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FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 54

[WC Docket No. 17-310; FCC 19-78]

Promoting Telehealth in Rural America

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: In this document, the Federal Communications Commission (Commission) takes a variety of measures to promote transparency and predictability, and further the efficient allocation of limited Rural Health Care Program resources while guarding against waste, fraud and abuse.

DATES: Effective **[INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]**, except for §§ 54.622(d), 54.622(e)(2), 54.622(e)(4), 54.622(e)(5), 54.623(a)(2), 54.623(a)(3), 54.623(a)(4), 54.624, 54.626(b), 54.627(b), 54.631(d), which contain new or modified information collection requirements, as provided in the Report and Order, that will not be effective until approved by the Office of Management and Budget. The Federal Communications Commission will publish a document in the Federal Register announcing the effective date for those sections not yet effective.

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SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Report and Order (R&O) in WC Docket No. 17-310; FCC 19-78, adopted on August 1, 2019 and released on August 20, 2019. 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 or at the following Internet address: https://docs.fcc.gov/public/attachments/FCC-19-78A1.pdf.

I. INTRODUCTION

1. Nearly 60 million people—roughly 1 out of every 5 Americans—live in a rural area. For these millions of Americans, affordable, quality health care at the local level can be scarce. Geographic isolation, combined with low population densities, make the provision of sustainable local health care in rural areas a challenge. Many rural areas also have witnessed an increasing number of local health care facilities closing in recent years. Inadequate local resources and difficulties in recruiting and retaining physicians further complicate local access to quality health care. As a result, millions of rural Americans are forced to travel long distances to obtain medical treatment, at significant time and expense not only for the patient but also for friends and family. Those unable to bear the expense may forgo treatment altogether and risk a personal health care crisis. Telehealth services are one important solution to the challenge of health care access in rural areas by connecting rural patients with general physicians and medical specialists located outside the patients' communities. The Commission promotes telehealth in rural areas through the Rural Health Care Program (RHC Program or Program), which provides financial support to help rural health care providers obtain broadband and other communications services at discounted rates. These services are in turn used by health care providers to offer telehealth to patients living in and around the communities they serve.

2. As the demand for robust broadband has increased throughout the country, the RHC Program has witnessed a dramatic increase in health care provider participation. This increased demand and resulting administrative challenges required the Commission to take a closer look at whether the current rules and procedures are cost-effective and efficient and adequately protect the Universal

Service Fund against waste, fraud, and abuse. Accordingly, in the R&O, the Commission adopted a number of the proposals made in the *2017 Promoting Telehealth Notice of Proposed Rulemaking and Order (2017 Promoting Telehealth NPRM & Order)*, 83 FR 303, January 3, 2018, to reform the RHC Program rules to promote transparency and predictability, and further the efficient allocation of limited RHC Program resources.

II. DISCUSSION

3. *Improving Transparency, Predictability, and Efficiency for the Telecom Program.* The Telecom Program is rooted in section 254(h)(1)(A) of the Communications Act, as amended by the Telecommunications Act of 1996 (the Act). This statutory provision allows eligible health care providers to obtain telecommunications services in rural areas at rates comparable to the rates charged to customers in urban areas for similar services in a state. Section 254(h)(1)(A) is intended "to ensure that health care providers for rural areas . . . have affordable access to modern telecommunications services that will enable them to provide . . . medical services to all parts of the Nation." The statute also limits the types of health care providers that can receive the services supported by the RHC Program. Health care providers eligible for discounts include: (1) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (2) community health centers or health centers providing health care to migrants; (3) local health departments or agencies; (4) community mental health centers; (5) not-for-profit hospitals; (6) rural health clinics; (7) skilled nursing facilities; and (8) consortia consisting of eligible health care providers.

4. The Telecom Program provides eligible health care providers with a discount on telecommunications services so they can purchase services at rates reasonably comparable to the rates paid for similar services in urban areas as directed by the statute. The amount of the discount is the difference between the urban and rural rate calculated under the Commission's rules. The current system requires health care providers to identify the urban and rural rates for an eligible service and

submit that information to the Universal Service Administrative Company (the Administrator) in their funding applications. To do this, health care providers often (and in some cases, must) rely on information obtained from carriers. Ultimately, the urban rate identified by the health care provider is what the health care provider pays for the service. Accordingly, the health care provider has an incentive to identify the lowest urban rate possible for the requested service in the state to minimize its out-of-pocket expense. The Telecom Program compensates carriers for the difference between the rural rate and corresponding urban rate for the service as identified under the Commission's rules. The carrier, therefore, also has an incentive to identify the highest rural rate it can justify to maximize the support received.

5. Under existing Telecom Program rules, the process of determining the urban and rural rates is cumbersome, and the current system lacks transparency. Health care providers individually determine, according to the Commission's rules, the rates used to set the program discount. Health care providers are further required to submit documentation substantiating their requested urban and rural rates to the Administrator with their funding applications; however, the information submitted by a health care provider in support of a particular funding request is not publicly available for review by other service or health care providers looking to compare and scrutinize the rates. Consequently, the Administrator must either accept the rate information submitted by the health care provider or conduct a burdensome investigation of the submitted rates. Conducting such investigations on a case-by-case basis for thousands of Telecom Program funding requests filed each year is a laborious, time-intensive task in a program where the speed of funding decisions may determine vital outcomes. Not conducting investigations, on the other hand, may favor those more willing to manipulate the Commission's current approach, and thus reduces funding otherwise available to other health care providers and thwarts the purpose of the RHC Program to support the delivery of critical health care services to rural America. In short, the current system of Telecom Program rate determinations results in wasteful spending, fraud,

and abuse as reflected in recent enforcement actions; is not serving the statute as intended; and is causing a significant drain on the limited resources of the Telecom Program.

6. The Commission took the following steps to reform the Telecom Program: (1) clarified the scope of similar services for rate determination; (2) defined the geographic contours of urban and comparable rural areas for rate determination; (3) reassigned to the Universal Service Administrative Company (the Administrator) the task of determining urban and rural rates for similar services from health care and service providers; (4) reformed the determination of rates based on the median of all available rates for functionally similar services; (5) directed the Administrator to create a publicly available database for the posting of urban and rural rates; (6) eliminated the limitation on support for satellite services; and (7) eliminated distance-based support.

7. *Defining Similar Services for Determining Rates.* The amount of the discount health care providers receive in the Telecom Program is the difference between the urban rate, which must be "reasonably comparable to the rates charged for *similar services* in urban areas in that State," and the rural rate—*i.e.*, "the rates for *similar services* provided to other customers in comparable rural areas." As the Commission recognized, the currently outdated speed tiers "ha[ve] led to significant variability in how the 'similar services' analysis is conducted and is a potential source of waste." Thus, the Commission, in the R&O, placed the burden of identifying "similar services" for rate determination on the Administrator. This approach will reduce health care provider burdens and will also preclude manipulation of urban and rural rates through *ad hoc* assessments of service similarity by service and health care providers. It will also promote a more equitable distribution of program funding by ensuring that funding requests for Telecom Program support are consistently evaluated and based on the same parameters.

8. The Commission retained the existing requirement that the similarity of services be determined from the perspective of the end user, rather than technical similarity of the services, and

direct the Administrator to evaluate whether services are similar based on that. For purposes of determining functional similarity, the Administrator will consider other services with advertised speeds 30% above or below the speed of the requested service.

9. The current designated speed tiers, in effect since 2003, have failed to keep pace with the rising demand for faster connectivity. A range based on the requested service speed eliminates the need to continually update the speed tiers to reflect advances in technology. Moreover, the Commission anticipates that a 30% range will provide a sufficiently large range of functionally similar services to enable reasonable rate comparisons. While the universe of functional equivalents may be larger in limited cases, depending on the telecommunications service, the Commission found a 30% range strikes the appropriate balance to furthering specific, predictable, and sufficient mechanisms to preserve and advance universal service while ensuring rural health care providers obtain telecommunications services at reasonable comparable rates for similar services.

10. The Commission also found that factors other than bandwidth are relevant to whether a service is functionally similar. Rural health care providers may have mission critical needs requiring highly secure and reliable telecommunications services for which a dedicated service offering is necessary. In these instances, a best-efforts service may not be functionally similar. In future funding years, the Commission expects health care providers to indicate whether they require a dedicated service or other service level guarantees when they seek bids for eligible services. By doing so, the question of whether dedicated and best-efforts services are similar from the perspective of the end user will be in the hands of the end user (*i.e.*, the health care provider requesting the service). If a health care provider does not indicate a need for dedicated services or is otherwise silent on the subject in its competitive bidding documentation, then the Administrator may reasonably conclude that best-efforts services are sufficient from the perspective of the health care provider. Where a health care provider specifies that it requires a dedicated service or other service level guarantees, the Commission

instructed the Administrator to take that into account when identifying functionally similar services for rate comparisons. For the same reasons, the Commission also retained its earlier conclusion that the Administrator should consider whether the requested service is symmetrical or asymmetrical when assessing functional similarity of services for rate comparisons. Depending on the health care provider's identified needs, asymmetrical services would not be functionally similar to the requested service because they would not fulfill those needs. The Commission directed the Wireline Competition Bureau (the Bureau) and the Administrator to work on any appropriate revisions to the competitive bidding forms that will enable health care providers to provide the necessary information.

11. Additionally, the Commission directed the Administrator not to limit the functionally similar inquiry to solely telecommunications services. The Telecom Program is statutorily limited to supporting telecommunications services but determining similarity of services is a technology-agnostic inquiry as to whether there are functionally equivalent substitutes from the end user's viewpoint. The end-user experience is not dictated by regulatory classification. Therefore, the Commission determined that it is appropriate to determine median rates for telecommunications services using non-telecommunications service rates and instructed the Administrator to expand the inquiry beyond telecommunications to other services, including functionally equivalent private carriage and information services.

12. The Commission found that expanding the inquiry not only more closely aligns with the functionally similar standard but also with the statutory language directing the Commission to ensure access to telecommunications services by health care providers at rates "reasonably comparable" to those charged for "similar services in urban areas." For example, the Commission anticipated that the inclusion of less expensive, information services that are nonetheless functional substitutes will result in lower urban rates than if only similar telecommunications services are considered. Accordingly, health care providers will likely pay less for telecommunications services supported by the Universal Service

Fund, reflecting the availability of lower priced alternatives in urban areas. This result should place health care providers on a more equal footing with their urban counterparts, as intended by the statute, than if non-telecommunications services were excluded from the similar services inquiry.

13. And as with urban rates, the Commission found that expanding the similar services inquiry could also serve to lower rural rates by increasing the pool of services to include similar information services when determining the rural rate. A lower rural rate determination, in turn, decreases the support ceiling and thus could further reduce demand on the Universal Service Fund. An expanded inquiry will also alleviate administrative burdens by eliminating the need for the Administrator to identify the regulatory classification of commercially available services when determining urban and rural rates. Lastly, the Commission determined that expanding the similar services inquiry to include other services will further serve the Commission's overall directive to act in a competitively neutral manner.

14. *Defining Geographic Contours for Determining Rates.* Section 254(h)(1)(A) of the Act requires carriers to provide rural health care providers, upon receiving a bona fide request, with telecommunications services at rates reasonably comparable to those charged in urban areas of the state. The provisioning carrier is then entitled to receive support in the amount of the difference between the urban rate charged and the "rates for similar services provided to other customers in comparable rural areas in the state." To determine the urban rate, the Commission determined that it will use the "urbanized areas" as designated by the Census Bureau based on the most recent decennial Census to define the geographic contours of urban areas in a state. The Commission concluded that urbanized areas are appropriate because they include urban cores with at least 50,000 people "along with adjacent territory containing non-residential urban land uses as well as territory with low population density included to link outlying densely settled territory with the densely settled core." For determining rural rates, the Commission established three tiers of rurality to determine the comparable

rural areas in a state or territory: (1) *Extremely Rural*, areas entirely outside of a Core Based Statistical Area; (2) *Rural*, areas within a Core Based Statistical Area that does not have an Urban Area with a population of 25,000 or greater; and (3) *Less Rural,* areas in a Core Based Statistical Area that contains an Urban Area with a population of 25,000 or greater, but are within a specific census tract that itself does not contain any part of a Place or Urban Area with a population of greater than 25,000. In Alaska, however, given the vast number of communities without access to roads and the unique cost considerations they may face for obtaining service, the Commission further bifurcated the Extremely Rural tier into two sub-tiers. That is, areas in Alaska entirely outside of a Core Based Statistical Area that are inaccessible by road will be treated as Frontier areas for purposes of determining comparable rural rates. Communities outside of a Core Based Statistical Area and accessible by road will be in the Extremely Rural tier.

15. *Geographic Contours for Urban Areas*. The Commission's rules do not explicitly define "urban area" with respect to determining the urban rate. Instead, the rules require the applicant to base the urban rate on rates for similar services charged to a commercial customer in "any city with a population of 50,000 or more" in the state.

16. In the R&O, the Commission retained the current population threshold of 50,000 in defining the geographic contours of urban areas for purposes of the determining the urban rate. Consistent with the Commission's conclusion in 1997, the Commission continued to believe that cities with populations of 50,000 or more are large enough so the rates for telecommunications services in these areas reflect cost reductions associated with high-volume, high-density factors. The Commission concluded, however, that defining urban areas by the jurisdictional boundaries of cities is unrealistic and unnecessarily restrictive because it fails to account for adjacent areas that are socioeconomically tied to the urban core. Failing to include a city's suburban areas runs counter to the goal of using urban rates that reflect the cost reductions associated with higher population density present in urban areas.

Omitting such areas is also contrary to how urban areas are designated by the nation's top two Federal agencies on the subject, the Census Bureau and the Office of Management and Budget (OMB), both of which evaluate surrounding areas when considering urban designations regardless of a city's jurisdictional boundary. Accordingly, the Commission updated the contours of urban areas for determining urban rates to: (1) more accurately reflect the socioeconomic realities of metropolitan cities and (2) ensure rates relevant to the urban rate determination are not unnecessarily excluded.

17. The Commission noted that urbanized areas are used by OMB to designate Metropolitan Statistical Areas which the Commission originally referenced when establishing the 50,000 population threshold. The Commission decided, however, to use urbanized area designations as opposed to the Metropolitan Statistical Areas to minimize the potential for the inadvertent inclusion of pocket rural areas. Because Metropolitan Statistical Areas are based on counties and urbanized areas designations consisting of census tracts and blocks, there is a greater likelihood of the less granular Metropolitan Statistical Area containing an area that is rural for purposes of reflecting the costs of deploying telecommunications services. Using urbanized areas thus allows for a more granular designation of high population density areas than attainable with the county-based Metropolitan Statistical Areas.

18. The Commission clarified, however, that consistent with the statute, the Administrator will review public rates in all urbanized areas to the extent those urbanized areas fall within the boundaries of the state where the health care provider is located. For example, in urbanized areas like the Washington, D.C.-Virginia-Maryland urbanized area that cross multiple state boundaries, this means the Administrator could factor in available rates for determining an urban rate for a service delivered to a health care provider in Virginia from that portion of the urbanized area that falls within the Commonwealth of Virginia. For example, a public rate that is available throughout the urbanized area (i.e., the rate is the same irrespective of location within the urbanized area) could be part of the

determination along with a local cable company rate that is only available in northern Virginia. The Administrator could not, however, factor in a local cable company rate that is only available in portions of the urbanized area outside of Virginia, like neighboring areas in Maryland and the District of Columbia.

19. *Geographic Contours for Comparable Rural Areas.* Historically, the Commission has defined "comparable rural areas" to mean the immediate rural area in which the health care provider is located. The Commission concluded, however, that the better, more inclusive interpretation of "comparable rural areas" includes not only rural areas in the health care provider's own immediate rural location but all similar rural areas, namely all those within the same rural tier in the health care provider's state. Two rationales support the Commission's shift in interpretation. First, the use of the plural "comparable rural areas" in the Act indicates an intent to encompass rates from more than a single area, including, by default, areas where the health care provider is not located. Second, consideration of available rates for services offered across the health care provider's state provides significantly more service rate data points and thus a more accurate measure of the actual costs of providing services to rural areas.

20. The Commission noted that the existing definition of rural area used for Telecom Program eligibility naturally breaks down into degrees of rurality for the purpose of determining rates in comparable rural areas. Under the existing definition, a rural area is "an area that is entirely outside of a Core Based Statistical Area; is within a Core Based Statistical Area that does not have any Urban Area with a population of 25,000 or greater; or is in a Core Based Statistical Area that contains an Urban Area with a population of 25,000 or greater, but is within a specific census tract that itself does not contain any part of a Place or Urban Area with a population of greater than 25,000." In the R&O, the Commission established three rural tiers—which it designated Extremely Rural, Rural, and Less Rural, respectively—based on this existing definition.

21. The Commission concluded that using rural area tiers is a more precise means of determining rurality because it prevents rates in the most rural areas from being unfairly reduced by being combined with rates from less rural areas. The Commission based this conclusion on the reasonable assumption that the cost to provide telecommunications services increases as the density of an area decreases, as rates are generally a function of population density. The Commission also found that tying the new rural tiers to the existing three-part definition of "rural area" used for eligibility purposes has the advantage of familiarity, and thus avoids a change that introduces a new concept that may be needlessly complicated. The approach also benefits from the ease with which the new rurality tiers can be employed to determine support.

22. Additionally, the Commission will treat areas outside of a Core Based Statistical Area that are inaccessible by road as a separate tier, *i.e.*, Frontier areas. Areas outside of a Core Based Statistical Area that are accessible by road will be treated as Extremely Rural for purposes of rate determination. To determine communities connected by roads, the Commission will use the data provided by the Alaska Department of Commerce Community and Economic Development; Division of Community and Regional Affairs. This data source will allow participants to determine the appropriate tier for the relevant health care provider and simplifies the administration of this aspect of the program. To ensure that the process used to establish rural tiers is objective, administratively feasible, transparent, and simple to apply, the Commission declined at this time to further sub-divide off-road communities for determining comparable rural areas.

23. The Commission expects that by broadening the scope of comparable rural areas used to compute the rural rate, it will increase the likelihood of identifying available rates for the same or similar services within a state to determine rural rates, which addresses a concern raised by some commenters. Moreover, because the Commission now requires consideration of available rates outside the health care provider applicant's immediate rural area (but within similarly tiered rural areas within

the health care provider's state), the approach reflects a more faithful interpretation of the statutory obligation to reimburse carriers using rates for similar services provided to other customers in "comparable rural areas" in the state.

24. *Ensuring Reasonable Comparable Urban Rates.* Based on the record and the Commission's past experiences with the Telecom Program, the Commission found that the current process for determining urban rates does not adequately advance the goals of the statute and requires reform. The Commission thus revised its rules to require the Administrator to determine the urban rate based on a median of available rates for similar services across all urbanized areas in a state. The Commission also directed the Administrator to create a publicly available database to post the urban rates for each state for program participants. These changes will: (1) eliminate incentives by health care and service providers to manipulate the urban rate determination; (2) promote rate determination transparency and consistency; (3) provide health care providers with predictability on the urban rates prior to choosing among service offerings; and (4) decrease administrative burdens for rural health care providers participating in the Telecom Program.

25. The Commission's rules currently place a ceiling on the amount a health care provider is required to pay for a requested service, stating the urban rate "shall be a rate no higher than the highest publicly-available rate charged to a commercial customer for a functionally similar service in any city with a population of 50,000 or more in that state." The current process for determining urban rates contributes to the inefficient increase in support demand. As the data shows, health care providers are increasingly paying less and less for eligible services. For example, the Telecom Program commitments increased in size by more than 80% from approximately $116 million in funding year 2012 to approximately $211 million in funding year 2016. Gross demand for Telecom Program requests respectively totaled approximately $272 million and $206 million for funding years 2017 and 2018. The overall out-of-pocket expenses for health care providers, however, have decreased from approximately

$23 million in funding year 2012 to approximately $12 million in funding year 2017. The overall effective discount rate thus rose steadily during this period to 92% in funding year 2017, meaning health care providers were collectively paying only 8% of the total cost of the service. In many cases, individual health care providers paid as little as 1% or less for the services they received. In funding year 2016, 5% of participating health care providers in the Telecom Program received 62% of the committed funding, *i.e.*, $131 million, with an effective discount rate of 99% and above. As a result, health care providers increasingly have less incentive, because they have increasingly less money invested, to cost-effectively obtain services to minimize strain on the Universal Service Fund.

26. The Commission is also concerned that urban rates submitted on the Telecom Program's request for funding form (FCC Form 466) are being held artificially low and may not reflect the comparable urban rates charged for services in urban areas. For example, after comparing available information for the E-Rate Program, the median rates reported by rural health care providers are in many cases far less than the median rates paid by schools and libraries in urbanized areas of the state for the same or similar services.

27. Accurately determining the urban rate is imperative to the integrity of the Telecom Program. The urban rate is not only key to incentivizing health care providers to make service choices in a cost-efficient manner but is also critical to determining the level of universal service support provided to participants. Based on review of the record and program data, the Commission found that the existing approach for determining urban rates is not producing reasonably comparable urban rates and required reform to reflect the rates actually being charged in urban areas of the state more accurately than the current methodology. The Commission also was concerned that the current methodology fails to provide adequate incentives for health care providers to act in the best interests of the Universal Service Fund and is susceptible to rate manipulation. Therefore, the Commission found that reforming the urban rate determination necessary to further the intent of Congress of ensuring that rural health

care providers are placed on equal footing with their urban counterparts, and to preserve and advance the Universal Service Fund.

28. To this end, in the R&O, the Commission changed course and now requires that the Administrator calculate urban rates based on the available rates, including data available from the E-Rate Open Data Platform, for functionally similar services offered across all urbanized areas of the state. The Commission found that this approach will more likely produce a reasonably comparable urban rate than the current approach by taking into account a wider range of urban rates. In addition, the Commission requires the Administrator to determine the urban rate by using the median of the available rates for functionally similar services. Having the Administrator conduct the rate determination, as opposed to the health care provider, will further eliminate any potential incentives to manipulate rates and will provide transparency and predictability to the rate determination process as well as ease burdens on health care providers.

29. The Commission will no longer allow health care providers to determine the urban rate from the rates available in any particular city in the state. In 2003, the Commission expanded the geographical boundaries from which urban rates could be considered from the nearest city with a population of 50,000 or more to any such city in the state with the goal that rural health care providers "benefit from the lowest rates for service in the State." The Commission reasoned the largest cities in a state likely have significantly lower rates and more service options than the city nearest to the rural health care provider with a population of least 50,000. The Commission now concludes that this approach goes beyond the intent of Congress of providing "reasonably comparable" urban rates to rural health care providers and leads to funding inefficiencies. This approach is no longer tenable given the growing demand for program funding.

30. The median urban rate for a particular service will be the sole urban rate that a health care provider may use on its FCC Form 466 application to request Telecom Program support. The

Commission believes that using multiple price points to determine the urban rate will bring restraint and discipline to the Program and will minimize opportunities for rate manipulation. The Commission is concerned, however, with using an average because rates may be skewed by a very high or very low rate for that service in some location. For example, in Texas for funding year 2017, health care providers reported on the FCC Form 466 urban rates for voice grade business circuits ranging from about $938 to $9 at the high and low ends but with a large majority of the urban rates falling in the $40 to $400 range. The high and low rates in this scenario could skew the average upwards or downwards depending on the other rates in the data set whereas a median mutes these potential outliers. The potential for intentionally manipulating the urban rate determination, by interjecting available outlier rates, is thus lessened.

31. *Eliminate "No Higher Than" Standard*. In moving to a median urban rate determination conducted by the Administrator, the Commission eliminated the "no higher than the highest publicly available rate" restriction on the urban rate determination. In practice, the existing ceiling has no effect as a health care provider would be unlikely to ever determine and report an urban rate that is higher than the highest available rate in any city in the state. Moreover, the median urban rate adopted is by definition a rate that is no higher than the highest available rate. Accordingly, the Commission eliminated the "no higher than" restriction and instead requires health care providers to use the median urban rate identified by the Administrator for the relevant eligible service when submitting FCC Form 466 filings.

