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Federal Communications Commission

47 CFR Part 54

**Rural Health Care Universal Service
Support Mechanism; Proposed Rule**

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 54

[WC Docket No. 02–60; FCC 10–125]

Rural Health Care Universal Service Support Mechanism

AGENCY: Federal Communications Commission.

ACTION: Notice of proposed rulemaking.

SUMMARY: In this document, the Commission seeks comment on a package of reforms that would expand the use of broadband to improve the quality and delivery of health care, and addresses each of the major recommendations in the National Broadband Plan regarding the Commission's rural health care program. The Commission proposes three major changes to the rural health care program. To create a health infrastructure program that would support up to 85 percent of the construction costs of new or upgraded regional or statewide dedicated broadband networks for health care purposes. To create a health broadband services program that would provide 50 percent of the monthly recurring costs for access to broadband services for eligible health care providers. To expand the definition of "eligible health care provider" to include administrative offices, data centers, skilled nursing facilities, and renal dialysis centers. The Commission also proposes to eliminate the offset contribution rule for the rural health care program, and seeks comment on prioritizing funding requests, and establishing performance measures.

DATES: Comments on the proposed rules are due on or before September 8, 2010, and reply comments are due on or before September 23, 2010. Written comments on the Paperwork Reduction Act proposed information collection requirements must be submitted by the public, Office of Management and Budget (OMB), and other interested parties on or before October 8, 2010. If you anticipate that you will be submitting comments, but find it difficult to do so within the period of time allowed by this notice, you should advise the contact listed below as soon as possible.

ADDRESSES: You may submit comments, identified by WC Docket No. 02–60, by any of the following methods:

- *Federal eRulemaking Portal:* <http://www.regulations.gov>. Follow the instructions for submitting comments.
- *Federal Communications Commission's Web Site:* <http://www.fcc.gov>.

<http://www.fcc.gov/ecfs2/>. Follow the instructions for submitting comments.

- *Paper Filers.* See instructions in the Supplementary Information section of this document (under Comment Filing Procedures).

- *People with Disabilities:* Contact the FCC to request reasonable accommodations (accessible format documents, sign language interpreters, CART, etc.) by e-mail: FCC504@fcc.gov or phone: (202) 418–0530 or TTY: (202) 418–0432.

- In addition to filing comments with the Secretary, a copy of any comments on the Paperwork Reduction Act information collection requirements contained herein should be submitted to the Federal Communications Commission via e-mail to PRA@fcc.gov and to Nicholas A. Fraser, Office of Management and Budget, via e-mail to Nicholas.A.Fraser@omb.eop.gov or via fax at 202–395–5167.

For detailed instructions for submitting comments and additional information on the rulemaking process, see the **SUPPLEMENTARY INFORMATION** section of this document.

FOR FURTHER INFORMATION CONTACT:

Ernesto Beckford (202) 418–1523, Wireline Competition Bureau, Telecommunications Access Policy Division or TTY: (202) 418–0484. For additional information concerning the Paperwork Reduction Act information collection requirements contained in this document, send an e-mail to PRA@fcc.gov or contact Judith B. Herman, Office of Managing Director, via e-mail to Judith-B.Herman@fcc.gov.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Notice of Proposed Rulemaking (NPRM) in WC Docket No. 02–60, FCC 10–125, adopted July 15, 2010, and released July 15, 2010. The complete text of this document is available for inspection and copying during normal business hours in the FCC Reference Information Center, Portals II, 445 12th Street, SW., Room CY–A257, Washington, DC 20554. The document may also be purchased from the Commission's duplicating contractor, Best Copy and Printing, Inc., 445 12th Street, SW., Room CY–B402, Washington, DC 20554, telephone (800) 378–3160 or (202) 863–2893, facsimile (202) 863–2898, or via the Internet at <http://www.bcpweb.com>. It is also available on the Commission's Web site at <http://www.fcc.gov>.

Comment Filing Procedures

Pursuant to §§ 1.415 and 1.419 of the Commission's rules, 47 CFR 1.415, 1.419, interested parties may file comments and reply comments on or

before the dates indicated on the first page of this document. Comments and reply comments may be filed using: (1) The Commission's Electronic Comment Filing System (ECFS), (2) the Federal Government's eRulemaking Portal, or (3) by filing paper copies. See *Electronic Filing of Documents in Rulemaking Proceedings*, 63 FR 24121, May 1, 1998.

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

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

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

- Commercial overnight mail (other than U.S. Postal Service Express Mail and Priority Mail) must be sent to 9300 East Hampton Drive, Capitol Heights, MD 20743.

- U.S. Postal Service first-class, Express, and Priority mail must be addressed to 445 12th Street, SW., Washington DC 20554.

- In addition, one copy of each paper filing must be sent to each of the following: (i) The Commission's duplicating contractor, Best Copy and Printing, Inc., 445 12th Street, SW., Room CY–B402, Washington, DC 20554; Web site: <http://www.bcpweb.com>; phone: 1–800–378–3160; (ii) Ernesto Beckford, Telecommunications, Telecommunications Access Policy Division, Wireline Competition Bureau, 445 12th Street, SW., Room 5–A312, Washington, DC 20554; e-mail: Ernesto.Beckford@fcc.gov; and (iii) Charles Tyler, Telecommunications, Access Policy Division, Wireline Competition Bureau, 445 12th Street, SW., Room 5–A452, Washington, DC 20554, e-mail: Charles.Tyler@fcc.gov.

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

Filings and comments are available for public inspection and copying during regular business hours at the FCC Reference Information Center, Portals II, 445 12th Street, S.W., Room CY-A257, Washington, DC 20554. Copies may also be purchased from the Commission's duplicating contractor, BCPI, 445 12th Street, S.W., Room CY-B402, Washington, DC 20554. Customers may contact BCPI through its Web site: <http://www.bcpweb.com>, by e-mail at fcc@bcpweb.com, by telephone at (202) 488-5300 or (800) 378-3160 (voice), (202) 488-5562 (TTY), or by facsimile at (202) 488-5563.

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

Initial Paperwork Reduction Act of 1995 Analysis

This document contains proposed information collection requirements. The Commission, as part of its continuing effort to reduce paperwork burdens, invites the general public and the Office of Management and Budget (OMB) to comment on the information collection requirements contained in this document, as required by the Paperwork Reduction Act of 1995, Public Law 104-13. Public and agency comments are due October 8, 2010.

Comments on the proposed information and collection requirements should address: (a) Whether the proposed collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; (b) the accuracy of the Commission's burden estimates; (c) ways to enhance the quality, utility, and clarity of the information collected; (d) ways to minimize the burden of the

collection of information on the respondents, including the use of automated collection techniques or other forms of information technology; and (e) ways to further reduce the information collection burden on small business concerns with fewer than 25 employees. In addition, pursuant to the Small Business Paperwork Relief Act of 2002, Public Law 107-198, *see* 44 U.S.C. 3506(c)(4), we seek specific comment on how we might further reduce the information collection burden for small business concerns with fewer than 25 employees.

OMB Control Number: 3060-0804.

Title: Universal Service—Rural Health Care Program.

Form No.: FCC Form 465, 466, 466-A, 467 (currently approved), newly proposed FCC Forms 464-A, 464-B, 464-Q, and 468.

Type of Review: Revision of currently approved collection.

Respondents: Not-for-profit institutions; Business or other for-profit institutions; and State, local, or Tribal Government.

Number of Respondents and

Responses: 11,000 and 46,721.

Estimated Time per Response: 1.5 hours.

Frequency of Response: Annually, Quarterly and One-time only.

Obligation to Respond: Required to obtain or retain benefits.

Total Annual Burden: 58,360 hours.

Total Annual Costs: \$3,118,069.06.

Privacy Act Impact Assessment: This information collection does not affect individuals or households; thus, there are no impacts under the Privacy Act.

Nature and Extent of Confidentiality: There is no need for confidentiality.

However, respondents may request materials or information submitted to the Commission be withheld from public inspection under 47 CFR 0.459 of the Commission's rules.

Needs and Uses: The information collected provides the Commission with the necessary information to administer the rural health care support mechanism, determine the amount of support entities seeking funding are eligible to receive, and inform the Commission about the feasibility of revising its rules.

Statutory Authority: Statutory authority for this collection is contained in 47 U.S.C. 151, 154(i), 154(j), 201-205, 214, 254, and 403.

Synopsis of the Notice of Proposed Rulemaking

I. Introduction

1. The NPRM seeks comment on a package of potential reforms to the rural health care program that could be

implemented in funding year 2011 (July 1, 2011–June 30, 2012).

2. The proposed reforms include: (1) Establishing a broadband infrastructure program (the “health infrastructure program”) that would support up to 85 percent of the construction costs of new regional or statewide networks to serve public and non-profit health care providers in areas of the country where broadband is unavailable or insufficient; (2) establishing a broadband services access program (the “health broadband services program”) that would subsidize 50 percent of the monthly recurring costs for access to broadband services for eligible public or non-profit rural health care providers, which should make broadband connectivity more affordable for providers operating in rural areas; (3) expanding the Commission's interpretation of “eligible health care provider” to include acute care facilities that provide services traditionally provided at hospitals, such as skilled nursing facilities and renal dialysis centers and facilities, and administrative offices and data centers that do not share the same building as the clinical offices of a health care provider but that perform support functions critical for the provision of health care; (4) clarifying the Commission's existing recordkeeping requirements to enhance its ability to protect against waste, fraud and abuse; and (5) eliminating the current rule that requires that funding be offset against universal service contributions owed by participating service providers, and instead propose to allow service providers participating in the health broadband services program, telecommunications program, and health infrastructure program to receive rural health care funds directly from USAC.

3. The Commission also seeks comment on the following: (1) How to prioritize funding requests for rural health care support to the extent demand exceeds the annual \$400 million funding cap; and (2) ways to enhance ongoing program evaluation and implementation of performance measures to ensure that the public realizes benefits from the investment of universal service funding to improve broadband connectivity for health care providers.

4. In addition to the changes discussed below, the proposed rules include non-substantive changes to the rules applicable to the telecommunications program. We seek comment on such changes.

II. Health Infrastructure Program

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

6. In establishing the Pilot Program, the Commission noted that many health care providers were unable to access certain telehealth services without deployment of broadband facilities. Despite the overwhelming interest and participation levels in the Pilot Program, the National Broadband Plan found that a large broadband connectivity gap still exists, particularly among small, rural providers. For example, the National Broadband Plan identified a broadband connectivity gap among an estimated 3,600 out of approximately 307,000 small providers. 70 percent of those small providers lacking access to mass-market broadband services—approximately 2,500 providers—are located in areas that the Commission defines as rural. The National Broadband Plan also found that larger physician offices (*i.e.*, five or more physicians), larger clinics and hospitals also face broadband connectivity barriers; it noted that due to their size and health IT service needs, such health care providers cannot utilize mass-market broadband, but require dedicated Internet access (DIA) solutions.

7. Consistent with its authority under section 254(h)(2)(A) of the Act, the Commission proposes to create a “*health infrastructure program*” to fund up to 85 percent of eligible costs for the design, construction and deployment of dedicated broadband networks that connect public or non-profit health care providers in areas of the country where the existing broadband infrastructure is inadequate. The program would provide support for the construction of State or regional broadband health care networks that can, for example, connect rural and urban health care providers, facilitate the transmission of real time video, pictures, and graphics, bridge the silos that presently isolate relevant patient data, make communications

resources more robust and resilient, and maximize the efficiency and reliability of packet routing. Broadband infrastructure projects may include either new facilities or improvements to upgrade existing facilities (for example, converting a copper facility to a fiber facility capable of broadband delivery). In addition, funding may be used to support up to 85 percent of the cost of connecting health care networks to Internet2 or National LambdaRail (NLR), both of which are non-profit, nationwide backbone providers.

