APPENDIX D

Final Rules

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

PART 54—UNIVERSAL SERVICE

Subpart A – General Information

1. Amend § 54.5, to delete the definition of "rural area" for the health care universal service support mechanism, to read as follows:

§ 54.5 Terms and definitions.

*** * ***

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

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Subpart G – Universal Service Support for Health Care Providers

2. The authority citation continues to read as follows:

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

3. After giving effect to the amendments herein, the un-numbered index for Subpart G reads as follows:

DEFINED TERMS AND ELIGIBILITY

§ 54.600 Terms and definitions.
§ 54.601 Health care provider eligibility.
§ 54.602 Health care support mechanism.

TELECOMMUNICATIONS PROGRAM

§ 54.603 Competitive bidding requirements.
§ 54.604 Telecommunications services.
§ 54.605 Determining the urban rate.
§ 54.607 Determining the rural rate.
§ 54.609 Calculating support.
§ 54.613 Limitations on supported services for rural health care providers.
§ 54.615 Obtaining services.
§ 54.619 Audits and recordkeeping.
§ 54.625 Support for services beyond the maximum supported distance for rural health care providers.

HEALTHCARE CONNECT FUND

GENERAL PROVISIONS

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

DEFINED TERMS AND ELIGIBILITY

5. Add Section 54.600, to read as follows:

§ 54.600 Terms and definitions.

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

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

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

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

(3) Local health department or agency;

(4) Community mental health center;

(5) Not-for-profit hospital;

(6) Rural health clinic; or

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

(b) *Rural area*.

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

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

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

6. Amend Section 54.601 to revise paragraph (a) and add new paragraph (b), to read as follows:

§ 54.601 Health care provider eligibility.

(a) *Eligible health care providers*.

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

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

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

7. Add Section 54.602, to read as follows:

§ 54.602 Health care support mechanism.

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

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

through 54.602 and sections 54.630 through 54.680. This support is referred to as the "Healthcare Connect Fund."

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

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

8. Add an undesignated centered heading above Section 54.603, to read as follows:

TELECOMMUNICATIONS PROGRAM

9. Amend Section 54.603 to revise the section heading and paragraphs (a) and (b), to read as follows:

§ 54.603 Competitive bidding and certification requirements.

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

(b) *Posting of FCC Form 465.*

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

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

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

(iii) Deleted.

(iv) * * *

(v) * * *

(vi) * * *

(2) * * *

(3) * * *

(4) * * *

(5) * * *

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

§ 54.604 Consortia, telecommunications services, and existing contracts.

(a) *Consortia.*

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

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

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

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

(1) * * *

(d) * * *

(e) * * *

11. Amend Section 54.605 to revise paragraphs (a), to read as follows:

§ 54.605 Determining the urban rate.

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

(b) * * *

(c) * * *

(d) * * *

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

§ 54.609 Calculating support.

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

(1) * * *

(i) * * *

(ii) * * *

(iii) * * *

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

(2) * * *

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

(b) * * *

(c) * * *

(d) *Satellite services.*

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

(2) Rural health care providers seeking support from the Telecommunications Program for

satellite services shall provide to the Administrator with the Form 466, documentation of the urban and rural rates for the terrestrial-based alternatives.

(3) * * *

(e) *Mobile rural health care providers—*

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

(2) * * *

13. Redesignate § 54.611 [Offset Election] as § 54.679.

14. Amend Section 54.613 to delete paragraph (b), to read as follows:

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

(a) * * *

(b) Deleted.

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

§ 54.615 Obtaining services.

(a) * * *

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

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

(1) * * *

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

(3) Deleted;

(4) * * *

(5) * * *

(6) * * *

(7) * * *

(d) * * *

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

17. Amend Section 54.619 paragraphs (a) and (d), to read as follows:

§ 54.619 Audits and recordkeeping.

(a) *Health care providers.*

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

(2) * * *

(b) * * *

(c) * * *

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

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

19. Amend Section 54.623 to revise the section heading, redesignate paragraphs (a)-(c) and (f) as Section 54.675, redesignate paragraph (d) as paragraph (a), redesignate paragraph (e) as paragraph (b), and revise redesignated paragraphs (a) and (b), to read as follows:

§ 54.623 Annual filing and funding commitment requirement.

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

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

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

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

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

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

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

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

HEALTHCARE CONNECT FUND

22. Add Section 54.630, to read as follows:

§ 54.630 Eligible recipients.

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

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

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

23. Add Section 54.631, to read as follows:

§ 54.631 Designation of Consortium Leader.

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

(b) *Consortium Leader eligibility*. The Consortium Leader may be the consortium itself (if it is a distinct legal entity); an eligible health care provider participating in the consortium; or a state organization,

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

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

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

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

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

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

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

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

24. Add Section 54.632, to read as follows:

§ 54.632 Letters of agency (LOA).

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

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

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

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

(c) *Required Information in LOA.*

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

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

25. Add Section 54.633, to read as follows:

§ 54.633 Health care provider contribution.

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

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

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

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

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

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

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

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

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

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

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

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

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

26. Add Section 54.634, to read as follows:

§ 54.634 Eligible services.

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

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

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

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

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

(c) *Dark and lit fiber maintenance costs*.

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

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

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

(e) *Upfront charges for vendor deployment of new or upgraded facilities*.

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

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

27. Add Section 54.635, to read as follows:

§ 54.635 Eligible equipment.

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

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

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

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

(2) Computers, including servers, and related hardware (e.g. printers, scanners, laptops) that are used exclusively for network management;

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

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

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

(d) *Additional Limitations*. Support for network equipment is limited to equipment (i) purchased or leased by a Consortium Leader or eligible health care provider and (ii) used for health care purposes.

28. Add Section 54.636, to read as follows:

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

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

(1) Consortia seeking support to construct and own network facilities are required to solicit bids for both (i) services provided over third-party networks and (ii) construction of participant-owned network facilities, in the same request for proposals. Requests for proposals must provide sufficient detail so that cost-effectiveness can be evaluated over the useful life of the proposed network facility to be constructed.

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

29. Add Section 54.637, to read as follows:

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

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

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

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

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

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

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

(ii) two off-site data centers,

(iii) two off-site administrative offices,

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

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

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

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

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

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

30. Add Section 54.638, to read as follows:

§ 54.638 Upfront payments.

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

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

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

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

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

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

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

31. Add Section 54.639, to read as follows:

§ 54.639 Ineligible expenses.

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

NOTE TO PARAGRAPH (a): The following are examples of ineligible expenses.

(1) Costs associated with general computing, software, applications, and Internet content development are not supported, including the following:
   (i) Computers, including servers, and related hardware (*e.g.*, printers, scanners, laptops), unless used exclusively for network management, maintenance, or other network operations;
   (ii) End user wireless devices, such as smartphones and tablets;
   (iii) Software, unless used for network management, maintenance, or other network operations;
   (iv) Software development (excluding development of software that supports network management, maintenance, and other network operations);
   (v) Helpdesk equipment and related software, or services, unless used exclusively in support of eligible services or equipment;
   (vi) Web server hosting;
   (vii) Website portal development;
   (viii) Video/audio/web conferencing equipment or services; and
   (ix) Continuous power source.

(2) Costs associated with medical equipment (hardware and software), and other general health care provider expenses are not supported, including the following:
   (i) Clinical or medical equipment;
   (ii) Telemedicine equipment, applications, and software;
   (iii) Training for use of telemedicine equipment;
   (iv) Electronic medical records systems; and
   (v) Electronic records management and expenses.

