A Report on Rural Healthcare Program Reimbursements for Eligible Wyoming Telehealth Network Telecommunications Charges

Prepared for The Wyoming Telehealth Consortium and the Wyoming Department of Health

June 16, 2010

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June 16, 2010

Dear Dr. Bush:

The Wyoming Health Information Organization (WyHIO) is pleased to present the report on Universal Services Administrative Company reimbursements of the Wyoming Telehealth Network telecommunications charges. This document addresses the USAC Rural Health Care Program, outlining purpose, eligibility conditions/requirements, estimated recovery amounts, process for filing for recovery, and recommendations to the Consortium.

Additionally, the document discusses the recently-released FCC Broadband Plan, and potential implications for the Network and healthcare providers in Wyoming.

The WyHIO appreciates the opportunity to present this document.

Sincerely,

Jerry Calkins, Ph.D., M.D.
Chairman
WyHIO Board of Directors

MISSIONS

The mission of the Consortium shall include:

Facilitating the operation of a statewide interoperable telemedicine/telehealth network using existing internet protocol based communication and videoconferencing infrastructure and telecommunication services to the extent possible;

Coordinating with appropriate state agencies to establish incentives to implement, promote and facilitate the voluntary exchange of secure telemedicine/telehealth network information between and among individuals, entities and agencies that are providing and paying for services authorized under the Medicaid program, in conformity with rules adopted by the state chief information officer;

Develop and promote a common direction for a statewide interoperable telemedicine/telehealth network among state agencies, in conformity with rules adopted by the state chief information officer.

The mission of the Wyoming Health Information Organization (WyHIO) is to enhance access, quality, safety, and the efficiency of healthcare in Wyoming through the implementation of a telecommunications network supporting telehealth/telemedicine and the interoperable exchange of electronic health information exchange that is secure and confidential, assuring interconnectivity within Wyoming and the rest of the nation.

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ACKNOWLEGEMENTS

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Additionally, we appreciate the input of healthcare providers and other interested parties. Their cooperation and assistance was essential in completing this document.

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Purpose/Scope of the Plan Document

This document is the product of the Wyoming Telehealth Consortium. It addresses the USAC Rural Health Care Program, outlining purpose, eligibility conditions/requirements, estimated recovery amounts, administrative and structural issues, process for filing for recovery, and recommendations to the Consortium.

The primary objective of this document is to inform the Consortium of the benefits and requirements of the Rural HealthCare Program reimbursements. Based on this information, the Consortium can make an informed decision regarding pursuit of the reimbursements.

Additionally, the document describes the anticipated impacts of implementation of the FCC Broadband Plan on the Rural Health Care Program, and provides an opportunity to plan for expected impacts.

Please provide your feedback to

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Executive Summary

The Universal Service Fund (USF) was established by the Telecommunications Act of 1996 to ensure telecommunications access to all regions of the country. The Rural Health Care Program of the USF provides reduced rates to rural health care providers for telecommunications services and internet access comparable to that of urban telecommunications providers. The USF is administered by the Universal Service Administrative Company (USAC).

Not-for-profit, rural health care providers (HCPs) are eligible to participate in the program if they fall into one of the following categories:

- Post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools;
- Community health centers or health centers providing health care to migrants;
- Local health departments or agencies;
- Community mental health centers;
- Not-for-profit hospitals;
- Rural health clinics;
- Consortia of HCP's consisting of one or more of the above entities;
- Dedicated emergency departments of rural for-profit hospitals;
- Part-time eligible entities located in facilities that are ineligible.[1]

Rural telecommunications services eligible for reimbursement include:

- ATM (Asynchronous Transfer Mode)
- Centrex
- DSL
- Ethernet
- Fiber
- Fractional T1
- Frame Relay
- Internet Access Charges
- ISDN
- Mileage-related Charges
- MPLS
- NRS – Network Reconfiguration Service
- OC-1
- OC-3
- Redundant Circuit
- Satellite Service
- Telephone Service
- T1
- T3 or DS3.[2]

Eligible Internet services are limited to the following:

- Monthly Internet access charges
- Email

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[1] http://www.universalservice.org/rhc/health-care-providers/step01/eligible-health-care-providers.aspx

[2] http://www.universalservice.org/rhc/health-care-providers/step01/eligible-services.aspx

- Web hosting.[3]

To obtain the reimbursement, eligible HCPs must complete a nine-step process:
- Determine eligibility
- Submit a service request
- Evaluate and accept a bid for service
- Sign a contract
- Submit a service agreement form
- Receive funding commitment letter
- Submit confirmation of service
- Receive support schedule
- Receive credit for service.

The federal regulations authorize two methods of computing reimbursement for regular Monthly Recurring Charges (MRC):
- A mileage based calculation;
- A comparison of rates between rural and urban areas.

Additionally, one-time reimbursement is available for eligible installation costs using a rural/urban cost comparison.

Wyoming has received an FCC Rural Health Care Pilot Program grant to support infrastructure development and Monthly Recurring Costs for participating sites. The bulk of these participating sites would be eligible to participate in the Rural Health Care Program. Estimated annual reimbursement for MRCs, and reimbursement of one-time installation costs for eligible HCPs would total $120,648.00 and $18,699.00, respectively.

The FCC has recently released its National Broadband Plan, including its strategy for achieving affordability and maximizing use of broadband to advance a number of areas, including healthcare delivery. Specific Plan recommendations, if implemented, could provide additional reimbursement and expand the list of eligible HCPs.

[3] http://www.universalservice.org/rhc/health-care-providers/step01/eligible-services.aspx

Overview of FCC Universal Services Program

The concept of Universal Service can be traced back to the early days of the Bell System, when it originally referred to the ability of one customer to call another customer using a single telephone service. It wasn't until later that the concept grew into support for telephone service.[4]

In 1983, the FCC established the Universal Service Fund (USF) to subsidize rates in high cost areas, supported by contributions of long distance carriers.[5]

Until 1996, the Fund compensated companies providing services in high-cost, low-income and rural areas. However, the Telecommunications Act of 1996 expanded that coverage to include support for rural healthcare providers, and schools and libraries. The Act directed the FCC to establish the support mechanisms to ensure access to consumers in all regions of the country, as well as advanced telecommunications for schools, libraries, and healthcare providers.[6]

Telecommunications service providers and certain other providers are required to pay into the federal USF based on a percentage of their interstate and international end-user telecommunications revenues. Companies in this group of contributors include wireline phone companies, wireless phone companies, paging service companies, and certain Voice over Internet Protocol (VoIP) providers.

Companies contribute a percentage of the amount billed to their residential and business customers for interstate and international calls. The percentage contribution is adjusted every quarter based on projected demand for Universal Service funding. The proposed contribution factor for the second quarter 2010 is 15.3 percent.[7]

A company may choose to pay this USF contribution themselves or recover contributions from its customers. A recovery will be shown on the customer's bill as a "Universal Service" line item. These charges usually appear as a percentage of the consumer's phone bill.

The USF helps provide communities across the country with affordable telecommunications services. The Universal Service Fund supports four programs, as follows:

- High Cost – provides support to ensure that consumers in all regions have access to and pay rates for telecommunications services that are comparable to those in urban areas;
- Low Income - provides discounts that make basic, local telephone service affordable for low-income consumers;

[4] Gasman, CATO Institute, Universal Service: The New Telecommunications Entitlements and Taxes, http://www.cato.org/pubs/pas/pa-310.html

[5] Weinberg, The Internet and "Telecommunications Services," Universal Service Mechanisms, Access Charges and Other Flotsam of the Regulatory System, http://faculty.law.wayne.edu/Weinberg/FLOTSAM.a04.pdf

[6] http://www.law.cornell.edu/uscode/uscode47/usc_sec_47_00000254----000-.html

[7] http://www.fcc.gov/omd/contribution-factor.html

- Rural Health Care - provides reduced rates to rural health care providers for telecommunications and Internet services so they pay rates comparable to urban providers for similar services;
- Schools & Libraries - commonly referred to as E-rate support, provides affordable telecommunications and Internet access services to connect schools and libraries to the Internet.[8]

The USF is administered by the Universal Service Administrative Company (USAC), an independent, not-for-profit corporation.

[8] http://www.usac.org/about/usac/

The Rural Health Care Program

History

The Rural Health Care Program provides reduced rates for eligible rural health care providers for telecommunications and Internet services. This Program was created by Section 254 of the Telecommunications Act of 1996. Section 254 specifically addressed the needs of healthcare providers by ensuring access to advanced telecommunications services. [9] Language from Section 254 is shown below.

> (b) UNIVERSAL SERVICE PRINCIPLES - The Joint Board and the Commission shall base policies for the preservation and advancement of universal service on the following principles:
>
> > (6) ACCESS TO ADVANCED TELECOMMUNICATIONS SERVICES FOR SCHOOLS, HEALTH CARE, AND LIBRARIES- Elementary and secondary schools and classrooms, health care providers, and libraries should have access to advanced telecommunications services as described in subsection (h).
>
> (h) TELECOMMUNICATIONS SERVICES FOR CERTAIN PROVIDERS-
> 1) IN GENERAL-
> A) HEALTH CARE PROVIDERS FOR RURAL AREAS- A telecommunications carrier shall, upon receiving a bona fide request, provide telecommunications services which are necessary for the provision of health care services in a State, including instruction relating to such services, to any public or nonprofit health care provider that serves persons who reside in rural areas in that State at rates that are reasonably comparable to rates charged for similar services in urban areas in that State. A telecommunications carrier providing service under this paragraph shall be entitled to have an amount equal to 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 treated as a service as a part of its obligation to participate in the mechanisms to preserve and advance universal service.[10]

The Program was originally established with a funding cap of $400 million annually, and has undergone a number or changes since its initial creation. See Appendix A for additional information on the historical changes to the program.

In 2009, just over $61million was distributed under the Rural Health Care Program, of a total USF distribution of $7.3 billion.