A. Program Process

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

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

10. *Project Selection Phase.* The Commission proposes that applications submitted for funding be made publicly available on USAC’s Web site. Publicly available information would include the names of the parties seeking funding, their geographic location, and information filed by the applicants to corroborate that sufficient broadband infrastructure is unavailable or insufficient in their geographic location. During the second quarter of each funding year (October 1 to December 31), USAC would review all

applications received during the initial application phase. The Commission seeks comment below on limiting the total number of projects that may be selected in a given year. The Commission also seeks comment below on prioritization rules to be applied by USAC in the event that funding requests exceed the annual amount available under the health infrastructure program. After applications have been reviewed, and prioritization rules have been applied, USAC would notify selected participants of their project eligibility status. This would normally occur during the third quarter of each funding year (January 1 to March 30). After a participant is notified of project eligibility, it may proceed with the project commitment phase per the requirements set forth below. During the project commitment phase, participants may receive funding from the health infrastructure program for a portion of the reasonable administrative expenses incurred in connection with the project, subject to certain caps as discussed further below.

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

12. *Build-Out Period.* The Commission proposes that participants have a period of three funding years (commencing with the funding year in which the initial online application was submitted) to file all forms and supporting documents necessary to

receive funding commitment letters from USAC; and a period of five years (commencing on the date on which the participant receives its first funding commitment letter for the project) in which to complete build-out.

B. Demonstrated Need for Infrastructure Funding

13. The Commission proposes that applicants under the health infrastructure program demonstrate that broadband, at the connectivity speeds defined below, is presently unavailable or insufficient for health IT needed to improve or provide health care delivery requested by the eligible health care providers seeking funding. The Commission seeks comment on this proposal.

14. *Connectivity Speed.* The Commission seeks comment on setting a minimum threshold for broadband connectivity speeds under the health infrastructure program. The National Broadband Plan suggested that most businesses in the United States, including health care providers, have two choices of broadband service: Mass-market, small business solutions of 4 Mbps or more, or dedicated Internet access (DIA) solutions of 10 Mbps or more. Because the focus of the health infrastructure program is to fund dedicated networks, the Commission proposes setting 10 Mbps as the minimum broadband speed for infrastructure deployment supported under the health infrastructure program. The Commission seeks comment on this proposal. The Commission also seeks comment on minimum levels of reliability, including physical redundancy, to support health IT services and what can be done to encourage reliability. The Commission also seeks comment on the minimum quality of service standards necessary to meet health IT needs. The Commission seeks comment on whether the health infrastructure program should contain a minimum quality of service requirement.

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

qualified network vendors for such services.

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

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

- Provide copies or linked references to recognized broadband mapping studies, such as NTIA's national broadband map, State or local broadband maps, and other mapping sources that adequately depicts the available broadband in the proposed network area. In addition to referencing such NTIA or State broadband mapping studies, the applicant would be required to provide a report detailing why existing broadband infrastructure would be insufficient to meet the needs of the eligible health care providers that are proposing the infrastructure project.

- Certify that, for a continuous period of not less than six months, the health care providers in the proposed dedicated network requested broadband

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

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

18. The Commission invites comments on whether the above criteria are sufficient to establish that broadband is unavailable or insufficient. In addition, the Commission invites comments on other ways in which health care providers could demonstrate, or interested stakeholders could challenge, the sufficiency of existing broadband infrastructure. When possible, such comments should indicate publicly available sources that could be used to determine the existence or absence of adequate broadband infrastructure.

19. All information submitted by applicants to establish that broadband is unavailable or insufficient would be

subject to review and verification by USAC.

C. Letters of Agency

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

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

under the health infrastructure program would be passed on to the consortium members that are eligible health care providers.

22. The Commission also proposes that in the case of a consortium, the legally and financially responsible entity that owns dedicated facilities funded by the health infrastructure program could be a State organization, public sector (governmental), or not-for-profit entity acting as a fiduciary agent for eligible health care providers within such consortium. For example, a State, public (government) or non-profit entity acting as administrative agent for a consortium of eligible health care providers seeking funding for a dedicated network could also serve as the title owner of the dedicated network. However, the Commission proposes that title to the dedicated network would be held exclusively for the benefit of eligible health care providers. The Commission seeks comment on the above proposals.

D. Funding Requests and Budgets

23. The Commission proposes that every applicant's initial application include a funding request, a brief project description and a detailed budget. The funding request should not exceed 85 percent of the eligible costs identified in the budget. The Commission seeks comment on the proposals set forth below.

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

25. *Cap on Number of Projects per Year.* Further, the Commission seeks comment on whether to adopt a rule setting a maximum number of projects to be selected for funding each year. One of the lessons learned from the Pilot Program is that many applicants

were ill-prepared to undertake the complex process of developing a new health care network, and consequently many required ongoing coaching and support to navigate their way through the process. A smaller number of projects will allow USAC to devote greater resources and time in ensuring their success. Also, unlike the Pilot Program, projects not selected for funding in any funding year will have opportunities to apply for funding in subsequent funding years. If the number of projects that apply and qualify for funding in any year exceeded such a cap, should priority be given to those projects that connect the greatest number of rural health care providers? If the Commission adopts a cap on the number of projects that may be funded per year, it seeks comment on whether such cap should be in addition to or in lieu of a cap on the amounts funded per project.

26. *Budget.* The Commission proposes that together with the funding request, applicants submit a detailed budget that identifies all costs related to the proposed project. The budget should be reasonable, and should be based on pricing information available to the applicant. All material assumptions used in preparing the budget should be noted and discussed in narrative form. The budget should separately identify the following (each subject to the limitations identified in this NPRM): (1) Eligible non-recurring costs; (2) eligible administrative expenses; (3) eligible network design costs; (4) eligible maintenance costs; (5) eligible NLR or Internet2 membership fees; and (6) all costs that are necessary for completion of the project, but that are not eligible for support under the health infrastructure program. If a budget line item contains both eligible and ineligible components, costs should be allocated to the extent that a clear delineation can be made between the eligible and ineligible components.

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

28. The Commission proposes that USAC review all project budgets for compliance with program rules. USAC could assist prospective applicants with tools that provide benchmark cost estimates for certain items common to

all infrastructure projects. The Commission proposes allowing budgets submitted by program applicants and program participants to be made available publicly so that other prospective applicants may use such information as a basis for preparing their own budgets. The Commission seeks comment on the above proposals.

E. Eligible Costs

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

30. *Network Design.* While network design would be eligible for funding, the primary focus of the health infrastructure program should be capital costs for infrastructure construction and deployment. Therefore, the Commission proposes that support for eligible network design costs be limited to \$1 million per project or 15 percent of the project's eligible costs, whichever is less. The Commission seeks comment on this proposal.

31. *Administrative Expenses.* The Commission proposes that, for the health infrastructure program only, reasonable administrative expenses incurred by participants for completing the application process may be eligible for some limited support. Examples of administrative expenses are costs incurred in preparing request for proposals, negotiating with vendors, reviewing bids, *etc.* The Commission's experience with the Pilot Program supports the need to provide some amount of funding for administrative expenses in infrastructure projects, to support the process of designing the network and securing necessary agreements. Participants have indicated that the costs associated with infrastructure deployment can be a considerable financial burden on participants that are designing and deploying networks over vast geographic areas. Allowing a portion of funding to be used for administrative expenses could enable program participants to explore more efficient,

effective means of deploying broadband for the delivery of health care. Accordingly, the Commission proposes that after a participant is selected for funding based on its initial application, it may request funding for up to 85 percent of the reasonable administrative expenses incurred in connection with the project.

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

33. *Maintenance Costs.* The Commission proposes allowing limited support for up to 85 percent of the reasonable, necessary and customary ongoing maintenance costs for networks funded by the health infrastructure program. Such costs would include, for example, service agreements to operate and maintain dedicated broadband facilities. The primary focus of the health infrastructure program is to create a sustainable broadband infrastructure where access is presently inadequate. The Commission seeks comment on whether support for maintenance costs should be limited to a defined period of time, such as three years from completion of build-out of a

project, or five years from the first funding commitment letter issued for such project (whichever period is shorter). Participants should be able to demonstrate in their sustainability plans that the costs of network operations and maintenance will be sustainable after such period of support from the health infrastructure program. Service agreements for network maintenance will be subject to competitive bidding rules, and may be bid either at the time of construction of the network or at a later time. The Commission seeks comment on this proposal.

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

35. For the Pilot Program, the Commission provided that connections to Internet2 or NLR were not subject to the competitive bidding rules requirement. For the health infrastructure program, the Commission proposes that participants may either pre-select to connect with either Internet2 or NLR, and seek funding for such connection, or may (at their discretion) seek competitive bids from NLR and Internet2 through the normal competitive bidding process. Allowing a participant to pre-select NLR on

Internet2 should provide the participant with an opportunity to more fully develop the specific elements of its infrastructure proposal, particularly where only a specific non-profit nationwide backbone provider will fulfill the participant's network plan or meet its need to access a particular institution that is currently connected to only one nationwide network. If Internet2 or NLR are pre-selected by a participant, the costs of connection to such nationwide backbone must be reasonable. The Commission invites comment on its proposal to exempt connections to Internet2 and NLR from the competitive bidding rules in the new health infrastructure program. Regardless of whether they choose to pre-select NLR or Internet2, participants in the health infrastructure program will be subject to the Commission's audit authority. The Commission emphasizes that it retains the discretion to evaluate the activities of participants and determine on a case-by-case basis whether waste, fraud, or abuse has occurred and whether corrective action is necessary.

F. Ineligible Costs

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

- Personnel costs (including salaries and fringe benefits), except for those costs that qualify as administrative expenses, subject to the limitations set forth in paragraphs 37 and 38 of this NPRM.

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

- Legal costs.

- Training, except for basic training or instruction directly related to and required for broadband network installation and associated network operations. For example, costs for end-user training, *e.g.*, training of health care provider personnel in the use of telemedicine applications, are ineligible.

- Program administration or technical coordination, except for those costs that qualify as administrative expenses, subject to the limitations set forth in paragraphs 37 and 38 of this NPRM.

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

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

- Helpdesk equipment and related software, or services.

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

- Telemedicine applications and software.

- Clinical or medical equipment.

- Electronic records management and expenses.

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

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

- Administration and marketing costs (*e.g.*, administrative costs; supplies and materials; marketing studies, marketing activities, or outreach efforts; evaluation and feedback studies), except for those costs that qualify as eligible administrative expenses, subject to the limitations set forth in paragraphs 37 and 38 of this NPRM.

- Continuous power source.

37. *Billing and Operational Expenses.*

The Commission proposes that the health infrastructure program not provide support for billing and operational expenses incurred either by a health care provider or its selected vendor. An example of billing or operational costs is the expense that service providers may charge for

allocating costs to each health care provider in a project's network. Because the Commission does not require that costs be allocated in this manner, such billing and operational costs should not be eligible for support. The Commission seeks comment on this proposal.

G. *Fifteen Percent Contribution Requirement*

38. *Minimum Participant*

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

39. The Commission notes that the matching funds requirement for the Broadband Technology Opportunities Program (BTOP), established pursuant to the Recovery Act, is generally 20 percent of eligible costs, and that the Broadband Initiatives Program (BIP), also established pursuant to the Recovery Act, will fund 75 percent in grants and 25 percent in loans. The Commission has learned from its experience with the Pilot Program that some applicants have difficulty even meeting a 15 percent contribution requirement. At the same time, one of the benefits of increasing the contribution requirement to 20 percent or higher would be that more funds would be available under the program to fund additional projects. The Commission invites comment on whether it should consider a higher level of participant contribution for

health infrastructure projects. Commenters should identify whether, in light of higher levels of participant contributions in the BTOP and BIP programs, the contribution requirement for the health infrastructure program should be more than 15 percent to ensure better efficiencies and greater level of "at risk" commitment by participants to their projects.

40. *Evidence of Viable Source for 15 Percent Contribution.* The Commission proposes that, within 90 days after being notified of project selection, participants demonstrate that they have a reasonable and viable source for the minimum 15 percent contribution. Many projects in the Pilot Program indicated deployment delays due to many factors, including difficulty in obtaining the minimum 15 percent contribution. This, among other factors, resulted in the Bureau extending (by one year) the deadline for participants in the Pilot Program to select vendors and request funding commitments from USAC. To ensure that projects are completed in a timely manner, it is important for participants in the health infrastructure program to meet a date certain by which they have secured the minimum 15 percent contribution for eligible project costs. Doing so will ensure that program funds are not indefinitely allocated to projects that cannot proceed to completion due to lack of adequate financial contribution from the participant. The Commission therefore proposes that after a participant has been notified that, based on its initial application, its project is eligible for funding, the participant have a period of 90 days to submit letters of assurances confirming funds from eligible sources to meet the 15 percent minimum contribution requirement. The Commission seeks comment on this proposal.

