecting those providers;

(4) How the broadband services will be used to improve or provide health care delivery;

(5) Any previous experience in developing and managing health IT (including telemedicine) programs; and

(6) A project management plan outlining the project's leadership and management structure, and a work plan, schedule, and budget.

The network planning requirements are consistent with those in the Pilot Program. For purposes of the Healthcare Connect Fund, however, submission of this information is a minimum requirement, not a scoring metric for choosing funding recipients. We do not intend for this planning to be an undue administrative burden, and will continue to allow consortia to put forth a variety of strategies for accomplishing their goals, as the Commission did in the Pilot Program.

Consortium applicants are required to use program support. All applicants are subject to the Commission's procedures for audits and other measures to prevent waste, fraud, and abuse.

• *Form 460.* Applicants should submit Form 460 to certify to the eligibility of HCP(s) listed on the application, if they have not previously done so.

• *Letters of Agency for Consortium Applicants.* Consortium applicants should submit letters of agency demonstrating that the Consortium Leader is authorized to submit Form 461, including required certifications and any supporting materials, on behalf of each participating HCP in the consortium.

• *Declaration of Assistance.* As the Commission did in the Pilot Program, we require that all applicants identify, through a declaration of assistance, any consultants, service providers, or any other outside experts, whether paid or unpaid, who aided in the preparation of their applications. The declaration of assistance must be filed with the Form 461. Identifying these consultants and outside experts facilitates the ability of USAC, the Commission, and law enforcement officials to identify and prosecute individuals who may seek to defraud the program or engage in other illegal acts. To ensure participants

comply with the competitive bidding requirements, they must disclose all of the types of relationships.

186. Applicants may submit Form 461 starting 180 days before the beginning of the funding year. Our experience in the Pilot Program is that it can take as long as six months for more complex projects to complete bid evaluation and select a vendor. To allow sufficient time to complete this process prior to the beginning of the funding year, HCPs should submit Form 461 as soon as possible after the filing window opens. USAC may provide applicants with the opportunity to cure errors on their submissions, up to the date of posting of the Form 461 package. The responsibility to submit complete and accurate information to USAC, however, remains at all times the sole responsibility of the applicant.

4. 28-Day Posting Requirement

187. After the HCP submits Form 461, USAC will post the form and any accompanying documents (the Form 461 ''package'') on its Web site. USAC may institute reasonable procedures for processing Form 461 and the associated documents and may provide applicants with an opportunity to correct errors in the submissions. We caution applicants, however, that they remain ultimately responsible for ensuring that all forms and documents submitted comply with our rules and any other applicable state or local procurement requirements. We also remind applicants that they must certify under penalty of perjury on Form 461 that all statements of facts contained therein are true to the best of their knowledge, information, and belief, and that under federal law, persons willfully making false statements on the form can be punished by fine, forfeiture, or imprisonment. If an applicant makes any changes to its RFP post-submission, it is responsible for ensuring that USAC has a current version of the RFP for the Web site posting.

188. The *NPRM* proposed that applicants seeking infrastructure bids should be required to distribute their RFPs in a method likely to garner attention from interested vendors. In keeping with our objective of minimizing administrative costs to applicants, however, we decline to adopt a formal requirement for applicants to distribute an RFP beyond the USAC posting process. We do encourage applicants, however, to disseminate their requests for services (Form 461 package) as widely as possible, in order to maximize the quality and quantity of bids received. Such methods could include, for example, (1) posting a notice of the Form 461 package in trade journals or newspaper advertisements; (2) send the RFP to known or potential service providers; (3) posting the Form 461 package (or a link thereto) on the HCP's Web page or other Internet sites, or (4) following other customary and reasonable solicitation practices used in competitive bidding.

189. After posting of the Form 461 package, USAC will send confirmation of the posting to the applicant, including the posting date and the date on which the applicant may enter into a contract with the selected service provider (the ''Allowable Contract Selection Date,'' or ACSD). Once USAC posts the package, interested bidders should submit bids directly to the applicant. Applicants must wait at least 28 calendar days from the date on which their Form 461 packages are posted on USAC's Web site before making a commitment with a service provider, so the ACSD is the 29th calendar day after the posting. Applicants may not agree to or sign a contract with a service provider until the ACSD, but may discuss requirements, rates, and conditions with potential service providers prior to that date. Applicants who select a service provider before the ACSD will be denied funding.

190. Applicants are free to extend the time period for receiving bids beyond 28 days from the posting of Form 461 and may do so without prior approval. In addition, some applicants who propose larger, more complex projects may wish to undertake an additional ''best and final offer'' round of bidding. Allowing sufficient time and opportunity for all potential bidders to develop and submit bids can lead to more and better bids, and has the potential to enhance the quality and lower the price of services ultimately received. We encourage HCPs contemplating more complex projects (including those with an infrastructure component) to utilize a longer bidding period, as done by many Pilot projects. If an applicant has plans to utilize a period longer than 28 days, it should so indicate clearly on the Form or in accompanying documentation. An applicant that decides to extend the bidding period after USAC's posting of Form 461 should notify USAC promptly, so that USAC can update its Web site posting with notice of the extension.

5. Selection of the Most ''Cost-Effective'' Bid and Contract Negotiation

191. Once the 28-day period expires, applicants may evaluate bids, select a winning bidder and negotiate a contract. Applicants should develop appropriate evaluation criteria for selecting the ''most cost-effective'' bid according to the Commission's rules before submitting a Form 461 package to USAC. Applicants should follow those evaluation criteria in evaluating bids and selecting a service provider. All applicants subject to competitive bidding will be required to certify to USAC that the services and/or infrastructure selected are, to the best of the applicant's knowledge, the most cost-effective option available.

192. Applicants must submit documentation to USAC to support their certification that they have selected the most cost-effective vendor, including a copy of each bid received (winning, losing, and disqualified), the bid evaluation criteria, and any other related documents, such as bid evaluation sheets; a list of people who evaluated bids (along with their title/role/relationship to the applicant organization); memos, board minutes, or similar documents related to the vendor selection/award; copies of notices to winners; and any correspondence with service providers during the bidding/evaluation/award phase of the process. We explain how applicants may seek confidential treatment for these documents. We do not require bid evaluation documents to be in a certain format, but the level of documentation should be appropriate for the scale and scope of the services for which support is requested. Thus, for example, we expect that the documentation for a large network project will be more extensive than for an individual HCP seeking support for a single circuit. Applicants should also retain the supporting documentation for five years from the end of the relevant funding year, pursuant to the recordkeeping requirements.

193. Certain tariffed or month-to-month services are typically not provided pursuant to a signed, written contract. For all other services, the contract should be negotiated and signed before applicants submit a request for a funding commitment. Applicants who wish to enter into a multi-year contract and be exempt from competitive bidding for the duration of the contract (''evergreen status'') should ensure that the contract identifies both parties; is signed and dated by the HCP or Consortium Leader after the Allowable Contract Selection Date; and specifies the type, term, and cost of service(s). Applicants will be required to submit a copy of the final contract(s) with their funding requests.

6. Competitive Bidding Exemptions

194. An applicant that qualifies for any of the exemptions (and does not wish to use the competitive bidding process) is not required to prepare and post a Form 461. Instead, the applicant may proceed directly to filing the request for funding commitment (Form 462). If the applicant has not previously submitted Form 460 to certify to its eligibility, it should submit that form at the same time, or prior to, submitting Form 462. The exemptions only apply to participants receiving support through the Healthcare Connect Fund, not the existing RHC or Pilot Programs.

a. Annual Undiscounted Cost of $10,000 or Less

195. Discussion. Based on our experience with the Telecommunications and Pilot programs, we adopt an exemption to the competitive bidding requirements under the Healthcare Connect Fund for an applicant and any related applicants that seek support for $10,000 or less of total undiscounted eligible expenses for a single year (*i.e.,* with a required HCP contribution of 35 percent, up to $6,500 in Fund support). This exemption does not apply to multi-year contracts. This approach recognizes that for applicants pursuing small dollar value contracts, the administrative costs associated with the competitive bidding process may likely outweigh the potential benefits. Even with the exemption, however, we encourage smaller applicants to consider using the competitive bidding process to help ensure they are receiving the best service and pricing available.

196. The $10,000 annual limit is based on the average undiscounted recurring monthly cost of a 1.5 to 3.0 Mbps connection as observed under both the Telecommunications and Pilot programs. Based on this limit, small applicants, typically single HCP sites, should be able to secure support for a T–1 line or similar service without having to go through the competitive bidding process. A consortium application seeking support for undiscounted costs of $10,000 or less is also exempt from competitive bidding if the total of all consortium members' undiscounted costs for which support is sought, in this and any other application combined, is not more than $10,000 for that year. We recognize that as a practical matter, this will likely prevent all but the smallest consortia from qualifying for the exemption, but as observed under the Pilot Program, consortia can substantially benefit from the competitive bidding process in terms of better pricing and higher quality of service.

197. We recognize that an applicant may not always be able to exactly predict its annual eligible expenses in advance. If the applicant chooses to forego competitive bidding, however, its annual support will be capped at $6,500 (65 percent of $10,000) for any services that are not subject to an exemption. If a qualifying applicant later discovers that it requires additional services beyond the $10,000 limit, the applicant may receive support for the additional services if it first completes the competitive bidding process for the additional services.

b. Government Master Service Agreements

198. Discussion. We adopt a competitive bidding exemption for HCPs who are purchasing services and/or equipment from MSAs negotiated by federal, state, Tribal, or local government entities on behalf of such HCPs and others, if such MSAs were awarded pursuant to applicable federal, state, Tribal, or local competitive bidding requirements. This exemption helps streamline the application process by removing unnecessary and duplicative government competitive bidding requirements while still ensuring fiscal responsibility. Because these MSAs have government requirements for competitive bidding, this fairly ''removes the burden from the Rural Health Care Provider to conduct an additional competitive bid.'' This exemption only applies to MSAs negotiated by, or under the direction of, *government* entities and subject to government competitive bidding requirements. Applicants must submit documentation demonstrating that they qualify for the exemption, including a copy of the MSA and documentation that it was subject to government competitive bidding requirements. In many cases these government contracts were negotiated on behalf of a large number of users, so are likely to generate similar cost efficiencies as those derived through the Healthcare Connect Fund competitive bidding process.

199. Commenters generally support the adoption of a competitive bidding exemption that allows applicants to take services from a government MSA, so long as the original master contract was subject to a competitive bidding process. For instance, CCHCS ''recommends that the Commission exempt from competitive bidding requirements State HCPs that are required to use the State mandated Master Services Agreements for the procurement of telecommunication and/or broadband services.'' Similarly, VAST argues that the ''Commission should allow eligible Health Care Providers to take services from a federal or state Master Service Agreement (MSA) that has been awarded through a competitive bidding process.''

c. Master Service Agreements Approved Under the Pilot Program or the Healthcare Connect Fund

200. Discussion. We adopt a competitive bidding exemption for HCPs purchasing services or equipment from an MSA, whether the contract was originally secured through the competitive bidding process under the Pilot Program or in the future through the Healthcare Connect Fund. As the Commission stated in the July 2012 *Bridge Funding Order,* 77 FR 42185, July 18, 2012, sufficient safeguards are in place to protect against waste, fraud, and abuse in these situations because HCPs have already gone through the competitive bidding process to identify and select the most cost-effective service provider in instituting these contracts. This exemption also applies to MSAs that have been secured through competitive bidding with funding approved by USAC during the Pilot Program bridge period. In addition, the exemption will apply to services or equipment purchased during an MSA extension approved by USAC. The exemption is limited to those MSAs that were developed and negotiated from an RFP that specifically sought a mechanism for adding additional sites to the network. This exemption does not extend to MSAs or extensions thereof that are not approved by USAC.

d. Evergreen Contracts

201. Discussion. As proposed in the *NPRM,* and as supported in the record, we allow contracts to be designated as ''evergreen'' in the Healthcare Connect Fund. As stated in the *NPRM* and echoed by commenters, evergreen procedures likely will benefit participating HCPs by affording them: (1) lower prices due to longer contract terms; and (2) reduced administrative burdens due to fewer required Form 465s.

202. A contract entered into by an HCP or consortium as a result of competitive bidding will be designated as evergreen if it meets all of the following requirements: (1) Signed by the individual HCP or consortium lead entity; (2) specifies the service type, bandwidth and quantity; (3) specifies the term of the contract; (4) specifies the cost of services to be provided; and (5) includes the physical addresses or other

identifying information of the HCPs purchasing from the contract. Consortia will be permitted to add new HCPs if the possibility of expanding the network was contemplated in the competitive bidding process, and the contract explicitly provides for such a possibility. Similarly, service upgrades will be permitted as part of an evergreen contract if the contemplated upgrades are proposed during the competitive bidding process, and the contract explicitly provides for the possibility of service upgrades.

203. Participants may also exercise voluntary options to extend an evergreen contract without undergoing additional competitive bidding, subject to certain limitations. First, the voluntary extension(s) must be memorialized in the evergreen contract. Second, the decision to extend the contract must occur before the participant files its funding request for the funding year when the contract would otherwise expire. Third, voluntary extension(s) may not exceed five years, after which the service(s) must be re-bid. We find that this limitation strikes an appropriate balance between two competing considerations: (1) providing HCPs with the price and administrative savings of entering into a long-term contract; and (2) ensuring that HCPs periodically re-evaluate whether they can obtain better prices through re-bidding a service.

204. We also conclude that, if an HCP has a contract that was designated as evergreen under Telecommunications Program or Internet Access Program procedures prior to January 1, 2014, it may choose to seek support for services provided under the evergreen contract from the Healthcare Connect Fund instead without undergoing additional competitive bidding, so long as the services are eligible for support under the Healthcare Connect Fund, and the HCP complies with all other Healthcare Connect Fund rules and procedures. The Commission noted in the *NPRM* that codifying the evergreen policy ''would maintain consistency while transitioning from the existing internet access program to the new health broadband services program.'' Allowing HCPs who have already competitively bid (and received evergreen status for) multi-year contracts seamlessly to transition into the Healthcare Connect Fund furthers our program goals to streamline the application process and promote fiscal responsibility and cost-effectiveness. Pilot Program participants who have negotiated a long-term contract that extends beyond the period of their Pilot awards may also seek to have their contracts designated as ''evergreen'' by USAC for purposes of the Healthcare Connect Fund without undergoing a new competitive bidding process, as long as the existing contract meets the requirements for an evergreen contract. If an evergreen contract approved under the Telecommunications Program, Internet Access Program, or a Pilot Program contract designated as evergreen under the Healthcare Connect Fund includes voluntary extensions, HCPs utilizing such contracts in the Healthcare Connect Fund may also exercise such voluntary extensions consistent with the requirements.

e. Contracts Negotiated Under E-Rate

205. Discussion. Consistent with § 54.501(c)(1) of our rules, we conclude that an HCP entering into a consortium with E-rate participants and becoming a party to the consortium's existing contract should be exempt from the RHC competitive bidding requirements, so long as the contract was competitively bid consistent with E-rate rules, approved for use in the E-rate program as a master contract, and the Healthcare Connect Fund applicant (*i.e.* the individual HCP or consortium) otherwise complies with all Healthcare Connect Fund rules and procedures. An applicant utilizing this exemption must submit documentation with its request for funding that demonstrates that (1) the applicant is eligible to take services under the consortium contract; and (2) the consortium contract was approved as a master contract in the E-rate program. We agree with MiCTA that such an exemption will reduce HCPs' individual administrative burdens and encourage consortia, and likely will save universal service funds due to the lower contract prices often associated with consortia bulk-buying. We thus find that a competitive bidding exemption for HCPs entering into contracts negotiated under the E-rate program will further our program goals to streamline the application process, facilitate consortium applications, and promote fiscal responsibility and cost-effectiveness. We note that an HCP in a consortium with E-rate participants may receive support only for services eligible for support under the RHC programs.

f. No Exemption for Internet2 and National LambdaRail

206. Discussion. We require participants to seek competitive bids from any research and education networks, including Internet2 and National LambdaRail, through our standard competitive bidding process. There may be instances where a more cost-effective solution is available from a commercial provider, or even a non-profit provider other than Internet2 or National LambdaRail, and a competitive bidding requirement will ensure that HCPs consider options from all interested service providers. Many commenters opposed the Commission's proposal to exempt National LambdaRail and Internet2 from competitive bidding, arguing, among other things, that such an exemption would be anti-competitive by disadvantaging other telecommunications providers. We find that requiring HCPs to seek bids from National LambdaRail and Internet2 through the normal competitive bidding process could result in lower-priced bids, and should therefore be required. This approach furthers our program goal to promote fiscal responsibility and cost-effectiveness.

C. Funding Commitment From USAC

207. Once a service provider is selected, applicants in the current RHC program submit a ''Funding Request'' (and supporting documentation) to provide information about the services selected and certify that the services were the most cost-effective offers received. If USAC approves the ''Request for Funding,'' it will issue a ''Funding Commitment Letter.'' USAC's role is to review the funding request for accuracy and completeness. Once an applicant receives a funding commitment, it may invoice USAC after receiving a bill from the service provider. Applicants do not need to file a Form 467 to notify USAC that the service provider began providing services for which the applicant is seeking support.

1. Requirements for Service Providers

208. All vendors that participate in the Healthcare Connect Fund are required to have a Service Provider Identification Number (SPIN). The SPIN is a unique number assigned to each service provider by USAC, and serves as USAC's tool to ensure that support is directed to the correct service provider. SPINs must be assigned before USAC can authorize support payments. Therefore, all service providers submitting bids to provide services to selected participants will need to complete and submit a Form 498 to USAC for review and approval if selected by a participant before funding commitments can be made.

209. Service providers in the Healthcare Connect Fund must certify on Form 498, as a condition of receiving support, that they will provide to HCPs, on a timely basis, all information and documents regarding the supported

service(s) that are necessary for the HCP to submit required forms or respond to FCC or USAC inquiries. In addition, USAC may withhold disbursements for the service provider if the service provider, after written notice from USAC, fails to comply with this requirement.

2. Filing Timeline for Applicants

210. Discussion. Unless and until the Commission adopts other procedures to prioritize requests for funding, we retain the rule that requests for funding may be submitted at any point during the funding year, and direct USAC to process and prioritize funding requests on a rolling basis (according to the date of receipt) until it reaches the program cap established by the Commission. Given the historical utilization of RHC support and the implementation timetable for funding year 2013, we do not currently anticipate that demand will exceed the $400 million cap in FY 2013 or for the foreseeable future. We conclude, however, that this longstanding default rule will apply in the unlikely event that the cap is exceeded, unless and until the Commission adopts a different rule for prioritizing funding requests. We also direct USAC to periodically inform the public, through its Web site, of the total dollar amounts (1) requested by HCPs and (2) actually committed by USAC for the funding year, as well as the amounts committed in upfront payments (for purposes of the $150 million cap on upfront payments).

211. We also direct USAC to establish a filing window for funding year 2013 and for future funding years as necessary, for both the Telecommunications Program and the Healthcare Connect Fund. When USAC establishes a filing window, it should provide notice of the window in advance via public notice each year. The filing window may begin prior to the first day of the funding year, as long as actual support is only provided for services provided during the funding year.

212. As in the Telecommunications Program, applicants may initiate services at their own risk during the funding year pending the processing of their funding requests, as long as the services are provided pursuant to a contract or other service agreement that complies with program requirements (including the competitive bidding process). The contract must be signed (or the service agreement entered into) before the applicant submits a funding request.

213. Funding will be available for Pilot participants starting July 1, 2013, and starting January 1, 2014, for other applicants.

3. Required Documentation for Applicants

214. This information should be submitted to USAC to support a request for commitment of funds.

215. Form 462. Form 462 is the means by which an applicant identifies the service(s), rates, service provider(s), and date(s) of service provider (vendor) selection. In the Primary Program, applicants are required to submit a separate form for each service or circuit for which the applicant is seeking support. In the Healthcare Connect Fund, we will not require separate forms for each service or circuit, thereby lessening administrative burden on potential Fund recipients. Each individual applicant will submit a single form for each service provider that lists the relevant information for all service(s) or circuit(s) for which the individual applicant is seeking support at the time. Similarly, each consortium applicant will submit a single form for each service provider that lists the relevant information for all consortium members, including the service(s) or circuit(s) for which each member is seeking support at the time.