32. *Eliminate the Standard Urban Distance.* The Commission eliminated the standard urban distance demarcation contained in the current urban rate rule. The current rule provides two methods for determining the urban rate depending on whether the requested service is provided over a distance that is either less than or equal to, or else greater than the "standard urban distance." Based on the current rules, a rural health care provider's rate for services provided over a distance greater than the

standard urban distance would be no greater than the urban rate for services provided over the standard urban distance, while the rate for services provided at a distance equal to or less than the standard urban distance would be equal to the urban rate for services provided over the actual distance to be covered. Because the urban rate adopted is determined using rate data from all urbanized areas in the state, the Commission believes it will reflect a reasonably comparable rate for the particular service regardless of the distance actually covered, and as a result, a distance measure is no longer relevant.

33. *Reforming the Determination of Rural Rates.* To simplify rural rate determinations, encourage transparency and predictability, and minimize the risk of rate manipulation, the Commission revised the rules to establish a single method for determining the rural rate, which will be the median of all available rates charged for the same or functionally similar service in the rural tier where the health care provider is located within the state. The Commission also directed the Administrator to determine the rural rate for each eligible service and rural tier in each state and publish the rural rates in a publicly available database. The Commission further established a standard of review for carriers that wish to seek a waiver of a rural rate determined pursuant to these steps that requires a demonstration that the carrier will be unable to recover its economically reasonable costs of supplying service, as defined in the following, if it is limited to the rural rates determined by the Administrator.

34. The Commission's rules currently permit three methods for calculating the rural rate depending on each health care provider's situation: (1) averaging the rates that the carrier actually charges to non-health care provider commercial customers for the same or similar services provided in the rural area where the health care provider is located; (2) averaging publicly available rates charged by other service providers for the same or similar services over the same distance in the rural area where the health care provider is located (applicable in cases where the service provider does not provide service to the health care provider's rural area); or (3) requesting approval of a cost-based rate from the

Commission (for interstate services) or a state commission (for intrastate services) if there are no rates for same or similar services in that rural area or the carrier believes the calculated rural rate is unfair. Applicants must justify the rural rate calculation on which they rely when seeking Telecom Program support by using one of these three methods.

35. Like the urban rate, the rural rate has proven to be difficult for health care and service providers to calculate and is susceptible to manipulation. The complexity of the rural rate rules has caused health care providers to frequently rely on consultants or their service providers to navigate the rules, which AT&T observes has "made it easy for unscrupulous parties to create artificially high 'rural rates,' and, in some cases, artificially low 'urban rates' thus maximizing the alleged disparity between rural and urban rates." Indeed, the risk of artificially inflated rural rates is very real under the Commission's existing framework. When a carrier sets the rural rate by averaging the rates of identical or similar services, the service rates of other carriers are not considered by design (in cases where the carrier offers commercial service to the health care provider's rural location) or may not be considered by selective omission (in cases where the carrier does not offer commercial service to the health care provider's location). Either way, the lack of consideration of competitors' offerings can lead to a rural rate that does not reflect the true rate of service available at the health care provider's location and which can be manipulated upwards because the service provider is incentivized to do so. In each of the foregoing examples, health care providers have no countervailing incentive to check carrier pricing because they pay only the lower urban rate without regard to the rural rate.

36. Additionally, it is a matter of record that rural rates are rising sharply, as reflected in the increasing combined levels of Telecom Program funding commitments over the past several years. The aggregate rural rate in 2004, for example, was $42 million. That aggregate figure climbed steadily over the next seven years to $142 million by funding year 2011, and then increased again by $80 million over the next five years to $222 million. The rural rate is not only increasing in the aggregate, it is increasing

on an individual basis as well. Between funding year 2011 and funding year 2016, as the rural rate increased in the aggregate by $80 million, the number of health care provider sites requesting support decreased by 30%. These numbers equate to an average rural rate (per individual health care provider site) that more than doubled from $37,755 in 2011 to $84,797 in 2016. Although some of the increase in the rural rate can be attributed to legitimate causes such as a health care provider's location, demand for and availability of higher speed services, and limited access to high speed middle-mile transport capacity, that appears to be only part of the story. Given the widely divergent rates for the same services the Commission has seen, it appears much of the increase results from the lack of adequate transparency, standardization, and enforceability in the existing method of determining rural rates, collectively opening the door to rate manipulation. The Administrator currently must examine each funding request individually to determine if the associated rural rate was properly calculated and substantiated, and whether the substantiated rate complies with the requirements under the Commission's rules. This task requires access either to all of the service providers' rates or to available rates for the applicable rural area. Because this information is not readily available to the Administrator in-house, it has come to rely on rate data provided by the very parties, namely carriers, with the greatest interest in keeping rural rates high. This can lead to rural rates inconsistently calculated, artificially inflated, and difficult to verify against public data sources. It also results in review process delays that understandably tax the patience of RHC Program participants waiting for final support determinations and funding commitments. Inefficiency and waste of this type is especially problematic now given the extreme demands on limited RHC Program funds. For these reasons, the Commission was compelled to make the programmatic changes to the rural rate rules.

37. *Modifying the Rural Rate Calculation.* The Commission's rules require health care and service providers to justify the requested rural rate by using one of three methods that require, depending on the circumstances, either averaging rates offered by the service provider, averaging rates

offered by carriers other than the service provider, or conducting a cost-based analysis. In the R&O, the Commission adopted a new method of calculating rural rates, applicable in all cases, to be applied and publicly maintained by the Administrator. The rural rate will be the median of available rates for the same or similar services offered within the health care provider's rural tier (*i.e.*, Extremely Rural, Rural, or Less Rural) in the state. For example, the maximum rural rate for a particular service requested by a health care provider located in an Extremely Rural area would be the median rate charged for that same or similar service in all areas within the health care provider's state that are deemed Extremely Rural.

38. As with the median urban rate, the relevant rates to be used when determining the median rural rate will be broadly inclusive and comprised of the service provider's own available rates to other non-health care providers, as well as other available rates in the rural area, including rates posted on service providers' websites, rate cards, contracts such as state master contracts, undiscounted rates charged to E-Rate Program applicants, prior funding year RHC Program pricing data, and National Exchange Carrier Association (NECA) tariff rates. In the unlikely event that a health care provider's rural tier includes no available rates for a particular service, the Commission directed the Administrator to use the available rates for that service available from the tier next lowest in rurality in the health care provider's state (i.e., the Administrator will use the rates from the Rural tier if no rates are available in the Extremely Rural tier, and from the Less Rural tier if no rates are available in the Rural tier).

39. The new standardized approach to determining the rural rate will eliminate the problem of rate inconsistency that results from the current method. For example, three rural health care providers in Alamosa, Colorado, requested support for T1 service for funding year 2017. These health care providers, located within less than two miles of each other, included rural rates of $294.24, $827.00, and $2,077.65. Discrepancies such as these arise under the existing rate-setting framework because health care and service providers are left to their own devices to select the data required to make rate determinations for each funding request and would have to conduct exhaustive research on

their own to ensure that the data is comprehensive. Indeed, because any number of variables can affect rates for the same service offering, health care and service providers have had to grapple with an inconsistent process that lacks the controls, transparency, and predictability necessary to ensure a fair and reliable allocation of scarce Telecom Program funds.

40. The Commission adopted a median-based approach for rate determinations in lieu of rate averaging to account for the significant effect that a small number of outlier rates (*i.e.*, those that are very high or very low in cost) can have on the average rural rate. If a rural tier within a state has few service providers offering a certain service, there may be incentives to publicize artificially high rates to influence the rural rate. This incentive is stronger if the average rural rate is used rather than the median rate because the average rate can be more easily manipulated. The median figure established by the Commission's new approach represents a rate "ceiling," in that the Commission will not provide support in excess of the median rate. Health care providers may of course enter into contracts with carriers at a rate lower than the median rural rate. If the health care provider enters into a contract with a carrier at a rate that falls below the median rural rate determined pursuant to its new rules, the health care provider should enter the *lower* of the two rates into the FCC Form 466 funding application that it submits to the Administrator. The Commission believes that this approach balances the pro-competitive advantages of market-based rates with protections against possible rate manipulation in circumstances where insufficient levels of competition exist.

41. Several commenters favored using only competitive bidding to set a fair market rate. To these parties, reliance on market forces offers several benefits, including a check on outlier pricing that keeps prices low and no need to depend on rates that they assert are often unavailable. The Commission did not agree with these commenters that there are sufficient competing service alternatives in all rural areas to allow for the exclusive reliance on market-based methods of rate determination. Indeed, there is a striking lack of competition in the Telecom Program. In funding year

2017, of a total of 7,357 Telecom Program funding requests received by the Administrator, 6,699 requests included no bids, and 242 requests included only one bid, from carriers. In other words, nearly 95% of requests for Telecom Program support were submitted without an effective competitive bidding process. Given these numbers, competitive bidding alone cannot be expected to set efficient rural rates. Nor would the Commission expect carriers to compete on *rural* rates in their bids. After all, rural health care providers do not pay the rural rate—they pay the urban rate. So, while the Commission cannot discount some possibility that competition could lower rural rates, the far greater likelihood is that carriers compete (in those discrete instances where they do compete) on urban rates and the non-price characteristics of the service.

42. The Commission believes that a uniformly applied standard for determining rural rates based on a state-wide pool of available rates significantly enhances the efficiency of the Telecom Program in several ways. First, a definitively determined rural rate will facilitate rate transparency, thereby reducing rural rate inconsistencies and simplifying the review process, thus expediting funding commitment determinations and encouraging more competition from service providers. Second, by limiting rate determinations to available rates, rural rates are more predictable and easily verifiable, and harder for service providers to artificially inflate or otherwise manipulate. Third, the ability to determine a rural rate using available rates from other parts of the health care provider's state (under conditions where sufficient data is not available in the provider's rural area) eliminates the need for resource-intensive cost-based rural rate reviews by the Commission.

43. *Allowing Cost-Based Rates Only Via Waiver.* Under the current rules, carriers may request approval of a cost-based rate from the Commission (for interstate services) or a state commission (for intrastate services) if there are no rates for same or similar services in that rural area or the carrier reasonably determines that the calculated rural rate is unfair. The Commission adopted the cost-based mechanism when it created the Telecom Program in 1997, but the cost-based rural rate

mechanism was only invoked for the first time in funding year 2017, and since then, only a small number of carriers have attempted to use it.

44. The Commission eliminated the cost-based support mechanism. To the extent the Commission created it in anticipation of rates for same or similar services not being available in some rural areas, the Commission found that such circumstances have not materialized on a significant scale, given how infrequently the cost-based mechanism has been invoked. Moreover, commenters generally disfavor the cost-based method for determining rural rates, which they view as challenging to calculate and difficult to obtain approval for due to the burdensome itemized cost summaries that the method requires. Further, the rural rate methodology that the Commission adopted in the R&O will include rates from a geographic range that is broader than a health care provider's immediate rural area, making it unlikely that the data necessary to determine a rural rate for a particular service will not be available.

45. The Commission concluded that cost-based reviews should not be an alternative method of determining a rural rate under its rules but should be reserved for extreme cases where a carrier can demonstrate that determining Telecom Program support under the new rural rate rules adopted by the R&O would result in an objective, measurable economic injury. Parties that seek exemptions from the requirements of the Commission's rules for the other universal service support mechanisms do so through petitions for waiver. To that end, the Commission established specific evidentiary requirements for carriers that seek waivers of its new rural rate rules in order to use a cost-based rate.

46. A petition seeking such a waiver will only be granted if, based on documentary evidence, the carrier demonstrates that application of the rural rate published by the Administrator would result in a projected rate of return on the net investment in the assets used to provide the rural health care service that is less than the Commission-prescribed rate of return for incumbent rate of

return local exchange carriers (LECs). This demonstration will constitute "good cause" to support a waiver of the rural rate rules.

47. The Commission emphasized that this standard of review constitutes a specific application of the "good cause" standard that generally applies to petitions for waiver of its program rules. All such waiver requests must articulate the specific facts that demonstrate that the good cause waiver standard has been met, substantiated through documentary evidence as stated in the following, to demonstrate that granting the waiver would be in the public interest. Further, a petition for such a waiver will not be entertained if it does not also set forth a rural rate that the carrier demonstrates will permit it to obtain no more than the current Commission prescribed rate of return authorized for incumbent rate-of-return LECs. The Commission concluded that the current prescribed rate of return authorized for incumbent rate-of-return LECs is compensatory for carriers in the Telecom Program, and the Commission will not approve a rural rate that yields a higher return through the waiver process.

48. *Evidentiary Requirements*. All petitions seeking such a waiver must include all financial data and other information to verify the service provider's assertions, including, at a minimum, the following information: 1) Company-wide and rural health care service gross investment, accumulated depreciation, deferred state and federal income taxes, and net investment; capital costs by category expressed as annual figures (*e.g.*, depreciation expense, state and federal income tax expense, return on net investment); operating expenses by category (*e.g.*, maintenance expense, administrative and other overhead expenses, and tax expense other than income tax expense); the applicable state and federal income tax rates; fixed charges (*e.g.*, interest expense); and any income tax adjustments; 2) An explanation and a set of detailed spreadsheets showing the direct assignment of costs to the rural health care service and how company-wide common costs are allocated among the company's services, including the rural health care service, and the result of these direct assignments and allocations as necessary to develop a rate for the rural health care service; 3) The company-wide and rural health care

service costs for the most recent calendar year for which full-time actual, historical cost data are available; 4) Projections of the company-wide and rural health care service costs for the funding year in question and an explanation of these projections; 5) Actual monthly demand data for the rural health care service for the most recent three calendar years (if applicable); 6) Projections of the monthly demand for the rural health care service for the funding year in question, and the data and details on the methodology used to make that projection; 7) The annual revenue requirement (capital costs and operating expenses expressed as an annual number plus a return on net investment) and the rate for the funded service (annual revenue requirement divided by annual demand divided by 12 equals the monthly rate for the service), assuming one rate element for the service, based on the projected rural health care service costs and demands; 8) Audited financial statements and notes to the financial statements, if available, and otherwise unaudited financial statements for the most recent three fiscal years, specifically, the cash flow statement, income statement, and balance sheets. Such statements shall include information regarding costs and revenues associated with, or used as a starting point to develop, the rural health care service rate; and 9) Density characteristics of the rural area or other relevant geographical areas including square miles, road miles, mountains, bodies of water, lack of roads, remoteness, challenges and costs associated with transporting fuel, satellite and backhaul availability, extreme weather conditions, challenging topography, short construction season, or any other characteristics that contribute to the high cost of servicing the health care providers.

49. Failure to provide the listed information shall be grounds for dismissal without prejudice. The petitioner also shall respond and provide any additional information as requested by Commission staff. Such petitions will be placed on public notice for comment. The Bureau is directed to approve or deny all or part of requests for waiver of the rural rate rules adopted in the R&O.

50. *Establishing an Urban and Rural Rate Database.* In the R&O, the Commission directed the Administrator to create a publicly available database that lists the eligible services in the Telecom

Program, the median urban rate and rural rate for each such service in each state, and the underlying rate data used by the Administrator to determine the median rates. The urban and rural rates shall be based on available rates (*e.g.*, rates posted on service providers' websites, rate cards, publicly available contracts (*i.e.*, state master contracts), undiscounted E-Rate Program data, tariffs (*i.e.*, intrastate tariffs filed with state commissions, FCC's Electronic Tariff Filing System), and prior funding year Telecom Program rate data). The Commission directed the Administrator to determine the median urban and rural rate for eligible services as described in the R&O. The Commission further directed the Administrator to establish the database and post its first set of median urban and rural rates on its website as soon as possible, but no later than July 1, 2020, and to update the rates periodically based on market and technology changes. Rural health care providers generally will be required to use the currently posted median rates as their urban and rural rates when requesting funding on FCC Form 466 once the Administrator posts median urban and rural rates for the relevant services. In cases where a rural health care provider enters into a service agreement with a carrier featuring a rural rate lower than the rate posted by the Administrator, however, the health care provider should enter the lower rural rate.

51. The new urban and rural rate database to be established by the Administrator will provide several benefits. By centralizing and categorizing rate information in one place and by providing rural health care providers with pre-determined median urban and rural rates based on the information, the process will increase transparency compared to the current RHC Program. The database will allow quick identification of the median rates for a particular service within any state and how these rates were determined, ensuring that urban and rural rates are applied consistently and fairly to similarly situated health care providers seeking Telecom Program support for the same or similar services. In addition, because the database is publicly available, it will also promote predictability in the rate-setting process. The new database approach should also lessen the risk of rate manipulation. Requiring rural

health care providers to use the median rates as determined by the Administrator will prevent the health care provider and its carrier from using urban rates that are artificially low and rural rates that are artificially high, thereby safeguarding the integrity of the Telecom Program.

52. The Commission also believes that having rates determined by the Administrator will greatly lessen the administrative burden that rural health care providers (and their carriers) currently experience. The Commission's new approach removes the onus of determining rates from Telecom Program participants and places this function in the hands of a single expert entity without a financial interest in the outcome. And while the Administrator will have to determine the median rates, it will not have to verify individually the rates on each funding request application other than to confirm that the rates match those on the website. This approach should ultimately result in and a more efficient, transparent, and timely funding decision process.

53. Two Commissioners dissent from these decisions, contending that the Commission should defer from implementing the rules for determining urban and rural rates in the Telecom Program because the Commission does not "describe," "analyze," "test[]," "model[]," or "assess[]" the impact of those rules on the rural health care facilities that rely on the program today. This contention is somewhat curious. *For one*, the Commission describes, analyzes, and assesses the impacts of the rules adopted. For example, the Commission finds that the rules adopted will provide more certain and transparent funding for rural health care providers across the board—more "predictable," in the words of section 254 of the Act. To the extent that the current rules subject rural health care providers to wildly varying urban rates for the same service (recall that urban rates in Texas for voice grade business circuits ranged from $9 to $938), the impact of using a statewide urban median will be to eliminate outliers and ensure that all rural health care providers pay what Congress mandated: "rates that are reasonably comparable to rates charged for similar services in urban areas in that State." And as discussed in the document, the Commission concludes that existing rules have led to widely divergent

rural rates, thus imposing wasteful inefficiencies on the program and its administration. In contrast, the rules adopted by the Commission will eliminate divergent rural rates in similar areas, eliminating problematic incentives and the real costs this imposes on rural health care providers and the Universal Service Fund. Or to put it a different way (and as fully explained in the R&O), the Commission has exercised its predictive judgment to develop an approach to developing both urban and rural rates of the analysis suggestion is reasonable, that takes into account and balances the relevant considerations, and that fully satisfies the requirements of section 254 while safeguarding the Universal Service Fund from wasteful spending.

54. For another, these critiques ignore the real costs of delayed implementation. As described more fully in the R&O, current rules have enabled waste, fraud, and abuse in the Telecom Program and yielded results that appear contrary to Congress's mandate. After all, how could rates of $9 and $938 for the same service be considered "reasonably comparable" to each other, let alone the urban rates in a single state? How could rural rates ranging from $420 to $4,308 for the same service in the same county (Tulare County, California) be a faithful implementation of Congress's command that the rural rate be based on "rates for services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in comparable rural areas in that State"? These discrepancies threaten the ability of the Telecom Program to fund the telecommunications services that health care providers need to deliver critical health care services to their rural communities from the Program's limited resources. Program data establishes that commitments in the Telecom Program grew by more than 80% between funding year 2012 and funding year 2016. And yet, as explained in the R&O, *more and more* of the program's limited resources are devoted to *fewer* health care providers. The dissenting Commissioners do not offer any defense of existing rules and the negative impact they have on rural health care facilities—and delay would only prolong these problems. By removing the problematic provisions of the Commission's existing rules, its approach will enable rural

health care providers to continue to receive the services and support they need, with fewer administrative burdens and at lower cost to the Universal Service Fund. Or in other words, it is neither necessary nor desirable to delay the benefits of implementing the new urban and rural rate rules.

55. For yet another, the Commission found that no modeling is necessary at this point to reject the suggestion of one Commissioner, without factual basis, that health care providers in the most remote locations might be forced to close as a result of the new rules. Ensuring that remote regions receive sufficient support is precisely why the Commission divided rural areas into differing tiers (with an additional subtier for the most remote regions of the country). More fundamentally, health care providers will continue to receive needed telecommunications services "at rates that are reasonably comparable to rates charged for similar services in urban areas in that State," as provided by Congress, and carriers are obligated to provide them service at that rate. The Commission also noted that the waiver process helps ensure that any carrier outliers have an opportunity to receive sufficient support. Further, because of the prioritization rules adopted by the Commission, the most rural and remote locations actually will have more protection than they do today, because those locations will receive prioritized funding. What is more, health care providers will have a full year between the posting of the applicable urban rates and the first day they will begin to receive service at those rates, so they will have adequate time to adjust. Thus, participants in the Program will be protected from undue rate impacts under the Commission's new rules, and will receive support that is "specific, predictable and sufficient," as required by Congress.

56. In sum, the Commission adopted a process that eliminates largely subjective urban and rural rate determinations made by the applicants and service providers and substitutes objective determinations by the Administrator in full view of the public. The Commission expects that the result will be a more equitable and efficient use of limited available funding and a more predictable application process for Program participants.

57. In its Second July 25, 2019 *Ex Parte* Letter, GCI contends that the Commission has engaged in unlawful delegation of functions to the Administrator. That is incorrect as both a legal and factual matter. Initially, GCI identifies no valid legal authority for its claim that the Commission is prohibited from delegating to the Administrator the administrative roles contemplated by the R&O. GCI argues, for example, that section 5(c)(1) of the Act blocks the Commission from assigning a role to the Administrator in administering the urban and rural rates for the program. But nothing in that section mentions section 254. Rather, that section provides only that the Commission cannot delegate its ratemaking hearing authority under section 204(a)(2) of the Act, which does not apply to the development of urban and rural rates under section 254. Nor does section 5(c)(1) even mention section 205, the other provision upon which GCI relies.

58. In a contorted interpretation of the Act, GCI contends that section 205 of the Act applies to the Commission's establishment of rural and urban rates under section 254(h)(1)(A). GCI then argues that because the section 204(a)(2) hearing function cannot be delegated (citing Section 5(c)(1)), the Administrator can have no role in establishing the applicable urban and rural rates for the Telecom Program. But sections 205 and 204 simply do not apply to section 254(h)(1)(A), which is structured as a universal service obligation, and which uses very different statutory terms to describe the rate determinations involved. Specifically, section 254(h)(1)(A) imposes a requirement on telecommunications carriers, as part of their universal service obligation, to provide service to eligible rural health care providers at rates "*reasonably comparable* to rates charged for *similar services* in urban areas in that State." It then entitles those carriers to "the difference, if any, between rates for services provided to health care providers for rural areas within a State and the rates for *similar services* provided to other customers in *comparable rural areas* in that State . . . ." Had Congress intended for the Commission to conduct a section 204(a)(2) hearing in order to give effect to the universal service obligation, it would not have used such different language in section 254(h)(1)(A), and it would have

presumably cross-referenced section 204. Nor is the mere compilation of available rates and calculation of a median rate used to calculate universal service support amounts equivalent to a rate "prescription" under section 205(a) that would require a hearing, as GCI contends. Indeed, although the Act and the Commission's rules discuss a rural "rate," the Act and rules do not contemplate requiring or even allowing any carriers participating in the program to ever charge that rate (and hence it lies outside the scope of the ratemaking contemplated in sections 204 and 205 of the Act). Instead the "rural rate" is a legal placeholder simply used to carry out the statutory requirement of calculating "the difference, if any, between the rates for services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in comparable rural areas in that State."

