change and briefly explain in readily understandable fashion the cause of the rate change (e.g. inflation, changes in external costs or the addition/deletion of channels). When the change involves the addition or deletion of channels, each channel added or deleted must be separately identified. Section 76.1602(c) requires cable operators to inform subscribers in writing of their right to file complaints about changes in cable programming service tier rates and services, and shall provide the address and phone number of the local franchising authority. 47 CFR 76.1619(b) states that in case of a billing dispute, the cable operator must respond to a written complaint from a subscriber within 30 days. In addition, Section 76.1619 sets forth requirements for information on subscriber bills.

Federal communications commission.

Marlene H. Dortch,

Secretary.

[FR Doc. E8–2805 Filed 2–13–08; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL COMMUNICATIONS COMMISSION

Notice of Public Information Collection(s) Being Reviewed by the Federal Communications Commission, Comments Requested

February 6, 2008.

SUMMARY: The Federal Communications Commission, as part of its continuing effort to reduce paperwork burdens, invites the general public and other Federal agencies to take this opportunity to comment on the following information collection, as required by the Paperwork Reduction Act (PRA) of 1995, Public Law 104–13. An agency may not conduct or sponsor a collection of information unless it displays a currently valid control number. Pursuant to the PRA, no person shall be subject to any penalty for failing to comply with a collection of information that does not display a valid control number. Comments are requested concerning (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 estimate; (c) ways to enhance the quality, utility, and clarity of the information collected; and (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.

DATES: Written PRA comments should be submitted on or before April 14, 2008. 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: Interested parties may submit all PRA comments by e-mail or U.S. mail. To submit your comments by e-mail, send them to *PRA@fcc.gov.* To submit your comments by U.S. mail, mark them to the attention of Cathy Williams, Federal Communications Commission, Room 1–C823, 445 12th Street, SW., Washington, DC 20554.

FOR FURTHER INFORMATION CONTACT: For additional information about the information collection, send an e-mail to *PRA@fcc.gov* or contact Cathy Williams at 202–418–2918.

SUPPLEMENTARY INFORMATION:

OMB Control Number: 3060–0717.

Title: Billed Party Preference for InterLATA 0+ Calls, CC Docket No. 92–77, 47 CFR 64.703(a), 64.709, and 64.710.

Form Number: Not applicable.

Type of Review: Extension of a currently approved collection.

Respondents: Business or other for-profit entities.

Number of Respondents: 630 respondents.

Estimated Time per Response: 30 seconds to 50 hours.

Frequency of Response: On occasion reporting requirement.

Total Annual Burden: 475,728 hours.

Total Annual Cost: $216,150.

Obligation to Respond: Required to obtain or retain benefit.

Nature and Extent of Confidentiality: An assurance of confidentiality is not offered because this information collection does not require the collection of personally identifiable information from individuals.

Privacy Impact Assessment: No impact.

Needs and Uses: Pursuant to 47 CFR 64.703(a), Operator Service Providers (OSPs) are required to disclose, audibly and distinctly to the consumer, at no charge and before connecting any interstate call, how to obtain rate quotations, including any applicable surcharges. 47 CFR 64.710 imposes similar requirements on OSPs to inmates at correctional institutions. 47 CFR 64.709 codifies the requirements for OSPs to file informational tariffs with the Commission. These rules help to ensure that consumers receive information necessary to determine what the charges associated with an OSP-assisted call will be, thereby enhancing informed consumer choice in the operator services marketplace.

Federal Communications Commission.

Marlene H. Dortch,

Secretary.

[FR Doc. E8–2807 Filed 2–13–08; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL COMMUNICATIONS COMMISSION

[WC Docket No. 02–60, FCC 07–198]

Rural Health Care Support Mechanism

AGENCY: Federal Communications Commission.

ACTION: Notice.

SUMMARY: In this document, the Commission selects participants for the universal service Rural Health Care (RHC) Pilot Program established by the Commission in the *2006 Pilot Program Order.* Sixty-nine of these applicants have demonstrated the overall qualifications consistent with the goals of the Pilot Program to stimulate deployment of the broadband infrastructure necessary to support innovative telehealth and, in particular, telemedicine services to those areas of the country where the need for those benefits is most acute.

FOR FURTHER INFORMATION CONTACT: Thomas Buckley, Senior Deputy Chief; Elizabeth Valinoti McCarthy, Attorney; or Antoinette Stevens, Telecommunications Access Policy Division, Wireline Competition Bureau, (202) 418–7400, TTY (202) 418–0484.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's *Order*, in WC Docket No. 02–60, released November 19, 2007. The full text of this document is available for public inspection during regular business hours in the FCC Reference Center, Room CY–A257, 445 12th Street, SW., Washington, DC 20554.

I. Introduction

1. In this *Order,* the Commission selects participants for the universal service Rural Health Care (RHC) Pilot Program established by the Commission in the *2006 Pilot Program* Order, 71 FR 65517, November 8, 2006, pursuant to section 254(h)(2)(A) of the Communications Act of 1934, as amended by the Telecommunications Act of 1996 (1996 Act). The initiation of the Pilot Program resulted in an overwhelmingly positive response from those entities the Commission intended to reach when it established the program last year—health care providers, particularly those operating

in rural areas. Exceeding even the Commission's own high expectations, the Commission received 81 applications representing approximately 6,800 health care facilities from 43 states and three United States territories. Sixty-nine of these applicants have demonstrated the overall qualifications consistent with the goals of the Pilot Program to stimulate deployment of the broadband infrastructure necessary to support innovative telehealth and, in particular, telemedicine services to those areas of the country where the need for those benefits is most acute.

2. Accordingly, selected participants will be eligible for universal service funding to support up to 85 percent of the costs associated with the construction of state or regional broadband health care networks and with the advanced telecommunications and information services provided over those networks. In addition, because of the large number of selected participants, the Commission modifies the Pilot Program so that selected participants may be eligible for funding for the appropriate share of their eligible two-year Pilot Program costs over a three-year period beginning in Funding Year 2007 and ending in Funding Year 2009. By spreading the two-year costs over a three-year commitment period, the Commission is able to increase the available support for selected participants from the amount established in the *2006 Pilot Program Order* to approximately $139 million in each funding year of the three-year Pilot Program. This will ensure that all qualifying applicants are able to participate in the Pilot Program and yet do so in an economically reasonable and fiscally responsible manner, well below the $400 million annual cap, and enable selected participants to have sufficient available support to achieve the goals and objectives demonstrated in their applications. For the reasons discussed below, the Commission also denies 12 applicants from participating in the Pilot Program because these applicants have not demonstrated they satisfy the overall criteria, principles, and objectives of the *2006 Pilot Program Order.*

3. In light of the many applications the Commission received seeking funding and the wide range of network and related components for which support is sought, the Commission further clarifies the facilities and services that are eligible and ineligible for support to ensure that the Pilot Program operates to facilitate the goals set forth in the *2006 Pilot Program Order.* For example, the Commission clarifies that eligible costs include the non-recurring costs for design, engineering, materials, and construction of fiber facilities and other broadband infrastructure; the non-recurring costs of engineering, furnishing, and installing network equipment; and the recurring and non-recurring costs of operating and maintaining the constructed network. The Commission also clarifies that ineligible costs include those costs not directly associated with network design, deployment, operations, and maintenance.

4. The Commission provides specific guidance to the selected participants regarding how to submit existing FCC Forms to the universal service Fund Administrator, the Universal Service Administrative Company (USAC). For example, selected participants, in order to receive universal service support, must submit with the required FCC Forms detailed network cost worksheets concerning their proposed network costs, certifications demonstrating universal service support will be used for its intended purposes, and letters of agency from each participating health care provider. In order to receive reimbursement, selected applicants must also submit, consistent with existing processes and requirements, detailed invoices showing actual incurred costs of project build-out and, if applicable, network design studies. The Commission also requires that selected participants' network build-outs be completed within five years of receiving an initial funding commitment letter (FCL). As discussed below, selected participants that fail to comply with the terms of this Order and with the USAC administrative processes will be prohibited from receiving support under the Pilot Program. The Commission also sets forth data reporting requirements for selected participants where participants must submit to USAC and to the Commission quarterly reports containing data on network build-out and use of Pilot Program funds. This information will inform the Commission of the cost-effectiveness and efficacy of the different state and regional networks funded by the Pilot Program and of whether support is being used in a manner consistent with section 254 of the 1996 Act, and the Commission's rules and orders.

5. The Commission also addresses various requests for waivers of Commission rules filed by applicants concerning participation in the Pilot Program. Among other things, the Commission denies waiver requests of the Commission's rule requiring that Pilot Program selected participants competitively bid their proposed network projects. In doing so, the Commission reaffirms that the competitive bidding process is an important safeguard for ensuring universal service funds are used wisely and efficiently by requiring the most cost effective service providers be selected by Pilot Program participants.

6. In addition, the Commission establishes an audit and oversight mechanism for the Pilot Program to guard against waste, fraud, and abuse, and to ensure that funds disbursed through the Pilot Program are used for appropriate purposes. In particular, each Pilot Program participant and service provider shall be subject to audit by the Commission's Office of Inspector General (OIG) and, if necessary, investigated by the OIG to determine compliance with the Pilot Program, Commission rules and orders, and section 254 of the 1996 Act. As discussed in greater detail below, because audits or investigations may provide information showing that a beneficiary or service provider failed to comply with the statute or Commission rules and orders, such proceedings can reveal instances in which Pilot Program disbursement awards the Commission improperly distributed or used in a manner inconsistent with the Pilot Program. To the extent the Commission finds funds were not used properly, USAC or the Commission may recover such funds and the Commission may assess forfeitures or pursue other recourse.

7. Finally, selected participants shall coordinate the use of their health care networks with the Department of Health and Human Services (HHS) and, in particular, with its Centers for Disease Control and Prevention (CDC) in instances of national, regional, or local public health emergencies (*e.g.*, pandemics, bioterrorism). In such instances, where feasible, selected participants shall provide access to their supported networks to HHS, including CDC, and other public health officials. Similarly selected participants shall use Pilot Program funding in ways that are consistent with HHS' health information technology (IT) initiatives that ''provide leadership for the development and nationwide implementation of an interoperable health information technology infrastructure to improve the quality and efficiency of health care.'' Accordingly, where feasible, selected participants, as part of their Pilot Program network build-out projects shall: (1) Use health IT systems and products that meet interoperability standards recognized by the HHS Secretary; (2) use health IT products certified by the Certification

Commission for Healthcare Information Technology; (3) support the Nationwide Health Information Network (NHIN) architecture by coordinating their activities with the organizations performing NHIN trial implementations; (4) use resources available at HHS's Agency for Healthcare Research and Quality (AHRQ) National Resource Center for Health Information Technology; (5) educate themselves concerning the Pandemic and All Hazards Preparedness Act and coordinate with the HHS Assistant Secretary for Public Response as a resource for telehealth inventory and for the implementation of other preparedness and response initiatives; and (6) use resources available through CDC's Public Health Information Network (PHIN) to facilitate interoperability with public health organizations and networks.

II. Discussion

8. The *2006 Pilot Program Order* generated overwhelming interest from the health care community. The Commission received 81 applications representing approximately 6,800 health care providers. Of these, 69 applications covering 42 states and three United States territories demonstrate the overall qualifications consistent with the goals, objectives, and other criteria outlined in the *2006 Pilot Program Order* necessary to advance telehealth and telemedicine in their areas by: Describing strategies for aggregating the specific needs of health care providers within a state or region, including providers serving rural areas; providing strategies for leveraging existing technology to adopt the most efficient and cost effective means of connecting those providers; describing previous experience in developing and managing telemedicine programs; and detailing project management plans. Rather than limit participation to a select few among the 69 qualified applicants, the Commission finds that it would be in the best interests of the Pilot Program, and appropriate as a matter of universal service policy, to accommodate as many of these qualified applicants as possible. Moreover, having more participants will enable the Commission to collect more data and thus enhance the Commission's ability to critically evaluate the Pilot Program. To accommodate the 69 qualified applicants in an economically reasonable and fiscally responsible manner, including remaining well within the existing $400 million annual RHC program cap, the Commission modifies the Pilot Program to spread funding equally over a three-year period. Specifically, total available support for Year One of the Pilot Program (FY 2007 of the existing RHC Program), Year Two (FY 2008 of the existing RHC Program), and Year Three (FY 2009 of the existing RHC Program) of the Pilot Program will be approximately $139 million per funding year. With this modification, the Commission is thus able to select all of the 69 qualified applicants as eligible to participate in the Pilot Program. Finally, selected participants shall work with HHS and, in particular, CDC, to make the health care networks funded by the Pilot Program available for use in instances of nationwide, regional, or local public health emergencies (e.g., pandemics, bioterrorism). Selected participants shall also use funding in a manner consistent with HHS's health IT initiatives.

A. Overview of Applicants

9. Consistent with the Commission's goal in the *2006 Pilot Program Order* to learn from the health care community through the design of a bottom-up application process, selected participants proffered a wide array of proposals to construct new health care networks or to upgrade existing networks and network components in an efficient manner. The selected proposals range from small-scale, local networks to large-scale, statewide or multi-state networks. Examples of applicants proposing small-scale networks include Mountain States Health Alliance which seeks $54,400 to connect two rural Virginia hospitals to an existing network consisting of 11 Tennessee hospitals. Rural Healthcare Consortium of Alabama seeks $232,756 to connect four critical access hospitals in rural Alabama to enable teleradiology, lab information systems, video conferencing, and secure networking with academic medical centers and universities.

10. Other applicants propose networks much larger in scope. For instance, Tennessee Telehealth Network (TTN) seeks approximately $7.8 million to expand upon the existing Tennessee Information Infrastructure, a pre-existing broadband network serving state, local, and educational agencies in Tennessee. Upon completion of the project, TTN's network will reach more than 440 additional health care providers throughout the state enabling it to bring the benefits of innovative telehealth, such as access to specialists in urban areas, to rural sites. In addition, certain applicants plan to connect multi-state networks, such as New England Telehealth Consortium (NETC) which seeks approximately $25 million to connect 555 sites in Vermont, New Hampshire, and Maine to the Northern Crossroads network, enabling connectivity to hospitals and universities throughout New England, including Rhode Island, Massachusetts, and Connecticut. NETC's resulting network would facilitate expansive telemedicine benefits, including remote trauma consultations, throughout the multi-state region.