216. Certifications. Applicants must provide the following certifications on Form 462.

- The person signing the application is authorized to submit the application on behalf of the applicant, and has examined the form and all attachments, and to the best of his or her knowledge, information, and belief, all statements of fact contained therein are true.
- Each service provider selected is, to the best of the applicant's knowledge, information, and belief, the most cost-effective service provider available, as defined in the Commission's rules.
- All Healthcare Connect Fund support will be used only for the eligible health care purposes, as described in this *Order* and consistent with the Act and the Commission's rules.
- The applicant is not requesting support for the same service from both the Telecommunications Program and the Healthcare Connect Fund.
- The applicant satisfies all of the requirements under section 254 of the Act and applicable Commission rules, and understands that any letter from USAC that erroneously commits funds for the benefit of the applicant may be subject to rescission.
- The applicant has reviewed all applicable requirements for the program and will comply with those requirements.
- The applicant will maintain complete billing records for the service for five years.

217. Contracts or other documentation. All applicants must submit a contract or other documentation that clearly identifies (1) the vendor(s) selected and the HCP(s) who will receive the services; (2) the service, bandwidth, and costs for which support is being requested; (3) the term of the service agreement(s) if applicable (*i.e.* if services are not being provided on a month-to-month basis). For services provided under contract, the applicant must submit a copy of a contract signed and dated (after the Allowable Contract Selection Date) by the individual HCP or Consortium Leader. If the service is not being provided under contract, the applicant must submit a bill, service offer, letter, or similar document from the service provider that provides the required information. In either case, applicants must ensure that the documentation provided specifies all charges for which the applicant is receiving support (for example, if the contract does not specify all such charges, applicants should submit a bill or other similar documentation to support their request). In addition, applicants may wish to submit a network or circuit diagram for requests involving multiple vendors or circuits.

218. Competitive bidding documents. Applicants must submit documentation to support their certifications that they have selected the most cost-effective option. Relevant documentation includes a copy of each bid received (winning, losing, and disqualified), the bid evaluation criteria, and any other related documents. Applicants who are exempt from competitive bidding should also submit any relevant documentation to allow USAC to verify that the applicant is eligible for the exemption (*e.g.,* a copy of the relevant government MSA and documentation showing that the applicant is eligible to purchase from the MSA, or USAC correspondence identifying and approving a contract previously approved for the Pilot Program).

219. Cost allocation for ineligible entities or components. Applicants who seek to include ineligible entities within a consortium, or to obtain support for services or equipment that include both eligible and ineligible components, should submit a description of their cost allocation methodology per the requirements. Applicants should also submit any agreements that memorialize cost-sharing arrangements with ineligible entities.

220. Evidence of viable source for 35 percent contribution. Many projects in

the Pilot Program experienced implementation delays, in part due to the difficulty in obtaining their required contribution. In the *NPRM,* the Commission suggested participants in the proposed infrastructure program be required to demonstrate they have a reasonable and viable source for their contribution by submitting letters of assurances confirming funds from eligible sources to meet the contribution requirement.

221. We require all consortium applicants to submit, with their funding requests, evidence of a viable source for their 35 percent contribution. We adopt this requirement to minimize administrative processing of applications that do not have a source for the required match, which will lessen USAC's administrative costs and thereby lessen the burden on the Fund. Applicants, especially those that intend to undertake high-dollar projects, should begin identifying potential sources for their contribution as early as possible. The funding request is the last major step in the application process before applicants receive a funding commitment, and at this stage applicants should be well advanced in determining the amount of their contribution and the source for that contribution. We also note that program participants will be required to submit a certification that they have paid their 35 percent contribution before USAC will disburse universal service support, so it is important for participants to have a ready source of payment before they begin receiving services.

222. Consortia may provide evidence of a viable source by submitting a letter signed by an officer, director, or other authorized employee of the Consortium Leader. The letter should identify the entity that will provide the 35 percent contribution, and the type of eligible source (*e.g.* HCP budget, grant/loan, etc.). If the applicant contribution is dependent on appropriations, grant funding, or other special conditions, the applicant should include a description of any special conditions and general information regarding those conditions. If the applicant has already identified secondary sources of funding, it should also include information regarding such sources in its letter. If the source for the participant contribution is excess capacity, applicants must identify the entit(ies) who will pay for the excess capacity, and submit evidence of arrangements made to comply with the requirements.

223. Consortium applicants are not required to identify the funding source for each consortium member if each consortium member will pay its contribution individually. Instead, the Consortium Leader should (1) verify that each member will pay its contribution from an eligible source (*e.g.,* by requesting a certification to that effect in the consortium member's LOA) and (2) submit documentation (*e.g.* consortium membership agreement) that shows that each member has agreed to pay its own contribution from an eligible source.

224. We delegate authority to the Bureau to provide more specific guidance, if needed, on the content of the letter and documentation to be submitted. USAC may, as needed, request additional documentation from applicants in order to ensure compliance with this requirement.

225. Additional documentation for consortium applicants. Consortium applicants should submit any revisions to the project management plan, work plan, schedule, and budget previously submitted with the Request for Services (Form 461). If not previously provided with the project management plan, applicants should also provide (or update) a narrative description of how the network will be managed, including all administrative aspects of the network (including but not limited to invoicing, contractual matters, and network operations.) If the consortium is required to provide a sustainability plan, the revised budget should include the budgetary factors discussed in the sustainability plan requirements. Finally, consortium applicants will be required to provide electronically (via a spreadsheet or similar method) a list of the participating HCPs and all of their relevant information, including eligible (and ineligible, if applicable) cost information for each participating HCP. USAC may reject submissions that lack sufficient specificity to determine that costs are eligible.

226. Sustainability plans for applicants requesting support for long-term capital expenses. In the *NPRM,* the Commission proposed to require sustainability plans similar to those required in the Pilot Program for HCPs who intended to have an ownership interest, indefeasible right of use, or capital lease interest in facilities funded by the Fund. We adopt the proposal in the *NPRM,* and require that consortia who seek funding to construct and own their own facilities or obtain IRUs or capital lease interests to submit a sustainability plan with their funding requests demonstrating how they intend to maintain and operate the facilities that are supported over the relevant time period. A sustainability plan for such projects is appropriate to protect the Fund's investment, because such projects are requesting support for capital expenses that are intended to have long-term benefits.

227. We largely adopt the same specific requirements for sustainability plans proposed in the *NPRM* and utilized in the Pilot Program. Although participants are free to include additional information to demonstrate a project's sustainability, the sustainability plan must, at a minimum, address the following points:

- *Projected sustainability period.* Indicate a reasonable sustainability period that is at least equal to the useful life of the funded facility. Although a sustainability period of 10 years is generally appropriate, the period of sustainability should be commensurate with the investments made from the health infrastructure program. For example, if the applicant is purchasing a 20 year IRU, the sustainability period should be a minimum of 20 years. The applicant's budget should show projected income and expenses (*i.e.* for maintenance) for the project at the aggregate level, for the sustainability period.
- *Principal factors.* Discuss each of the principal factors that were considered by the participant to demonstrate sustainability. This discussion should include all factors that show that the proposed network will be sustainable for the entire sustainability period. Any factor that will have a monetary impact on the network should be reflected in the applicant's budget.
- *Terms of membership in the network.* Describe generally any agreements made (or to be entered into) by network members (*e.g.,* participation agreements, memoranda of understanding, usage agreements, or other documents). If the consortium will not have agreements with the network members, it should so indicate in the sustainability plan. The sustainability plan should also describe, as applicable: (1) Financial and time commitments made by proposed members of the network; (2) if the project includes excess bandwidth for growth of the network, describe how such excess bandwidth will be financed; and (3) if the network will include eligible HCPs and other network members, describe how fees for joining and using the network will be assessed.
- *Ownership structure.* Explain who will own each material element of the network (*e.g.,* fiber constructed, network equipment, end user equipment). For purposes of responding to this question, ''ownership'' includes an IRU interest. Applicants should clearly identify the legal entity who will own each material

element so that USAC can verify that only eligible entities receive the benefits of program support. Applicants should also describe any arrangements made to ensure continued use of such elements by the network members for the duration of the sustainability period.

- *Sources of future support.* If sustainability is dependent on fees to be paid by eligible HCPs, then the sustainability plan should confirm that the HCPs are committed and have the ability to pay such fees. If sustainability is dependent on fees to be paid by network members that will use the network for health care purposes, but are not eligible HCPs under the Commission's rules, then the sustainability plan should identify such entities. Alternatively, if sustainability is dependent on revenues from excess capacity not related to health care purposes, then the sustainability plan should identify the proposed users of such excess capacity. Projects who have multiple sources of funding should address each source of funding and the likelihood of receiving that funding. Eligible HCPs may not receive support twice for the same service. For example, if the Healthcare Connect Fund provides support for a network to procure an IRU to be used by its members, and the network charges its members a fee to cover the undiscounted cost of the IRU, the members may not then individually apply for program support to further discount the membership fee.
- *Management.* The applicant's management plan should describe the management structure of the network for the duration of the sustainability period, and the applicant's budget should describe how management costs will be funded.

228. The Pilot Program required projects to submit a copy of their sustainability plan with every quarterly report. Based on our experience with the Pilot Program, we conclude submission of the sustainability report on a quarterly basis is unnecessarily burdensome for applicants, and provides little useful information to the Administrator. We therefore conclude that sustainability reports for the Healthcare Connect Fund should only be required to be re-filed if there is a material change in sources of future support or management, a change that would impact projected income or expenses by the greater of 20 percent or $100,000 from the previous submission, or if the applicant submits a funding request based on a new Form 461 (*i.e.,* a new competitively bid contract). In that event, the revised sustainability report should be provided to USAC no later than the end of the relevant quarter, clearly showing (*i.e.,* by redlining or highlighting) what has changed.

4. Requests for Multi-Year Commitments

229. In the *July 19 Public Notice,* 77 FR 43773, July 26, 2012, the Bureau sought to further develop the record on issues relating to multi-year contracts, including issues relating to upfront payments. Commenters unanimously supported multi-year commitments as a measure that would reduce administrative costs and increase the value of the services procured.

230. Discussion. We will allow applicants in the Healthcare Connect Fund to receive multi-year funding commitments that cover a period of up to three funding years. The multi-year funding commitments we adopt will reduce uncertainty and administrative burden by eliminating the need for HCPs to apply every year for funding, as is required under the Primary Program, and reduce administrative expenses both for the projects and for USAC. Multi-year funding commitments, prepaid leases, and IRUs also encourage term discounts and produce lower rates from vendors. Multi-year commitments will also allow consortium applicants to choose HCP-constructed-and-owned infrastructure where it is the most cost-effective way to obtain broadband. Applicants receiving support for long-term capital investments whose useful life extends beyond the period of the funding commitment may be subject to additional reporting requirements to ensure that such facilities continue to be used for their intended purpose throughout their useful life. We delegate authority to the Bureau to issue administrative guidance to implement such requirements.

231. Applicants requesting a funding commitment for a multi-year funding period should indicate the years for which funding is required on Form 462 and, for consortia, with the attachment that lists the HCPs and costs for each HCP within the network. If a long-term contract covers a period of more than three years, the applicant may also have the contract designated as ''evergreen'' if the contract meets the criteria specified, which will allow the applicant to re-apply for a funding commitment under the contract after three years without having to undergo additional competitive bidding. In choosing a three-year period, we strike a balance between allowing applicants and the Fund to reap the benefits of long-term contracts, reducing administrative burdens on applicants and the Fund, and ensuring that applicants are not ''locked in'' to long-term contracts which may prevent them from seeking more cost-effective options when prices drop, or they choose to upgrade to higher bandwidths/newer technologies. Three years is also consistent with our requirement that upfront payments averaging more than $50,000/site be amortized over at least three years. Commenters generally support a three-year period as being reasonable. Consistent with current rules, a multi-year funding commitment cannot extend beyond the end of the contract submitted with the request for funding. For example, if an applicant submits a two-year contract and requests a multi-year funding commitment, USAC will only issue a funding commitment for two years. Similarly, if a contract ends in the middle of the funding year, the funding commitment can only extend to the end date of the contract.

232. In the *NPRM,* the Commission proposed a $100 million cap for infrastructure projects. We institute a single cap of $150 million annually that will apply to all commitments for upfront payments during the funding year, and all multi-year commitments made during a funding year. This approach for the hybrid infrastructure-services program will provide greater flexibility than the $100 million cap proposed in the *NPRM* for infrastructure projects; it recognizes that upfront payments also can be substantial when purchasing services from a commercial provider who needs to deploy facilities to serve the HCP. This cap takes into account the need for economic reasonableness and responsible fiscal management of the program, and will help prevent large annual fluctuations in program demand. We direct USAC to process and prioritize funding requests for upfront payments and multi-year commitments on a rolling basis, similar to the process for funding requests generally. We also direct USAC to periodically inform the public, through its Web site, of the total dollar amounts subject to the $150 million cap that have been (1) requested by HCPs (2) actually committed by USAC for the funding year. We may consider adjusting the cap upward if it appears a significant number of Primary Program participants are moving to the Healthcare Connect Fund. Finally, USAC may establish a filing window tailored toward funding requests subject to the $150 million cap, if necessary.

233. Current Commission rules allow universal service support for state and federal taxes and surcharges assessed on eligible services. We recognize that taxes and surcharges can fluctuate over a three-year commitment period. In the

Pilot Program, projects were allowed to estimate taxes and surcharges over the commitment period. Similarly, in the Healthcare Connect Fund, we will take into account the year-to-year fluctuation in taxes and surcharges by allowing HCPs and consortia to estimate the expense using either current tax rates or by projecting the tax rate for the commitment period. Projected taxes and surcharges shall be limited to no higher than 110 percent of the current rate at the time that the HCP or consortium files a funding request. The funding commitment will be issued based on the tax and surcharge rate provided by the applicant. We note that this does not lead to an additional potential for waste, fraud, and abuse, because disbursements will be based on actual expenses, not the projections.

5. USAC Processing and Issuance of Funding Commitment Letters

234. USAC will review funding requests and, if approved, issue a funding commitment letter to the applicant. We allow applicants the opportunity to cure errors on their submissions after initial USAC review, although the responsibility to submit complete and accurate information remains at all times the sole responsibility of the applicant. In order to expedite HCPs' ability to initiate service once they have selected a service provider, we specify a timeframe for USAC's initial review of funding commitment requests. Within 21 calendar days of receipt of a complete funding commitment request, USAC will inform applicants in writing of (1) any and all ministerial or clerical errors that it identifies in the funding commitment request, along with a clear and specific explanation of how the selected participants can remedy those errors; (2) any missing, incomplete, or deficient certifications; and (3) any other deficiencies that USAC finds, including any ineligible network components or ineligible network components that are mislabeled in the funding request. If USAC needs more than 21 calendar days to complete its initial review of the funding request, it should inform the applicant in writing that it needs additional time, and provide the applicant with a date on or before which it expects to provide the information. We remind applicants that this 21-day period is not a deadline for USAC to issue a funding commitment letter. Instead, it is a timeframe for USAC to check that information provided by applicants is complete and accurate, which will then allow USAC to subsequently process the funding request. If an applicant receives a notice that its funding request includes deficiencies, it will have 14 calendar days from the date of receipt of the USAC written notice to amend or re-file its funding request for the sole purpose of correcting the errors identified by USAC.

235. For purposes of prioritizing funding requests, funding requests are deemed to have been filed when the applicant submits an application that is complete. If USAC identifies any errors or deficiencies during its initial 21-day review, the application is not considered to be complete until all such errors and deficiencies are corrected. Applicants may make material changes to their funding requests prior to USAC's issuance of a funding commitment letter, but will be considered, for priority purposes, to have filed their applications as of the date when a complete notice of the material change (*i.e.* without the types of errors or deficiencies identified in the prior paragraph) is submitted to USAC.

236. Upon completion of its review process, USAC will send funding commitment letter or a denial. The funding commitment letter should specify whether the contract has been deemed evergreen (if requested), and whether a multi-year commitment has been issued (and if so, the annual amount of the commitment). Applicants denied funding for errors other than ministerial or clerical errors must follow USAC's and the Commission's regular appeal procedures. Applicants that do not comply with the terms of this *Order,* section 254 of the 1996 Act, and Commission rules and orders will be denied funding in whole or in part, as appropriate.

D. Invoicing and Payment Process

237. Discussion. In Healthcare Connect Fund, we adopt an invoicing procedure similar to the one currently in use by the Pilot Program. In the Pilot Program, service providers bill HCPs directly for services that they have provided. Upon receipt of a service provider's bill, the HCP creates and approves an invoice for the services it has received, certifies that the invoice is accurate and that it has paid its contribution, and sends the invoice to the service provider. The service provider then certifies the invoice's accuracy and uses it to receive payment from USAC.

238. This invoicing procedure is different from the Primary Program in two principal ways. In the Healthcare Connect Fund, as in the Pilot Program, (1) a HCP or Consortium Leader must certify to USAC that it has paid its contribution to the service provider before the invoice can be sent to USAC and the service provider can be paid, and (2) before any invoice is sent to USAC, both the HCP and service provider must certify that they have reviewed the document and that it is accurate. We believe the adoption of these requirements in the new program will help eliminate waste, fraud, and abuse by making sure that HCPs have made their required contribution to the cost of the services they receive and that the invoice accurately reflects the services an HCP is receiving and the support due to the service provider. It is permissible to certify that these steps have been taken via electronic signature of an officer, director, or other authorized employee of the Consortium Leader or HCP. All invoices must be received by the Administrator within six months of the end date of the funding commitment.

E. Contract Modifications

239. Discussion. The *Universal Service Fourth Order on Reconsideration,* 63 FR 2094, January 13, 1998, concluded that requiring a competitive bid for every minor contract modification would place an undue burden upon eligible entities. The Commission found that an eligible school, library, or rural HCP would be entitled to make minor modifications to a contract that was previously approved for funding without completing an additional competitive bid process. The Commission also noted that any service provided pursuant to a minor contract modification also must be an eligible supported service as defined in the *Order* to receive support or discounts.

240. Consistent with existing requirements, HCPs should look to state or local procurement laws to determine whether a proposed contract modification would be considered minor and therefore exempt from state or local competitive bidding processes. If a proposed modification would be exempt from state or local competitive bidding requirements, the applicant likewise would not be required to undertake an additional competitive bidding process in connection with the applicant's request for discounted services under the federal universal service support mechanisms. Similarly, if a proposed modification would have to be rebid under state or local competitive bidding requirements, then the applicant also would be required to comply with the Commission's competitive bidding requirements before entering into an agreement adopting the modification.

241. The *Universal Service Fourth Order on Reconsideration* also

addressed instances in which state and local procurement laws are silent or are otherwise inapplicable with respect to whether a proposed contract modification must be rebid under state or local competitive bidding processes. In such cases, the Commission adopted the ''cardinal change'' doctrine as the standard for determining whether the contract modification requires rebidding. The cardinal change doctrine looks at whether the modified work is essentially the same as that for which the parties contracted. A cardinal change occurs when one party affects an alteration in the work so drastic that it effectively requires the contractor to perform duties materially different from those originally bargained for. In determining whether the modified work is essentially the same as that called for under the original contract, factors considered are the extent of any changes in the type of work, performance period, and cost terms as a result of the modification. Ordinarily a modification falls within the scope of the original contract if potential offerors reasonably could have anticipated the modification under the changes clause of the contract.

242. The cardinal change doctrine recognizes that a modification that exceeds the scope of the original contract harms disappointed bidders because it prevents those bidders from competing for what is essentially a new contract. The Commission adopted the cardinal change doctrine as the test for determining whether a proposed modification will require rebidding of the contract, absent direction on this question from state or local procurement rules, because it believed this standard reasonably applies to contracts for supported services arrived at via competitive bidding. If a proposed modification is not a cardinal change, there is no requirement to undertake the competitive bidding process again.

243. An eligible HCP seeking to modify a contract without undertaking a competitive bidding process should, within 30 calendar days of signing or otherwise entering into the contract modification, file a revised funding commitment request indicating the value of the proposed contract modification so that USAC can track contract performance. The HCP also must demonstrate that the modification is within the original contract's change clause or is otherwise a minor modification that is exempt from the competitive bidding process. The HCP's justification for exemption from the competitive bidding process will be subject to audit and will be reviewed by USAC to determine whether the applicant's request is, in fact, a minor contract modification that is exempt from the competitive bidding process. We note that program participants make contract modifications without competitive bidding at their own risk. If a participant makes a contract modification without competitive bidding, and the modification does not qualify as minor, USAC will not allow support for the modification.

244. We emphasize that even though minor modifications will be exempt from the competitive bidding requirement, parties are not guaranteed support with respect to such modified services. A commitment of funds pursuant to an initial FCC Form 462 does not ensure that additional funds will be available to support the modified services. We conclude that this approach is reasonable and is consistent with our effort to adopt the least burdensome application process possible while maintaining the ability of USAC and the Commission to perform appropriate oversight.