59. In any event, the Commission has not delegated ratemaking authority to the Administrator. In the R&O, the Commission itself adopted rules dictating how urban and rural rates will be determined for the Telecom Program. Those rules and the R&O contain specific requirements to which the Administrator must adhere in developing these rates. For example, the Commission has delineated the geographic areas that are to be considered "comparable" rural areas under section 254(h)(1)(A); it has determined which services are "similar" within the meaning of that statutory provision (including bandwidth tiers, service quality, etc.); and it has determined how the Administrator is to assemble the available rates that will form the basis for calculating the median urban and rural rates for relevant geographic areas. The Commission has also required the Administrator to make public not only the median rates but also all the rates that the Administrator used to calculate the median.

60. GCI nevertheless contends that the Commission has delegated "ultimate authority over RHC Program rates" to the Administrator. But the only change the Commission made in the R&O is to have the Administrator, rather than the service provider, make the initial determination of what the rural rate should be. The Commission has no more delegated the "ultimate authority" over RHC Program rates to the Administrator than it delegated such "ultimate authority" to service providers

under the prior rules. As always, the authority to establish the appropriate urban and rural rates under section 254(h)(1)(A) remains squarely with the Commission. First, the Commission ultimately decides what the rates should be and how the rules should be applied and interpreted. Should a health care provider or service provider believe that the Administrator failed to follow the Commission's rules in determining the applicable urban or rural rates, or otherwise believe the Administrator erred, it may appeal that decision to the Commission, which will conduct *de novo* review. Second, the Administrator is expressly prohibited from making policy or interpreting Commission rules. Section 54.702(c) of the Commission's rules, which applies to the RHC Program, prohibits the Administrator from making policy or interpreting the statute or Commission rules and requires the Administrator to seek guidance from the Commission when the Act or rules are unclear.

61. For these reasons, there is no merit to GCI's alternative contention that the Commission has impermissibly delegated an "inherently governmental function." If GCI were correct that the determination of initial rates under section 254(h)(1)(A) is an "inherently governmental function" that cannot be delegated, then the Commission could not have lawfully permitted service providers to calculate initial rural rates, as it did under the prior rules. Determining the initial urban and rural rates under section 254(h)(1)(A) is something the service providers and the Administrator have been doing for many years, always subject to the Commission's oversight and review, and it will be no different under the program rules adopted. Because the Administrator carries out this function only pursuant to the Commission's rules and guidance, and subject to its review, and because the Administrator is prohibited from making policy or interpreting rules or statutes, there is nothing "inherently governmental" in the Administrator's role—rather, the Commission continues to exercise that function.

62. *Eliminating the Limitation of Support for Satellite Services.* The Commission eliminated, as no longer necessary, effective for funding year 2020, § 54.609(d) of the rules, which allows rural health care providers to receive discounts for satellite service, up to the amount providers would have

received if they purchased functionally similar terrestrial-based alternatives, even where terrestrial-based services are available. The Commission determined that the limitation on support for satellite services in § 54.609(d) of the rules is unnecessary where the rural rates are constrained to an average, or in the case of the newly adopted approach a median, of available rates (including satellite service to the extent functionally similar to the service requested by the health care provider) as determined by the Administrator. The Commission previously adopted the cap on satellite service support because the prices of satellite services in rural areas were "often significantly more expensive than terrestrial-based services." As acknowledged by USTelecom, however, and reflected in the data reported by health care providers in the FCC Form 466, rates for satellite services are in many instances comparable to, and in some instances less expensive than, the cost of terrestrial-based services. For example, in Alaska for funding year 2017, health care providers reported, on the FCC Form 466, rural rates ranging from $30,000 to $40,500 for a 10 Mbps satellite service per month. In comparison, rural rates for a terrestrial-based 10 Mbps MPLS service in Alaska, in many instances, were between $60,000 and $75,000 per month.

63. The Commission believes the changes made in the R&O in determining the rural rate place a check on the service provider's ability to inflate the rural rate by requiring the rural rate to be determined by taking a median of available rates outside the health care provider's immediate rural area (but within similarly tiered rural areas within the health care provider's state). This method of using the median takes into account rates by *all* competitive service providers offering services, including terrestrial and satellite services, but eliminates outlier rates that would unduly influence the rural rate determination. The median approach will thus alleviate concerns that excessively high terrestrial-based rates skew the rural rate determination to the detriment of the Universal Service Fund. Treating both services equally when functionally similar also furthers the principle of technological neutrality and recognizes the role that *both* satellite and terrestrial services may play in delivering

telehealth services in rural areas without placing significant demand on the Fund. Additionally, by strengthening the Commission's competitive bidding process and rules, it ensures that health care providers select the most cost-effective service offering based on their telehealth needs and do not purchase services that exceed their needs. The Commission therefore found that the need to cap support for satellite service at the lower of the satellite service rate or the terrestrial service rate, where both services are available, would serve no additional purpose. Accordingly, the Commission rejected ACS's proposal to limit Telecom Program support to the lower of the rural rate for functionally similar satellite or terrestrial service, where both are available and eliminated § 54.609(d) of its rules.

64. *Eliminating Distance-Based Support*. The Commission eliminated distance-based support, which allows rural health care providers to obtain support for charges based on distance. With the reforms to the urban and rural rate calculations adopted in the R&O, the Commission found that distance-based support is no longer necessary. Moreover, the Administrator-created and maintained databases and median rates will provide rural health care providers with a mandatory median urban rate and a median rural rate to guide their determination of the rural rate. The Commission believes that the median rate determinations for urban and rural rates adopted in the R&O will provide a reliable proxy for reasonably comparable rates in a state. The Commission expects the dataset that the Administrator will compile will include sufficient rate information to allow the Administrator to determine meaningful median urban and rural rates for use by rural health providers. By providing a mechanism to determine urban and rural rates that is less complex and more straightforward, the Commission believes it will simplify the application process for the rural health care provider so that it can focus on its primary business of providing health care. Finally, by eliminating the distance-based support method, the Commission reduces the administrative burden on the Administrator by no longer requiring the Administrator to manage two separate rate methodologies in the Telecom Program. Although the distance-based approach was infrequently used by rural health care providers, the

Administrator nonetheless was required to have in place the necessary procedures and processes to handle such requests.

65. *Supported Services in the Telecom Program.* Section 254(h)(1)(A) of the Act "explicitly limits supported services for [rural] health care providers to telecommunications services" for the Telecom Program. Over time, as technology has evolved, the line between telecommunications services and other services is not always evident to some health care providers. Therefore, the Commission took the opportunity in the R&O to remind participants that the Telecom Program only supports telecommunications services and not private carriage services, network buildout expenses, equipment, or information services. Services and expenses not covered by the Telecom Program may be supported to the extent eligible under the Healthcare Connect Fund Program. Accordingly, rural health care providers needing services not covered by the Telecom Program should seek support to the extent eligible under the Healthcare Connect Fund Program.

66. *Prioritizing RHC Program Funding for Rural and Medically Underserved Areas*. Under the Commission's rules, proration is required when funding requests submitted during a filing window exceed the amount of available funds. This process results in an across-the-board reduction of support by a pro-rata factor calculated by the Administrator. All eligible support requests are reduced by the same percentage amount regardless of the location and need of the health care provider applicant. Parties to the underlying contracts are responsible for any shortfall due to reduced support. Either health care providers have to shoulder a larger portion of the cost of the supported services, or service providers will offer price reductions to avoid curtailing service, or some combination thereof.

67. In the R&O, the Commission changed course and replaced the proration rules with a new process that prioritizes funding based on the rurality of the site location and whether the area is considered medically underserved. This approach furthers the goals of section 254(h) and is consistent with the universal service principles of section 254(b). First, health care providers in more rural areas

have less access to telecommunications and advanced services than those in less rural areas, and those services tend to be more costly. Prioritizing limited funding for those areas fulfills the Commission's statutory mandate to preserve and advance universal service, including for "low-income consumers and those in rural, insular, and high cost areas." Second, in areas in which medical care is less available, there is a greater need for and reliance on delivery of health care services via telehealth (which in turn requires access to telecommunications and advanced services). Prioritizing funding for those rural areas with the greatest medical need thus also serves the public interest. When demand exceeds the funds available, the Commission will first prioritize support based on rurality tiers, with extremely rural areas getting the highest priority over less rural areas. The Commission will further prioritize funding based on whether the area is a Medically Underserved Area/Population (MUA/P) as designated by the Health Resources and Services Administration (HRSA).

68. *Rural Prioritization Criteria.* The Commission first bases rural prioritization criteria on the existing definition of rural area. The current definition lends itself well to prioritization because it includes gradations of rurality instead of having simply two categories, *e.g.*, rural and non-rural. Accordingly, using the current definition of "rural area" contained in § 54.600(b) of the Commission's rules, 47 CFR 54.600(b), the Commission will prioritize funding based on the following rurality tiers: *Extremely rural* – counties entirely outside of a Core Based Statistical Area; *Rural* – census tracts within a Core Based Statistical Area that does not have an urban area or urban cluster with a population equal to or greater than 25,000; *Less Rural* – census tracts within a Core Based Statistical Area with an urban area or urban cluster with a population equal to or greater than 25,000, but the census tract does not contain any part of an urban area or cluster with population equal to or greater than 25,000; and *Non-Rural* – all other non-rural areas.

69. The Commission considered and declined to use, as a proxy for rurality, the "Highly Rural" areas used by the Department of Veterans Affairs for its Highly Rural Transportation Grant

program. Highly Rural areas are counties located in 25 states, primarily in the west and southwest United States, with a population density of fewer than seven people per square mile. The Commission found Highly Rural areas lack the necessary gradations of rurality and create an additional layer of complexity as to what is considered rural for purposes of prioritization. For example, using just a Highly Rural designation would prioritize only one category of rural areas for funding and would not allow the Commission to set subsequent prioritization levels among other areas that likely have varying degrees of rurality. In comparison, the current definition of rural area allows the Commission to designate multiple prioritization levels based on rurality. Moreover, creating a definition of rural just for prioritization that is separate and apart from the definition used for funding eligibility would further complicate the process for applicants and increase the burden for administering the program. With the rejection of using Highly Rural areas, the Commission likewise rejected GCI's alternative proposal to prioritize funding for such areas in exchange for increased minimum payments by health care providers over a five-year period.

70. Additionally, the Commission declined to base rurality on the number of patients in rural areas served rather than the location of the health care provider. Such an approach would not only increase the complexity of determining prioritization but would also potentially shift funding to health care facilities in urban areas. For example, the Commission would need to determine, and then update, the areas where patients served by each participating health care facility actually live to determine the facilities entitled to funding prioritization. Commenters supporting this approach fail to suggest how such a process is administratively feasible. In addition, the Commission recognized many rural Americans have limited local opportunities for health care access and must travel to more populated areas for quality care. Accordingly, urban health care facility sites, participating as part of a consortium under the Healthcare Connect Fund Program, and that serve patients living in rural areas could receive funding priority based on this approach. One of the major goals of the RHC Program is to help promote

local access in rural areas for health care so patients do not have to travel as far to obtain care. Prioritizing based on how many rural patients a facility serves could act contrary to this goal by shifting the funding priority to more populated areas that likely already have greater quality health care delivery systems than more rural areas.

71. *Health Care Shortage Measure.* The most commonly used Federal shortage designations are the Medically Underserved Areas and Populations (MUA/P) and the Health Professional Shortage Area (HPSA) designations. Both are administered by the Health Resources & Services Administration (HRSA) but are based in different statutory provisions for different Federal programs. The designation criteria for both rely on measures of physician supply relative to the size of the local population to assess geographically available care. MUA/Ps, however, also include weighted need-based variables for low-income, infant mortality, and population age. Designations are used to identify counties and census tracts not adequately served by available health care resources, and in the case of HPSAs, individual facilities that provide care to HPSA-designated areas or population groups. Both methods primarily rely on state governments, i.e., the state primary care office, to identify areas or populations for designation and to gather information to document satisfaction of the designation criteria. Designations are approved by HRSA. Once designated, MUA/Ps are not subject to any subsequent renewal or update requirement. The U.S. Department of Health & Human Services is required to conduct periodic reviews and revisions for HPSA designations.

72. To determine whether an area is medically underserved, the Commission will use, with limited exception, the MUA/P as designated by HRSA. MUA/P designation relies on the Index of Medical Underservice (IMU), developed by the U.S. Department of Health & Human Services, which is calculated on a 1-100 scale (with 0 representing completely underserved and 100 representing best served or least underserved). An area or population with an IMU of 62.0 or below qualifies for designation as an MUA/P. The IMU is calculated by assigning a weighted value to an area or population's performance on

four demographic and health indicators: (1) provider per 1,000 population ratio; (2) percent population at 100% of the Federal Poverty Level; (3) percent of population age 65 and over; and (4) infant mortality rate. As of June 10, 2019, MUA/P designated areas covered 41.6% of the 2010 U.S. population. The Commission recognized rural areas may experience shortages in other health care areas, *e.g.*, mental health services and other specialty areas, but adding additional shortage designation types would significantly increase the complexity of the prioritization process. Accordingly, the Commission decided to measure shortages based on primary care at this time to facilitate predictability and to simplify the prioritization process.

73. The Commission found that MUA/Ps have two distinct advantages over HPSAs for purposes of RHC Program prioritization. First and most importantly, the MUA/P designation criteria includes variables for poverty, infant mortality, and population age in addition to provider supply as compared to population. Use of the MUA/P ensures consideration of population indicators for health need in addition to the number of primary care physicians in the area. Second, the focus on primary care with counties, census tracts, block groups, and blocks designated as shortage areas makes administering MUA/Ps in the prioritization process relatively straight-forward as compared to HPSAs. By using MUA/Ps, however, loses some degree of accuracy as compared to HPSAs because there is no requirement for renewal or subsequent review of MUA/P designations. But other benefits of using MUA/Ps outweigh this concern at this time. That said, the Commission will monitor and plan to revisit the use of MUA/Ps in the future to determine whether this proxy is sufficient for identifying medically underserved areas.

74. *Application of Prioritization Factors.* The Commission directed the Administrator in the R&O to fully fund all eligible requests falling in the first prioritization category before funding requests in the next lower prioritization category. The Administrator will continue to process all funding requests by prioritization category until there are no available funds. If there is insufficient funding to fully fund

all requests in a particular prioritization category, then the Administrator will prorate the funding available among all eligible requests in that prioritization category only pursuant to the current proration process. The Administrator would then multiply the pro rata factor by the total dollar amount requested by each applicant in the prioritization category and then commit funds consistent with this calculation. While the Commission changed the overall prioritization process to minimize proration, the Commission found the limited use of proration prudent to equitably address instances where funding is insufficient for all applicants similarly situated within the same prioritization category. The Administrator will then deny requests falling within subsequent prioritization categories due to lack of available funds.

75. The prioritization process applies equally when demand exceeds the $150 million Healthcare Connect Fund Program cap for upfront and multi-year commitments. The Commission clarified that if requests for support exceed both the overall RHC Program cap and the $150 million Healthcare Connect Fund Program cap, the Administrator will first apply the prioritization process adopted in the R&O to requests subject to the $150 million Healthcare Connect Fund Program cap as that may eliminate the need to prioritize funding for the RHC Program cap.

76. The Commission recognized funding requests submitted by a consortium may contain multiple member sites falling in more than one prioritization categories, including member sites in non-rural areas. Nonetheless, the same prioritization process will apply, meaning those consortium sites in the highest prioritization category would receive funding commitments while other consortium sites in less rural and non-rural areas may not, i.e., based on prioritization, the consortium may only get a partial grant for some but not all of its sites. This potential outcome could dissuade future consortium participation but is necessary to better ensure support is directed to the most rural and medically underserved areas when demand exceeds the available support in a funding year. This outcome will also eliminate additional complexity in trying to prioritize consortia requests based on the percentage of

member sites falling into particular prioritization categories as suggested in the *2017 Promoting Telehealth NPRM & Order*.

77. Under the approach adopted by the Commission, prioritization will not depend on whether the applicant seeks support under the Telecom or Healthcare Connect Fund Programs. Seeking to both ensure Telecom Program applicants have telecommunications services necessary to provide health care services and also support the deployment and adoption of advanced, next-generation broadband capabilities as promoted by the Healthcare Connect Fund Program. Accordingly, at this time, the Commission declined to prioritize funding based on program type and will treat both programs equally. The Commission disagreed with those commenters who state the language of section 254(h) requires the Commission to favor the Telecom Program over the Healthcare Connect Fund Program. The language of section 254(h) does not expressly require such prioritization; Congress did not express such an intent in the Joint Explanatory Statement accompanying the enactment of section 254(h); and the Commission has never interpreted the statute in this manner. Further, section 254(h)(1)(A) does not by its terms or otherwise require the Commission to prioritize support under that section over support to health care providers under section 254(h)(2)(A) or to other universal service programs under section 254. The Commission found that the goals of sections 254(b) and 254(h) are best served by prioritizing both RHC Programs according to degree of rurality and medical need, rather than arbitrarily prioritizing one program over another.

78. The Commission also declined to prioritize funding based on the type of service, e.g., whether the support sought is for a monthly recurring service charge versus a one-time upfront payment, such as for infrastructure. Support of infrastructure and equipment costs are only available under the Healthcare Connect Fund Program so trying to prioritize by service raises the same issues as prioritizing one program over another. The Commission intends to treat both programs equally and to provide applicants the necessary flexibility to choose the services and infrastructure that best satisfy

their needs in a given funding year without concern over losing funding priority. The Commission recognized that this approach deviates from that taken under the E-Rate Program, but found that this is the right approach for the RHC Program at this time.

79. *Retaining the Current Definition for Rural Area*. In the R&O, the Commission found that a modification of its definition of "rural area" is unwarranted at this time and could cause uncertainty for program recipients. That said, the Commission indicated it would add to the definition as necessary to reflect the three different rurality tiers discussed in the R&O, which has relevance for not only prioritization but also for the determination of rates for comparable rural areas in a state. This change will not result in a substantive modification of the definition for rural area for eligibility purposes, however.

80. Separately, with the 2020 decennial census approaching, the Commission reminded program participants of the procedures previously outlined to address revisions to the list of eligible rural areas (Rural Areas List). In addition, the Commission took the opportunity in the R&O to make one minor change to those procedures. Specifically, to simplify and minimize disruptions in between decennial data releases and the corresponding Core Based Statistical Area designation updates, the Commission instructed the Administrator to only refresh the Rural Areas List when the decennial census data and Core Based Statistical Area designations based on the new decennial census data are released. The Administrator should not update the Rural Areas List in between the decennial updates to reflect periodic data refreshes. For example, the Administrator should not update the list to reflect the ongoing American Community Survey that occurs in between decennial updates. While this means the Rural Areas List will not be based on the most up-to-date data each year, it will simplify the process and minimize potential disruptions for program participants in between decennial releases.

81. *Funding Is Not without Limit*. The Telecom Program is rooted in section 254(h)(1)(A). The Commission previously read this language to mean the "amount of credit or reimbursement to

carriers from the health care support mechanism is based on the difference between the price actually charged to eligible health care providers [i.e., the discounted urban rate] and the rates for similar, if not identical, services provided to 'other customers' in rural areas in that State." Several commenters argue this statutory language requires the Commission to fully fund without limit all requests for commitments under the Telecom Program. The Commission disagrees.

82. Section 254(h)(1)(A) does not expressly provide for the creation of a funding support mechanism for telecommunications services to rural health care providers, but the Commission has relied on this provision to create the Telecom Program. Prior to creation of the Telecom Program, the Joint Board recommended the Commission rely on offsets and "disallow the option of direct reimbursement" given the statutory language to treat the discounted amount "as a service obligation as part of [the carrier's] obligation to participate in the mechanisms to preserve and advance universal service." The Commission instead allowed for direct compensation when and if the amount of discounted services provided exceeded the provider's Universal Service Fund contribution. In 2012, the Commission changed its rules to "permit USF contributors in the Telecommunications Program and the Healthcare Connect Fund to elect whether to treat the amount eligible for support as an offset against their universal service contribution obligation, or to receive direct reimbursement from USAC."

83. The Commission has never treated the section 254(h)(1)(A) provision as creating an unlimited right to Universal Service Fund support for telecommunication services provided to rural health care providers. As discussed in the R&O, the Commission adopted a $400 million cap in 1997 on the Telecom Program in order to "control the size of the support mechanism" and "to fulfill [its] statutory obligation to create specific, predictable, and sufficient universal service support mechanisms." The following year, the Commission adopted a proration mechanism should demand ever exceed the cap. The Commission would not have adopted a cap or a proration mechanism if it believed that it lacked statutory authority to set limits on the Telecom Program, which was

implemented by section 254(h)(1)(A). The Commission has also placed other limitations on support provided under section 254(h)(1)(A). When creating the Telecom Program in 1997, the Commission also limited services eligible for support to services with a bandwidth equal to or less than 1.544 Mbps per location, finding telecommunications services in excess of this threshold "not necessary for the provision of health care services at th[at] time." Faced with tepid participation in the program, in 1999 the Commission eliminated the per-location limit and the limitation on service bandwidth finding such restrictions "no longer necessary to ensure that demand for support remains below the . . . per year cap."

84. Congress intended section 254(h) "to ensure that health care providers for rural areas . . . have affordable access to modern telecommunications services that will enable them to provide medical . . . services to all parts of the nation." The language of section 254(h) provides the Commission with ample flexibility on how to structure a support mechanism to further this goal. As with any support mechanism, the Commission must base its decisions on the principles set forth in section 254(b), including having "specific, predictable, and sufficient Federal and State mechanisms to preserve and advance universal service." The prioritization approach adopted in the R&O serves this principle. Allowing funding without any limit runs counter to fiscal responsibility. The Commission does not believe Congress intended such a result, and instead concludes that Congress has given the Commission the necessary tools to preserve and advance universal service, including the ability to place limits on the amount of funding available.

85. *Maintaining the Funding Cap on Multi-Year Commitments and Upfront Payments and Instituting an Inflation Adjustment*. The Commission retained the $150 million cap on multi-year commitment and upfront payment requests in the Healthcare Connect Fund Program, but provided for the cap to be adjusted annually for inflation. The $150 million funding cap on multi-year and upfront payment requests has only been exceeded once since its creation in 2012. In funding year 2018, gross

demand for multi-year commitments and upfront payments was $237 million, and demand for remaining Healthcare Connect Fund Program requests and Telecom Program requests was approximately $411 million. The overall program funding cap for funding year 2018 was approximately $581 million. If not for the $150 million cap on multi-year commitment and upfront payment requests, all funding year 2018 requests would have had to be prorated to bring the $648 million total gross demand for RHC Program funding below the $581 million funding cap, resulting in reductions of funding for *all* program participants. Because the $150 million cap on multi-year and upfront requests was in place, the Administrator was able to process single-year funding year 2018 requests at their full eligible amounts. Stated differently, the $150 million cap did the job the Commission intended when it was established – to prevent multi-year and upfront payment requests from usurping the funding available for single-year requests for recurring services and safeguard against large fluctuations in demand for RHC Program funds. Absent additional data demonstrating the need to increase the $150 million cap (if it is exceeded in future funding years), providing an economic basis for a particular increase amount, and establishing that an increase would not have a detrimental impact on single-year requests, the Commission concluded that increasing the base amount of the $150 million cap on multi-year commitments and upfront payments would not be a fiscally responsible measure consistent with the obligation to be good stewards of the Universal Service Fund.