Estimated 2009 Support:	$7.3 billion
High Cost:	$4.3 billion
Low Income:	$1.0 billion
Rural Health Care:	$61 million

[9] American Hospital Association, The Rural Health Care Universal Service Support Program, http://www.aha.org/aha/content/2004/pdf/univsersum.pdf

[10] Excerpts from Section 254 of the Telecommunications Act of 1996, http://www.fcc.gov/learnnet/254.html

Schools & Libraries: $1.95 billion[11]

Wyoming Participation

Table 1 below shows the allocation by state and program for calendar year 2009. [12]

[11] Universal Service Fund Facts, http://www.usac.org/about/universal-service/fund-facts/fund-facts.aspx

[12] Universal Service Fund Disbursements by Program, http://www.usac.org/about/universal-service/fund-facts-charts/usf-Disbursements-by-Program.pdf

Table 1. USAC Disbursements for 2009 by State and Program

Universal Service Fund Disbursements by Program

Calendar Year 2009
Unaudited (in thousands)

State	High Cost	Low Income	Rural Health Care	Schools & Libraries	Total 2009 Disbursements	Total All Programs 1998–2009
Alabama	$ 100,060	$ 25,652	$ 229	$ 28,922	$ 154,864	$ 1,459,057
Alaska	168,272	24,479	29,122	22,542	244,415	1,716,677
American Samoa	3,938	38	141	4,282	8,399	42,640
Arizona	67,204	21,812	1,954	49,278	140,248	1,327,003
Arkansas	148,252	4,018	401	14,974	167,645	1,516,311
California	107,507	194,238	942	281,161	583,848	6,862,415
Colorado	79,397	2,904	234	14,452	96,987	1,026,788
Connecticut	(390)	5,388	0	22,255	27,253	308,150
Delaware	226	661	0	831	1,719	19,946
District of Columbia	0	1,077	0	8,440	9,517	92,898
Florida	70,395	74,719	854	75,933	221,901	1,686,717
Georgia	136,139	33,513	1,989	67,875	239,515	1,984,611
Guam	16,649	307	101	334	17,391	122,505
Hawaii	58,415	494	196	1,930	61,035	321,761
Idaho	50,779	3,602	257	4,750	59,387	633,319
Illinois	74,939	13,648	1,389	63,987	153,963	1,540,132
Indiana	74,417	4,916	822	22,702	102,857	843,822
Iowa	127,434	4,314	571	9,899	142,218	1,027,786
Kansas	230,301	3,127	327	15,278	249,033	1,797,542
Kentucky	101,804	9,802	708	28,136	140,450	1,126,960
Louisiana	156,494	12,011	40	35,427	203,971	1,709,949
Maine	27,443	6,798	63	6,159	40,463	504,881
Maryland	3,965	857	0	9,850	14,672	190,234
Massachusetts	2,412	21,042	150	22,729	46,333	507,007
Michigan	63,193	30,328	941	51,300	145,762	1,248,063
Minnesota	127,037	7,042	2,637	17,168	153,884	1,327,691
Mississippi	281,267	9,879	148	29,982	321,276	2,529,824
Missouri	108,639	8,197	578	26,168	143,582	1,375,387
Montana	79,855	3,875	843	4,201	88,774	849,851
Nebraska	116,611	2,156	1,391	9,004	129,162	791,307
Nevada	25,570	2,906	73	4,295	32,844	361,697
New Hampshire	8,575	745	11	2,285	11,616	135,364
New Jersey	1,058	15,053	0	37,106	53,217	539,597
New Mexico	71,390	14,595	386	26,912	113,283	1,019,184
New York	44,967	60,081	62	237,857	342,967	3,358,285
North Carolina	85,634	33,899	312	57,744	177,590	1,322,974
North Dakota	94,452	3,100	1,201	3,560	102,313	726,082
Northern Mariana Islands	1,308	168	0	1,142	2,618	39,891
Ohio	33,857	36,707	426	63,578	134,568	1,281,415
Oklahoma	142,547	71,141	809	35,314	249,810	1,889,210
Oregon	78,825	5,412	312	15,057	99,606	939,835
Pennsylvania	57,769	21,602	109	69,524	149,005	1,366,845
Puerto Rico	74,387	28,854	0	8,735	111,976	1,824,162
Rhode Island	33	3,425	0	5,466	8,924	110,147
South Carolina	98,375	9,628	47	37,412	145,462	1,240,299
South Dakota	97,337	3,333	1,388	5,536	107,593	764,429
Tennessee	58,896	31,349	242	49,110	139,597	1,087,442
Texas	262,048	101,913	889	155,009	519,859	4,950,984
Utah	19,220	3,808	666	15,628	39,322	356,141
Vermont	21,208	2,575	115	1,382	25,281	353,997
Virgin Islands	15,986	77	74	2,014	18,152	318,448
Virginia	72,933	15,297	731	29,056	117,916	1,048,792
Washington	94,458	17,704	80	27,850	140,092	1,292,873
West Virginia	58,640	1,189	308	10,647	70,784	818,795
Wisconsin	139,287	9,340	5,281	22,569	176,477	1,505,659
Wyoming	50,740	469	148	3,559	54,916	575,844
TOTAL BY PROGRAM	$ 4,292,180	$ 1,025,194	$ 60,698	$ 1,878,295	$ 7,256,367	$ 65,719,680

Note: Numbers may not add due to rounding.

In calendar year 2009, Wyoming providers received approximately $148,000 in Rural Health Care Program support. That support benefitted 18 Wyoming healthcare providers, as shown in Table 2 below.[13]

Table 2. 2009 Program Participation by Wyoming Providers

Count	HCP Number	HCP Name	City	County	State	Posting Date	Allowable Contract Date
1	11252	IHS/BIL Fort Washakie Health Center	Ft. Washakie	WY-Fremont	WY	4/15/2009	5/13/2009
2	11334	IHS/BIL Arapahoe Health Center	Arapahoe	WY-Fremont	WY	4/15/2009	5/13/2009
3	11400	Memorial Hospital of Converse County	Douglas	WY-Converse	WY	5/31/2009	6/28/2009
4	11804	Community Hospital-Torrington	TORRINGTON	WY-Goshen	WY	5/20/2009	6/17/2009
5	11822	Platte County Memorial Hospital	WHEATLAND	WY-Platte	WY	5/20/2009	6/17/2009
6	11825	Washakie Medical Center	WORLAND	WY-Washakie	WY	5/20/2009	6/17/2009
7	12256	NORTH BIG HORN HOSPITAL	LOVELL	WY-Big Horn	WY	8/7/2009	9/4/2009
8	12368	CAMPBELL COUNTY MEMORIAL HOSPITAL	GILLETTE	WY-Campbell	WY	6/3/2009	7/1/2009
9	12719	Star Valley Medical Center	Afton	WY-Lincoln	WY	9/2/2009	9/30/2009
10	12981	West Park Hospital	Cody	WY-Park	WY	4/9/2009	5/7/2009
11	14235	Niobrara County Hospital	Lusk	WY-Niobrara	WY	9/27/2009	10/25/2009
12	16124	Memorial Hospital of Sweetwater County	Rock Springs	WY-Sweetwater	WY	7/16/2009	8/13/2009
13	16368	Weston County Hospital District	Newcastle	WY-Weston	WY	5/8/2009	6/5/2009
14	17029	Sheridan Memorial Hospital	Sheridan	WY-Sheridan	WY	2/18/2010	3/18/2010
15	17433	St Johns Medical Center	Jackson	WY-Teton	WY	5/27/2009	6/24/2009
16	17478	Hot Springs County Memorial Hospital	Thermopolis	WY-Hot Springs	WY	5/26/2009	6/23/2009
17	17480	Big Horn Clinic	Basin	WY-Big Horn	WY	5/26/2009	6/23/2009
18	18054	Castle Rock Hospital District	Green River	WY-Sweetwater	WY	8/25/2009	9/22/2009

Recommendation 1: *Wyoming should work to increase the Rural Health Care Program reimbursement collected by eligible Health Care Providers.*

As shown in Table 3 below, Wyoming has the lowest total Rural Health Care Program reimbursement and the third lowest per capita reimbursement of the states in its geographic region.

[13] http://www.rhc.universalservice.org/serviceproviders/searchpostings/default.asp

Table 3. Comparison of Rural Health Care Program Reimbursements in Neighboring States

State	2009 Program Reimb.	2009 State Population	Reimb. / Capita		
Colorado	$234,000	5,024,748	$0.05		
Montana	$843,000	974,989	$0.86		
Nebraska	$1,391,000	1,796,619	$0.77		
N. Dakota	$1,201,000	646,844	$1.86		
S, Dakota	$1,388,000	812,383	$1.71		
Utah	$666,000	2,784,572	$0.24		
Wyoming	$148,000	544,270	$0.27		
	$5,871,000	12,584,425			
Average			$0.47		
Note: Population estimates - 2009 Bureau of the Census Population Estimates,					
http://www.census.gov/popest/states/NST-ann-est.html					

Increasing Wyoming's per capita amount to the average of the regional amount would yield an estimated reimbursement of approximately $256,000 annually.

As shown earlier, the Rural Health Care program has the lowest annual disbursement of any of the USF programs, and has traditionally been underutilized. In response to this underutilization, the FCC created the Rural Health Care Pilot Program to support costs associated with construction of state or regional broadband networks to serve healthcare providers.[14] Wyoming was one of 42 states receiving a grant under this program.[15]

The FCC has outlined program operating requirements in 45 CFR Part 54, Subpart G. See Appendix B for a reprint of those regulations.

[14] Federal Communications Commission, Bringing Broadband to Rural America: Report on a Rural Broadband Strategy, May 22, 2009, http://www.fcc.gov/Document_Indexes/WCB/2009_index_WCB_Report.html

[15] http://www.fcc.gov/cgb/rural/rhcp.html

Steps in the Rural Health Care Program

There are nine basic steps in the Rural Health Care Program process:

- Determine eligibility
- Submit a service request
- Evaluate and accept a bid for service
- Sign a contract
- Submit a service agreement form
- Receive funding commitment letter
- Submit confirmation of service
- Receive support schedule
- Receive credit for service.