11. Numerous applicants also demonstrate the serious need to deploy broadband networks for telehealth and telemedicine services to the rural areas of the nation where the needs for these services are most acute. For example, Pacific Broadband Telehealth Demonstration Project seeks to connect Hawaii and 11 Pacific Islands to one broadband network in the region where transportation costs are extremely high and health care specialists are concentrated mainly in the region's urban centers such as Honolulu.

12. Similarly, Health Care Research & Education Network convincingly demonstrates its state's need for expanded telemedicine services: North Dakota is an extremely rural state where 42 of its 53 counties include 30 percent or more residents living at or below 200 percent of the Federal Poverty Level. Part or all of 83 percent of North Dakota's counties are designated as Health Professional Shortage Areas, and 94 percent are designated as mental health shortage areas. To help alleviate these hardships, the University seeks to construct a high-speed data network to connect, via the existing state fiber network, Stagenet, its medical school's four main campus sites and clinical medical sites to five rural North Dakota health care facilities. Doing so will allow for research which would greatly accelerate the ability to bring contemporary treatment options to rural areas.

13. The Wyoming Telehealth Network also demonstrates the need for broadband infrastructure for health care use. In its application, it explains that Wyoming is an extremely low populous and rural state, suffering from a severe shortage of health care providers. Wyoming ranks 45th in physicians per 100,000 people, and have only 18 psychiatrists, four certified psychological practitioners, and two school psychologists statewide. Wyoming Telehealth Network's proposed network will extend the reach of health care professionals by linking the entire state's 72 hospitals, community mental health centers, and substance abuse centers, which will enable these facilities to transmit data to one another and videoconference. As these and other applications

demonstrate, health care providers in rural areas need access to broadband facilities for telehealth and telemedicine services to be available in rural areas.

14. Some applicants request Pilot Program funding to support build-out to tribal lands. For example, Tohono O'odham Nation Department of Information Technology (Nation) seeks funding to connect three of the Nation's remote health care facilities to Internet2 and to Arizona health care providers with existing networks to facilitate implementation of a comprehensive telemedicine program for the Tohono O'odham Nation that will enable the Nation to connect into a nationwide backbone of networks. The Nation's planned dedicated broadband network will result in a comprehensive health care delivery system that reaches even its most remote geographic areas—a particularly important goal considering the Nation's extremely limited public transportation system.

15. The Commission finds that the selected participants demonstrate a viable strategy for effective utilization of Pilot Program support consistent with the principles established in the *2006 Pilot Program Order,* and sufficiently set forth how their networks will meet the detailed Pilot Program criteria set forth in the *2006 Pilot Program Order.* As discussed in detail below, while the Commission finds that the selected applications overall satisfy the criteria set forth in the *2006 Pilot Program Order,* many applicants must submit additional information to USAC to ensure that fund commitments and disbursements will be consistent with section 254 of the 1996 Act, this Order, and the Commission's rules and orders.

B. Scope of Pilot Program and Selected Participants

16. In the *2006 Pilot Program Order,* the Commission stated, ''[o]nce we have determined funding needs of the existing program, the Commission will fund the Pilot Program in an amount that does not exceed the difference between the amount committed under our existing program for the current year and $100 million.'' The Commission estimated that approximately $55–60 million would be available for the Pilot Program, based on its past experience and estimates of funding requests received under the existing program for Funding Year 2006. In the *2006 Pilot Program Order,* the Commission also established the Pilot Program as a two-year program.

17. *Funding Cap.* In light of the overwhelming need for the Pilot Program funding to build-out dedicated health care network capacity to support telehealth and telemedicine, the Commission increases the funding cap amount from that set in the *2006 Pilot Program Order* to approximately $139 million for each year of the Pilot Program. The Commission finds this modification necessary to enable the 69 qualified applicants to implement their plans to the fullest extent possible. In particular, the Commission believes this increased amount of Pilot Program funding will enable participants to fully realize the benefits to telehealth and telemedicine services by making universal service support available for significant build-out of dedicated broadband network capacity. Increased support will also provide the Commission with an RHC Pilot Program extensive enough to soundly evaluate and to serve as a basis to propose to modify the existing RHC support mechanism, all without requiring the Commission to reject otherwise compliant applications. Although available yearly Pilot Program support is higher than the Commission originally contemplated in the *2006 Pilot Program Order,* this amount is still well below the $400 million cap for each funding year of the existing RHC support mechanism (even when combined with the most recent disbursements under the existing RHC support mechanism of $41 million), and therefore remains well within the existing parameters of economic reasonability and fiscal responsibility.

18. *Duration of Pilot Program.* To continue to maintain fiscal discipline, the Commission modifies the duration of the Pilot Program to require that commitments for the two-year program costs identified by selected participants in their applications occur over a three-year period. Funding the selected applications over a three-year period at somewhat lower levels than requested based on a two-year program will better serve goals of section 254(h)(2)(A) of the 1996 Act because it provides the Commission with sufficient flexibility to support more expansive network build-outs, thereby significantly enhancing health care providers' access to broadband services and enabling such access to occur considerably quicker than it otherwise would. Spreading commitments over a three-year period will also ensure that the Program moves forward seamlessly to facilitate uninterrupted rural telehealth/telemedicine network build-outs, while balancing the need for economic reasonableness and responsible fiscal management of the program, including by staying well within the $400 million RHC mechanism cap. In addition, expansion of the Pilot Program's duration, as well as increasing available aggregate support, will provide greater certainty of support to applicants that requested funding for multiple years, and will obviate the need for reapplications during the duration of the Pilot Program. Accordingly, the Pilot Program will begin in Funding Year 2007 and end in Funding Year 2009 of the existing RHC support mechanism.

19. *Administration of Funding Year 2006 Funds.* In establishing the Pilot Program duration, the Commission applies to Funding Year 2007 the moneys that USAC already collected in Funding Year 2006 for the Pilot Program. Because the Commission did not receive approval from the OMB until March 8, 2007, only two months prior to the application deadline of May 7, 2007, and because applicants could not meet the June 30, 2007, deadline for submitting Funding Year 2006 forms to USAC, the Commission finds it impracticable to begin the Pilot Program in Funding Year 2006 as originally contemplated. Consequently, the Commission begins the USAC application, commitment, and disbursement process for the Pilot Program with Funding Year 2007. Total available support for Year One of the Pilot Program (Funding Year 2007 of the existing RHC support mechanism), Year Two (Funding Year 2008 of the existing RHC support mechanism), and Year Three (Funding Year 2009 of the existing RHC support mechanism) of the Pilot Program will be approximately $139 million per Pilot Program funding year. The funding total is capped by the maximum amount allowable funding for each applicant during the three-year period.

20. *Selected Participants.* Appendix B of this Order lists each selected participant's eligible support amounts for each Pilot Program funding year. As indicated in Appendix B, selected participants' available support for each funding year of the Pilot Program is one-third of the sum of their Year One and Year Two application funding requests, as calculated by the Commission. Calculations are based on 85 percent of each selected participant's funding request. For selected participants that did not clearly request 85 percent funding for their total costs, the Commission has adjusted the support level to the appropriate 85 percent level. The Commission finds that committing this funding over a three-year period ensures the Pilot Program remains economically reasonable and fiscally responsible while allowing selected participants to remain eligible to receive their entire eligible Funding Year One

and Year Two support as identified in their applications. Although the Commission increases available support amounts, as explained in greater detail below, selected participants may not exceed the available support for each funding year as listed in Appendix B. The selected participants also remain required to provide at least 15 percent of their network costs from other specified sources. In addition, the Commission requires that selected participants' network build-outs be completed within five years of receiving an initial funding commitment letter (FCL).

21. *Priority System.* Contrary to the Commission's findings in the *2006 Pilot Program Order,* the Commission also, on its own motion, modifies the Pilot Program structure by declining to establish a funding priority system similar to the priority system provided for in the universal service schools and libraries mechanism. In the *2006 Pilot Program Order,* the Commission found that applications for support under the existing rural health care program would be funded before funding any of the projects proposed in the Pilot Program. The Commission had limited funding for the Pilot Program to the difference between the amount committed to the existing rural health care program and $100 million. The Commission finds it is not necessary to establish a priority system for the rural health care program because the Commission has eliminated the $100 million cap on funding for the existing program and the Pilot Program. As such, the Commission's expansion of the Pilot Program will ensure that both the applicants under the existing program and those under the Pilot Program receive funding for all eligible expenses they have included in their applications.

C. Qualifications of Selected Participants

22. In the *2006 Pilot Program Order,* the Commission instructed applicants to indicate how they plan to fully utilize a broadband network to provide health care services and to present a strategy for aggregating the specific needs of health care providers within a state or region, including providers that serve rural areas. Overall, selected participants demonstrated significant need for RHC Pilot Program funding for health care broadband infrastructure and services for their identified health care facilities, and provided the Commission with sufficiently detailed proposals. In their applications, each selected participant explained the goals and objectives of their proposed networks and generally addressed other criteria on which the Commission sought information in the *2006 Pilot Program Order.* Selected participants must meet the goals and objectives they identified in their Pilot Program applications. In addition, each selected participant must comply with all Pilot Program administrative requirements discussed below to receive universal service support funding.

23. *Network Utilization.* In the *2006 Pilot Program Order,* the Commission set forth the network goals and objectives for applicants to meet to be considered for Pilot Program funding. In particular, the Commission requested that applicants indicate how they will utilize dedicated broadband capacity to provide health care services. Selected participants sufficiently set forth the various ways in which they would appropriately utilize a broadband network. For example, Virginia Acute Stroke Telehealth Project proposes a broadband network that would focus on the continuum of care (prevention through rehabilitation) for stroke patients in rural and underserved areas of Virginia. Illinois Rural HealthNet Consortium plans to use its network for a wide variety of telemedicine applications, including video conferencing, remote doctor-patient consultations, and tele-psychiatry. Pacific Broadband Telehealth Demonstration Project seeks to interconnect seven existing networks to link health care providers throughout Hawaii and the Pacific Island region. The network will enable delivery of broadband telehealth and telemedicine for clinical applications, continuing medical, nursing and public health education, and electronic health records support. Alaska Native Tribal Health Consortium plans to connect rural health care providers throughout Alaska to urban health centers *via* a network that will support teleradiology, electronic medical records, and telepsychiatry through video conferencing.

24. Based on the Commission's review of all 81 of the applications, the Commission finds that the 69 selected participants have shown that they intend to utilize dedicated health care network capacity consistent with the goals set forth in the *2006 Pilot Program Order.* Thus, in selecting these applicants as eligible to receive funding for broadband infrastructure and services, the Commission will advance the goals of, among other things, bringing the benefits of telehealth and telemedicine to areas where the need for these benefits is most acute; allowing patients to access critically needed specialists in a variety of practices; and enhancing the health care community's ability to provide a rapid and coordinated response in the event of a national health care crisis.

25. *Leveraging of Existing Technology.* In the *2006 Pilot Program Order,* the Commission stated that applicants should leverage existing technology to adopt the most efficient and cost effective means of connecting providers. The Commission explained that the Pilot Program would be ''technically feasible'' because it would not require development of any new technology, but rather would enable participants to utilize any currently available technology. In general, selected participants explained how their proposed networks would leverage existing technology. Examples of applicants leveraging existing technology include the Association of Washington Public Hospital Districts, which plans to create a ''network of networks'' by interconnecting six existing networks to create a state-wide network. And Colorado Health Care Connections proposes to leverage an existing state network as the basis for a dedicated health care network for Colorado's public and non-profit health care providers. The goal is to connect all 50 rural hospitals and 76 rural clinics to the state network, which in turn is connected to the major metropolitan tertiary hospitals, and Internet2 and National LambdaRail.

26. *Aggregation.* In the *2006 Pilot Program Order,* the Commission instructed applicants to provide strategies for aggregating the specific needs of health care providers, including providers that serve rural areas within a state or region. In general, selected participants sufficiently explained how their proposed networks would aggregate the needs of health care providers, including rural health care providers. For example, Palmetto State Providers Network plans to link large tertiary centers, academic medical centers, rural hospitals, community health centers, and rural office-based practices in four separate rural/underserved areas in South Carolina into a developing fiber optic statewide backbone which connects to Internet2, NLR, and the public Internet. Similarly, Iowa Rural Health Telecommunications Program plans to link 100 hospitals in 57 counties in Iowa, one Nebraska hospital, and two South Dakota hospitals to a broadband network which will: Facilitate timely diagnosis and initiation of appropriate treatment or transfer of patients in rural communities; facilitate rapid access to and transmission of diagnostic images

and patient information between hospitals; extend and improve terrorism and disaster preparedness and response through communication network interoperability between hospitals, the Iowa Department of Public Health, and Iowa Homeland Security and Emergency Management; and enable future remote monitoring and care coordination for intensive care patients.

27. *Creation of Statewide or Regional Health Care Networks and Connection to Dedicated Nationwide Backbone.* In the *2006 Pilot Program Order,* the Commission instructed applicants to submit proposals that would facilitate the creation of state or regional networks and (optionally) connect to a nationwide broadband network. These networks should be dedicated to health care, thereby connecting public and non-profit health care providers in rural and urban locations. The selected participants generally demonstrated how their proposals would result in new or expanded state or regional networks and connection to a nationwide broadband network dedicated to health care. For example, Wyoming Telehealth Network will connect more than 30 hospitals and 42 community health centers, providing consortium health care professionals with access to a statewide network, and facilitating connection to Internet2 or NLR. West Virginia Telehealth Alliance's proposed network will facilitate access in every region, health care market, and community in West Virginia, with particular focuses on medically underserved rural areas; health professional shortage areas; communities with high disease and chronic health condition disparities; and communities that demonstrate ''readiness for deployment.'' Southwest Alabama Mental Health Consortium plans to establish a broadband network connecting 34 mental health providers in 16 counties in Southwest Alabama, and this network will connect to Internet2 thereby creating a large regional mental health care network that has access to the national backbone.

28. *Tribal Lands.* A significant number of applicants plan to use Pilot Program funds to create or expand health care networks serving tribal lands. The Commission finds that network reach to tribal lands to be a positive use of Pilot Program funds; these areas traditionally have been underserved by health care facilities and reflect unique health care needs, particularly compared to non-tribal areas. In addition to inadequate access to health care, tribal lands suffer from relatively low levels of access to important telecommunications services. For example, Native American communities have the lowest reported levels of telephone subscribership in America.