41. *Eligible Sources.* The Commission proposes placing limitations on the eligible sources for matching funds. Selected participants would be required to identify with specificity their source(s) of funding for the minimum 15 percent contribution of eligible network costs. Only funds from an eligible source may apply towards meeting this requirement. As in the Pilot Program, eligible sources would be limited to (1) Eligible health care providers; (2) State grants, funding, or appropriations; (3) Federal funding, grants, loans, or appropriations (but not other universal service funding); and (4) other grant funding, including private grants. Participants who do not demonstrate that their 15 percent contribution comes from an eligible source or whose minimum 15 percent contribution is derived from an ineligible source would

be denied funding by USAC. Ineligible sources would include (1) in-kind or implied contributions; (2) a local exchange carrier (LEC) or other telecom carrier, utility, contractor, consultant, or other service provider; and (3) for-profit participants. Moreover, selected participants may not obtain any portion of their 15 percent contribution from any universal service support program. These limitations on eligible sources would safeguard against program manipulation, and would prevent conflicts of interest or influence from vendors and for-profit entities that may lead to waste, fraud, and abuse. The Commission therefore proposes that these limitations, which were applied to the Pilot Program, be applied to the health infrastructure program. The Commission seeks comment on the proposed list of eligible sources.

H. Project Milestones

42. To ensure that projects proceed to completion, the Commission proposes that participants submit a project schedule that identifies the following project milestones: start and end date for network design; Start and end date for drafting and posting RFPs; start and end date for selecting vendors and negotiating contracts; start date for commencing construction and end date for completing construction; and target dates for each health care provider to be connected to the network and operational. The project schedule should be submitted within 90 days after a participant has been notified that, based on its initial application, the project is eligible for funding. The project schedule would also have to be updated at the time that quarterly reports are filed by the participants, noting which project milestones have been met and any progress or unanticipated delays in meeting other milestones. The Commission proposes that in the event a project milestone is not achieved, or there is a material deviation from the project schedule, the participant would provide an explanation in the quarterly reports. Requiring participants to establish a schedule and report on project milestones for infrastructure projects would assist USAC and the Commission in assessing a participant's progress in completing project build-out, and would reduce fraud, waste and abuse. The Commission seeks comment on these proposals. The Commission also seeks comment on whether it should require participants to include other information in addition to or in lieu of project milestones. Such information should serve as a way to monitor project progress.

I. Detailed Project Description

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

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

45. *Network Coverage.* The Commission proposes that the project description should include the identity and location of all network participants, and should include a network diagram. Participants would be required to indicate how they plan to fully utilize their proposed network to provide health care services, and would be required to present a strategy for aggregating the specific needs of health care providers within a State or region, including providers that serve rural areas. The project description should also discuss whether the proposed network will connect to a national backbone, such as NLR or Internet2. Networks may be limited to a particular State or region, but participants should describe feasible ways in which such networks will connect to a national broadband network. Designing networks so that they may, where feasible, connect to a dedicated national network will allow health care providers the

opportunity to benefit from advanced applications in continuing education and research and will also enhance the health care community's ability to provide a rapid and coordinated response in the event of a national crisis. The Commission seeks comment on these proposals.

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

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

48. *Emergency Response Connectivity.* The Commission seeks comment on whether every project should be

required to include ways in which the proposed network will be used in emergency response and meet disaster preparedness requirements. The Commission also seeks comment on whether every project should be required to include ways in which the proposed network will provide effective and secure connectivity, and peering with other networks in order to address global public health and border issues.

J. Facilities Ownership, IRU or Capital Lease Requirements

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

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

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

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

particular lease under GAAP, the participant may be required to provide an explanation justifying the classification of its leasing arrangement as a capital lease. The Commission invites comment on this proposal.

52. *No Short-Term Leases.* The Commission proposes that short-term or operating leases are not eligible for funding under the health infrastructure program. Because the primary focus of the health infrastructure program is the construction and sustainability of broadband infrastructure facilities, the Commission does not believe that short-term or operating leases are appropriate. In a short-term lease, ownership of the funded asset would revert back to the vendor at the conclusion of the term of the lease, conferring a benefit on the vendor and not the health care provider. This is inconsistent with the goal of funding infrastructure programs for the creation of sustainable, long-term dedicated broadband networks used for health care purposes. The Commission therefore proposes that short-term or operating leases are not an acceptable vehicle for deploying facilities under the health infrastructure program. The Commission invites comment on this proposal.

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

K. Standard Terms and Conditions

54. The Commission proposes adopting requirements that construction contracts, IRUs or eligible capital leases entered into by health care providers for infrastructure projects contain certain mandatory provisions. This would ensure consistency among projects, and

will help health care providers to negotiate contracts that meet at least a basic level of assurance. The Commission emphasizes that such standard terms and conditions would not be a substitute for further negotiated terms that health care providers may deem necessary in their business judgment. The Commission expects health care providers to exercise due diligence in negotiating such contracts with vendors. The Commission seeks comments on these proposed terms and conditions, and inquires whether additional or different provisions should be required.

55. *Construction Contracts.* The Commission proposes that the following provisions should be included in all construction contracts:

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

56. *IRU.* The Commission proposes that the following provisions should be included in all IRUs:

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

57. *Capital Leases.* The Commission proposes requiring that the payment structure in a capital lease should be reflective of the term of the lease. Lease payments in advance of the lease term would not be allowed. For example, in a ten-year lease, the Commission would not allow an upfront payment of the

entire ten-year lease period. Such prepayments present a significant risk that the vendor could default or go into bankruptcy after the pre-payment has been made, resulting in the loss of funds.

58. *Provisions Applicable to all Contracts.* Whether a construction contract, an IRU, or a capital lease, the Commission proposes that all contracts should have provisions that address the following:

- *Laws and Regulations.* The vendor shall comply with all Federal, State and municipal laws, ordinances and regulations (including building and construction codes) applicable to the performance of the work.
- *Environmental Protection.* The vendor shall comply with all applicable Federal, State and municipal environmental laws and regulations which relate to environmental protection, inspection and monitoring of property and environmental reporting and information requirements.
- *Performance Bonds.* For contracts in excess of \$150,000, the vendor shall deliver a performance bond. For construction contracts, performance bonds should be for the construction term of the contract plus a period of not less than one year (*i.e.*, the same period in which the health care provider may require the vendor to remedy defects in the work). For a lease or an IRU, performance bonds should be for the entire term of the agreement.
- *Indemnification.* The vendor agrees to indemnify and hold harmless the health care provider from any and all claims, actions, or causes of action to the extent the claimed loss or damages arises out of the vendor's negligent performance or nonperformance of its obligations under the contract.

L. Sustainability Reporting Requirement

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

- *Principal Factors.* Discuss each of the principal factors that were considered by the participant to demonstrate sustainability.
- *Minimum Fifteen Percent Funding Contribution.* Discuss the status of obtaining the minimum 15 percent

contribution for eligible project costs. If project funding is dependent on appropriations or other special conditions, such conditions should be discussed.

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

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

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

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

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

60. The Commission seeks comment on whether additional or different

sustainability requirements should be included.

M. Shared Use

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

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

63. *Fully-Distributed and Incremental Costs.* Telecommunications networks generally provide multiple services over a shared plant. Telecommunications regulators in setting prices for telecommunications services have generally had to allocate the costs of the shared plant to the various services. Two traditional methods for assigning costs to services are to employ incremental cost or fully distributed costs. In economic theory, the term "incremental cost" refers to "the additional costs (usually expressed as a cost per unit of output) that a firm will incur as a result of expanding the output of a good or service by producing an additional quantity of the good or service." The term "common cost" refers to "cost that are incurred in connection with the production of multiple products or services, and remains unchanged as the relative proportion of those products or services varies * * *". Where multiple services are produced by a shared plant, pricing those services on the basis of their incremental cost is unlikely to generate revenues sufficient to recover the total costs of production. Accordingly, regulators traditionally have allocated the common costs among the multiple services so as to recover the total costs of the plant. A common approach has been to adopt "fully

distributed cost" (or fully allocated cost) pricing rules, which allocate costs on the basis of relative output levels, revenues or attributable costs.

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

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

66. The Commission seeks comment on these proposed distinctions between fully-distributed costs and incremental costs, and solicits alternative proposals.

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

planning and design, obtaining rights of way, deployment, modulating equipment costs, and maintenance and operation costs?

68. In the event the Commission adopts an incremental cost approach, should it make a bright line distinction so if ineligible users take more than a set percentage of the network's capacity, then they would be required to pay a larger share based on fully-distributed costs (rather than merely incremental cost)?

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

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

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

- All revenues generated by the network from allowing non-eligible health care providers to use the network's excess capacity must be retained by the network to operate,

maintain and support the network. This could include, for example, purchasing equipment or applications necessary for the network or the applications that run over it.

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

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

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

71. *Excess Capacity Disclosures.* If an infrastructure project includes excess capacity, the Commission proposes requiring applicants to disclose the estimated amount of excess capacity as part of its sustainability plan, and to explain how they plan to allocate the cost of the network between the network members that are eligible health care providers and the members that are not eligible health care providers. In doing so, participants would be required to: (1) identify non-eligible users of such excess capacity and explain what proportion of the network non-recurring and recurring costs they will bear, and (2) describe all agreements made between the eligible health care providers and other participants in the network (*e.g.*, cost allocation, facility sharing agreements, maintenance and access obligations, ownership rights). The Commission seeks comment on this proposal, and on how recipients should be required to document the required cost allocation (whether fully-distributed cost or/and incremental cost). Particularly, the Commission seeks comment on how to determine what constitutes "fully-distributed costs" in situations where there are various types of ownership interests (*e.g.*, IRU or capital lease) proposed in this notice.

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

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

73. *Priority Preferences for Projects That Include Additional Capacity for Community Use.* For each of the above types of additional capacity for community use listed in paragraph 77, the Commission seeks comments on whether projects funded by the health infrastructure program should include, restrict, or allow these types of joint or shared projects. The Commission also invites comment on priority preference and other issues. For example:

- If the Commission caps the number of projects per year, or if the number of projects per year under the health infrastructure program exceeds the proposed \$100 million funding cap, should the Commission give special prioritization treatment to projects that plan to allow use of excess capacity by schools and libraries that are otherwise eligible for universal service funding?

- Should the Commission give priority to projects that allow use of excess capacity by State or local government (including government offices, police, fire departments and Emergency Medical Services)?

- Should other community use be allowed or restricted?

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

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

76. Commenters should address how permitting joint projects that include additional capacity for community use would be consistent with the resale restrictions contained in section 254(h)(3) of the Act. The use of such

additional capacity by the community would not violate the restrictions against sale, resale or other transfer contained in section 254(h)(3) of the Act because, in such instances, health care providers would retain ownership of the additional capacity, and payments to the network for the use of such additional capacity would be retained to sustain the network. The Commission seeks comment on this analysis.

N. Vendor Cost Reporting Requirements

77. The Commission proposes requiring that health care providers obtain certain cost information from vendors. The Commission seeks comment on its proposal, as detailed below. Because infrastructure projects are complex and involve a significant amount of funding, it is important that participants exercise due diligence in determining costs. To assist participants in this process, and to mitigate waste, fraud and abuse, the Commission proposes that participants in the health infrastructure program should:

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

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

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

O. Quarterly Reporting Requirements

78. The Commission proposes requiring that health infrastructure program participants submit quarterly reports that provide information on the following: (1) Attaining project milestones, (2) status of obtaining the 15 percent minimum match, (3) status of the competitive bidding process, (4) details on how the supported network has complied with HHS health IT

guidelines or requirements, such as meaningful use, if applicable; and (6) performance measures. The Commission seeks comment on this proposal, and on whether such reports should only be required annually or semi-annually. Such information could inform the Commission's understanding of cost-effectiveness and efficacy of the different State and regional networks funded by the program and guide future decision-making. This information should also enable the Commission to ensure that universal service funds are being used in a manner consistent with section 254 of the Act and the Commission's rules and orders. In particular, collection of this information is critical to the goal of preventing waste, fraud, and abuse by ensuring that funding is flowing to its intended beneficiaries. Participants should also note that submission of a quarterly report is not a substitute for seeking consent for any material modification to the original application.