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

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

NOTE TO PARAGRAPH (c): Ineligible administrative expenses include, but not limited to, the following expenses:

(1) Personnel costs (including salaries and fringe benefits), except for personnel expenses in a consortium application that directly relate to designing, engineering, installing, constructing, and managing a dedicated broadband network. Ineligible costs of this category include, for example, personnel to perform program management and coordination, program administration, and marketing;
(2) Travel costs, except for travel costs that are reasonable and necessary for network design or deployment and that are specifically identified and justified as part of a competitive bid for a construction project;
(3) Legal costs;
(4) Training, except for basic training or instruction directly related to and required for broadband network installation and associated network operations;
(5) Program administration or technical coordination (*e.g.*, preparing application materials, obtaining letters of agency, preparing request for proposals, negotiating with vendors, reviewing bids, and working with the Administrator) that involves anything other than the design, engineering, operations, installation, or construction of the network;

(6) Administration and marketing costs (*e.g.*, administrative costs; supplies and materials, except as part of network installation/construction; marketing studies, marketing activities, or outreach to potential network members; evaluation and feedback studies);
(7) Billing expenses (*e.g.*, expense that vendors may charge for allocating costs to each health care provider in a network);
(8) Helpdesk expenses (*e.g.*, equipment and related software, or services); and
(9) Technical support services that provide more than basic maintenance.

(d) *Cost allocation for ineligible sites, services, or equipment*.

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

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

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

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

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

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

32. Add Section 54.640, to read as follows:

§ 54.640 Eligible vendors.

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

(b) *Obligation to assist health care providers*. Vendors in the Healthcare Connect Fund must certify, as a condition of receiving support, that they will provide to health care providers, on a timely basis, all

information and documents regarding supported equipment, facilities, or services that are necessary for the health care provider to submit required forms or respond to Commission or Administrator inquiries. The Administrator may withhold disbursements for the vendor if the vendor, after written notice from the Administrator, fails to comply with this requirement.

33. Add Section 54.642, to read as follows:

§ 54.642 Competitive bidding requirement and exemptions.

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

(b) *Fair and open process.*

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(4) *Request for proposal (if applicable).*

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

(ii) An applicant must submit an RFP (1) if it is required to issue an RFP under applicable state, Tribal, or local procurement rules or regulations; (2) if the applicant is a consortium seeking more than $100,000 in program support during the funding year, including applications that seek more than $100,000 in program support for a multi-year commitment; or (3) if the applicant is a consortium seeking support for participant-constructed and owned network facilities.

(iii) *RFP requirements.*

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

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

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

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

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

(5) *Additional requirements for consortium applicants.*

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

(1) Goals and objectives of the network;

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

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

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

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

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

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

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

(1) Form 461,

(2) Bid evaluation criteria,

(3) Request for proposal, and

(4) Network plan.

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

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

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

(h) *Exemptions to competitive bidding requirements*.

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

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

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

(4) *Evergreen contracts*.

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

(ii) A contract entered into by a health care provider or consortium as a result of competitive bidding may be designated as evergreen if it meets all of the following requirements: (1) is signed by the individual health care provider or consortium lead entity; (2) specifies the service type, bandwidth and quantity; (3) specifies the term of the contract; (4) specifies the cost of services to be provided; and (5) includes the physical location or other identifying information of the health care provider sites purchasing from the contract.

(iii) Participants may exercise voluntary options to extend an evergreen contract without undergoing additional competitive bidding, if (1) the voluntary extension(s) is memorialized in the evergreen contract; (2) the decision to extend the contract occurs before the participant files its funding request for the funding year when the contract would otherwise expire; and (3) the voluntary extension(s) do not exceed five years in the aggregate.

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

contract. The health care provider must comply with all Healthcare Connect Fund rules and procedures except for those applicable to competitive bidding.

34. Add Section 54.643, to read as follows:

§ 54.643 Funding commitments.

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

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

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

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

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

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

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

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

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

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

(3) *Contracts or other documentation*. All applicants must submit a contract or other documentation that clearly identifies (1) the vendor(s) selected and the health care provider(s) who will receive the services, equipment, or facilities; (2) the service, bandwidth, and costs for which support is being requested; and (3) the term of the service agreement(s) if applicable (*i.e.*, if services are not being provided on a month-to-month basis). For services, equipment, or facilities provided under contract, the applicant must submit a copy of the contract signed and dated (after the Allowable Contract Selection Date) by the individual health care provider or Consortium Leader. If the service, equipment, or facilities are not being provided under contract, the applicant must submit a bill, service offer, letter, or similar document from the vendor that provides the required information.

(4) *Competitive bidding documents*. Applicants must submit documentation to support their certifications that they have selected the most cost-effective option, including a copy of each bid received (winning, losing, and disqualified), the bid evaluation criteria, and the following

documents (as applicable): bid evaluation sheets; a list of people who evaluated bids (along with their title/role/relationship to the applicant organization); memos, board minutes, or similar documents related to the vendor selection/award; copies of notices to winners; and any correspondence with vendors during the bidding/evaluation/award phase of the process. Applicants who claim a competitive bidding exemption must submit relevant documentation to allow the Administrator to verify that the applicant is eligible for the claimed exemption.

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

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

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

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

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

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

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

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

(3) *Terms of membership in the network*. Describe generally any agreements made (or to be entered into) by network members (*e.g.*, participation agreements, memoranda of understanding, usage agreements, or other similar agreements). The sustainability plan must also describe, as applicable: (1) financial and time commitments made by proposed

members of the network; (2) if the project includes excess bandwidth for growth of the network, describe how such excess bandwidth will be financed; and (3) if the network will include ineligible health care providers and other network members, describe how fees for joining and using the network will be assessed.

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

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

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

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

35. Add Section 54.644, to read as follows:

§ 54.644 Multi-year commitments.

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

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

36. Add Section 54.645, to read as follows:

§ 54.645 Payment process.

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

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

37. Add Section 54.646, to read as follows:

§ 54.646 Site and service substitutions.

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

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

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

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

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

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

38. Add Section 54.647, to read as follows:

§ 54.647 Data Collection and Reporting.

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

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

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

39. Add Section 54.648, to read as follows:

§ 54.648 Audits and recordkeeping.

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

(b) *Recordkeeping*.

(1) Participants, including Consortium Leaders and health care providers, shall maintain records to document compliance with program rules and orders for at least 5 years after the last day of service delivered in a particular funding year. Participants who receive support for long-term capital investments in facilities whose useful life extends beyond the period of the funding commitment shall maintain records for at least 5 years after the end of the useful life of the facility. Participants shall maintain asset and inventory records of supported network equipment to verify the actual location of such equipment for a period of 5 years after purchase.

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

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

40. Add Section 54.649, to read as follows:

§ 54.649 Certifications.

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

41. Add an undesignated centered heading below Section 54.649, to read as follows:

GENERAL PROVISIONS

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

§ 54.671 Resale.

(a) * * *

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

43. Add Section 54.672, to read as follows:

§ 54.672 Duplicate support.

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

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

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

§ 54.675 Cap.

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

(b) * * *

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

(1) * * *

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

(3) * * *

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

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

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

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

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

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

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

45. Amend redesignated section 54.679 by revising the section heading, and revising the rule to read as follows:

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

(a) A service provider that contributes to the universal service support mechanisms under subpart H of this section and also provides services eligible for support under this subpart to eligible health care providers may, at the election of the contributor: (i) treat the amount eligible for support under this subpart as an offset against the contributor's universal service support obligation for the year in which

the costs for providing eligible services were incurred; or (ii) receive direct reimbursement from the Administrator for that amount.

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

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

46. Add Section 54.680, to read as follows:

§ 54.680 Validity of Electronic Signatures.

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

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

APPENDIX E

Forms

FCC Form **460**

Approval by OMB XXXX—XXXX
Estimated time per response: XXX

Rural Health Care (RHC) Universal Service
Eligibility and Registration Form

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.