29. The Commission finds that these health care and telecommunications disparities between tribal lands and other areas of the country underscore the serious need for Pilot Program support of telemedicine and teleheath networks in tribal areas. Many selected participants plan to use Pilot Program support for networks on or near tribal lands. For example, Health Care Research & Education Network plans to construct a network that will serve a significant Native American population. According to the Health Care Research & Education Network, Native Americans report being uninsured at a rate of 37.1 percent and North Dakota's Indian population is 1.5 times as likely to die of heart disease, cancer, stroke, and influenza/pneumonia as those living on non-tribal lands. The Network seeks to alleviate some of these disparities through use of its planned network that will provide a link to improve educational opportunities, and will facilitate new and ongoing research in health care delivery to rural areas.

30. In the first year of the Pilot Program, Western Carolina University (WCU) in collaboration with the Eastern Band of Cherokee Indians (EBCI) seeks to connect the WCU's health care facilities to health care facilities on the reservation and in outlying areas so that patients can access critically needed medical specialists in a variety of practices without leaving their homes or their communities. In year two of the Pilot Program, WCU plans to connect the United South and Eastern Tribes, Inc. (USET), a non-profit, inter-tribal organization of 24 federally recognized tribes, to its network. The Commission finds that these and the other planned uses of Pilot Program funds to support network build-out to tribal lands will further our goal of bringing innovative health care services to those areas of the country with the most acute health care needs.

31. *Cost Estimates.* In the *2006 Pilot Program Order,* the Commission requested that applicants provide estimates of their network's total costs for each year. Selected participants provided cost estimates or budgets. Several applicants provided significant cost and budget details, including Adirondack-Champlain Telemedicine Information Network whose budget includes a clear analysis of network costs with significant detail, including, *e.g.*, cost per foot of fiber, cost of a pole installation, number of feet of fiber, and number of poles where fiber is installed. Alaska Native Tribal Health Consortium provides detailed cost estimates for each phase of its network, including deployment and services, and provides significant information about its revenue stream, operating expenses, and maintenance for five years. Although the Commission finds selected participants have satisfied this criterion, to ensure support is used for eligible costs, as part of the USAC application process, applicants must submit detailed network cost worksheets.

32. *Fair Share.* To prevent improper distribution of Pilot Program funds, in the *2006 Pilot Program Order,* the Commission instructed applicants to describe how for-profit network participants will pay their fair share of the network and other costs. In general, selected participants provided significant assurances that for-profit participants will be responsible for all of their network costs. Several applicants provided more detailed plans targeted to insuring that all for-profit participants pay their fair share of the costs. For instance, Northeast HealthNet states that its proposed network does not include for-profit entities and that, if for-profit entities are added to its network, they would be invoiced separately for each service item and USAC would receive invoice documentation that reflects only eligible rural health care providers. Similarly, Tennessee Telehealth Network notes that although it will not include for-profit participants in the first two years, for-profits will later be allowed to join and will be required to pay 100 percent of their actual costs.

33. *Funding Source.* In the *2006 Pilot Program Order,* the Commission instructed applicants to identify their source of financial support and anticipated revenues that will pay for costs not covered by the fund. To preserve the integrity of the Pilot Program, the Commission will continue to require selected participants to indicate how for-profit participants pay their fare share of network costs. Accordingly, selected participants must submit this information to USAC as part of their detailed line-item network costs worksheet submission and Pilot Program Participants Quarterly Data Reports. Generally, selected participants identified their source or sources of support for costs not covered by the Pilot Program. Several applicants provided the well-documented assurances that their costs not supported by the Pilot Program will be funded by reliable sources. For example, University Health Systems of Eastern Carolina states that it, the participating health care providers, and the North Carolina Office of Rural Health will

provide funding for their network costs not supported by Pilot Program funds. And, Wyoming Telehealth Network has received a commitment from the Wyoming Department of Public Health and Terrorism Preparedness Program to fund the Network's costs not covered by the Program.

34. *85 Percent Funding.* The Commission also stated in the *2006 Pilot Program Order* that no more than 85 percent of their costs incurred by a participant will be funded to deploy a state or regional dedicated broadband health care network, and to connect that network to NLR or Internet2. Selected participants demonstrated their commitment to seeking no more than 85 percent of their network costs from the Pilot Program. Michigan Public Health Institute, for example, explains that the Michigan Legislature has appropriated funds to cover a portion of its 15 percent share of costs. California Telehealth Network stated that it will receive its 15 percent share from the California Emerging Technology Fund, which is operated by the California Public Utility Commission. Iowa Health System states that it plans to fund approximately 39 percent of the total cost of extending its existing fiber backbone to 78 rural sites.

35. *Included Facilities.* With respect to health care facilities, the Commission directed applicants in the *2006 Pilot Program Order:* (1) To list the health care facilities that will be included in their networks; and (2) to demonstrate that they will connect more than a *de minimis* number of rural health care providers in their networks. All selected participants satisfied this request by providing the names and details of facilities to be included and by proposing to connect more than a *de minimis* number of rural health care facilities. Although some proposals include only a few rural health care providers, relative to the total number of facilities to be included in these networks, and recognizing the significant benefits these networks will confer on their rural populations, the Commission finds these small numbers of rural health care providers are more than *de minimis* when viewed in context. For example, Erlanger Health System's proposed network in Tennessee and Georgia includes five rural health care providers out of a total of 11 facilities, and Puerto Rico Health Department's proposed network includes six rural health care providers out of a total of 52 facilities. Considering the total number of health care providers to be included in these proposed networks, the Commission finds that the number of rural health care providers is more than *de minimis*.

36. *Prior Experience.* To help ensure sufficient skill and competency of Pilot Program participants, in the *2006 Pilot Program Order* the Commission asked whether applicants had previous experience in developing and managing telemedicine programs, and specifically whether applicants had successful track records in developing, coordinating, and implementing telehealth/telemedicine programs within their states or regions. In general, selected participants exhibited experience with telehealth/telemedicine programs, and some exhibited significant, impressive experience in this area. Notably, University Health Systems of Eastern Carolina has been recognized as one of the nation's ''100 Most Wired Healthcare Organizations'' five of the previous six years by *Hospitals and Health Networks* magazine, and connects regional hospitals *via* a high-speed fiber-optic network enabling telemedicine, teleradiology and telehealth services. University of Mississippi Medical Center's TelEmergency program already provides real-time medical care to patients in rural emergency departments utilizing specially-trained nurse practitioners linked with their collaborating physicians. The Commission finds this experience, and the experiences cited in other applications, will further the goals of the *2006 Pilot Program Order* by ensuring that applicants have the necessary experience to successfully implement telemedicine/telehealth programs within their states or regions.

37. *Project Management.* To ensure proper network oversight and implementation, in the *2006 Pilot Program Order,* the Commission instructed applicants to provide project management plans which outline leadership and management structures, work plans, schedules, and budgets. Selected participants provided project management plans that demonstrate a strong commitment to the success of their proposed networks. For example, Southwest Alabama Mental Health Consortium sets forth a detailed management structure, budget, and schedule, and its work plan provides for: Establishment of a legal partnership; selection of a service provider based on Commission requirements; installation of WAN and connection to Internet2; monthly project assessment meetings; implementation of telehealth and telemedicine services; implementation evaluation; and project continuation to achieve goals and objectives. Missouri Telehealth Network describes in detail the program manager's responsibilities; provides a month-by-month project timeline; and lists specific funding amounts requested for network costs, equipment, connections, and operation.

38. *Coordination.* To ensure efficiencies and avoid duplication of efforts or network facilities, in the *2006 Pilot Program Order,* the Commission instructed applicants to indicate how their proposed telemedicine program will be coordinated throughout the state or region. In general, selected participants sufficiently described such coordination. Notably, New England Telehealth Consortium (NETC) members represent 57 hospitals, three universities, 57 behavioral health sites, eight correctional facilities' clinics, 81 federally qualified health care centers, six health education sites, and two health research sites throughout Maine, Vermont and New Hampshire. Each NETC member, through its representation on the NETC Board of Directors, will be able to provide input into critical NETC decisions including network implementation priority among the various sites and telemedicine programs implemented as a result of this network. According to NETC, all members have agreed in writing that an Executive Committee will facilitate efficient management of the organization between meetings of the full Board. Rural Nebraska Healthcare Network (RNHN), a non-profit membership organization consisting of nine local hospitals and their associated clinics in the Panhandle of Nebraska, has coordinated health care efforts in the Panhandle since 1996. RNHN plans to utilize and enhance its existing regional coordination for programs and services by employing a system of Regional Leadership Teams that will draft regional priorities and be responsible for communication between all participants. The Regional Leadership Teams also will coordinate with the Board of Directors which includes the Chief Executive Officer of each member hospital.

39. *Self Sustainability.* A primary goal of the Pilot Program is to ensure the long-term success of rural health care networks and to prevent wasteful allocation of limited universal service funds. Accordingly, in the *2006 Pilot Program Order,* the Commission sought assurances from applicants that their proposed networks will be self sustaining once established. To the extent a network is not self sustainable once established, that may be an indicia of non-compliance with the terms of this Order and may be considered as part of any Pilot Program audits and oversight. Generally, selected participants provided sufficient evidence that their proposed networks

will be self sustaining by the completion of the Pilot Program. For example, Heartland Unified Broadband Network identifies three possible scenarios for network sustainability for Year Three and beyond, including: Reliance on the existing RHC support mechanism; reliance on fees from network partners; and reduction (not elimination) of bandwidth should full funding be unavailable. Wyoming Telehealth Network envisions some ongoing costs covered by the existing RHC support mechanism or state funding, and plans to use as a model Nebraska's statewide telehealth network which is supported through a combination of existing RHC support mechanisms, state funding through the Nebraska universal service program, and minimal consortium fees.

40. *USAC Application Process.* As described in detail above, the Commission finds that selected participants have sufficiently set forth how they will meet the overall Pilot Program's goals and objectives, and how their networks will meet the detailed Program criteria set forth in the *2006 Pilot Program Order.* Although the Commission finds that the selected applications overall satisfy the criteria set forth in the *2006 Pilot Program Order,* additional information will be needed from many applicants to ensure funds are disbursed and used consistent with section 254 of the 1996 Act, this Order, and the Commission's rules and orders. Accordingly, as described more fully below, each selected participant will be required to comply with this Order, and to thoroughly and clearly provide all necessary information with its forms and other data through the USAC administrative process. These additional requirements will ensure that Pilot Program funds are appropriately disbursed and will prevent, to the extent possible, waste, fraud, and abuse.

D. Denied Applications

41. In this section, the Commission denies 12 applications because these applicants do not demonstrate that they overall satisfy the goals, objectives, and other criteria of the *2006 Pilot Program Order.* Unlike the applications selected for participation above, the 12 applications the Commission denies either have substantial deficiencies across the range of criteria established in the *2006 Pilot Program Order* or seek funding for costs that are well beyond the scope of the *2006 Pilot Program Order.* Accordingly, the Commission finds that these applications do not warrant further participation in the Rural Health Care Pilot Program.

42. *OpenCape Corporation Application.* OpenCape fails to satisfy the goals and objectives of the *2006 Pilot Program Order* because, among other things, its application seeks support focused not for a network dedicated to telehealth, but instead for a network for use by public schools, community colleges, and commercial firms. In fact, in the application, health care is only mentioned once and the letters of support and funding in the OpenCape application appear to be limited to school districts, community colleges, and the towns that would be served by the network. To the extent OpenCape seeks funding for schools, it may do so through the universal service support mechanism for schools and libraries (E-Rate program). Significantly, none of the seven members of the proposed board is affiliated with a health care provider; none of the 41 entities listed as supporting the network is a health care provider; and none of the six entities providing funds to cover the 15 percent minimum funding contribution is a health care provider. The seven board members primarily come from education backgrounds. OpenCape's application is also deficient because it fails to provide adequate details of its costs. For example, the budget provided with OpenCape's application provides information on tasks it will perform, but does not provide costs associated with those tasks. For instance, OpenCape states that it will perform a wireless engineering study and a topography study, but does not provide the costs associated with these studies. In addition, OpenCape does not adequately identify its source of the financial support and anticipated revenues that will pay for costs not covered by the Pilot Program, but instead merely indicates that it will pursue grants, donations and earmarks for capital funding of the full implementation. Not only does this show that OpenCape does not presently know who will pay for its share of the costs, the Commission cannot even determine from the application whether its expectations to obtain funding are realistic because OpenCape provides little to no evidence of its ability to secure funding from these sources. Rather, OpenCape merely explains that its federal and state legislative delegations generally (but not for its specific Pilot Program application) have shown an interest in expanding access to underserved regions of Massachusetts. Accordingly, the Commission denies OpenCape's request to participate in the Pilot Program.

43. *North Link of Northern Enterprises, Inc. Application.* North Link of Northern Enterprises, Inc. (North Link of Northern Enterprises) seeks $2.5 million in funding for a project generally described as connecting eight hospitals and medical centers to the regional fiber optic backbone to promote the use of a photo archiving system (PAS), virtual intensive care units, and teleconferencing. However, beyond the vague description of the project, North Link of Northern Enterprises does not provide sufficient information to determine how the project will advance the goals of the *2006 Pilot Program Order.* Notably, like OpenCape's application, North Link of Northern Enterprises fails to provide budget information that would permit the Commission to assess whether the application comports with program requirements including, in particular, whether the funding request is for eligible services. Additionally, the work plan submitted by North Link of Northern Enterprises fails to provide specific details on the phases of construction anticipated by Northern Enterprises. Instead, the work plan merely states that Phase I, which consists of laying 75 miles of the 400 miles of fiber optics, will begin June 4, 2007, with the balance of the project completed by 2009. The Commission therefore denies North Link of Northern Enterprises' request for Pilot Program participation because it does not demonstrate it is qualified to be eligible for its broad request for funding.