P. Competitive Bidding

79. The Commission proposes that all projects funded by the health infrastructure program be subject to fair and open competitive bidding. Currently, health care providers seeking support under the Rural Health Care Support Mechanism post a request for services on USAC's Web site for a period of at least 28 days, using FCC Form 465, which serves as a method for USAC and potential vendors to be aware of requests for services. Because of the complexity of infrastructure projects, participants in the health infrastructure program should be explicitly required to prepare a detailed request for proposals (RFP) that provides sufficient information to define the scope of the project, and to distribute the RFP in a method likely to garner attention from interested vendors. For example, participants could (1) post a notice of the RFP in trade journals or newspaper advertisements, (2) send the RFP to known or potential service providers, (3) include the RFP on the health care provider's Web page or other Internet sites, or (4) follow other customary and reasonable solicitation practices used in competitive bidding. Adding this mandatory RFP preparation and distribution requirement could increase the quality and quantity of bids received by health care providers for their network projects, and will therefore result in a more efficient use of funding under the health infrastructure program. The Commission seeks comment on whether participants also should be required to post an FCC Form 465 and note on that form that they have issued

a detailed RFP. If participants using an RFP are not required to use an FCC Form 465, then the certifications that are contained in the Form 465 would be included in a substitute form.

80. The Commission recognizes that in certain smaller projects, or in projects that are subject to mandatory, State or local procurement rules, its proposed RFP preparation and distribution requirements may not be practical or cost-effective. Accordingly, the Commission's proposed RFP requirements would not be applicable to infrastructure projects of \$100,000 or less or projects that are subject to mandatory State or local procurement rules. However, such projects would still be required to complete a request for services on an Form 465 and post this request on USAC's Web page for a period of at least 28 days before selecting a vendor. The Commission proposes that health care providers be required to certify that each service or facility provider selected for an infrastructure project supported by the health infrastructure program is, to the best of the health care provider's knowledge, the most cost-effective service or facility provider available, as defined in our rules. The Commission seeks comment on the above proposals.

Q. Designation of Successor Projects

81. The Commission proposes that USAC monitor each funded participant's progress, as defined by their project milestones, and alert the Wireline Competition Bureau (Bureau) in the event of any significant project delays or concerns. Similar to the Pilot Program, the Commission proposes delegating to the Bureau the authority to waive the relevant sections of Subpart G of Part 54 of the Commission's rules to the extent waiver may be necessary to the sound and efficient administration of the health infrastructure program.

82. The Commission also proposes that in instances where a participant is unable to complete its project, the Wireline Competition Bureau would have authority to designate a successor project, similar to the delegation of authority for the Pilot Program. Such designation of a successor could be made upon request of the participant, or on the Bureau's own motion. The Bureau would exercise such discretion in instances where a project fails to meet a specified milestone, or a participant fails to adequately notify the Commission of modifications to the project milestone deadlines. In selecting a successor project, the Bureau would take into consideration the likelihood that the successor will be able, at a minimum, to complete the project in a

manner that provides new broadband infrastructure to the identified region or area. The Commission also proposes delegating authority to the Bureau to revoke funding awarded to any selected participant making unapproved material changes to the network design plan set forth in the participant's detailed project description submitted as part of the funding application materials. The Commission seeks comment on the proposals outlined above. As a final matter, the Commission also seeks comment on ways for the Bureau and USAC to improve outreach efforts in assisting projects through the Commission's administrative process.

R. NEPA and NHPA Requirements

83. Certain projects funded by the health infrastructure program could implicate the National Environmental Policy Act (NEPA) and the National Historic Preservation Act (NHPA). If NEPA and NHPA are implicated by a particular proposed project, the Commission invites comment on the point in the application process at which participants should be required to comply with the requirements codified in the Commission's rules.

II. Health Broadband Services Program

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

85. In establishing the level of support for the Internet access program, the Commission concluded that a flat discount percentage of 25 percent off the cost of monthly Internet access would assist health care providers seeking to purchase Internet services, while also providing incentives for rural health care providers to make prudent economic decisions concerning their telehealth needs. The Commission found that a flat discount would be easy to administer and consistent with section 254(b)(5), which requires "a specific, sufficient, and predictable

mechanism * * * because it limits the amount of support that each health care provider may receive per month to a reasonable level." The Commission also determined that a flat discount would lead to greater predictability and fairness among health care providers. In setting the discount level at 25 percent, the Commission acted conservatively based on the belief that this amount would provide an incentive for rural health care providers to choose a level of service appropriate to their needs, ensure that demand for Internet access support would not exceed the annual funding cap, and deter wasteful expenditures. The Commission stated that as it gained more experience with this aspect of the support mechanism, it would reassess the appropriateness of the 25 percent discount level.

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

A. Eligible Services

87. *Eligible Access and Transport Services.* Pursuant to section 254(h)(2)(A), and consistent with the recommendations made in the National Broadband Plan, the Commission proposes to replace the existing Internet access program with a new health broadband services program, which will subsidize 50 percent of an eligible rural health care provider's recurring monthly costs for any advanced telecommunications and information services that provide point-to-point broadband connectivity, including Dedicated Internet Access. The Commission seeks comment on this proposal. The Commission notes that section 254(h)(2)(A) is not limited to health care providers in rural areas. The Commission seeks comment on whether an appropriate first step for expanding funding for broadband services should be to focus on rural areas, given the particular challenges that rural communities often face in obtaining access to health care. The Commission also invites comment on whether this

proposal implicates section 254(h)(1)(A), and if so, how the Commission would implement the proposed health broadband services program in light of section 254(h)(1)(A). For instance, should the Commission require that recipients seeking funding for telecommunications services make an election as to whether they wish to receive support under the telecommunications program or under the new proposed health broadband services program?

88. As noted by the National Broadband Plan, when used effectively, broadband-based technologies can "help health care professionals and consumers make better decisions, become more efficient, engage in innovation, and understand both individual and public health more effectively." Currently, the Internet access program provides support equal to 25 percent of the monthly cost of Internet access reasonably related to the health care needs of rural health care providers. The Commission's current rules define Internet access as "an information service that enables rural health care providers to post their own data, interact with stored data, generate new data, or communicate over the World Wide Web." Under this definition, the Commission determined that Internet access provides access to the world-wide information resource of the Internet, and includes all features typically provided by Internet service providers to provide adequate functionality and performance. To qualify as Internet access under the definition, the Commission further stated that transmissions must traverse the Internet in some fashion.

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

Internet Access does not align with the needs of health care practitioners.

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

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

92. *Eligible Service Providers.* In the past, the Commission has permitted health care providers to seek discounts on “the most cost-effective form of Internet access, regardless of the platform.” Consistent with section 254(h)(2)(A), the Commission proposes that participants in the health broadband services program may seek supported services from any type of broadband provider, as long as the

participant selects the most cost-effective option to meet its health care needs. The Commission seeks comment on this proposal.

93. *Limitations to Prevent Waste, Fraud, and Abuse.* To guard against the possibility of waste, fraud, and abuse in the health broadband services program, the Commission proposes that the supported services must be reasonably related to the provision of health care services by an eligible health care provider. Second, eligible health care providers that seek support for telecommunications service offerings may not also request support from the telecommunications program for the same service. Lastly, all requests for discounts under the health broadband services program would comply with our rules on competitive bidding and cost-effectiveness, as discussed below. The Commission seeks comment on these proposals.

B. No Capital or Infrastructure Costs

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

95. The National Broadband Plan recommended that “federal and state policies should facilitate demand aggregation and use of state, regional and local networks when that is the most cost-efficient solution for anchor institutions to meet their connectivity.” The Commission proposes that eligible health care providers should be able to receive support for the lease of dark or lit fiber to provide broadband connectivity from any provider. Under such an approach, applicants would, for instance, be able to lease dark fiber that may be owned by State, regional or local governmental entities, when that is the most cost-effective solution to their connectivity needs.

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

C. Restrictions on Satellite Services

97. Section 254 directs the Commission to adopt rules that enhance access to advanced telecommunications and information services to the extent “technologically feasible and economically reasonable.” As noted by the National Broadband Plan, “the high fixed costs of designing, building and launching a satellite mean that satellite-based broadband is likely to be cheaper than terrestrial service only for the most expensive-to-serve areas.” The Commission proposes to require that a health care provider seeking support for satellite service demonstrate that it is the most cost-effective option available to meet the provider’s health care needs. The Commission also proposes to incorporate the rules currently governing the purchase of satellite services under the telecommunications program into the new health broadband services program. Currently, eligible health care providers may seek support for rural satellite services, even if a similar terrestrial-based service is available. However, discounts are capped at the amount that the provider would have received if they purchased a functionally similar terrestrial-based

alternative. The Commission seeks comment on these proposals.

D. Level of Support

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

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

100. The Commission notes that, on average, health care providers that applied for the urban/rural cost difference for eligible telecommunications services under the existing telecommunications program received funding commitments for a 60 percent discount on their cost of service; a significant number of those funding commitments are for T-1 lines. The Commission does not have sufficient information at this time regarding the comparative costs of higher bandwidth services that increasingly may be used by health care providers in the future as they employ health IT applications for telehealth and e-care, nor does the Commission have information that would enable it to develop an administratively workable affordability benchmark. Given the dearth of available information, a cautious approach could be to adopt a flat discount of 50 percent for monthly recurring costs and evaluate, after some period of time, whether such a flat discount results in increased adoption and utilization of broadband for health

care purposes. The Commission seeks comment on this proposal, as discussed in this section.

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

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

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

E. Competitive Bidding

104. The National Broadband Plan suggests that the Commission should evaluate the tools at its disposal, such as competitive bidding, to enhance its oversight of the Rural Health Care Support Mechanism. The Commission proposes to extend the competitive bidding requirements that are currently applicable to the Internet access program to the new health broadband services program. Specifically, the Commission proposes that each participant undertake a competitive bidding process by posting an FCC Form 465 prior to selecting a service provider, and certify that it considered all bids

received and selected the most cost-effective bid. The Commission seeks comment on this proposal. Are there changes the Commission can make to the competitive bidding mechanism to make it more successful or efficient? Are there certain types of situations that should be exempted from the competitive bidding requirements?

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

106. The Commission proposes to codify this practice as part of the new health broadband services program. If they choose to do so, program participants will be allowed to enter into multi-year contracts for recurring broadband services. Further, the Commission proposes that multi-year contracts that are competitively bid in accordance with the Commission's rules and are deemed to have evergreen status by USAC do not need to be re-bid each year, for the life of the contract. However, consistent with current policy, all health care providers would be required to continue to request support annually by filing an FCC Form 466-A. Additionally, any changes to the parties' evergreen contract, such as an extension, renewal, or the addition of services, would require the posting of a new FCC Form 465. Codifying this existing practice would maintain consistency while transitioning from the existing Internet access program to the new health broadband services program. Health care providers would also benefit from the opportunity to enter into long-term contracts with service providers, which may offer lower pricing than would be available on an annual basis. Moreover, the administrative obligations would be reduced for those providers who do not file a Form 465 each year. The Commission seeks comment on this proposal.

107. *Opting into the Health Broadband Services Program.* Under the Pilot Program, the Commission permitted participants to seek support for both the recurring and non-recurring costs associated with the deployment of broadband health care networks and the advanced telecommunications and

information services provided over those networks. When the Pilot Program ends, some participants may wish to transition to the new health broadband services program to subsidize the recurring costs formerly funded by the Pilot Program. The Commission seeks comment on whether Pilot Program participants whose original request for competitive bids included both non-recurring and recurring costs should be permitted to transition to the health broadband services program without undergoing a new competitive bidding process.