F. Site and Service Substitutions

245. Based on our experience in the Pilot Program, we adopt a site and service substitution policy for participants in the Healthcare Connect Fund that is similar to that applied in the Pilot Program. Consortia may make site substitutions in accordance with the policy (because individual applicants are by definition single-site, no site substitutions are allowed for individual applicants). Both individual and consortium applicants may make service substitutions in accordance with the policy.

246. As the Commission found in the Pilot Program, allowing site and service substitutions minimizes the burden on consortium participants and increases administrative efficiency by enabling HCPs to ask USAC to substitute or modify the site or service without modifying the actual commitment letter. Moreover, this policy recognizes the changing broadband needs of HCPs by providing the flexibility to substitute alternative services within the constraints. This policy is a more administratively efficient approach than the Primary Program, in which any modification of funding requires a new application and a new funding commitment letter for each HCP impacted. In its *July 19 Public Notice,* the Bureau asked for comment on whether to adopt the Pilot Program approach to site and service substitutions in the reformed program. The commenters generally supported applying the same approach in the new program.

247. The Pilot Program permits site and service substitutions within a project in certain specified circumstances, in order to provide some amount of flexibility to project participants. Under the Pilot Program, a site or service substitution may be approved if (i) the substitution is provided for in the contract, within the change clause, or constitutes a minor modification, (ii) the site is an eligible HCP and the service is an eligible service under the Pilot Program, (iii) the substitution does not violate any contract provision or state or local procurement laws, and (iv) the requested change is within the scope of the controlling FCC Form 465, including any applicable Request for Proposal. Once USAC has issued a funding commitment letter, support under the letter is capped at the amount provided in the letter. Therefore, support for a qualifying site and service substitution is only guaranteed if the substitution will not cause the total amount of support under the funding commitment letter to increase. We adopt these same criteria for the Healthcare Connect Fund, which we include in a new rule.

G. Data Collection and Reporting Requirements

248. Discussion. Data from participants and from the Fund Administrator are essential to the Commission's ability to evaluate whether the program is meeting the performance goals adopted and to measure progress toward meeting those goals. We anticipate collecting the necessary data through a combination of the application process and annual reporting requirements. For consortium participants under the Healthcare Connect Fund, we require the submission of annual reports. Annual, rather than quarterly, reports minimize the burden on participants and the Administrator alike while still supporting performance evaluation and enabling us to protect against waste, fraud, and abuse. Because we expect to be able to collect data from single applicants in the Healthcare Connect Fund on forms they already submit, we do not at this time expect that they will need to submit an annual report, unless a report is required for other reasons. To further minimize the burden on participants, we direct the Bureau to work with the Administrator to develop a simple and streamlined reporting system that integrates data collected through the application process, thereby eliminating the need to resubmit any information that has already been provided to the Administrator. We agree with several commenters that to the

extent feasible, USAC should collect information through automated interfaces.

249. In the Healthcare Connect Fund, each consortium lead entity must file an annual report with the Administrator on or before September 30 for the preceding funding year (*i.e.,* July 1 through and including June 30). Each consortium is required to file an annual report for each funding year in which it receives support from the Healthcare Connect Fund. For consortia that receive large upfront payments, the reporting requirement extends for the life of the supported facility. The Administrator shall make the annual reports publicly available as soon as possible after they are filed.

250. All participants are required to provide the information necessary to ensure the Commission can assess progress towards the performance goals and measures adopted. To track progress toward the first goal, increasing access to broadband, we require participants to report the characteristics, including bandwidth and price, of the connections supported by the Healthcare Connect Fund. To track progress toward the second goal, fostering broadband health care networks, we require participants to report the number and characteristics of the eligible and non-eligible sites connecting to the network. We also expect participants to report whether and to what extent the supported connections are being used for telemedicine, exchange of EHRs, participation in a health information exchange, remote training, and other telehealth applications. To track progress toward the third goal, maximizing the cost-effectiveness of the program, in addition to the reporting requirements under the first goal, we require that participants report the number and nature of all responsive bids received through the competitive bidding process as well as an explanation of how the winning bid was chosen.

251. We delegate authority to the Bureau to provide, and modify as necessary, further guidance on the reporting requirements, for both participants and the Administrator, to ensure the Commission has the necessary information to measure progress towards meeting the performance goals adopted in this *Order*. For consortium applicants, the consortium leader will be responsible for preparing and submitting these annual reports. Some of the data will already be collected through other forms that participants will submit through the funding process. We do not require non-consortium applicants to file annual reports at this time because we expect to be able to collect information through forms they already submit in connection with the application process, or if necessary, through other simplified automated interfaces. We delegate authority to the Bureau to work with USAC to accomplish these tasks, and to modify specific reporting requirements if necessary consistent with the requirements.

252. We also extend the current Pilot Program reporting requirement for each Pilot project through and including the last funding year in which the project receives Pilot support, but make it an annual instead of a quarterly obligation. We will also make the Pilot Program reporting requirements the same as the Healthcare Connect Fund reporting requirements and delegate to the Bureau the authority to specify whether any additional information from the quarterly report should continue to be included in the annual report that might be needed to evaluate the Pilot Program or to prevent waste, fraud, and abuse in that program. As of the effective date of this *Order,* Pilot projects are no longer required to file quarterly reports and instead may file their first annual report on September 30, 2013. We further delegate authority to the Bureau to determine the expiration of any supplemental Pilot Program reporting requirements.

253. In specifying these reporting requirements, we have sought to simplify and streamline the requirements as much as possible, in order to minimize the burden on participants while still ensuring the funding is used for its intended purpose. This furthers all of our performance goals—expanding access to broadband and fostering health care networks while maximizing the cost-effectiveness of the program. The data we collect will also help us to measure progress toward each of these goals.

VI. Additional Measures To Prevent Waste, Fraud, and Abuse

254. We adopt additional safeguards against waste, fraud, and abuse. These are discussed set forth in new rule § 54.648, in various rule provisions requiring certifications, and elsewhere in the rules and in this *Order.* The safeguards are patterned on the rules for the Telecommunications Program, and incorporate many of the provisions that proved effective in the Pilot Program in making the program efficient and in safeguarding against waste, fraud, and abuse. The provisions we adopt here also take into account the comments we received in response to the *NPRM.* These safeguards are in addition to many of the requirements for the Healthcare Connect Fund that are also designed to protect against waste, fraud, and abuse.

255. In addition to the requirements, we remind participants in the Healthcare Connect Fund that they will be subject to existing Commission rules governing the exclusion of certain persons from activities associated with or relating to the USF support mechanisms (the ''suspension and disbarment'' rules). We also remind participants that all entities that are delinquent in debt owed to the Commission are be prohibited from receiving support until full payment or satisfactory arrangement to pay the delinquent debt(s) is made, pursuant to the Commission's ''red light'' rule implementing the Debt Collection Improvement of 1996.

A. Recordkeeping, Audits, and Certifications

256. As proposed in the *NPRM,* we apply all relevant Pilot and Telecommunications program requirements regarding recordkeeping, audits, and certifications to participants in the Healthcare Connect Fund, as modified herein, and we recodify those requirements in a new rule section applicable to the new program.

257. Recordkeeping. Consistent with §§ 54.619(a), (b), and (d) of our current rules, program participants and vendors in the Healthcare Connect Fund must maintain for five years certain documentation related to the purchase and delivery of services, network equipment, and participant-owned facilities funded by the program, and they will be required to produce these records upon request. In particular, participants who receive support for long-term capital investments in facilities whose useful life extends beyond the period of the funding commitment shall maintain records for at least 5 years after the end of the useful life of the facility. The *NPRM* also proposed to: (1) Clarify that the documents to be retained by participants and vendors must include all records related to the participant's application for, receipt of, and delivery of discounted services; and (2) mandate that vendors, upon request, produce the records kept pursuant to the Commission's recordkeeping requirement. We adopt rules consistent with these proposals to enable the Commission and USAC to obtain the records necessary for effective oversight of the new Healthcare Connect Fund.

258. Audits and Site Visits. The Commission will continue to use the

audit process to ensure there is a focused and effective system for identifying and deterring program abuse. Consistent with existing § 54.619(c) of the Commission's rules, participants in the Healthcare Connect Fund will be subject to random audits to ensure compliance with program rules and orders.

259. USAC must assess compliance with the program's requirements, including the new requirements established in this *Order* for recipients of RHC support. We direct USAC to review and revise the Beneficiary/Contributor Compliance Audit Program (BCAP) and the Payment Quality Assurance (PQA) program to take into account the changes adopted in this *Order* when designing procedures for recipients of funding under the Healthcare Connect Fund. We further direct USAC to submit a report to the Bureau and Office of Managing Director (OMD), within 60 days of the effective date of this *Order* or by May 31, 2013, whichever is later, proposing changes to the BCAP and PQA programs consistent with this *Order.*

260. We also direct USAC to conduct random site visits to Healthcare Connect Fund participants to ensure that support is being used for its intended purposes, or as necessary and appropriate based on USAC's review of participants' submissions to USAC. We further direct USAC to notify the Wireline Competition Bureau and the Office of the Managing Director of any site visit findings and analysis within 45 days of the site visit.

261. Certifications. We adopt certification requirements for the Healthcare Connect Fund that are similar to those in the existing RHC programs. Participants in the Healthcare Connect Fund must certify under oath to compliance with certain program requirements, including the requirements to select the most cost-effective bid and to use program support solely for purposes reasonably related to the provision of health care services or instruction.

262. For individual HCP applicants, required certifications must be provided and signed by an officer or director of the HCP, or other authorized employee of the HCP (electronic signatures are permitted). For consortium applicants, an officer, director, or other authorized employee of the Consortium Leader must sign the required certifications. USAC may not knowingly accept certifications signed by a person who is not an officer, director, or other authorized employee of the HCP or Consortium Leader.

263. Third parties may submit forms and other documentation on behalf of the applicant, including the HCP or Consortium Leader's signature and certifications, if USAC receives, prior to submission of the forms or documentation, a written, dated, and signed authorization from the relevant officer, director, or other authorized employee stating that the HCP or Consortium Leader accepts all potential liability from any errors, omissions, or misrepresentations on the forms and/or documents being submitted by the third party. Consistent with longstanding precedent, we find that a HCP or Consortium Leader may not contractually reallocate responsibility for compliance with program requirements to a consultant or similar third party.

264. We find that our actions here will preserve the integrity of the program by protecting against wasteful or unlawful use of support.

B. Duplicative Support and Relationship to Other RHC Programs

265. Discussion. As the Commission proposed in the *NPRM,* we adopt a rule prohibiting HCPs from receiving universal service support for the same services from both the Telecommunications Program and the Healthcare Connect Fund. This prohibition is necessary because, in certain instances, an HCP's selected service could be eligible for support under both the Telecommunications Program and the Healthcare Connect Fund. Where this is the case, HCPs will not be permitted to ''double dip'' from the USF for the same connections. Applicants are prohibited from submitting a funding request for the same service in the Telecommunications Program and the Healthcare Connect Fund. Further, consistent with the *NPRM,* we adopt a rule prohibiting HCPs from receiving funds for the same services under either the Telecommunications or the reformed RHC program and any other universal service program. If an HCP is still receiving support under the Pilot Program, it also will be subject to this same restriction on receiving support from another FCC program for the same services. Under this rule, an HCP only will be prohibited from receiving *duplicative* support for the *same* services—not from receiving *complementary* support for *different* services.

266. Our action here is consistent with the Commission's Pilot Program requirement that participants cannot receive support for the same service from both the Pilot Program and other universal service programs. We believe that the prohibition on using funds from other Universal Service programs as part of the HCP's 35 percent contribution requirement is equally important in our reformed RHC program, and that it will help safeguard against wasteful and unlawful duplicative distribution of universal service support.

267. We do not believe, however, that it is necessary in the Healthcare Connect Fund to prohibit the use of federal funds from non-universal service program sources to be part of the HCP's 35 percent contribution requirement. Here, the HCP contribution amount is significantly greater than in the Pilot Program (35 percent as opposed to 15 percent in the Pilot Program). While we are not aware of other sources of federal funding for HCPs that could be used towards their 35 percent contribution, we do not want to preclude the possibility that a recipient in our program could use funding from another federal agency towards its 35 percent contribution. We anticipate that even if other federal funding may be available, HCPs will still be required to secure a significant portion of the cost of broadband supported by this program through their own efforts.

268. We also do not preclude federal government entities, such as the Indian Health Service, or other Tribal entities, from receiving support under the Healthcare Connect Fund, even though their 35 percent contribution may come from federal sources, as does the balance of the budget of such entities. We also do not preclude HCPs from purchasing services from entities that have received federal funds to assist in infrastructure construction, such as through the Broadband Telecommunications Opportunities Program or the Rural Utilities Service Broadband Infrastructure Program. These programs are intended to develop broadband infrastructure in geographic areas that are unserved or underserved by broadband. It would defeat the value of federal investment in such facilities if we were to prohibit such entities from bidding to provide service under the Healthcare Connect Fund.

C. Recovery of Funds, Enforcement, and Debarment

269. Recovery of Funds. Consistent with the 2007 *Program Management Order,* 72 FR 54214, September 24, 2007, Healthcare Connect Fund monies that are disbursed in violation of a Commission rule that implements the Act, or a substantive program goal, will be recovered. Recovery of funds will be directed at the party or parties (including both beneficiaries and

vendors) who have committed the statutory or rule violation. If more than one party shares responsibility for a statutory or rule violation, recovery actions may be initiated against both parties, and pursued until the amount is satisfied by one of the parties. Failure to repay recovery amounts may subject recipients to enforcement action by the Commission, in addition to any collection action.

270. Enforcement and Criminal Sanctions. In the 2007 *Program Management Order,* the Commission also found that sanctions, including enforcement action, are appropriate in cases of waste, fraud, and abuse in the universal service support programs, but not in cases of clerical or ministerial errors. If any participant or vendor fails to comply with Commission rules or orders, or fails to timely submit filings required by such rules or orders, the Commission has the authority to assess forfeitures for violations of such Commission rules and orders under section 503 of the Act. In addition, any participant or service provider that willfully makes a false statement(s) can be punished by fine or forfeiture under sections 502 and 503 of the Communications Act, or fine or imprisonment under Title 18 of the United States Code (U.S.C.) including, but not limited to, criminal prosecution pursuant to section 1001 of Title 18 of the U.S.C.

271. Debarment. In order to prevent fraud, and to prevent bad actors from continuing to participate in the universal service programs, § 54.8 of the Commission's rules provides that the Commission shall suspend and debar parties for conviction of, or civil judgment for, fraud or other criminal offenses arising out of activities associated with or related to the universal service support mechanisms, absent extraordinary circumstances. These debarment procedures in § 54.8 of the Commission's rules will apply to the Healthcare Connect Fund, just as they do to other Commission universal service programs.

VII. Telecommunications Program Reform

272. This *Order* focuses on the creation of a new, reformed health care support mechanism. The Healthcare Connect Fund replaces the current RHC Internet Access Program. For the time being, we maintain the current RHC Telecommunications Program, which funds the difference between the rural rate for telecommunications services and the rate paid for comparable services in urban areas. In doing so, we recognize that the RHC Telecommunications Program is particularly important for extremely remote places like Alaska. However, we would expect the Healthcare Connect Fund to prove attractive to many of the HCPs that currently receive support under the Telecommunications Program, as well as to HCPs that do not currently participate in any RHC Program. Unlike the Telecommunications Program, the new program will provide a flat rate discount, a simpler application process for both single and consortium applicants, flexibility for consortia to design their networks in a cost-effective manner to best serve the needs of their communities, support for certain network-related expenses, the availability of multi-year and prepaid funding arrangements, and the option for health care provider self-construction. And most importantly, we also expect that many HCPs will be able to get higher bandwidth service for lower out-of-pocket costs under the new program. For all these reasons, we expect significant migration of HCPs out of the Telecommunications Program and into the Healthcare Connect Fund over time.

273. As the new Healthcare Connect Fund is implemented, we expect to consider whether the Telecommunications Program remains necessary, and if so whether reforms to the program are appropriate to ensure that any continuing support under that program is provided in a cost-effective manner. In doing so, we will, in particular, look at the needs of extremely remote places like Alaska. Such reforms could include changes to ensure subsidies provided under the program are set at appropriate levels, to provide greater incentives for cost-efficient purchasing by program participants, and to reduce the administrative costs of the program, both to participants and to USAC.

274. In the meantime, the current Telecommunications Program rules and procedures will continue to apply. In addition, because we view our health care universal service programs as accomplishing the same overarching goals, we make the performance goals and measures adopted in this *Order* applicable in the Telecommunications Program as well as to the Healthcare Connect Fund.

VIII. Pilot Program for Skilled Nursing Facility Connections

275. Discussion. There is evidence that skilled nursing facilities are particularly well-suited to improve patient outcomes through greater use of broadband. By their nature, they are often remote from doctors and sophisticated laboratory and testing facilities, making the availability of EHRs and telehealth an especially valuable benefit to convalescents or patients for whom traveling to see a doctor, diagnostician, or specialist would be especially difficult. On the record before us, however, we are unable to determine how support for SNFs can be provided as part of an ongoing program in a ''technically feasible and economically reasonable'' manner, as required by section 254(h)(2)(A). Nor does the record currently allow us to balance the potential benefits of supporting SNFs against the potential impact on Fund demand. On this record, we reach no conclusion about whether or under what circumstances a SNF might qualify as a health care provider under the statute. We find, however, that funding connections used by SNFs in working with HCPs has the potential to enhance access to advanced services and to generate the associated health care benefits, and that a limited pilot program would enable us to gain experience and information that would allow us to determine whether such funding could be provided on a permanent basis in the future.

276. We therefore conclude that it is both technically feasible and economically reasonable to launch, as an initial step, a pilot program to test how to support broadband connections for SNFs, with safeguards to ensure that the support is directed toward SNFs that are using broadband to help provide hospital-type care for those patients, and that are using those broadband connections for telehealth applications that improve the quality and efficiency of health care delivery. The Skilled Nursing Facilities Pilot Program (SNF Pilot) will focus on determining how we can best utilize program support to assist SNFs that are using broadband connectivity to work with eligible HCPs to optimize care for patients in SNFs through the use of EHRs, telemedicine, and other broadband-enabled health care applications. We will fund up to $50 million for this purpose within the existing health care support mechanism, which remains capped at $400 million annually. We expect to implement this SNF Pilot in Funding Year 2014. We conclude that a total of $50 million may be disbursed for the SNF Pilot over a funding period not to exceed three years, which will moderate the annual impact on Fund demand.

277. We direct the Bureau to develop scoring criteria for applications for the SNF Pilot consistent with the program goals, soliciting input from HHS

(including IHS) and other stakeholders, and to specify other requirements for the SNF Pilot, including safeguards to ensure that funding is directed towards facilities that are engaged in the provision of skilled care comparable to what is available in a hospital or clinic. In order to maximize other Fund investments, only SNFs that do not currently have broadband services sufficient to support their intended telehealth activities are eligible to participate in the SNF Pilot. The Bureau shall give a preference to applicants that partner with existing or new consortia in the existing Pilot Program or the Healthcare Connect Fund and to SNFs located in rural areas, and will require applicants to demonstrate how proposed participation of SNFs will improve the overall provision of health care by eligible HCPs. The SNF Pilot Program will seek to collect data on a number of variables related to the broadband connections supported and their health care uses, so that at the conclusion of the SNF Pilot, the Commission can use the data gathered to determine how to proceed with regard to including SNFs in the Commission's health care support programs on a permanent basis.

278. Once the scoring criteria are developed, the Bureau shall release a Public Notice specifying the application procedures, including dates, deadlines, and other details of the application process. Except as necessary to meet the goals of the SNF Pilot, all requirements applicable to the Healthcare Connect Fund, as described in this *Order,* will apply to the SNF Pilot. After reviewing the applications, the Bureau then will announce the SNF Pilot participants. We delegate authority to the Bureau to implement the SNF Pilot consistent with the framework established in this *Order,* and specify that USAC shall disburse no more than $50 million to fund the SNF Pilot, as directed by the Bureau.

279. To be eligible for funding, those seeking to participate in SNF Pilot projects must commit to robust data gathering as well as analysis and sharing of the data and to submitting an annual report. Applicants will be expected to explain what types of data they intend to gather and how they intend to gather that data. At the conclusion of the Pilot, we expect applicants to be prepared to demonstrate with objective, observable metrics the health care cost savings and/or improved quality of patient care that have been realized through greater use of broadband to provide telemedicine to treat the residents of SNFs. We authorize USAC to use administrative expenses from the Fund to perform data gathering and related functions. The Commission plans to make this data public for the benefit of all interested parties, including third parties that may use such information for their own studies and observations.