44. *Illinois Hospital Association Application.* The Commission also denies the application of Illinois Hospital Association because it seeks funding primarily for costs that are beyond the scope of the Pilot Program. In particular, Illinois Hospital Association states that it seeks over $800,000 for its proposed project to provide greater access to the existing state broadband network, Illinois Century Network, for rural health care providers to promote the use of telehealth and telemedicine throughout the state. The funding, however, is primarily for staff support and customer premises equipment, which are outside the scope of the Pilot Program. Thus, the Commission denies this application for participation in the Pilot Program. The Commission notes, however, that the Illinois Rural HealthNet Consortium and the Iowa Health System will be participants in the Pilot Program and will offer services in Illinois. The Commission also notes that the two main proposed recipients in Illinois Hospital Association's application, University of Illinois College of Medicine at Rockford and Southern

Illinois School of Medicine, are also included in Illinois Rural HealthNet Consortium's application.

45. *Institute for Family Health Application.* Similarly, the Institute for Family Health in New York seeks $2.4 million in funding for its proposed network that would extend its current electronic health records (EHR) and practice management system from its New York City-based urban network to rural health centers throughout the Mid-Hudson Valley region. Of the requested Pilot Program funding, over 75 percent is for costs that are beyond the scope of the Pilot Program, including customer premises equipment such as personal computers and server hardware, personnel costs, and $1.5 million in funding for software licenses. Accordingly, the Commission declines to select Institute for Family Health to participate in the Pilot Program.

46. *Valley View Hospital Application.* The Valley View Hospital in Colorado's application also fails to qualify for participation in the Pilot Program because it seeks funding primarily for ineligible Pilot Program costs. Specifically, Valley View Hospital seeks $195,000 in funding for the rental of an RP–7 robotic system, which is a tele-operated, mobile robotic system that enables remote presence. As stated above, the Pilot Program funding will promote the utilization of dedicated broadband capacity to provide health care services. Valley View Hospital, however, seeks funding not for network design or build-out, but for medical equipment, which is specifically excluded from funding. The Commission finds, therefore, that participation in the Pilot Program by Valley View Hospital is not appropriate.

47. *Alabama Rural Health Network.* The application submitted by the Alabama Department of Economic and Community Affairs (Alabama Rural Health Network) also seeks funding for ineligible Pilot Program costs. In particular, ADECA seeks $91,275 in funding, of which $45,000 is for a category simply labeled ''contractual.'' The rest of the funding is divided amongst personnel costs, travel, ''fringe benefits,'' and ''indirect costs.'' None of these costs are eligible costs for which Alabama Rural Health Network could receive reimbursement. Further, none of those costs appear to be associated with network design or deployment of infrastructure. Instead, Alabama Rural Health Network's application appears to be seeking funding for a survey it will conduct of the state's hospitals to determine their needs, and an evaluation of the state's broadband providers to determine their capabilities. These deficiencies in Alabama Rural Health Network's proposal warrant its exclusion from participation in the Pilot Program.

48. *Pioneer Health Network Application.* Pioneer Health Network's application states that it seeks to develop a health information system focusing on health information technology (such as patient level health and quality information exchange and establishing a health information environment that emphasizes security and privacy of patient data and that leverages technologies that are enhanced by the evolving interoperability standards) as opposed to telehealth and telemedicine applications. Beyond this general description, Pioneer Health Network does not provide any details concerning its proposal except to indicate the project involves software applications, as opposed to network infrastructure (which the applicant states will largely be provided by the existing statewide backbone). Because the Pilot Program does not fund medical software applications, the Commission declines to find Pioneer Health Network eligible for funding.

49. *Taylor Regional Hospital Application.* Taylor Regional Hospital's application is so vague in providing overall details about how it qualifies for participation in the Pilot Program that the Commission denies its application. In particular, Taylor Regional Hospital's application fails to specify the amount of funding it seeks, specifying only that its proposed project would cost $7,200 per year. In addition, Taylor Regional Hospital fails to provide any detail supporting its costs for the Commission to determine whether these costs are associated with network design or network costs. Taylor Regional Hospital's stated objective is to use the funding to enhance its imaging distribution system, community-wide scheduling system, and its Laboratory Information System. It is unclear from the application whether such enhancements would require network upgrades or whether they are software application upgrades, which would be ineligible for support. Moreover, Taylor Regional Hospital does not identify the health care providers it seeks to connect. Instead, Taylor Regional Hospital states that the facilities that will be included in the network are ''Taylor Regional Hospital and all the affiliates associated with [it].'' This omission on the part of Taylor Regional Hospital makes it impossible, among other things, to determine whether there will be a *de minimis* number of the rural health care providers; identify network configuration; and to ensure that the proposed project is consistent with the goals, objectives, and other criteria of the *2006 Pilot Program Order.* Thus, the Commission denies this application.

50. *United Health Services Application.* Similarly, United Health Services of New York (United Health Services) provides such inadequate detail of its network costs that it does not merit further participation in the Pilot Program. Notably, United Health Services provides no budget, but instead merely lists its monthly connectivity costs, without specifying whether the costs would support an existing network or construction of a new network. The Commission notes that United Health Services does include a management and work plan and schedule. However, without a budget, the Commission is not able to identify how United Health Services intends to allocate the funding for each phase of the plan. In addition, its application fails to include financial data or to detail in any meaningful way its proposed network build-out and costs. Consequently, the Commission finds Pilot Program participation by United Health Services would not be consistent with the *2006 Pilot Program Order.*

51. *World Network Institutional Services Application.* World Network Institutional Services (WNIS) also fails to detail its costs or almost any other aspect of its proposal in its cursory four-page application to adequately assess its qualifications for participation in the Pilot Program. WNIS seeks $100 million in funding but fails to provide a budget breaking out its cost estimates. Additionally, WNIS does not provide any detail as to which health care facilities it would include in its network, preventing the Commission, among other things, from determining whether the network would serve more than a *de minimis* number of rural health care providers. Rather, WNIS states that a list will be provided in ''later correspondence'' (which was never provided). Further, WNIS fails to provide specific information on how it will pay for its portion of the costs of the network. Instead, WNIS offers that its financial support will come from ''advertisers and users.'' Based on these deficiencies and the overall vagueness of the application, the Commission declines to include WNIS as a participant in the Pilot Program.

52. *Hendricks Regional Health Application.* Hendricks Regional Health (Hendricks), like WNIS, fails to provide a work plan that sufficiently details the management/leadership structure, work plan, or budget. In particular, Hendricks provides no budget information in its

application. The only estimate in its application is for the per mile cost of deploying the fiber optic cable it seeks, which is $50,000 per mile for approximately 58 miles. And, even this information is not accompanied by any specific detail or documentation. The Commission also has concerns about the work plan presented by Hendricks. Instead of providing detailed information, Hendricks provides a vague timeline with no additional information to support its assumptions on deployment of the fiber optic cable. Like Taylor, United Health, and WNIS, the deficiencies in Hendricks's application do not warrant its participation in the Pilot Program.

53. *Southwest Pennsylvania Regional Broadband Health Care Network Application.* Similarly, the application submitted by Southwest Pennsylvania Regional Broadband Health Care Consortium (Southwest Pennsylvania Regional Broadband Health Care Network) fails to provide information that sufficiently details its work plan or budget. Specifically, Southwest Pennsylvania Regional Broadband Health Care Network offers a budget that fails to provide any line-item details. Rather, Southwest Pennsylvania Regional Broadband Health Care Network indicates that it intends to build 180 miles of fiber optic cable and states that it will need $7.2 million in funding to do so. Southwest Pennsylvania Regional Broadband Health Care Network provides no detail on how it arrived at this figure or what it includes. SW Pennsylvania Consortium also provides no information regarding the on-going cost of operating its network. Because there are no details in its budget, the Commission is also not able to determine what network equipment Southwest Pennsylvania Regional Broadband Health Care Network intends to purchase. Additionally, Southwest Pennsylvania Regional Broadband Health Care Network's fails to document its funding sources. It, instead, lists the facilities that would join the network and assigns an annual cost of $5,456.95 to each facility for five years without providing detail on where the entities will get the additional money or providing letters of support from these entities. Moreover, like Hendricks, Southwest Pennsylvania Regional Broadband Health Care Network's work plan represents nothing more than a timeline. Finally, the Commission notes that of the 99 facilities listed in its application, only five are eligible rural health care providers. Given the amount of funding requested, the lack of financial and other detail needed to justify funding, and the small percentage of rural health care providers that will be connected, the Commission finds Pilot Program participation would not be consistent with the *2006 Pilot Program Order.*

54. Finally, as noted above, in the *2006 Pilot Program Order,* one of the purposes of the Pilot Program was to encourage health care providers to aggregate their connection needs to form a comprehensive statewide or regional dedicated health care network. The applications that the Commission is approving in this Order have fulfilled that purpose and together will cover 42 states and three United States territories. The Commission encourages those eligible health care providers that are part of the denied applications to pursue ways to be included in the approved consortia in their states or regions. The Commission also encourages the rural health care facilities in the denied applications to contact USAC to discuss their possible participation in the existing RHC support mechanism. In addition, after three years, the Commission intends to revisit its rules and determine how to improve the current program. The Commission encourages the denied applicants to participate in any subsequent proceedings and reapply at that time.

E. Pilot Program Administration

55. In this section, the Commission discusses several issues related to the effective administration of the Pilot Program. The Commission first provides clarification regarding what entities are eligible health care providers for purposes of the Pilot Program, which services are eligible and ineligible for Pilot Program support, and which sources of funding are eligible and ineligible for selected participants' 15 percent minimum funding contribution. The Commission also provides specific guidance concerning selected participants' compliance with the submission of program forms to the USAC. For example, in order to receive universal service support, selected participants must submit with the required USAC Forms, detailed worksheets concerning their proposed network costs, certifications demonstrating universal service support will be used for its intended purposes, letters of agency from each participating health care provider, and detailed invoices showing actual incurred costs of project build-out. As discussed below, selected participants that fail to comply with these procedures and the other program requirements the Commission discusses here will be prohibited from receiving support under the Pilot Program. Finally, the Commission addresses various requests for waiver of Commission rules filed by applicants. Among other things, the Commission denies waiver requests of the Commission's rule requiring that Pilot Program selected participants competitively bid their proposed network projects. In doing so, the Commission reaffirms that the competitive bidding process remains an important safeguard to ensuring universal service support is used wisely and efficiently ensuring that the most cost effective service providers are selected by selected participants, and the Commission discusses the factors on which selected participants should rely in making their cost effectiveness determinations in the competitive bidding process.

1. Eligible Health Care Providers

56. As stated above, the existing RHC support mechanism utilizes the statutory definition of ''health care provider'' established in section 254(h)(7)(b) of the 1996 Act. Excluded from the list of eligible health care providers are nursing homes, hospices, other long-term care facilities, and emergency medical service facilities. Although emergency medical service facilities are not eligible providers for purposes of the RHC Pilot Program, Pilot Program funds may be used to support costs of connecting emergency medical service facilities to eligible health care providers to the extent that the emergency medical services facility is part of the eligible health care provider. Additionally, pharmacies are excluded from the definition of health care providers. Accordingly, under the RHC Pilot Program, only eligible health care providers and consortia that include eligible health care providers may apply for and receive discounts. Additionally, applicants, as well as individual health care facilities included in an application, that have been convicted of a felony, indicted, suspended, or debarred from award of federal or state contracts, or are not in compliance with FCC rules and requirements shall not be eligible for discounts under the Pilot Program. To the extent that the applications the Commission selects herein contain ineligible health care providers, such providers may participate but must be treated by the applicant and by USAC as if the providers were for-profit entities and therefore are ineligible to receive any support associated with their portion of the Pilot Program network. Further, selected participants

or individual health care facilities that are part of the network of a selected participant that are delinquent in debt owed to the Commission shall be prohibited from receiving universal service Pilot Program support until full payment or satisfactory arrangement to pay the delinquent debt(s) is made. Also, selected participants or individual health care facilities included in the network of a selected participant that are barred by the General Services Administration (GSA) from receiving federal contracts, subcontracts, and certain types of federal assistance shall be prohibited from receiving universal service Pilot Program support until the GSA determines that they are eligible for federal contracts, subcontracts, and certain types of federal assistance.

57. *Participation of State Organizations and Entities as Consortia Members.* State organizations and entities may apply for funding on behalf of consortia members, but cannot themselves receive funding for services under the Pilot Program unless they satisfy the statutory definitions for health care provider under section 254(h)(7)(b) of the 1996 Act. In addition, state organizations or entities that provide eligible service offerings are eligible to be selected as a service provider by a Pilot Program selected participant through the competitive bidding processes. Notably, the Commission previously determined that the term ''health care provider'' should be interpreted narrowly and, in the past, excluded potential entities from the eligible health care provider definition when not explicitly included in the statutory definition by Congress. Despite the limitations of section 254(h)(7)(b), however, the Commission's rules allow eligible health care providers to join consortia with other eligible health care providers; with schools, libraries, and library consortia eligible under Subpart F of 47 CFR part 54; and with public sector (governmental) entities to order telecommunications services. As state organizations or entities constitute ''public sector (governmental) entities,'' they may join consortia under the Commission's rules.

58. Therefore, although state organizations and entities do not constitute eligible health care providers, the Commission finds they may apply on behalf of eligible health care providers as part of a consortium (*e.g.*, as consortia leaders) to function, for example, in an administrative capacity for eligible health care providers within the consortium. In doing so, however, state organizations and entities are prohibited from receiving any funding from the Pilot Program. The Commission notes that in the E-Rate context, it has explicitly required state telecommunications networks that secure discounts under the universal service support mechanisms on behalf of eligible schools and libraries, or consortia that include an eligible school or library, to pass on these discounts to the eligible schools or libraries. The Commission clarifies here and makes explicit that any discounts, funding, or other program benefits secured by a state entity or organization or other ineligible entity functioning as a consortium leader under the Pilot Program must be passed on to consortia members that are eligible health care providers. In addition, the Commission also finds that, like state entities, other not-for-profit ineligible entities may apply on behalf of eligible health care providers as part of a consortium (*i.e.*, as consortia leaders), and otherwise function in an administrative capacity for eligible health care providers within the consortium. Like state organizations and entities, these not-for-profit entities are prohibited from receiving any funding from the Pilot Program.