Block 1: General Information			
1 Date Submitted:			
2 Applying to:	○ Determine eligibility of an HCP site ○ Determine eligibility of Consortium ○ Register an off-site data center	○ Register an ineligible site ○ Register an off-site administrative office	
2a If applying as an off-site data center, list all sites (eligible and ineligible) that will use the services of this data center.			
2b If applying as an off-site administrative office, list all sites (eligible and ineligible) that will use the services of this administrative office.			
Block 2: Physical Location			
Enter the actual physical location of the HCP site.			
3 HCP Number		4 Name of Site	
5 FCC Registration Number (FCC RN)		6 Site Contact Name	
7 Address Line 1			
8 Address Line 2			9 County
10 GeoLocation (optional)			
11 City		12 State	13 Zip Code
14 Phone	Ext.	15 Email	
Block 3: Consortium Information			
16 HCP Number			
17 Name of Consortium			
18 Is the Consortium a legal entity? ○ Yes ○ No		If yes, Consortium FCC RN:	
19 Consortium has a written agreement allocating legal and financial responsibility. ○ Yes ○ No			
If yes, submit the agreement to USAC. If no, see instructions regarding the default entity that bears legal and financial responsibility for the consortium's activities in connection with the Healthcare Connect Fund.			
20 Consortium Leader Type: ○ The Consortium ○ An eligible HCP participating in the Consortium HCP Number: _____		○ Ineligible State organization ○ Ineligible public sector (government) entity ○ Ineligible non-profit entity	
21 Consortium Leader Contact Information		22 Name of Consortium Leader	
Consortium applicants are required to have a Letter of Agency from each participating HCP that authorizes the Consortium to file forms on the HCP's behalf. Attach a Letter of Agency for each participating HCP.			
23 List participating HCPs (eligible/ineligible)		24 HCP Number	
Block 4: Contact Information			
25 Primary Account Holder/Project Coordinator Name			
26 Employer			
27 Address Line 1			○ Same as Physical Location
28 Address Line 2			
29 City		30 State	31 Zip Code
32 Phone #	Ext.	33 Email	
34 Application Contact/Assistant Project Coordinator Name			
35 Employer			
36 Address Line 1			○ Same as Primary Account Holder Address
37 Address Line 2			
38 City		39 State	40 Zip Code
41 Phone #	Ext.	42 Email	

Block 5: Eligibility Information (HCP must be public or non-profit health care provider)	
43 Select the organization type from Column A that best describes the organization	
○ **A.** Community health center or health center providing health care to migrants	
○ **B.** Community mental health center	
○ **C.** Local health department/agency	
○ **D.** Non-profit hospital	
○ **E.** Part-time eligible entity located in an ineligible facility	
○ **F.** Post-secondary educational Institution offering health care instruction, teaching hospital, or medical school	
○ **G1.** Rural health clinic	
G2. Is this a mobile rural health care provider? ☐ Yes ☐ No	
○ **H.** Dedicated ER of rural, for-profit hospital	
○ **I.** Consortium of the above	
44 Provide a brief explanation of why this site qualifies as the organization type selected above:	
Block 6: Additional Information	
45 Non-Profit Tax ID:	46 Employer ID Number:
47 [HHS Unique Identifier:]	
48 If a Non-Profit Hospital, is this a Critical Access Hospital?	☐ Yes ☐ No
49 If a Non-Profit Hospital, how many licensed hospital beds are at the site?	
50 Is the site located on Tribal Lands or serve primarily Tribal populations?	☐ Yes ☐ No
51 [Reserved]	52 [Reserved]
Block 7: Certifications and Signatures	
53 ☐ I certify that I am authorized to submit this request on behalf of the site or consortium and that to the best of my knowledge, information and belief, all responses contained herein are true.	
54 ☐ If applying as an individual health care provider site, I certify that the health care provider is a non-profit or public entity and that the site is located in a FCC designated rural area, or is grandfathered rural pursuant to 47 C.F.R. Sec. 54.600(b)(2).	
55 ☐ If applying as a consortium, I certify that the eligible health care providers participating in the consortium are non-profit or public entities.	
56 ☐ I understand that all documentation associated with this form must be retained for a period of five years.	
57 ☐ If applying as a consortium, I understand I must obtain letters of agency from each consortium member that grants me the authority to complete, sign, and submit all forms for the funding year(s) for which support is sought.	
58 Signature	59 Date
60 Printed Name of Authorized Person	
61 Title/Position of Authorized Person	
62 Phone Ext.	63 Email
64 Employer	65 Employer's FCC RN

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FCC NOTICE FOR INDIVIDUALS REQUIRED BY THE PRIVACY ACT AND THE PAPERWORK REDUCTION ACT
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FCC Form 460

action. Information requested by this form will be available for public inspection. Your response is required to obtain the requested authorization.

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FCC Form 460

FCC Form
461

Approval by OMB XXXX—XXXX
Estimated time per response: XXX

Rural Health Care (RHC) Universal Service
Healthcare Connect Fund
Request for Services and Certifications

USAC Internal Use Only	
FCC Form 461 Application Number:	FCC Form 460 Number:
Posting Start Date:	Posting End Date:
Allowable Contract Selection Date (ACSD):	Form 461 Friendly Name:

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.

Block 1: General Information

1 Funding Year	2 HCP Number	
3 HCP Name/Consortium Name		
4 Address Line 1		
5 Address Line 2	6 County	
7 City	8 State	9 Zip Code

Block 2: Individual HCP Site Request for Services

10 ☐ Applicant has prepared and is submitting an RFP with this form.
☐ Applicant has not and will not prepare an RFP.

11 Number of Days RFP Posted
Number of days USAC should post RFP: _____ Posting end date: _____

12 Category of Service Requested (check all applicable)
☐ Network Equipment
☐ Leased/Tariffed Facilities or Services

12a Select requested capabilities (select all that apply)

☐ Large image file transmission	☐ Interface/edge device	☐ Video conferencing
☐ Backup/redundancy	☐ Live data transmission and monitoring	☐ Voice
☐ Internet access	☐ Mobile unit communications	
☐ Electronic medical records/Patient billing	☐ Store and forward consultations	

12b Reserved

13 Contact for Request for Services:
a. ○ Same as HCP Physical Location Contact ○ Same as HCP Primary Account Holder ○ Other
b. If other, provide full contact information:

Contact Name	Organization Name
Contact Name Title	
Phone #	Email

Block 3: Consortium Application Request for Services

14 Participating Entities (list all sites (eligible and ineligible) participating in this competitive bid request)

HCP Number:	HCP Number:
HCP Number:	HCP Number:

15 ☐ Applicant has prepared and is submitting an RFP with this form. If selected, complete 15a.
☐ Applicant has not and will not prepare an RFP.

15a Applicant is submitting an RFP because:

☐ It is seeking more than $100,000 in program support	☐ Of state, Tribal, or local procurement rules
☐ It is seeking support for infrastructure	☐ The applicant has elected to use an RFP

16 Number of Days Posted

Number of days USAC should post RFP: _____ Posting end date: _____

17 Category of Service Requested

- ☐ Network Design
- ☐ Network Equipment
- ☐ Infrastructure/Outside Plant
- ☐ Leased/Tariffed Facilities or Services
- ☐ Network Management/Maintenance/Operations Cost (not captured elsewhere)

17a If requesting only Infrastructure/Outside Plant, has the Consortium previously requested Leased/Tariffed Facilities or Services?

○ Yes. If yes, provide FCC Form 461 Posting Number ○ No

18 Description of Services Requested (Required to provide a summary of RFP if submitting one)

19 Contact for Request for Services:

a. ○ Same as Project Coordinator ○ Same as Assistant Project Coordinator ○ Other

b. If other, provide full contact information:

Contact Name	Organization Name
Contact Name Title	
Phone #	Email

Block 4: Declaration of Assistance

20 Did anyone other than employees of the HCP or consortium listed in Block 1, or employees of the HCPs listed in Block 3 assist in the completion of this application?