III. Eligible Health Care Providers

A. Administrative Offices

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

109. There are several reasons why the Commission thinks it appropriate to revisit this issue. In today's environment, while administrative offices do not provide "hands on" delivery of patient care, they often perform support functions that are critical to the provision of clinical care by rural health care providers. For example, administrative offices may coordinate patient admissions and discharges, ensure quality control and patient safety, and maintain the security and completeness of patients' medical records. Administrative offices also perform ministerial tasks, such as billing and collection, claims processing, and regulation compliance. Without an administrative office capable of carrying out these functions, an eligible health care provider may not be able to successfully provide patient care. From the Pilot Program, the Commission has also learned that administrative costs can be significant for rural health care providers and, in some cases, may prevent providers from adopting telemedicine at all. For example, one Pilot Program participant stated in its response to the *NBP Public Notice #17* that, despite efforts to

minimize costs, it had spent over \$160,000 on administrative expenses in approximately two years. By expanding the Commission's interpretation of section 254(h)(7)(B) to include funding for off-site administrative offices, the Commission could help to reduce the costs of telemedicine adoption for rural providers.

110. The Commission also recognizes that there is a wide variation in the way that health care providers structure their facilities. While some providers perform both clinical and administrative functions at a single, stand-alone facility, other providers require multiple sites and choose to house their administrative and clinical operations in separate buildings. It is becoming a best practice among health care providers to locate their administrative facilities off-site from the provider's primary facility. To the extent that administrative offices are owned or controlled by an eligible health care provider, the Commission proposes that they should be funded as a part of the eligible health care provider under section 254(h)(7)(B). It is impractical to distinguish administrative offices that are located off-site but otherwise perform the same functions as in-house administrative offices. The Commission seeks comment on this proposed change.

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

used primarily for performing services that are integral to the provision of health care by eligible health care providers. The Commission seeks comment on these proposals.

C. Data Centers

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

113. As health care providers rely more on advanced applications to meet the challenges of sharing, storing and retrieving electronic medical data and images, health care providers and organizations will likely need to depend more heavily on high-speed connectivity between key sites and data centers. As an administrative matter, it is impractical to disallow funding to data centers that provide the same functions as on-site entities, but happen to be located off-site. Like off-site administrative offices, the Commission therefore proposes that off-site data

centers that are owned or controlled by eligible health care providers should receive rural health care support as a part of the eligible health care provider under section 254(h)(7)(B).

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

D. Skilled Nursing Facilities

115. The Commission proposes that non-profit skilled nursing facilities be considered eligible for rural health care support under the category of “not-for-profit hospitals.” Skilled nursing facilities provide some of the same post-acute services that are traditionally provided at hospitals, such as the management, observation, and evaluation of patient care. As noted by the National Broadband Plan, under the changing technological landscape of rural health care, services are no longer clearly divided into traditional delivery models. The CDC reports that the number of acute care facilities has decreased, and services traditionally provided in hospital settings are increasingly performed at non-acute and post-acute care facilities. Skilled nursing facilities are an example of this trend. Specifically, due to advances in telemedicine, in many instances patients no longer need to be transferred to hospitals for treatment because they

can receive the same or similar treatment at a skilled nursing facility.

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

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

E. Renal Dialysis Centers and Facilities

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

119. Acute care provided by renal dialysis centers and renal dialysis facilities is consistent with the general schema of services traditionally provided by hospitals. The Commission also believes that inclusion of renal dialysis centers and renal dialysis facilities is consistent with CMS’s classification of these facilities. Additionally, the Commission proposes that a renal dialysis center or renal dialysis facility seeking rural health care support should be required to certify that, over the 12-month period preceding the date of application for support, the facility provided life-preserving ESRD treatment to at least 51 percent of its patients. The Commission seeks comment on the above proposals.

6. Annual Caps and Prioritization Rules

120. The aggregate annual cap for the Rural Health Care Support Mechanism is \$400 million. Given that current demand under the existing program has historically been less than \$70 million, we see no need to revisit the overall funding cap. The Commission does, however, believe it would be prudent to set an initial cap for the proposed health infrastructure program (within the overall \$400 million cap) to manage the portion of funding that supports new deployment as opposed to ongoing services. The Commission proposes to allocate up to \$100 million for infrastructure projects under the health infrastructure program, leaving at least \$300 million available annually for the telecommunications program and the health broadband services program. In the existing Pilot Program, the Commission made funding commitments to 62 infrastructure

projects in 42 States, which represented \$139 million per year. As discussed above, funding a smaller number of infrastructure projects on an annual basis, at least as it initially implements the new program, would be more administratively workable, and therefore the Commission proposes a cap of \$100 million per year for infrastructure projects. As the Commission gains more experience, it can re-evaluate and make subsequent changes to the program as appropriate.

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

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

123. For the health infrastructure program, the Commission seeks comments on how to prioritize funding in the event projects apply and qualify for funding in any funding year that collectively exceed the proposed \$100 million cap. For example, one method for prioritizing projects could be based on the following factors: (1) Total number of rural health care providers in the proposed network; (2) total number of health care providers (both urban and

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

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

125. The Commission also seeks comment on whether there are other publicly available criteria, in addition to HPSA scores, that could be used to prioritize funding. Alternatively, should

the Commission collect additional information from applicants that could be used to prioritize applications, and if so, what information should be collected in a standardized fashion for such purpose? Commenters should discuss the burden or additional reporting obligations that would be imposed on health care providers in compiling and submitting such information as part of their applications for funding.

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

7. Offset Rule

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

128. While the original intent of the offset rule was to prevent fraud, waste and abuse, it may no longer make sense today, particularly in light of the proposed reforms in this NPRM. The Commission has recognized that the offset rule can create inequities and inefficiencies, and has modified its applicability in the past. In establishing the Pilot Program, the Commission determined that the offset rule should not apply to that program because both telecommunications carriers and non-telecommunications carriers were eligible to provide services under the

program. The Commission determined it was in the public interest to distribute support to Pilot Program service providers in a neutral fashion, where neither the telecommunications carriers nor the non-telecommunications carrier would be subject to the offset rule. The Commission recognizes that the offset rule could create administrative difficulties in the future, if the Commission authorizes support for services provided by entities that do not contribute to the universal service fund.

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

8. Protecting Against Waste, Fraud, and Abuse

130. The Commission proposes that participants in the health infrastructure program and the health broadband services program should continue to be subject to any currently applicable rules pertaining to audits, recordkeeping, and duplicate support. The Commission seeks comment on the proposals described below.

131. With respect to audits, the Commission proposes that participants in both programs will be subject to random compliance audits to ensure compliance with program rules and orders. The Commission also proposes that program participants and service providers will be required to maintain certain documentation related to the purchase and delivery of services funded by the Rural Health Care Support Mechanism, and will be required to produce those records upon request. However, the Commission proposes to make the following clarifications to its recordkeeping rules: First, the Commission proposes to clarify that the documents to be retained by participants and service providers under the program should include all

records related to the participant's application for, receipt of, and delivery of discounted services. Second, the Commission proposes to amend the Commission's existing rules to mandate that service providers, upon request, produce the records kept pursuant to the Commission's recordkeeping requirement.

132. Finally, the Commission proposes that health care providers may not receive funds for the same services under the health broadband services program and the telecommunications program. Similarly, the Commission proposes to prohibit participants from receiving funds for the same services under the Rural Health Care Support Mechanism and any other universal service program (*i.e.*, the E-rate program, the High Cost program, and the Low Income program), or from any other Federal program, including, for example, Federal grants, awards, or loans. The Commission seeks comment on these proposals.

IV. Data Gathering and Performance Measures

A. "Meaningful Use" Criteria

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

134. The National Broadband Plan suggested that the Commission should condition receipt of rural health care support on providers' compliance with the HHS meaningful use requirements after a certain period of time, such as three years. The Commission recognizes that any new compliance obligations

may impose burdens on health care providers, and that these burdens may be more significant for rural providers. At the same time, the goals reflected in the HHS meaningful use requirements are important, and there may be benefits both to providers and the Federal government in aligning policies to the extent feasible. The Commission seeks comment on whether and how the Commission could align its performance measures with HHS's meaningful use criteria. The Commission also seeks comment on whether there are other Federal criteria that it should consider adopting.

135. The Commission seeks comment on whether, assuming full implementation of meaningful use requirements in 2015, recipients of funding from the Rural Health Care Support Mechanism should be required to document their compliance with meaningful use requirements as a condition of receiving support. What would be the practical and operational implications of such a requirement? The Commission notes that, under HHS' draft proposed regulations, meaningful use will be certified at the individual physician level (with the exception of hospitals), while the Commission's program provides support to a variety of eligible entities that do not necessarily include physician offices (such as post-secondary educational institutions offering health care instruction, local health departments, community health centers, community mental health centers and rural health clinics). If the Commission were to adopt a meaningful use requirement, how should it evaluate whether the health care entity has satisfied meaningful use? The Commission also seeks comment on what the remedy should be for failure to meet such a requirement, if adopted? For instance, if a health care provider is required to comply with HHS meaningful use regulations as of 2015, should the Commission reduce or eliminate rural health care support if the entity has not achieved the HHS meaningful use standard by 2018?

C. Other Performance Measures

136. To measure the impact of the Commission's universal service programs, it is important for participants in the health broadband services program and the health infrastructure program to have measurable performance goals to demonstrate how they are using the Federal support to take advantage of broadband capabilities for medical services or support. The Commission therefore seeks comment on what generally-applicable performance

criteria the Commission should adopt. For example, the Commission could adopt criteria regarding consistency or frequency of use of broadband services for record-keeping, remote monitoring, or remote consultation on complex or non-routine medical issues. The Commission seeks comment on these and other possible criteria by which to measure performance. The Commission also seeks comment on whether the Commission should employ existing industry standards or metrics, such as the American Telemedicine Association's Standards and Guidelines for Teledermatology, Telemental Health and Telepathology, as part of its performance measure criteria. Are there other existing metrics that would be suitable for measuring accomplishments related to the Rural Health Care Support Mechanism?

137. The Commission also recognizes there are a wide variety of eligible entities that may obtain support from the proposed health broadband services program and the health infrastructure program, and therefore there may be a need for some flexibility in performance measures to reflect the many potential uses and varying needs of program beneficiaries. Therefore, the Commission seeks comment on whether to require each program beneficiary to identify more specific performance measures. For example, the Commission might require all beneficiaries to report on progress of bringing services online, and the individual recipient would identify a specific timeline and report on whether it met the timeline. The Commission might require beneficiaries to identify particular goals, such as increasing network speed or reliability, and the beneficiary would identify the specific goal and report on whether the goal was accomplished. The Commission seeks comment on this proposal. The Commission seeks comment on how this process should work. For example, the Commission might require a beneficiary to submit specific performance measures within 60 days of notification that its application for support has been approved. The Commission also seeks comment on whether it should have the opportunity to reject or propose modifications to the individualized performance measurements that beneficiaries submit.

138. The Commission seeks comment on the frequency of assessing performance and how often the beneficiary should report on performance. For example, should performance measures be made annually or more frequently? Should ongoing support be conditioned wholly

or partly on demonstrated satisfaction of performance standards? The Commission also seeks comment on what, if any, additional information the report should contain, such as an explanation for any failure to meet performance goals or the opportunity to propose revisions to the performance measurements.