2. Rural Health Care Pilot Program Network Components Eligible and Ineligible for Support

59. In the *2006 Pilot Program Order,* the Commission stated that funding provided under the Pilot Program would be used to support the costs of constructing dedicated broadband networks that connect health care providers in a state or region, and that connect such state and regional networks to the public Internet, Internet2, or NLR. The Commission explained that eligible costs include those for initial network design studies. The Commission stated in the *2006 Pilot Program Order* that it would fund necessary network design studies for selected participants, as these studies would enhance access to advanced telecommunications and information services by enabling applicants to determine how best to deploy an efficient network that includes multiple locations and various technologies. Several applicants requested funding for network design studies. For example, Kentucky Behavioral Telehealth Network proposes to complete a network design study in Year One, and in Year Two build out the designed network to link the existing statewide network of regional behavioral health providers with rural health care providers to improve access to a full range of medical care. And, Penn State Milton S. Hershey Medical Center plans in Year One to connect several rural hospitals to the Medical Center and to conduct a comprehensive inventory and capacity analysis of additional facilities it seeks to add in Year Two. For purposes of the Pilot Program, the Commission clarifies that funding for network design studies includes costs paid to a consultant to analyze both technical and non-technical requirements and develop feasible network designs based on the analyses. The Commission further explained that eligible costs also include those for deploying transmission facilities and providing access to advanced telecommunications and information services, including non-recurring and recurring costs. The Commission notes that in the *2006 Pilot Program Order,* it stated that authorized purposes include the costs of ''advanced telecommunications and information services.'' The Commission clarifies here that, consistent with the Act, authorized purposes include the costs of access to advanced telecommunications services. In light of the many applications the Commission received seeking funding and the wide range of network and related components for which support is sought, the Commission further clarifies the services eligible and ineligible for support to ensure that the Pilot Program operates to facilitate the goals of the *2006 Pilot Program Order.* The Commission thus clarifies that eligible non-recurring costs include those for design, engineering, materials and construction of fiber facilities or other broadband infrastructure, and the costs of engineering, furnishing (*i.e.*, as delivered from the manufacturer), and installing network equipment. Recurring and non-recurring costs of operating and maintaining the constructed network are also eligible once the network is operational. Further, to the extent that a selected participant subscribes to carrier-provided transmission services (*e.g.*, SONET, DS3s) in lieu of deploying its own broadband network and access to advanced telecommunications and information services, the costs for subscribing to such facilities and services are also eligible.

60. Ineligible costs include costs that are not directly associated with network design, deployment, operations and maintenance. These ineligible costs include, but are not limited to:

- Personnel costs (including salaries and fringe benefits), except for those personnel directly engaged in designing, engineering, installing, constructing, and managing the dedicated broadband network. Ineligible costs of this category include, for example, personnel to perform program management and

coordination, program administration, and marketing.

- Travel costs.
- 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 that involves anything other than the design, engineering, operations, installation, or construction of the network.
- 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) and network costs apportioned to ineligible network participants.
- Administration and marketing costs (*e.g.*, administrative costs; supplies and materials (except as part of network installation/construction); marketing studies, marketing activities, or outreach efforts; evaluation and feedback studies).

61. USAC may only fund eligible costs as described in this Order and is prohibited from funding ineligible costs or providing funding to ineligible participants. The Commission requires, as discussed below, Pilot Program participants to identify and detail all ineligible costs, including costs apportioned to for-profit and other ineligible network participants or sites, in their line-item network cost worksheets submitted to USAC with FCC Forms 465 and 466–A, and to clearly demonstrate that Pilot Program support amounts will not be used to fund ineligible costs. The Commission notes that some applicants sought waivers of the *2006 Pilot Program Order*, if necessary, for certain costs. To the extent that these costs constitute ineligible costs, as described in this Order, selected participants may not request or receive Pilot Program funds to support these costs. Accordingly, the Commission denies these applicants' requests to expand the scope of funding available under the *2006 Pilot Program Order*. The Commission notes that if a product or service 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. The clear delineation must have a tangible basis and the price for the eligible portion must be the most cost-effective means of receiving the eligible service. If the ineligible functionality is ancillary to an eligible component, the costs need not be allocated to the ineligible functionality. An ineligible functionality may be considered ''ancillary'' if (1) a price for the ineligible component that is separate and independent from the price of the eligible components cannot be determined, and (2) the specific package remains the most cost-effective means of receiving the eligible services, without regard to the value of the ineligible functionality.

3. Eligible Sources for 15 Percent of Non-Funded Costs

62. The Commission finds that selected participants' minimum 15 percent contribution of eligible network costs must be funded by an eligible source as described in this Order. Selected participants are required to identify with specificity their source of funding for the minimum 15 percent contribution of eligible network costs in their submissions to USAC, as discussed below. The Commission emphasizes that selected participants' 15 percent contributions must go towards eligible network costs only, as described in this Order. In order to ensure that the Pilot Program operates consistent with the goals and objectives of the *2006 Pilot Program Order* and that funds are used to the benefit of public and non-profit health care providers, the Commission places limitations on from what source selected participants may derive their minimum 15 percent contribution of eligible network costs. Only funds from an eligible source will apply towards selected participants' required 15 percent minimum contribution. Eligible sources include the applicant or eligible health care provider participants; state grants, funding, or appropriations; federal funding, grants, loans, or appropriations except for RHC funding; and other grant funding, including private grants. The Commission stresses that participants who do not demonstrate that their 15 percent contribution comes from an eligible source or whose minimum 15 percent funding contribution is derived from an ineligible source will be denied funding by USAC. Ineligible sources include in-kind or implied contributions; a local exchange carrier (LEC) or other telecom carrier, utility, contractor, or other service provider; and for-profit participants. Moreover, selected participants may not obtain any portion of their 15 percent contribution from the existing RHC support mechanism. The Commission finds that these limitations on sources are necessary to ensure that participating health care providers adequately invest in their network projects to ensure efficiency in both cost and design and to assume some minimal level of risk. Requiring participants to have a vested interest in the approved network project safeguards against program manipulation and protects against waste, fraud, and abuse. The Commission recognizes that some selected participants identified improper sources for their participant contribution in their Pilot Program applications; however, the Commission allows those selected participants to amend their project proposals in their submissions to USAC solely for the purpose of coming into compliance with the requirements of this Order. Applicants so amending their applications are prohibited from using this opportunity to increase in any way the amount of support they are seeking.

4. Cost Effectiveness

63. Consistent with existing rules and requirements, selected participants must comply with the competitive bidding process to select a service provider for their proposed projects. As part of this requirement, the Commission reiterates that each selected participant is required to certify to USAC that the service provider it chooses is, to the best of the applicant's knowledge, the most cost-effective service or facility provider available. The Commission has defined ''cost effective'' for purposes of the existing RHC support mechanism as ''the method that costs the least after consideration of the features, quality of transmission, reliability, and other factors that the health care provider

deems relevant to * * * choosing a method of providing the required health care services.'' In selecting the most cost-effective bid, in addition to price, the Commission requires selected participants to consider non-cost evaluation factors that include prior experience, including past performance; personnel qualifications, including technical excellence; management capability, including solicitation compliance; and environmental objectives (if appropriate). The Commission has previously concluded that non-price evaluation factors, such as prior experience, personnel qualifications, and management capability, may form a reasonable basis on which to evaluate whether a bid is cost effective. Because designing and constructing a new network or building upon an existing network represents a substantial undertaking that requires technical expertise, training, and skills of a different level than those services supported by the existing RHC support mechanism, the Commission makes consideration of these factors mandatory for selected participants.

64. The existing RHC support mechanism, unlike the schools and libraries universal service support (E-Rate) program, does not require participants to consider price as the primary factor in selecting service providers. The Commission has stated that applicants to the RHC support mechanism should not be required to use the lowest-cost technology because factors other than cost, such as reliability and quality, may be relevant to fulfill their telemedicine needs. This rationale remains appropriate for the Pilot Program. Thus, selected participants are not required to select the lowest bid offered, and need not consider price as the sole primary factor in selecting bids for construction of their broadband networks and the services provided over those networks. The applications selected for participation in the Pilot Program serve a variety of telemedicine and telehealth needs and entail complex network design, as well as infrastructure planning and construction. In developing a telemedicine network infrastructure, selected participants may find non-cost factors to be as or more important than price. For example, selected participants may find technical excellence and personnel qualifications particularly relevant in determining how to best meet their health care and telemedicine needs. Requiring applicants to use the lowest cost technology available could result in selected participants being relegated to using obsolete or soon-to-be retired technology. In addition, initially higher cost options may prove to be lower in the long-run, by providing useful benefits to telemedicine in terms of future medical and technological developments and maintenance. Thus, the Commission does not require selected participants to make price the sole primary factor in bid selection, but it must be a primary factor.

5. Network Modifications

65. Selected participants shall follow the network design plan outlined in their applications. Nevertheless, the Commission recognizes that selected participants may find it necessary or desirable to modify the network design plans set forth in their Pilot Program applications. For example, less expensive network components that may be available since applications were compiled may permit selected participants to acquire higher capacity at lower prices. Alternatively, selected participants may be able to add health care providers to their network within the available maximum support amounts. Although network modifications may deviate from a selected participant's initial application, to the extent a modification results in a supported network only connecting a de minimis number of rural health care providers, the modification may result in adjustment of available support or denial of participation in the Pilot Program for a selected participant. Therefore, to the extent a selected participant wishes to upgrade, replace technology, or add eligible health care providers to its proposed network prior to commencing and completing the competitive bidding process, it may receive support to do so as long as that support does not exceed the maximum available support amount and the support is used for eligible expenses. The Commission also notes that selected participants, including health care provider consortium members, may decline to participate in the Pilot Program, if they choose, subject to the restrictions noted in this Order. However, once a service provider is selected and an FCL is issued by USAC, selected participants' support will be capped at the FCL amount, and the selected participant may only modify the network within that support amount. Any modifications that would increase the amount of support needed above the maximum available support amount for the selected participant in this *Order* will not be funded by the Pilot Program. After the issuance of the FCL, selected participants must complete the project for which funding is awarded.

6. Public Safety and Coordination for Emergencies

66. In 2004, the President issued an Executive Order calling for the development and implementation of a national interoperable health information technology infrastructure. A key element of this plan is the NHIN initiative which promotes a ''network of networks,'' where state and regional health information exchanges and other networks that provide health information services work together, through common architecture (services, standards, and requirements), processes and policies to securely exchange information. In response to the Pilot Program, HHS has identified ways the Pilot Program and the NHIN can advance the provision of critical patient information to clinicians at the point of care to enable vital links for disaster preparedness and emergency response, improve healthcare, population health, and prevention of illness and disease.

67. The Commission agrees with HHS that the Pilot Program can advance the goals of the NHIN initiative. Accordingly, selected participants shall use Pilot Program funding in ways to ensure their funded projects are consistent with HHS's health IT initiatives in several areas: Health IT standards; certification of electronic health records (EHRs), personal health records (PHRs), and networks; the NHIN architecture; the National Resource for Health Information Technology; and the Public Health Information Network (PHIN). In particular, where feasible, selected participants shall: (1) Use health IT systems and products that meet interoperability standards recognized by the HHS Secretary; (2) use health IT products certified by the Certification Commission for Healthcare Information Technology; (3) support the NHIN architecture by coordinating activities with the organizations performing NHIN trial implementations; (4) use resources available at HHS's Agency for Healthcare Research and Quality National Resource Center for Health Information Technology; (5) educate themselves concerning the Pandemic and All Hazards Preparedness Act and coordinate with the HHS Assistant Secretary for Public Response as a resource for telehealth inventory and for the implementation of other preparedness and response initiatives; and (6) use resources available through HHS's Centers for Disease Control and Prevention PHIN to facilitate interoperability with public health and emergency organizations. In addition, as

part of the Pilot Program quarterly reporting requirements, selected participants shall inform the Commission whether or how they have complied with these initiatives. The Commission finds that expecting selected participants to comply with these HHS initiatives likely will result in more secure, efficient, effective, and coordinated use of Pilot Program funding and the supported networks. Finally, selected participants shall coordinate in the use of their health care networks with HHS and, in particular, with CDC in instances of national, regional, or local public health emergencies (*e.g.*, pandemics, bioterrorism). In such instances, where feasible, selected participants shall provide access to their supported networks to HHS, including CDC, and other public health officials.

7. Forms and Related Program Requirements

68. Selected participants are required to follow the normal RHC support mechanism procedures. USAC currently provides funds directly to the telecommunications service providers, not to the applicant. The Commission reminds selected participants and service providers that universal service support received by service providers must be distributed to or credited against the portion of the project approved for eligible health care providers only. In instances where credits cannot be issued to a service provider, selected participants may receive payment directly from USAC, provided the selected participant complies with the administrative requirements in this Order. Under the current program, to obtain discounted telecommunications services, applicants must file certain forms with USAC. The Commission notes that all selected participants must obtain FCC registration numbers (FRNs). An FRN is a 10-digit number that is assigned to a business or individual registering with the FCC. This unique FRN is used to identify the registrant's business dealings with the FCC. Selected participants may obtain an FRN through the Commission's Web site. Selected participants may obtain a single FRN for the entire application or consortium (*i.e.*, each health care provider does not need a separate FRN). First, applicants file FCC Form 465 with USAC to make a bona fide request for supported services. FCC Form 465 is the means by which an applicant requests bids for supported services and certifies to USAC that the applicant is eligible to benefit from the RHC support mechanism. USAC posts the completed FCC Form 465 on its Web site and an applicant must wait at least 28 days from the date on which its FCC Form 465 is posted on USAC's the Web site before making commitments with the selected service provider(s). Next, after the 28 days have expired, an applicant submits FCC Form 466 and/or 466–A. These forms are used to indicate the type(s) of service ordered by the applicant, the cost of the ordered service, information about the service provider(s), and the terms of the service agreement(s). Each applicant must certify, on the FCC Form 466 and 466–A, that the applicant has selected the most cost-effective method of providing the selected service(s). FCC Form 467 is the next and final form an applicant submits. FCC Form 467 is used by the applicant to notify USAC that the service provider has begun providing the supported service. An applicant must submit one FCC Form 467 for each FCC Form 466 and or 466–A that the applicant submitted to USAC. FCC Form 467 is also used to notify USAC when the applicant has discontinued the service or if the service was or will not be turned on during the funding year. The Commission reminds selected participants that all health care providers participating in the RHC Pilot Program must maintain documentation of their purchases of service for five years from the end of the funding year, which must include, among other things, records of allocations for consortia and entities that engage in eligible and ineligible activities. Upon request, beneficiaries must make available all documents and records that pertain to them, including those of contractors and consultants working on their behalf, to the Commission's Office of Inspector General, to USAC, and to their auditors. This record retention requirement also applies to service providers that receive support for serving rural health care providers.