The following text discusses the steps in the Rural Health Care process.

Determine Eligibility

This issue of eligibility concerns both the Health Care Provider's eligibility to participate in the Program as well as the services eligible for reimbursement.

Eligible Health Care Providers

For the most part, HCPs must be both rural and not-for-profit entities.

The definition of rural was established by the FCC, and the FCC has provided a search tool to determine rural status on their website.[16] The Wyoming results are shown in Table 4 below.[17] With the exception of Laramie and Natrona Counties, and the bulk of Albany County, the rest of Wyoming is considered rural. Only census tract 9639 in Albany County is rural.

[16] http://www.universalservice.org/rhc/tools/rhcdb/Rural/2005/search.asp
[17] http://www.universalservice.org/rhc/tools/rhcdb/Rural/2005/result.asp

Table 4. List of FCC Designated Rural Areas in Wyoming

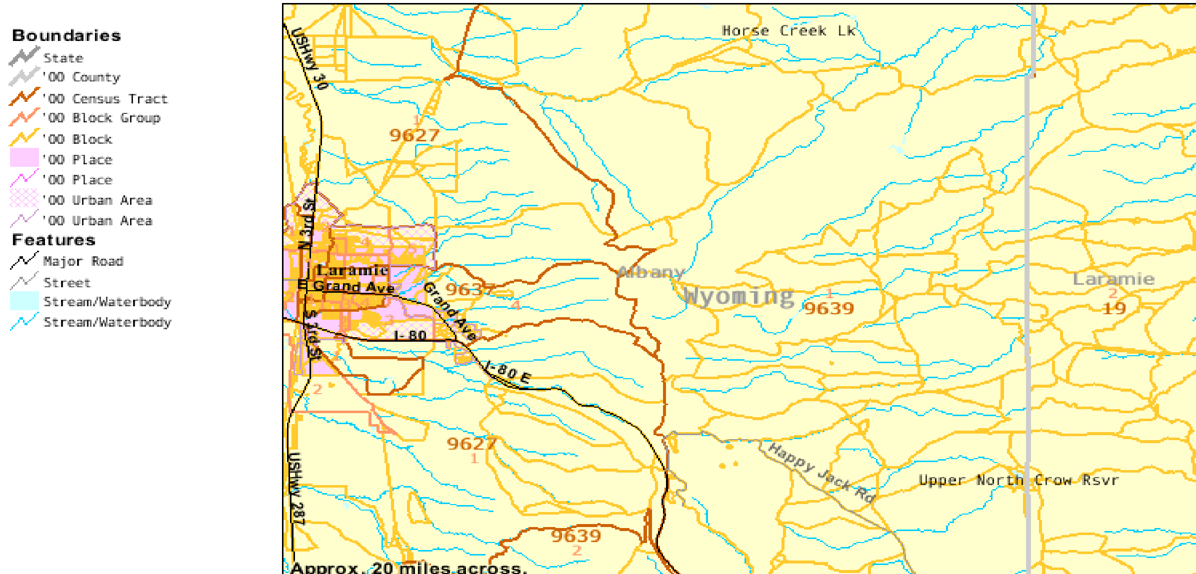
List of Eligible Rural Areas - Wyoming

Search Again >

State	County	Rural Eligibility
Wyoming	Albany	Rural only in 9639.00
Wyoming	Big Horn	Rural
Wyoming	Campbell	Rural
Wyoming	Carbon	Rural
Wyoming	Converse	Rural
Wyoming	Crook	Rural
Wyoming	Fremont	Rural
Wyoming	Goshen	Rural
Wyoming	Hot Springs	Rural
Wyoming	Johnson	Rural
Wyoming	Laramie	Urban
Wyoming	Lincoln	Rural
Wyoming	Natrona	Urban
Wyoming	Niobrara	Rural
Wyoming	Park	Rural
Wyoming	Platte	Rural
Wyoming	Sheridan	Rural
Wyoming	Sublette	Rural
Wyoming	Sweetwater	Rural
Wyoming	Teton	Rural
Wyoming	Uinta	Rural
Wyoming	Washakie	Rural
Wyoming	Weston	Rural

In Albany County, census tract 9639 is located east of the city of Laramie, near the Laramie County border, as shown in Figure 1 below.

Figure 1. Map of Census Tract 9639 in Albany County



In addition to being rural and non-profit, HCPs should fall into one of the following eligible groups:

- Post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools;
- Community health centers or health centers providing health care to migrants;
- Local health departments or agencies;
- Community mental health centers;
- Not-for-profit hospitals;
- Rural health clinics;
- Consortia of HCP's consisting of one or more of the above entities;
- Dedicated emergency departments of rural for-profit hospitals;
- Part-time eligible entities located in facilities that are ineligible.[18]

Eligible Services

The second eligibility segment of the Rural Health Care Program is eligible services. Providers are eligible for reimbursement of a variety of charges, including

- ATM (Asynchronous Transfer Mode)
- Centrex
- DSL
- Ethernet
- Fiber
- Fractional T1
- Frame Relay

[18] http://www.universalservice.org/rhc/health-care-providers/step01/eligible-health-care-providers.aspx

- Internet Access Charges
- ISDN
- Mileage-related Charges
- MPLS
- NRS – Network Reconfiguration Service
- OC-1
- OC-3
- Redundant Circuit
- Satellite Service
- Telephone Service
- T1
- T3 or DS3.[19]

Eligible Internet services are limited to the following:

- Monthly Internet access charges
- Email
- Web hosting.[20]

Submit a Service Request – Form 465

The second step in the Process is posting a service request with the USAC. The submission is done by filing an FCC Form 465.[21] The form 465 serves two purposes: it enables an HCP to obtain bids for supported services and also certifies that the HCP meets eligibility requirements.

Eligible HCPs are required by FCC regulation to use a competitive bid process to select telecommunications providers. See Appendix B for the text of the regulations.

> **§ 54.603 Competitive bid requirements.**
>
> (a) *Competitive bidding requirement.* To select the telecommunications carriers that will provide services eligible for universal service support to it under this subpart, each eligible health care provider shall participate in a competitive bidding process pursuant to the requirements established in this subpart and any additional and applicable state, local, or other procurement requirements.
>
> (b) *Posting of FCC Form 465* . (1) An eligible health care provider seeking to receive telecommunications services eligible for universal service support under this subpart shall submit a completed FCC Form 465 to the Rural Health Care Division…..

HCPs are required to obtain an FCC Registration Number prior to filing the Form 465. The online process for an FCC Registration Number is available on the FCC website[22] or by filing an FCC Form 160.[23] Upon successful registration, an HCP will receive an FCC Registration Number and a password for use of the FCC Commission Registration System (CORES).

---

[19] http://www.universalservice.org/rhc/health-care-providers/step01/eligible-services.aspx
[20] http://www.universalservice.org/rhc/health-care-providers/step01/eligible-services.aspx
[21] Available for download at http://www.usac.org/rhc/tools/required-forms.aspx
[22] https://fjallfoss.fcc.gov/coresWeb/publicHome.do
[23] http://www.fcc.gov/Forms/Form160/160.pdf

Once the FCC Registration Number is received, HCPs can file the Form 465. First time filers must submit a paper copy of the Form 465. Based on the initial filing, the USAC will provide first-time filers with an HCP number. The HCP number and CORES password will allow HCPs to file and certify subsequent documents electronically. These include additional Forms 465 (Description of Requested Services), 466 (Description of Services Requested and Certification), 466-A (Internet Service Funding Request and Certification Form), and 467 (Receipt of Service Confirmation).[24]

The FCC Form 465 consists of two pages, with sections requesting information on location, contact information, funding year, eligibility, services to be reimbursed, and required certifications.

Once the Form 465 is filed and accepted by the USAC, it is posted to the USAC website, and the USAC sends an acknowledgement to the HCP. The acknowledgement will indicate the earliest date on which an HCF may contract for telecommunications services. The posting must remain on the USAC website a minimum of 28 days. During the 28 days, telecommunications providers can use the website to search for postings and respond to the HCP.[25]

Evaluate and Accept a Bid for Service

During the 28-day period following posting of the Form 465 to the USAC website, HCPs may issue Requests for Proposal (RFPs) or contact telecommunications providers directly to obtain bids for service. Additionally, service providers may contact the HCPs directly to offer or negotiate service rates. HCPs must wait for the full 28-day period to expire before entering into an agreement for services. Additionally, the service chosen must be the most cost-effective and must be provided by a common carrier.
The regulations at 47 CFR 54.603 (b)(2) define the most cost effective method 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."

Service providers must also be eligible to participate in the program. This includes all telecommunications companies who provide program eligible services.[26] However, providers must register with the USAC and be issued a Service Provider Identification Number (SPIN) to participate in the program.

Sign a Contract

Following expiration of the 28-day period, review and evaluation of bids, and selection of the most cost effective method, an HCP may enter into a service agreement with the preferred service provider.

Contracts containing all required information are considered long-term or "evergreen" contracts.

> **Evergreen Contracts:** A contract that has been reviewed and approved by USAC is considered "evergreen" if the following conditions are met:
> a) Both parties to the contract have signed and dated the agreement

[24] http://www.rhc.universalservice.org/onlineforms/default.asp
[25] http://www.rhc.universalservice.org/serviceproviders/searchpostings/default.asp
[26] http://www.universalservice.org/rhc/service-providers/step01/

b) The type and terms of service are specified
c) The duration is specified

HCPs that present such contracts will be considered to have "evergreen" status, meaning that for the life of the contract (without any optional extension), they need not re-compete the service (by posting an FCC Form 465), and may annually apply for support of the contracted service by filing the Form 466 and/or Form 466-A.