IX. Miscellaneous

A. Implementation Timeline

280. Discussion. In this *Order,* we adopt for the Healthcare Connect Fund the same general funding schedule that is currently used in the Telecommunications and Internet Access Programs. Thus, applicants seeking support under the Healthcare Connect Fund may start the competitive bidding process anytime after January 1 (six months before the July 1 start of the funding year) and can submit a request for funding at any time during that funding year (*i.e.* between July 1 and June 30) for services received during that funding year.

281. For the first funding year of the Healthcare Connect Fund (FY 2013, which runs from July 1, 2013 to June 30, 2014), we adopt a schedule in which the funding for Pilot project applicants and new applicants begins at different times. The schedule for Pilot project applicants will remain unchanged. Starting on July 1, 2013, Pilot projects can seek universal service support under the Healthcare Connect Fund at a 65 percent discount level for existing HCP sites that have exhausted funding allocated to them as well as for new sites to be added to Pilot project networks.

282. For new applicants (either current Telecommunications or Internet Access Program participants or HCPs new to the Commission's programs), the funding schedule will be different in FY 2013. For FY 2013 only, the competitive bidding process for non-Pilot Healthcare Connect Fund applicants will start in late summer 2013, with applicants eligible to receive funds starting on January 1, 2014. This six-month delay is necessary to complete administrative processes relating to the new program, including obtaining approval for new forms under the Paperwork Reduction Act. Starting in FY 2014 (July 1, 2014-June 30, 2015), all applicants will be on the same funding year schedule and will be able to request funds from USAC between July 1-June 30, after completing a competitive bidding process that may start on or after January 1. In addition, to ensure a smooth transition and to minimize the administrative burden, eligible rural HCPs may continue to receive support under the RHC Internet Access Program through the end of funding year 2013, or through June 30, 2014.

283. A timeline of the funding schedule for the first year of the program for both Pilot project applicants and non-Pilot applicants appears in the figure below.

FUNDING YEAR 2013 IMPLEMENTATION TIMELINE

	Jan. 2013	Feb. 2013	Mar. 2013	Apr. 2013	May 2013	June 2013	July 2013	Aug. 2013	Sept. 2013	Oct. 2013	Nov. 2013	Dec. 2013	Jan. 2014	Feb. 2014	Mar. 2014	Apr. 2014	May 2014	June 2014
Pilot Project Applicants	Pilot projects determine their service needs and prepare RFPs in accordance with reformed program rules			Competitive bidding starts during second quarter 2013			2013 Funding											
Non-Pilot Project Applicants	New program applicants organize themselves, determine their service needs, and prepare RFPs						Competitive bidding starts during third quarter 2013 and continues through fourth quarter 2013						2013 Funding					

284. As shown in the chart, starting the competitive bidding process in summer of 2013 will give non-Pilot Healthcare Connect Fund applicants time to organize as consortia, to determine their service needs, to design RFPs, and to complete the competitive bidding process before requesting funds from USAC. The experience of Pilot Program participants suggest that it takes at least six months for consortia to organize themselves, obtain the necessary authorizations from individual health care providers, assess broadband needs for the members, and

prepare RFPs. Pilot experience also suggests that can take approximately six additional months for a consortium to post the RFP, receive bids, evaluate bids properly, and negotiate a contract. If funding were available July 1, 2013, new applicants would not have enough time to complete all these steps. A possible result could be poorly organized consortia and ill-considered network designs, which would be inconsistent with our overarching program goals. In order to maximize the cost-effectiveness of bulk buying and competitive bidding, it is important to allow sufficient time for needs assessment, network design, and RFP preparation, as well sufficient time to solicit a range of competitive bids, select a vendor, and negotiate a contract. Making funding available beginning January 1, 2014, will allow time for all these activities to take place and to enable applicants to create well-designed networks and to obtain cost-effective bids.

285. This funding cycle also will encourage individual HCPs to join new or existing consortia rather than applying for funding alone. We expect that some potential single HCP applicants will receive offers to join existing Pilot project networks or newly-formed consortia. We encourage this collaboration. As discussed in the *Pilot Evaluation,* consortia are able to obtain higher bandwidths, lower rates, and better service quality, and they save on administrative costs. By making funding available at the same time for consortium applicants and single applicants, there will be more time for coordination and outreach between consortia applicants and their prospective members to occur. In the meantime, individual HCPs can still receive support through the Telecommunications or Internet Access Programs until they are eligible to seek funds under the Healthcare Connect Fund.

286. The same considerations do not apply to the Pilot projects. They have already completed the multi-step process of forming consortia and conducting competitive bidding. Allowing them to begin receiving funding effective July 1, 2013, will benefit both existing Pilot project HCPs and HCPs that seek to join existing Pilot projects. Allowing new sites joining existing Pilot projects to receive funds on July 1, 2013, will encourage those projects to grow and become large-scale networks. This funding schedule will also provide sites that will exhaust Pilot Program funding on or before July 1, 2013, a smooth transition into the new program. As the Commission observed in providing transitional funding to such Pilot project HCPs in the *Bridge Funding Order,* it is important for the sustainability of these networks that they are not forced to transition twice to different RHC programs—first to the Telecommunications or Internet Access Programs and then to the Healthcare Connect Fund. Without an orderly transition to the new program, some individual Pilot project HCPs could be at risk of discontinuing their participation in their respective networks. This would be contrary to the goals of the Pilot Program. Providing continuing support (albeit at the discount level applicable under the Healthcare Connect Fund) will help protect the investment the Commission has already made in these networks.

287. Outreach efforts will be essential in order to maximize potential of the Healthcare Connect Fund to support broadband and thereby transform the provision of health care for both individual HCPs and consortia. We therefore direct the Bureau to work with USAC to develop and execute a range of outreach activities to make HCPs aware of the new program and to educate them about the application process. We expect the Bureau will consult with other health care regulatory agencies (such as HHS); with state, local, and Tribal governments; with organizations representing HCPs (especially rural HCPs); and with other stakeholder groups to identify the best means to publicize the new program and to identify likely beneficiaries of the new program—both HCPs already participating in RHC programs and those that are not. We direct USAC to produce and disseminate outreach materials designed to educate eligible HCPs about the new program. In addition, we direct USAC to implement a mechanism for any interested party to subscribe to an automated alert from USAC when Healthcare Connect Fund requests for services or RFPs are posted, based on available filtering criteria.

B. Pilot Program Transition Process and Requests for Additional Funds

288. The final deadline for filing requests for funding commitments in the RHC Pilot Program was June 30, 2012. As discussed in the *Pilot Evaluation,* several projects either withdrew from the program or merged with other projects, leaving 50 active Pilot projects. Every one of these remaining projects met the June 30 deadline for filing funding commitment requests. USAC is likely to complete the processing of all these funding requests by the end of calendar year 2012. Projects have up to six years from the date of issuance of the initial funding commitment letter for the applicable project to complete invoicing. Thus, by the latter part of calendar year 2017, all invoicing under the Pilot Program should be completed.

289. We would expect that as the Pilot projects and their member HCPs begin to exhaust Pilot funding, they will migrate as consortia into the Healthcare Connect Fund. Pilot participants are at different points in the process of implementing their networks and invoicing for the services or infrastructure in their projects. As discussed in the Commission's *Bridge Funding Order,* released in July 2012, a number of projects began to exhaust funding for some of their HCP sites in 2012, and the Commission provided continued funding for those sites pursuant to that order. Although we believe the rules we adopt in this *Order* should permit an easy transition for the Pilot Program participants, we delegate to the Bureau the authority to adopt any additional procedures and guidelines that may be necessary to smooth this process. In the Implementation Timeline section, we make support under the Healthcare Connect Fund for the transitioning Pilot Program participants effective on July 1, 2013, in order to ensure that there are no gaps in support for them. We permit them to use the same forms they used in the Pilot Program to secure funding pursuant to the *Bridge Funding Order*. Once their currently committed Pilot funds are exhausted, they will be required to provide a 35 percent contribution (not the 15 percent in the Pilot Program), and will not be eligible to receive support for anything that is not covered under the Healthcare Connect Fund.

290. Several Pilot projects filed requests for additional support, asking the Commission to use funds that were originally allocated to the Pilot Program, but were relinquished or unspent by other Pilot projects that withdrew or did not use their full awards. In their requests for additional funding, these pilot projects argued, among other things, that remaining Pilot funding should be redirected to projects that have demonstrated substantial progress with their original awards and that these additional funds would facilitate expansion of these successful projects.

291. In light of our creation of the new Healthcare Connect Fund, we deny these requests for additional Pilot Program funding. First, we note that Pilot projects may now seek additional funding through the Healthcare Connect Fund, once their current awards are exhausted, so there is no reason to

provide these Pilots preferential treatment over other consortia. Second, the Pilot Program was just that—a pilot, or trial, program launched to examine how the RHC program could be used to enhance HCP access to advanced services and to lay the foundation for the reformed program. It would be contrary to the limited scope of the Pilot Program to authorize additional Pilot Program support at this time. Finally, disbursement of additional Pilot program support would be inconsistent with the Commission's 2007 directive that Pilot Program applicants that were denied funding at that time could reapply for RHC funding in the reformed program. The Pilot projects requesting additional support may reapply in the reformed program, just as denied applicants may do. To grant these requesting Pilot projects additional support without requiring new applications would unfairly advantage them to the detriment of the denied Pilot applicants. Instead, we direct USAC to utilize unused Pilot Program funds for the demand associated with the Healthcare Connect Fund.

292. We also dismiss a request by the Texas Health Information Network Collaborative (TxHINC) for an extension of the June 30, 2012, Pilot Program deadline for projects to choose vendors and request funding commitment letters from USAC. In its request, TxHINC explains that, due to circumstances unique to Texas, it was delayed in choosing vendors and submitting funding requests to USAC. We dismiss TxHINC's request, finding it moot because TxHINC ultimately filed its request for funding commitments by the June 30, 2012 deadline.

C. Prioritization of Funding

293. In the *NPRM,* the Commission sought comment on whether to establish an annual cap of $100 million for support under the proposed Health Infrastructure Program, and sought comment on whether to establish criteria for prioritizing funding should the infrastructure program exceed that cap in a particular year. The Commission stated that it did not believe that the proposed Health Broadband Services Program initially would exceed the amount of available funds, but sought comment on possible prioritization procedures in the event that the total requests for funding under the Telecommunications and the new programs were to exceed the Commission's established $400 million annual cap.

294. Discussion. After consideration of the record received in response to the prioritization proposals in the *NPRM,* we will continue for the time being to apply the existing rule for addressing situations when total requests exceed the $400 million cap. Demand in this program has never come close to the $400 million annual cap, and we believe that we are unlikely to reach the cap in the foreseeable future. We direct USAC to periodically inform the public, through its web site, of the total dollar amounts that have been (1) requested by HCPs, as well as the total dollar amounts that have been actually committed by USAC for the funding year. USAC should post this information for both the $150 million cap on multi-year commitments and the $400 million cap that applies to the entire rural health care supporty mechanism. We do intend, however, to conduct further proceedings and issue an Order by the end of 2013 regarding the prioritization of support for all the RHC universal service programs. In the meantime, we will continue to rely upon, as a backstop, the approach codified in our existing rules, in the unlikely event that funding requests do reach the $400 million cap before we have established other prioritization procedures.

295. We believe it is unlikely that the combined health care support programs will approach the $400 million annual cap any time soon. It will likely take a significant amount of time for new consortia to organize, identify broadband needs, prepare RFPs, conduct competitive bidding, and select vendors, and for that reason it will be at least a year before funding will begin to flow to new applicants in the program. Given the Pilot Program experience, it will likely take even longer than that for many consortium applicants to be ready to seek funding under the Healthcare Connect Fund. In addition, our decision to require a 35 percent participant contribution, the limitations we impose on participation by non-rural HCPs, and the $150 million cap on annual funds for upfront payments all should moderate demand for funding in the near term. Finally, the pricing and other efficiencies made possible through consortium purchase of a broader array of services also should help drive down the cost of connections supported by the RHC component of the Universal Service Fund, as some Telecommunications Program participants migrate to the reformed program. For that reason, we project growth in the combined health care universal service fund to remain well under the $400 million cap over the next five years. Because we lack historical demand data for the Healthcare Connect Fund, and because the new program provides support for multi-year contracts and other upfront payments, we direct the Bureau, working with OMD and with the Administrator, to project the amounts to be collected for the USF for the early period of the new program, until such time as historical data provides an adequate basis for projecting demand.

D. Offset Rule

296. In the *NPRM,* the Commission explained that, despite its intended benefits, the offset rule can create inequities and inefficiencies. Based on the offset rule's shortcomings, the Commission proposed to eliminate the rule for participants in the Broadband Services Program (now part of the Healthcare Connect Fund) and the existing RHC program, and replace it with a rule allowing service providers to receive direct reimbursement from USAC. The Commission also sought comment on whether to retain the offset rule as an option for contributors who wish to utilize this method.

297. Discussion. While the original intent of the offset rule was to prevent waste, fraud, and abuse, we find that mandatory application of the rule is no longer necessary or advisable. Our action here is not the first instance in which the Commission has recognized the shortcomings of the offset rule. Indeed, the Bureau has waived the offset rule in several instances because strict application of the rule would have jeopardized the precarious finances and operations of some small, rural HCPs and their service providers. Further, service providers who are not required to contribute to the Fund already receive direct reimbursement. Based on the wide variety of vendors participating in the Pilot Program, we believe that direct reimbursement encouraged extensive bidding on RFPs in the Pilot Program. Likewise, we expect that enabling carriers to elect direct reimbursement in the Healthcare Connect Fund will encourage many more vendors to bid on RFPs than if offset was mandatory, because they will not have to wait to receive reimbursement until they can offset their universal service contribution amount.

298. In light of the shortcomings of the offset rule discussed above, and in consideration of the relevant comments, we revise § 54.611 of the Commission's rules to eliminate mandatory application of the offset procedure. Commenters unanimously support having the option of direct reimbursement, arguing, among other

things, that the offset requirement is obsolete, outdated, and administratively burdensome, and that it delays payment to carriers. We will permit USF contributors in the Telecommunications Program and the Healthcare Connect Fund to elect whether to treat the amount eligible for support as an offset against their universal service contribution obligation, or to receive direct reimbursement from USAC. We adopt a new rule for the Healthcare Connect Fund and the Telecommunications Program to effectuate this approach.

299. We note that, while commenters unanimously support direct reimbursement, they do not agree on whether to maintain offset as an option. TeleQuality recommends that service providers be given an offset option. Several other commenters do not directly advocate for an offset option but implicitly support it in their support of our proposed rule which includes an offset option. Conversely, a few commenters seek elimination of offset even as an option, with Charter Communications asking the Commission to ''formalize its recognition of the deficiencies of the offset rule by eliminating it in the new RHC programs.'' While we recognize the deficiencies of mandatory offset, we conclude it is appropriate to maintain offset as an option because it affords flexibility to carriers that deem offset simpler or otherwise more beneficial than direct reimbursement. Further, while carriers such as Charter and GCI prefer, and likely will choose, direct reimbursement, an offset option will not disadvantage them in any way. Finally, our revised rule is consistent with the choice available in the E-rate program, in which service providers may opt to use the offset method or receive direct reimbursement from USAC.

300. Also as we do in the E-rate program, each January we will require service providers to elect the method by which they will be reimbursed, and require that they remain subject to this method for the duration of the calendar year using Form 498, as is the case in the E-rate program. Form 498 will need to be revised to accommodate such elections in the health care support mechanism, and the revised form is unlikely to be approved by OMB under the Paperwork Reduction Act prior to January 31, 2013. Therefore, once revised Form 498 is available, we direct the Bureau to announce via public notice a 30-day window for service providers to make their offset/direct reimbursement election for the health care support mechanism for 2013. To the extent that a service provider fails to remit its monthly universal service obligation, however, any support owed to it under the Healthcare Connect Fund or the Telecommunications Program will automatically be applied as an offset to the service provider's annual universal service obligation.

E. Delegation To Revise Rules

301. Given the complexities associated with modifying existing rules as well as other reforms adopted in this *Order,* we delegate authority to the Bureau to make any further rule revisions as necessary to ensure the reforms adopted in this *Order* are reflected in the rules. This includes correcting any conflicts between the new and or revised rules and existing rules as well as addressing any omissions or oversights. If any such rule changes are warranted, the Bureau shall be responsible for such change. We note that any entity that disagrees with a rule change made on delegated authority will have the opportunity to file an Application for Review by the full Commission.

X. Procedural Matters

A. Final Regulatory Flexibility Certification

302. As required by the Regulatory Flexibility Act of 1980, as amended (RFA), an Initial Regulatory Flexibility Analysis (IRFA) was incorporated in the NPRM. The Commission sought written public comment on the proposals in the *NPRM,* including comment on the IRFA. This present Final Regulatory Flexibility Analysis (FRFA) conforms to the RFA.

1. Need for, and Objectives of, the Order

303. 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. 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. Among other programs, the Commission adopted a program to provide discounted telecommunications services to public or non-profit health care providers (HCPs) that serve persons in rural areas. 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.

304. In this *Order,* we reform the Rural Health Care (RHC) Support Mechanism and adopt the Healthcare Connect Fund to expand HCP access to high-speed broadband capability and broadband health care networks, improving the quality and reducing the cost of health care throughout America, particularly in rural areas. Additionally, we adopt a pilot program to be implemented in 2014 to test how to support broadband connections for skilled nursing facilities (SNF Pilot).

305. Building on recommendations from the Staff Evaluation of the Pilot Program and comments received in response to the Commission's *NPRM* and the *July 19 Public Notice,* the reforms adopted in this *Order* build on the substantial impact the RHC program has on improving broadband connectivity to HCPs. Broadband connectivity generates a number of benefits and cost savings for HCPs. First, telemedicine enables patients in rural areas to access specialists and can improve the speed and enhance the quality of health care everywhere. Second, connectivity enables the exchange of electronic health records, which is likely to become more widespread as more providers adopt ''meaningful use'' of such records. Third, connectivity enables the exchange of large medical images (such as MRIs and CT scans), which can improve the speed and quality of diagnosis and treatment. Fourth, connectivity enables remote health care personnel to be trained *via* videoconference and to exchange other technical and medical expertise. Fifth, these ''telehealth'' applications have the potential to greatly reduce the cost of providing health care, for example by reducing length of stay or saving on patient transport costs. Finally, telemedicine can help rural HCPs keep and treat patients locally, thus enhancing revenue streams and helping rural providers to keep their doors open.

2. Summary of Significant Issues Raised by Public Comments in Response to the IRFA

306. No comments were filed in response to the IFRA attached to the *NPRM.* Notwithstanding the foregoing, some general comments discussing the impact of the proposed rules on small businesses were submitted in response to the *NPRM* and the *July 19 Public Notice.*

307. Several commenters expressed concern that administrative and reporting requirements for the new program might be too burdensome for small HCPs. Many commenters suggested abandoning quarterly reporting requirements in favor of annual or semi-annual reporting to reduce administrative burdens. Several commenters asked for a common

reporting format, and requested that reporting requirements not be too onerous. OHN recommended that the Commission authorize electronic signatures for all processes, especially the invoice approval process; permit electronic document submission; permit electronic administrative linkage into FCC/USAC project tracking systems; and support web-based electronic survey and reporting tools to gather, present, and compare data. Some commenters also expressed concern that imposing detailed technical requirements on health services infrastructure projects might ''discourage investment in broadband infrastructure projects and even foreclose the use of certain technologies.''

308. Responses to the *NPRM* and *July 19 Public Notice* also emphasized a streamlined approach to the competitive bidding requirements through the use of consortium applications and multiyear contracts. For example, one commenter stated that consortium applications would take the administrative burden off small HCPs who do not have the time or resources to apply for funds. However, one of the Pilot Projects, PSPN, noted that a mandated multi-year contract for at least 5 years could be burdensome to service providers.

309. Finally, one commenter specifically recommended that the Commission encourage participation from small and women-owned businesses by reducing or waiving matching contributions requirements for non-profit small and women-owned businesses acting as consortium leaders; streamlining administrative reporting requirements; and increasing the performance bond minimum requirement for contracts of $300,000 or higher from the $150,000 floor. In making the determinations reflected in this *Order,* we have considered the impact of our actions on small entities.