69. The Commission recognizes that due to the unique structure of the Pilot Program, selected participants may have difficulty in preparing the required RHC forms to be submitted to USAC. The Commission therefore finds it necessary to provide guidance regarding how these forms should be completed to minimize the possibility of unintentional error on the part of selected participants. The Commission also takes this opportunity to provide further guidance on Pilot Program requirements and additional data that must be submitted with the FCC RHC forms. In addition, the Commission directs USAC to conduct a targeted outreach program to educate and inform selected participants on the Pilot Program administrative process, including the various filing requirements and deadlines, in order to minimize the possibility of making inadvertent ministerial, or clerical errors in completing the required forms.

70. *FCC Form 465 Process.* To ensure a fair and transparent bidding process, the Commission directs selected participants to clearly identify, on form Line 29 (description of Applicant's telecommunications/Internet needs) of the FCC Form 465, the bids the applicant is requesting for the network it intends to construct under the three-year Pilot Program. The Commission reiterates that selected participants cannot receive support that exceeds the amount designated in Appendix B. For selected participants seeking funding in the first year of the Pilot Program (Funding Year 2007), they should indicate that Funding Year 2007 is the year for which they are seeking support in Line 26 of the FCC Form 465. Selected participants should also indicate if they will be seeking funding for Year Two (Funding Year 2008) and/or Year Three (Funding Year 2009) of the Pilot Program in Line 29 of FCC Form 465 in their filings in Year One. Selected participants should also indicate the Year(s) for which each health care provider is seeking funding in the FCC Form 465 attached spreadsheet, discussed further below.

71. Selected participants are not required to submit multiple FCC Forms 465 for each participating health care provider, although they may choose to do so. The Commission notes that vendors or service providers participating in the competitive bid process are prohibited from assisting with or filling out a selected participants' FCC Form 465. Specifically, for purposes of administrative efficiency, selected participants may submit one master FCC Form 465, provided the information contained in the FCC Form 465 identifies each eligible health care provider participating in the Pilot Program and is included in an attached Excel or Excel compatible spreadsheet. Appendix E of this Order provides a spreadsheet for selected participants. The Commission notes also that Southern Ohio Healthcare Network requests a waiver of the number of locations permitted per FCC Form 465. Because the Commission permits selected participants to submit a single master FCC Form 465 with attachment that identifies each eligible health care provider participating, it denies this waiver request as moot. The Commission also requires selected

participants to provide a brief explanation for each health care provider participating in the network, identifying why each health care provider is eligible under section 254 of the 1996 Act and the Commission's rules and orders. This information should be included in an attachment to the FCC Form 465 submitted to USAC. The Commission notes also that FCC Form 465 requires applicants to certify that the health care provider is located in a rural area. As described above, the Pilot Program is open to all eligible public and non-profit health care providers. Therefore, the Commission clarifies that a participating non-rural eligible health care provider need not certify that it is located in a rural area. Consistent with USAC procedures, electronic signatures are permissible for purposes of the FCC Form 465 attachment. Selected participants that anticipate competitively bidding out their entire approved network project need only submit FCC Form 465 and the attached spreadsheet in Year One (or the first year they intend to competitively bid the project). Selected participants that anticipate competitively bidding their network project each Funding Year of the Pilot Program (*e.g.*, Year One, Year Two, and Year Three) shall submit a new FCC Form 465 within the appropriate Funding Year window(s) and requisite attachments for each stage. Selected participants whose network projects include both an initial network design study and network construction based on that initial network design study are required to competitively bid the network construction portion of the project separate from the initial network design study. To the extent that a selected participant seeks to add, remove, or substitute a health care provider in its proposed network after a funding commitment has been made by USAC, the selected participant must file an amended FCC Form 465 Attachment providing any new FCC Form 465 information in order to allow USAC to determine its statutory eligibility. The Commission notes, however, once USAC has issued an FCL, program support for the relevant Pilot Program Funding Year is capped at that amount. In addition, along with its FCC Form 465 and related spreadsheet, each selected participant must also submit a copy of the most recent record version of its application previously submitted to the Commission as of the release date of this Order (as modified by, or consistent with, this Order, if applicable). Selected participants must also provide sufficient information to define the scope of the project and network costs to enable an effective competitive bidding process. The Commission notes that selected participants may not pre-qualify service providers for the competitive bidding process.

72. Finally, the Commission requires each applicant to include with its FCC Form 465 a Letter of Agency (LOA) from each participating health care facility to authorize the lead project coordinator to act on its behalf, to demonstrate that each health care provider has agreed to participate in the selected participant's network, and to avoid improper duplicate support for health care providers participating in multiple networks. The Commission has affirmed USAC's requirement that an applicant applying as a consortium in the E-Rate program must submit an LOA from each of its members expressly authorizing the applicant to submit an applicant on its behalf. LOAs should include, at a minimum: The name of the entity filing the application (i.e., lead applicant or consortium leader); name of the entity authorizing the filing of the application (i.e., the participating health care provider/consortium member); the relationship of the facility to the lead entity filing the application; the specific timeframe the LOA covers; the signature, title and contact information (including phone number, physical address, and e-mail address) of an official who is authorized to act on behalf of the health care provider/consortium member; signature date; and the type of services covered by the LOA. For health care providers located on tribal lands, LOAs must also be signed by the appropriate management representative of the health care facility. In most cases, this will be the director of the facility. If the facility is a contract facility that is run solely by the tribe, the appropriate tribal leader, such as the tribal chairperson, president, or governor, shall also sign the LOA, unless the health care responsibilities have been duly delegated to another tribal government representative. The Commission notes that a number of selected participants have included health care provider participants in their networks that are also participating in another selected participant's proposed network. Although the Commission does not prohibit a health care provider from participating in more than one selected participant's supported project, it is prohibited from receiving support for the same or similar services. Specifically, network costs for participation in one project must be separate and distinct from network costs resulting from participation in any other project.

73. *SPIN Requirement.* All service providers that participate in the RHC Pilot Program are required to have a Service Provider Identification Number (SPIN). SPINs must be assigned before USAC can authorize support payments; therefore, all service providers submitting bids to provide services to selected participants will need to complete and submit a Form 498 to USAC for review and approval if selected by a participant before funding commitments can be made. Only service providers that have not already been assigned a SPIN by USAC will need to complete and submit a Form 498. Form 498 can be found on the USAC Web site on its forms page.

74. *FCC Form 466–A Process.* Selected participants should submit an FCC Form 466–A to indicate the type(s) of network construction ordered, the cost of the ordered network construction, information about the service provider(s), and the terms of the service agreements. To the extent a selected participant files an FCC Form 466 instead of an FCC Form 466–A, USAC may permit the selected participant to amend its filing by submitting an FCC Form 466–A to replace the FCC Form 466. The Commission notes that although the title of this Form is ''Internet Services Funding Request and Certification Form,'' selected participants should use the FCC Form 466–A for all eligible funding requests under the Pilot Program because it is suitable for Pilot Program purposes. Selected participants are not required to submit multiple FCC Forms 466–A for each participating health care provider location, although they may choose to do so. Specifically, for purposes of administrative efficiency, selected participants may submit one master FCC Form 466–A, provided the information contained in the FCC Form 466–A identifies the location of each health care provider participating in the Pilot Program and is included in an attached Excel or Excel compatible spreadsheet. Appendix F of this Order provides a spreadsheet for selected participants. Consistent with USAC procedures, electronic signatures are permissible for purposes of the FCC Form 466–A attachment. Selected participants seeking funding for Year One of the Pilot Program (Funding Year 2007) should indicate this in Line 16. For selected participants that seek to receive support under Year One of the Pilot Program, the due date is June 30, 2008, consistent with Commission rules. Thereafter, the due date for each year of the Pilot Program corresponds with the

existing RHC support mechanism deadline. Thus, the FCC Form 466–A is due on June 30, and the FCC Form 465 is due 28 days prior, on June 2. Selected participants seeking funding for Year Two (Funding Year 2008) and/or Year Three (Funding Year 2009) of the Pilot Program should indicate the applicable Funding Years in their description in Box 17. In addition, on Line 18 of FCC Form 466–A, upon request, selected participants should provide documentation to allow USAC to clearly identify allocated eligible costs related to the provision of services for each health care provider.

75. Along with its FCC Form 466–A, a selected participant must submit to USAC a copy of the contracts or service agreements with the selected service provider(s). Selected participants shall also include a detailed line-item network costs worksheet that includes a breakdown of total network costs (both eligible and ineligible costs). Selected participants choosing to submit multiple FCC Forms 466–A need only submit one master network costs worksheet. Selected participants' network costs worksheet submissions shall demonstrate how ineligible (*e.g.*, for-profit) participants will pay their fair share of network costs. Selected participants shall identify these costs with specificity in their network costs worksheet submissions. USAC may reject line-item worksheets that lack sufficient specificity to determine that costs are eligible under this Order or the 1996 Act. Selected participants shall also identify in their network costs worksheet Pilot Program the applicable maximum funding amounts pursuant to this Order. In addition, each selected participant must identify with specificity its source of funding for its 15 percent contribution of eligible network costs in its line-item network costs worksheet submitted to USAC. A network costs worksheet for submission to USAC is attached to this Order at Appendix G. Selected participants must use this worksheet when submitting their funding requests to USAC.

76. A selected participant requesting funds for a multi-year contract (*e.g.*, Year One and Year Two, or Year One, Two, and Three) should indicate this in its initial network costs worksheet submissions. Although a selected participant may utilize a multi-year contract, USAC may commit funding for only a single year in that year's FCL for the participant, *i.e.*, USAC shall issue a separate FCL upon receiving the FCC Form 466–A and related attachments on an annual basis for the applicable funding year. A participant using multi-year contracts is not required to re-bid the contract in subsequent Pilot Program funding years, but it must submit a network costs worksheet and FCC Form 466–A to USAC for commitment approval for each funding year it participates in the Pilot Program. A selected participant who seeks funding for a multi-year agreement may only modify its network (including adding, deleting, or substituting health care providers) to the extent that funding does not exceed the funding year amount listed in the selected participant's initial network costs worksheet for the applicable funding year.

77. Selected participants alternatively may choose to competitively bid their projects in phases (*e.g.*, Year One—network design study; Year Two—network construction and installation) for each year that they participate in the Pilot Program, in which case selected participants shall submit FCC Forms 465 and 466–A and the requisite attachments, as described in this Order, for each year they participate. Selected participants that elect to request funding for a single year (*e.g.*, Year One), but intend to request funding for additional Pilot Program Years (*e.g.*, Year Two or Year Three) should submit a detailed line-item network costs worksheet for the additional Pilot Program Years for which it intends to request funding in Year One.

78. The Commission requires selected participants and participating service providers (once selected through the competitive bidding process) to file a certification with their FCC Form 466–A with the Commission and with USAC stating that all federal RHC Pilot Program support provided to selected participants and participating service providers will be used only for the eligible Pilot Program purposes for which the support is intended, as described in this Order, and consistent with related Commission orders, section 254(h)(2)(A) of the 1996 Act, and § 54.601 *et seq.* of the Commission's rules. For selected participants, certifications shall be filed by the lead applicant, as well as the legally and financially responsible organization, if not the same entity. Pilot Program support amounts shall only be committed by USAC to the extent that the requisite certification has been filed. The certification must be filed with both the Office of the Secretary of the Commission, clearly referencing WC Docket No. 02–60, and with USAC in the form of a sworn affidavit executed by a corporate officer attesting to the use of the Pilot Program support for the approved Pilot Program purposes for which support is intended. Selected participants and participating service providers must also send a courtesy copy of their certifications to Antoinette Stevens, (202) 418–7387, *antoinette.stevens@fcc.gov* in the Telecommunications Access Policy Division, Wireline Competition Bureau, Federal Communications Commission, 445 12th Street, SW., Washington, DC 20554. Failure to certify will result in suspension of processing of the selected participant's forms and support. Upon receipt and approval of a selected participant's FCC Form 466–A, USAC will then issue a FCL for each Pilot Program funding year. USAC shall also provide the lead project coordinator with a copy of an FCL concerning any funding request for which it is the lead project coordinator.

79. *FCC Form 467 Process.* The Commission also finds that it is necessary to provide selected participants with guidance regarding how to fill out FCC Form 467 for reimbursement. In the third box of Block 3 on FCC Form 467, selected participants are asked to indicate, among other things, whether ''service was not (or will not be) turned on during the funding year.'' Selected participants should leave the third box of Block 3 blank. Instead, the Commission directs selected participants to notify USAC and the Commission, in writing, when the approved network project has been initiated within 45 calendar days of initiation. Selected participants must file a copy of this notice with the Commission in WC Docket No. 02–60. Selected participants must also send a courtesy copy of this notification to Antoinette Stevens, (202) 418–7387, *antoinette.stevens@fcc.gov* in the Telecommunications Access Policy Division, Wireline Competition Bureau, Federal Communications Commission, 445 12th Street, SW., Washington, DC 20554. If the selected participant's network build-out has not been initiated within six months of the FCL sent by USAC to the selected participant and service provider(s) approving funding, the selected participant must notify USAC and the Commission within 30 days thereafter explaining when it anticipates that the approved network project will be initiated. Upon receipt and approval of a selected participant's FCC Form 467, USAC will then issue a Health Care Provider Support Schedule to the health care provider and the service provider. The purpose of the support schedule is to provide a detailed report of the approved service(s) and support information for each health care provider and service

provider. The service provider uses the support schedule to determine how much credit the health care provider will receive each month. Once the service provider receives the schedule, the provider must start applying program discounts to the health care provider during the next possible billing cycle based on the schedule. Selected participants must complete build-out of the networks funded by this Pilot Program within five years from the date of the initial FCL, after which the funding commitments made in this Order will no longer be available. It is appropriate to allow five years for selected participants to build out their Pilot Program networks. Unlike the E-Rate program and the existing RHC support mechanism which does not have deadlines for submitting invoices to USAC, the Pilot Program, in keeping with its limited scope, imposes a five-year invoicing deadline. The Commission finds this time period sufficient for network build-outs. Further, selected participants may not receive any Pilot Program support after the expiration of the invoice deadline, which is five years from receipt of their initial FCL for all Pilot Program funding years. To the extent that a Pilot Program participant fails to meet this build-out deadline, the Commission intends also to require the applicant repay any Pilot Program funds already disbursed. In addition, selected participants shall also notify the Commission and USAC in writing upon completion of the pilot project construction and network buildout. Selected participants must file a copy of this notice with the Commission in WC Docket No. 02–60. Selected participants must also send a courtesy copy of this notification to Antoinette Stevens, (202) 418–7387, *antoinette.stevens@fcc.gov* in the Telecommunications Access Policy Division, Wireline Competition Bureau, Federal Communications Commission, 445 12th Street, SW., Washington, DC 20554.