A contract that does not meet these FCC requirements is considered to have month-to-month status and the HCP must post an FCC Form 465 and select the most cost-effective service and service provider each year.[27]

Submit a Service Agreement Form

Activities to this point have prepared the program application. Two forms are needed to actually request the reimbursement:

- Form 466 – for non-internet services
- Form 466-A – for internet services (see Appendix C for examples of both forms).

In addition to the completed forms, HCPs should include all required documentation, such as

- Copies of bills showing service costs;
- A network diagram for a large network or consortium member;
- Type of service and bandwidth;
- Copies of any bids received in response to posting of the Form 465;
- Copies of contracts.

The deadline for filing the Forms 466 and 466-A is June 30 of the funding year.

Form 466

The Form 466 requests information for reimbursement of non-internet services and addresses the following:

- Type of service;
- Service provider;
- Mileage based or comparative rate adjustment;
- Bid information;
- Certifications on cost effective method, record keeping, and authorization to submit reimbursement requests.

A significant item on the Form 466 is the selection between the two methods of calculating reimbursements for eligible costs:

- A mileage-based calculation;
- A comparison of the differences between urban and rural rates.

Mileage-based Calculation

The mileage-based calculation is made using four pieces of information:

1. Total billed miles for the connection or circuit distance,

[27] http://www.usac.org/rhc/tools/glossary-terms-II.aspx

2. Cost per mile,
3. Maximum Allowable Distance (MAD),
4. Standard Urban Distance (SUD) for the state.

Total billed miles and cost per mile are obtained from the telecommunications provider. The Maximum Allowable Distance (MAD) is the distance from the health care provider, in whole miles, to the far side of the largest city in the HCP's state.[28] The Standard Urban Distance is a mileage allowance for urban areas. There is a single SUD for each state (Wyoming = 10 miles).[29]

Briefly stated, the USF will support reimbursement for the lesser of the

- Circuit distance (CD) less the SUD x cost/mile, or
- MAD less the SUD x cost/mile.

For example, assume the circuit distance is 150 miles, the cost per mile is $5.00, the Wyoming SUD is 10 miles, and the MAD (distance from the HCP to the largest city in Wyoming) is 110 miles.

CD (150) – SUD (10) = 140 x $5.00 = $700.00
MAD (110) – SUD (10) = 100 x $5.00 = $500.00

The mileage-based support would be the lesser of the amounts, or $500.00 per month.

Urban/Rural Rate Comparison

In the comparative rate method, HCPs make a comparison between urban and rural rates for similar services in their state, and calculate support equal to the difference between what they pay (the rural rate) and what they would pay if they were receiving the service in the largest city with a population of 50,000 or more in their state (the urban rate). Both monthly recurring service charges and one-time installation charges are eligible for reimbursement.

The urban/rural comparison requires four pieces of information:

1. The rural charge for service;
2. The rural charge for installation;
3. The urban charge for comparable service;
4. The urban charge for installation for comparable service.

The rural service and installation charges would be obtained from the HCP's telecommunications provider.

Because there may be differences in service offerings between rural and urban areas, the FCC allows HCPs to compare functionally similar services.

> Applicants may compare rates for functionally similar services as viewed from the end user's perspective. Services are considered functionally similar when operated at advertised speeds within the same category (see below) and when the nature of the service is the same (symmetrical or asymmetrical). The FCC's November 2003 Order created the following "safe harbor" categories of functionally equivalent services:

[28] http://www.universalservice.org/rhc/tools/glossary-terms-II.aspx
[29] http://www.universalservice.org/rhc/health-care-providers/step05/standard-urban-distance.aspx

Low	144 - 256 kilobytes per second (kbps)
Medium	257 - 768 kbps
High	769 - 1,400 kbps
T-1	1.4 - 8 Megabits per second (mbps)
T-3	8.1 - 50 mbps[30]

The USAC publishes urban rates for comparable services by state on their website. The Wyoming information is shown in Figure 2 below.

Figure 2. Wyoming Urban Rates by Service Type[31]

USAC
Universal Service Administrative Company
Helping Keep Americans Connected
Rural Health Care

Home > Rural Health Care Main > Search Tools > Urban Rates Search > Results

2010 Urban Rates for WY

Service	Monthly Recurring Charge
DS3 MTM	$2,800.00
DS1	$224.60
FR 1.544 MTM	$366.50
FR 768 MTM	$436.50
FR 512 MTM	$361.50
FR 384 MTM	$326.50
FR 256 MTM	$286.50
FR 128 MTM	$140.00
FR 64 MTM	$111.53
FR 56 MTM	$111.53

Search Again >

Last Modified: March 18, 2010

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If HCP does not want to use the published rates, it can obtain and the urban rate for the largest city with a population of 50,000 or more in the HCP's state.

In many cases, contract rates are lower than the month-to-month rates posted on USAC's website. USAC will allow HCPs to use this lower rate, by submitting their contract showing the lower rates with the Form 466. USAC will validate the contract, and use the lower rate, if applicable

The USAC does not publish a list of comparable urban installation costs.

[30] http://www.universalservice.org/rhc/tools/rhc-search-tools/urban-rates-search.aspx
[31] http://www.universalservice.org/rhc/tools/rhcdb/UrbanRates/2010/result.asp

Briefly stated, the USF will support reimbursement for the difference between the urban rate and rural rate for all non-distance sensitive charges based on functionally similar services.

For example, assume the urban rate in Table 2 for a T-1 line of $366.50, a one-time urban installation charge of $1,160.00, a monthly recurring rural charge of $800.00, and a one-time rural installation charge of $1,600.00.

Rural monthly ($800.00) – Urban monthly ($366.50) = $433.50
Rural install ($1,600.00) – Urban install ($1,160.00) = $440.00 (one time only)

In this case, the rural HCP would receive ongoing monthly support of $433.50 and a one-time installation support of $440.00.

Form 466-A

Form 466-A requests information on internet services, addressing the following areas:

- Type of service;
- Cost of service;
- Certifications on cost effective method, record keeping, and authorization to submit reimbursement requests.

The FCC defines (FCC) defines eligible Internet access as "an information service that enables rural health care providers to post their own data, interact with stored data, generate new data, or communicate over the World Wide Web." Transmissions must traverse the Internet in some fashion. Internal connections, computer equipment or other telecommunications equipment, even when used to access the Internet, are not eligible for support. [32]

HCPs can receive up to 25% of the monthly costs for eligible Internet access charges, when using a toll-free service. For those HCP without access to a toll-free connection, reimbursement is available for the lesser of 30 hours of connection charges or $180.00 monthly.

> **§ 54.621 Access to advanced telecommunications and information services.**
>
> (a) Twenty-five percent of the monthly cost of eligible Internet access shall be eligible for universal support. Health care providers shall certify that the Internet access selected is the most cost-effective method for their health care needs as defined in §54.615(c)(7), and that purchase of the Internet access is reasonably related to the health care needs of the rural health care provider.
>
> (b) Each eligible health care provider that cannot obtain toll-free access to an Internet service provider shall be entitled to receive the lesser of the toll charges incurred for 30 hours of access per month to an Internet service provider or $180 per month in toll charge credits for toll charges imposed for connecting to an Internet service provider.

[32] http://www.usac.org/_res/documents/rhc/pdf/forms/2010/Form-466-A-FY2010-instructions.pdf

(c) Health care providers located in States that are entirely rural shall be eligible to receive universal service support equal to 50 percent of the monthly cost of advanced telecommunications and information services reasonably related to the health care needs of the facility.[33]

Receive Funding Commitment Letter

The USAC will review the FCC Form 466 and/or 466-A and supporting documentation submitted by the HCP, and make a determination as to eligibility for reimbursement. If eligible, the USAC will forward a Funding Commitment Letter (FCL) and a Form 467, *Connection Certification Form* to the HCP, along with a copy of the FCL to the HCP's telecommunications provider.

The HCL will confirm eligibility and the reimbursement amount. Reimbursement is not official until the HCL is issued to the HCP. The Form 467 is covered in the next Section.

Submit confirmation of service

The HCP confirms that the intended service has begun by filing the Form 467. Form 467 can be filed only after the HCP receives the Funding Commitment Letter and the telecommunications provider has initiated the intended service. Reimbursement of eligible services will commence once the USAC receives and processes the From 467. The Form 467 is the last form in the application process. See Appendix C for a copy of the form.

A separate Form 467 must be filed for each Form 466 or Form 466-A which was previously filed by the HCP. The Form 467 is also used to notify the USAC when a reimbursed service has been discontinued.

The HCP will receive service credits directly from the telecommunications provider, who in turn will receive financial reimbursement from the USAC. Support will be provided by USAC directly to the telecommunications provider. Further information on this process is provided in the next two sections.

Receive support schedule

Once the USAC has received and approved the Form 467, it will send a Support Schedule to the HCP and the telecommunications provider. The Support Schedule (see Appendix C for an example) contains information on items such as:

- Funding year;
- Identification and contact information for the HCP;
- Identification and contact information for the telecommunications provider;
- Support start and end dates;
- Monthly and annual support amounts.

A third party may act on behalf of the HCP in the billing process. The FCC allows the credit to flow from the telecommunications provider to the designated third party. The Billing Account Number on the Support Schedule should reflect the correct entity that receives and pays the bill for the HCP. The billing entity information is initially entered in Block 2 of the Form 466 or Form 466-A, as appropriate.

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[33] See Appendix B.

The HCP should review all information on the Support Schedule for accuracy. Service credits will be based on information in the Support Schedule.

Once the telecommunications provider receives the Form 467, it can begin crediting or making a direct reimbursement to the HCP for eligible services.

Receive credit for service

The final step in the process is for the telecommunications provider to receive payment from the USAC for eligible service credits or reimbursements to the HCP. Eligible telecommunications providers have established a USF account with the USAC, and credits are made to those accounts by the USAC.