○ Yes ○ No

Organization Type:

List all individuals who aided in the preparation of this application (Form, RFP, Bid Evaluation, and Network Plan).

a. Name (First, Middle Initial, Last)	b. Organization Type	
c. Title/Role	d. Employer	
e. Address Line 1		
f. Address Line 2		
g. City	h. State	i. Zip Code

Block 5: Bid Evaluation

22 Select selection criteria (and weights assigned to each) that will be used to evaluate bids received as a result of this request for services. Attach supplemental information (if necessary).

Criteria	Weight
a.	
b.	
c.	

Block 6: Additional Documentation

23 List all supporting documentation (RFP, Network Plan, etc) that is required to be submitted with this form.

Type of Documentation
a.
b.
c.

Block 7: Certifications

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

25 ☐ I certify that the applicant has followed any applicable state, Tribal, or local procurement rules.

FCC Form 461

Block 7: Certifications		
26 ☐	I certify that the supported connections, infrastructure and/or equipment associated with this request for funding will be used solely for purposes reasonably related to the provision of health care service or instruction, and that the health care provider or consortium is legally authorized to provide under the law of the state in which the services were provided and will not be sold, resold, or transferred in consideration for money or any other thing of value.	
27 ☐	I certify that the applicant satisfies all of the requirements under section 254 of the Act and applicable Commission rules.	
28 ☐	I certify that the applicant has reviewed all applicable requirements for the program and will comply with those requirements.	
29 ☐	I understand all documentation that is part of this form must be kept for a period of five years (including a copy of the signed 461, any bids/contracts resulting from the 461 posting, scoring sheet, and other information that was used in the decision-making process) from the last day of the funding year.	
30 Signature		31 Date (mm/dd/yyyy)
32 Printed Name of Authorized Person		
33 Title/Position of Authorized Person		
34 Phone #		35 Email
36 Employer		37 Employer's FCC RN

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FCC Form 461

FCC Form
462

Approval by OMB XXXX-XXXX
Estimated time per response: XXX

Rural Health Care (RHC) Universal Service
Healthcare Connect Fund
Funding Request Form

Read instructions thoroughly before completing this form. Failure to comply may cause delayed or denied funding.

Block 1: General Information		
1 Funding Year _____	2 Funding Request Number (FRN):	
3 HCP Number:	4 HCP Name/Consortium Name:	
Block 2: Competitive Bidding Information		
5 FCC Form 461 Application Number:		
6 Allowable Contract Selection Date (ACSD):		
7 Number of vendors who bid:		
8 Applicant's request is exempt from competitive bidding. ☐ Evergreen Contract Evergreen Contract ID: Friendly Name:		
☐ The annual cost of services received is equal to or less than $10,000		
☐ Applicant is purchasing services from a Government Master Services Agreement		
☐ Applicant is purchasing services from a master contract negotiated through the E-rate Program		
Block 3: Service Provider Information		
9 Service provider identification number (SPIN):		
10 Service provider name:	11 Service provider contact information:	
12 Address Line 2		
13 Address Line 2	14 County	
15 City	16 State	17 Zip Code
18 Phone	19 Email	
Block 4: Type of Funding Request		
20 ☐ Individual HCP, single service ☐ Individual HCP, multiple services ☐ Consortium Application		
Block 5: Single Service Request for Funding		
21 Category of Service	22 Service Type	
23 Bandwidth	23a Is this service symmetrical? ○ Yes ○ No If no, what is the upload bandwidth _____. What is the download bandwidth _____.	
24 Circuit ID (optional)		
25 Percentage of service used for provision of health care (eligible usage)		
26 Does the Service Type include both eligible and ineligible components? ○ Yes ○ No If yes, what percentage is eligible? _____		
27 Billing Account Number (BAN)	28 Date contract signed/circuit end location	
29 Expected service start date	30 Contract expiration date (write N/A if month-to-month)	
31 Circuit start location	32 Circuit end location	
33 Monthly rate	34 Source of HCP contribution	
35 One-time installation charge	36 Is this a multi-year funding request? ○ Yes ○ No	
37 Number of months requested	Multi-year commitments cannot exceed 36 months of funding and may not extend beyond the expiration date of an Evergreen Contract.	

38 This contract contains a Service Level Agreement. ○ Yes ○ No If yes, provide the following information concerning the SLA in the contract:	
a. Latency:	b. Jitter:
d. Packet Loss:	d. Reliability:
Block 6: Multi Service and Consortium Requests for Funding (attach Network Cost Worksheet)	
39 Total cost for eligible monthly recurring service	
40 Total cost for eligible non-recurring service	
Block 7: Additional Documentation	
41 List all supporting documentation (Competitive bids, Contract, etc.) that is required to be submitted with this form.	
Type of Documentation	
a.	
b.	
c.	
Block 8: Additional Information	
42 Election for Invoice Initiation:	
☐ Applicant will request that service provider initiate invoicing process	
☐ Applicant will initiate invoicing process	
43 I certify that financial information including, but not limited to, pricing, bids, and contract terms, is confidential and the public disclosure of such information would likely cause substantial harm to the competitive position of the associated parties. I request nondisclosure of this information contained in or submitted with this form pursuant to section 0.459 of the Commission's rules. ○ Yes ○ No	
Block 9: Certifications	
44 ☐ I certify that I am authorized to submit this request on behalf of the health care provider or consortium, and that I have examined this form and attachments and to the best of my knowledge, information, and belief, all statements of fact contained herein are true.	
45 ☐ I certify that the health care provider or consortium has considered all bids received and selected the most cost-effective method of providing the requested services. The "most cost-effective service" is defined as the "method that costs the least after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems relevant to choosing a method of providing the required health care services." 47 C.F.R. Sec. 54.642(c).	
46 ☐ I certify that all Healthcare Connect Fund support will be used only for the eligible program purposes for which support is intended.	
47 ☐ I certify that the health care provider or consortium is not requesting support for the same service from both the Telecommunications Program and the Healthcare Connect Fund.	
48 ☐ I certify that the health care provider or consortium satisfies all of the requirements under Section 254 of the Telecommunications Act of 1996, as amended, and applicable Commission rules, and understand that any letter from the Administrator that erroneously commits funds for the benefit of the applicant may be subject to recission.	
49 ☐ I certify that I have reviewed all applicable requirements for the program and will comply with those requirements.	
50 ☐ I certify that all documentation associated with this application including all bids, contracts, scoring matrices, and other information associated with the competitive bidding process, and all billing records for services received must be retained for a period of five years pursuant to 47 C.F.R. Sec. 54.648.	
51 Signature	52 Date
53 Printed Name of Authorized Person	
54 Title/Position of Authorized Person	
55 Phone Ext.	56 Email
57 Employer of Authorized Person	58 Employer's FCC RN

FCC Form 462

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FCC Form 462

Rural Health Care (RHC) Universal Service
Healthcare Connect Fund
Network Cost Worksheet (attach, if required, to form 462)

Section	Field
HCP Information	HCP Number
	HCP Name
Contract Information	Date Contract Signed/Carrier Selected
	Contract Expiration Date
	Billing Account Number
Quality of Service Requirements (if available)	Service Level Agreement?
	Latency
	Jitter
	Packet Loss
	Reliability
Circuit Information	Circuit ID (optional)
	Expected Service Start Date
	Circuit Start Location
	Circuit End Location
Services Received Information	Category of Service
	Service Type
	Bandwidth
	Is this Service Symmetrical?
	Upload Bandwidth
	Download Bandwidth
Financial Information	Quantity of Items
	Is this a Recurring Expense?
	Cost Per Quantity
	Explanation of Service Received
	Percentage of Service Type Eligible
	Percentage of Service Used for Provision of Healthcare
	Source of HCP Contribution
Multi-Year Funding Information (not to exceed 36 months)	Do you wish to receive a multi-year commitment?
	Quantity of Months