86. That said, the Commission concluded that the $150 million funding cap on multi-year and upfront payment requests should be adjusted annually for inflation. In the *2018 Report and Order* (*2018 R&O*), FCC 18-82, the Commission found that health care providers purchasing services with RHC Program support should be able to maintain consistent purchasing power in the event of price inflation. To provide the flexibility necessary for that to occur, the Commission adopted a rule that annually adjusts the overall RHC Program cap for inflation, using the GDP-CPI inflation index. The Commission found that adjusting the $150 million funding cap on multi-year commitments and upfront payments

within the Healthcare Connect Fund Program by the same index was a fiscally responsible means of preventing inflation from eroding the purchasing power of health care providers seeking such requests without overburdening the Universal Service Fund, unreasonably increasing contribution charges passed through to consumers, or risking an untenable depletion of funding available for single-year requests. In the R&O, the Commission directed the Bureau to compute the annual inflation adjustment pursuant to the same criteria established for adjusting the overall RHC Program funding cap in the *2018 R&O*. Any increases to the $150 million funding cap will be accounted for *within* the overall RHC Program cap, i.e., an increase in the $150 million funding cap on multi-year commitments and upfront payments will not increase the overall RHC Program cap. The Commission also directed the Bureau to announce any inflation-adjusted increase in the $150 million funding cap on multi-years and upfront payments in the same Public Notice that announce the inflation adjustment of the overall cap, if any.

87. The Commission appreciates that health care providers want certainty of funding approvals when applying for multi-year commitments and upfront payments. The reality of the RHC Program and other universal service mechanisms is that available funds are limited, however, and there is no guarantee that funding requests submitted to the Administrator in a particular funding year will be approved. The Commission noted that the inability to obtain a multi-year *commitment* from the RHC Program due to a lack of available funds in a particular funding year does not prevent health care providers from obtaining the benefits of a multi-year *contract*. Health care providers remain free to seek advantageous pricing through multi-year service arrangements and seek evergreen treatment of those contracts so that funding requests may be submitted to the Administrator for each year of the contract without rebidding the services. Indeed, multi-year commitments are not permitted in the E-Rate Program, but that does not prevent schools and libraries from benefitting from the cost-benefits of negotiating multi-year contracts for services, including substantial broadband projects. Applicants that

are concerned that a multi-year commitment may be denied in a particular funding year due to lack of funding should consider seeking annual funding for services provided under multi-year contracts.

88. *Clarifying the Carry-Forward Process for the RHC Program*. In the *2018 R&O*, the Commission adopted rules to address increasing demand in the RHC Program. Specifically, the Commission: (1) increased the annual RHC Program funding cap to $571 million and applied it to funding year 2017; (2) provided for the annual RHC Program funding cap to be adjusted for inflation, beginning with funding year 2018; and (3) established a process to carry-forward unused funds from past funding years for use in future funding years. As part of that process, the Commission committed to announcing in the second quarter of each calendar year "a specific amount of unused funds from prior funding years to be carried forward to increase available funding for future funding years." The Commission indicated unused funds "may be used to commit to eligible services in excess of the annual funding cap in the event demand in a given year exceeds the cap, or it may be used to reduce collection for the RHC Program in a year when demand is less than the cap." The Commission directed the Bureau to "announce the availability and amount of carryover funds during the second quarter of the calendar year."

89. To provide additional clarity for the carry-forward process, the Commission, in the R&O, directed the Bureau, in consultation with the Office of the Managing Director, to determine the proportion of unused funding for use in the RHC Program in accordance with the public interest to either satisfy demand notwithstanding the annual cap, reduce collections for the RHC Program, or to hold in reserve to address contingencies for subsequent funding years. The Bureau has authority to direct the Administrator to carry out the necessary actions for the use of available funds consistent with the direction specified in the document. The Commission previously provided similar authority to the Bureau in the context of allocating unused funding between demand for Category 1 and 2 services for the E-Rate Program.

90. *Targeting Support to Tribal Health Care Providers*. The Commission sought comments on targeting more support to health care providers located on Tribal lands and asked how the prioritization proposals would impact Tribal populations. The Commission received several comments on this issue, including comments from the Alaska Native Tribal Consortium and the Council of Athabascan Tribal Governments. Commenters generally emphasized the need for Tribal consultation and supported funding for health care providers on Tribal lands, specifically supporting prioritization based on the most rural areas. The Commission believes the prioritization approach adopted in the R&O, which prioritizes funding in those most rural areas with the greatest medical shortages, will help those living and seeking health care on Tribal lands as they are likely often the most remote and medically underserved areas of the country.

91. *Increasing Rural Participation in Healthcare Connect Fund Program Consortia.* The Healthcare Connect Fund Program provides support for eligible non-rural health care providers in majority-rural consortia ("more than 50% rural health care providers)." Consortia have three years from the filing date of their first funding request under the Healthcare Connect Fund Program to meet the majority-rural requirement. To ensure that eligible rural health care providers are benefiting from limited RHC Program dollars, the Commission eliminated the three-year grace period for consortia to come into compliance with the majority-rural rule. The Commission concluded that the prior rationale for a three-year grace period is no longer applicable to the RHC Program as it exists today. It was established at the time when there was significantly less demand for RHC Program funding and the Commission sought to encourage the formation of consortia within the Healthcare Connect Fund Program. Now, approximately seven years later, circumstances have changed. The Commission's focus now is to ensure that the limited RHC Program funding reaches the rural beneficiaries the RHC Program was created to support, and the Commission determined that requiring all Healthcare Connect Fund

Program consortia to comply with the majority-rural requirement is an appropriate step toward achieving those ends.

92. Eliminating the grace period (rather than shortening it) will also eliminate administrative burdens for the Commission and the Administrator in overseeing it—and eliminate an opportunity for regulatory arbitrage. No longer, for example, would the Administrator need to track how long a consortium had failed to meet the majority-rural requirement. And no longer would the Commission potentially face thorny compliance questions, such as whether a "new" consortium consisting of non-rural health care providers that switched from other non-compliant consortia would receive a new grace period.

93. The Commission now requires all consortia to comply with the majority-rural requirement by funding year 2020. Although the Commission recognized that some existing consortia may need a slight ramp-up period to negotiate and enter into contractual relationships amongst their participants and form a technology plan, almost two out of every three consortia have already demonstrated that achieving more than 50% rural participation is feasible—and 37% of consortia have reached at least 75% rural participation. For those that have not yet met the 50% threshold, the Commission found that allowing them until funding year 2020 to reach it strikes the appropriate balance between ensuring that RHC Program support reaches eligible non-rural health care providers during the transition to majority-rural status and the Commission's duty to ensure that RHC Program support is focused on the delivery of services to eligible health care providers in rural areas. For new consortia seeking to participate in the Healthcare Connect Fund Program, the majority-rural threshold must be met at the time that they apply for RHC Program funding. And while Kellogg & Sovereign, LLC asserts that, in some circumstances, it can take up to three years "to establish the contracts" to initiate the consortium and to add the eligible rural health care providers to "ensure a proper balance"—the

Commission does not see that as a reason to steer scarce RHC Program funds to non-compliant consortia when so many rural health care providers as well as compliant consortia are in need.

94. Given the Commission's elimination of the grace period, the Commission declined to increase the majority-rural threshold at this time. Rather, the Commission determined that increases to the majority-rural threshold should be consistent with overall RHC Program demand and the need to prioritize funding to health care providers in rural areas. Accordingly, the Commission will increase the majority-rural consortia percentage requirement only when RHC Program demand exceeds the funding cap. Specifically, if the Commission must prioritize funding in one year because demand exceeds the cap, the majority-rural threshold will automatically increase by 5% for the following funding year (up to a maximum of 75%). Consistent with the statutory mandate, this will ensure, as demand increases, that more Healthcare Connect Fund Program funding is focused on eligible health care providers serving rural areas. The Commission found that the more incremental approach—making such increases only when further evidence of demand outstripping supply comes in—better accomplishes the goals of such commenters without preemptively limiting participation by currently compliant consortia.

95. The Commission was not persuaded by commenters who oppose increasing the majority-rural health care provider requirement for Healthcare Connect Fund Program consortia. These commenters argue that: (1) the rural/non-rural composition of consortia is artificial; (2) increasing the majority-rural requirement may prevent small consortia from participating; (3) non-rural health care providers that deliver institutional knowledge, specialization, and expertise to rural communities may be disincentivized from participating; and (4) non-rural participants help to offset the expense of middle- and last-mile costs. Based on RHC Program data, the majority of consortia currently participating in the Healthcare Connect Fund Program exceed the current majority-rural participation requirement without any apparent degradation of benefits to the eligible rural health care participants. The Commission determined, based on the current make-up of participating consortia, and with no data to support the

arguments of the commenters opposing an increase, that increasing the majority-rural requirement by an incremental percentage as demand exceeds the cap, focuses the limited RHC Program dollars on support for eligible rural health care providers while still encouraging the participation of eligible non-rural health care providers. Thus, the Commission requires all existing and new consortia to reach any increased threshold, as necessary, and in so doing ensure the focus of RHC Program support remains primarily on supporting eligible rural health care providers.

96. *Applicability to Grandfathered Pilot Program Consortia*. The rule changes the Commission adopted in the R&O will apply equally to those consortia that participated in the prior Pilot Program and were grandfathered from complying with the majority-rural requirement in 2012. These grandfathered consortia were allowed to participate in the Healthcare Connect Fund Program with limitations on adding eligible non-rural member sites. The Commission grandfathered these consortia in recognition of their ability to encourage eligible rural health care provider participation in the Healthcare Connect Fund Program, and to minimize potential disruption in rural health care as the Commission transitioned from a pilot to a permanent program. Currently, 32 grandfathered Pilot Program consortia are participating in the Healthcare Connect Fund Program. All but three of these consortia now have more eligible rural than non-rural sites, i.e., a rural majority. Fourteen of the 32 grandfathered Pilot Program consortia consist of 75% or more eligible rural sites. Given the limited number of such consortia and the current percentage of eligible rural health care provider sites within each consortia, the Commission sees no detrimental impact from requiring the remaining three consortia to meet the majority-rural requirement in one year. As the Commission indicated, circumstances have changed significantly since the Commission decided to grandfather Pilot Program consortia in 2012. The Commission therefore found all these requirements should apply equally to those grandfathered Pilot Program consortia.

97. *Requiring Applicants to Seek Bids for Particular Services, Not Tasks Performed by a Service.* Under the Commission's rules governing the Telecom Program and Healthcare Connect Fund Program, health care providers during the competitive bidding process are required to select the most "cost-effective" service offering. As the Commission explained in the *2017 Promoting Telehealth NPRM & Order*, the definition of "cost-effective" applicable to both RHC Programs places virtually no limitation on how health care providers make their service selection. In addition, because the definition of "cost-effective" does not require health care providers to identify their specific service requirements when posting their requests for service, they can select carriers whose service offerings meet the current "cost-effective" definition, but which exceed the needs of the health care providers irrespective of cost. The result is a procedure that can lead to wasteful inefficiency in the competitive bidding process.

98. To increase the effectiveness of the competitive bidding process, the Commission implemented a new safeguard intended to reduce the risk of the type of inefficiency described in the R&O. Specifically, the Commission requires RHC Program applicants to list the requested services for which they seek bids (*e.g.*, Internet access, bandwidth) rather than merely listing what those services are intended to do (*e.g.*, transmit x-rays), and requires applicants to provide sufficient information to enable bidders to reasonably determine the needs of the applicant and provide responsive bids. The Commission believes requiring applicants to describe with greater specificity the precise *services* that they need, rather than just more specific uses, will reduce the likelihood of funding being used for excessively expensive services that are not necessary. This in turn will ensure a more equitable distribution of limited RHC Program funding. This change will become effective for funding year 2020.

99. *Harmonizing Certification and Documentation Requirements Between the RHC Programs.* To further promote the effectiveness of the competitive bidding process, the Commission harmonized the competitive bidding rules requiring Telecom Program applicants and Healthcare Connect Fund Program applicants to submit the same certifications and documentation (with limited

exceptions) as part of their requests for service. The Commission first harmonized the certifications that RHC Program applicants must make when requesting service. Effective with funding year 2020, both Telecom Program and Healthcare Connect Fund Program applicants will be required to provide, contemporaneously with their requests for services, the following identical certifications that: (1) the health care provider seeking supported services is a public or nonprofit entity that falls within one of the seven categories set forth in the definition of health care provider listed in § 54.600 of the Commission's rules; (2) the health care provider seeking supported services is physically located in a rural area as defined in § 54.600 of the Commission's rules, or is a member of a Healthcare Connect Fund Program consortium which satisfies the rural health care provider composition requirements set forth in § 54.607 of the Commission's rules; (3) the person signing the application is authorized to submit the application on behalf of the applicant, has examined the form and attachments, and to the best of his or her knowledge, information, and belief, all statements contained therein are true; (4) the applicant has complied with any applicable state, Tribal, or local procurement rules; (5) RHC Program support will be used solely for purposes reasonably related to the provision of health care service or instruction that the health care provider is legally authorized to provide under the law of the state in which the services will be provided and will not be sold, resold, or transferred in consideration for money or any other thing of value; (6) the applicant satisfies all requirements under section 254 of the Act and applicable Commission rules; and (7) the applicant has reviewed and is compliant with all applicable RHC Program requirements. The Commission will also require applicants of both RHC Programs to provide full details of any arrangement involving the purchasing of service or services as part of an aggregated purchase with other entities or individuals.

100. In addition to the foregoing, the Commission also harmonized and expanded two key competitive bidding documentation requirements. Applicants of both RHC Programs currently submit with their requests for service weighted evaluation criteria (*e.g.*, a scoring matrix) that demonstrate how

the applicant will choose the most cost-effective bid and a declaration of assistance identifying each paid or unpaid consultant, vendor, and other outside expert who aided in the preparation of their applications. There are, however, no RHC Program-wide rules governing either type of documentation. Therefore, the Commission amended its rules to codify the requirement that both Telecom Program and Healthcare Connect Fund Program applicants submit weighted bid evaluation criteria as before, but also specify on their bid evaluation worksheet/scoring matrix their minimum requirements for each criteria and record on their worksheet/matrix each service provider's proposed service levels for the established criteria. The Commission also required applicants of both programs to specify their disqualification factors, if any, that they will use to remove bids or bidders from further consideration.

101. The Commission further amended its rules to codify the requirement that both Telecom Program applicants and Healthcare Connect Fund Program applicants submit a declaration of assistance identifying each paid or unpaid consultant, vendor, and other outside expert who aided in the preparation of their application. In addition, to better safeguard against the possibility of conflicts of interest, the Commission also required applicants to describe the nature of the relationship they have with any such outside entity identified in their declaration of assistance. While cognizant of the additional time that these new requirements may require of health care providers preparing their requests, the Commission concluded that any increased administrative burden will likely be minimal and offset by the increase in competitive bidding transparency and accountability. The new documentation requirements discussed in the R&O will become effective for funding year 2020.

102. *Extending Healthcare Connect Fund Program's "Fair and Open" Competitive Bidding Process to the Telecom Program.* To improve RHC Program uniformity and transparency, the Commission aligned the "fair and open" competitive bidding standard applied in each program. While most Telecom Program participants already comply with this standard, and the Commission has long stated that an applicant must conduct a fair and open competitive bidding process, there is no rule

codifying this standard in the Telecom Program as there is in the Healthcare Connect Fund Program. The Commission found that this standard should apply to all participants in the RHC Program as it ensures that they are accountable for engaging in improper conduct that undermines the competitive bidding process or otherwise violates the Commission's rules. The Commission therefore amended its rules to codify the requirement that the Telecom Program competitive bidding process be "fair and open."

103. The following actions are necessary to satisfy the "fair and open" competitive bidding standard in each RHC Program: (1) all potential bidders and service providers must have access to the same information and must be treated in the same manner throughout the procurement process; (2) vendors who intend to bid on supported services may not simultaneously help the applicant complete its request for proposal (RFP) or request for services form; and (3) vendors who intend to bid on supported services may not simultaneously help the applicant evaluate submitted bids or select the winning bid. The Commission also required applicants to respond to all service providers that have submitted questions or proposals during the procurement process. The Commission also reminded program participants that they also have an obligation to comply with any applicable state or local procurement laws, in addition to the Commission's competitive bidding requirements.

104. Conversely, as in the past, the Commission will find that it is a violation of the Commission's "fair and open" competitive bidding standard if: (1) a vendor, or any individual that has a financial or ownership interest in such a vendor, submits a bid and also prepares, signs, or submits the applicant's request for services; (2) a vendor, or any individual that has a financial or ownership interest in such a vendor, submits a bid and also participates in the applicant's bid evaluation or vendor selection process in any way; (3) the applicant has a relationship with a vendor that would unfairly influence the outcome of a competition or would furnish the vendor with "inside" information; (4) the applicant's RFP or request for services form does not describe the desired products and services with sufficient

specificity to enable interested parties to submit responsive bids; (5) a vendor representative is listed as the contact person on the applicant's request for services and that vendor also participates in the competitive bidding process; or (6) the applicant's consultant is affiliated with the vendor selected to provide the requested services. Although some of these clarifications of the "fair and open" standard have yet to be applied to the RHC Program, the Commission believes that the RHC Program is equally at risk to the anti-competitive conduct that prompted the Commission to issue the clarifications in other Universal Service Fund contexts. The Commission also emphasized that this is not an exhaustive list of the types of conduct that violate the Commission's "fair and open" competitive bidding standard. Because the Commission cannot anticipate and address every possible action that parties may take in the RHC Program application and competitive bidding process, the Commission expects to continue to use the appeal process as necessary to address alleged competitive bidding violations.

105. *Extending the Healthcare Connect Fund Program Competitive Bidding Exemptions to the Telecom Program.* The Commission aligned the Commission's rules exempting certain applicants from the competitive bidding requirements in the Telecom and Healthcare Connect Fund Programs. Under Healthcare Connect Fund Program rules, there are five exemptions to the competitive bidding process: (1) applications seeking support for $10,000 or less of total undiscounted eligible expenses for a single year; (2) applicants who are purchasing services and/or equipment from master services agreements (MSAs) negotiated by federal, state, Tribal, or local government entities on behalf of such applicants; (3) applicants purchasing services and/or equipment from an MSA that was subject to the Healthcare Connect Fund and Pilot Programs competitive bidding requirements; (4) applicants seeking support under a contract that was deemed "evergreen" by the Administrator; and (5) applicants seeking support under an E-Rate contract that was competitively bid consistent with E-Rate Program rules. Only the "evergreen" contract exemption applies to applicants in the Telecom Program, although that exception is not codified in the rules.

106. In the R&O, the Commission harmonized its rules in both RHC Programs by codifying the following Healthcare Connect Fund Program competitive bidding exemptions in the Telecom Program: (1) applicants who are purchasing services and/or equipment from MSAs negotiated by federal, state, Tribal, or local government entities on behalf of such applicants; (2) applicants purchasing services and/or equipment from an MSA that was subject to the Healthcare Connect Fund and Pilot Programs competitive bidding requirements; (3) applicants seeking support under a contract that was deemed "evergreen" by the Administrator; and (4) applicants seeking support under an E-Rate contract that was competitively bid consistent with E-Rate Program rules. The Commission declined to apply the $10,000 or less exemption it to the Telecom Program because it runs counter to the Commission's efforts to strengthen the competitive bidding process under the Telecom Program. As the Commission has seen in the Healthcare Connect Fund Program, sufficient safeguards are already in place to protect against waste, fraud, and abuse in these situations because the contracts are the result of a competitive bidding process in which the most cost-effective service provider is identified and selected. These exemptions also remove unnecessary and duplicative competitive bidding requirements while still ensuring fiscal responsibility, and better serve health care providers by improving and streamlining the application process. Codifying these exemptions in the Telecom Program will likely yield the same benefits for Telecom Program applicants.

107. *Adopting the E-Rate Program Gift Rule.* The Commission codified gift restrictions for the RHC Program that are similar to the gift rules applicable in the E-Rate Program. Specifically, the Commission adopted restrictions prohibiting an RHC Program applicant and/or its consultant, if applicable, from directly or indirectly soliciting or accepting a gift (*i.e.*, anything of value, including meals, tickets to sporting events, or trips) from a service provider participating in or seeking to participate in the RHC Program. As part of this rule, the Commission also prohibited service providers participating in or seeking to participate in the RHC Program from offering or providing any such gifts,

gratuity, favor, entertainment, loan, or any other thing of value to those personnel of eligible entities participating in the RHC Program. The prohibition on offering or providing gifts includes any on-site product demonstration where the cost of the product, if purchased, licensed, or leased by the eligible entity's personnel for the length of time of the demonstration, would exceed the *de minimis* gift exception discussed in the following.

108. Like the E-Rate Program, the rules adopted by the Commission allows two exceptions for *de minimis* gifts: (1) modest refreshments that are not offered as part of a meal (*e.g.*, coffee and donuts provided at a meeting) and items with little intrinsic value solely for presentation (*e.g.*, certificates and plaques); and (2) items that are worth $20 or less, as long as those items do not exceed $50 per employee from any one source per calendar year. In determining the amount of gifts from any one source, the Commission will consider the aggregate value of all gifts from any employees, officers, representatives, agents, independent contractors, or directors of the service provider in a given calendar year. These restrictions do not discourage companies from making charitable donations to RHC Program applicants, as long as such contributions are not directly or indirectly related to RHC Program procurement activities or decisions. If contributions have no relationship to the procurement of RHC Program-eligible services and are not given by service providers to circumvent any RHC Program rules, such contributions will not violate the prohibition against gift-giving. Similarly, gifts to family members and personal friends, when those gifts are made using personal funds of the donor (without reimbursement from an employer) and are not related to a business transaction or business relationship, will not violate the gift rules.

109. The Commission emphasized that the restriction on gifts is always applicable and is not in effect or triggered only during the time period when competitive bidding is taking place. In the Commission's experience, solicitation, offering, or acceptance of improper gifts may take place outside of the competitive bidding period. Accordingly, the Commission required an RHC Program applicant

and/or its consultant, if applicable, to certify that it has not solicited or accepted a gift or any other thing of value from a service provider participating in or seeking to participate in the RHC Program. The Commission also required service providers to certify that they have not offered or provided a gift or any other thing of value to the applicant (or to the applicant's personnel, including its consultant) for which it will provide services. To assist service providers to more easily identify those entities that are covered by the gift restrictions, the Commission recommended that service providers routinely search the Open Data platform maintained by the Administrator listing the entities participating in the RHC Program, as well as the locations receiving RHC Program support.

110. The gift rules codified by the Commission offer a fair balance between prohibiting gifts that may have undue or improper influence on a procurement decision and acknowledging the realities of professional interactions, which may occasionally involve giving people modest refreshments or a token gift. The rules also are appropriate for ease of administration and provide clarity for applicants and service providers. The Commission also believes that they are a necessary step to eliminate fraud and abuse in the RHC Program. The Commission reminded applicants and service providers that they remain subject to applicable state and local gift restrictions. To the extent a state or local provision is more stringent than the federal requirements, violation of the state or local provision constitutes a violation of the Commission's rules adopted in the R&O. The new rules applicable to gifts will become effective for funding year 2020.

111. *Implementing Rules Governing Consultants.* The RHC Program permits applicants to use a consultant or other third party to file FCC Forms and supporting documentation on their behalf. In the R&O, the Commission harmonized across both programs requirements regarding the use of consultants as well as adopted other specific requirements to ensure the integrity of the competitive bidding process and to prevent incidents of waste, fraud, and abuse. Specifically, the Commission required applicants to submit a declaration of assistance with their request for services identifying each and

every consultant, vendor, or other outside expert, whether paid or unpaid, who aided in the preparation of their applications and, as part of this declaration, to describe the nature of their relationship with the consultant, vendor, or other outside expert providing the assistance. The Commission also required participating service providers (in each RHC Program) to disclose, on the appropriate RHC Program form, the names of any consultants or third parties who helped them identify the applicant's RFP or otherwise helped them to connect with the health care provider participating in the RHC Program. Applicants and service providers must certify, on the appropriate RHC Program form, that the consultants or other third parties they hire do not have an ownership interest, sales commission arrangement, or other financial stake in the vendor chosen to provide the requested services, and that they have otherwise complied with RHC Program rules, including the Commission's rules requiring fair and open competitive bidding. The Commission Emphasized that applicants and service providers are accountable for the actions of their consultants or outside experts should the Commission find that those consultants or experts have engaged in conduct that undermines fair and open competitive bidding. The new rules governing consultants and other third parties will become effective for funding year 2020.