Estimated Support Payments to Wyoming Telehealth Network Participants

The Wyoming Telehealth Network (WTN) has applied for and received an FCC Rural Health Care Pilot Program grant to support network equipment and recurring telecommunications charges for participating sites. There are currently 41 sites committed in the Pilot Program, consisting of hospitals and Mental Health/Substance Abuse Centers. The grant will support network equipment and connectivity to those entities at the T-1 or dual T-1 level.

Eligible HCPs participating in that grant may file for reimbursement under the Rural Health Care Program. Of the 41 sites participating in the Program, 7 are either in an urban location or for-profit organizations, and therefore ineligible. This leaves 34 sites potentially eligible for reimbursement.

Eligible costs would include installation and ongoing monthly circuit charges. Equipment needed for network operations is not eligible for reimbursement. Of the 34 potentially eligible sites, 27 will have single T-1 connectivity and 7 will have dual T-1 connectivity. These services would be eligible for reimbursement.

Recommendation 2*: The Network, on behalf of eligible Wyoming HCPs participating in the Rural Health Care Program should file for reimbursement of eligible charges as soon as possible.*

As discussed earlier, there are two methods for calculating reimbursement of charges: mileage based and urban vs. rural reimbursement. The circuits being supplied through the FCC grant are Asynchronous Transfer Mode (ATM)[34] circuits, and as such are virtual circuits. According to a representative of the telecommunications provider, since these circuits operate virtually, the mileage based reimbursement method discussed earlier would not be applicable.

[34] http://en.wikipedia.org/wiki/ATM_NIC

An estimate of potential reimbursement was made for the eligible charges using the urban vs. rural method for both the one-time installation charges as well as the monthly recurring charges (MRC) for the connectivity.

For the one-time installation charges, the estimated total reimbursement is $8,024.00. This represents approximately 14% of the total installation costs of $57,180.00 for participating sites. The per site reimbursement ranged from a low of zero to a high of $1,644.00, depending upon the site's location.

For the MRCs, monthly reimbursement was estimated at $8,059.04 or $96,708.48 annually. This represents approximately 28.3% of the total MRC of $28,469.74 for participating sites. Monthly reimbursement ranged from zero to $992.44 per month depending upon the site location and bandwidth.

Appendix D shows the detailed calculation.

Administrative Issues

There are a number of administrative and programmatic areas that should be addressed as the WTN prepares to participate in the Rural Health Care Program, as shown below:

- The roles/responsibilities in the procurement and filing process;
- Record keeping and audit requirements;
- Additional requirements on consortia of HCPs.

Roles/responsibilities in the filing process

There are three primary administrative roles and sets of associated responsibilities in the procurement and filing process:

- Service need identification and delivery coordination;
- Filing required forms and making payments;
- Process oversight.

Service need identification and delivery coordination involves a number of responsibilities and activities:

- Identification of the telecommunication needs of the HCPs and the services that best meet those needs;
- Ensuring the eligibility of the HCP and the needed services for USAC reimbursement;
- Seeing and evaluating bids for service delivery, and negotiating contract terms;
- Coordination with the HCPs on the procurement process and service installation and testing;
- Providing appropriate records to administrative staff and coordination on retention of those records.

General administrative duties include filing of necessary forms, making payments to telecommunications providers, and retention of records. Documents to be filed include the Forms 465, 466, 466-A, and 467. Required documents must be retained for a minimum of 5 years, and include the required FCC forms, contracts, invoices, bids, and other consortia records. Additional duties include making estimates of the

reimbursement amounts and matching the estimated reimbursement amounts to the actual reimbursements.

Process and program oversight encompasses a number of responsibilities, including:

- Approving all contracts for services;
- Verifying eligibility of HCPs and services;
- Reviewing and approving all telecommunications provider billings;
- Providing copies of all invoices and other associated documents for retention;
- Ensuring all required documents are retained for the appropriate time period.

Record keeping requirements

HCPs or consortia of HCPs are required to keep the appropriate records, as well as produce records and participate in audits as requested.

In general, HCPs or consortia are required to retain all program records for a period of five years. This includes all forms and supporting schedules, contracts, invoices, payments to telecommunications providers, consortia agreements, network plans, and other materials that would support the reimbursement process. For consortia, this requirement pertains to all members and activities of the consortium, including both eligible and not eligible members and activities.

Additionally, HCPs claiming reimbursement for mobile connectivity charges must maintain additional documentation:

- Annual logs of activity, including the location of each clinic stop and number of patients served;
- Documentation to support the price of bandwidth for equivalent wireline services.

Required records must be available to appropriate program auditors, or other federal and state auditors with jurisdiction.

As a condition of program participation, HCPs or consortia must agree to participate in random audits to ensure compliance with program and eligibility requirements.

Additional Consortia requirements

Section 54-601 (a) (2) (vii) of the federal regulations (see Appendix A) allow consortia of multiple HCPs to participate in the Rural Health Care Program. Consortium members can include both eligible and ineligible entities if the Consortium is receiving services at tariffed or market rates.[35]

Service purchased by the Consortium under an aggregated basis must be documented by the Consortium at the time the Form 465 is filed.[36]

The Consortium, in conjunction with the telecommunications provider, also has additional responsibilities for providing eligible members with information needed to make the reimbursement calculation. These include an allocation of total charges under

[35] 54-601 (b) (1)
[36] 54-601 (b) (vi)

the distance based method, or an applicable rural based rate under the rural/urban rate comparison method.

The Consortium may act on behalf of eligible entities when filing the appropriate forms and receiving credit from the telecommunications providers. Block 2 of the Forms 466 and 466-A allow for the designation of a billing entity which can receive the service reimbursement on behalf of the eligible HCP.

> Recommendation 3*: The Wyoming Telehealth Consortium should consider filing as a Consortium of HCPs for the Rural Health Care Program Reimbursement.*

The reimbursements to the Wyoming Telehealth Network (WTN) can be a significant source of cost reductions. Estimates of ongoing WTN operational costs are approximately $1.5 to $1.6 million annually, and the reimbursements could total an estimated 6.2% of annual operating costs.

FCC Broadband Plan

Plan Overview

In March 2010, the FCC released the congressionally mandated National Broadband Plan. The Plan includes a detailed strategy for "… achieving affordability and maximizing use of broadband to advance…" a number of areas, including healthcare delivery.[37]

The healthcare-related recommendations are outlined in Chapter 10 of the Plan. With its recommendations, the FCC moves beyond a telecommunications focus, and looks for ways to support the larger national agenda of improving healthcare outcomes, especially through the consistent, meaningful use of Healthcare Information Technology.

> Broadband is not a panacea. However, there is a developing set of broadband-enabled solutions that can play an important role in the transformation required to address these issues. These solutions, usually grouped under the name health information technology, offer the potential to improve health care outcomes while simultaneously controlling costs and extending the reach of the limited pool of health care professionals. Furthermore, as a major area of innovation and entrepreneurial activity, the health IT industry can serve as an engine for job creation and global competitiveness.
>
> This chapter's recommendations aim to encourage maximum utilization of these solutions. In its traditional role, the FCC would evaluate this challenge primarily through a network connectivity perspective. However, it is the ecosystem of networks, applications, devices and individual actions that drives value, not just the network itself. It is imperative to focus on adoption challenges, and specifically the government decisions that influence the system in which private actors operate, if America is to realize the enormous potential of broadband-enabled health IT.[38]

[37] FCC National Broadband Plan, Executive Summary, http://www.broadband.gov/plan/executive-summary/
[38] FCC National Broadband Plan, Chapter 10, http://www.broadband.gov/plan/10-healthcare/

The FCC National Broadband Plan contains a number of recommendations that may potentially impact telemedicine generally as well as Rural Health Care Program specifically. The focus of this document is the Rural Health Care Program under the Universal Services Fund, This section briefly reviews the Plan's recommendations with impact on the Rural Health Care Program. Appendix E provides additional information on other areas of the Plan with impact on HCPs and healthcare delivery.

Rural Health Care Program Recommendations

The following outlines Plan recommendations that may impact the Rural Health Care Program. These are taken from Chapter 10 of the Plan.[39]

Recommendation 10.6: The FCC should replace the existing Internet Access Fund with a Health Care Broadband Access Fund.

- Support bundled services, such as telecommunications, broadband, broadband based internet access;
- Include both urban and rural providers, based on need;
- Increase program support levels;
- Simplify the application process.

Recommendation 10.7: The FCC should establish a Health Care Broadband Infrastructure Fund to subsidize network deployment to health care delivery locations where existing networks are insufficient.

- Build upon the lessons learned in the FCC Rural Health Care Pilot Program for the Infrastructure Fund:
  - Continue the15% required match as in the FCC Pilot Program;
  - Allow excess infrastructure capacity developed in the FCC Pilot Program to be shared by other participants at incremental cost rather than fair share;[40]
  - Maintain existing FCC Pilot Program criteria such as sustainability, leveraging existing networks, and joining nationwide backbone networks.
- Focus on geographic areas which meet defined needs-based criteria such as the following:
  - Broadband infrastructure is insufficient or unaffordable:
  - Broadband network deployment is more affordable than purchase from existing carriers;
  - HCPs are not receiving viable service proposals from telecommunications providers.
- Simplify the application and administration process for eligible HCPs;
- For non-eligible HCPs, simplify the process to estimate their share of network deployment costs and joint infrastructure deployment projects.

Recommendation 10.8: The FCC should authorize participation in the Health Care Broadband Funds by long-term care facilities, off-site administrative offices, data centers

[39] FCC National Broadband Plan, Chapter 10, http://www.broadband.gov/plan/10-healthcare/

[40] Fair share has been defined as a proportionate share of all costs, including trenching and rights-of-way. http://www.broadband.gov/plan/10-healthcare/

and other similar locations. Congress should consider providing support for for-profit institutions that serve particularly vulnerable populations.