80. *USAC Outreach.* In addition to the filing requirements discussed above, each selected participant shall provide to USAC within 14 calendar days of the effective date of this Order the name, mailing address, e-mail address, and telephone number of the lead project coordinator for the Pilot Program project or consortium. Within 30 days of the effective date of this Order, USAC shall conduct an initial coordination meeting with selected participants. USAC shall further conduct a targeted outreach program to educate and inform selected participants on the Pilot Program administrative process, including various filing requirements and deadlines, in order to minimize the possibility of selected participants making inadvertent ministerial, or clerical errors in completing the required forms. The Commission also directs USAC to notify selected participants when each funding year begins. The Commission expects that these outreach and educational efforts will assist selected participants in meeting the Pilot Program's requirements. Further, the Commission believes such an outreach program will increase awareness of the filing rules and procedures and will improve the overall efficacy of the Pilot Program. The Commission also encourages selected participants to contact USAC with questions prior to filing their FCC forms. The direction the Commission provides USAC will not lessen or preclude any of its review procedures. Indeed, the Commission retains its commitment to detecting and deterring potential instances of waste, fraud, and abuse by ensuring that USAC scrutinizes Pilot Program submissions and takes steps to educate selected participants in a manner that fosters appropriate Pilot Program participation.

81. As part of its outreach program, USAC shall also conduct educational efforts to inform selected participants of which network components are eligible for RHC Pilot Program support in order to better assist selected participants in meeting the Pilot Program's requirements. When USAC has reason to believe that a selected participant's funding request includes ineligible network components or ineligible health care providers, USAC shall: (1) Inform the selected participant promptly in writing of the deficiencies in its funding request, and (2) permit the selected participant 14 calendar days from the date of receipt of notice in writing by USAC to revise its funding request to remove the ineligible network components or facilities for which Pilot Program funding is sought or allow the selected participant to provide additional documentation to show why the components or facilities are eligible. To the extent a selected participant does not remove ineligible network components or facilities from the funding request, USAC must deny funding for those components or facilities. The 14-day period should provide sufficient time for selected participants to modify their funding requests to remove ineligible services.

82. Selected participants must submit complete and accurate information to USAC as part of the application and review process. Selected participants, however, will be provided the opportunity to cure ministerial and clerical errors on their FCC Forms and accompanying data submitted to USAC pertaining to the Pilot Program. USAC shall inform selected participants within 14 calendar days in writing of any and all ministerial or clerical errors that it identifies in a selected participant's FCC Forms, along with a clear and specific explanation of how the selected participants can remedy those errors. USAC shall also inform selected participants within this same 14 calendar days in writing of any missing or incomplete certifications. Selected participants will be presumed to have received notice five days after such notice is postmarked by USAC. USAC shall, however, continue to work beyond the 14 days with selected participants attempting in good faith to provide documentation. Selected participants shall have 14 calendar days from the date of receipt of notice in writing by USAC to amend or re-file their FCC Forms for the sole purpose of correcting the ministerial or clerical errors identified by USAC. Selected participants shall not be permitted to make material changes to their applications. Selected participants denied funding for errors other than ministerial or clerical errors are instructed to follow USAC's and the Commission's regular appeal procedures. Selected participants that do not comply with the terms of this Order, section 254 of the 1996 Act, and Commission rules and orders will be denied funding in whole or in part, as appropriate.

83. *Disbursement of Pilot Program Funds.* USAC will disburse Pilot Program funds based on monthly submissions (*i.e.*, invoices) of actual incurred eligible expenses. The Commission notes that several applicants requested that awarded funds be distributed in a specific manner, departing from established USAC precedents. For the reasons explained herein, Pilot Program funds will be distributed as described in this Order. Service providers are only permitted to invoice USAC for eligible services apportioned to eligible health care provider network participants. Service providers shall submit detailed invoices to USAC on a monthly basis for actual incurred costs. This invoice process will permit disbursement of funds to ensure that the selected participants' network projects proceed, while allowing USAC and the Commission to monitor expenditures in order to ensure compliance with the Pilot Program and prevent waste, fraud, and abuse. USAC shall respond to service provider

invoices in accordance with its current invoicing payment plan. USAC follows a bi-monthly invoicing cycle. Invoices received from the 1st through the 15th of the month will be processed by the 20th of the month. Invoices received from the 16th through the 31st of the month will be processed by the 5th of the following month. The Commission directs USAC to modify its current sample ''RHCD Service Provider Invoice'' for purposes of the Pilot Program to ensure consistency with this Order. In doing so, USAC shall ensure that invoices reflect total incurred eligible costs, including those eligible costs for which selected participants will be responsible, to enable USAC to adjust disbursements to service providers to 85 percent or less of eligible incurred costs. All invoices shall also be approved by the lead project coordinator authorized to act on behalf the health care provider(s), confirming the network build-out or services related to the itemized costs were received by each participating health care provider. The lead project coordinator shall also confirm and demonstrate to USAC that the selected participant's 15 percent funding contribution has been provided to the service provider for each invoice. Further, the Commission expects USAC to review data submitted by Pilot Program participants to ensure that participants' data submissions are consistent with invoices submitted as well as to ensure that network deployments are proceeding according to the approved dedicated network plans. Finally, the Commission directs USAC to conduct random site visits to selected participants to ensure support is being used for its intended purposes, as well as to conduct site visits as necessary and appropriate based on USAC's review of the selected participants' data submissions. If funding is disbursed to any service provider and the approved network project is abandoned or left incomplete, the Commission permits USAC to pursue recovery of funds from the selected participant's financially and legally responsible organization, eligible health care providers, or service provider, as appropriate. In addition, as discussed *infra*, the Commission may seek recovery of funds, assess forfeitures, or impose fines if it determines that Pilot Program support has been used in violation of Commission rules or orders, or section 254 of the 1996 Act.

8. Waivers

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

a. Competitive Bidding

85. Pursuant to §§ 54.603 and 54.615 of the Commission's rules, each eligible health care provider must participate in a competitive bidding process and follow any additional applicable state, local, or other procurement requirements to select the most cost-effective provider of services eligible for universal service support under the RHC support mechanism. The Commission previously granted a limited waiver of the rural health care program's competitive bidding and cost-effectiveness rules to allow selected participants to pre-select Internet2 or NLR. The Commission clarifies that this waiver only applies to pre-selecting Internet2 or NLR and that selected participants must follow the competitive bidding rules for all other service requests. To satisfy the competitive bidding requirements, selected participants must submit an FCC Form 465 that includes a description of the services for which the health care provider is seeking support and wait at least 28 days from the date on which this information is posted on the USAC's website before making commitments with the selected service provider. After selecting a service provider, the participant must certify that it selected the most cost-effective method of providing service. A selected Pilot Program participant may select a service provider(s) that may be part of a pre-existing contract(s), provided that the selection of the provider(s) complies with the terms of this Order, including the Commission's competitive bidding rules. Construction or services completed prior to compliance with the competitive bidding requirements are not eligible for Pilot Program funding. Various selected participants request a waiver of these competitive bidding requirements. The majority of these selected participants argue that waivers are necessary because they have pre-selected their preferred service provider or would like to select service providers without the burden or uncertainty of the competitive bidding process. Other selected participants argue that waivers are necessary because they have already contracted with service providers. For the reasons discussed below, the Commission does not find selected participants have demonstrated good cause exists for waiving the competitive bidding rules.

86. In establishing the competitive bidding process, the Commission determined that a competitive bidding requirement was necessary to ''help minimize the support required by ensuring that rural health care providers are aware of cost-effective alternatives'' and ''ensure that the universal service fund is used wisely and efficiently.'' The selected participants requesting waivers identify service providers they would like to provide service or those that are already providing service but give no assurance that they are aware of other alternatives or that the identified providers offer the most cost-effective method of providing service. For example, Rural Nebraska Healthcare Network claims that the competitive bidding process is unnecessary because Mobius Communications Company is ''uniquely positioned to bury fiber and maintain the system in western Nebraska'' but does not demonstrate that Mobius is the most cost-effective choice because it does not explain whether it sought bids from, or even considered providers other than Mobius. Similarly, Rural Wisconsin Health Cooperative requests a waiver of the competitive requirements because it has ''identified Charter Communications as the optimal provider'' but does not explain if it considered or is aware of other providers or why Charter Communications is superior to other potential providers. The competitive bidding requirements are not unduly burdensome because, if the service provider the selected participant

identified in its application is the most cost-effective, the selected participant can select that service provider after completing the competitive bidding process; if this service provider is not the most cost-effective, then the competitive bidding process may identify more cost-effective solutions. In using the competitive bidding process, selected participants will thus have an opportunity to identity and select the most cost-effective service provider to build-out their proposed network projects. The competitive bidding requirements also will not create any unreasonable delays for selected participants because the selected participant must wait only 28 days from the date its service request is posted on USAC's website to select the most cost-effective method of providing service. Accordingly, the Commission finds selected participants have not demonstrated that special circumstances warrant deviation from §§ 54.603 and 54.615 of the Commission's rules.

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

88. Heartland Unified Broadband Network seeks a waiver of § 54.611 of the Commission's rules to allow it to be reimbursed for equipment that it has already ordered. The Commission denies this waiver as moot because, as explained above, all selected participants are required to comply with the competitive bidding requirements that require soliciting bids prior to entering into agreements with providers. The Commission also denies this waiver because it is inconsistent with the Pilot Program goal to only fund the construction of new broadband facilities.

89. To further prevent against waste, fraud, and abuse, the Commission requires participants to identify, when they submit their Form 465, to USAC and the Commission any consultants, service providers, or any other outside experts, whether paid or unpaid, who aided in the preparation of their Pilot Program applications. Pilot Program participants must also retain records and make available all document and records that pertain to them, including those of contractors and consultants working on their behalf, to the Commission's OIG, to the USF Administrator, and to their auditors. The Commission also notes that sanctions, including enforcement action, are appropriate in cases of waste, fraud, and abuse. For example, Rocky Mountain HealthNet identifies service provider participants and a consultant who helped prepare its application. Also, Northeast HealthNet identifies a consultant who helped prepare its applications. Identifying these consultants and outside experts could facilitate the ability of USAC, the Commission, and law enforcement officials to identify and prosecute individuals that may seek to manipulate the competitive bidding process or engage in other illegal acts. To ensure selected participants comply with the competitive bidding requirements, they must disclose all of the types of relationships explained above.

b. Restriction on Resale

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

91. As an initial matter, the Commission notes that although the Commission has authority to waive regulatory requirements, it does not have authority to waive a requirement imposed by statute. Although Rural Nebraska Healthcare Network couches its request as one of waiver of the Commission's rules, it is actually requesting a waiver of the statute. The implementation of rule 54.617(a) flowed directly from the plain meaning of the statute. Thus, regardless of whether the Commission were to waive the rule, the statutory prohibition on resale would still remain. The Commission concludes, because rule 54.617(a) is based on a statute, it cannot be waived.

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

93. To prevent against violation of the prohibition on resale of supported services and to further prevent against waste, fraud, and abuse, the Commission requires participants to identify all for-profit or other ineligible entities, how their fair share of network costs was assessed, and proof that these entities paid or will pay for their costs. Specifically, as part of their reporting requirements in Appendix D of this Order, selected participants must: Provide project contact and coordination information; identify all health care facilities included in the network; provide a network narrative; provide a diagram of the planned network indicating those facilities currently in place; identify the non-recurring and recurring costs; describe how costs have been apportioned and the sources of the funds to pay them; identify any technical or non-technical requirements or procedures necessary for ineligible entities to connect to the

participant's network; provide an update on the project management plan; provide information on the network's self sustainability; and provide detail on how the supported network has advanced telemedicine benefits.

c. Eligibility

94. Texas Health Information Network Collaborative and Virginia Acute Stroke Telehealth Project request that the Commission expand the list of facilities eligible for support. Section 254(h)(7)(b) of the 1996 Act defines health care providers. The Commission adopted § 54.601 of its rules based on a plain reading of the statute. In the *2006 Pilot Program Order,* the Commission explained that it would use the definition of health care provider found in § 54.601 of the Commission rules to determine what facilities are eligible for support. As explained above, the Commission does not have authority to waive a requirement imposed by statute. The Commission concludes, because § 54.601 is based on a statutory requirement, the Commission cannot waive § 54.601 and expand the types of health care facilities that are eligible for support under the Pilot Program. The Commission finds however, although emergency medical service facilities themselves are not eligible providers for purposes of the RHC Pilot Program, Pilot Program funds may be used to support costs of connecting emergency medical service facilities to eligible health care providers to the extent that the emergency medical services facility is part of the eligible health care provider.

d. Service Eligibility

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

e. Filing Deadline

96. The deadline for receipt of Pilot Program applications was May 7, 2007. A number of applicants filed their applications one day after the deadline on May 8, 2007. Some of these applicants filed petitions with the Commission seeking a waiver of the May 7, 2007, filing deadline. For example, Texas Health Information Collaborative seeks a waiver because it contends it attempted to file its application electronically before the deadline but, due to technical difficulties, its application was received at 12:02 a.m. on May 8, 2007. Also, Western Carolina University contends it should be granted a waiver because technical difficulties prevented it from timely filing its application.