112. To enable the Administrator and the Commission to identify individuals providing consultant services in the RHC Program, the Commission directed the Administrator to establish a consultant registration process that is similar to the process in place for the E-Rate Program. Requiring unique registration numbers for consultants or outside experts is a simple and effective way of identifying those individuals and the firms that employ them. Under this registration process, an individual who has been identified as the applicant's consultant or other outside expert must provide to the Administrator his or her name and contact information, the name and contact information of the consulting firm or company that employs him or her, and a brief description of the role he or she will undertake in assisting the applicant. Once this information is provided, the Administrator will then issue a unique registration number to the consultant or outside expert and that number will be linked to the

applicant's organization. These measures provide transparency for RHC Program participants regarding the roles and limitations of their consultants, while at the same time, facilitate the ability of the Administrator, the Commission, and law enforcement officials to identify and hold accountable those individuals who engage in illegal acts or otherwise damage the integrity of an applicant's competitive bidding process.

113. *Providing Additional Time for Competitive Bidding Process.* The Commission revised the RHC Program procedures, effective funding year 2021, to give applicants additional time to conduct their competitive bidding process prior to the start of the funding year rather than the current six months. This six-month period gives applicants very limited time within which to conduct competitive bidding prior to the opening of the application filing window for a given funding year. For example, for funding years 2018 and 2019, the application filing window opened on February 1, giving applicants, in practice, only one month to conduct a competitive bidding process prior to the start of the application filing window. While January 1 provides six months prior to the start of the funding year for competitive bidding, in practice, applicants need to complete bidding prior to the start of the application filing window, which opens months prior to the start of the funding year.

114. In the R&O, the Commission recognized that this time period is insufficient for applicants to thoroughly conduct competitive bidding and select a service provider prior to submitting an application for RHC Program support. The Commission concluded that applicants merit additional time prior to the opening of the application filing window to submit their request for services along with a request for proposal, if necessary, so they can more thoroughly review bids received and complete contracts with a service provider prior to the application filing window. The Commission thus provided applicants with additional time beyond the current six months to initiate the competitive bidding process prior to the start of the funding year. Specifically, beginning in funding year 2021, applicants can initiate their competitive bidding processes as early as July 1 of the prior year. This will give

applicants more time to complete the bidding process and finalize contracts prior to filing their applications. This timeframe is also consistent with the E-Rate Program in which applicants generally have one year before the start of the funding year. Additionally, it will help to ensure that applicants' requests for services are more detailed and better targeted to meet their telehealth needs.

115. *Establishing an Application Filing Window.* The Commission revised its rules to require the Administrator to open an initial application filing window with an end date no later than 90 days prior to the start of the funding year (*i.e.*, no later than April 1). Similar to the E-Rate Program, where the application filing window closes in advance of the funding year, these revisions will give the Administrator time to begin processing submitted RHC Program applications prior to the start of the funding year and, therefore, expedite the issuance of funding decisions. It will also provide more certainty to applicants by establishing an end date by which applications must be filed and provide sufficient time for the Administrator to publish a gross demand estimate prior to the start of the funding year. The Administrator will continue to treat all eligible health care providers filing within this initial window period as if their applications were simultaneously received. All funding requests submitted outside of a filing window will not be accepted unless and until the Administrator opens another filing window. Prior to announcing the initial opening and closing dates of the application filing window each year, the Administrator shall seek approval of the proposed dates from the Chief of the Bureau. This change will become effective for funding year 2021 to coincide with the Commission's change to the start date of the competitive bidding process for the RHC Program.

116. In the R&O, the Commission recognized the value in establishing a set application filing window for applicants for planning purposes, given the potential for unforeseeable events and variables; the Commission also seeks, however, to ensure that the Administrator is prepared to open the application filing window (*i.e.*, adequate staffing resources, information technology system is fully operational) prior to announcing it for a given funding year. The Commission believes that requiring the

Administrator to establish an initial application filing window end date sufficiently far in advance of the start of the funding year provides applicants with a more predictable timeframe as they prepare their competitive bidding processes and applications. It also provides flexibility to the Administrator to take any steps necessary to prepare for the application filing window. Given that the Commission is providing applicants with a full year to conduct their competitive process and finalize contracts with their service providers prior to the start of the funding year, they should be in a better position to submit their funding requests upon the opening of the application filing window period.

117. The Commission also believes that establishing an initial application filing window that treats all eligible health care providers filing within the window as if their applications were simultaneously received rather than issuing funding requests on a rolling basis, provides more certainty to the application and funding commitment process. Specifically, by establishing a filing window period, the Commission provides a mechanism for the Administrator to more efficiently administer the RHC Program and process requests while providing an incentive for applicants to timely submit their applications for support. The Administrator will immediately begin reviewing applications submitted within the initial application filing window and will not wait until the close of the application filing window to begin its review.

118. If requests submitted during an established application filing window period exceed the RHC Program's cap, per the rules adopted, the Administrator shall prioritize support based on the prioritization categories until all available RHC Program funding is committed. If funding requests submitted during the initial application filing window do not exceed the cap, the Administrator will determine, based on demand and available funding, and after consultation with Commission staff, whether to open additional application filing window periods and the duration of any such application filing window periods. To the extent the Administrator opens an additional application filing window period, it shall continue to provide notice and include either in that notice, or soon thereafter, the

amount of remaining available funding. The Commission believes that these changes to the application filing window period will provide applicants with more certainty regarding the initial application filing window, thus making it easier for applicants to plan accordingly, and will allow the Administrator to start making commitments prior to the start of the funding year.

119. *Expanding the Administrator's Authorization to Extend Service Delivery Deadline.* Health care providers are required to use the services for which support has been committed by the Administrator within the funding year for which the support was sought. Consistent with this requirement, the Administrator has routinely issued funding commitments to RHC Program applicants for recurring and non-recurring eligible services with a funding end date no later than June 30. The Commission has acknowledged that external circumstances beyond a health care provider's control can create situations where implementing non-recurring services by the end of the applicable funding year is impractical. Further, the Commission realizes that many applicants understandably are hesitant to install services or begin construction before receipt of a funding commitment letter, particularly in instances where there is a significant financial obligation required. The Commission also recognizes that implementing non-recurring services, such as service installation, infrastructure and network construction, are significant undertakings, both in time and cost. If the Administrator does not issue funding commitments for a given funding year until the final quarter of that funding year, this then leaves insufficient time for applicants to complete their projects by the end of the applicable funding year. For those applicants where the Administrator has issued a funding commitment letter with a funding end date prior to June 30 to coincide with a contract end date, this further shortens the period of time an applicant that waits until the issuance of a funding commitment letter has to install services or complete a construction project to receive RHC Program support for eligible services. In these instances, applicants are precluded from maximizing the value of their funding commitments to cover the cost of eligible services for a given funding year.

120. Unlike the E-Rate Program, there is no mechanism in the RHC Program to seek an extension of the non-recurring service delivery deadline from the Administrator, except in the limited context of dark fiber. An RHC Program applicant's only recourse, in instances where they are unable to meet the service delivery deadline, is to seek a waiver of the service delivery deadline from the Commission. Until the Commission addresses the waiver request, an applicant is uncertain whether any charges incurred after the end of the non-recurring service delivery deadline will be granted.

121. To mitigate such uncertainty and reduce administrative burdens, in the R&O, the Commission took two actions to simplify the administration and resolution of service delivery deadline issues in the RHC Program. First, the Commission eliminated funding request-specific service delivery deadlines based on individual contract end dates, and established June 30 of the funding year for which the program support was sought as the service delivery deadline for all services in the RHC Program. This creates a single implementation deadline for the RHC Program that is easy for the Administrator to track and allows applicants to pursue options for maximizing their approved funding commitments up to the end of the funding year should circumstances beyond their control prevent delivery by an earlier contract date. Applicants will still be required to submit their service contracts to the Administrator with their funding requests, and the support amount approved must be limited to charges incurred during the contract's term. Stated differently, by establishing a universal June 30 service delivery deadline, the Commission does not making additional funding available to applicants beyond their contract terms. Thus, applicants whose contract term ends prior to June 30 must obtain a contract extension and notify the Administrator of such extension in order to receive funding through the June 30 service delivery deadline.

122. Second, the Commission adopted, with a few modifications, the E-Rate Program's rule authorizing the Administrator to grant a one-year extension of the service delivery deadline for non-recurring services. Specifically, effective funding year 2020, RHC Program applicants meeting the

following criteria will qualify for a one-year extension of the service delivery deadline for non-recurring services: (1) applicants whose funding commitment letters are issued by the Administrator on or after March 1 of the funding year for which discounts are authorized; (2) applicants that receive service provider change authorizations or site and service substitution authorizations from the Administrator on or after March 1 of the funding year for which discounts are authorized; (3) applicants whose service providers are unable to complete implementation for reasons beyond the service provider's control; or (4) applicants whose service providers are unwilling to complete delivery and installation because the applicant's funding request is under review by the Administrator for program compliance. The Administrator shall automatically extend the service delivery deadline in situations where criteria (1) or (2) are met. Applicants, however, must affirmatively request an extension on or before the June 30 deadline for criteria (3) and (4). The Commission directed the Administrator to create a mechanism for health care providers to submit such extension requests. The Commission also directed the Administrator to issue its decisions on service delivery deadline requests within two months.

123. March 1 is the key date for determining whether to extend the deadline based on criteria (1) or (2). If one of the conditions is satisfied before March 1 (of any year), the deadline will not be extended, and the applicant will have until June 30 of that calendar year to complete implementation. If one of the conditions is satisfied on or after March 1, the applicant will have until June 30 of the following calendar year to complete implementation. The Commission found that applicants who satisfy the conditions prior to March 1 have sufficient time before the end of the funding year to install services or complete their construction projects.

124. With regard to criterion (3)—applicants whose service providers are unable to complete implementation for reasons beyond the service provider's control—the Commission recognizes that there may be a wide range of situations in which an applicant, through no fault of its own, is unable to complete installation by June 30. Unable to anticipate every type of circumstance that may arise, the

Commission directed the Administrator to address such situations on a case-by-case basis. Applicants must submit documentation to the Administrator requesting relief on these grounds on or before June 30 of the relevant funding year. That documentation must include, at a minimum, an explanation regarding the circumstances that make it impossible for installation to be completed by June 30 and a certification by the applicant that, to the best of its knowledge, the request is truthful.

125. Finally, with regard to criterion (4)—applicants whose service providers are unwilling to complete delivery and installation because the applicant's funding request is under review by the Administrator for program compliance—applicants must certify to the Administrator that their service provider was unwilling to deliver or install the non-recurring services before the end of the funding year. Applicants must make this certification on or before June 30 of the relevant funding year. The revised implementation date will be calculated based on the date the Administrator issues a funding commitment. For example, if the Administrator delays funding for funding year 2020 while reviewing an applicant's funding request for program compliance, the applicant will need to file a certification with the Administrator by June 30, 2021.

126. The Commission found that this one-year extension for all non-recurring services, including the existing one-year extension available for dark fiber, provides an appropriate timeframe within which to install services or complete construction, and is consistent with the Commission's existing extensions for non-recurring services and special construction under the E-Rate Program in order for the services to be eligible for support. Additionally, implementation of this policy will provide clarity to the Administrator and applicants by establishing a certain deadline for installation of services.

127. *Improving the Invoicing Process. Establishing a Uniform Invoicing Deadline*. To alleviate inefficiencies with respect to the Telecom Program funding disbursement process and harmonize the filing deadlines for the Telecom and Healthcare Connect Fund Programs, the Commission established a uniform invoice filing deadline for the RHC Program beginning with funding year 2020. This rule

adopted by the Commission requires all invoices under the RHC Program to be submitted to the Administrator within four months (120 days) after the later of: (1) the service delivery deadline; or (2) the date of a revised funding commitment letter issued pursuant to an approved post-commitment request made by the applicant or service provider or a successful appeal of a previously denied or reduced funding request. For example, for funding year 2020 funding commitments ending on June 30, 2021, the invoice deadline for submitting the invoice forms by the applicant to the Administrator, after approval by the service provider, is October 31, 2021. If the service delivery deadline is extended until June 30, 2022, then the invoice deadline would be October 31, 2022. Similarly, if the Administrator approves a post-commitment request for funding year 2020 (*e.g.*, a SPIN change request to change service providers or correct a service provider's identification number or a service substitution) and the Administrator issues a revised funding commitment letter dated December 31, 2021, the invoice deadline would be April 30, 2022.

128. The Commission recognized that a deadline of 120 days reduces the current invoice deadline under the Healthcare Connect Fund Program for applicants by 60 days, but believes that 120 days coupled with the one-time 120-day invoice deadline extension adopted, will provide applicants with sufficient time to submit their invoices and seek reimbursement from the Administrator. As the Commission has explained, filing deadlines are necessary for the efficient administration of the RHC Program. The Commission previously found in the E-Rate context that a uniform 120-day invoice deadline provides the right balance between the need for efficient administration of the program and the need to ensure applicants and service providers have sufficient time to finish their own invoicing processes. Establishing a uniform invoicing deadline will also provide certainty to applicants and service providers. Providing certainty on invoicing deadlines will allow the Administrator to de-obligate committed funds immediately after the invoicing deadline has passed, providing increased certainty about how much funding is available to be carried forward in future funding years. This approach will

result in a more efficient and effective administration of the RHC Program's disbursement process as well as providing applicants with faster funding timetables. The Commission emphasized, however, that it is incumbent on the applicant and the service provider in each RHC Program to complete and timely submit their invoices to the Administrator or to timely seek an extension of the invoice deadline.

129. *Establishing a One-Time Invoice Deadline Extension*. The Commission also adopted a rule allowing service providers and billed entities to request and automatically receive a single one-time 120-day extension of the invoice deadline as is done in the E-Rate Program. The invoice deadline extension rule will be effective beginning in funding year 2020. The Commission recognized there may be circumstances beyond some applicants' or service providers' control that could prevent them from meeting the 120-day invoice filing deadline for the RHC Program. For example, an Administrator error, administrative process, or system issue may prevent or delay the timely submission of forms or invoices. In other instances, a pending appeal of a specific funding request may impact the applicant's ability to submit invoices before the invoicing deadline. Therefore, the Commission adopted a rule allowing service providers and billed entities to seek and receive from the Administrator a single one-time invoice extension for any given funding request, provided the extension request is made no later than the original invoice deadline.

130. By adopting such a rule, the Commission eliminates the need for applicants and service providers to identify a reason for the requested extension and the need for the Administrator to determine whether such timely requests meet certain criteria, which will ease the administrative burden of invoice extension requests on the Administrator. Additionally, it will provide applicants additional time to receive the service provider certification and for the service provider to submit the invoice to the Administrator. The Commission directed the Administrator to create a mechanism for service providers and billed entities to submit such extension requests.

131. *Strengthening Service Provider Certifications*. As part of the Commission's efforts to improve the invoicing process, the Commission also strengthened the certifications made by the service provider when submitting invoices under the Telecom and Healthcare Connect Fund Programs. Currently, the invoicing form for the Telecom Program requires the service provider to certify that "the information contained in the invoice is correct and the health care providers and the Billed Account Numbers listed in the document have been credited with the amounts shown under Support Amount to be Paid by [the Administrator]." The Commission took the opportunity in the R&O to strengthen the certifications under the Telecom Program and require the service provider, in addition to the current certification in the R&O, to certify that: (1) it has abided by all program requirements, including all applicable Commission rules and orders; (2) it has received and reviewed the Health Care Provider Support Schedule (HSS), invoice form and accompanying documentation, and that the rates charged for the telecommunications services are accurate and comply with the Commission's rules; (3) the service provider's representative is authorized to submit the invoice on behalf of the service provider; (4) the health care provider paid the appropriate urban rate for the telecommunications services; and (5) it has charged the health care provider for only eligible services prior to submitting the form and accompanying documentation.

132. While the invoice form for the Healthcare Connect Fund Program requires a service provider to certify to the accuracy of the form and attachments, that its representative is authorized to make the certifications, and that it will apply the amount paid by the Administrator to the billing account of the health care provider, it does not include any certifications regarding compliance with the rules. The Commission therefore also strengthened the certifications under the Healthcare Connect Fund Program requiring the service provider, in addition to the current certifications, to certify that it has: (1) abided by all program requirements, including all applicable Commission rules and orders and (2) charged the health care provider for only eligible services prior to submitting the form. The inclusion of

these additional certifications on the invoicing forms does not impose any further burdens on service providers because, as participants in the RHC Program, they are already required to abide by RHC Program rules. These additional certifications simply serve as a reminder to service providers of their responsibilities under the RHC Program and help to further ensure compliance with the Commission's rules and program requirements as part of the ongoing efforts to reduce, waste, fraud, and abuse in the RHC Program. These certifications will become effective for funding year 2020.

133. *Site and Service Substitutions*. The Commission further aligned the RHC Programs by making the site and service substitution criteria under the Healthcare Connect Fund Program applicable to the Telecom Program. In 2012, the Commission adopted site and service substitution procedures for the Healthcare Connect Fund Program. Under these procedures, a consortium leader or health care provider may request a site and service substitution if: (1) the substitution is provided for in the contract, within the change clause, or constitutes a minor modification; (2) the site is an eligible health care provider and the service is an eligible service under the Healthcare Connect Fund Program; (3) the substitution does not violate any contract provision or state, Tribal or local procurement laws; and (4) the requested change is within the scope of the controlling request for services, including any applicable request for proposal used in the competitive bidding process. Additionally, support is restricted to qualifying site and service substitutions that do not increase the total amount of support under the applicable funding commitment.

134. The Commission found that allowing site and service substitutions decreased burdens on program participants and increased administrative efficiencies by allowing applicants to request the Administrator to substitute or modify a site or service without modifying the actual funding commitment letter. Moreover, the Commission found that these procedures recognized the changing broadband needs of health care providers by providing them with the flexibility to substitute alternative services if they satisfied certain criteria. Despite these procedural and administrative benefits, the

Commission never adopted, and the Administrator has never established, similar procedures for the Telecom Program. The Commission's new rules make the site and service substitution criteria under the Healthcare Connect Fund Program applicable to the Telecom Program. The Commission believes that making these criteria applicable to both RHC Programs will decrease burdens on all program participants and increase administrative efficiencies by enabling applicants to request the Administrator to substitute or modify a site or service without modifying their funding commitment letter. The new rule will become effective for the Telecom Program for funding year 2020.

135. The Commission also requires applicants under both the Healthcare Connect Fund and Telecom Programs to file requests for site and service substitutions with the Administrator by no later the applicable service delivery deadline. Applicants and service providers seeking funding under the RHC Program are currently required to submit invoices for the services they are seeking funding for by the invoicing deadline. Applicants often file requests for site and service substitutions on or near the invoicing deadline, which increases administrative burdens on the Administrator and causes delays in the funding disbursement process. The Commission believes that requiring applicants under the RHC Program to submit requests for site and service substitution by no later than the applicable service delivery deadline will ensure that the Administrator has ample time to review such requests prior to the invoicing deadline or the extension thereof. This change will become effective funding year 2020 for all applicants under the RHC Program.

136. Service Provider Identification Number (SPIN) Changes. To further improve the administration of the RHC Program and to establish consistency between the universal service programs, the Commission adopted rules, similar to those used in the E-Rate Program, governing requests for SPIN changes applicable to both the Telecom and the Healthcare Connect Fund Programs. A SPIN is a unique number that the Administrator assigns to an eligible service provider seeking to participate in the universal service support mechanisms. When requesting funding under the RHC

Program, an applicant must use the SPIN to identify its chosen service provider when filing an FCC Form 462 (Healthcare Connect Fund Program) or an FCC Form 466 (Telecom Program). An applicant may change the SPIN on its FCC Form 462 or FCC Form 466 by filing a written request with the Administrator. While the Administrator has general procedures for implementing SPIN changes, there are no established program-wide procedures for the RHC Program.

137. To establish consistency between the universal service programs and provide guidance to RHC program participants, the SPIN change rules adopted by the Commission are modeled after the SPIN change procedures established under the E-Rate Program. As part of the rules, the Commission defined "corrective" SPIN changes as any "amendment to the SPIN associated with a Funding Request Number that does not involve a change to the service provider associated with that Funding Request Number." Similar to the E-Rate Program, an applicant may request a "corrective" SPIN change if the applicant is: (1) correcting data entry errors (*e.g.*, fixing clerical errors such naming the correct service provider in the funding request but providing the incorrect SPIN); (2) updating a service provider's SPIN that has changed due to the merger of companies or the acquisition of one company by another; or (3) effectuating a change that was not imitated by the applicant. The Commission also defined "operational" SPIN changes as "any change to the service provider associated with a specific Funding Request Number." Limiting "operational" SPIN changes to situations where: (1) the applicant has a legitimate reason to change providers (*e.g.*, breach of contract or the service provider is unable to perform); and (2) and the applicant's newly selected service provider received the next highest point value in the original bid evaluation, assuming there were multiple bidders.

138. Additionally, the Commission will require applicants to file requests for either a "corrective" or "operational" SPIN change in a manner prescribed by the Administrator by no later than the service delivery deadline as defined by the rules. Accordingly, the Commission directed the Administrator to implement procedures for requesting either a corrective or operational SPIN change

consistent with the new rules and the R&O. The Commission believes that these rules will provide applicants with clarity on what is considered to be permissible SPIN changes under the RHC Program. Further, the Commission believes that requiring applicants to file their requests by no later than the service delivery date will help alleviate the administrative burdens on the Administrator and reduce the number of requests for waiver of the invoicing deadline filed with the Commission. These rules will become effective for funding year 2020.

139. *Consolidating and Simplifying RHC Program Rules.* As part of the efforts to streamline the RHC Program, the Commission consolidated duplicative rules that exist between the Telecom and Healthcare Connect Fund Programs. For example, merging § 54.619 (Telecom Program) and § 54.648 (Healthcare Connect Fund Program) of the current rules into a single program-wide rule governing audits and recordkeeping. The Commission also created a single program-wide competitive bidding rule that combines the existing rules under the Telecom and Healthcare Connect Fund Programs, as amended and harmonized. Further, the Commission included some additional definitions in other sections of the current rules into the "Definitions" section. The Commission included those merged rules, and the new rules adopted by the R&O that apply, for the most part, to both the Telecom and Healthcare Connect Fund Programs, under the "General Provisions" section of the RHC Program rules. All rules specifically applicable to either the Telecom or Healthcare Connect Fund Program will remain under separate sections within the rules. The Commission, to the extent possible, in consolidating the rules, retained the language of the current rules.

140. The Commission also reorganized and renumbered the RHC Program rules to reflect consolidation efforts. Where necessary, the Commission also simplified the language in the rules to use plain language so they are more easily understood by RHC Program stakeholders. Once these rules are published in the Federal Register, RHC Program participants are encouraged to familiarize themselves with the rules and the new format of the RHC Program rules. The Commission believes that these

changes to the rules will reduce the administrative burdens on RHC Program stakeholders by making the rules easier to read and providing clarity on which rule requirements are program specific and which are program-wide. It will also help ensure that future amendments to program rules that apply to all RHC Program participants are implemented consistently in the Code of Federal Regulations.

141. Given the complexities associated with reforming the RHC Program and modifying the rules, the Commission directed the Bureau to make any further ministerial rule revisions as necessary to ensure the changes to the RHC Program adopted in the R&O are properly codified. This includes correcting any technical or textual conflicts between new and/or revised rules and existing rules, as well as addressing any technical or textual omissions or oversights. If any such ministerial rule changes are warranted, the Bureau shall be responsible for such changes.