- Expand the definition of eligible HCPs to include those institutions that have become integral in the delivery of care in the United States, and specifically include those entities cited in Recommendation 10.8 above;
- Look to the Office of the National Coordinator (ONC) for guidance on eligible HCPs as Healthcare Information Technology (HIT) evolves;
- Include for-profit entities as eligible HCPs where appropriate;
- Consider extension of the HITECH criteria for HIT adoption incentives to HCPs for eligibility in the Health Care Broadband Funds.

Recommendation 10.9: To protect against waste, fraud and abuse in the Rural Health Care Program, the FCC should require participating institutions to meet outcomes-based performance measures to qualify for USF subsidies, such as HHS's meaningful use criteria.

- Align the FCC Health Care Program criteria with those of other federal programs to measure the efficient use of HIT, such as the Meaningful Use criteria developed by the U.S. Department of Health and Human Services (HHS);
- Work with HHS to develop outcome metrics to assess the FCC program's impact on broadband usage and delivery of medicine;
- Improve FCC program oversight to ensure proper use of funds and impact on broadband usage and delivery of medicine.

Plan Implementation Steps

> Recommendation 4*: The Consortium should follow the FCC's progress in implementing its National Broadband Plan, and take advantage of any opportunities to improve broadband connectivity for Wyoming's HCPs*

Chapter 17 of the Plan outlines recommendations for Implementation and Benchmarks.[41]

There are competing views on how the FCC should proceed with implementation of the Plan recommendations. One thought is that the FCC should request Congress pass legislation authorizing the FCC to implement the specific recommendations. A second thought is that the FCC rely on its existing statutory authority, where applicable, to implement recommendations, and rely on Congressional action for those recommendations outside its existing authority. The FCC indicates it will consider both options as it moves forward.

Recommendation 17.2: The FCC should quickly publish a timetable of proceedings to implement plan recommendations within its authority, publish an evaluation of plan progress and effectiveness as part of the annual Section 706 Advanced Services Inquiry, create a Broadband Data Depository, and continue to utilize Broadband.gov as a public resource for broadband information.

- The FCC should quickly publish a timetable of proceedings for implementing broadband plan recommendations directed to the FCC:

[41] FCC Broadband Plan, Implementation and Benchmarks, http://www.broadband.gov/plan/17-implementation-and-benchmarks/

- Rural Healthcare Pilot Program deadlines have been extended;
- The FCC has set a tentative target date of the third quarter 2010 for issuance of a Notice of Proposed Rulemaking (NPRM) to create a Health Care Infrastructure Fund to support deployment of dedicated health care networks to underserved areas and a Health Care Access Fund to connect hospitals and doctors.

- The Plan should be periodically reviewed and revised to reflect changing conditions;
- The FCC should also create a Broadband Data Depository on the Internet to give researchers and the public better access to the FCC's data;
- The FCC should also continue to utilize Broadband.gov for communicating with the public.

Once the NPRM is released, the FCC expects the process to continue as shown below:

- Comment period (30 to 90 days);
- FCC reply to comments
- Ex-parte presentations[42] (60 days);
- Order establishing rules.[43]

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[42]An ex parte presentation is any written or oral communication by an outside party to the Commission, or any Commission staff involved in decision making, directed to the merits or outcome of a proceeding and not served on (mailed or delivered to) all the parties to the proceeding (if written) or of which all the parties have not been given advance notice (if oral). http://www.fcc.gov/cgb/consumerfacts/howtocomment.html

[43] USAC: Notes from the Rural Health Care monthly conference call: April 8, 2010 http://www.universalservice.org/_res/documents/rhc/pdf/conference-calls/2010/040810minutes.pdf

Appendix A. Changes to the Rural Health Care Program

The following has been adapted from American Hospital Association, The Rural Health Care Universal Service Support Program, http://www.aha.org/aha/content/2004/pdf/univsersum.pdf

The Rural Health Care Program was mandated by the Telecommunications Act of 1996, and has been implemented and undergone a number of changes since then, as described below:

- May 1997 - the FCC released a *Report and Order on Universal Service* implementing Section 254 of the Act;
- January 1998 - a universal service support system became effective;
  - FCC provided guidance concerning the funding mechanism to support telecommunications services used by rural health care providers;
  - Defined eligible services, and stipulated a funding cap of $400 million;
  - Established the Rural Health Care Corporation (RHCC) to administer the Program;
- May 1998 - the Universal Service Administrative Company (USAC) assumed responsibility for the Rural Health Care Program:
- November 1999 - the FCC published the *Fourteenth and Fifteenth Orders on Reconsideration of the Universal Service Order*, addressing concerns with implementation of the Rural Health Care Program.
  - Expanded eligibility of telecommunication carriers to include non-long distance carriers;
  - Streamlined the application process;
  - Changed the discount calculation to distanced based charges paid by rural healthcare providers rather than a comparison of urban and rural published tariffs;
  - Eliminated bandwidth and quantity limits so that any bandwidth and any number of services could be supported.
- November 2003 - the FCC published a *Report and Order, Order on Reconsideration and Further Notice of Proposed Rulemaking* (*Report and Order*):
  - Expanded the scope of entities eligible to receive discounts;
  - Provided support for Internet access;
  - Modified the discount calculation for more flexibility;
  - Expanded eligibility to include dedicated emergency departments of rural for-profit hospitals participating e in Medicare;
  - Expanded eligibility to include not-for-profit entities that function as part-time health care providers;
  - Included support for Internet access equal to 25 percent of the monthly cost for any form of Internet access reasonably related to the health care needs of the facility;
  - Expanded the Maximum Allowable Distance (MAD) for distance based charges to equal the distance from the rural health care provider to the farthest point on the jurisdictional boundary of the city with the largest population in the state;

- Allowed discounts for satellite services even where alternative land-based services may be available;
- Allowed rural health care providers to compare rural rates to urban rates in any city with a population of at least 50,000 in the state;
- Allowed rural health care providers to compare the urban and rural rates for functionally similar services viewed from the perspective of the end user.

Appendix B. 47 C.F.R. Part 54, Subpart G.

From Electronic Code of Federal Regualtions
http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=0bc69de4ffee4393efc78ba249acc072&rgn=div6&view=text&node=47:3.0.1.1.7.7&idno=47

e-CFR data is current as of May 13, 2010

Title 47: Telecommunication
PART 54—UNIVERSAL SERVICE

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Subpart G—Universal Service Support for Health Care Providers

§ 54.601 Eligibility.

(a) *Health care providers.* (1) Except with regard to those services provided under §54.621(b), only an entity that is either a public or non-profit rural health care provider, as defined in this section, shall be eligible to receive supported services under this subpart.

(2) For purposes of this subpart, a "health care provider" is any:

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

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

(iii) Local health department or agency;

(iv) Community mental health center;

(v) Not-for-profit hospital;

(vi) Rural health clinic; or

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

(3) For purposes of this subpart, a rural health care provider is a public or non-profit health care provider located in a rural area, as defined in this subpart.

(i) Any health care provider that was located in a rural area under the definition used by the Commission prior to July 1, 2005, and that had received a funding commitment from

USAC since 1998, remain eligible for support under this subpart though the funding year ending on June 30, 2011.

(ii) [Reserved]

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

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

(c) *Services.* (1) Any telecommunications service that is the subject of a properly completed bona fide request by a rural health care provider shall be eligible for universal service support, subject to the limitations described in this paragraph. The length of a supported telecommunications service may not exceed the distance between the health care provider and the point farthest from that provider on the jurisdictional boundary of the largest city in a state as defined in §54.625(a).

(2) *Internet access and limited toll-free access to internet.* (i) For purposes of this subpart, eligible Internet access is an information service that enables rural health care providers to post their own data, interact with stored data, generate new data, or communicate over the World Wide Web.

(ii) Internet access shall be eligible for universal service support under §54.621(a).

(iii) Limited toll-free access to an Internet service provider shall be eligible for universal service support under §54.621(b).

(3) Advanced telecommunications and information services as provided under §54.621.

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

[62 FR 32948, June 17, 1997, as amended at 64 FR 66787, Nov. 30, 1999; 68 FR 74502, Dec. 24, 2003; 70 FR 6372, Feb. 7, 2005; 73 FR 19438, Apr. 10, 2008]

§ 54.603 Competitive bid requirements.

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

(b) *Posting of FCC Form 465* . (1) An eligible health care provider seeking to receive telecommunications services eligible for universal service support under this subpart shall submit a completed FCC Form 465 to the Rural Health Care Division. FCC Form 465 shall be signed by the person authorized to order telecommunications services for the health care provider and shall include, at a minimum, that person's certification under oath that:

(i) The requester is a public or non-profit entity that falls within one of the seven categories set forth in the definition of health care provider, listed in §54.601(a);

(ii) The requester is physically located in a rural area, unless the health care provider is requesting services provided under §54.621;

(iii) If the health care provider is requesting services provided under §54.621, that the requester cannot obtain toll-free access to an Internet service provider;

(iv) The requested service or services will be used solely for purposes reasonably related to the provision of health care services or instruction that the health care provider is legally authorized to provide under the law in the state in which such health care services or instruction are provided;

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

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

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

(3) After posting an eligible health care providers FCC Form 465 on the Rural Health Care Corporation website, the Rural Health Care Division shall send confirmation of the posting to the entity requesting services. The health care provider shall wait at least 28 days from the date on which its FCC Form 465 is posted on the website before making commitments with the selected telecommunications carrier(s).

(4) After selecting a telecommunications carrier, the health care provider shall certify to the Rural Health Care Division that the provider is selecting the most cost-effective method of providing the requested service or services, where the most cost-effective method of providing a service is defined as the method that costs the least after

consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems relevant to choosing a method of providing the required health care services. The health care provider shall submit to the Administrator paper copies of the responses or bids received in response to the requested services.

(5) The confirmation from the Rural Health Care Division shall include the date after which the requester may sign a contract with its chosen telecommunications carrier(s).