FCC Form 463
Rural Health Care (RHC) Universal Service
USAC Invoice and Request for Disbursement

Approval by OMB XXXX-XXXX
Estimated time per response: XXX

Funding Request Number		RHC Invoice Number	
Funding Year		SPIN	
HCP Number		Service Provider Name	
HCP Name/Consortium Name		Total Invoice Amount	

						Items Requested				USAC Internal Use Only		
FRN ID	HCP Number	HCP Name	Category of Service	Service Type	Bandwidth	Installation Date of Service	Billing Period Start Date	Billing Period End Date	Total Actual Cost	Percent of Service Eligible	Total Eligible Actual Cost	USF Support Amount to be paid (65%)

Request for Confidentiality

I certify that financial information including, but not limited to, pricing, bids and contract terms, is confidential and the public disclosure of such information would likely cause substantial harm to the competitive position of the associated parties. I request nondisclosure of this information contained in or submitted with this form pursuant to section 0.459 of the Commission's rules. _____ Yes _____ No

Service Provider Certification

I certify that I am an authorized representative of the above-named service provider, that I have examined the information provided in the Rural Health Care Healthcare Connect Fund Invoice, and to the best of my knowledge, information and belief, all costs contained in this invoice are true and correct and represent actual incurred costs for components (services) received by the health care providers(s) listed above.

Signature : _____ **Date :** _____
Name : _____ **Phone :** _____ **Email :** _____

Health Care Provider/Consortium Certification

I certify that I have examined the information provided in the Rural Health Care Healthcare Connect Fund Invoice, and to the best of my knowledge, information and belief, the health care provider or consortium has received the related services itemized on this invoice.

I certify under penalty of perjury that the 35 percent minimum funding contribution for each item on this invoice required by the Healthcare Connect Fund rules was funded by eligible sources as defined in the rules and has been provided to the service provider listed above.

Signature : _____ Date : _____
Name : Phone : Email :

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APPENDIX F

List of Commenters

Comments on July 15, 2012 NPRM

Commenter	Abbreviation/Short Name
Advanced Regional Communications Cooperative	ARCC
Alaska Communications Systems	ACS
American Academy of Home Care Physicians	AAHCP
American Hospital Association	AHA
American Telemedicine Association	ATA
Arizona Rural Health Office	ARHO
AT&T	AT&T
ATC Broadband	ATC
Avera Health	Avera
Benton Foundation	Benton
Broadband Principals	Broadband Principals
California Hospital Association	CHA
California Public Utilities Commission	CPUC
California Telehealth Network	CTN
Centerstone Research Institute	CRI
Charter Communications, Inc.	Charter
Colorado Health Care Connections & Rocky Mountain HealthNet	CHCC/RMHN
Eastern Montana Telemedicine Network	EMTN
Evangelical Lutheran Good Samaritan Society	ELGSS
Fort Drum Regional Health Planning Organization	FDRHPO
Geisinger Health System	Geisinger
General Communications Inc.	GCI
Health Information Exchange of Montana	HIEM
Healthsense, Inc.	Healthsense
Illinois Rural HealthNet	IRHN
Immarsat, Inc.	Immarsat
Internet2 Ad Hoc Health Group	Internet2
Iowa Health System	IHS
Long Term and Post Acute Care Collaborative of Associations	LTPACCA
Mike Knutson	Mike Knutson
Modern Technologies Group, AirCom Consultants, and Quality Tower Services, Ltd.	MTG
Montana Independent Telecommunications Systems	MITS
Montana Telecommunications Association	MTA
Motorola, Inc.	Motorola
National Association of Black Owned Broadcasters	NABOB
National Association of State EMS Officials	NASEO
National LambdaRail	NLR
National Rural Health Association	NRHA
National Telecommunications Cooperative Association	NTCA
Nebraska Statewide Telehealth Network	NSTN
New England Telehealth Consortium	NETC
North Carolina Telehealth Network (David Kirby)	NCTN

Oregon Association of Hospitals and Health Systems	OAHHS
Oregon Health Network and Telehealth Alliance of Oregon	OHN
Palmetto State Providers Network	PSPN
Paul Amendt	Paul Amendt
PEM Filings, LLC	PEM
Qualcomm, Inc.	Qualcomm
Qwest Communications	Qwest
Rural Nebraska Health Care Network	RNHN
Rural Wisconsin Health Cooperative Information Technology Network	RWHC
Southwest Alabama Community Mental Health	SWAMH
Telecommunications Industry Association	TIA
TeleQuality Communications	TeleQuality
Texas Health Information Network Collaborative	TxHINC
United States Department of Health and Human Services	HHS
University of Arkansas for Medical Sciences	UAMS
University of Hawaii Telecommunications and Information Policy Group	UHTIPG
University of Virginia Office of Telemedicine	UVA
USF Consultants	USF Consultants
Utah Telehealth Network	UTN
Verizon and Verizon Wireless	Verizon
Virginia Telehealth Network	VTN
Washington Rural Health Association	WRHA
West Wireless Health Institute	WWHI

Reply Comments on July 15, 2012 NPRM

Commenter	Abbreviation/Short Name
Advocates for EMS	AEMS
American Telemedicine Association	ATA
Association of Public Safety Communications Officials Int'l	APCO
AT&T	AT&T
CenturyLink	CenturyLink
Charter Communications, Inc.	Charter
Chippewa Valley Hospital	Chippewa
Colorado Rural Health Center	CRHC
Comcast	Comcast
Continua Health Alliance	Continua
General Communications, Inc.	GCI
Geisinger Health System	Geisinger
Georgia State Office of Rural Health	GSORH
Hawaiian Telecom	HT
Health Information Exchange of Montana	HIEM
Health IT Now Coalition	HITNC
Horizon Telecom	Horizon
Hughes Network Systems	HNS
Illinois Critical Access Hospital Network	ICAHN
International Association of Chiefs of Police	IACP
International Association of Fire Chiefs	IAFC
Internet2 Ad Hoc Health Group	Internet2
Iowa EMS Association	IEMSA

Iowa State Office of Rural Health	ISORH
Kansas EMS Association	KEMSA
Kentucky Office of Rural Health	KORH
Marshfield Clinic	Marshfield
Michigan Department of Community Health	MDCH
Modern Technologies Group, AirCom Consultants, and Quality Tower Services Ltd	MTG
Montana Telecommunications Association	MTA
National Association of Emergency Medical Technicians	NAEMT
National Association of EMS Physicians	NAEMSP
National Association of Telecommunications Offices and Advisors	NATOA
National EMS Management Association	NEMSMA
National LambdaRail	NLR
National Organization of State Offices of Rural Health	NOSORH
National Sheriffs' Association	NSA
New Hampshire Department of Health and Human Services	NHDHHS
North Arkansas Regional Medical Center EMS	NARMC
North Carolina Office of Rural Health and Community Care	NCORHCC
National Telecommunications Cooperative Association	NTCA
Oklahoma Ambulance Association	OAA
Oklahoma EMT Association	OEMTA
Rhode Island Office of Primary Care and Rural Health	RIOPCRH
Ripon Medical Center	Ripon
Rural Nebraska Health Care Network	RNHN
South Carolina Office of Rural Health	SCORH
Sprint Nextel	Sprint
Texas Statewide Telephone Cooperative	TSTC
USF Consultants	USF Consultants
UW Health Partners – Watertown Regional Medical Center	UW
ViaSat and WildBlue	ViaSat
Virginia Telehealth Network	VTN
West Virginia Department of Rural Health and Recruitment	WVDRHR