3. Description and Estimate of the Number of Small Entities to Which Rules Will Apply

310. The RFA directs agencies to provide a description of, and, where feasible, an estimate of, the number of small entities that may be affected by the rules adopted herein. The RFA generally defines the term ''small entity'' as having the same meaning as the terms ''small business,'' ''small organization,'' and ''small governmental jurisdiction.'' In addition, the term ''small business'' has the same meaning as the term ''small business concern'' under the Small Business Act. A ''small business concern'' is one which: (1) Is independently owned and operated; (2) is not dominant in its field of operation; and (3) satisfies any additional criteria established by the Small Business Administration (SBA). In 2009, there were 27.5 million businesses in the United States, according to SBA Office of Advocacy estimates. The latest available Census data show that there were 5.9 million firms with employees in 2008 and 21.4 million without employees in 2008. Small firms with fewer than 500 employees represent 99.9 percent of the total (employers and non-employers), as the most recent data show there were 18,469 large businesses in 2008.

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

i. Health Care Entities

312. 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. 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. 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. The category of Ambulatory Health Care Services providers with $34.5 million or less in annual receipts consists of Kidney Dialysis Centers. For all of these Ambulatory Health Care Service Providers, census data indicate that there are a combined total of 368,143 firms that operated for all of 2002. Of these, 356,829 had receipts for that year of less than $5 million. In addition, an additional 6,498 firms had annual receipts of $5 million to $9.99 million; and additional 3,337 firms had receipts of $10 million to $24.99 million; and an additional 865 had receipts of $25 million to $49.99 million. We therefore estimate that virtually all Ambulatory Health Care Services providers are small, given SBA's size categories. We note, however, that our rules affect non-profit and public health care providers, and many of the providers noted above would not be considered ''public'' or ''non-profit.''

313. 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. 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. We therefore estimate that most Hospitals are small, given SBA's size categories.

314. The broad category of Nursing and Residential Care Facilities consists, *inter alia,* of the category of Skilled Nursing Facilities, with a small business size standard of annual receipts of $13.5 million or less. For these businesses, census data indicate that there were a total of 16,479 firms that operated for all of 2002. All of these firms had annual receipts of below $1 million. We therefore estimate that such firms are small, given SBA's size standard.

315. 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. For these health care providers, census data indicate that there were a total of 55 firms that operated for all of 2002. All of these firms had annual receipts of below $1 million. We therefore estimate that all such firms are small, given SBA's size standard.

ii. Providers of Telecommunications and Other Services

a. Telecommunications Service Providers

316. *Wired Telecommunications Carriers.* The SBA has developed a small business size standard for Wired Telecommunications Carriers, which consists of all such companies having 1,500 or fewer employees. According to Census Bureau data for 2007, there were a total of 3,188 firms in this category that operated for the entire year. Of this total, 3144 firms employed 999 or fewer employees, and 44 firms employed 1000 employees or more. Thus, under this size standard, the majority of firms can be considered small entities that may be affected by rules adopted pursuant to this *Order.*

317. *Incumbent Local Exchange Carriers (LECs).* Neither the Commission nor the SBA has developed a size standard for small businesses specifically applicable to local exchange services. The closest applicable size standard under SBA rules is for Wired Telecommunications Carriers. Under that size standard, such a business is small if it has 1,500 or fewer employees. According to Commission data, 1,307 carriers reported that they were incumbent local exchange service providers. Of these carriers, an estimated 1,006 have 1,500 or fewer employees and 301 have more than 1,500 employees. Consequently, the Commission estimates that most providers of local exchange service are small entities that may be affected by rules adopted pursuant to this *Order.*

318. We have included small incumbent LECs in this present 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.'' The SBA's Office of Advocacy contends that, for RFA purposes, small incumbent LECs are not dominant in their field of operation because any such dominance is not ''national'' in scope. We have therefore included small incumbent LECs in this RFA analysis, although we emphasize that this RFA action has no effect on Commission analyses and determinations in other, non-RFA contexts.

319. Competitive Local Exchange Carriers (competitive LECs), Competitive Access Providers (CAPs), Shared-Tenant Service Providers, and Other Local Service Providers. Neither the Commission nor the SBA has developed a small business size standard specifically for these service providers. The closest applicable size standard under SBA rules is for Wired Telecommunications Carriers. Under that size standard, such a business is small if it has 1,500 or fewer employees. According to Commission data, 1,442 carriers reported that they were engaged in the provision of either competitive local exchange services or competitive access provider services. Of these carriers, an estimated 1,256 have 1,500 or fewer employees and 186 have more than 1,500 employees. In addition, 17 carriers have reported that they are Shared-Tenant Service Providers, and all 17 are estimated to have 1,500 or fewer employees. In addition, 72 carriers have reported that they are Other Local Service Providers. Of these 72 carriers, an estimated 70 have 1,500 or fewer employees and two have more than 1,500 employees. Consequently, the Commission estimates that most providers of competitive local exchange service, competitive access providers, Shared-Tenant Service Providers, and Other Local Service Providers are small entities that may be affected by rules adopted pursuant to this *Order.*

320. *Interexchange Carriers.* Neither the Commission nor the SBA has developed a size standard for small businesses specifically applicable to interexchange services. The closest applicable size standard under SBA rules is for Wired Telecommunications Carriers. Under that size standard, such a business is small if it has 1,500 or fewer employees. According to Commission data, 359 companies reported that their primary telecommunications service activity was the provision of interexchange services. Of these companies, an estimated 317 have 1,500 or fewer employees and 42 have more than 1,500 employees. Consequently, the Commission estimates that the majority of interexchange service providers are small entities that may be affected by rules adopted pursuant to this *Order.*

321. *Wireless Telecommunications Carriers (except Satellite).* Since 2007, the SBA has recognized wireless firms within this new, broad, economic census category. Prior to that time, such firms were within the now-superseded categories of ''Paging'' and ''Cellular and Other Wireless Telecommunications.'' Under the present and prior categories, the SBA has deemed a wireless business to be small if it has 1,500 or fewer employees. For this category, census data for 2007 show that there were 1,383 firms that operated for the entire year. Of this total, 1,368 firms employed 999 or fewer employees and 15 employed 1000 employees or more. Similarly, according to Commission data, 413 carriers reported that they were engaged in the provision of wireless telephony, including cellular service, Personal Communications Service (PCS), and Specialized Mobile Radio (SMR) Telephony services. Of these, an estimated 261 have 1,500 or fewer employees and 152 have more than 1,500 employees. Consequently, the Commission estimates that approximately half or more of these firms can be considered small. Thus, using available data, we estimate that the majority of wireless firms can be considered small entities that may be affected by the rules adopted pursuant to this *Order.*

322. *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). Under the SBA small business size standard, a business is small if it has 1,500 or fewer employees. According to the *2008 Trends Report,* 434 carriers reported that they were engaged in wireless telephony. Of these, an estimated 222 have 1,500 or fewer employees and 212 have more than 1,500 employees. We have estimated that 222 of these are small under the SBA small business size standard.

323. *Satellite Telecommunications and All Other Telecommunications.* Since 2007, the SBA has recognized satellite firms within this revised category, with a small business size standard of $15 million. The most current Census Bureau data are from the economic census of 2007, and we will use those figures to gauge the prevalence of small businesses in this category. Those size standards are for the two census categories of ''Satellite Telecommunications'' and ''Other Telecommunications.'' Under the ''Satellite Telecommunications'' category, a business is considered small if it had $15 million or less in average annual receipts. Under the ''Other Telecommunications'' category, a business is considered small if it had $25 million or less in average annual receipts.

324. The first category of Satellite Telecommunications ''comprises establishments primarily engaged in providing point-to-point telecommunications services to other establishments in the telecommunications and broadcasting industries by forwarding and receiving communications signals via a system of satellites or reselling satellite

telecommunications.'' For this category, Census Bureau data for 2007 show that there were a total of 512 firms that operated for the entire year. Of this total, 464 firms had annual receipts of under $10 million, and 18 firms had receipts of $10 million to $24,999,999. Consequently, we estimate that the majority of Satellite Telecommunications firms are small entities that might be affected by rules adopted pursuant to this *Order.*

325. The second category of Other Telecommunications ''primarily engaged in providing specialized telecommunications services, such as satellite tracking, communications telemetry, and radar station operation. This industry also includes establishments primarily engaged in providing satellite terminal stations and associated facilities connected with one or more terrestrial systems and capable of transmitting telecommunications to, and receiving telecommunications from, satellite systems. Establishments providing Internet services or voice over Internet protocol (VoIP) services via client-supplied telecommunications connections are also included in this industry.'' For this category, Census Bureau data for 2007 show that there were a total of 2,383 firms that operated for the entire year. Of this total, 2,346 firms had annual receipts of under $25 million. Consequently, we estimate that the majority of Other Telecommunications firms are small entities that might be affected by our action.

b. Internet Service Providers

326. *Internet Service Providers.* Since 2007, these services have been defined within the broad economic census category of Wired Telecommunications Carriers; that category is defined as follows: ''This industry comprises establishments primarily engaged in operating and/or providing access to transmission facilities and infrastructure that they own and/or lease for the transmission of voice, data, text, sound, and video using wired telecommunications networks. Transmission facilities may be based on a single technology or a combination of technologies.'' The SBA has developed a small business size standard of 1,500 or fewer employees. According to Census Bureau data from 2007, there were 3,188 firms in this category, total, that operated for the entire year. Of this total, 3,144 firms had employment of 999 or fewer employees, and 44 firms had employment of 1000 employees or more. Consequently, we estimate that the majority of these firms are small entities that may be affected by rules adopted pursuant to this *Order.*

327. *Data Processing, Hosting, and Related Services.* Entities in this category ''primarily * * * provid[e] infrastructure for hosting or data processing services.'' The SBA has developed a small business size standard for this category; that size standard is $25 million or less in average annual receipts. According to Census Bureau data for 2007, there were 8,060 firms in this category that operated for the entire year. Of these, 7,744 had annual receipts of under $24,999,999. Consequently, we estimate that the majority of these firms are small entities that may be affected by rules adopted pursuant to this *Order.*

328. *All Other Information Services.* The Census Bureau defines this industry as including ''establishments primarily engaged in providing other information services (except news syndicates, libraries, archives, Internet publishing and broadcasting, and Web search portals).'' Our action pertains to interconnected VoIP services, which could be provided by entities that provide other services such as email, online gaming, web browsing, video conferencing, instant messaging, and other, similar IP-enabled services. The SBA has developed a small business size standard for this category; that size standard is $7.0 million or less in average annual receipts. According to Census Bureau data for 2007, there were 367 firms in this category that operated for the entire year. Of these, 334 had annual receipts of under $5.0 million, and an additional 11 firms had receipts of between $5 million and $9,999,999. Consequently, we estimate that the majority of these firms are small entities that may be affected by rules adopted pursuant to this *Order.*

c. Vendors and Equipment Manufacturers

329. *Vendors for Infrastructure Development or ''Network Buildout'' Construction.* The Commission has not developed a small business size standard specifically directed toward manufacturers of network facilities. The closest applicable definition of a small entity are the size standards under the SBA rules applicable to manufacturers of ''Radio and Television Broadcasting and Communications Equipment'' (RTB) and ''Other Communications Equipment.''

330. *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.'' The SBA has developed a small business size standard for Telephone Apparatus Manufacturing, which is: All such firms having 1,000 or fewer employees. According to Census Bureau data for 2002, there were a total of 518 establishments in this category that operated for the entire year. Of this total, 511 had employment of under 1,000, and an additional 7 had employment of 1,000 to 2,499. Thus, under this size standard, the majority of firms can be considered small.

331. *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.'' 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. According to Census Bureau data for 2002, there were a total of 1,041 establishments in this category that operated for the entire year. Of this total, 1,010 had employment of under 500, and an additional 13 had employment of 500 to 999. Thus, under this size standard, the majority of firms can be considered small.

332. *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).'' The SBA has developed a small business size standard for Other Communications Equipment Manufacturing, which is: All such firms

having 750 or fewer employees. According to Census Bureau data for 2002, there were a total of 503 establishments in this category that operated for the entire year. Of this total, 493 had employment of under 500, and an additional 7 had employment of 500 to 999. Thus, under this size standard, the majority of firms can be considered small.

4. Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements for Small Entities

333. The reporting and recordkeeping requirements in this *Order* could have an impact on both small and large entities. However, even though the impact may be more financially burdensome for smaller entities, the Commission believes the impact of such requirements is outweighed by the benefit of providing the additional support necessary to make broadband available for HCPs to provide health care to rural and remote areas, and to make broadband rates for public and non-profit HCPs lower. Further, these requirements are necessary to ensure that the statutory goals of section 254 of the Telecommunications Act of 1996 are met without waste, fraud, or abuse.

334. *Eligibility Determination.* For each HCP listed, applicants will be required to provide the HCP's address and contact information; identify the eligible HCP type; provide an address for each physical location that will receive supported connectivity; provide a brief explanation for why the HCP is eligible under the Act and the Commission's rules and orders; and certify to the accuracy of this information under penalty of perjury.

335. Consortium Leaders should obtain supporting information and/or documents to support eligibility for each HCP when they collect LOAs. Consortium applicants must also submit documentation regarding network planning as part of the application process, although the Commission will monitor experience under the new rule, and may make adjustments in the future, if necessary, to ensure that this requirement is minimally burdensome while creating appropriate incentives for applicants to make thoughtful, cost-effective purchases. Applicants in the Healthcare Connect Fund are not required to submit technology plans with their requests for service, but the Commission may re-evaluate this decision in the future based on experience with the new program.

336. *Process for initiating competitive bidding for requested services.* Applicants must develop appropriate evaluation criteria for selecting the winning bid *before* submitting a request for services to USAC to initiate competitive bidding. The evaluation criteria should be based on the Commission's definition of ''cost-effective,'' and include the most important criteria needed to provide health care, as determined by the applicant. Applicants should also begin to identify possible sources for the 35 percent of undiscounted costs.

337. Applicants subject to competitive bidding must submit new FCC Form 461 and supporting documentation to the Universal Service Administrative Company (USAC). On Form 461, applicants must provide basic information regarding the HCP(s) on the application (including contact information for potential bidders); a brief description of the desired services; and certifications designed to ensure compliance with program rules and minimize waste, fraud, and abuse.

338. Applicants must supplement their Form 461 with a Request for Proposals (RFP) on USAC's Web site in the following instances: (1) Consortium applications that seek more than $100,000 in program support in a funding year; (2) applicants who are required to issue an RFP under applicable state or local procurement rules or regulations; and (3) consortium applications that seek support for infrastructure (*i.e.* HCP-owned facilities) as well as services. In addition, any applicant is free to post an RFP.

339. Applicants also are required to submit the following documents, which will not be publicly posted by USAC.

340. *Form 460.* Applicants should submit Form 460 to certify to the eligibility of HCP(s) listed on the application, if they have not previously done so.

341. *Letters of Agency for Consortium Applicants.* Consortium applicants should submit letters of agency demonstrating that the Consortium Leader is authorized to submit Forms 460, 461, and 462, as applicable, including required certifications and any supporting materials, on behalf of each participating HCP in the consortium.

342. *Declaration of Assistance.* As in the Pilot Program, all applicants must identify, through a Declaration of Assistance, any consultants, service providers, or any other outside experts, whether paid or unpaid, who aided in the preparation of their applications. The Declaration of Assistance must be filed with the Form 461. Identifying these consultants and outside experts facilitates the ability of USAC, the Commission, and law enforcement officials to identify and prosecute individuals who may seek to defraud the program or engage in other illegal acts. To ensure participants comply with the competitive bidding requirements, they must disclose all of the types of relationships explained above.

343. Finally, all applicants subject to competitive bidding must certify to USAC that the services and/or infrastructure selected are, to the best of the applicant's knowledge, the most cost-effective option available. Applicants must submit documentation to USAC to support their certifications, including a copy of each bid received (winning, losing, and disqualified), the bid evaluation criteria, and any other related documents, such as bid evaluation sheets; a list of people who evaluated bids (along with their title/role/relationship to the applicant organization); memos, board minutes, or similar documents related to the vendor selection/award; copies of notices to winners; and any correspondence with service providers during the bidding/evaluation/award phase of the process. Bid evaluation documents need not be in a certain format, but the level of documentation should be appropriate for the scale and scope of the services for which support is requested.

344. *Reporting Requirements.* Data from participants and USAC are essential to the Commission's ability to evaluate whether the program is meeting its performance goals, and to measure progress toward meeting those goals. In the Healthcare Connect Program, each consortium lead entity must file an annual report with USAC on or before July 30 for the preceding funding year (*i.e.,* July 1 through and including June 30). Individual HCP applicants do not have to fine annual reports, however.

345. *Recordkeeping.* Consistent with §§ 54.619(a), (b), and (d) of the Commission's current rules, participants and service providers in the Healthcare Connect Fund must maintain certain documentation related to the purchase and delivery of services funded by the RHC programs, and will be required to produce these records upon request.

346. The *NPRM* also proposed to: (1) clarify that the documents to be retained by participants and service providers must include all records related to the participant's application for, receipt of, and delivery of discounted services; and (2) amend the existing rules to mandate that service providers, upon request, produce the records kept pursuant to the Commission's recordkeeping requirement. This *Order* adopts rules consistent with these proposals to enable the Commission and USAC to

obtain the records necessary for effective oversight of the RHC programs.

347. *Certifications.* Consistent with §§ 54.603(b) and 54.615(c) of the current rules, participants in the Healthcare Connect Fund must certify under oath to compliance with certain program requirements, including the requirements to select the most cost-effective bid and to use program support solely for purposes reasonably related to the provision of health care services or instruction. For individual HCP applicants, required certifications must be provided and signed by an officer or director of the HCP, or other authorized employee of the HCP (electronic signatures are permitted). For consortium applicants, an officer, director, or other authorized employee of the Consortium Leader must sign the required certifications.

348. *Vendors SPIN Requirement.* All vendors participating in the Healthcare Connect Fund must obtain a Service Provider Identification Number (SPIN) by submitting an FCC Form 498. The SPIN is a unique number assigned to each service provider by USAC, and serves as USAC's tool to ensure that support is directed to the correct service provider. SPINs must be assigned before USAC can authorize support payments. Therefore, all service providers submitting bids to provide services to selected participants will need to complete and submit a Form 498 to USAC for review and approval if selected by a participant before funding commitments can be made.

349. *Skilled Nursing Facility (SNF) Pilot.* SNF Pilot applicants must demonstrate how proposed participation of SNFs will improve the overall provision of health care by eligible HCPs. SNF Pilot applicants and participants must submit data on a number of variables (to be determined by the Bureau at a later date) related to the broadband connections supported and their health care uses, so that at the conclusion of the SNF Pilot, the Commission can use the data gathered to determine how to proceed with regard to including SNFs in the Commission's health care support programs on a permanent basis. SNF Pilot applicants also must commit to robust data gathering and analysis, and to submission of an annual report. Applicants must explain what types of data they intend to gather and how they intend to gather that data. At the conclusion of the Pilot, participants must demonstrate the health care cost savings and/or improved quality of patient care that have been realized through greater use of broadband to provide telemedicine to treat the residents of SNFs.

5. Steps Taken To Minimize the Significant Economic Impact on Small Entities, and Significant Alternatives Considered

350. The FRFA requires an agency to describe any significant alternatives that it has considered in developing its approach, which may include the following four alternatives (among others): ''(1) The establishment of differing compliance or reporting requirements or timetables that take into account the resources available to small entities; (2) the clarification, consolidation, or simplification of compliance and reporting requirements under the rule for such small entities; (3) the use of performance rather than design standards; and (4) an exemption from coverage of the rule, or any part thereof, for such small entities.'' Accordingly, we have taken the following steps to minimize the impact on small entities.

351. *Consortium approach.* Consistent with support from commenters, this *Order* adopts a streamlined application process that facilitates consortium applications, which should enable HCPs to file many fewer applications and to share the administrative costs of all aspects of participation in the program. Each consortium must file only one application, instead of each individual HCP filing separate applications. Applying as a consortium is simpler, cheaper, and more efficient for small HCPs. Under the consortium approach adopted in this *Order,* the expenses associated with planning the network, applying for funding, issuing RFPs, contracting with service providers, and invoicing are shared among a number of providers. This should help ensure that applicants, including small entities, will not be deterred from applying for support due to administrative burdens.

352. *Flat-Rate Discount.* In order to encourage participation in the Healthcare Connect Fund and relieve planning uncertainties for smaller entities, this *Order* adopts a flat-rate discount of 65 percent, clearly identifying the level of support that providers can reasonably expect to receive. By adopting a flat-rate discount, the Commission provides a clear and predictable support amount, thereby helping eligible HCPs to plan for their broadband needs. This approach is also less complex and easier to administer, which should expedite the application process and reduce administrative expenses for small entities.