D. Data Gathering and Analysis

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

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

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

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

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

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

V. Procedural Matters

A. Initial Regulatory Flexibility Analysis

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

1. Need for, and Objectives of, the Notice for Proposed Rulemaking

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

3. In this NPRM, the Commission seeks comment on a package of potential reforms to the rural health care program that could be implemented in funding year 2011 (July 1, 2011–June 30, 2012). The proposed reforms include: (1) Establishing a broadband infrastructure program (the “health infrastructure program”) that would support up to 85 percent of the construction costs of new regional or statewide networks to serve public and non-profit health care providers in areas of the country where broadband is unavailable or insufficient; (2) establishing a broadband services access program (the “health broadband services program”) that would subsidize 50 percent of the monthly recurring costs for access to broadband services for eligible public or non-profit rural health care providers, which should make broadband connectivity more affordable for providers operating in rural areas; (3) expanding the Commission’s interpretation of “eligible health care provider” to include acute care facilities that provide services traditionally provided at hospitals, such as skilled nursing facilities and renal dialysis centers and facilities, and administrative offices and data centers that do not share the same building as the clinical offices of a health care provider but that perform support functions critical for the provision of health care; (4) clarifying the Commission’s existing recordkeeping requirements to enhance our ability to protect against waste, fraud and abuse; and (5) eliminating the current rule that requires that funding be offset against universal service contributions owed by participating service providers, and instead propose to allow service providers participating in the health

broadband services program, telecommunications program, and health infrastructure program to receive rural health care funds directly from USAC.

2. Legal Basis

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

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

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

6. Small entities potentially affected by the proposals herein include eligible rural non-profit and public health care providers and the eligible service providers offering their services, including telecommunications service providers, Internet Service Providers (ISPs), and vendors of the services and

equipment used for dedicated broadband networks.

a. Rural Health Care Providers

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

8. As noted earlier, non-profit businesses and small governmental units are considered “small entities” within the RFA. In addition, the Commission notes that census categories and associated generic SBA small business size categories provide the following descriptions of small entities. The broad category of Ambulatory Health Care Services consists of further categories and the following SBA small business size standards. The categories of small business providers with annual receipts of \$7 million or less consists of: Offices of Dentists; Offices of Chiropractors; Offices of Optometrists; Offices of Mental Health Practitioners (except Physicians); Offices of Physical, Occupational and Speech Therapists and Audiologists; Offices of Podiatrists; Offices of All Other Miscellaneous Health Practitioners; and Ambulance Services. The category of such providers with \$10 million or less in annual receipts consists of: Offices of Physicians (except Mental Health Specialists); Family Planning Centers; Outpatient Mental Health and Substance Abuse Centers; Health Maintenance Organization Medical Centers; Freestanding Ambulatory Surgical and Emergency Centers; All Other Outpatient Care Centers, Blood and Organ Banks; and All Other Miscellaneous Ambulatory Health Care Services. The category of such providers with \$13.5 million or less in annual receipts consists of: Medical Laboratories; Diagnostic Imaging Centers; and Home Health Care Services. The category of Ambulatory Health Care Services providers with \$34.5 million or less in annual receipts consists of Kidney Dialysis Centers. For all of these Ambulatory Health Care Service Providers, census data indicate that there are a combined total of 368,143 firms that operated for all of 2002. Of these, 356,829 had receipts for that year of less than \$5 million. In addition, an additional 6,498 firms had annual receipts of \$5 million to \$9.99 million; and an additional 3,337 firms

had receipts of \$10 million to \$24.99 million; and an additional 865 had receipts of \$25 million to \$49.99 million. The Commission therefore estimates that virtually all Ambulatory Health Care Services providers are small, given SBA's size categories. The Commission notes, however, that its rules affect non-profit and public health care providers, and many of the providers noted above would not be considered "public" or "non-profit." In addition, the Commission has no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

9. The broad category of Hospitals consists of the following categories with an SBA small business size standard of annual receipts of \$34.5 million or less: General Medical and Surgical Hospitals, Psychiatric and Substance Abuse Hospitals; and Specialty (Except Psychiatric and Substance Abuse) Hospitals. For these health care providers, census data indicate that there is a combined total of 3,800 firms that operated for all of 2002, of which 1,651 had revenues of less than \$25 million, and an additional 627 firms had annual receipts of \$25 million to \$49.99 million.. The Commission therefore estimates that most Hospitals are small, given SBA's size categories. In addition, the Commission has no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

10. The broad category of Social Assistance consists, *inter alia*, of the category of Emergency and Other Relief Services with a small business size standard of annual receipts of \$7 million or less. For all of these health care providers, census data indicate that there was a total of 55 firms that operated for all of 2002. All of these firms had annual receipts of below \$1 million. The Commission therefore estimates that all such firms are small, given SBA's size standard. In addition, the Commission has no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

b. Providers of Telecommunications and Other Services

Telecommunications Service Providers

11. *Incumbent Local Exchange Carriers (LECs)*. Neither the Commission nor the SBA has developed a size standard for small incumbent local exchange services. The closest size standard under SBA rules is for Wired Telecommunications Carriers. Under that size standard, such a business is small if it has 1,500 or fewer employees.

According to Commission data, 1,311 incumbent carriers reported that they were engaged in the provision of local exchange services. Of these 1,311 carriers, an estimated 1,024 have 1,500 or fewer employees and 287 have more than 1,500 employees. Thus, under this category and associated small business size standard, the Commission estimates that the majority of entities are small.

12. The Commission has included small incumbent local exchange carriers in this RFA analysis. A "small business" under the RFA is one that, *inter alia*, meets the pertinent small business size standard (e.g., a telephone communications business having 1,500 or fewer employees), and "is not dominant in its field of operation." The SBA's Office of Advocacy contends that, for RFA purposes, small incumbent local exchange carriers are not dominant in their field of operation because any such dominance is not "national" in scope. The Commission has therefore included small incumbent carriers in this RFA analysis, although the Commission emphasizes that this RFA action has no effect on the Commission's analyses and determinations in other, non-RFA contexts.

13. *Interexchange Carriers*. Neither the Commission nor the SBA has developed a definition of small entities specifically applicable to providers of interexchange services (IXCs). The closest applicable definition under the SBA rules is for wired telecommunications carriers. This provides that a wired telecommunications carrier is a small entity if it employs no more than 1,500 employees. According to the Commission's 2008 *Trends Report*, 300 companies reported that they were engaged in the provision of interexchange services. Of these 300 IXCs, an estimated 268 have 1,500 or fewer employees and 32 have more than 1,500 employees. Consequently, the Commission estimates that most providers of interexchange services are small businesses.

14. *Competitive Access Providers*. Neither the Commission nor the SBA has developed a definition of small entities specifically applicable to competitive access services providers (CAPs). The closest applicable definition under the SBA rules is for wired telecommunications carriers. This provides that a wired telecommunications carrier is a small entity if it employs no more than 1,500 employees. According to the 2008 *Trends Report*, 1,005 CAPs and competitive local exchange carriers (competitive LECs) reported that they

were engaged in the provision of competitive local exchange services. Of these 1,005 CAPs and competitive LECs, an estimated 918 have 1,500 or fewer employees and 87 have more than 1,500 employees. Consequently, the Commission estimates that most providers of competitive exchange services are small businesses.

15. *Wireless Telecommunications Carriers (except Satellite)*. Since 2007, the Census Bureau has placed wireless firms within this new, broad, economic census category. Prior to that time, such firms were within the now-superseded categories of "Paging" and "Cellular and Other Wireless Telecommunications." Under the present and prior categories, the SBA has deemed a wireless business to be small if it has 1,500 or fewer employees. Because Census Bureau data are not yet available for the new category, the Commission will estimate small business prevalence using the prior categories and associated data. For the category of Paging, data for 2002 show that there were 807 firms that operated for the entire year. Of this total, 804 firms had employment of 999 or fewer employees, and three firms had employment of 1,000 employees or more. For the category of Cellular and Other Wireless Telecommunications, data for 2002 show that there were 1,397 firms that operated for the entire year. Of this total, 1,378 firms had employment of 999 or fewer employees, and 19 firms had employment of 1,000 employees or more. Thus, the Commission estimates that the majority of wireless firms are small.

16. *Wireless Telephony*. Wireless telephony includes cellular, personal communications services, and specialized mobile radio telephony carriers. As noted, the SBA has developed a small business size standard for Wireless Telecommunications Carriers (except Satellite). Under the SBA small business size standard, a business is small if it has 1,500 or fewer employees. According to the 2008 *Trends Report*, 434 carriers reported that they were engaged in wireless telephony. Of these, an estimated 222 have 1,500 or fewer employees and 212 have more than 1,500 employees. The Commission has estimated that 222 of these are small under the SBA small business size standard.

17. *Satellite Telecommunications and All Other Telecommunications*. These two economic census categories address the satellite industry. The first category has a small business size standard of \$15 million or less in average annual receipts, under SBA rules. The second has a size standard of \$25 million or less

in annual receipts. The most current Census Bureau data in this context, however, are from the (last) economic census of 2002, and the Commission will use those figures to gauge the prevalence of small businesses in these categories.

18. The category of Satellite Telecommunications “comprises establishments primarily engaged in providing telecommunications services to other establishments in the telecommunications and broadcasting industries by forwarding and receiving communications signals via a system of satellites or reselling satellite telecommunications. For this category, Census Bureau data for 2002 show that there were a total of 371 firms that operated for the entire year. Of this total, 307 firms had annual receipts of under \$10 million, and 26 firms had receipts of \$10 million to \$24,999,999. Consequently, the Commission estimates that the majority of Satellite Telecommunications firms are small entities that might be affected by its action.

19. The second category of All Other Telecommunications comprises, *inter alia*, “establishments primarily engaged in providing specialized telecommunications services, such as satellite tracking, communications telemetry, and radar station operation. This industry also includes establishments primarily engaged in providing satellite terminal stations and associated facilities connected with one or more terrestrial systems and capable of transmitting telecommunications to, and receiving telecommunications from, satellite systems.” For this category, Census Bureau data for 2002 show that there were a total of 332 firms that operated for the entire year. Of this total, 303 firms had annual receipts of under \$10 million and 15 firms had annual receipts of \$10 million to \$24,999,999. Consequently, the Commission estimates that the majority of All Other Telecommunications firms are small entities that might be affected by its action.

Internet Service Providers

20. The 2007 Economic Census places these firms, whose services might include voice over Internet protocol (VoIP), in either of two categories, depending on whether the service is provided over the provider’s own telecommunications facilities (e.g., cable and DSL ISPs), or over client-supplied telecommunications connections (e.g., dial-up ISPs). The former are within the category of Wired Telecommunications Carriers, which has an SBA small business size standard of 1,500 or fewer

employees. The latter are within the category of All Other Telecommunications, which has a size standard of annual receipts of \$25 million or less. The most current Census Bureau data for all such firms, however, are the 2002 data for the previous census category called Internet Service Providers. That category had a small business size standard of \$21 million or less in annual receipts, which was revised in late 2005 to \$23 million. The 2002 data show that there were 2,529 such firms that operated for the entire year. Of those, 2,437 firms had annual receipts of under \$10 million, and an additional 47 firms had receipts of between \$10 million and \$24,999,999. Consequently, the Commission estimates that the majority of ISP firms are small entities.

Vendors and Equipment Manufacturers

21. *Vendors of Infrastructure Development or “Network Buildout.”* The Commission has not developed a small business size standard specifically directed toward manufacturers of network facilities. The closest applicable definition of a small entity are the size standards under the SBA rules applicable to manufacturers of “Radio and Television Broadcasting and Communications Equipment” (RTB) and “Other Communications Equipment.” According to the SBA’s regulations, manufacturers of RTB or other communications equipment must have 750 or fewer employees in order to qualify as a small business. The most recent available Census Bureau data indicates that there are 1,187 establishments with fewer than 1,000 employees in the United States that manufacture radio and television broadcasting and communications equipment, and 271 companies with less than 1,000 employees that manufacture other communications equipment. Some of these manufacturers might not be independently owned and operated. Consequently, the Commission estimates that the majority of the 1,458 internal connections manufacturers are small.

22. *Telephone Apparatus Manufacturing.* The Census Bureau defines this category as follows: “This industry comprises establishments primarily engaged in manufacturing wire telephone and data communications equipment. These products may be standalone or board-level components of a larger system. Examples of products made by these establishments are central office switching equipment, cordless telephones (except cellular), PBX

equipment, telephones, telephone answering machines, LAN modems, multi-user modems, and other data communications equipment, such as bridges, routers, and gateways.” The SBA has developed a small business size standard for Telephone Apparatus Manufacturing, which is: All such firms having 1,000 or fewer employees. According to Census Bureau data for 2002, there were a total of 518 establishments in this category that operated for the entire year. Of this total, 511 had employment of under 1,000, and an additional 7 had employment of 1,000 to 2,499. Thus, under this size standard, the majority of firms can be considered small.