Comments on July 19, 2012 Public Notice

Commenter	Abbreviation/Short Name
Alaska Communications Systems	ACS
American Academy of Pediatrics	AAP
American Hospital Association	AHA
American Telemedicine Association (Jonathan Linkous)	ATA
California Telehealth Network	CTN
CDCR California Correctional Health Care Services	CCHCS
Colorado Health Care Connections and Rocky Mountain HealthNet	CHCC/RMHN
Geisinger Health System	Geisinger
General Communication, Inc.	GCI
Health Information Exchange of Montana	HIEM
Illinois Rural HealthNet	IRHN
Indiana Telehealth Network (Don Kelso)	ITN
Iowa Rural Health Telecommunications Program	IRHTP
MiCTA (Gary Green)	MiCTA
Missouri Telehealth Network	MTN
Montana Telecommunications Association	MTA
National Telecommunications Cooperative Association	NTCA
North Carolina TeleHealth Network	NCTN
Oregon Health Network	OHN
Rural Wisconsin Health Cooperative (Louis Wenzlow)	RWHC
Southwest Telehealth Access Grid	SWTAG
St. Joseph's Hospital/Hospital Sisters Health System	HSHS
Telecommunications Industry Association	TIA
The University of Arkansas for Medical Sciences	UAMS
United Way Worldwide and United Ways of California	United Way
USF Consultants	USF Consultants
Utah Telehealth Network	UTN
Western New York Rural Area Health Education Center	WNYRAHEC

Reply Comments on July 19, 2012 Public Notice

Commenter	Abbreviation/Short Name
California Broadband Council	CBC
California Emerging Technology Fund	CETF
California Hospital Association	CHA
California Rural Indian Health Board	CRIHB
Charter Communications, Inc.	Charter
Eastern Plumas Health Care	EPHC
General Communication, Inc.	GCI
Health Information Exchange of Montana	HIEM
Manchester Community Technologies, Inc.	MCT
Nevada Hospital Association	NHA
New England Telehealth Consortium	NETC
Rural Nebraska Healthcare Network	RNHN
UC Davis (Michael Minear)	UC Davis
Virginia Acute Stroke Telehealth Network	VAST

STATEMENT OF
CHAIRMAN JULIUS GENACHOWSKI

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

Earlier this year, I visited Barton Memorial Hospital, part of the path-breaking California Telehealth Network, to see first-hand how FCC Universal Service funding has improved health care for people in the area. At Barton, doctors and nurses are using broadband to enable remote examination through a live IP video feed and a relatively inexpensive telemedicine cart. Patients in rural El Dorado County are now being treated by specialists as far away as San Francisco, San Diego, Irvine, and Reno. And Barton has expanded its remote services to include cardiology, infectious disease, neurology and other specialties for which there are no specialists at Barton.

So patients who before had to travel many miles and many hours, or forgo diagnosis or care, can now have access to experts while staying in their home town.

This is transformational, and it's hardly the only example in our pilot program. In Florence, South Carolina, high-risk expectant mothers used to travel 168 miles to see a doctor. If the doctor drove there, he or she only had time to see each patient for 3 minutes. Now, unnecessary travel is eliminated and the doctor sees patients for an average of 30 minutes during each tele-consult. In Jefferson County, Iowa, patients used to have to wait 3 to 4 hours to have a radiology scan read. Now, it only takes half an hour. In North Carolina, the turnaround time for diagnosing communicable disease outbreaks has gone from 5 to 10 days, to 24 to 48 hours. These are cases where speed can be literally life-or-death.

And here's another important learning from our pilot program: telemedicine simultaneously drives down costs. In South Dakota, e-ICU services have saved eight hospitals over $1.2 million in patient transfer costs over just 30 months. In upstate New York, a network of about 50 providers expect $9 million in cost savings from providing cardiology, trauma, mental health, neurology and respiratory services over their broadband connections.

Broadband can revolutionize healthcare in our country, with powerful potential to improve quality of care for patients, while saving billions of dollars. But we'll only realize the full benefits of this incredible technical revolution if we get all our hospitals and clinics connected. The new Healthcare Connect program will expand the Commission's health care broadband initiative from pilot to program. It will allow thousands of new providers across the country to share in the benefits of connectivity and dramatically cut costs for both hospitals and USF. These are transformational changes that build on our major reforms across our universal service system.

For years, the FCC's primary healthcare program has made it much more difficult than it should be for hospitals serving rural patients to get high bandwidth connections of the kind that are needed for modern telemedicine. It does this in two ways: by limiting funding to telecommunications services, and by creating a complex discount formula that makes it hard for consortia to effectively bargain for the lowest cost service. So even where hospitals can get broadband connections under the program, they are often incredibly expensive, both for the hospital and for USF. Today's reform builds on the success of the Pilot program, and especially the model of state and regional health networks. Using this model, the new Healthcare Connect Fund will finally allow hospitals across the country to get broadband, while driving down costs.

In fact, based on the results in the Pilot program, we expect Healthcare Connect will bring thousands of new providers across the country into the program, and allow thousands of others to upgrade their connections. These providers offer lifesaving care to rural communities and small towns.

And Healthcare Connect could cut the costs of connections –for both providers and the Fund – in half. As we've done in reforming and modernizing all of our Universal Service programs, we've stayed true to our commitment to fiscal responsibility, maintaining the current overall program budget of $400 million, while increasing the program's impact within this limit.

Just as today's reform builds on the success of the existing pilot program, today we launch a new $50 million pilot to evaluate bringing skilled nursing facilities skilled nursing facilities into the Healthcare Connect program. These facilities allow skilled nursing staff to treat, manage, observe, and evaluate patients, many of whom have been recently discharged from the hospital. Skilled nursing facilities stand to benefit tremendously from participation in healthcare networks: nurses say that having the broadband connection is a "godsend" and it's like having the urban doctor "in the room" with them as they care for a patient.

And helping these nurses helps patients and saves money: patients can be discharged earlier from the hospital as they are recovering from injury or illness and get more focused care, closer to home. If they hit a bump on the road to recovery, they can be quickly evaluated for further care. So a patient who is recovering from open heart surgery in rural Virginia and develops an infection can have it diagnosed from afar. Or a resident in a facility in a small town in Kansas or Montana that develops a persistent cough can have chest X-rays sent to a doctor in a nearby hospital. And these consultations can save an ambulance trip or an emergency room visit, avoiding further complications.

We're starting with a rigorous, competitive trial because including these providers in the programs does raise some tricky issues. This is a fiscally responsible, data driven way to proceed, and we move ahead on completely solid legal ground. But it's vital that we do proceed so that we can harness the opportunities of broadband for health care as quickly as possible.

So yes, we're leaning forward here – but that's what it will to ensure that the broadband revolution doesn't bypass rural and low income Americans. It's the right choice and I thank Commissioners Clyburn and Rosenworcel for their support.

Let me also briefly address the idea of a "contingency plan" in case we hit the $400 million program cap. The staff's careful analysis makes clear that we're very unlikely to hit this cap within the next five years. But just in case, we've said we'll complete a rulemaking on this issue next year, well before any need could possibly arise, or any of the parade of horribles some have speculated about could occur.

I want to thank the team of the Wireline Bureau for their excellent, data intensive review of the healthcare pilot, and their careful, creative work to translate that review into the permanent Healthcare Connect Fund. Working on this program is especially challenging because it requires the team to develop an expertise not just in broadband, but also in healthcare. Linda Oliver and her team did a fantastic job.

When we said in the Broadband Plan that we were going to tackle Universal Service reform not just for schools and libraries, or for low-income Americans, or rural Americans, or Healthcare Providers and their patients – but for all of these groups, there were few who thought this Commission could get it done. Working together, we have. I'm grateful to each of my colleagues - and a special thanks to Commissioners McDowell and Clyburn who have been through, and made substantial contributions to, each of the reforms. People all across America are the beneficiaries of this vital and collaborative work.