353. *Competitive Bidding Exemptions.* While competitive bidding is essential to the program, it is not without administrative costs to participants. In three situations, exempting funding requests from competitive bidding strikes a common-sense balance between efficient use of program funds and reducing regulatory costs. First, based on our experience in the existing RHC programs, it will be more administratively efficient to exempt applicants seeking support for relatively small amounts. The threshold for this exemption is $10,000 or less in total annual undiscounted costs (which, with a 35 percent minimum applicant contribution, results in a maximum of $6,500 annually in Fund support). Second, if an applicant is required by federal, state or local law or regulations to purchase services from a master service agreement negotiated by a governmental entity on its behalf, and the master service agreement was awarded pursuant to applicable federal, state, Tribal, or local competitive bidding processes, the applicant is not required to re-undergo competitive bidding. Third, applicants who wish to request support under the Healthcare Connect Fund while utilizing contracts previously approved by USAC (under the Pilot Program, the RHC Telecommunications or Internet Access Programs, or the E-rate program) may do so without undergoing additional competitive bidding, as long as they do not request duplicative support for the same service and otherwise comply with all Healthcare Connect Fund requirements. In addition, consistent with current RHC program policies, applicants who receive evergreen status or multi-year commitments under the Healthcare Connect Fund are exempt from competitive bidding for the duration of the contract. Applicants who are exempt from competitive bidding can proceed directly to submitting a funding commitment request.

354. *Evergreen Contracts.* The existing RHC program allows ''evergreen'' contracts, meaning that for the life of a multi-year contract deemed evergreen by USAC, HCPs need not annually rebid the service or post an FCC Form 465. As stated in the *NPRM,* codification of existing evergreen procedures likely will benefit participating HCPs by affording them: (1) Lower prices due to longer contract terms; and (2) reduced administrative burdens due to fewer required Form 465s. Commenters supported the *NPRM's* proposal to codify the Commission's existing evergreen procedures, arguing, among other things, that the evergreen procedures significantly reduce HCPs'

administrative and financial burdens. This *Order* also makes one change to the existing evergreen policy to allow participants to exercise voluntary options to extend an evergreen contract without undergoing additional competitive bidding, subject to certain limitations.

355. *Multi-year funding commitments:* Applicants may receive multi-year funding commitments that cover a period of up to three funding years. The multi-year funding commitments will reduce uncertainty and administrative burden by eliminating the need for HCPs to apply every year for funding, as is required under the existing RHC Telecommunications and Internet Access Programs, and reduce administrative expenses both for the projects and for USAC. Multi-year funding commitments, prepaid leases, and IRUs also encourage term discounts and produce lower rates from vendors. The funding of HCP-constructed-and-owned infrastructure has allowed Pilot projects to choose this option where it is the most cost-effective way to obtain broadband.

356. *Annual Reporting Requirement:* Participants in the Healthcare Connect Fund must submit reports on an annual basis, consistent with suggestions from commenters to minimize the burdens of reporting requirements. Submitting annual, rather than quarterly reports, as required in the Pilot Program, will minimize the burden on participants and USAC alike while still supporting performance evaluation and enabling the Commission to evaluate the prevention of waste, fraud, and abuse. Because the Commission expects to be able to collect data from individual applicants in the Healthcare Connect Fund on forms they already submit, individual applicants are not required to submit annual reports unless a report is required for other reasons. To further minimize the burden on participants, the Order delegates authority to the Bureau to work with USAC to develop a simple and streamlined reporting system that leverages data collected through the application process, eliminating the need to resubmit any information that has already been provided to USAC.

357. *Sustainability plans for applicants that build their own infrastructure.* In the *NPRM,* the Commission proposed to require sustainability plans similar to those required in the Pilot Program for HCPs who intended to have an ownership interest, indefeasible right of use, or capital lease interest in supported facilities. The Pilot Program required projects to submit a copy of their sustainability plan with every quarterly report. Based on the Pilot Program, the Commission concludes that submission of sustainability reports on a quarterly basis is unnecessarily burdensome for applicants, and provides little useful information to USAC. Accordingly, sustainability reports for the Healthcare Connect Fund are only required to be re-filed if there is a material change that would impact projected income or expenses by the greater of 20 percent or $100,000 from the previous submission, or if the applicant submits a funding request based on a new Form 461 (*i.e.,* a new competitively bid contract). In such an event, the revised sustainability report must be provided to USAC no later than the end of the relevant quarter, clearly showing (*i.e.* by redlining or highlighting) what has changed.

358. *Skilled Nursing Facility Pilot Requirements.* Participants in the SNF Pilot must submit data on a number of variables; gather and analyze data; submit annual reports; and, at the conclusion of the Pilot, demonstrate the health care cost savings and/or improved quality of patient care that have been realized through greater use of broadband. While these requirements may impact small entities, we have determined that the benefits of these requirements—namely, preserving program integrity and ensuring cost-effectiveness—outweigh any costs. Specifically, we do not believe that these requirements will have significant impact on small entities for two reasons. First, the SNF is a voluntary pilot program and, as such, entities may choose whether to apply. Second, the Bureau will give preference to applicants that partner with existing or new consortia in the existing Pilot Program or the Healthcare Connect Fund. Small SNFs joining consortia should experience minimal reporting burdens as these consortia typically have the leadership and expertise to effectively assist their members with administrative requirements.

359. *Report to Congress:* The Commission will send a copy of the *Order,* including this FRFA, in a report to be sent to Congress pursuant to the Congressional Review Act. In addition, the Commission will send a copy of the *Order,* including this FRFA, to the Chief Counsel for Advocacy of the SBA. A copy of the *Order* (and FRFA summaries thereof) will also be published in the **Federal Register**.

B. Paperwork Reduction Act Analysis

360. This *Order* contains new information collection requirements subject to the Paperwork Reduction Act of 1995 (PRA), Public Law 104–13. It will be submitted to the Office of Management and Budget (OMB) for review under section 3507(d) of the PRA. OMB, the general public, and other Federal agencies are invited to comment on the new or modified information collection requirements contained in this proceeding. In addition, we note that pursuant to the Small Business Paperwork Relief Act of 2002, Public Law 107–198, see 44 U.S.C. 3506(c)(4), we previously sought specific comment on how the Commission might further reduce the information collection burden for small business concerns with fewer than 25 employees. We describe the impacts that might affect small businesses, which include most businesses with fewer than 25 employees, in the Final Regulatory Flexibility Analysis.

C. Congressional Review Act

361. The Commission will send a copy of this order to Congress and the Government Accountability Office pursuant to the Congressional Review Act, see 5 U.S.C. 801(a)(1)(A).

XI. Ordering Clauses

362. Accordingly, it is ordered that, pursuant to sections 1, 2, 4(i)–(j), 201(b), and 254 of the Communications Act of 1934, as amended, 47 U.S.C. 151, 152, 154(i), 154(j), 201(b), and 254, this Report and Order is adopted, and, pursuant to 5 U.S.C. 553(d)(3) and §§ 1.4(b)(1), 1.103(a), and 1.427(a) of the Commission's rules, 47 CFR 1.4(b)(1), 1.103(a), 1.427(a).

363. It is further ordered that Part 54 of the Commission's rules, 47 CFR Part 54, is amended as set forth in the Appendix, and such rules shall become effective April 1, 2013, except for those rules and requirements that involve Paperwork Reduction Act burdens, which shall become effective immediately upon announcement in the **Federal Register** of OMB approval and of effective dates of such rules.

364. It is further ordered that pursuant to 5 U.S.C. 801(a)(1)(A), the Commission shall send a copy of this Report and Order to Congress and to the Government Accountability Office pursuant to the Congressional Review Act.

365. It is further ordered that the Commission's Consumer and Governmental Affairs Bureau, Reference Information Center, shall send a copy of this Report and Order, including the Final Regulatory Flexibility Analysis, to the Chief Counsel for Advocacy of the Small Business Administration.

366. It is further ordered that, pursuant to the authority contained in

sections 1–4 and 254 of the Communications Act of 1934, as amended, 47 U.S.C. 151–154 and 254, the requests for additional Rural Health Care Pilot Program funding filed by Oregon Health Network, California Telehealth Network, Southwest Telehealth Access Grid, Western New York Rural Area Health Education Center, Inc., Palmetto State Providers Network, and Health Information Exchange of Montana *are denied.*

367. It is further ordered that, pursuant to the authority contained in sections 1–4 and 254 of the Communications Act of 1934, as amended, 47 U.S.C. 151–154 and 254, the request for an extension of the June 30, 2012, Rural Health Care Pilot Program deadline filed by the Texas Health Information Network Collaborative is dismissed as moot.

368. It is further ordered that, pursuant to the authority contained in sections 1–4 and 254 of the Communications Act of 1934, as amended, 47 U.S.C. 151–154 and 254, the requests for waiver of 47 CFR 54.611 of the Commission's rules filed by Network Services Solutions, L.L.C., and Richmond Connections, Inc., are granted.

369. It is further ordered that, pursuant to the authority contained in sections 1–4 and 254 of the Communications Act of 1934, as amended, 47 U.S.C. 151–154 and 254, USAC shall make an initial reimbursement payment to Network Services Solutions, L.L.C., and Richmond Connections, Inc., no later than December 31, 2012 as described herein.

370. It is further ordered that, pursuant to the authority contained in sections 1–4 and 254 of the Communications Act of 1934, as amended, 47 U.S.C. 151–154 and 254, the requests for stay of enforcement of 47 CFR § 54.611 of the Commission's rules filed by Network Services Solutions, L.L.C., and Richmond Connections, Inc., are dismissed as moot.

List of Subjects in 47 CFR Part 54

Communications common carriers, Health facilities, Reporting and recordkeeping requirements, Telecommunications, Telephone.

Federal Communications Commission.

Marlene H. Dortch,

Secretary.

Final Rules

For the reasons discussed in the preamble, the Federal Communications Commission amends 47 CFR part 54 as follows:

PART 54—UNIVERSAL SERVICE

■ 1. The authority citation for part 54 continues to read as follows:

Authority: Secs. 5, 48 Stat. 1068, as amended; 47 U.S.C. 155.

■ 2. In § 54.5, revise the definition of ''rural area'' to read as follows:

§ 54.5 Terms and definitions.

* * * * *

Rural area. For purposes of the schools and libraries universal support mechanism, a ''rural area'' is a nonmetropolitan county or county equivalent, as defined in the Office of Management and Budget's (OMB) Revised Standards for Defining Metropolitan Areas in the 1990s and identifiable from the most recent Metropolitan Statistical Area (MSA) list released by OMB, or any contiguous non-urban Census Tract or Block Numbered Area within an MSA–listed metropolitan county identified in the most recent Goldsmith Modification published by the Office of Rural Health Policy of the U.S. Department of Health and Human Services.

* * * * *

■ 3. Add § 54.600 to subpart G and an undesignated center heading to read as follows:

Defined Terms and Eligibility

§ 54.600 Terms and definitions.

As used in this subpart, the following terms shall be defined as follows:

(a) *Health care provider.* A ''health care provider'' is any:

(1) Post-secondary educational institution offering health care instruction, including a teaching hospital or medical school;

(2) Community health center or health center providing health care to migrants;

(3) Local health department or agency;

(4) Community mental health center;

(5) Not-for-profit hospital;

(6) Rural health clinic; or

(7) Consortium of health care providers consisting of one or more entities described in paragraphs (a)(1) through (a)(6) of this section.

(b) *Rural area.* (1) A ''rural area'' is an area that is entirely outside of a Core Based Statistical Area; is within a Core Based Statistical Area that does not have any Urban Area with a population of 25,000 or greater; or is in a Core Based Statistical Area that contains an Urban Area with a population of 25,000 or greater, but is within a specific census tract that itself does not contain any part of a Place or Urban Area with a population of greater than 25,000. For purposes of this rule, ''Core Based Statistical Area,'' ''Urban Area,'' and ''Place'' are as identified by the Census Bureau.

(2) Notwithstanding the definition of ''rural area,'' any health care provider that is located in a ''rural area'' under the definition used by the Commission prior to July 1, 2005, and received a funding commitment from the rural health care program prior to July 1, 2005, is eligible for support under this subpart.

(c) *Rural health care provider.* A ''rural health care provider'' is an eligible health care provider site located in a rural area.

■ 4. Revise § 54.601 to read as follows:

§ 54.601 Health care provider eligibility.

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

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

(b) *Determination of health care provider eligibility for the Healthcare Connect Fund.* Health care providers in the Healthcare Connect Fund may certify to the eligibility of particular sites at any time prior to, or concurrently with, filing a request for services to initiate competitive bidding for the site. Applicants who utilize a competitive bidding exemption must provide eligibility information for the site to the Administrator prior to, or concurrently with, filing a request for funding for the site. Health care providers must also notify the Administrator within 30 days of a change in the health care provider's name, site location, contact information, or eligible entity type.

■ 5. Add § 54.602 to subpart G to read as follows:

§ 54.602 Health care support mechanism.

(a) *Telecommunications Program.* Rural health care providers may request support for the difference, if any, between the urban and rural rates for telecommunications services, subject to the provisions and limitations set forth in §§ 54.600 through 54.625 and §§ 54.671 through 54.680. This support is referred to as the ''Telecommunications Program.''

(b) *Healthcare Connect Fund.* Eligible health care providers may request support for eligible services, equipment, and infrastructure, subject to the provisions and limitations set forth in §§ 54.600 through 54.602 and §§ 54.630

through 54.680. This support is referred to as the ''Healthcare Connect Fund.''

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

(d) *Health care purposes.* Services for which eligible health care providers receive support from the Telecommunications Program or the Healthcare Connect Fund must be reasonably related to the provision of health care services or instruction that the health care provider is legally authorized to provide under the law in the state in which such health care services or instruction are provided.

■ 6. In § 54.603, add an undesignated center heading; revise the section heading and paragraphs (a), (b)(1) introductory text, and (b)(1)(i) and (ii), and remove and reserve paragraph (b)(1)(iii).

The addition and revisions read as follows:

Telecommunications Program

§ 54.603 Competitive bidding and certification requirements.

(a) *Competitive bidding requirement.* To select the telecommunications carriers that will provide services eligible for universal service support to it under the Telecommunications Program, each eligible health care provider shall participate in a competitive bidding process pursuant to the requirements established in this section and any additional and applicable state, Tribal, local, or other procurement requirements.

(b) * * *

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

(i) The requester is a public or non-profit entity that falls within one of the seven categories set forth in the definition of health care provider, listed in § 54.600(a);

(ii) The requester is physically located in a rural area;

* * * * *

■ 7. In § 54.604, revise the section heading; redesignate paragraphs (b) and (c) as paragraphs (d) and (e) respectively; redesignate paragraph (a) as paragraph (c) and add new paragraphs (a) and (b); and revise newly redesignated paragraph (c) introductory text to read as follows:

§ 54.604 Consortia, telecommunications services, and existing contracts.

(a) *Consortia.* (1) Under the Telecommunications Program, an eligible health care provider may join a consortium with other eligible health care providers; with schools, libraries, and library consortia eligible under subpart F of this part; and with public sector (governmental) entities to order telecommunications services. With one exception, eligible health care providers participating in consortia with ineligible private sector members shall not be eligible for supported services under this subpart. A consortium may include ineligible private sector entities if such consortium is only receiving services at tariffed rates or at market rates from those providers who do not file tariffs.

(2) For consortia, universal service support under the Telecommunications Program shall apply only to the portion of eligible services used by an eligible health care provider.

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

(c) *Existing contracts.* A signed contract for services eligible for Telecommunications Program support pursuant to this subpart between an eligible health care provider as defined under § 54.600 and a telecommunications carrier shall be exempt from the competitive bid requirements set forth in § 54.603(a) as follows:

* * * * *

■ 8. In § 54.605, revise paragraph (a) to read as follows:

§ 54.605 Determining the urban rate.

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

* * * * *

■ 9. In § 54.609, revise paragraphs (a) introductory text, (a)(1)(iv) and (3), (d)(1) and (2), and (e)(1) to read as follows:

§ 54.609 Calculating support.

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

(1) * * *

(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.

* * * * *

(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.

* * * * *

(d) * * *

(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.

* * * * *

(e) * * *

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

* * * * *

§ 54.611 [Removed]

■ 10. Remove § 54.611.

§ 54.613 [Amended]

■ 11. In § 54.613, remove and reserve paragraph (b).

■ 12. In § 54.615, revise paragraphs (b), (c) introductory text, and (c)(2) and remove and reserve paragraph (c)(3).

The revisions read as follows:

§ 54.615 Obtaining services.

* * * * *

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

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

* * * * *

(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;

* * * * *

§ 54.617 [Removed]

■ 13. Remove § 54.617.

■ 14. In § 54.619, revise paragraphs (a)(1) and (d) to read as follows:

§ 54.619 Audits and recordkeeping.

(a) * * *

(1) Health care providers shall maintain for their purchases of services supported under the Telecommunications Program documentation for five years from the end of the funding year sufficient to establish compliance with all rules in this subpart. Documentation must include, among other things, records of allocations for consortia and entities that engage in eligible and ineligible activities, if applicable. Mobile rural health care providers shall maintain annual logs indicating: The date and locations of each clinic stop; and the number of patients served at each such clinic stop.

* * * * *

(d) *Service providers.* Service providers shall retain documents related to the delivery of discounted services under the Telecommunications Program for at least 5 years after the last day of the delivery of discounted services. Any other document that demonstrates compliance with the statutory or regulatory requirements for the rural health care mechanism shall be retained as well.

§ 54.621 [Removed]

■ 15. Remove § 54.621.

■ 16. Revise § 54.623 to read as follows:

§ 54.623 Annual filing and funding commitment requirement.

(a) *Annual filing requirement.* Health care providers seeking support under the Telecommunications Program shall file new funding requests for each funding year.

(b) *Long term contracts.* Under the Telecommunications Program, if health care providers enter into long term contracts for eligible services, the Administrator shall only commit funds to cover the portion of such a long term contract scheduled to be delivered during the funding year for which universal service support is sought.

■ 17. Revise § 54.625 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.

■ 18. Add § 54.630 and an undesignated center heading to subpart G to read as follows:

Healthcare Connect Fund

§ 54.630 Eligible recipients.

(a) *Rural health care provider site—individual and consortium.* Under the Healthcare Connect Fund, an eligible rural health care provider may receive universal service support by applying individually or through a consortium. For purposes of the Healthcare Connect Fund, a ''consortium'' is a group of two or more health care provider sites that request support through a single application. Consortia may include health care providers who are not eligible for support under the Healthcare Connect Fund, but such health care providers cannot receive support for their expenses and must participate pursuant to the cost allocation guidelines in § 54.639(d).

(b) *Limitation on participation of non-rural health care provider sites in a consortium.* An eligible non-rural health care provider site may receive universal service support only as part of a consortium that includes more than 50 percent eligible rural health care provider sites.

(c) *Limitation on large non-rural hospitals.* Each eligible non-rural public

or non-profit hospital site with 400 or more licensed patient beds may receive no more than $30,000 per year in Healthcare Connect Fund support for eligible recurring charges and no more than $70,000 in Healthcare Connect Fund support every 5 years for eligible nonrecurring charges, exclusive in both cases of costs shared by the network.

■ 19. Add § 54.631 to subpart G to read as follows:

§ 54.631 Designation of Consortium Leader.

(a) *Identifying a Consortium Leader.* Each consortium seeking support from the Healthcare Connect Fund must identify an entity or organization that will be the lead entity (the ''Consortium Leader'').

(b) *Consortium Leader eligibility.* The Consortium Leader may be the consortium itself (if it is a distinct legal entity); an eligible health care provider participating in the consortium; or a state organization, public sector (governmental) entity (including a Tribal government entity), or non-profit entity that is ineligible for Healthcare Connect Fund support. Ineligible state organizations, public sector entities, or non-profit entities may serve as Consortium Leaders or provide consulting assistance to consortia only if they do not participate as potential vendors during the competitive bidding process. An ineligible entity that serves as the Consortium Leader must pass on the full value of any discounts, funding, or other program benefits secured to the consortium members that are eligible health care providers.