[62 FR 32948, June 17, 1997, as amended at 62 FR 41304, Aug. 1, 1997; 63 FR 2131, Jan. 13, 1998; 68 FR 74502, Dec. 24, 2003]

§ 54.604 Existing contracts.

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

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

(2) [Reserved]

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

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

[63 FR 2131, Jan. 13, 1998; 63 FR 33586, June 19, 1998, as amended at 63 FR 70572, Dec. 21, 1998; 64 FR 22810, Apr. 28, 1999; 71 FR 65750, Nov. 9, 2006]

§ 54.605 Determining the urban rate.

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

(b) If a rural health care provider requests an eligible service to be provided over a distance that is greater than the “standard urban distance,” as defined in paragraph (c) of this section, for the state in which it is located, the urban rate for that service shall be a rate no higher than the highest tariffed or publicly-available rate charged to a

commercial customer for a functionally similar service provided over the standard urban distance in any city with a population of 50,000 or more in that state, calculated as if the service were provided between two points within the city.

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

(d) The Administrator shall calculate the “standard urban distance” and shall post the “standard urban distance” and the maximum supported distance for each state on its website.

[62 FR 32948, June 17, 1997, as amended at 63 FR 2131, Jan. 13, 1998; 63 FR 70572, Dec. 21, 1998; 68 FR 74502, Dec. 24, 2003]

§ 54.607 Determining the rural rate.

(a) The rural rate shall be the average of the rates actually being charged to commercial customers, other than health care providers, for identical or similar services provided by the telecommunications carrier providing the service in the rural area in which the health care provider is located. The rates included in this average shall be for services provided over the same distance as the eligible service. The rates averaged to calculate the rural rate must 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) If the telecommunications carrier serving the health care provider is not providing any identical or similar services in the rural area, then the rural rate shall be the average of the tariffed and other publicly available rates, not including any rates reduced by universal service programs, charged for the same or similar services in that rural area over the same distance as the eligible service by other carriers. If there are no tariffed or publicly available rates for such services in that rural area, or if the carrier reasonably determines that this method for calculating the rural rate is unfair, then the carrier shall submit for the state commission's approval, for intrastate rates, or the Commission's approval, for interstate rates, a cost-based rate for the provision of the service in the most economically efficient, reasonably available manner.

(1) The carrier must provide, to the state commission, or intrastate rates, or to the Commission, for interstate rates, a justification of the proposed rural rate, including an itemization of the costs of providing the requested service.

(2) The carrier must provide such information periodically thereafter as required, by the state commission for intrastate rates or the Commission for interstate rates. In doing so, the carrier must take into account anticipated and actual demand for telecommunications services by all customers who will use the facilities over which services are being provided to eligible health care providers.

§ 54.609 Calculating support.

(a) Except with regard to services provided under §54.621 and subject to the limitations set forth in this subpart, the amount of universal service support for an eligible service provided to a public or non-profit rural health care provider shall be the difference, if any, between the urban rate and the rural rate charged for the service, as defined herein. In addition, all reasonable charges that are incurred by taking such services, such as state and federal taxes shall be eligible for universal service support. Charges for termination liability, penalty surcharges, and other charges not included in the cost of taking such service shall not be covered by the universal service support mechanisms. Rural health care providers may choose one of the following two support options.

(1) *Distance based support.* The Administrator shall consider the base rates for telecommunications services in rural areas to be reasonably comparable to the base rates charged for functionally similar telecommunications service in urban areas in that state, and, therefore, the Administrator shall not include these charges in calculating the support. The Administrator shall include, in the support calculation, all other charges specified, and all actual distance-based charges as follows:

(i) If the requested service distance is less than or equal to the SUD for the state, the distance-based charges for the rural health care provider are reasonably comparable to those in urban areas, so the health care provider will not receive distance-based support.

(ii) If the requested service distance is greater than the SUD for the state, but less than the maximum allowable distance, the distance-based charge actually incurred for that service can be no higher than the distance-based charges for a functionally similar service in any city in that state with a population of 50,000 or more over the SUD.

(iii) “Distance-based charges” are charges based on a unit of distance, such as mileage-based charges.

(iv) Except with regard to services provided under §54.621, a telecommunications carrier that provides telecommunications service to a rural health care provider participating in an eligible health care consortium, and the consortium must establish the actual distance-based charges for the health care provider's portion of the shared telecommunications services.

(2) *Base rate support.* If a telecommunications carrier, health care provider, and/or consortium of health care providers reasonably determines that the base rates for telecommunications services in rural areas are not reasonably comparable to the base rates charged for functionally similar telecommunications service in urban areas in that state, the telecommunications carrier, health care provider, and/or consortium of health care providers may request that the Administrator perform a more comprehensive support calculation. The requester shall provide to the Administrator the information to establish both the urban and rural rates consistent with §54.605 and §54.607, and submit to the Administrator with Form 466 all of the documentation necessary to substantiate the request.

(3) *Base rate support-consortium.* Except with regard to services provided under §54.621, a telecommunications carrier that provides telecommunications service to a rural health care provider participating in an eligible health care consortium, and the

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

(b) Absent documentation justifying the amount of universal service support requested for health care providers participating in a consortium, the Administrator shall not allow telecommunications carriers to offset, or receive reimbursement for, the amount eligible for universal service support.

(c) 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.

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

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

(3) Where a rural health care provider seeks a more expensive satellite-based service when a less expensive terrestrial-based alternative is available, the rural health care provider shall be responsible for the additional cost.

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

(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.

[68 FR 74502, Dec. 24, 2003, as amended at 70 FR 6373, Feb. 7, 2005]

Effective Date Notes: 1. At 68 FR 74502, Dec. 24, 2003, as corrected at 69 FR 3021, Jan. 22, 2004, §54.609 was revised, effective Jan. 23, 2004. Paragraph (d)(2) contains information collection and recordkeeping requirements and will not become effective until approval has been given by the Office of Management and Budget.

2. At 70 FR 6373, Feb. 7, 2005, §54.609 was amended by adding paragraph (e). Paragraph (e) contains information collection and recordkeeping requirements and will not become effective until approval has been given by the Office of Management and Budget.

§ 54.611 Distributing support.

(a) A telecommunications carrier providing services eligible for support under this subpart to eligible health care providers shall treat the amount eligible for support under this subpart as an offset against the carrier's universal service support obligation for the year in which the costs for providing eligible services were incurred.

(b) If the total amount of support owed to a carrier, as set forth in paragraph (a) of this section, exceeds its universal service obligation, calculated on an annual basis, the carrier may receive a direct reimbursement in the amount of the difference.

(c) Any reimbursement due a carrier shall be made after the offset is credited against that carrier's universal service obligation.

(d) Any reimbursement due a carrier shall be submitted to that carrier no later than the end of the first quarter of the calendar year following the year in which the costs were incurred and the offset against the carrier's universal service obligation was applied.

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

(a) 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 at a rate no higher than the highest urban rate, as defined in §54.605, at a distance not to exceed the distance between the eligible health care provider's site and the farthest point on the jurisdictional boundary of the city in that state with the largest population.

(b) This section shall not affect a rural health care provider's ability to obtain supported services under §54.621.

[64 FR 66787, NOV. 30, 1999, as amended at 68 FR 74503, Dec. 24, 2003]

§ 54.615 Obtaining services.

(a) *Selecting a provider.* In selecting a telecommunications carrier, a health care provider shall consider all bids submitted and select the most cost-effective alternative.

(b) *Receiving supported rate.* Except with regard to services provided under §54.621, upon receiving a bona fide request for an eligible service from an eligible health care provider, as set forth in paragraph (c) of this section, a telecommunications carrier shall provide the service at a rate no higher than the urban rate, as defined in §54.605, subject to the limitations set forth in this Subpart.

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

(1) The requester is a public or non-profit entity that falls within one of the seven categories set forth in the definition of health care provider, listed in §54.601(a);

(2) The requester is physically located in a rural area, unless the health care provider is requesting services provided under §54.621; or, if the requester is a mobile rural health care provider requesting services under §54.609(e), that the requester has certified that it is serving eligible rural areas.

(3) If the health care provider is requesting services provided under §54.621, that the requester cannot obtain toll-free access to an Internet service provider;

(4) The requested service or services will be used solely for purposes reasonably related to the provision of health care services or instruction that the health care provider is legally authorized to provide under the law in the state in which such health care services or instruction are provided;

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

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

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

(d) *Annual renewal.* The certification set forth in paragraph (c) of this section shall be renewed annually.

[62 FR 32948, June 17, 1997, as amended at 70 FR 6373, Feb. 7, 2005]

§ 54.617 Resale.

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

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

§ 54.619 Audits and recordkeeping.

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

(2) Mobile rural health care providers shall maintain its annual logs for a period of five years. Mobile rural health care providers shall make its logs available to the Administrator and the Commission upon request.

(b) *Production of records.* Health care providers shall produce such records at the request of any auditor appointed by the Administrator or any other state or federal agency with jurisdiction.

(c) *Random audits.* Health care providers shall be subject to random compliance audits to ensure that requesters are complying with the certification requirements set forth in §54.615(c) and are otherwise eligible to receive universal service support and that rates charged comply with the statute and regulations.

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

[68 FR 74503, Dec. 24, 2003, as amended at 69 FR 12087, Mar. 15, 2004; 70 FR 6373, Feb. 7, 2005; 71 FR 13281, Mar. 15, 2006; 72 FR 54218, Sept. 24, 2007]

§ 54.621 Access to advanced telecommunications and information services.

(a) Twenty-five percent of the monthly cost of eligible Internet access shall be eligible for universal support. Health care providers shall certify that the Internet access selected is the most cost-effective method for their health care needs as defined in §54.615(c)(7), and that purchase of the Internet access is reasonably related to the health care needs of the rural health care provider.

(b) Each eligible health care provider that cannot obtain toll-free access to an Internet service provider shall be entitled to receive the lesser of the toll charges incurred for 30 hours of access per month to an Internet service provider or $180 per month in toll charge credits for toll charges imposed for connecting to an Internet service provider.