Our staff has been amazing. Zac Katz, the FCC's Chief of Staff, has also been through each of the reforms, and this work reached a true level of excellence thanks to the two Bureau Chiefs, Sharon Gillett

and Julie Veach, and Michael Steffen in my office. I want to acknowledge one other person who deserves particular recognition for this achievement. The substantive and inspirational leader of this soup to nuts effort, scrutinizing and honing every sentence and every rule in all the orders, has been Carol Mattey. Today Carol completes the USF Grand Slam – a Steffi Graf level achievement. Carol, you are a model public servant, and the American people who ultimately benefit from our programs are better off for your service. Congratulations and thank you.

STATEMENT OF
COMMISSIONER ROBERT M. McDOWELL
APPROVING IN PART, CONCURRING IN PART, DISSENTING IN PART

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

While the rural health care program is the smallest of the four Universal Service Fund (USF) programs, its size certainly does not diminish its value. The program has enabled the health care community to improve and expand services offered to patients in the most remote parts of our country.

I travelled to Alaska during my first few weeks as an FCC commissioner. I flew to the far ends of the Alaskan frontier to learn more about the health and communications challenges facing Alaska Natives and the telecommunications carriers that endeavor to serve them. I saw how medical images from the most remote corners of Alaska were transmitted to specialists in Anchorage. I learned how using telehealth technology can actually save money because, in many instances, having that technology close at hand means the patient can avoid flying hundreds of miles to a hospital. And, at other times, the patient may not be able to fly at all due to "white outs" or other extreme weather conditions.

Regarding Alaska, I am encouraged that these reforms do not undermine the current Rural Health Care Telecommunications Program which has proven to have been a success story and a critical component of health care service in that part of the country. In fact, this order specifically recognizes the importance of that particular program for places like Alaska.

Unfortunately, not all parts of rural America have been able to benefit from the current rural health care program as successfully as in Alaska. As such, I support the Commission's reform efforts today which originated from lessons learned after the Commission's tireless analysis of the FCC's pilot program that I supported several years ago. For example, we are embracing the valuable benefits that can flow from health care providers working together to create consortia which can spark a virtuous cycle of investment and opportunity. Our action today will promote efficiencies in the system and ensure that taxpayers' funds are being used wisely. Additionally, it is fiscally responsible for the Commission to require a thirty-five percent contribution from participants. These comprehensive reform efforts will hopefully encourage participation throughout rural America.

I have, however, raised concerns that the new program only requires that a "majority" of consortia members be rural. While some rural health care participants may benefit by using the experts and specialists that non-rural participants can offer as members of a consortia, simply requiring a "majority" of the members to be rural is insufficient. The intended focus of this USF program should be for *rural* America, that is, parts of the country that typically are far from hospitals. Although I had hoped for a higher minimum threshold, I appreciate the fact that the order includes language that the Commission expects that the percentage of participants will be on average higher than 51 percent and, if not, the Commission commits to commencing a proceeding to reevaluate the percentage.

Additionally, I am pleased that the Commission maintains the $400 million annual spending cap, but I am not convinced that the annual demand will stay below the cap in the foreseeable future, as projected in this order. As such it would have been more prudent for the Commission to include in this order a contingency plan to allocate priorities if the program does approach the spending cap. Due to these concerns, I concur in part.

Finally, without questioning the importance and value of skilled nursing facilities, I respectfully dissent from the portion of the order that establishes a pilot program to include these facilities as eligible entities. It is not fiscally prudent for the Commission to launch a new pilot program without first waiting

to see how our overall reforms will affect the demand for the program. Furthermore, I am disappointed that the Commission's record does not indicate whether ongoing support of skilled nursing facilities could be accomplished in a manner that is "technically feasible and economically reasonable,"[1] as the statute requires. We certainly shouldn't be laying the foundation for inflating the program before assessing the effect of the other reforms we adopt today.

In sum, I appreciate the Chairman's leadership on guiding these reforms through the process. And, I thank the dedicated staff in the Wireline Competition Bureau who have spent countless hours analyzing the successes and failures of the prior rural health care program and pilot in an effort to assemble reforms that are designed to enhance health care in rural America in a way that will be fiscally responsible and administratively feasible. I look forward to continue working with my colleagues on these issues as this order is implemented.

[1] 47 U.S.C. § 254(h)(2)(A).

STATEMENT OF
COMMISSIONER MIGNON L. CLYBURN

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

Today's Order to create the Healthcare Connect Fund is a momentous event—one in the making since the Commission voted a Further Notice just over two years ago. Before I discuss its importance for consumers, I must first acknowledge the significance of the vote itself: this marks the fourth time, under the leadership of Chairman Genachowski that the FCC has voted to reform a Universal Service Fund program, as recommended by the National Broadband Plan. We have now implemented significant reforms for every program in the Fund, and what this means for us all, is that now each program is better equipped, to serve Americans in today's broadband world. Mr. Chairman, congratulations. Well done. And I am proud to support your Order.

The Chairman assembled an incredible team in this reform effort, so I must also acknowledge Zac Katz, Michael Steffen, and the rest of the team including Julie Veach, who became Bureau Chief this summer and hit the ground running, and Carol Mattey, her Deputy, who has been intimately involved with reforming each USF program since the drafting phase of the National Broadband Plan. Carol's dedication to the universal service principles espoused by the Act, is second to none. Of course, she has a team of people in the Telecommunications Access Policy Division, led by Trent Harkrader and assisted by Linda Oliver, who have been diligently assessing and improving upon the Rural Healthcare Pilot Program. The Rural Healthcare team prepared a well written report this summer on the Pilot Program, then applied the lessons learned from it, as reflected in today's Order. Implementing the USF reforms we already have undertaken is a significant task, so I am especially grateful that you continued to work on this program as well. That commitment will help ensure that rural Americans have better access to healthcare, through the Fund, which is an important goal for our nation.

Many of you know that I am from South Carolina, and in addition, I have had the privilege to visit other rural states since joining this Commission. I've seen first-hand how rural healthcare networks can make a difference in our citizens' lives. Through the Palmetto State Providers Network back home, an at-risk expectant mother can now receive quality prenatal care, without having to travel a long distance, at great expense, missing work and pay. A head injury patient in rural Montana, can now have his CT scan read in minutes, averting a several hundred mile trip to Kalispell in an ambulance, saving time, money and more importantly his life. And in Barrow, Alaska, that person needing psychiatric care, will be in a better position to have her needs met, without leaving familiar surroundings. Our record is full of examples of the important benefits rural healthcare networks provide, the lives that have been saved, and the significant out of pocket and Medicaid and health insurance costs that have been avoided.

So yes, I say momentous. Today's Order *is* momentous. We are moving forward in supporting new broadband networks and services, recognizing that we should build on the successes of the consortia formed in the Pilot Program. We are avoiding wasteful spending, by requiring that competitive bids be solicited for both broadband services and infrastructure, and that participants must choose the most cost effective option. Moreover, through the provisioning of a 65 percent discount for both services and infrastructure, the program will not advantage one type of support over the other. This reformed framework encourages consortia to realize the many benefits they offer, such as faster broadband speeds at lower costs, but it will not punish single site needs. We are permitting both consortia and single site entities to apply, and we have struck the right balance of encouraging consortia with a mix of rural and urban, by requiring that more than 50 percent of the consortia must be rural.

Our staff has taken great care, to make the Rural Healthcare Connect Fund simple for participants as well as for USAC, the Fund's administrator. Clear rules have been put forth to advance our objectives,

of increasing health care providers access to broadband in rural areas, and fostering the development of health care broadband networks, while increasing program efficiency. But the good news does not stop there.