(c) *Consortium Leader responsibilities.* The Consortium Leader's responsibilities include the following:

(1) *Legal and financial responsibility for supported activities.* The Consortium Leader is the legally and financially responsible entity for the activities supported by the Healthcare Connect Fund. By default, the Consortium Leader is the responsible entity if audits or other investigations by Administrator or the Commission reveal violations of the Act or Commission rules, with individual consortium members being jointly and severally liable if the Consortium Leader dissolves, files for bankruptcy, or otherwise fails to meet its obligations. Except for the responsibilities specifically described in paragraphs (c)(2) through (c)(6) of this section, consortia may allocate legal and financial responsibility as they see fit, provided that this allocation is memorialized in a formal written agreement between the affected parties (*i.e.,* the Consortium Leader, and the consortium as a whole and/or its individual members), and the written agreement is submitted to the Administrator for approval with or prior to the Request for Services. Any such agreement must clearly identify the party(ies) responsible for repayment if the Administrator is required, at a later date, to recover disbursements to the consortium due to violations of program rules.

(2) *Point of contact for the FCC and Administrator.* The Consortium Leader is responsible for designating an individual who will be the ''Project Coordinator'' and serve as the point of contact with the Commission and the Administrator for all matters related to the consortium. The Consortium Leader is responsible for responding to Commission and Administrator inquiries on behalf of the consortium members throughout the application, funding, invoicing, and post-invoicing period.

(3) *Typical applicant functions, including forms and certifications.* The Consortium Leader is responsible for submitting program forms and required documentation and ensuring that all information and certifications submitted are true and correct. The Consortium Leader must also collect and retain a Letter of Agency (LOA) from each member, pursuant to § 54.632.

(4) *Competitive bidding and cost allocation.* The Consortium Leader is responsible for ensuring that the competitive bidding process is fair and open and otherwise complies with Commission requirements. If costs are shared by both eligible and ineligible entities, the Consortium Leader must ensure that costs are allocated in a manner that ensures that only eligible entities receive the benefit of program discounts.

(5) *Invoicing.* The Consortium Leader is responsible for notifying the Administrator when supported services have commenced and for submitting invoices to the Administrator.

(6) *Recordkeeping, site visits, and audits.* The Consortium Leader is also responsible for compliance with the Commission's recordkeeping requirements and for coordinating site visits and audits for all consortium members.

■ 20. Add § 54.632 to subpart G to read as follows:

§ 54.632 Letters of agency (LOA).

(a) *Authorizations.* Under the Healthcare Connect Fund, the Consortium Leader must obtain the following authorizations.

(1) Prior to the submission of the request for services, the Consortium Leader must obtain authorization, the necessary certifications, and any supporting documentation from each consortium member to permit the Consortium Leader to submit the request for services and prepare and post the request for proposal on behalf of the member.

(2) Prior to the submission of the funding request, the Consortium Leader must secure authorization, the necessary certifications, and any supporting documentation from each consortium member to permit the Consortium Leader to submit the funding request and manage invoicing and payments on behalf of the member.

(b) *Optional two-step process.* The Consortium Leader may secure both required authorizations from each consortium member in either a single LOA or in two separate LOAs.

(c) *Required Information in LOA.* (1) An LOA must include, at a minimum, the name of the entity filing the application (*i.e.,* lead applicant or Consortium Leader); name of the entity authorizing the filing of the application (*i.e.,* the participating health care provider/consortium member); the physical location of the health care provider/consortium member site(s); the relationship of each site seeking support to the lead entity filing the application; the specific timeframe the LOA covers; the signature, title and contact information (including phone number, mailing address, and email address) of an official who is authorized to act on behalf of the health care provider/consortium member; signature date; and the type of services covered by the LOA.

(2) For HCPs located on Tribal lands, if the health care facility is a contract facility that is run solely by the tribe, the appropriate tribal leader, such as the tribal chairperson, president, or governor, shall also sign the LOA, unless the health care responsibilities have been duly delegated to another tribal government representative.

■ 21. Add § 54.633 to subpart G to read as follows:

§ 54.633 Health care provider contribution.

(a) *Health care provider contribution.* All health care providers receiving support under the Healthcare Connect Fund shall receive a 65 percent discount on the cost of eligible expenses and shall be required to contribute 35 percent of the total cost of all eligible expenses.

(b) *Limits on eligible sources of health care provider contribution.* Only funds from eligible sources may be applied toward the health care provider's required contribution.

(1) Eligible sources include the applicant or eligible health care provider participants; state grants, funding, or appropriations; federal funding, grants, loans, or appropriations except for other federal universal service funding; Tribal government funding; and other grant funding, including private grants.

(2) Ineligible sources include (but are not limited to) in-kind or implied contributions from health care providers; direct payments from vendors or other service providers, including contractors and consultants to such entities; and for-profit entities.

(c) *Disclosure of health care provider contribution source.* Prior to receiving support, applicants are required to identify with specificity their sources of funding for their contribution of eligible expenses.

(d) *Future revenues from excess capacity as source of health care provider contribution.* A consortium applicant that receives support for participant-owned network facilities under § 54.636 may use future revenues from excess capacity as a source for the required health care provider contribution, subject to the following limitations.

(1) The consortium's selection criteria and evaluation for ''cost-effectiveness'' pursuant to § 54.642 cannot provide a preference to bidders that offer to construct excess capacity.

(2) The applicant must pay the full amount of the additional costs for excess capacity facilities that will not be part of the supported health care network.

(3) The additional cost of constructing excess capacity facilities may not count toward a health care provider's required contribution.

(4) The inclusion of excess capacity facilities cannot increase the funded cost of the dedicated health care network in any way.

(5) An eligible health care provider (typically the consortium, although it may be an individual health care provider participating in the consortium) must retain ownership of the excess capacity facilities. It may make the facilities available to third parties only under an indefeasible right of use (IRU) or lease arrangement. The lease or IRU between the participant and the third party must be an arm's length transaction. To ensure that this is an arm's length transaction, neither the vendor that installs the excess capacity facilities nor its affiliate is eligible to enter into an IRU or lease with the participant.

(6) Any amount prepaid for use of the excess capacity facilities (IRU or lease) must be placed in an escrow account. The participant can then use the escrow account as an eligible source of funds for the participant's 35 percent contribution to the project.

(7) All revenues from use of the excess capacity facilities by the third party must be used for the health care provider contribution or for sustainability of the health care network supported by the Healthcare Connect Fund. Network costs that may be funded with any additional revenues that remain include administration, equipment, software, legal fees, or other costs not covered by the Healthcare Connect Fund, as long as they are relevant to sustaining the network.

■ 22. Add § 54.634 to subpart G to read as follows:

§ 54.634 Eligible services.

(a) *Eligible services.* Subject to the provisions of §§ 54.600 through 54.602 and §§ 54.630 through 54.680, eligible health care providers may request support from the Healthcare Connect Fund for any advanced telecommunications or information service that enables health care providers to post their own data, interact with stored data, generate new data, or communicate, by providing connectivity over private dedicated networks or the public Internet for the provision of health information technology.

(b) *Eligibility of dark fiber.* A consortium of eligible health care providers may receive support for ''dark'' fiber where the customer, not the vendor, provides the modulating electronics, subject to the following limitations:

(1) Support for recurring charges associated with dark fiber is only available once the dark fiber is ''lit'' and actually being used by the health care provider. Support for non-recurring charges for dark fiber is only available for fiber lit within the same funding year, but applicants may receive up to a one-year extension to light fiber if they provide documentation to the Administrator that construction was unavoidably delayed due to weather or other reasons.

(2) Requests for proposals (RFPs) that solicit dark fiber solutions must also solicit proposals to provide the needed services over lit fiber over a time period comparable to the duration of the dark fiber lease or indefeasible right of use.

(3) If an applicant intends to request support for equipment and maintenance costs associated with lighting and operating dark fiber, it must include such elements in the same RFP as the dark fiber so that the Administrator can review all costs associated with the fiber when determining whether the applicant chose the most cost-effective bid.

(c) *Dark and lit fiber maintenance costs.* (1) Both individual and consortium applicants may receive support for recurring maintenance costs associated with leases of dark or lit fiber.

(2) Consortium applicants may receive support for upfront payments for maintenance costs associated with leases of dark or lit fiber, subject to the limitations in § 54.638.

(d) *Reasonable and customary installation charges.* Eligible health care providers may obtain support for reasonable and customary installation charges for eligible services, up to an undiscounted cost of $5,000 per eligible site.

(e) *Upfront charges for vendor deployment of new or upgraded facilities.* (1) Participants may obtain support for upfront charges for vendor deployment of new or upgraded facilities to serve eligible sites.

(2) Support is available to extend vendor deployment of facilities up to the ''demarcation point,'' which is the boundary between facilities owned or controlled by the vendor, and facilities owned or controlled by the customer.

■ 23. Add § 54.635 to subpart G to read as follows:

§ 54.635 Eligible equipment.

(a) Both individual and consortium applicants may receive support for network equipment necessary to make functional an eligible service that is supported under the Healthcare Connect Fund.

(b) Consortium applicants may also receive support for network equipment necessary to manage, control, or maintain an eligible service or a dedicated health care broadband network. Support for network equipment is not available for networks that are not dedicated to health care.

(c) Network equipment eligible for support includes the following:

(1) Equipment that terminates a carrier's or other provider's transmission facility and any router/switch that is directly connected to either the facility or the terminating equipment. This includes equipment required to light dark fiber, or equipment necessary to connect dedicated health care broadband networks or individual health care providers to middle mile or backbone networks;

(2) Computers, including servers, and related hardware (*e.g.* printers, scanners,

laptops) that are used exclusively for network management;

(3) Software used for network management, maintenance, or other network operations, and development of software that supports network management, maintenance, and other network operations;

(4) Costs of engineering, furnishing (*i.e.* as delivered from the manufacturer), and installing network equipment; and

(5) Equipment that is a necessary part of health care provider-owned network facilities.

(d) Additional limitations: Support for network equipment is limited to equipment:

(1) Purchased or leased by a Consortium Leader or eligible health care provider; and

(2) Used for health care purposes.

■ 24. Add § 54.636 to subpart G to read as follows:

§ 54.636 Eligible participant-constructed and owned network facilities for consortium applicants.

(a) Subject to the funding limitations under §§ 54.675 and 54.638 and the following restrictions, consortium applicants may receive support for network facilities that will be constructed and owned by the consortium (if the consortium is an eligible health care provider) or eligible health care providers within the consortium.

(1) Consortia seeking support to construct and own network facilities are required to solicit bids for both:

(i) Services provided over third-party networks; and

(ii) Construction of participant-owned network facilities, in the same request for proposals. Requests for proposals must provide sufficient detail so that cost-effectiveness can be evaluated over the useful life of the proposed network facility to be constructed.

(2) Support for participant-constructed and owned network facilities is only available where the consortium demonstrates that constructing its own network facilities is the most cost-effective option after competitive bidding, pursuant to § 54.642.

(b) [Reserved].

■ 25. Add § 54.637 to subpart G to read as follows:

§ 54.637 Off-site data centers and off-site administrative offices.

(a) The connections and network equipment associated with off-site data centers and off-site administrative offices used by eligible health care providers for their health care purposes are eligible for support under the Healthcare Connect Fund, subject to the conditions and restrictions set forth in paragraph (b) of this section.

(1) An ''off-site administrative office'' is a facility that does not provide hands-on delivery of patient care, but performs administrative support functions that are critical to the provision of clinical care by eligible health care providers.

(2) An ''off-site data center'' is a facility that serves as a centralized repository for the storage, management, and dissemination of an eligible health care provider's computer systems, associated components, and data, including (but not limited to) electronic health records.

(b) *Conditions and Restrictions.* The following conditions and restrictions apply to support provided under this sections.

(1) Connections eligible for support are only those that are between:

(i) Eligible health care provider sites and off-site data centers or off-site administrative offices,

(ii) Two off-site data centers,

(iii) Two off-site administrative offices,

(iv) An off-site data center and the public Internet or another network,

(v) An off-site administrative office and the public Internet or another network, or

(vi) An off-site administrative office and an off-site data center.

(2) The supported connections and network equipment must be used solely for health care purposes.

(3) The supported connections and network equipment must be purchased by an eligible health care provider or a public or non-profit health care system that owns and operates eligible health care provider sites.

(4) If traffic associated with one or more ineligible health care provider sites is carried by the supported connection and/or network equipment, the ineligible health care provider sites must allocate the cost of that connection and/or equipment between eligible and ineligible sites, consistent with the ''fair share'' principles set forth in § 54.639(d).

■ 26. Add § 54.638 to subpart G to read as follows:

§ 54.638 Upfront payments.

(a) Upfront payments include all non-recurring costs for services, equipment, or facilities, other than reasonable and customary installation charges of up to $5,000.

(b) The following limitations apply to all upfront payments:

(1) Upfront payments associated with services providing a bandwidth of less than 1.5 Mbps (symmetrical) are not eligible for support.

(2) Only consortium applicants are eligible for support for upfront payments.

(c) The following limitations apply if a consortium makes a request for support for upfront payments that exceeds, on average, $50,000 per eligible site in the consortium:

(1) The support for the upfront payments must be prorated over at least three years.

(2) The upfront payments must be part of a multi-year contract.

■ 27. Add § 54.639 to subpart G to read as follows:

§ 54.639 Ineligible expenses.

(a) Equipment or services not directly associated with eligible services. Expenses associated with equipment or services that are not necessary to make an eligible service functional, or to manage, control, or maintain an eligible service or a dedicated health care broadband network are ineligible for support.

Note to Paragraph (a): The following are examples of ineligible expenses:

1. Costs associated with general computing, software, applications, and Internet content development are not supported, including the following:

i. Computers, including servers, and related hardware (*e.g.,* printers, scanners, laptops), unless used exclusively for network management, maintenance, or other network operations;

ii. End user wireless devices, such as smartphones and tablets;

iii. Software, unless used for network management, maintenance, or other network operations;

iv. Software development (excluding development of software that supports network management, maintenance, and other network operations);

v. Helpdesk equipment and related software, or services, unless used exclusively in support of eligible services or equipment;

vi. Web server hosting;

vii. Web site portal development;

viii. Video/audio/web conferencing equipment or services; and

ix. Continuous power source.

2. Costs associated with medical equipment (hardware and software), and other general health care provider expenses are not supported, including the following:

i. Clinical or medical equipment;

ii. Telemedicine equipment, applications, and software;

iii. Training for use of telemedicine equipment;

iv. Electronic medical records systems; and

v. Electronic records management and expenses.

(b) Inside wiring/internal connections. Expenses associated with inside wiring or internal connections are ineligible for support under the Healthcare Connect Fund.

(c) Administrative expenses. Administrative expenses are not eligible for support under the Healthcare Connect Fund.

Note to Paragraph (c): Ineligible administrative expenses include, but not limited to, the following expenses:

1. Personnel costs (including salaries and fringe benefits), except for personnel expenses in a consortium application that directly relate to designing, engineering, installing, constructing, and managing a dedicated broadband network. Ineligible costs of this category include, for example, personnel to perform program management and coordination, program administration, and marketing;

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

3. Legal costs;

4. Training, except for basic training or instruction directly related to and required for broadband network installation and associated network operations;

5. Program administration or technical coordination (*e.g.,* preparing application materials, obtaining letters of agency, preparing request for proposals, negotiating with vendors, reviewing bids, and working with the Administrator) that involves anything other than the design, engineering, operations, installation, or construction of the network;

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

7. Billing expenses (*e.g.,* expense that vendors may charge for allocating costs to each health care provider in a network);

8. Helpdesk expenses (*e.g.,* equipment and related software, or services); and

9. Technical support services that provide more than basic maintenance.

(d) Cost allocation for ineligible sites, services, or equipment. (1) Ineligible sites. Eligible health care provider sites may share expenses with ineligible sites, as long as the ineligible sites pay their fair share of the expenses. An applicant may seek support for only the portion of a shared eligible expense attributable to eligible health care provider sites. To receive support, the applicant must ensure that ineligible sites pay their fair share of the expense. The fair share is determined as follows:

(i) If the vendor charges a separate and independent price for each site, an ineligible site must pay the full undiscounted price.

(ii) If there is no separate and independent price for each site, the applicant must prorate the undiscounted price for the ''shared'' service, equipment, or facility between eligible and ineligible sites on a proportional fully-distributed basis. Applicants must make this cost allocation using a method that is based on objective criteria and reasonably reflects the eligible usage of the shared service, equipment, or facility. The applicant bears the burden of demonstrating the reasonableness of the allocation method chosen.

(2) *Ineligible components of a single service or piece of equipment.* Applicants seeking support for a service or piece of equipment that includes an ineligible component must explicitly request in their requests for proposals that vendors include pricing for a comparable service or piece of equipment that is comprised of only eligible components. If the selected provider also submits a price for the eligible component on a stand-alone basis, the support amount is calculated based on the stand-alone price of the eligible component on a stand-alone basis. If the vendor does not offer the eligible component on a stand-alone basis, the full price of the entire service or piece of equipment must be taken into account, without regard to the value of the ineligible components, when determining the most cost-effective bid.

(3) *Written description.* Applicants must submit a written description of their allocation method(s) to the Administrator with their funding requests.

(4) *Written agreement.* If ineligible entities participate in a network, the allocation method must be memorialized in writing, such as a formal agreement among network members, a master services contract, or for smaller consortia, a letter signed and dated by all (or each) ineligible entity and the Consortium Leader.

■ 28. Add § 54.640 to subpart G to read as follows:

§ 54.640 Eligible vendors.

(a) *Eligibility.* For purposes of the Healthcare Connect Fund, eligible vendors shall include any provider of equipment, facilities, or services that are eligible for support under Healthcare Connect Fund.

(b) *Obligation to assist health care providers.* Vendors in the Healthcare Connect Fund must certify, as a condition of receiving support, that they will provide to health care providers, on a timely basis, all information and documents regarding supported equipment, facilities, or services that are necessary for the health care provider to submit required forms or respond to Commission or Administrator inquiries. The Administrator may withhold disbursements for the vendor if the vendor, after written notice from the Administrator, fails to comply with this requirement.

■ 29. Add § 54.642 to subpart G to read as follows:

§ 54.642 Competitive bidding requirement and exemptions.

(a) *Competitive bidding requirement.* All applicants are required to engage in a competitive bidding process for supported services, facilities, or equipment consistent with the requirements set forth in this subpart, unless they qualify for one or more of the exemptions in paragraph (h) of this section. In addition, applicants may engage in competitive bidding even if they qualify for an exemption. Applicants who utilize a competitive bidding exemption may proceed directly to filing a funding request as described in § 54.643.

(b) *Fair and open process.* (1) All entities participating in the Healthcare Connect Fund must conduct a fair and open competitive bidding process, consistent with all applicable requirements.

(2) Vendors who intend to bid to provide supported services, equipment, or facilities to a health care provider may not simultaneously help the health care provider choose a winning bid. Any vendor who submits a bid, and any individual or entity that has a financial interest in such a vendor, is prohibited from:

(i) Preparing, signing or submitting an applicant's request for services;

(ii) Serving as the Consortium Leader or other point of contact on behalf of applicant(s);

(iii) Being involved in setting bid evaluation criteria; or

(iv) Participating in the bid evaluation or vendor selection process (except in their role as potential vendors).

(3) All potential bidders must have access to the same information and must be treated in the same manner.

(4) All applicants and vendors must comply with any applicable state, Tribal, or local competitive bidding requirements. The competitive bidding requirements in this section apply in addition to state, Tribal, and local competitive bidding requirements and are not intended to preempt such state, Tribal, or local requirements.

(c) *Cost-effective.* For purposes of the Healthcare Connect Fund, ''cost-effective'' is defined as the method that costs the least after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems relevant to

choosing a method of providing the required health care services.

(d) *Bid evaluation criteria.* Applicants must develop weighted evaluation criteria (*e.g.,* scoring matrix) that demonstrate how the applicant will choose the most ''cost-effective'' bid before submitting a Request for Services. Price must be a primary factor, but need not be the only primary factor. A non-price factor can receive an equal weight to price, but may not receive a greater weight than price.

(e) *Request for services.* Applicants must submit the following documents to the Administrator in order to initiate competitive bidding.

(1) *Form 461, including certifications.* The applicant must provide the following certifications as part of the request for services.

(i) The person signing the application is authorized to submit the application on behalf of the applicant and has examined the form and all attachments, and to the best of his or her knowledge, information, and belief, all statements of fact contained therein are true.

(ii) The applicant has followed any applicable state, Tribal, or local procurement rules.

(iii) All Healthcare Connect Fund support will be used solely for purposes reasonably related to the provision of health care service or instruction that the HCP is legally authorized to provide under the law of the state in which the services are provided and will not be sold, resold, or transferred in consideration for money or any other thing of value.

(iv) The applicant satisfies all of the requirements under section 254 of the Act and applicable Commission rules.

(v) The applicant has reviewed all applicable requirements for the program and will comply with those requirements.