23. *Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing.* The Census Bureau defines this category as follows: “This industry comprises establishments primarily engaged in manufacturing radio and television broadcast and wireless communications equipment. Examples of products made by these establishments are: transmitting and receiving antennas, cable television equipment, GPS equipment, pagers, cellular phones, mobile communications equipment, and radio and television studio and broadcasting equipment.” The SBA has developed a small business size standard for Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing, which is: All such firms having 750 or fewer employees. According to Census Bureau data for 2002, there were a total of 1,041 establishments in this category that operated for the entire year. Of this total, 1,010 had employment of under 500, and an additional 13 had employment of 500 to 999. Thus, under this size standard, the majority of firms can be considered small.

24. *Other Communications Equipment Manufacturing.* The Census Bureau defines this category as follows: “This industry comprises establishments primarily engaged in manufacturing communications equipment (except telephone apparatus, and radio and television broadcast, and wireless communications equipment).” The SBA has developed a small business size standard for Other Communications Equipment Manufacturing, which is: All such firms having 750 or fewer employees. According to Census Bureau data for 2002, there were a total of 503 establishments in this category that operated for the entire year. Of this total, 493 had employment of under 500, and an additional 7 had employment of 500 to 999. Thus, under

this size standard, the majority of firms can be considered small.

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

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

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

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

28. *Project Selection Phase.* The Commission proposes that applications submitted for funding be made publicly available on USAC's Web site. Publicly available information would include the

names of the parties seeking funding, their geographic location, and information filed by the applicants to corroborate that sufficient broadband infrastructure is unavailable or insufficient in their geographic location. During the second quarter of each funding year (October 1 to December 31), USAC would review all applications received during the initial application phase. After applications have been reviewed, and prioritization rules have been applied, USAC would notify selected participants of their project eligibility status. This would normally occur during the third quarter of each funding year (January 1 to March 30). After a participant is notified of project eligibility, it may proceed with the project commitment phase per the requirements set forth below. During the project commitment phase, participants may receive funding from the health infrastructure program for a portion of the reasonable administrative expenses incurred in connection with the project, subject to certain caps.

29. *Project Commitment Phase.* Within 90 days after a participant in the health infrastructure program is notified that, based on its initial application, the participant's project is eligible for funding, the participants would complete and submit all application materials and comply with all program requirements, including the following: (1) Certification of the availability of funds for not less than 15 percent of all eligible costs; (2) a project schedule; and (3) a detailed project description. The project schedule would identify key milestones that the project will accomplish and the date that the tasks would be achieved. The detailed project description would describe the network, identify the proposed technology, demonstrate that the project is technically feasible and reasonably scalable, and describe each specific development phase of the project (e.g., network design phase, construction period, deployment, maintenance period).

30. In addition, prior to receiving a funding commitment letter from USAC, participants would be required to submit a sustainability report demonstrating that the costs of network operations and maintenance will be sustainable after such period of support from the health infrastructure program. If an infrastructure project includes bandwidth that may be used by entities that are not eligible health care providers, the Commission will consider the extra bandwidth to be excess capacity and would require the participant to file excess capacity disclosures. The Commission would

require the excess capacity disclosures to: (1) Identify users of the excess capacity and delineate how they are paying for their portion of the costs, and (2) describe generally agreements made between the health care network portion of the project and the community use portion of the project (e.g., cost allocation, sharing agreements, maintenance and access, ownership).

31. We also propose adopting a rule that would require health care providers to obtain certain cost information from vendors. Vendors would be required to make certain certifications with respect to the construction and deployment of the dedicated network. They would also be required to provide participants with a depreciation schedule showing the useful life of fixed assets, as well as maintain books and records that support all cost allocations.

32. USAC would review each step of the project commitment phase to confirm the participant's compliance with all data and information requirements and compliance with program rules. USAC would conduct technical and financial review of all proposed projects to ensure that they comply with the Commission's rules. USAC may request additional information from applicants and participants if deemed necessary to substantiate, explain or clarify any materials submitted as part of the funding process.

33. Health infrastructure program participants would be required to submit quarterly reports that provide information regarding the following: (1) Attaining project milestones, (2) status of obtaining 15 percent minimum match, (3) status of the competitive bidding process, (4) details on how the supported network has complied with HHS health IT initiatives, and (6) performance measures. The project milestones would be updated at the time that quarterly reports are filed by the participants, noting which project milestones have been met and any delays or progress in meeting other milestones. The Commission believes that requiring participants in the health infrastructure program to establish a schedule and report on project milestones will assist USAC and the Commission in assessing a participant's progress in completing project buildout, and will reduce waste, fraud, and abuse.

34. The Commission also proposes several reporting and recordkeeping requirements for the health broadband services program and the health infrastructure program. The Commission proposes that health care providers that receive support under the health broadband services program or

the health infrastructure program would be required to complete a certification that identifies the speed of any connection supported by the Rural Health Care Support Mechanism. They would also indicate, as a result of broadband access, the type of health IT applications they were using and the frequency with which they used them. The Commission also proposes the retention of the existing competitive bidding requirements for both programs, because the Commission believes that competitive bidding has been successful regarding the prevention of waste, fraud, and abuse in the Rural Health Care Support Mechanism.

35. Finally, the current rules establish a five year document retention period for health care providers. The Commission recommends that it adopt the same requirement for service providers and non-telecommunications carriers. The Commission believes that it should clarify that the documents would include all records related to the application for, receipt and delivery of discounted services. The Commission also seeks comment on whether it should adopt any additional rules regarding recordkeeping requirements.

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

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

37. In this NPRM, the Commission makes a number of proposals that may have an economic impact on small entities that participate in the universal service support mechanism for rural health care providers. Specifically, as addressed above, the Commission seeks comment on: (1) Establishing a broadband infrastructure program (the "health infrastructure program") for eligible health care providers; (2) establishing a broadband services access program (the "health broadband services program") for eligible health care providers; (3) expanding the number of entities eligible for discounts

by broadening the interpretation of the definition of eligible health care providers to include off-site data centers and administrative offices, as well as skilled nursing facilities and renal dialysis centers; and (4) establishing performance measures for eligible health care providers receiving broadband support. If adopted, these proposals will change the size of the overall pool of eligible applicants that may receive universal service support under the Rural Health Care Support Mechanism, as well as affect the amount of support that eligible entities may receive.

38. In seeking to minimize the burdens imposed on small entities where doing so does not compromise the goals of the universal service mechanism, the Commission has invited comment on how these proposals might be made less burdensome for small entities. The Commission again invites commenters to discuss the benefits of such changes on small entities and whether these benefits are outweighed by resulting costs to rural health care providers that might also be small entities. The Commission anticipates that the record will reflect whether the overall benefits of such programmatic changes would outweigh the burdens on small entities, and if so, suggest alternative ways in which the Commission could lessen the overall burdens on small entities. The Commission encourages small entities to comment.

39. The Commission has taken the following steps to minimize the impact on small entities. First, to ease the administrative burden on applicants, the Commission proposes an approach that simplifies the application process for rural health care providers. The Commission believes that this will help ensure that applicants, including small entities, will not be deterred from applying for support due to administrative burdens. Applicants for support from the health infrastructure program may choose between three methods in order to demonstrate the need requirement for infrastructure funding. An applicant may choose a method that would not require preparation by a third party. The Commission also proposes that participants in the health infrastructure program may receive funding for a portion of their administrative expenses in order to ease the financial burden of compliance with the various reporting requirements associated with participation in the health infrastructure program.

40. The Commission also recognizes that participants in the health

infrastructure program, particularly smaller projects, or projects that are subject to mandatory, State or local procurement rules, may find the proposed RFP preparation and distribution requirements to be overly burdensome. Accordingly, the Commission has included an exception for such projects that would exclude infrastructure projects of \$100,000 or less or projects that are subject to mandatory, State or local procurement rules. However, such projects would still be required to complete a request for services on a Form 465 and posting this request on USAC's Web page for a period of at least 28 days before selecting a vendor.

41. Next, in order to encourage participation in the health broadband services program, the Commission proposes a simplified application process that clearly identifies the level of support that providers can reasonably expect to receive. The proposed 50 percent flat discount promotes prudent business decisions thereby assisting rural health care providers in planning for their Health IT needs. Moreover, a flat rate discount is easy to administer and consistent with section 254(b)(5), which requires "a specific, sufficient, and predictable mechanism * * * because it limits the amount of support that each health care provider may receive per month to a reasonable level." The Commission proposes to simplify the forms process used in the application process.

6. Federal Rules That May Duplicate, or Conflict With Proposed Rules

42. None.

B. Paperwork Reduction Act Analysis

43. This document contains proposed [new or modified] information collection requirements. The Commission, as part of its continuing effort to reduce paperwork burdens, invites the general public and the Office of Management and Budget (OMB) to comment on the information collection requirements contained in this document, as required by the Paperwork Reduction Act of 1995, Public Law 104-13. In addition, pursuant to the Small Business Paperwork Relief Act of 2002, Public Law 107-198, *see* 44 U.S.C. 3506(c)(4), we seek specific comment on how we might further reduce the information collection burden for small business concerns with fewer than 25 employees.

C. Ex Parte Presentations

44. The rulemaking this Notice initiates shall be treated as a "permit-but-disclose" proceeding in accordance

with the Commission's *ex parte* rules. Persons making oral *ex parte* presentations are reminded that memoranda summarizing the presentations must contain summaries of the substance of the presentations and not merely a listing of the subjects discussed. More than a one- or two-sentence description of the views and arguments presented generally is required. Other requirements pertaining to oral and written presentations are set forth in § 1.1206(b) of the Commission's rules.

List of Subjects in 47 CFR Part 54

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

Marlene H. Dortch,
Secretary, Federal Communications Commission.

Proposed Rules

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

PART 54—UNIVERSAL SERVICE

Subpart G—Universal Service Support for Health Care Providers

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

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

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

Defined Terms and Eligibility

§ 54.600 Index of defined terms.

The following definitions apply to this subpart.

Administrative office is defined in § 54.601.

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

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

Data centers is defined in § 54.601(c).

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

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

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

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

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

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

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

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

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

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

Installation charges is defined in § 54.633.

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

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

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

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

NTIA is defined in § 54.651(a)(2).

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

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

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

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

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

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

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

Telecommunications program is defined in § 54.602(a).

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

3. Section 54.601 is revised to read as follows:

§ 54.601 Eligibility.

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

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

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

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

(iii) Local health department or agency;

(iv) Community mental health center;

(v) Not-for-profit hospital;

(vi) Rural health clinic; or

(vii) Consortium of health care providers consisting of one or more entities described in paragraphs (a)(2)(i) through (vi) of this section.

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

(i) Any health care provider that was located in a rural area under the definition used by the Commission prior to July 1, 2005, and that had received a funding commitment from USAC since 1998, remains eligible for support under this subpart through the funding year ending on June 30, 2011.

(ii) [Reserved]

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

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

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

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

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

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

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

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

(e) *Renal dialysis centers and facilities.* As used in this subpart, a “renal dialysis center” means a hospital unit that is approved by the Centers for Medicare and Medicaid Services (CMS) to furnish the full spectrum of diagnostic, therapeutic, and rehabilitative services required for the care of End Stage Renal Disease (ESRD) dialysis patients (including both inpatient and outpatient dialysis services). As used in this subpart, a “renal dialysis facility” is a unit that is approved by CMS to furnish dialysis services directly to ESRD patients. Public or non-profit renal dialysis centers or facilities qualify as eligible health care providers as not-for-profit hospitals under paragraph (a)(5) of this section, provided that the facility or

center seeking support certifies that, over the 12-month period preceding the date of application for support, the facility or center provided life preserving ESRD treatment to at least 51 percent of its patients.

(f) *Consortia.* (1) 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 this subpart shall apply only to the portion of eligible services used by an eligible health care provider.

4. Add § 54.602 to read as follows:

§ 54.602 Eligible services.