142. *Streamlining and Improving the RHC Program Forms and Data Collection.* As part of the Commission's efforts to simplify and improve the efficiency of the application process for RHC Program participants, the Commission directed the Administrator to streamline the data collection requirements and consolidate the RHC Program online forms in order to reduce the administrative burden on RHC Program participants. The record strongly supports making procedural improvements to the process that will reduce the time it takes the Administrator to issue funding commitment decisions. Specifically, to the extent possible, the Commission directed the Bureau to work with the Administrator to streamline the data collection requirements and consolidate the program forms. The Commission also directed the Bureau to work with the Administrator to align the data collections between the Healthcare Connect Fund and Telecom Programs, to the extent possible, for ease of use and consistency between the Programs.

143. The Commission recognizes, that in some instances, it may be necessary to include some additional data elements to certain online forms to harmonize the RHC Program and ensure compliance with the Commission's rules and procedures (*e.g.*, requiring RHC Program applicants to list

the requested services for which they seek bids, including service provider certifications on the invoice forms to ensure that the rates charged for services are accurate and that services are eligible). The Commission also realizes that some changes to the data collection requirements may be dependent upon the changes made to the RHC information technology systems. To the extent certain changes can be made to the data collection requirements within the existing RHC information technology systems, and do not require approval pursuant to the Paperwork Reduction Act, the Administrator will implement such changes so that they will become effective for funding year 2020. All other changes to the data collection requirements shall become effective no later than funding year 2021. Making this process easier for RHC Program applicants will reduce the administrative cost for health care providers by reducing the need for hiring skilled professionals to navigate the process and reducing the number of hours spent on completing the forms.

144. Additionally, as part of the improving the application process, the Administrator shall provide RHC Program participants with direction on the proper use of all the forms by posting a guide for each form which includes screenshots and instructions for completing and submitting each form. This will help those applicants who are new to the RHC Program or only occasionally participate in the program with guidance on how to complete the forms and the ability view screenshots of various sections of the form in order to better understand in advance how each section relates to other sections within a form. Because the RHC Program includes both large and small stakeholders, the Administrator should be particularly careful to draft the form instructions, and all other correspondence from the Administrator to RHC Program participants, in a simple, direct, user-friendly, and helpful manner. The Commission believes that these improvements to the Administrator's application process and communications will reduce applicant confusion, ensure parties have the information necessary to comply with the rules and the Administrator's procedures, and expedite the application process. These requirements will become effective for funding year 2020.

145. *Ensuring Effective Procedures for Program Administration.* The Administrator enforces and implements the Commission's rules and performs its functions as the Administrator of the RHC Program, through various administrative procedures. In the E-Rate Program, the Administrator submits its administrative procedures for application review to the Bureau for approval on an annual basis, and submits its administrative procedures for other functions at the Bureau's request. This process enables the Bureau to assess whether the Administrator's procedures sufficiently address the requirements of the rules, and to better understand the demands that are being made of program participants to demonstrate compliance with the rules. Given the increasing demand for limited RHC Program funds, it is imperative that the Administrator carefully review funding applications to ensure that support is distributed in accordance with the rules, including the new measures adopted in the R&O. It is also critically important that the Administrator's post-commitment processes, including invoicing, appeals, and recovery actions, are implemented efficiently and in accord with the precedent. At the same time, the Commission is committed to making participation in the RHC Program as straight-forward and predictable as possible. Health care providers and service providers should be required to demonstrate compliance with RHC Program rules to receive funding and should also understand the questions being asked, why they are being asked those questions, and what data and documents are required to answer those questions. There should also be a clear process for each potential step of a funding request's life cycle – from the filing of an application through disbursements or review of a decision by the Administrator – so that RHC Program participants can understand the status of their requests and advocate for them as necessary.

146. To effectuate these ends and enable the Commission to perform its oversight role, the Commission directed the Administrator to document all of its administrative procedures for the RHC Program, including procedures for measures adopted by the R&O, and submit them to the Commission staff for review and approval. Specifically, the Commission directed the Administrator to submit to the

Bureau within 90 days from **[INSERT DATE OF PUBLICATION IN THE FEDERAL REGISTER]**, and annually thereafter, comprehensive, consolidated, written procedures for: (1) application review; (2) post-commitment reviews (*e.g.*, SPIN changes); (3) recovery actions; (4) invoicing; (5) appeals; and (6) any other procedures as further directed by the Bureau. The Bureau will review the procedures to determine whether further action is needed and whether such procedures should be adopted. The Commission believes formalizing the annual review and approval process for RHC Program procedures will promote greater transparency, efficiency, and timeliness regarding review of RHC Program forms and appeals and will enable quicker decisions for RHC Program participants. The Commission directed the Bureau to oversee the format for the submission of these procedures and the timeline going forward for submitting the annual RHC Program procedures to the Bureau for review and approval.

147. *Outreach.* The Commission recognizes that program participants will have questions about how the reforms adopted by the R&O will be implemented and how they can best prepare for the substantive and procedural changes. Although the Commission concluded that the effective dates established for the new rules provide sufficient time for health care and service providers to make any necessary adjustments, particularly given that the new rules reduce and streamline their procedural obligations, the Commission understands that they need clear information to successfully navigate the reformed RHC Program. Accordingly, the Commission directed the Administrator to prepare a series of outreach materials that set forth step-by-step requirements for health care and service providers under the new program rules. The outreach materials should include, at a minimum: (1) filing guides setting forth the requirements of each form or online submission that health care and service providers are required to submit to the Administrator; (2) webinars separately addressing what health care and service providers must do to successfully participate in the Telecom Program and the Healthcare Connect Fund Program, from eligibility determinations through funding decisions and all post-commitment activities; and (3) updates to the Administrator's website providing the aforementioned

information and materials. The Commission further directed the Administrator to collect the questions that it receives about the implementation of the new rules, identify the most commonly asked questions, and prepare answers to those questions that can be posted on its website in a Questions and Answers section. The Commission believes that providing clear and easily accessible information to program participants about the implementation of the new rules will ease their concerns about transitioning to them and allow them to take full advantage of the more predictable, transparent, and streamlined processes.

148. *Promoting Data Quality and Transparency.* As part of the Commission's efforts to improve transparency into the RHC Program, the Commission directed the Administrator to continue to timely publish through electronic means all non-confidential RHC data in open, standardized, electronic formats, consistent with the Open, Public, Electronic and Necessary (OPEN) Government Data Act. In doing so, the Commission recognized the efforts already made by the Administrator to publicize RHC Program data taken from the RHC FCC Forms in an open, electronic format. In July 2019, the Administrator released initial RHC Program data on its website, including information related to commitments and disbursements. The Commission directed the Administrator to provide a robust dataset that includes information on the type of services being requested and the rates charged by service providers for services provided to health care providers similar to the type of information provided for the E-Rate Program as part of the Administrator's Open Data. The Administrator shall continue to provide the public with the ability to easily view and download non-confidential RHC Program data, for both individual datasets and aggregate data. The Administrator must also design open and accessible data solutions in a modular format to allow extensibility and agile development, such as providing for the use of application programming interfaces (APIs) where appropriate and releasing the code, as open source code, where feasible. The Administrator's solutions must also be

accessible to people with disabilities, as is required for federal agency information technology. Additionally, the solutions must meet the federal information security and privacy requirements.

149. The record supports the Administrator releasing RHC Program data in as open a manner as possible so that health care providers that receive support from the RHC Program and their associated service providers can view funding request and pricing information, track the status of their RHC applications and requests for discounts, and so that they, and the public at large, can benefit from greater program transparency and public accountability. Commenters also assert that making RHC Program funding requests publicly and readily available will promote increased competition in the RHC Program and help to reduce waste, fraud, and abuse in the program. Further, making non-confidential RHC data open and accessible will allow members of the public to develop new and innovative methods to analyze RHC Program data, which will benefit all stakeholders, including the Commission, as the Commission continued to improve the RHC Program. Releasing RHC Program data in this manner should also enable greater integration with other datasets such as those maintained by the Health Resources & Services Administration (HRSA)'s Federal Office of Rural Health Policy. This integration will create opportunities for new and innovative analyses about connectivity to the nation's health care facilities to support medical care to rural communities.

150. *Implementation Schedule.* The RHC Program reforms will be effective **[INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]** unless specifically identified or if a rule contains an "information collection" subject to approval under the Paperwork Reduction Act. Because there are several interlocking changes to the rules, the Commission summarized when certain rules will take effect to ease the burden on program applicants.

151. In funding year 2020, rules for prioritizing funding if demand exceeds the available funding, rules governing majority-rural requirement for Healthcare Connect Fund Program, consortia certification rules, competitive bidding rules, invoicing rules, site and service substitutions and SPIN

change rules, service delivery deadline and extension rules, gift rules, and rules governing use of consultants and other third parties will all take effect. In funding year 2021, the rules for determining urban and rural rates in the Telecom Program, the rule providing additional time to complete the competitive bidding process, and the application filing window rule will take effect.

III. PROCEDURAL MATTERS

A. Paperwork Reduction Act Analysis

152. The R&O contain new and modified information collection requirements subject to the Paperwork Reduction Act of 1995 (PRA), Public Law No. 104-13. It will be submitted to OMB for review under section 3507(d) of the PRA. OMB, the general public, and other Federal agencies will be invited to comment on the new and modified information collection requirements contained in the proceeding. In addition, the Commission notes that pursuant to the Small Business Paperwork Relief Act of 2002, it previously sought specific comments on how to "further reduce the information collection burden for small business concerns with fewer than 25 employees." The Commission has described impacts that might affect small businesses, which includes most businesses with fewer than 25 employees, in the Final Regulatory Flexibility Analysis (FRFA).

B. Congressional Review Act

153. The Commission will send a copy of the R&O to Congress and the Government Accountability Office pursuant to the Congressional Review Act, *see* 5 U.S.C. 801(a)(1)(A). In addition, the Commission will send a copy of the R&O, including the FRFA, to the Chief Counsel for Advocacy of the Small Business Administration pursuant to the Small Business Regulatory Enforcement Fairness Act of 1996.

C. Final Regulatory Flexibility Analysis

154. As required by the Regulatory Flexibility Act of 1980 (RFA), as amended, the Commission included an Initial Regulatory Flexibility Analysis (IRFA) of the possible significant economic impact on a

substantial number of small entities by the policies and rules proposed in the *2017 Promoting Telehealth NPRM & Order.* The Commission sought written public comment on the proposals in the *2017 Promoting Telehealth NPRM & Order*, including comment on the IRFA. The Commission did not receive any relevant comments in response to this IRFA. This Final Regulatory Flexibility Analysis (FRFA) conforms to the RFA.

155. *Need for, and Objectives of, the Report and Order.* Section 254(h)(1)(A) of the Telecommunications Act of 1996 (1996 Act) mandates that telecommunications carriers provide telecommunications services for health care purposes to eligible rural public or non-profit health care providers at rates that are "reasonably comparable" to rates in urban areas. In addition, section 254(h)(2)(A) of the 1996 Act directs the Commission to establish competitively neutral rules to enhance, to the extent technically feasible and economically reasonable, access to "advanced telecommunications and information services" for public and non-profit health care providers. Based on this legislative mandate, the Commission established the two components of the Rural Health Care (RHC) Program—the Telecommunications (Telecom) Program and the Healthcare Connect Fund Program. The Telecom Program subsidizes the difference between urban and rural rates for telecommunications services. Eligible rural health care providers can obtain rates on telecommunications services for their rural health care facilities that are reasonably comparable to rates charged for similar services in corresponding urban areas. The Telecom Program has not undergone any significant change since its creation more than two decades ago. The Healthcare Connect Fund Program, created in 2012, provides a flat 65% discount on an array of advanced telecommunications and information services. These services include Internet access, dark fiber, business data, traditional Digital Subscriber Line (DSL), and private carriage services. With the Healthcare Connect Fund Program, the Commission intended to promote the use of broadband services and facilitate the formation of health care provider consortia.

156. Demand for RHC Program funding has rapidly increased over the past few years. As the demand for robust broadband has increased throughout the country, the RHC Program has witnessed a dramatic increase in health care provider participation. This recent increase in RHC Program demand necessitated a re-evaluation of the RHC Program rules and procedures to promote the efficient allocation of limited funds and provide predictability and transparency for the RHC Program. To this end, in December 2017, the Commission released the *2017 Promoting Telehealth NPRM & Order* seeking comments on various ways to improve the RHC Program. Specifically, the Commission sought comment on whether and how to reform the calculation of urban and rural rates used to determine the amount of support available to health care providers under the Telecom Program. The Commission also sought comment on whether and how to prioritize RHC Program funding when demand exceeds the cap to ensure limited support is better targeted to rural and Tribal health care providers. Additionally, the Commission sought comment on the rules concerning the appropriate percentage of rural versus non-rural health care providers in Healthcare Connect Fund Program consortia; various actions to prevent waste, fraud, and abuse in the RHC Program; and how to better align procedures between the Telecom and Healthcare Connect Fund Programs.

157. In the R&O, the Commission implemented a number of the proposals in the *2017 Promoting Telehealth NPRM & Order* to improve the RHC Program. First, the Commission reformed the Telecom Program to more efficiently distribute RHC Program funding and minimize the potential for waste, fraud, and abuse in the program in order to better maximize RHC Program funding. Second, the Commission took several actions to target and prioritize funding to those rural areas in the most need of health care services and ensure that eligible rural health care providers continue to benefit from RHC Program funding. Third, the Commission implemented a variety of measures directed at strengthening the competitive bidding requirements under the RHC Program to ensure that program participants comply with the RHC Program rules and procedures, and improve uniformity and transparency across

the RHC Program. Fourth, the Commission adopted a series of program-wide rules and procedures, applying both to the Telecom and Healthcare Connect Fund Programs, intended to simplify the application process for program participants and provide more clarity regarding the RHC Program procedures. Lastly, the Commission directed the Administrator, the administrator of the universal service programs, to take a variety of actions to simplify the RHC Program's applications process, increase transparency in the RHC Program, and ensure that all applicants receive complete and timely information to help inform their decisions regarding RHC eligible services and purchases. The Commission believes that these changes, taken together, will increase the ability of health care providers to better utilize telecommunications and broadband services to meet the health care needs in their communities, and will ensure that RHC Program dollars are serving their intended purpose.

158. Pursuant to the Small Business Jobs Act of 2010, which amended the RFA, the Commission is required to respond to any comments filed by the Chief Counsel of the Small Business Administration (SBA), and to provide a detailed statement of any change made to the proposed rule(s) as a result of those comments. The Chief Counsel did not file any comments in response to the proposed rule(s) in this proceeding.

159. The RFA directs agencies to provide a description of and, where feasible, an estimate of the number of small entities that may be affected by the proposed rules, if adopted. The RFA generally defines the term "small entity" as having the same meaning as the terms "small business," "small organization," and "small governmental jurisdiction." In addition, the term "small business" has the same meaning as the term "small business concern" under the Small Business Act. A small business concern is one that: (1) is independently owned and operated; (2) is not dominant in its field of operation; and (3) satisfies any additional criteria established by the SBA.

160. Small entities potentially affected by the reforms adopted in the R&O include eligible non-profit and public health care providers and the eligible service providers offering them services,

including telecommunications service providers, Internet Service Providers (ISPs), and service providers of the services and equipment used for dedicated broadband networks.

161. Several of the rule changes will result in additional recordkeeping and compliance requirements for small entities. For all of those rule changes, the Commission has determined that the benefits of an RHC Program that is more aligned with its intended mission, administratively streamlined, and stronger in its deterrence of waste, fraud, and abuse outweigh the burden of the increased recordkeeping and compliance requirements. Other rule changes decrease recordkeeping requirements for small entities and make the RHC Program administratively less burdensome.

162. All of the rules implemented by the Commission impose minimal burden on small entities by requiring them to become familiar with the new rules to comply with them. For many new rules such as –determining the urban and rural rates, prioritizing funding based on rurality tiers and Medically Underserved Area/Population (MUA/P) designations, expanding the timeframe to conduct a competitive bidding process, establishing an application filing window, implementing a "fair and open" competitive bidding standard, establishing competitive bidding exemptions and gift rules – the burden of becoming familiar with the new rules, including the new format, in order to comply with them is the only burden the news rules impose.

163. *Expanding USAC's Authorization to Extend Service Delivery Deadline.* The Commission adopted a service delivery deadline of June 30 and four criteria for extending this deadline for non-recurring services for qualified applicants. While the Administrator will automatically extend the service delivery deadline in situations where criteria (1) and (2) are met, applicants must affirmatively request an extension and provide documentation to the Administrator for criteria (3) and (4). For those applicants seeking an extension under criteria (3) or (4), this will minimally increase their recordkeeping requirements. The benefit to rural health care providers in receiving additional time to implement eligible services outweighs this burden.

164. *Extending the Invoice Deadline.* The Commission adopted a uniform invoice filing deadline for the RHC Program. Service providers and billed entities may request and automatically receive an extension of this deadline. For those service providers and billed entities seeking an extension, this will minimally increase their recordkeeping requirements. The benefit to rural health care providers in receiving additional time to submit their invoices to receive universal service support outweighs this burden.

165. *Strengthening Service Provider Invoice Certifications*. Requiring service providers to make additional certifications on the Telecom and Healthcare Connect Fund Program invoice forms increases their compliance requirements. However, the inclusion of these additional certifications does not impose any further burdens on service providers because, as participants in the RHC Program, they are already required to abide by RHC Program rules. These additional certifications simply serve as reminder to service providers of their current responsibilities under the RHC Program and help to further ensure compliance with the Commission's rules and program requirements as part of the ongoing efforts to reduce, waste, fraud, and abuse in the RHC Program.

166. *Site and Service Substitutions*. The Commission aligned the RHC Programs and made the site and service substitution criteria under the Healthcare Connect Fund Program applicable to the Telecom Program. Those rural health care providers under the Telecom Program seeking to make such substitutions must submit requests to the Administrator with supporting documentation. While this rule will increase rural health care providers' recordkeeping requirements, the benefit to health care providers of having a mechanism to request substitutions or modifications to a site or service without modifying their funding commitment letter outweighs this burden.

167. *Service Provider Identification Number (SPIN) Changes*. The Commission adopted a rule permitting rural health care providers to make service provider changes under certain conditions. Although the rule will increase rural health care providers' recordkeeping requirements, the benefit to

rural health care providers of having a mechanism for requesting such changes and clarity on what is considered to be permissible SPIN changes under the RHC Program outweighs this burden.

168. *Requiring Applicants to Seek Bids for Particular Services*. Requiring RHC Program applicants to list the requested services for which they seek bids (*e.g.*, Internet access, bandwidth), and to provide sufficient information to enable bidders to reasonably determine the needs of the applicant and provide responsive bids, will increase applicants' recordkeeping requirements. Ensuring a more equitable distribution of limited RHC Program funding justifies this burden.

169. *Cost-Effective Documentation*. In the R&O, the Commission required applicants to submit documentation to support their certifications that they have selected the most cost-effective option increases recordkeeping requirements, but found that this is necessary to help protect against wasteful spending and ensure that RHC Program funds can be distributed as widely and equitably as possible.

170. *Competitive Bidding Certifications and Documentation*. The Commission took a variety of measures to harmonize the competitive bidding rules between the Telecom and Healthcare Connect Fund Programs, including harmonizing the certifications that applicants must make when requesting service, harmonizing and expanding two key competitive bidding documentation requirements, and codifying the requirement that both Telecom Program applicants and Healthcare Connect Fund Program applicants submit a declaration of assistance identifying each consultant or outside expert who aided in the preparation of their application in addition to describing the nature of the relationship. While these rules increase compliance and recordkeeping requirements, the increased burden is outweighed by the increase in competitive bidding transparency and accountability within the RHC Program.

171. *Certifications Governing Consultants*. The Commission adopted rules requiring both rural health care providers and service providers to certify that that they have not solicited or accepted a gift or any other thing of value from those seeking to participate or participating in the RHC Program.

While the rules increase compliance requirements, the burden is outweighed by the interest in ensuring that the competitive bidding process is not unduly or improperly influenced by the receipt of gifts.

172. Cost-Based Rates. The Commission eliminated the cost-based mechanism for service providers to establish a rural rate, which will decrease recordkeeping requirements for those service providers that use the mechanism.

173. *Limitation of Support for Satellite Services.* The Commission eliminated § 54.609(d) of the rules which allows rural health care providers to receive discounts for satellite service even where wireline services are available, but caps the discount at the amount providers would have received if they purchased functionally similar wireline alternatives. Elimination of the rules will decrease recordkeeping requirements for rural health care providers.

174. *Eliminating Distance-Based Support*. The Commission eliminated distance-based support which allows rural health care providers to obtain support for charges based on distance. Elimination of the rule will decrease recordkeeping requirements for rural health care providers.

175. Streamlining and Improving the RHC Program Forms and Data Collection. Streamlining the data collection requirements and consolidating the Telecom and Healthcare Connect Fund Programs' online forms should reduce recordkeeping requirements for RHC Program participants.

176. *Data Quality and Transparency.* Requiring the Administrator to release RHC Program data in as open a manner as possible will benefit rural health care providers and service providers by enabling them to view funding and pricing information and track the status of their applications, thereby promoting competition within the RHC Program and increasing access to pertinent information.

177. *FCC Form Directions.* Providing direction on the use of the FCC Forms, should make it easier for small entities, particularly those who are new to the RHC Program or only occasionally participate in the program, to complete the forms by reducing applicant confusion and ensuring that

entities have the information necessary to comply with the Commission's rules and the Administrator's procedures, and expedite the application process.

178. *Competitive Bidding Exemptions.* The Commission adopted a rule aligning the RHC Program rules exempting certain applicants from the competitive bidding requirements in the Telecom and Healthcare Connect Fund Programs. The rule will decrease rural health care providers' recordkeeping requirements under the Telecom Program because those applicants qualifying for a competitive bidding exemption will not be required to initiate a bidding process by preparing and posting a request for services.

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

180. This rulemaking could impose additional burdens on small entities. The Commission considered alternatives to the rulemaking changes that increase projected reporting, recordkeeping and other compliance requirements for small entities. Specifically, in determining how best to establish urban and rural rates under the Telecom Program, the Commission concluded that the Administrator is the best entity to make publicly available a standardized set of urban and rural rates for use with all Telecom Program applications. Although the Commission could obtain this information from rural health care providers or service providers, the Administrator is in the best position as a single expert entity to establish a publicly accessible urban and rural rate database and will greatly lessen the administrative burden on rural health care providers and their service providers.

IV. ORDERING CLAUSES

181. Accordingly, IT IS ORDERED, pursuant to the authority contained in sections 1-4, 201-205, 214, 254, 303(r), and 403 of the Communications Act of 1934, as amended, 151 through 154, 201 through 205, 214, 254, 303(r), and 403, that the R&O is ADOPTED, effective **[INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]**, except that modifications to Paperwork Reduction Act burdens shall become effective upon approval by OMB and any new rules that contain information collection requirements shall become effective immediately upon announcement in the Federal Register of OMB approval.

182. IT IS FURTHER ORDERED that Part 54 of the Commission's rules, 47 CFR Part 54 IS AMENDED as set forth in the Final Rules, and such rule amendments shall be effective **[INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]**, except those rules and requirements which contain new or modified information collection requirements that require approval by the Office of Management and Budget under the Paperwork Reduction Act. The new rules that contain information collections subject to PRA review SHALL BECOME EFFECTIVE immediately upon announcement in the Federal Register of OMB approval.

List of Subjects

47 CFR Part 54

Communications common carriers, Health facilities, Infants and children, Internet, Libraries, Reporting and recordkeeping requirements, Schools, Telecommunications, Telephone.

FEDERAL COMMUNICATIONS COMMISSION

Katura Jackson,

Federal Register Liaison Officer.

FINAL RULES

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

PART 54 – UNIVERSAL SERVICE

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

Authority: 47 U.S.C. §§ 151, 154(i), 155, 201, 205, 214, 219, 220, 254, 303(r), 403, and 1302 unless otherwise noted.