Because they always are planning ahead, staff is proposing a skilled nursing facilities pilot program, to determine whether such facilities, should be eligible under the permanent program. It is believed that if supported, this type of program will afford optimal care for patients, who are too sick to stay at home, but not ill enough for a hospital admission. Broadband is especially useful for these facilities, as it permits a doctor to be virtually present, and offers patients and their families' increased peace of mind. As we have seen from the Commission's earlier Pilot Program, we learn a great deal from those pilots, before implementing changes to our programs. Thus, I fully support the Chairman's plan, to implement a time-limited pilot, for skilled nursing facilities.

Finally, staff has put together a thoughtful outreach plan, to inform healthcare facilities, of the Healthcare Connect Fund in order to help promote the benefits this new program. It is important, as we implement modifications to our programs and offer new opportunities, that we do our part, to inform the public, about these modifications. We've seen success in other recently reformed programs, such as Lifeline, when we put great care in providing information to the public, working with our sister agencies in the federal government, and with other state and local government entities, in addition to distributing details of the changes to affected industries and those who represent them.

We are living longer, playing harder; working, residing and vacationing in places that, not so long ago, seemed out of reach. On top of and as a result of these trends, with our healthcare bills rising, and the demand of electronic health records becoming the norm, broadband has the greatest potential to aid us in realizing the optimal efficiencies in healthcare service delivery in even the most remote areas of this nation. With the implementation of the Healthcare Connect Fund, facilities in rural, currently underserved communities will now have opportunities to obtain desired broadband services, allowing for better healthcare to their areas. I am pleased to support this Order which gives expanded and deserved critical services to rural America.

STATEMENT OF
COMMISSIONER JESSICA ROSENWORCEL

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

Like some of my colleagues, I have had the chance to see the power of telemedicine up close and at work. I have watched as pediatric surgeons in California share their expertise via video with patients many miles away. I have seen how village clinics in rural Alaska use broadband to provide first-class care to patients in some of this country's most remote communities. These experiences amaze because they can challenge our traditional notions of health care. They can collapse distance and time; enhance the quality of care; improve outcomes; and lower costs.

Today's Report and Order seizes this transformative power by updating our rural health care universal service mechanism with a new Healthcare Connect Fund. The Commission's existing universal service rural health care programs have had some success, but I believe they are also due for a check-up. After all, good programs do not thrive without continuous attention and care, and I am hopeful that today's order will position this program for doing even more good in the days ahead.

I am optimistic. Because in critical part, today's decision addresses three key recommendations made by the Government Accountability Office in its 2010 assessment of the agency's universal service rural health care programs. This is important.

First, the Commission evaluated its Pilot Program and assessed the communications needs of rural health care providers. To this end, the new program encourages applications by consortia that include both urban and rural health care providers, fostering higher capacity services at lower cost.

Second, the Commission coordinated with both the Department of Health and Human Services and Universal Service Administrative Company in crafting the Healthcare Connect Fund. In addition, we set the stage for additional coordination going forward. The ability to draw regularly on experts in program administration, telemedicine, and telehealth is essential.

Third, the Commission has put in place clear performance goals and measures to ensure that this program will do what it is intended to do: increase broadband access for health care providers and support the deployment of health care networks in a cost-effective manner.

This is good governance and good medicine. It has my full support. Thank you to the Wireline Competition Bureau for its efforts.

STATEMENT OF
COMMISSIONER AJIT PAI
APPROVING IN PART AND DISSENTING IN PART

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

When I was growing up, I remember my father getting up early in the morning to drive from our hometown of Parsons 45 minutes west in order to provide medical care in the town of Independence. On another day, he would drive 45 minutes north to do the same in the town of Chanute. Other towns were on his itinerary as well. In most cases, he was the only specialist residents of those towns would ever have a chance to see. When I think of how far he went, literally and figuratively, to deliver health care to people in Southeast Kansas, it makes me appreciate the power of today's communications services all the more. With a broadband connection, we can improve health care and reduce substantially the burdens on doctors and patients alike in rural Kansas and many other places.

This background, together with our careful analysis of lessons learned from the 2006 rural health care pilot program, explains why I support the vast majority of today's item, including all of the reforms that create the Healthcare Connect Fund. I am especially pleased that a majority of participants in this program must be rural health care providers. Connecting country clinics to facilities in big cities like Wichita and Kansas City will enhance the services that all Americans receive in their hometowns and ensure that people have access to advanced medicine and health care services no matter where they live.

Similarly, I believe today's order strikes an appropriate balance in several other respects. The uniform discount we adopt should provide ample incentive for eligible providers to join a consortium and participate. The significant contribution we require from participants aligns their incentives with those of universal service contributors. The option to construct facilities gives health care providers a competitive alternative. And the safeguards we adopt ensure that existing broadband network operators will have a full and fair opportunity to compete for that business.

There are two parts of today's item, unfortunately, where I part ways with my colleagues. The first part involves the Skilled Nursing Facility Pilot Program. The order recognizes that, "on this record," this program may not comply with Section 254 of the Communications Act. That provision directs us to support "health care providers,"[1] and yet the order reaches "no conclusion about whether or under what circumstances a [skilled nursing facility] might qualify as a health care provider under the statute."[2] It's also fair to say that we have not had the chance to assess how the reforms we implement today will work

[1] 47 U.S.C. § 254(h)(2)(A).

[2] *Report and Order*, para. 346. A post-adoption footnote now directs the Bureau to "approve any given application only to the extent that it demonstrates that it satisfies the statutory criteria," *i.e.*, the application must show that funding skilled nursing facilities will "enhance eligible [health care provider] access to 'advanced telecommunications and information services.'" *Id*. at n.798. I welcome the news that the statutory criteria will now play a factor in the administration of the Pilot Program. But this direction is wholly unhelpful. Skilled nursing facilities do not offer "advanced telecommunications and information services" any more than banks or grocery stores do. I therefore do not see how funding skilled nursing facilities could "enhance" the access of an eligible health care provider to such services; indeed, the sparse explanation contained in the item would appear to justify also including in the rural health care program banks, grocery stores, or *any* entity that could be connected to a health care provider. To be sure, including a skilled nursing facility in the program could be authorized by the statute if it were itself an eligible health care provider—but that, of course, is precisely the question the Commission cannot answer "on this record."

on the ground and how much the new Healthcare Connect Fund will cost. Nonetheless, the order instructs the Bureau to set up the Pilot Program—without specifying any rules or giving much guidance. In my view, it is a mistake to go forward with this program before the full Commission figures out the basics, namely how the program will work and whether it complies with the Communications Act.

The second part involves the rural health care program's budget caps. The order defers hard decisions about enforcing these caps. This leaves in place the current first-come-first-served system. As a result, everyone who submits an application will get fully funded—until one day, they won't. Once we hit the cap, rural health care providers that long relied on the Telecommunications Program to span the breadth of Kansas or Alaska will be cut off, without forewarning or prioritization. Pilot program sites that have incorporated telemedicine into their practices will go offline. The Commission quickly abandoned this approach in the E-Rate program, and I do not think leaving that work for a later day serves health care providers who are starting their investment plans now.

Finally, I would be remiss not to thank the staff of Telecommunications Access Policy Division of the Wireline Competition Bureau for developing the reforms we adopt today: Christi Barnhart, Soumitra Das, Chas Eberle, Trent Harkrader, Beth McCarthy, Avis Mitchell, Linda Oliver, Michelle Schaefer, Geoff Waldau, Mark Walker, and Chin Yoo. These experts dug through the Code of Federal Regulations to find the 46 amendments to our rules (spanning 29 pages) needed to put the Healthcare Connect Fund in place. They also reviewed over twelve hundred filings since the Notice of Proposed Rulemaking and scrubbed over a thousand footnotes in the item. They remind us all that being a public servant is about *service*, and I thank you all for serving so adeptly.