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

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

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

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

(e) *Health care purposes.* Telecommunications and broadband access services for which eligible health

care providers receive support from the telecommunications program, the health infrastructure program or the health broadband services program, must be reasonably related to the provision of health care services by the eligible health care provider.

5. Section 54.603 is revised to read as follows:

§ 54.603 Competitive bid and certification requirements.

(a) *Competitive bidding requirements.* Each eligible health care provider shall participate in a competitive bidding process pursuant to the requirements established in this section and any additional and applicable State, local, or other procurement requirements to select the telecommunications carriers or other services providers that will provide services eligible for universal service support under this subpart.

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

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

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

(i) The requester is a public or not-for-profit entity that falls within one of the categories set forth in the definition of

health care provider, listed in

§ 54.601(a), 54.601(b) or 54.601(c);

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

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

(iv) The requested service or services will be used solely for purposes 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;

(v) The requested service or services will not be sold, resold or transferred in consideration of money or any other thing of value;

(vi) If the service or services are being purchased as part of an aggregated purchase with other entities or individuals, the full details of any such arrangement, including the identities of all co-purchasers and the portion of the service or services being purchased by the health care provider; and

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

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

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

(4) *Selecting a service provider.* In selecting a service provider for services eligible for universal service support under this subpart, a health care provider shall consider all bids submitted by service providers and select the most cost-effective alternative. After selecting a service provider for services eligible for support under this subpart: The health care provider shall certify to the Administrator that the health care provider is selecting the most cost-effective method of providing the requested service or services, where

the most cost-effective method of providing a service is defined as the method that costs the least after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems relevant to choosing a method of providing the required health care services; and The health care provider shall submit to the Administrator paper copies of the responses or bids received in response to the requested services.

6. Add an undesignated centered heading "TELECOMMUNICATIONS PROGRAM" above § 54.604 subpart G.

7. Section 54.604 is revised to read as follows:

§ 54.604 Telecommunications services.

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

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

(1) A contract signed on or before July 10, 1997 is exempt from the competitive bid requirement for the life of the contract.

(2) [Reserved]

(c) For rural health care providers that take service under or pursuant to a master contract, as defined in § 54.500(f), the date of execution of that master contract represents the applicable date for purposes of determining whether and to what extent the rural health care provider is exempt from the competitive bid requirements.

(d) The competitive bid system will be deemed to be operational when the Administrator is ready to accept and post FCC Form 465 from rural health care providers on a Web site and that Web site is available for use by telecommunications carriers.

8. Section 54.605 is amended by revising paragraphs (a) and (c), to read as follows:

§ 54.605 Determining the urban rate.

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

* * * * *

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

* * * * *

9. Section 54.609 is amended by revising paragraphs (a) introductory text, (a)(1)(iv), (a)(3), (d)(1), (d)(2), and (e)(1) to read as follows:

§ 54.609 Calculating support.

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

(1) * * *

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

* * * * *

(3) *Base rate support-consortium.* A telecommunications carrier that provides telecommunications service to a rural health care provider participating in an eligible health care consortium, and the consortium must

establish the applicable rural base rates for telecommunications service for the health care provider's portion of the shared telecommunications services, as well as the applicable urban base rates for the telecommunications service.

* * * * *

(d) * * *

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

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

* * * * *

(e) * * *

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

* * * * *

10. Section 54.611 is revised to read as follows:

§ 54.611 Election to offset support against annual USF contribution.

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

(b) Carriers shall elect in January of each year the method by which they

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

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

11. Section 54.613 is amended by revising paragraph (b) to read as follows:

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

* * * * *

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

12. Section 54.615 is amended by revising paragraphs (b) and (c) to read as follows:

§ 54.615 Obtaining services.

* * * * *

(b) *Receiving supported rate.* Upon receiving a bona fide request, as defined in paragraph (c) of this section, from a rural health care provider for a telecommunications service eligible for support under the telecommunications program, a telecommunications carrier

shall provide the service at a rate no higher than the urban rate, as defined in § 54.605, subject to the limitations set forth in this Subpart.

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

(1) 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 § 54.601(a);

(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) [Reserved].

(4) The requested service or services will be used solely for purposes 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;

(5) The requested service or services will not be sold, resold or transferred in consideration of money or any other thing of value;

(6) If the service or services are being purchased as part of an aggregated purchase with other entities or individuals, the full details of any such arrangement, including the identities of all co-purchasers and the portion of the service or services being purchased by the health care provider; and

(7) The requester is selecting the most cost-effective method of providing the requested service or services, where the most cost-effective method of providing a service is defined as the method that costs the least after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems relevant to choosing a method of providing the required health care services.

§ 54.617 [Redesignated as § 54.671]

13. Redesignate § 54.617 as § 54.671.

§ 54.619 [Redesignated as § 54.673]

14. Redesignate § 54.619 as § 54.673.

§ 54.621 [Removed]

15. Remove § 54.621.

§ 54.623 [Redesignated as § 54.675]

16. Redesignate § 54.623 as § 54.675.

17. Section 54.625 is revised to read as follows:

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

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

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

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

18. Add an undesignated centered heading "HEALTH BROADBAND SERVICES PROGRAM" below § 54.625 of subpart G.

19. Add § 54.631 to read as follows:

§ 54.631 Eligible services.

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

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

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

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

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

20. Add § 54.633 to read as follows:

§ 54.633 Installation charges and other non-recurring costs.

(a) Rural health care providers may request one-time support from the health broadband services program for 50 percent of the reasonable and customary installation charges for broadband access services. "Installation charges" are defined as charges that are normally charged by service providers to commence service, and are not charges that are based on an amortization of construction or infrastructure costs.

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

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

21. Add § 54.635 to read as follows:

§ 54.635 Eligible service providers.

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

22. Add § 54.637 to read as follows:

§ 54.637 Competitive bidding requirements.

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

23. Add § 54.639 to read as follows:

§ 54.639 Restrictions on satellite services.

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

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

functionally similar terrestrial-based alternative.

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

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

24. Add § 54.641 to read as follows:

§ 54.641 Multi-year contracts.

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

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

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

25. Add an undesignated centered heading and § 54.650 to read as follows:

Health Infrastructure Program

§ 54.650 Obtaining support.

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

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

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

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

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

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

(c) *Project selection phase.* (1) Applications submitted for funding will be made publicly available on the Administrator's Web site.

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

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

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

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

26. Add § 54.651 to read as follows:

§ 54.651 Demonstrated need for infrastructure funding.

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

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

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

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

(iii) The applicant must also provide a report detailing either that there is no available broadband infrastructure, or explaining why existing broadband infrastructure would be insufficient for health IT needed to provide or improve health care delivery by the eligible health care providers that are proposing the infrastructure project.

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

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

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

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

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

27. Add § 54.652 to read as follows:

§ 54.652 Letters of agency.

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

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

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

28. Add § 54.653 to read as follows:

§ 54.653 Funding requests and budgets.

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

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

- (i) Eligible non-recurring costs, subject to the limitations set forth in § 54.654(a);
- (ii) Eligible network design costs, subject to the limitations set forth in § 54.654(b);
- (iii) Eligible administrative expenses, subject to the limitations set forth in § 54.654(c);
- (iv) Eligible maintenance costs, subject to the limitations set forth in § 54.654(d);
- (v) Eligible NLR or Internet2 membership fees, subject to the limitations set forth in § 54.654(e); and
- (vi) All costs that are necessary for completion of the project, but that are

not eligible for support under the health infrastructure program.

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

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

29. Add § 54.654 to read as follows:

§ 54.654 Eligible costs.

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

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

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

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

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

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

(d) *Maintenance costs.* Selected participants may request funding for up to 85 percent of the reasonable, necessary and customary ongoing maintenance costs for networks funded

by the health infrastructure program, subject to the following limitations:

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

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

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

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

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

30. Add § 54.655 to read as follows:

§ 54.655 Ineligible costs.

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

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

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

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

(3) Legal costs.

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

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

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

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

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

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

(10) Telemedicine applications and software.

(11) Clinical or medical equipment.

(12) Electronic records management and expenses.

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

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

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

(16) Continuous power source.

(c) *Billing and operational expenses.* The health infrastructure program will not provide support for billing and operational expenses incurred either by a health care provider or its selected

vendor. An example of billing or operational costs is the expense that service providers may charge for allocating costs to each health care provider in a project's network.

31. Add § 54.656 to read as follows:

§ 54.656 Minimum participant contribution requirement.

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

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

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

- (1) Eligible health care providers;
- (2) State grants, funding, or appropriations;
- (3) Federal funding, grants, loans, or appropriations, but not other universal service funding; and
- (4) Other grant funding, including private grants, but not grants from ineligible sources.

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

- (1) In-kind or implied contributions;
- (2) A local exchange carrier (LEC) or other telecom carrier, utility, contractor, consultant, or other service provider;
- (3) For-profit participants; and
- (4) Any other universal service support program.

32. Add § 54.657 to read as follows:

§ 54.657 Project milestones.

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

- (1) Start and end date for network design;

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

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

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

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

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

33. Add § 54.658 to read as follows:

§ 54.658 Detailed project description.

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

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

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

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

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

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

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

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

34. Add § 54.659 to read as follows:

§ 54.659 Facilities ownership, IRU or capital lease.

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

- (1) Own the infrastructure facilities funded by the program,
- (2) Have an IRU for such facilities, or
- (3) Have a capital lease.

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

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

35. Add § 54.660 to read as follows:

§ 54.660 Standard terms and conditions.

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

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

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

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

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

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

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

(2) *Beneficial ownership interest.* The health care provider receives beneficial title and interest or equitable title in the

facilities funded by the health infrastructure program. Such title should include the right to use the facilities, the right to have access for repairs, and the right to let others use such facilities.

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

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

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

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

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

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

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

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

(i) The infrastructure project will only involve the construction and deployment of the dedicated health care network, and will not involve the construction or deployment of

additional facilities or capacity that will not be part of the dedicated network; or

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

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

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

36. Add § 54.661 to read as follows:

§ 54.661 Sustainability.

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

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

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

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

(d) *Terms of membership in the network.* Describe generally any agreements made (or to be entered into) by network members, e.g., participation agreements, memoranda of understanding, usage agreements, or other documents. Describe financial and time commitments made by proposed

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

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

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

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

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

(h) *Excess capacity disclosures.* If an infrastructure project includes excess capacity, as part of its sustainability plan the selected participant must disclose the estimated amount of excess capacity and explain how it plans to allocate the cost of the network between the network members that are eligible health care providers and the members that are not eligible health care providers. In doing so, selected participants are required to: Identify non-eligible users of such excess capacity and explain what proportion of

the network non-recurring and recurring costs they will bear, and describe all agreements made between the eligible health care providers and other participants in the network (e.g., cost allocation, facility sharing agreements, maintenance and access obligations, ownership rights).

37. Add § 54.662 to read as follows:

§ 54.662 Excess capacity.

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

39. Add § 54.663 to read as follows:

§ 54.663 Quarterly reporting requirements.

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

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

40. Add § 54.664 to read as follows:

§ 54.664 Designation of successor projects.

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

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

minimum, to complete the project in a manner that provides new broadband infrastructure to the identified region or area.

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

40. Add an undesignated centered heading "GENERAL PROVISIONS" below § 54.664 of subpart G.

41. Amend newly redesignated § 54.671 by revising paragraph (b) to read as follows:

§ 54.671 Resale.

* * * * *

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

42. Amend newly redesignated § 54.673 by revising paragraph (d) to read as follows:

§ 54.673 Audits and recordkeeping.

* * * * *

(d) *Service providers.*

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

43. Amend newly redesignated § 54.675 by revising paragraphs (a), (c), and (f) to read as follows:

§ 54.675 Cap.

(a) *Amount of the annual cap.* The aggregate annual cap on Federal universal service support for health care providers shall be \$400 million per

funding year, of which up to \$100 million per funding year will be available for the health infrastructure program, and the remainder shall be available for the telecommunications program and the health broadband services program.

* * * * *

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

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

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

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

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

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

* * * * *

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

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

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

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

44. Add § 54.677 to read as follows:

§ 54.677 Data gathering.

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

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