(2) *Bid evaluation criteria.* Requirements for bid evaluation criteria are described in paragraph (d) of this section.

(3) *Declaration of assistance.* All applicants must submit a ''Declaration of Assistance'' with their Request for Services. In the Declaration of Assistance, applicants must identify each and every consultant, vendor, and other outside expert, whether paid or unpaid, who aided in the preparation of their applications.

(4) *Request for proposal (if applicable).* (i) Any applicant may use a request for proposals (RFP). Applicants who use an RFP must submit the RFP and any additional relevant bidding information to the Administrator with Form 461.

(ii) An applicant must submit an RFP:

(A) If it is required to issue an RFP under applicable State, Tribal, or local procurement rules or regulations;

(B) If the applicant is a consortium seeking more than $100,000 in program support during the funding year, including applications that seek more than $100,000 in program support for a multi-year commitment; or

(C) If the applicant is a consortium seeking support for participant-constructed and owned network facilities.

(iii) RFP requirements. (A) An RFP must provide sufficient information to enable an effective competitive bidding process, including describing the health care provider's service needs and defining the scope of the project and network costs (if applicable).

(B) An RFP must specify the period during which bids will be accepted.

(C) An RFP must include the bid evaluation criteria described in paragraph (d) of this section, and solicit sufficient information so that the criteria can be applied effectively.

(D) Consortium applicants seeking support for long-term capital investments whose useful life extends beyond the period of the funding commitment (*e.g.,* facilities constructed and owned by the applicant, fiber indefeasible rights of use) must seek bids in the same RFP from vendors who propose to meet those needs via services provided over vendor-owned facilities, for a time period comparable to the life of the proposed capital investment.

(E) Applicants may prepare RFPs in any manner that complies with the rules in this subpart and any applicable state, Tribal, or local procurement rules or regulations.

(5) *Additional requirements for consortium applicants. (i) Network plan.* Consortium applicants must submit a narrative describing specific elements of their network plan with their Request for Services. Consortia applicants are required to use program support for the purposes described in their narrative. The required elements of the narrative include:

(A) Goals and objectives of the network;

(B) Strategy for aggregating the specific needs of health care providers (including providers that serve rural areas) within a state or region;

(C) Strategy for leveraging existing technology to adopt the most efficient and cost effective means of connecting those providers;

(D) How the supported network will be used to improve or provide health care delivery;

(E) Any previous experience in developing and managing health information technology (including telemedicine) programs; and

(F) A project management plan outlining the project's leadership and management structure, and a work plan, schedule, and budget.

(ii) *Letters of agency.* Consortium applicants must submit letters of agency pursuant to § 54.632.

(f) *Public posting by the Administrator.* The Administrator shall post on its web site the following competitive bidding documents, as applicable:

(1) Form 461,

(2) Bid evaluation criteria,

(3) Request for proposal, and

(4) Network plan.

(g) *28-day waiting period.* After posting the documents described in paragraph (f) of this section on its Web site, the Administrator shall send confirmation of the posting to the applicant. The applicant shall wait at least 28 days from the date on which its competitive bidding documents are posted on the Web site before selecting and committing to a vendor.

(1) *Selection of the most ''cost-effective'' bid and contract negotiation.* Each applicant subject to competitive bidding is required to certify to the Administrator that the selected bid is, to the best of the applicant's knowledge, the most cost-effective option available. Applicants are required to submit the documentation listed in § 54.643 to support their certifications.

(2) Applicants who plan to request evergreen status under § 54.642(h)(4)(ii) must enter into a contract that identifies both parties, is signed and dated by the health care provider or Consortium Leader after the 28-day waiting period expires, and specifies the type, term, and cost of service.

(h) *Exemptions to competitive bidding requirements. (1) Annual undiscounted cost of $10,000 or less.* An applicant that seeks support for $10,000 or less of total undiscounted eligible expenses for a single year is exempt from the competitive bidding requirements under this section, if the term of the contract is one year or less.

(2) Government Master Service Agreement (MSA). Eligible health care providers that seek support for services and equipment purchased from MSAs negotiated by federal, state, Tribal, or local government entities on behalf of such health care providers and others, if such MSAs were awarded pursuant to applicable federal, state, Tribal, or local competitive bidding requirements, are exempt from the competitive bidding requirements under this section.

(3) Master Service Agreements approved under the Pilot Program or

Healthcare Connect Fund. A eligible health care provider site may opt into an existing MSA approved under the Pilot Program or Healthcare Connect Fund and seek support for services and equipment purchased from the MSA without triggering the competitive bidding requirements under this section, if the MSA was developed and negotiated in response to an RFP that specifically solicited proposals that included a mechanism for adding additional sites to the MSA.

(4) Evergreen contracts. (i) Subject to the provisions in § 54.644, the Administrator may designate a multi-year contract as ''evergreen,'' which means that the service(s) covered by the contract need not be re-bid during the contract term.

(ii) A contract entered into by a health care provider or consortium as a result of competitive bidding may be designated as evergreen if it meets all of the following requirements:

(A) Is signed by the individual health care provider or consortium lead entity;

(B) Specifies the service type, bandwidth and quantity;

(C) Specifies the term of the contract;

(D) Specifies the cost of services to be provided; and

(E) Includes the physical location or other identifying information of the health care provider sites purchasing from the contract.

(iii) Participants may exercise voluntary options to extend an evergreen contract without undergoing additional competitive bidding, if:

(A) The voluntary extension(s) is memorialized in the evergreen contract;

(B) The decision to extend the contract occurs before the participant files its funding request for the funding year when the contract would otherwise expire; and

(C) The voluntary extension(s) do not exceed five years in the aggregate.

(5) Schools and libraries program master contracts. Subject to the provisions in §§ 54.500(g), 54.501(c)(1), and 54.503, an eligible health care provider in a consortium with participants in the schools and libraries universal service support program and a party to the consortium's existing contract is exempt from the Healthcare Connect Fund competitive bidding requirements if the contract was approved in the schools and libraries universal service support program as a master contract. The health care provider must comply with all Healthcare Connect Fund rules and procedures except for those applicable to competitive bidding.

■ 30. Add § 54.643 to subpart G to read as follows:

§ 54.643 Funding commitments.

(a) Once a vendor is selected, applicants must submit a ''Funding Request'' (and supporting documentation) to provide information about the services, equipment, or facilities selected and certify that the services selected were the most cost-effective option of the offers received. The following information should be submitted to the Administrator with the Funding Request.

(1) *Request for funding.* The applicant shall submit a request for funding (Form 462) to identify the service(s), equipment, or facilities; rates; vendor(s); and date(s) of vendor selection.

(2) *Certifications.* The applicant must provide the following certifications as part of the request for funding:

(i) The person signing the application is authorized to submit the application on behalf of the applicant and has examined the form and all attachments, and to the best of his or her knowledge, information, and belief, all statements of fact contained therein are true.

(ii) Each vendor selected is, to the best of the applicant's knowledge, information and belief, the most cost-effective vendor available, as defined in § 54.642(c).

(iii) All Healthcare Connect Fund support will be used only for eligible health care purposes.

(iv) The applicant is not requesting support for the same service from both the Telecommunications Program and the Healthcare Connect Fund.

(v) The applicant satisfies all of the requirements under section 254 of the Act and applicable Commission rules, and understands that any letter from the Administrator that erroneously commits funds for the benefit of the applicant may be subject to rescission.

(vi) The applicant has reviewed all applicable requirements for the program and will comply with those requirements.

(vii) The applicant will maintain complete billing records for the service for five years.

(3) *Contracts or other documentation.* All applicants must submit a contract or other documentation that clearly identifies the vendor(s) selected and the health care provider(s) who will receive the services, equipment, or facilities; the service, bandwidth, and costs for which support is being requested; and the term of the service agreement(s) if applicable (*i.e.,* if services are not being provided on a month-to-month basis). For services, equipment, or facilities provided under contract, the applicant must submit a copy of the contract signed and dated (after the Allowable Contract Selection Date) by the individual health care provider or Consortium Leader. If the service, equipment, or facilities are not being provided under contract, the applicant must submit a bill, service offer, letter, or similar document from the vendor that provides the required information.

(4) *Competitive bidding documents.* Applicants must submit documentation to support their certifications that they have selected the most cost-effective option, including a copy of each bid received (winning, losing, and disqualified), the bid evaluation criteria, and the following documents (as applicable): bid evaluation sheets; a list of people who evaluated bids (along with their title/role/relationship to the applicant organization); memos, board minutes, or similar documents related to the vendor selection/award; copies of notices to winners; and any correspondence with vendors during the bidding/evaluation/award phase of the process. Applicants who claim a competitive bidding exemption must submit relevant documentation to allow the Administrator to verify that the applicant is eligible for the claimed exemption.

(5) *Cost allocation for ineligible entities or components.* Pursuant to § 54.639(d)(3) through (d)(4), where applicable, applicants must submit a description of how costs will be allocated for ineligible entities or components, as well as any agreements that memorialize such arrangements with ineligible entities.

(6) *Additional documentation for consortium applicants.* A consortium applicant must also submit the following:

(i) Any revisions to the network plan submitted with the Request for Services pursuant to § 54.642(e)(5)(i), as necessary. If not previously submitted, the consortium should provide a narrative description of how the network will be managed, including all administrative aspects of the network, including but not limited to invoicing, contractual matters, and network operations. If the consortium is required to provide a sustainability plan as set forth in § 54.643(a)(6)(iv), the revised budget should include the budgetary factors discussed in the sustainability plan requirements.

(ii) A list of participating health care providers and all of their relevant information, including eligible (and ineligible, if applicable) cost information for each participating health care provider.

(iii) Evidence of a viable source for the undiscounted portion of supported costs.

(iv) Sustainability plans for applicants requesting support for long-term capital expenses: Consortia that seek funding to construct and own their own facilities or obtain indefeasible right of use or capital lease interests are required to submit a sustainability plan with their funding requests demonstrating how they intend to maintain and operate the facilities that are supported over the relevant time period. Applicants may incorporate by reference other portions of their applications (*e.g.,* project management plan, budget). The sustainability plan must, at a minimum, address the following points:

(A) *Projected sustainability period.* Indicate the sustainability period, which at a minimum is equal to the useful life of the funded facility. The consortium's budget must show projected income and expenses (*i.e.,* for maintenance) for the project at the aggregate level, for the sustainability period.

(B) *Principal factors.* Discuss each of the principal factors that were considered by the participant to demonstrate sustainability. This discussion must include all factors that show that the proposed network will be sustainable for the entire sustainability period. Any factor that will have a monetary impact on the network must be reflected in the applicant's budget.

(C) *Terms of membership in the network.* Describe generally any agreements made (or to be entered into) by network members (*e.g.,* participation agreements, memoranda of understanding, usage agreements, or other similar agreements). The sustainability plan must also describe, as applicable:

(*1*) Financial and time commitments made by proposed members of the network;

(*2*) If the project includes excess bandwidth for growth of the network, describe how such excess bandwidth will be financed; and

(*3*) If the network will include ineligible health care providers and other network members, describe how fees for joining and using the network will be assessed.

(D) *Ownership structure.* Explain who will own each material element of the network (*e.g.,* fiber constructed, network equipment, end user equipment). For purposes of this subsection, ''ownership'' includes an indefeasible right of use interest. Applicants must clearly identify the legal entity that will own each material element. Applicants must also describe any arrangements made to ensure continued use of such elements by the network members for the duration of the sustainability period.

(E) *Sources of future support.* Describe other sources of future funding, including fees to be paid by eligible health care providers and/or non-eligible entities.

(F) *Management.* Describe the management structure of the network for the duration of the sustainability period. The applicant's budget must describe how management costs will be funded.

(v) *Material change to sustainability plan.* A consortium that is required to file a sustainability plan must maintain its accuracy. If there is a material change to a required sustainability plan that would impact projected income or expenses by more than 20 percent or $100,000 from the previous submission, or if the applicant submits a funding request based on a new Form 462 (*i.e.,* a new competitively bid contract), the consortium is required to re-file its sustainability plan. In the event of a material change, the applicant must provide the Administrator with the revised sustainability plan no later than the end of the relevant quarter, clearly showing (*i.e.,* by redlining or highlighting) what has changed.

(b) [Reserved]

■ 31. Add § 54.644 to subpart G to read as follows:

§ 54.644 Multi-year commitments.

(a) Participants in the Healthcare Connect Fund are permitted to enter into multi-year contracts for eligible expenses and may receive funding commitments from the Administrator for a period that covers up to three funding years.

(b) If a long-term contract covers a period of more than three years, the applicant may also have the contract designated as ''evergreen'' under § 54.642(h)(4) which will allow the applicant to re-apply for a funding commitment under the contract after three years without having to undergo additional competitive bidding.

■ 32. Add § 54.645 to subpart G to read as follows:

§ 54.645 Payment process.

(a) The Consortium Leader (or health care provider, if participating individually) must certify to the Administrator that it has paid its contribution to the vendor before the invoice can be sent to Administrator and the vendor can be paid.

(b) Before the Administrator may process and pay an invoice, both the Consortium Leader (or health care provider, if participating individually) and the vendor must certify that they have reviewed the document and that it is accurate. All invoices must be received by the Administrator within six months of the end date of the funding commitment.

■ 33. Add § 54.646 to subpart G to read as follows:

§ 54.646 Site and service substitutions.

(a) A Consortium Leader (or health care provider, if participating individually) may request a site or service substitution if:

(1) The substitution is provided for in the contract, within the change clause, or constitutes a minor modification;

(2) The site is an eligible health care provider and the service is an eligible service under the Healthcare Connect Fund;

(3) The substitution does not violate any contract provision or state, Tribal, or local procurement laws; and

(4) The requested change is within the scope of the controlling request for services, including any applicable request for proposal used in the competitive bidding process.

(b) Support for a qualifying site and service substitution will be provided to the extent the substitution does not cause the total amount of support under the applicable funding commitment to increase.

■ 34. Add § 54.647 to subpart G to read as follows:

§ 54.647 Data collection and reporting.

(a) Each consortium lead entity must file an annual report with the Administrator on or before September 30 for the preceding funding year, with the information and in the form specified by the Wireline Competition Bureau.

(b) Each consortium is required to file an annual report for each funding year in which it receives support from the Healthcare Connect Fund.

(c) For consortia that receive large upfront payments, the reporting requirement extends for the life of the supported facility.

■ 35. Add § 54.648 to subpart G to read as follows:

§ 54.648 Audits and recordkeeping.

(a) *Random audits.* Participants shall be subject to random compliance audits and other investigations to ensure compliance with program rules and orders.

(b) *Recordkeeping.* (1) Participants, including Consortium Leaders and health care providers, shall maintain records to document compliance with program rules and orders for at least 5 years after the last day of service delivered in a particular funding year. Participants who receive support for long-term capital investments in

facilities whose useful life extends beyond the period of the funding commitment shall maintain records for at least 5 years after the end of the useful life of the facility. Participants shall maintain asset and inventory records of supported network equipment to verify the actual location of such equipment for a period of 5 years after purchase.

(2) Vendors shall retain records related to the delivery of supported services, facilities, or equipment to document compliance with program rules and orders for at least 5 years after the last day of the delivery of supported services, equipment, or facilities in a particular funding year.

(3) Both participants and vendors shall produce such records at the request of the Commission, any auditor appointed by the Administrator or the Commission, or of any other state or federal agency with jurisdiction.

■ 36. Add § 54.649 to subpart G to read as follows:

§ 54.649 Certifications.

For individual health care provider applicants, required certifications must be provided and signed by an officer or director of the health care provider, or other authorized employee of the health care provider. For consortium applicants, an officer, director, or other authorized employee of the Consortium Leader must sign the required certifications. Pursuant to § 54.680, electronic signatures are permitted for all required certifications.

■ 37. Add § 54.671 to subpart G and an undesignated center heading to read as follows:

General Provisions

§ 54.671 Resale.

(a) *Prohibition on resale.* Services purchased pursuant to universal service support mechanisms under this subpart shall not be sold, resold, or transferred in consideration for money or any other thing of value.

(b) *Permissible fees.* The prohibition on resale set forth in paragraph (a) of this section shall not prohibit a health care provider from charging normal fees for health care services, including instruction related to services purchased with support provided under this subpart.

■ 38. Add § 54.672 to subpart G to read as follows:

§ 54.672 Duplicate support.

(a) Eligible health care providers that seek support under the Healthcare Connect Fund for telecommunications services may not also request support from the Telecommunications Program for the same services.

(b) Eligible health care providers that seek support under the Telecommunications Program or the Healthcare Connect Fund may not also request support from any other universal service program for the same expenses.

■ 39. Add § 54.675 to subpart G to read as follows:

§ 54.675 Cap.

(a) *Amount of the annual cap.* The aggregate annual cap on federal universal service support for health care providers shall be $400 million per funding year, of which up to $150 million per funding year will be available to support upfront payments and multi-year commitments under the Healthcare Connect Fund.

(b) *Funding year.* A funding year for purposes of the health care providers cap shall be the period July 1 through June 30.

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

(1) Generally, funds shall be available to eligible health care providers on a first-come-first-served basis, with requests accepted beginning on the first of January prior to each funding year.

(2) For the Telecommunications Program and the Healthcare Connect Fund, the Administrator shall implement a filing window period that treats all eligible health care providers filing within the window period as if their applications were simultaneously received.

(3) [Reserved]

(4) The deadline to submit a funding commitment request under the Telecommunications Program and the Healthcare Connect Fund is June 30 for the funding year that begins on the previous July 1.

(d) *Annual filing requirement.* Health care providers shall file new funding requests for each funding year, except for health care providers who have received a multi-year funding commitment under § 54.644.

(e) *Long-term contracts.* If health care providers enter into long-term contracts for eligible services, the Administrator shall only commit funds to cover the portion of such a long-term contract scheduled to be delivered during the funding year for which universal service support is sought, except for multi-year funding commitments as described in § 54.644.

(f) *Pro-rata reductions for Telecommunications Program support.* The Administrator shall act in accordance with this section when a filing window period for the Telecommunications Program and the Healthcare Connect Fund, as described in paragraph (c)(2) of this section, is in effect. When a filing window period described in paragraph (c)(2) of this section closes, the Administrator shall calculate the total demand for Telecommunications Program and Healthcare Connect Fund support submitted by all applicants during the filing window period. If the total demand during a filing window period exceeds the total remaining support available for the funding year, the Administrator shall take the following steps:

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

(2) The Administrator shall calculate the amount of Telecommunications Program and Healthcare Connect Fund support requested by each applicant that has filed during the filing window.

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

■ 40. Add § 54.679 to subpart G to read as follows:

§ 54.679 Election to offset support against annual universal service fund contribution.

(a) A service provider that contributes to the universal service support mechanisms under subpart H of this part and also provides services eligible for support under this subpart to eligible health care providers may, at the election of the contributor:

(1) Treat the amount eligible for support under this subpart as an offset against the contributor's universal service support obligation for the year in which the costs for providing eligible services were incurred; or

(2) Receive direct reimbursement from the Administrator for that amount.

(b) Service providers that are contributors shall elect in January of each year the method by which they will be reimbursed and shall remain subject to that method for the duration of the calendar year. Any support amount that is owed a service provider that fails to remit its monthly universal service contribution obligation, however, shall first be applied as an offset to that contributor's contribution

obligation. Such a service provider shall remain subject to the offsetting method for the remainder of the calendar year in which it failed to remit its monthly universal service obligation. A service provider that continues to be in arrears on its universal service contribution obligations at the end of a calendar year shall remain subject to the offsetting method for the next calendar year.

(c) If a service provider providing services eligible for support under this subpart elects to treat that support amount as an offset against its universal service contribution obligation and the total amount of support owed exceeds its universal service obligation, calculated on an annual basis, the service provider shall receive a direct reimbursement in the amount of the difference. Any such reimbursement due a service provider shall be provided by the Administrator no later than the end of the first quarter of the calendar year following the year in which the costs were incurred and the offset against the contributor's universal service obligation was applied.

■ 41. Add § 54.680 to subpart G to read as follows:

§ 54.680 Validity of electronic signatures.

(a) For the purposes of this subpart, an electronic signature (defined by the Electronic Signatures in Global and National Commerce Act, as an electronic sound, symbol, or process, attached to or logically associated with a contract or other record and executed or adopted by a person with the intent to sign the record) has the same legal effect as a written signature.

(b) For the purposes of this subpart, an electronic record (defined by the Electronic Signatures in Global and National Commerce Act, as a contract or other record created, generated, sent, communicated, received, or stored by electronic means) constitutes a record.

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