97. The Commission finds that good cause exists to accept late filed applications because the applicants provide information and seek funding for projects that further the goals of the Pilot Program to stimulate deployment of innovative telehealth, and in particular, telemedicine services to those areas of the country where the need for those benefits is most acute. Furthermore, the late filed applications will help further the goals of the Pilot Program because they provide the Commission with information about how to revise the existing RHC support mechanism. Accepting these applications has not caused any delay; indeed, the Commission finds it significant that none of the applicants missed the filing deadline by more than one day. Moreover, many of the late applications were mailed before the deadline but received after the deadline, while other applicants tried unsuccessfully to file their applications electronically before the deadline. Accordingly, the Commission waives the May 7, 2007, deadline and accepts the applications filed after the deadline. The Commission waives this request for all applicants that filed late. This waiver, however, is not an ongoing waiver. The Commission will not consider applications that have yet to be filed. Further, the Commission clarifies that in supra Part D, the Commission denies United Health Services' application based on a review of its application, not because it was received after the filing deadline.

f. Distributing Support

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

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

100. The Commission finds good cause exists to waive § 54.611 of the rules, as described herein. The Commission agrees with those applicants that argue that a waiver is necessary for non-telecommunications carriers seeking funding. As explained above, section 254(h)(2)(A) does not limit support to only eligible telecommunications carriers. Because the rule is drafted to apply to eligible telecommunications carriers only, the Commission finds it necessary and in the public interest to waive it for non-eligible telecommunications carriers selected to participate in the Pilot Program.

101. The Commission also finds that good cause exists to waive this rule to permit both telecommunications carriers and non-telecommunications carriers to be distributed support in the same manner. Because § 54.611 requires USAC to reimburse carriers the first quarter of the calendar year following the year in which costs were incurred, providers receiving support under the Pilot Program could be owed millions of

dollars by the time they are reimbursed in full. Such a delay in reimbursement could jeopardize the timely deployment of selected participants' broadband networks, which would be contrary to the goals of the Pilot Program to stimulate deployment of broadband infrastructure necessary to support telemedicine services to those areas of the country where the needs for those benefits is most acute. Additionally, § 54.611 could produce an inequitable result by depriving providers of the funding flow needed to continue to perform their service contracts with selected participants because, among other things, service providers may potentially be unable to meet their payment obligations to vendors without finding other means of financial support. Waiving § 54.611 also serves the public interest because it promotes the goals of section 254 of the 1996 Act to enhance access to advanced telecommunications and information services for health care providers. Accordingly, the Commission finds good cause exists to waive § 54.611 and instructs all participants, service providers, and USAC to follow the support distribution method outlined in this Order.

g. Funding Year 2006 Deadline

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

h. Other Waiver Requests

103. The Pilot Program is broader in scope than the existing RHC support mechanism because it provides funding for up to 85 percent of eligible costs associated with the construction of dedicated broadband health care network capacity that connects health care providers in a state and region. In contrast, the existing RHC support mechanism is designed to ensure that rural health care providers pay no more than their urban counterparts for their telecommunications needs. Because the Pilot Program and existing RHC support mechanism support different network connections related to rural health care, many of the rules that apply to the existing program may not apply to the Pilot Program. Various participants note that the Commission's rules for the existing RHC support mechanism are either inapplicable or should be waived to achieve the goals of the Pilot Program. In particular, participants request waivers of and specific deviation from Commission rules to allow: (1) Funding for services supplied by providers who are not telecommunications carriers or Internet service providers; (2) non-rural eligible entities to directly request funding under the Pilot Program; (3) selected participants to receive funding for services that exceed the maximum supported distance for rural health care providers and not base support on the difference between the urban and rural rate; and (4) support to be based on actual costs, not the difference between the urban and rural rate. The Commission agrees with these commenters that many of these rules may be inapplicable to the Pilot Program but, to the extent any rule is inapplicable, selected participants must follow the eligibility requirements detailed in this Order and section 254 of the 1996 Act.

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

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

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

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

9. Other Administrative Issues

108. The Commission also clarifies that selected participants may not receive funds for the same services under the Pilot Program and either the existing universal service programs—

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

109. The Commission also seeks the timely and effective implementation of the three-year Pilot Program. To expedite implementation, and consistent with §§ 0.91 and 0.291 of the Commission's rules, the Commission delegates to the Bureau the authority to waive the relevant sections of subpart G of part 54 of the Commission's rules for selected participants to the extent they prove unreasonable or inconsistent with the sound and efficient administration of the Pilot Program. In instances where a selected participant, including a consortium, is unable to participate in the Pilot Program for the three-year term due to extenuating circumstances, a successor may be designated by the Bureau upon request.

III. Oversight of the Pilot Program

110. The Commission is committed to guarding against waste, fraud, and abuse, and ensuring that funds disbursed through the Pilot Program are used for appropriate purposes. In particular, the Commission intends to conduct audits of all selected participants and service providers and, if necessary, investigations of any selected participants and service providers to determine compliance of selected participants with the Pilot Program, Commission rules or orders, and section 254 of the 1996 Act. The beneficiary or service provider will be required to comply fully with the requirements of the audits including, but not limited to, providing full access to accounting systems and its reports, source documents, employees, contractors, and internal and external audit reports that are involved in whole or in part in the administration of this Pilot Program. This includes presenting personnel to testify, under oath, at a deposition if requested by of the Office of Inspector General. Such audits or investigations may provide information showing that a beneficiary or service provider failed to comply with the 1996 Act or Commission rules, and thus may reveal instances in which Pilot Program awards were improperly distributed or used. The Commission also delegates authority to the Bureau to revoke funding awarded to any selected participant making unapproved material changes to the network design plan set forth in their initial Pilot Program application. The Commission reiterates that payment may be suspended if the project appears not to be consistent with the approved network plan. To the extent the Commission finds that funds were distributed and/or used improperly, the Commission will require USAC to recover such funds though its normal processes, including adjustment of support amounts by selected participants or service providers in other universal service programs from which they receive support. The Commission intends that funds disbursed in violation of a Commission rule that implements section 254 or a substantive program goal will be recovered. Sanctions, including enforcement action, are appropriate in cases of waste, fraud, and abuse, but not in cases of clerical or ministerial errors. If a selected participant or service provider fails to comply with Commission rules, orders, or mandatory filings, the Commission also has the authority to assess forfeitures for violations of Commission rules and orders. In addition, selected participants and service providers that willfully make false statements can be punished by fine or forfeiture under sections 502 and 503 of the Communications Act, or fine or imprisonment under Title 18 of the United States Code. Further, the Commission has found that ''debarment of applicants, service providers, consultants, or others who have defrauded the USF is necessary to protect the integrity of the universal service programs.'' Therefore, the Commission intends to suspend and debar parties from the Pilot Program who are convicted of or held civilly liable for the commission or attempted commission of fraud and similar offenses arising out of their participation in the Pilot Program or other universal service programs. The Commission emphasizes that the Commission retains the discretion to evaluate the uses of monies disbursed through the RHC Pilot Program and to determine on a case-by-case basis whether waste, fraud, or abuse of program funds occurred and whether recovery is warranted. The Commission remains committed to ensuring the integrity of the program and will aggressively pursue instances of waste, fraud, and abuse under the Commission's procedures and in cooperation with law enforcement agencies. In doing so, the Commission intends to use any and all enforcement measures, including criminal and civil statutory remedies, available under law. The Commission will also monitor the use of awarded monies and develop rules and processes as necessary to ensure that funds are used in a manner consistent with the goals of the Pilot Program. Finally, the Commission reminds selected participants that nothing in this *Order* relieves them of their obligations to comply with other applicable federal laws and regulations.

IV. Reporting Requirements

111. Upon completion of the Pilot Program, the Commission intends to issue a report detailing the results of the program, its status, and recommended changes. In addition, the Commission intends to incorporate any information gathered as part of the Pilot Program in the record in any subsequent proceeding to reform the rural health care mechanism. To assist the Commission in this task, the Commission requires selected participants to submit to USAC and the Commission quarterly reports containing data listed in Appendix D of this *Order*. These data will serve as a guide for further Commission action by informing the Commission's understanding of cost-effectiveness and efficacy of the different state and regional networks funded. These data will also enable the Commission to ensure RHC program funds are being used in a manner consistent with section 254 of the 1996 Act, this *Order*, and the Commission's rules and orders. In particular, collection of this data is critical to the goal of preventing waste, fraud, and abuse by ensuring that funding is flowing through to its intended purpose. Also, we note that selected participants will be subject to audit oversight as discussed and, as such, the Commission will evaluate the allocation methods selected by selected participants in the course of its audit activities to ensure program integrity and to ensure that providers are complying with the program's certification requirements. The certification requirements for rural health care providers are set forth at 47 CFR 54.615(c).

112. The first quarterly report shall be due after two full quarters have passed following the effective date of this *Order* and shall include responsive data from

the effective date of the *Order* to the then-most recent month. These reports will be due on the 30th day of the month beginning each quarter and include data for the prior three months. Thus, reports will be due as appropriate on January 30 (including responsive data for the prior October to December), April 30 (including responsive data for the prior January to March), July 30 (including responsive data for the prior April to June), and October 30 (including responsive data for the prior July to September). Reports will be required for a 72-month period following the initial due date unless the Bureau extends this deadline. Quarterly reports shall also have responsive data separated by month.

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

V. Procedural Matters

A. Paperwork Reduction Act Analysis

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

VI. Ordering Clause

115. Pursuant to the authority contained in sections 1, 4(i), 4(j), 10, 201–205, 214, 254, and 403 of the Communications Act of 1934, as amended, 47 U.S.C. 151, 154(i), 154(j), 10, 201–205, 214, 254, and 403, this Order is adopted. The information collection contained in this Order will become effective following OMB approval. The Commission will publish a document at a later date establishing the effective date.

Federal Communications Commission.

Marlene H. Dortch,

Secretary.

[FR Doc. 08–684 Filed 2–13–08; 8:45am]

BILLING CODE 6712–01–P

FEDERAL COMMUNICATIONS COMMISSION

[DA 08–49]

Notice of Debarment; Schools and Libraries Universal Service Support Mechanism

AGENCY: Federal Communications Commission.

ACTION: Notice.

SUMMARY: The Enforcement Bureau (the ''Bureau'') debars Mrs. Evelyn Myers Scott from the schools and libraries universal service support mechanism (or ''E-Rate Program'') for a period of three years based on her conviction of conspiracy to defraud the United States in connection with her participation in the program. The Bureau takes this action to protect the E-Rate Program from waste, fraud and abuse.

DATES: Debarment commences on the date Mrs. Evelyn Myers Scott receives the debarment letter or February 14, 2008, whichever date comes first, for a period of three years.

FOR FURTHER INFORMATION CONTACT: Diana Lee, Federal Communications Commission, Enforcement Bureau, Investigations and Hearings Division, Room 4–C330, 445 12th Street, SW., Washington, DC 20554. Diana Lee may be contacted by phone at (202) 418–0843 or e-mail at *diana.lee@fcc.gov.* If Ms. Lee is unavailable, you may contact Ms. Vickie Robinson, Assistant Chief, Investigations and Hearings Division, by telephone at (202) 418–1420 and by e-mail at *vickie.robinson@fcc.gov.*

SUPPLEMENTARY INFORMATION: The Bureau debarred Mrs. Evelyn Myers Scott from the schools and libraries universal service support mechanism for a period of three years pursuant to 47 CFR 54.521 and 47 CFR 0.111(a)(14). Attached is the debarment letter, DA 08–49, which was mailed to Mrs. Evelyn Myers Scott and released on January 9, 2008. The complete text of the notice of debarment is available for public inspection and copying during regular business hours at the FCC Reference Information Center, Portal II, 445 12th Street, SW., Room CY–A257, Washington, DC 20554. In addition, the complete text is available on the FCC's Web site at *http://www.fcc.gov.* The text may also be purchased from the Commission's duplicating inspection and copying during regular business hours at the contractor, Best Copy and Printing, Inc., Portal II, 445 12th Street, SW., Room CY–B420, Washington, DC 20554, telephone (202) 488–5300 or (800) 378–3160, facsimile (202) 488–5563, or via e-mail *http://www.bcpiweb.com.*

Federal Communications Commission.

Trent B. Harkrader,

Deputy Chief, Investigations and Hearings Division, Enforcement Bureau.

The debarment letter, which attached the suspension letter, follows:

January 9, 2008

[DA 08–49]

VIA CERTIFIED MAIL

RETURN RECEIPT REQUESTED FACSIMILE (404–261–2842)

Mrs. Evelyn Myers Scott,
c/o Charles M. Abbott, Esq.,
C. Michael Abbott, P.C.,
3127 Maple Drive, NE.,
Atlanta, GA 30305–2503,
E-Mail: *michael@michaelabbottlaw.com*

Re: Notice of Debarment, File No. EB–07–IH–7305

Dear Mrs. Scott:

Pursuant to section 54.521 of the rules of the Federal Communications Commission (the ''Commission''), by this Notice of Debarment you are debarred from the schools and libraries universal service support mechanism (or ''E-Rate program'') for a period of three years.[1]

On October 18, 2007, the Enforcement Bureau (the ''Bureau'') sent you a Notice of Suspension and Initiation of Debarment Proceedings (the ''Notice of Suspension'').[2] That Notice of Suspension was published in the **Federal Register** on November 5, 2007.[3] The Notice of Suspension suspended you from the schools and libraries universal service support mechanism and described the basis for initiation of debarment proceedings against you, the applicable debarment procedures, and the effect of debarment.[4]

Pursuant to the Commission's rules, any opposition to your suspension or its scope or to your proposed debarment or its scope had to be filed with the Commission no later than thirty (30) calendar days from the earlier date of your receipt of the Notice of Suspension or publication of the Notice of Suspension in the **Federal Register**.[5] The Commission did not receive any such opposition.

As discussed in the Notice of Suspension, you pled guilty to and were convicted of conspiracy to defraud the United States, in violation of 18 U.S.C. 371, for activities in connection with your participation in the E-Rate program involving the Atlanta Public

[1] *See* 47 CFR 0.111(a)(14), 54.521.

[2] Letter from Hillary S. DeNigro, Chief, Investigations and Hearings Division, Enforcement Bureau, Federal Communications Commission, to Mrs. Evelyn Myers Scott, Notice of Suspension and Initiation of Debarment Proceedings, 22 FCC Rcd 18613 (Inv. & Hearings Div., Enf. Bur. 2007) (Attachment 1).

[3] 72 Fed. Reg. 62477 (November 5, 2007).

[4] *See* Notice of Suspension, 22 FCC Rcd at 18614–15.

[5] *See* 47 CFR 54.521(e)(3) and (4). That date occurred no later than December 5, 2007. *See supra* note 3.