2. Revise Subpart G to read as follows:

Subpart G – Defined Terms and Eligibility

Sec.

54.600 Terms and definitions.

54.601 Health care provider eligibility.

54.602 Health care support mechanism.

TELECOMMUNICATIONS PROGRAM

54.603 Consortia, telecommunications services, and existing contracts.

54.604 Determining the urban rate.

54.605 Determining the rural rate.

54.606 Calculating support.

HEALTHCARE CONNECT FUND PROGRAM

54.607 Eligible recipients.

54.608 Eligible service providers.

54.609 Designation of consortium leader.

54.610 Letters of agency (LOA).

54.611 Health care provider contribution.

54.612 Eligible services.

54.613 Eligible equipment.

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

54.615 Off-site data centers and off-site administrative offices.

54.616 Upfront payments.

54.617 Ineligible expenses.

54.618 Data collection and reporting.

GENERAL PROVISIONS

54.619 Cap.

54.620 Annual filing requirements and commitments.

54.621 Filing window for requests and prioritization of support.

54.622 Competitive bidding requirements and exemptions.

54.623 Funding requests.

54.624 Site and service substitutions.

54.625 Service Provider Identification Number (SPIN) changes.

54.626 Service delivery deadline and extension requests.

54.627 Invoicing process and certifications.

54.628 Duplicate support.

54.629 Prohibition on resale.

54.630 Election to offset support against annual universal service fund contribution.

54.631 Audits and record keeping.

54.632 Signature requirements for certifications.

54.633 Validity of electronic signatures and records.

§54.600 Terms and definitions.

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

(a) *Funding year*. A "funding year" for purposes of the funding cap shall be the period between July 1 of the current calendar year through June 30 of the next calendar year.

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

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

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

(3) Local health department or agency;

(4) Community mental health center;

(5) Not-for-profit hospital;

(6) Rural health clinic;

(7) Skilled nursing facility (as defined in section 395i–3(a) of Title 42); or a

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

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

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

(e) *Rural area*. A "rural area" is an area that is entirely outside of a Core Based Statistical Area; is within a Core Based Statistical Area that does not have any Urban Area with a population of 25,000 or greater; or is in a Core Based Statistical Area that contains an Urban Area with a

population of 25,000 or greater, but is within a specific census tract that itself does not contain any part of a Place or Urban Area with a population of greater than 25,000. For purposes of this rule, "Core Based Statistical Area," "Urban Area," and "Place" are as identified by the Census Bureau.

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

(g) *Urbanized area.* An "urbanized area" is an area with 50,000 or more people as designated by the Census Bureau based on the most recent decennial Census.

§ 54.601 Health care provider eligibility.

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

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

(b) *Determination of health care provider eligibility for the Healthcare Connect Fund Program*. Health care providers in the Healthcare Connect Fund Program may certify to the eligibility of particular sites at any time prior to, or concurrently with, filing a request for services to initiate competitive bidding for the site. Applicants who utilize a competitive bidding exemption must provide eligibility information for the site to the Administrator prior to, or concurrently with, filing a request for funding for the site. Health care providers must also notify the Administrator

within 30 days of a change in the health care provider's name, site location, contact information, or eligible entity type.

§ 54.602 Health care support mechanism.

(a) *Telecommunications Program*. Eligible rural health care providers may request support for the difference, if any, between the urban and rural rates for telecommunications services, subject to the provisions and limitations set forth in §§54.600 through 54.602 and 54.603 through §54.606. This support is referred to as the "Telecommunications Program."

(b) *Healthcare Connect Fund Program*. Eligible health care providers may request support for eligible services, equipment, and infrastructure, subject to the provisions and limitations set forth in §§54.600 through 54.602 and 54.607 through 54.618. This support is referred to as the "Healthcare Connect Fund Program."

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

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

TELECOMMUNICATIONS PROGRAM

§ 54.603 Consortia, telecommunications services, and existing contracts.

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

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

(b) *Telecommunications services*. Any telecommunications service that is the subject of a properly completed bona fide request by a rural health care provider shall be eligible for universal service support. Upon submitting a bona fide request to a telecommunications carrier, each eligible rural health care provider is entitled to receive the most cost-effective, commercially-available telecommunications service, and a telecommunications service carrier that is eligible for support under the Telecommunications Program shall provide such service at the urban rate, as defined in § 54.604.

(c) *Existing contracts.* A signed contract for services eligible for Telecommunications Program support pursuant to this subpart between an eligible health care provider, as defined under

§54.600, and a service provider shall be exempt from the competitive bid requirements as set forth in §54.622(i).

§ 54.604 Determining the urban rate.

(a) *Urban rate*. An applicant shall use the applicable urban rate currently available in the Administrator's database when requesting funding. The "urban rate" shall be the median of all available rates identified by the Administrator for functionally similar services in all urbanized areas of the state where the health care provider is located to the extent that urbanized area falls within the state.

(b) *Database.* The Administrator shall create and maintain on its website a database that lists, by state, the eligible Telecommunications Program services and the related urban rate.

§ 54.605 Determining the rural rate.

(a) *Rural rate*. An applicant shall use the lower of the applicable "rural rate" currently available in the Administrator's database or the rural rate included in the service agreement that the health care provider enters into with the service provider when requesting funding.

(1) For purposes of paragraph (a) of this section, The rural rate will be determined using the following tiers in which a health care provider is located:

(i) *Extremely Rural.* Areas entirely outside of a Core Based Statistical Area.

(ii) *Rural.* Areas within a Core Based Statistical Area that does not have an Urban Area with a population of 25,000 or greater.

(iii) *Less rural.* Areas in a Core Based Statistical Area that contains an Urban Area with a population of 25,000 or greater, but are within a specific census tract that itself does not contain any part of a Place or Urban Area with a population of greater than 25,000.

(iv) *Frontier.* For health care providers located in Alaska only, areas outside of a Core Based Statistical Area that are inaccessible by road as determined by the Alaska Department of Commerce, Community, and Economic Development, Division of Community and Regional Affairs. The "rural rate" shall be the median of all available rates for the same or functionally similar service offered within the rural tier, applicable to the health care provider's location within the state. The Administrator shall not include any rates reduced by universal service support mechanisms. The "rural rate" shall be used as described in this subpart to determine the credit or reimbursement due to a telecommunications carrier that provides eligible telecommunications services to eligible health care providers.

(b) *Database*. The Administrator shall create and maintain on its website a database that lists, by state, the eligible Telecommunications Program services and the related rural rate for each such service and for each rural tier.

(c) *Request for waiver*. A petition for a waiver of the "rural rate," as described in paragraph (a) in this section, may be granted if the service provider demonstrates that application of the rural rate published by the Administrator would result in a projected rate of return on the net investment in the assets used to provide the rural health care service that is less than the Commission-prescribed rate of return for incumbent rate of return local exchange carriers (LECs). All waiver requests must articulate specific facts that demonstrate that "good cause" exists to grant the requested waiver and that granting the requested waiver would be in the public interest. To satisfy this standard, the waiver request must be substantiated through

documentary evidence as stated in the following. A waiver request will not be entertained if it does not also set forth a rural rate that the service provider demonstrates will permit it to obtain no more than the current Commission prescribed rate of return authorized for incumbent rate of return local exchange carriers.

(1) For purposes of paragraph (c), petitions seeking a waiver must include all financial data and other information to verify the service provider's assertions, including, at a minimum, the following information:

(i) Company-wide and rural health care service gross investment, accumulated depreciation, deferred state and federal income taxes, and net investment; capital costs by category expressed as annual figures (e.g., depreciation expense, state and federal income tax expense, return on net investment); operating expenses by category (e.g., maintenance expense, administrative and other overhead expenses, and tax expense other than income tax expense); the applicable state and federal income tax rates; fixed charges (*e.g.*, interest expense); and any income tax adjustments;

(ii) An explanation and a set of detailed spreadsheets showing the direct assignment of costs to the rural health care service and how company-wide common costs are allocated among the company's services, including the rural health care service, and the result of these direct assignments and allocations as necessary to develop a rate for the rural health care service;

(iii) The company-wide and rural health care service costs for the most recent calendar year for which full-time actual, historical cost data are available;

(iv) Projections of the company-wide and rural health care service costs for the funding year in question and an explanation of those projections;

(v) Actual monthly demand data for the rural health care service for the most recent three calendar years (if applicable);

(vi) Projections of the monthly demand for the rural health care service for the funding year in question, and the data and details on the methodology used to make those projections;

(vii) The annual revenue requirement (capital costs and operating expenses expressed as an annual number plus a return on net investment) and the rate for the funded service (annual revenue requirement divided by annual demand divided by twelve equals the monthly rate for the service), assuming one rate element for the service), based on the projected rural health care service costs and demands;

(viii) Audited financial statements and notes to the financial statements, if available, and otherwise unaudited financial statements for the most recent three fiscal years, specifically, the cash flow statement, income statement, and balance sheets. Such statements shall include information regarding costs and revenues associated with, or used as a starting point to develop, the rural health care service rate; and

(ix) Density characteristics of the rural area or other relevant geographical areas including square miles, road miles, mountains, bodies of water, lack of roads, remoteness, challenges and costs associated with transporting fuel, satellite and backhaul availability, extreme weather

conditions, challenging topography, short construction season or any other characteristics that contribute to the high cost of servicing the health care providers.

§ 54.606 Calculating support.

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

(b) The universal service support mechanisms shall provide support for intrastate telecommunications services, as set forth in § 54.101(a), provided to rural health care providers as well as interstate telecommunications services.

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

(2) *Documentation of support*. (i) Mobile rural health care providers shall provide to the Administrator documentation of the price of bandwidth equivalent wireline services in the

urban area in the state or states where the service is provided. Mobile rural health care providers shall provide to the Administrator the number of sites the mobile health care provider will serve during the funding year.

(ii) Where a mobile rural health care provider serves less than eight different sites per year, the mobile rural health care provider shall provide to the Administrator documentation of the price of bandwidth equivalent wireline services. In such case, the Administrator shall determine on a case-by-case basis whether the telecommunications service selected by the mobile rural health care provider is the most cost-effective option. Where a mobile rural health care provider seeks a more expensive satellite-based service when a less expensive wireline alternative is most cost-effective, the mobile rural health care provider shall be responsible for the additional cost.

HEALTHCARE CONNECT FUND PROGRAM

§ 54.607 Eligible recipients.

(a) *Rural health care provider site—individual and consortium*. Under the Healthcare Connect Fund Program, an eligible rural health care provider may receive universal service support by applying individually or through a consortium. For purposes of the Healthcare Connect Fund Program, a "consortium" is a group of two or more health care provider sites that request support through a single application. Consortia may include health care providers who are not eligible for support under the Healthcare Connect Fund Program, but such health care providers cannot receive support for their expenses and must participate pursuant to the cost allocation guidelines in § 54.617(d).

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

consortium that includes more than 50 percent eligible rural health care provider sites. The majority-rural consortia percentage requirement will increase by 5 percent for the following funding year (up to a maximum of 75 percent) if the Commission must prioritize funding for a given year because Rural Health Care Program demand exceeds the funding cap.

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

§ 54.608 Eligible service providers.

For purposes of the Healthcare Connect Fund Program, eligible service providers shall include any provider of equipment, facilities, or services that is eligible for support under the Healthcare Connect Fund Program.

§ 54.609 Designation of Consortium Leader.

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

(b) *Consortium Leader eligibility*. The Consortium Leader may be the consortium itself (if it is a distinct legal entity); an eligible health care provider participating in the consortium; or a state organization, public sector (governmental) entity (including a Tribal government entity), or non-profit entity that is ineligible for Healthcare Connect Fund Program support. Ineligible state

organizations, public sector entities, or non-profit entities may serve as Consortium Leaders or provide consulting assistance to consortia only if they do not participate as potential service providers during the competitive bidding process. An ineligible entity that serves as the Consortium Leader must pass on the full value of any discounts, funding, or other program benefits secured to the consortium members that are eligible health care providers.

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

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

(2) *Point of contact for the FCC and Administrator*. The Consortium Leader is responsible for designating an individual who will be the "Project Coordinator" and serve as the point of contact

with the Commission and the Administrator for all matters related to the consortium. The Consortium Leader is responsible for responding to Commission and Administrator inquiries on behalf of the consortium members throughout the application, funding, invoicing, and post-invoicing period.

(3) *Typical applicant functions, including forms and certifications*. The Consortium Leader is responsible for submitting program forms and required documentation and ensuring that all information and certifications submitted are true and correct. The Consortium Leader must also collect and retain a Letter of Agency (LOA) from each member, pursuant to § 54.610.

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

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

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

§ 54.610 Letters of agency (LOA).

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

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

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

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

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

(2) For health care providers located on Tribal lands, if the health care facility is a contract facility that is run solely by the tribe, the appropriate Tribal leader, such as the Tribal chairperson,

president, or governor, shall also sign the LOA, unless the health care responsibilities have been duly delegated to another Tribal government representative.

§ 54.611 Health care provider contribution.

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

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

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

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

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

(d) *Future revenues from excess capacity as source of health care provider contribution*. A consortium applicant that receives support for participant-owned network facilities under §

54.614 may use future revenues from excess capacity as a source for the required health care provider contribution, subject to the following limitations:

(1) The consortium's selection criteria and evaluation for "cost-effectiveness," pursuant to § 54.622(g)(1), cannot provide a preference to bidders that offer to construct excess capacity;

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

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

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

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

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

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

§ 54.612 Eligible services.

(a) *Eligible services.* Subject to the provisions of §§54.600 through 54.602 and 54.607 through 54.633, eligible health care providers may request support under the Healthcare Connect Fund Program for any advanced telecommunications or information service that enables health care providers to post their own data, interact with stored data, generate new data, or communicate, by providing connectivity over private dedicated networks or the public Internet for the provision of health information technology.

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

(1) Support for recurring charges associated with dark fiber is only available once the dark fiber is "lit" and actually being used by the health care provider. Support for non-recurring charges for dark fiber is only available for fiber lit within the same funding year, but applicants may receive up to a one-year extension to light fiber, consistent with § 54.626(b), if they provide documentation to the Administrator that construction was unavoidably delayed due to weather or other reasons.

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

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

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

(2) Consortium applicants may receive support for upfront payments for maintenance costs associated with leases of dark or lit fiber, subject to the limitations in § 54.616.

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

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

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

§ 54.613 Eligible equipment.

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

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

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

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

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

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

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

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

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

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

(2) Used for health care purposes.

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

(a) Subject to the funding limitations of this subsection and the following restrictions, consortium applicants may receive support for network facilities that will be constructed and owned by the consortium (if the consortium is an eligible health care provider) or eligible health care providers within the consortium. Subject to the funding limitations under §§ 54.616 and 54.619 and the following restrictions, consortium applicants may receive support for network facilities that will be constructed and owned by the consortium (if the consortium is an eligible health care provider) or eligible health care providers within the consortium.

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

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

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

(2) Support for participant-constructed and owned network facilities is only available where the consortium demonstrates that constructing its own network facilities is the most cost-effective option after competitive bidding, pursuant to § 54.622(g)(1).

(b) [Reserved]

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

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

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

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

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

(ii) Two off-site data centers;

(iii) Two off-site administrative offices;

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

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

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

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

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

(4) If traffic associated with one or more ineligible health care provider sites is carried by the supported connection and/or network equipment, the ineligible health care provider sites must allocate the cost of that connection and/or equipment between eligible and ineligible sites, consistent with the "fair share" principles set forth in § 54.617(d)(1).

§ 54.616 Upfront payments.

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

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

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

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

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

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

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

§ 54.617 Ineligible expenses.

(a) *Equipment or services not directly associated with eligible services*. Expenses associated with equipment or services that are not necessary to make an eligible service functional, or to manage, control, or maintain an eligible service or a dedicated health care broadband network are ineligible for support. For purposes of paragraph (a) of this section, examples of ineligible expenses include:

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

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

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

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

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

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

(vi) Web server hosting;

(vii) Web site portal development;

(viii) Video/audio/web conferencing equipment or services; and

(ix) Continuous power source.

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

(i) Clinical or medical equipment;

(ii) Telemedicine equipment, applications, and software;

(iii) Training for use of telemedicine equipment;

(iv) Electronic medical records systems; and

(v) Electronic records management and expenses.

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

(c) *Administrative expenses*. Administrative expenses are not eligible for support under the Healthcare Connect Fund Program. For purposes of paragraph (c) of this section, ineligible administrative expenses include, but are not limited to, the following expenses:

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

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

(3) Legal costs;

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

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

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

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

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

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

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

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

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

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

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

(4) *Written agreement*. If ineligible entities participate in a network, the allocation method must be memorialized in writing, such as a formal agreement among network members, a master services

contract, or for smaller consortia, a letter signed and dated by all (or each) ineligible entity and the Consortium Leader.

§ 54.618 Data collection and reporting.

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

(b) Each applicant must file an annual report for each funding year in which it receives support from the Healthcare Connect Fund Program.

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

GENERAL PROVISIONS

§ 54.619 Cap.

(a) *Amount of the annual cap*. The aggregate annual cap on federal universal service support for health care providers shall be $571 million per funding year, of which up to $150 million per funding year will be available to support upfront payments and multi-year commitments under the Healthcare Connect Fund Program.

(1) *Inflation increase*. In funding year 2018 and subsequent funding years, the $571 million cap on federal universal support in the Rural Health Care Program shall be increased annually to take into account increases in the rate of inflation as calculated in paragraph (a)(2) in this section. In funding year 2020 and subsequent funding years, the $150 million cap on multi-year commitments and upfront payments in the Healthcare Connect Fund Program shall also be

increased annually to take into account increases in the rate of inflation as calculated in paragraph (a)(2) in this section.

(2) *Increase calculation*. To measure increases in the rate of inflation for the purposes of paragraph (a)(1) in this section, the Commission shall use the Gross Domestic Product Chain-type Price Index (GDP–CPI). To compute the annual increase as required by paragraph (a)(1) in this section, the percentage increase in the GDP–CPI from the previous year will be used. For instance, the annual increase in the GDP–CPI from 2017 to 2018 would be used for the 2018 funding year. The increase shall be rounded to the nearest 0.1 percent by rounding 0.05 percent and above to the next higher 0.1 percent. This percentage increase shall be added to the amount of the annual Rural Health Care Program funding cap and the internal cap on multi-year commitments and upfront payments in the Healthcare Connect Fund Program from the previous funding year. If the yearly average GDP–CPI decreases or stays the same, the annual Rural Health Care Program funding cap and the internal cap on multi-year commitments and upfront payments in the Healthcare Connect Fund Program shall remain the same as the previous year.

(3) *Public notice*. After calculating the annual Rural Health Care Program funding cap and the internal cap on multi-year commitments and upfront payments in the Healthcare Connect Fund Program based on the GDP–CPI, the Wireline Competition Bureau shall publish a public notice in the Federal Register within 60 days announcing any increase of the annual funding cap based on the rate of inflation.

(4) *Amount of unused funds*. All unused collected funds shall be carried forward into subsequent funding years for use in the Rural Health Care Program in accordance with the public interest

and notwithstanding the annual cap. The Administrator, on a quarterly basis, shall report to the Commission on unused Rural Health Care Program funding from prior years.

(5) *Application of unused funds*. On an annual basis, in the second quarter of each calendar year, all unused collected funds from prior years shall be available for use in the next full funding year of the Rural Health Care Program notwithstanding the annual cap as described in paragraph (a) in this section. The Wireline Competition Bureau, in consultation with the Office of the Managing Director, shall determine the proportion of unused funding for use in the Rural Health Care Program in accordance with the public interest to either satisfy demand notwithstanding the annual cap, reduce collections for the Rural Health Care Program, or to hold in reserve to address contingencies for subsequent funding years. The Wireline Competition Bureau shall direct the Administrator to carry out the necessary actions for the use of available funds consistent with the direction specified in this section.

(b) [RESERVED]

§ 54.620 Annual filing requirements and commitments.

(a) *Annual filing requirement*. Health care providers seeking support under the RHC Program shall file new funding requests for each funding year consistent with the filing periods established under this subpart, except for health care providers who have received a multi-year funding commitment in this section.

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

(c) *Multi-year commitments under the Healthcare Connect Fund Program*. Participants in the Healthcare Connect Fund Program are permitted to enter into multi-year contracts for eligible expenses and may receive funding commitments from the Administrator for a period that covers up to three years of funding. If a long-term contract covers a period of more than three years, the applicant may also have the contract designated as "evergreen" under § 54.622(i)(3), which will allow the applicant to re-apply for funding under the contract after three years without having to undergo additional competitive bidding.

§ 54.621 Filing window for requests and prioritization of support.

(a) *Filing window for requests*. (1) The Administrator shall open an initial application filing window with an end date no later than 90 days prior to the start of the funding year (*i.e.*, no later than April 1). Prior to announcing the initial opening and closing dates, the Administrator shall seek the approval of the proposed dates from the Chief of the Wireline Competition Bureau.

(2) The Administrator, after consultation with the Wireline Competition Bureau, may implement such additional filing periods as it deems necessary. To the extent that the Administrator opens an additional filing period, it shall provide notice and include in that notice or soon thereafter the amount of remaining available funding.

(3) The Administrator shall treat all health care providers filing an application within a filing window period as if their applications were simultaneously received. All funding requests submitted outside of a filing window will not be accepted unless and until the Administrator opens another filing window.

(b) *Prioritization of support*. The Administrator shall act in accordance with this section when a filing window period for the Telecommunications Program and the Healthcare Connect Fund

Program, as described in paragraph (a) in this section, is in effect. When a filing period described in paragraph (a) in this section closes, the Administrator shall calculate the total demand for Telecommunications Program and Healthcare Connect Fund Program support submitted by all applicants during the filing window period. If the total demand during the filing window period exceeds the total remaining support available for the funding year, then the Administrator shall distribute the available funds consistent with the following priority schedule:

Table 1 to paragraph (b)- Prioritization Schedule

Health Care Provider Site is Located in:	**In a Medically Underserved Area/Population (MUA/P)**	**Not in MUA/P**
Extremely Rural Tier (counties entirely outside of a Core Based Statistical Area)	*Priority 1*	*Priority 4*
Rural Tier (census tracts within a Core Based Statistical Area that does not have an urban area or urban cluster with a population equal to or greater than 25,000)	*Priority 2*	*Priority 5*
Less Rural Tier (census tracts within a Core Based Statistical Area with an urban area or urban cluster with a population equal	*Priority 3*	*Priority 6*

to or greater than 25,000, but where the census tract does not contain any part of an urban area or urban cluster with population equal to or greater than 25,000)		
Non-Rural Tier (all other non-rural areas)	*Priority 7*	*Priority 8*

(1) *Application of prioritization schedule*. The Administrator shall fully fund all eligible requests falling under the first prioritization category before funding requests in the next lower prioritization category. The Administrator shall continue to process all funding requests by prioritization category until there are no available funds remaining. If there is insufficient funding to fully fund all requests in a particular prioritization category, then the Administrator will pro-rate the available funding among all eligible requests in that prioritization category only pursuant to the proration process described in paragraph (b)(2) in this section.

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

(i) The Administrator shall divide the total remaining funds available for the funding year by the demand within the specific prioritization category to produce a pro-rata factor;

(ii) The Administrator shall multiply the pro-rata factor by the total dollar amount requested by each applicant in the prioritization category; and

(iii) The Administrator shall commit funds to each applicant for Telecommunications Program and Healthcare Connect Fund Program support consistent with this calculation.

§ 54.622 Competitive bidding requirements and exemptions.

(a) *Competitive bidding requirement*. All applicants are required to engage in a competitive bidding process for supported services, facilities, or equipment, as applicable, consistent with the requirements set forth in this section and any additional applicable state, Tribal, local, or other procurement requirements, unless they qualify for an exemption listed in paragraph (j) in this section. In addition, applicants may engage in competitive bidding even if they qualify for an exemption. Applicants who utilize a competitive bidding exemption may proceed directly to filing a funding request as described in § 54.623.

(b) *Fair and open process*. (1) Applicants participating in the Telecommunications Program or Healthcare Connect Fund Program must conduct a fair and open competitive bidding process. The following actions are necessary to satisfy the "fair and open" competitive standard in the Telecommunications Program and the Healthcare Connect Fund Program:

(i) All potential bidders and service providers must have access to the same information and must be treated in the same manner throughout the procurement process.

(ii) Service providers who intend to bid on supported services many not simultaneously help the applicant complete its request for proposal (RFP) or Request for Services form.

(iii) Service providers who have submitted a bid to provide supported services, equipment, or facilities to a health care provider may not simultaneously help the health care provider evaluate submitted bids or choose a winning bid.

(iv) Applicants must respond to all service providers that have submitted questions or proposals during the competitive bidding process.

(v) All applicants and service providers must comply with any applicable state, Tribal, or local procurement laws, in addition to the Commission's competitive bidding requirements. The competitive bidding requirements in this section are not intended to preempt such state, Tribal, or local requirements.

(c) *Selecting a cost-effective service*. In selecting a provider of eligible services, the applicant shall carefully consider all bids submitted and must select the most cost-effective means of meeting its specific health care needs. "Cost-effective" is defined as the method that costs the least after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems relevant to choosing a method of providing the required health care services. In the Healthcare Connect Fund Program, when choosing the most "cost-effective" bid, price must be a primary factor, but need not be the only primary factor. A non-price factor may receive an equal weight to price, but may not receive a greater weight than price.

(d) *Bid evaluation criteria*. Applicants must develop weighted evaluation criteria (*e.g.*, a scoring matrix) that demonstrates how the applicant will choose the most cost-effective bid before submitting its request for services. The applicant must specify on its bid evaluation worksheet

and/or scoring matrix the requested services for which it seeks bids, the information provided to bidders to allow bidders to reasonably determine the needs of the applicant, its minimum requirements for the developed weighted evaluation criteria, and each service provider's proposed service levels for the criteria. The applicant must also specify the disqualification factors, if any, that it will use to remove bids or bidders from further consideration. After reviewing the bid submissions and identifying the bids that satisfy the applicant's specific needs, the applicant must then select the service provider that offers the most cost-effective service.

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

(1) *Request for Services, including certifications*. The applicant must submit a Request for Services and make the following certifications as part of its Request for Services:

(i) The health care provider seeking supported services is a public or nonprofit entity that falls within one of the seven categories set forth in the definition of health care provider, listed in §54.600;

(ii) The health care provider seeking supported services is physically located in a rural area as defined in § 54.600, or is a member of a Healthcare Connect Fund Program consortium which satisfies the rural health care provider composition requirements set forth in § 54.607(b);

(iii) The person signing the application is authorized to submit the application on behalf of the health care provider or consortium applicant;

(iv) The person signing the application has examined the Request for Services and all attachments, and to the best of his or her knowledge, information, and belief, all statements contained in the request are true;

(v) The applicant has complied with any applicable state, Tribal, or local procurement rules;

(vi) All requested Rural Health Care Program support will be used solely for purposes reasonably related to the provision of health care service or instruction that the health care provider is legally authorized to provide under the law of the state in which the services are provided;

(vii) The supported services will not be sold, resold, or transferred in consideration for money or any other thing of value;

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

(ix) The applicant has reviewed all applicable requirements for the Telecommunications Program or the Healthcare Connect Fund Program, as applicable, and will comply with those requirements.

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

(3) *Bid evaluation criteria*. Requirements for bid evaluation criteria are described in paragraph (d) in this section and must be included with the applicant's Request for Services.

(4) *Declaration of Assistance*. All applicants must submit a "Declaration of Assistance" with their Request for Services. In the Declaration of Assistance, the applicant must identify each and every consultant, service provider, and other outside expert, whether paid or unpaid, who aided in the preparation of its applications. The applicant must also describe the nature of the relationship it has with each consultant, service provider, or other outside expert providing such assistance.

(5) *Request for proposal (if applicable)*. (i) Any applicant may use an RFP. Applicants who use an RFP must submit the RFP and any additional relevant bidding information to the Administrator with its Request for Services.

(ii) An applicant must submit an RFP:

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

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

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

(iii) RFP requirements.

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

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

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

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

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

(6) *Additional requirements for Healthcare Connect Fund Program consortium applicants.*

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

(A) Goals and objectives of the network;

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

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

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

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

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

(ii) *Letters of agency (LOA)*. Consortium applicants must submit LOAs pursuant to §54.610.

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

(1) Request for Services*;*

(2) Bid evaluation criteria;

(3) RFP; and

(4) Network plans for Healthcare Connect Fund Program applicants.

(g) *28-day waiting period*. After posting the documents described in paragraph (f) in this section, as applicable, on its website, the Administrator shall send confirmation of the posting to the applicant. The applicant shall wait at least 28 days from the date on which its competitive bidding documents are posted on the Administrator's website before selecting and committing to a service provider. The confirmation from the Administrator shall include the date after which the applicant may sign a contract with its chosen service provider(s).

(1) *Selection of the most ''cost-effective'' bid and contract negotiation*. Each applicant is required to certify to the Administrator that the selected bid is, to the best of the applicant's knowledge,

the most cost-effective option available. Applicants are required to submit the documentation, identified in § 54.623, to support their certifications.

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

(h) *Gift restrictions*. (1) Subject to paragraphs (h)(3) and (4) in this section, an eligible health care provider or consortium that includes eligible health care providers, may not directly or indirectly solicit or accept any gift, gratuity, favor, entertainment, loan, or any other thing of value from a service provider participating in or seeking to participate in the Rural Health Care Program. No such service provider shall offer or provide any such gift, gratuity, favor, entertainment, loan, or other thing of value except as otherwise provided in this section. Modest refreshments not offered as part of a meal, items with little intrinsic value intended solely for presentation, and items worth $20 or less, including meals, may be offered or provided, and accepted by any individual or entity subject to this rule, if the value of these items received by any individual does not exceed $50 from any one service provider per funding year. The $50 amount for any service provider shall be calculated as the aggregate value of all gifts provided during a funding year by the individuals specified in paragraph (h)(2)(ii) in this section.

(2) For purposes of this paragraph:

(i) The terms ‘‘health care provider” or “consortium’’ shall include all individuals who are on the governing boards of such entities and all employees, officers, representatives, agents, consultants, or independent contractors of such entities involved on behalf of such health care

provider or consortium with the Rural Health Care Program, including individuals who prepare, approve, sign, or submit Rural Health Care Program applications, or other forms related to the Rural Health Care Program, or who prepare bids, communicate, or work with Rural Health Care Program service providers, consultants, or with the Administrator, as well as any staff of such entities responsible for monitoring compliance with the Rural Health Care Program; and

(ii) The term ''service provider'' includes all individuals who are on the governing boards of such an entity (such as members of the board of directors), and all employees, officers, representatives, agents, consultants, or independent contractors of such entities.

(3) The restrictions set forth in this paragraph shall not be applicable to the provision of any gift, gratuity, favor, entertainment, loan, or any other thing of value, to the extent given to a family member or a friend working for an eligible health care provider or consortium that includes eligible health care providers, provided that such transactions:

(i) Are motivated solely by a personal relationship;

(ii) Are not rooted in any service provider business activities or any other business relationship with any such eligible health care provider; and

(iii) Are provided using only the donor's personal funds that will not be reimbursed through any employment or business relationship.

(4) Any service provider may make charitable donations to an eligible health care provider or consortium that includes eligible health care providers in the support of its programs as long as such contributions are not directly or indirectly related to the Rural Health Care Program procurement activities or decisions and are not given by service providers to circumvent

competitive bidding and other Rural Health Care Program rules, including those in § 54.611(a), requiring health care providers under the Healthcare Connect Fund Program to contribute 35 percent of the total cost of all eligible expenses.

(i) *Exemptions to the competitive bidding requirements*-(1) *Government Master Service Agreement (MSA)*. Eligible health care providers that seek support for services and equipment purchased from MSAs negotiated by federal, state, Tribal, or local government entities on behalf of such health care providers and others, if such MSAs were awarded pursuant to applicable federal, state, Tribal, or local competitive bidding requirements, are exempt from the competitive bidding requirements under this section.

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

(3) *Evergreen contracts*. (i) The Administrator may designate a multi-year contract as "evergreen," which means that the service(s) covered by the contract need not be re-bid during the contract term.

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

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

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

(C) Specifies the term of the contract;

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

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

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

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

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

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

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

The health care provider must comply with all Rural Health Care Program rules and procedures except for those applicable to competitive bidding.

(5) *Annual undiscounted cost of $10,000 or less*. An applicant under the Healthcare Connect Fund Program that seeks support for $10,000 or less of total undiscounted eligible expenses for a single year is exempt from the competitive bidding requirements under this section, if the term of the contract is one year or less. This exemption does not apply to applicants under the Telecommunications Program.

§ 54.623 Funding requests.

(a) Once a service provider is selected, applicants must submit a Request for Funding (and supporting documentation) to provide information about the services, equipment, or facilities selected; rates, service provider(s); and date(s) of service provider selection, as applicable.

(1) *Certifications*. The applicant must provide the following certifications as part of its Request for Funding:

(i) The person signing the application is authorized to submit the application on behalf of the health care provider or consortium.

(ii) The applicant has examined the form and all attachments, and to the best of his or her knowledge, information, and belief, all statements of fact contained in this section are true.

(iii) The health care provider or consortium has considered all bids received and selected the most cost-effective method of providing the requested services.

(iv) All Rural Health Care Program support will be used only for eligible health care purposes.

(v) The health care provider or consortium is not requesting support for the same service from both the Telecommunications Program and the Healthcare Connect Fund Program.

(vi) The health care provider or consortium and/or its consultant, if applicable, has not solicited or accepted a gift or any other thing of value from a service provider participating in or seeking to participate in the Rural Health Care Program.

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

(viii) The applicant has reviewed all applicable rules and requirements for the Rural Health Care Program and will comply with those rules and requirements.

(ix) The applicant will retain all documentation associated with the applications, including all bids, contracts, scoring matrices, and other information associated with the competitive bidding process, and all billing records for services received, for a period of at least five years.

(x) The consultants or third parties hired by the applicant do not have an ownership interest, sales commission arrangement, or other financial stake in the service provider chosen to provide the requested services, and that they have otherwise complied with the Rural Health Care Program rules, including the Commission's rules requiring a fair and open competitive bidding process.

(xi) *Additional certification for the Telecom Program*. Telecom Program applicants must certify that the rural rate on their Request for Funding does not exceed the appropriate rural rate determined by the Administrator.

(2) *Contracts or other documentation*. All applicants must submit a contract or other documentation, as applicable, that clearly identifies the service provider(s) selected and the health care provider(s) who will receive the services; costs for which support is being requested; and the term of the service agreement(s) if applicable (*i.e.*, if services are not being provided on a month-to-month basis). For services provided under contract, the applicant must submit a

copy of the contract signed and dated (after the Allowable Contract Selection Date) by the individual health care provider or Consortium Leader. If the services are not being provided under contract, the applicant must submit a bill, service offer, letter, or similar document from the service provider that provides the required information.

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

(4) *Cost allocation for ineligible entities or components.* Where applicable, applicants must submit a description of how costs will be allocated for ineligible entities or components, as well as any agreements that memorialize such arrangements with ineligible entities.

(5) *Additional documentation for Healthcare Connect Fund Program consortium applicants.* A consortium applicant must also submit the following:

(i) Any revisions to the network plan submitted with the Request for Services pursuant to §54.622, as necessary. If not previously submitted, the consortium should provide a narrative description of how the network will be managed, including all administrative aspects of the

network, including, but not limited to, invoicing, contractual matters, and network operations. If the consortium is required to provide a sustainability plan as set forth in the following, the revised budget should include the budgetary factors discussed in the sustainability plan requirements.

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

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

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

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

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

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

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

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

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

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

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

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

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

§ 54.624 Site and service substitutions.

(a) Health care providers or Consortium Leaders may request a site or service substitution if:

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

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

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

(4) The requested change is within the scope of the controlling Request for Services, including any applicable RFP used in the competitive bidding process.

(b) Filing deadline. An applicant must file their request for a site or service change to the Administrator no later than the service delivery deadline as defined in § 54.626.

§ 54.625 Service Provider Identification Number (SPIN) changes.

(a) *Corrective SPIN change*. A "corrective SPIN change" is any amendment to the SPIN associated with a Funding Request Number that does not involve a change to the service provider associated with that Funding Request Number. An applicant under the Telecommunications Program or the Healthcare Connect Fund Program may file a request for a corrective SPIN change with the Administrator to:

(1) Correct ministerial errors;

(2) Update the service provider's SPIN that resulted from a merger or acquisition of companies; or

(3) Effectuate a change to the SPIN that does not involve a change to the service provider of a funding request and was not initiated by the applicant.

(b) *Operational SPIN Change.* An "operational SPIN change" is any change to the service provider associated with a Funding Request Number. An applicant under the Telecommunications Program or the Healthcare Connect Fund Program may file a request for an operational SPIN change with the Administrator if:

(1) The applicant has a legitimate reason to change providers (*e.g.*, breach of contract or the service provider is unable to perform); and

(2) The applicant's newly selected service provider received the next highest point value in the original bid evaluation, assuming there were multiple bidders.

(c) *Filing deadline*. An applicant must file their request for a corrective or operational SPIN change with the Administrator no later than the service delivery deadline as defined by § 54.626.

§ 54.626 Service delivery deadline and extension requests.

(a) *Service delivery deadline*. Except as provided in the following, applicants must use all recurring and non-recurring services for which Telecommunications Program and Healthcare Connect Fund Program funding has been approved by June 30 of the funding year for which the program support was sought. The Administrator will deem ineligible for Telecommunications Program and Healthcare Connect Fund Program support all charges incurred for services delivered before or after the close of the funding year.

(b) *Deadline extension for non-recurring services*. An applicant may request and receive from the Administrator a one-year extension of the implementation deadline for non-recurring services if it satisfies one of the following criteria:

(1) Applicants whose funding commitment letters are issued by the Administrator on or after March 1 of the funding year for which discounts are authorized;

(2) Applicants that receive service provider change authorizations or site and service authorizations from the Administrator on or after March 1 of the funding year for which discounts are authorized;

Note 1 to paragraphs (b)(1) and (b)(2): The Administrator shall automatically extend the service delivery deadline for applicants who satisfy paragraphs (b)(1) or (2) in this section. When calculating the extended deadline, March 1 is the key date for determining whether to extend the service delivery deadline. If one of the conditions listed in paragraph (b) in this section is satisfied before March 1 (of any year), the deadline will not be extended and the applicant will have until June 30 of that calendar year to complete implementation. If one of the conditions under paragraph (b)(1) through (2) in this section is satisfied on or after March 1 the calendar year, the applicant will have until June 30 of the following calendar year to complete implementation.

(3) Applicants whose service providers are unable to complete implementation for reasons beyond the service provider's control; or

Note 1 to paragraph (b)(3): An applicant seeking a one-year extension must affirmatively request an extension on or before the June 30 deadline for paragraph (b)(3) in this section. The Administrator will address any situations arising under paragraph (b)(3) in this section on a case-by-case basis. Applicants must submit documentation to the Administrator requesting relief pursuant to paragraph (b)(3) in this section on or before June 30 of the relevant funding year. That documentation must include, at a minimum, an explanation regarding the circumstances that make it impossible for installation to be completed by June 30 and a certification by the applicant that, to the best of their knowledge, the request is truthful.

(4) Applicants whose service providers are unwilling to complete delivery and installation because the applicant's funding request is under review by the Administrator for program compliance.

Note 1 to Paragraph (b)(4): An applicant seeking a one-year extension must affirmatively request an extension on or before the June 30 deadline for paragraph (b)(4) in this section. Applicants seeking an extension under paragraph (b)(4) in this section must certify to the Administrator that their service provider was unwilling to deliver or install the non-recurring services before the end of the funding year. Applicants must make this certification on or before June 30 of the relevant funding year. The revised implementation date will be calculated based on the date the Administrator issues a funding commitment.

§ 54.627 Invoicing process and certifications.

(a) *Invoice filing deadline.* Invoices must be submitted to the Administrator within 120 days after the later of:

(1) The service delivery deadline, as defined in § 54.626; or

(2) The date of a revised funding commitment letter issued pursuant to an approved post-commitment request made by the applicant or service provider or a successful appeal of a previously denied or reduced funding request. Before the Administrator may process and pay an invoice, it must receive a completed invoice from the service provider.

(b) *Invoice deadline extension.* Service providers or billed entities may request a one-time extension of the invoicing deadline by no later than the deadline calculated pursuant to paragraph (a) in this section. The Administrator shall grant a 120-day extension of the invoice filing deadline, if it is timely requested.

(c) *Telecommunications Program*. (1) The applicant must submit documentation to the Administrator confirming the service start date, the service end or disconnect date, or whether the service was never turned on.

(2) Upon receipt of the invoice(s) and supporting documentation, the Administrator shall generate a Health Care Provider Support Schedule (HSS), which the service provider shall use to determine how much credit the applicant will receive for the services.

(3) *Certifications*. Before the Administrator may process and pay an invoice, both the health care provider and the service provider must make the following certifications.

(i) The health care provider must certify that:

(A) The service has been or is being provided to the health care provider;

(B) The universal service credit will be applied to the telecommunications service billing account of the health care provider or the billed entity as directed by the health care provider;

(C) It is authorized to submit this request on behalf of the health care provider;

(D) It has examined the invoice and supporting documentation and that to the best of its knowledge, information and belief, all statements of fact contained in the invoice and supporting documentation are true;

(E) It or the consortium it represents satisfies all of the requirements and will abide by all of the relevant requirements, including all applicable Commission rules, with respect to universal service benefits provided under 47 U.S.C. 254; and

(F) It understands that any letter from the Administrator that erroneously states that funds will be made available for the benefit of the applicant may be subject to rescission.

(ii) The service provider must certify that:

(A) The information contained in the invoice is correct and the health care providers and the Billed Account Numbers have been credited with the amounts shown under "Support Amount to be Paid by USAC;"

(B) It has abided by all of the relevant requirements, including all applicable Commission rules;

(C) It has received and reviewed the HSS, invoice form and accompanying documentation, and that the rates charged for the telecommunications services, to the best of its knowledge, information and belief, are accurate and comply with the Commission's rules;

(D) It is authorized to submit the invoice;

(E) The health care provider paid the appropriate urban rate for the telecommunications services;

(F) The rural rate on the invoice does not exceed the appropriate rural rate determined by the Administrator;

(G) It has charged the health care provider for only eligible services prior to submitting the invoice for payment and accompanying documentation;

(H) It has not offered or provided a gift or any other thing of value to the applicant (or to the applicant's personnel, including its consultant) for which it will provide services; and

(I) The consultants or third parties it has hired do not have an ownership interest, sales commission arrangement, or other financial stake in the service provider chosen to provide the requested services, and that they have otherwise complied with Rural Health Care Program rules, including the Commission's rules requiring fair and open competitive bidding.

(J) As a condition of receiving support, it will provide to the health care providers, on a timely basis, all documents regarding supported equipment or services that are necessary for the health care provider to submit required forms or respond to Commission or Administrator inquiries.

(d) *Healthcare Connect Fund Program*. (1) *Certifications*. Before the Administrator may process and pay an invoice, the Consortium Leader (or health care provider, if participating individually) and the service provider must make the following certifications:

(i) The Consortium Leader or health care provider must certify that:

(A) It is authorized to submit this request on behalf of the health care provider or consortium;

(B) It has examined the invoice form and attachments and, to the best of its knowledge, information, and belief, all information contained on the invoice form and attachments are true and correct;

(C) The health care provider or consortium members have received the related services, network equipment, and/or facilities itemized on the invoice form; and

(D) The required 35 percent minimum contribution for each item on the invoice form was funded by eligible sources as defined in the Commission's rules and that the required contribution was remitted to the service provider.

(ii) The service provider must certify that:

(A) It has been authorized to submit this request on behalf of the service provider;

(B) It has applied the amount submitted, approved, and paid by the Administrator to the billing account of the health care provider(s) and Funding Request Number (FRN)/FRN ID listed on the invoice;

(C) It has examined the invoice form and attachments and that, to the best of its knowledge, information, and belief, the date, quantities, and costs provided in the invoice form and attachments are true and correct;

(D) It has abided by all program requirements, including all applicable Commission rules and orders;

(E) It has charged the health care provider for only eligible services prior to submitting the invoice form and accompanying documentation;

(F) It has not offered or provided a gift or any other thing of value to the applicant (or to the applicant's personnel, including its consultant) for which it will provide services;

(G) The consultants or third parties it has hired do not have an ownership interest, sales commission arrangement, or other financial stake in the service provider chosen to provide the requested

services, and that they have otherwise complied with Rural Health Care Program rules, including the Commission's rules requiring fair and open competitive bidding; and

(H) As a condition of receiving support, it will provide to the health care providers, on a timely basis, all documents regarding supported equipment, facilities, or services that are necessary for the health care provider to submit required forms or respond to Commission or Administrator inquiries.

§ 54.628 Duplicate support.

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

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

§ 54.629 Prohibition on resale.

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

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

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

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

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

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

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

(c) If a service provider providing services eligible for support under this subpart elects to treat that support amount as an offset against its universal service contribution obligation and the total amount of support owed exceeds its universal service obligation, calculated on an annual basis, the service provider shall receive a direct reimbursement in the amount of the difference. Any such reimbursement due a service provider shall be provided by the Administrator no later than

the end of the first quarter of the calendar year following the year in which the costs were incurred and the offset against the contributor's universal service obligation was applied.

§ 54.631 Audits and recordkeeping.

(a) *Random audits.* All participants under the Telecommunications Program and Healthcare Connect Fund Program shall be subject to random compliance audits to ensure compliance with program rules and orders.

(b) *Recordkeeping*. Participants, including Consortium Leaders and health care providers, shall maintain records to document compliance with program rules and orders for at least five years after the last day of service delivered in a particular funding year sufficient to establish compliance with all rules in this subpart.

(1) *Telecommunications Program*. (i) Participants must maintain, among other things, records of allocations for consortia and entities that engage in eligible and ineligible activities, if applicable.

(ii) Mobile rural health care providers shall maintain annual logs for a period of five years. Mobile rural health care providers shall maintain annual logs indicating: the date and locations of each clinical stop; and the number of patients served at each clinical stop. Mobile rural health care providers shall make their logs available to the Administrator and the Commission upon request.

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

(2) *Healthcare Connect Fund Program*. (i) Participants who receive support for long-term capital investments in facilities whose useful life extends beyond the period of the funding commitment shall maintain records for at least five years after the end of the useful life of the facility. Participants shall maintain asset and inventory records of supported network equipment to verify the actual location of such equipment for a period of five years after purchase.

(ii) Service providers shall retain records related to the delivery of supported services, facilities, or equipment to document compliance with the Commission rules or orders pertaining to the Healthcare Connect Fund Program for at least five years after the last day of the delivery of supported services, equipment, or facilities in a particular funding year.

(c) *Production of records*. Both participants and service providers under the Telecommunications Program and Healthcare Connect Fund Program shall produce such records at the request of the Commission, any auditor appointed by the Administrator or Commission, or any other state or federal agency with jurisdiction.

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

§ 54.632 Signature requirements for certifications.

(a) For individual health care provider applicants, required certifications must be provided and signed by an officer or director of the health care provider, or other authorized employee of the health care provider.

(b) For consortium applicants, an officer, director, or other authorized employee of the Consortium Leader must sign the required certifications.

(c) Pursuant to § 54.633, electronic signatures are permitted for all required certifications.

§ 54.633 Validity of electronic signatures and records.

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

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

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