(c) Health care providers located in States that are entirely rural shall be eligible to receive universal service support equal to 50 percent of the monthly cost of advanced telecommunications and information services reasonably related to the health care needs of the facility.

[68 FR 74503, Dec. 24, 2003, as amended at 70 FR 6373, Feb. 7, 2005]

Effective Date Notes: At 68 FR 74503, Dec. 24, 2003, as corrected at 69 FR 3021, Jan. 22, 2004, §54.621 was revised, effective Jan. 23, 2004. Paragraph (a) contains information collection and recordkeeping requirements and will not become effective until approval has been given by the Office of Management and Budget.

§ 54.623 Cap.

(a) *Amount of the annual cap.* The annual cap on federal universal service support for health care providers shall be $400 million per funding year, with the following exceptions.

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

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

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

(2) [Reserved]

(3) [Reserved]

(4) The Administrator shall implement a filing period that treats all rural health care providers filing within the period as if their applications were simultaneously received.

(d) *Annual filing requirement.* Health care providers shall file new funding requests for each funding year.

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

(f) *Pro-rata reductions.* Administrator shall act in accordance with this paragraph when a filing period described in paragraph (c) of this section is in effect. When a filing period

described in paragraph (c) of this section closes, Administrator shall calculate the total demand for support submitted by all applicants during the filing window. If the total demand exceeds the total support available for the funding year, Administrator shall take the following steps:

(1) Administrator shall divide the total funds available for the funding year by the total amount of support requested to produce a pro-rata factor.

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

(3) Administrator shall multiply the pro-rata factor by the total dollar amount requested by each applicant. Administrator shall then commit funds to each applicant consistent with this calculation.

[62 FR 32948, June 17, 1997, as amended at 62 FR 56120, Oct. 29, 1997; 63 FR 2132, Jan. 13, 1998; 63 FR 3832, Jan. 27, 1998; 63 FR 43097, Aug. 12, 1998; 63 FR 70572, Dec. 21, 1998; 64 FR 2594, Jan. 15, 1999; 64 FR 30442, June 8, 1999; 70 FR 6373, Feb. 7, 2005; 71 FR 65750, Nov. 9, 2006]

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

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

(b) An eligible rural health care provider may purchase an eligible telecommunications service, as defined in §54.601(c)(1) through (c)(2), that is provided over a distance that exceeds the maximum supported distance.

(c) If an eligible rural health care provider purchases an eligible telecommunications service, as defined in §54.601(c)(1) through (c)(2), that exceeds the maximum supported distance, the health care provider must pay the applicable rural rate for the distance that such service is carried beyond the maximum supported distance.

[63 FR 2132, Jan. 13, 1998, as amended at 63 FR 70572, Dec. 21, 1998; 68 FR 74504, Dec. 24, 2003]

Appendix C. Required Forms

The website below provides access to the forms and associated instructions.
http://www.rhc.universalservice.org/forms/

FCC Form 465

FCC Form **465**

Health Care Providers Universal Service
Description of Services Requested & Certification Form

Approval by OMB 3060—0804
Estimated time per response: 1 hour

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

Form 465 Application Number (assigned by RHCD)

Information required in this block applies to the **physical location** of the HCP. Do not enter a "PO Box" or "Rural Route" address.

1 HCP Number	2 Consortium Name	
3 HCP Name	4 HCP FCC Registration Number (FCC RN)	
5 Contact Name		
6 Address Line 1		
7 Address Line 2	8 County	
9 City	10 State	11 ZIP Code
12 Phone # / 13 Fax #		14 E-mail

15 Is the HCP's mailing address (where correspondence should be sent) different from its physical location described in Block 1?
☐ Yes, complete Block 2
☐ No, go to Block 3.

16 Contact Name	17 Organization	
18 Address Line 1		
19 Address Line 2		
20 City	21 State	22 ZIP Code
23 Phone # / 24 Fax #		25 E-mail

26 Funding Year (Check only one box)
☐ Year 2005 (7/1/2005-6/30/2006) ☐ Year 2006 (7/1/2006-6/30/2007) ☐ Year 2007 (7/1/2007-6/30/2008)

27 Only the following types of HCPs are eligible. Indicate which category describes the applicant. (Check only one.)
☐ Post-secondary educational institution offering health care instruction, teaching hospital or medical school
☐ Rural health clinic
☐ Community health center or health center providing health care to migrants
☐ Consortium of the above
☐ Local health department or agency
☐ Dedicated ER of rural, for-profit hospital
☐ Community mental health center
☐ Not-for-profit hospital
☐ Part-time eligible entity

28 If consortium, dedicated emergency department, or part-time eligible entity was selected in Line 27, please describe the entity.

____

____

31 ☐ I certify that I am authorized to submit this request on behalf of the above-named entity or entities, that I have examined this request, and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.	
32 ☐ I certify that the health care provider has followed any applicable State or local procurement rules.	
33 ☐ I certify that the telecommunications services that the HCP receives at reduced rates as a result of the HCP's participation in this program, pursuant to 47 U.S.C. Sec. 254 as implemented by the Federal Communications Commission, will be used solely for purposes reasonably related to the provision of health care service or instruction that the HCP is legally authorized to provide under the law of the state in which the services are provided and will not be sold, resold, or transferred in consideration for money or any other thing of value.	
34 ☐ I certify that the health care provider is a non-profit or public entity.	
35 ☐ I certify that the health care provider is located in a rural area. Visit the RHCD website: (www.rhc.universalservice.org/eligibility/ruralareas.asp) or contact RHCD at 1-800-229-5476 for a listing of rural areas.	
36 ☐ Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or consortium that I am representing satisfies all of the requirements herein and will abide by all of the relevant requirements, including all applicable FCC rules, with respect to funding provided under 47 U.S.C. Sec. 254.	
37 Signature	38 Date
39 Printed name of authorized person	40 Title or position of authorized person
41 Employer of authorized person	42 Employer's FCC RN

Please remember:

- Form 465 is the **first** step a health care provider must take in order to receive the benefit of reduced rates resulting from participation in this universal service support program.
- After the HCP submits a complete and accurate Form 465, the RHCD will post it on the RHCD web site for 28 days.
- HCPs may not enter into agreements to purchase eligible services from service providers before the **28 days expire**.
- After the HCP selects a service provider, the HCP must initiate the **next** step in the application process, the filing of Form 466 and/or 466A.

Persons willfully making false statements on this form can be punished by fine or forfeiture under the Communications Act, 47 U.S.C. Secs. 502, 503(b), or fine or imprisonment under Title 18 of the United States Code, 18 U.S.C. Sec. 1001.

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

Part 3 of the Commission's Rules authorize the FCC to request the information on this form. The purpose of the information is to determine your eligibility for certification as a health care provider. The information will be used by the Universal Service Administrative Company and/or the staff of the Federal Communications Commission, to evaluate this form, to provide information for enforcement and rulemaking proceedings and to maintain a current inventory of applicants, health care providers, billed entities, and service providers. No authorization can be granted unless all information requested is provided. Failure to provide all requested information will delay the processing of the application or result in the application being returned without action. Information requested by this form will be available for public inspection. Your response is required to obtain the requested authorization.

The public reporting for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the required data, and completing and reviewing the collection of information. If you any comments on this burden estimate, or how we can improve the collection and reduce the burden it causes you, please write to the Federal Communications Commission, AMD-PERM, Paperwork Reduction Act Project (3060-0804), Washington, DC 20554. We will also accept your comments regarding the Paperwork Reduction Act aspects of this collection via the Internet if you send them to jboley@fcc.gov.
PLEASE DO NOT SEND YOUR RESPONSE TO THIS ADDRESS.

Remember - You are not required to respond to a collection of information sponsored by the Federal government, and the government may not conduct or sponsor this collection, unless it displays a currently valid OMB control number or if we fail to provide you with this notice. This collection has been assigned an OMB control number of 3060-0804.
THE FOREGOING NOTICE IS REQUIRED BY THE PRIVACY ACT OF 1974, PUBLIC LAW 93-579, DECEMBER 31, 1974, 5 U.S.C. 552a(e)(3) AND THE PAPEWORK REDUCTION ACT OF 1995, PUBLIC LAW 104-13, OCTOBER 1, 1995, 44 U.S.C. SECTION 3507.

This form should be submitted to:
Rural Health Care Division
80 S. Jefferson Rd.
Whippany, NJ 07981

FCC Form 466

FCC Form **466** — **Health Care Providers Universal Service** ***Funding Request and Certification Form*** — Approval by OMB 3060—0804

The Deadline to submit this Form is the June 30th End of the Funding Year. Estimated time per response: 3 hours

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

Block 1: HCP Information

1 HCP Name	2 HCP Number
3 Form 465 Application #	4 Consortium Name (If any)

Block 2: Bill Payer Information

5 Billed Entity Name		6 Billed Entity FCC RN
7 Contact Name		
8 Address Line 1		
9 Address Line 2		
10 City	11 State	12 Zip
13 Contact Phone #	14 Fax #	15 E-Mail

Block 3: Funding Year Information

16 Funding Year - Check only one box
[X] Year 2010 (7/1/2010-6/30/2011) [ ] Year 2011 (7/1/2011-6/30/2012) [ ] Year 2012 (7/1/2012-6/30/2013)

Block 4: Service Information

17 Type of Service & Circuit Bandwidth (Enclose documentation.)

18 Total Billed Miles	19 Maximum Allowable Distance (From Form 465)

20 Percentage of HCP's service used for the provision of health care. ________ (If less than 100%, please explain.)
If the HCP indicated it is a part-time eligible entity (on Form 465), describe method of allocating prorated support.

____

____

____

____

Connection Information	Carrier A	Carrier B	Carrier C	Carrier D
21 Service Provider Name				
22 Service Provider Identification Number (SPIN)				
23 Service Provider Contact Person Name				
24 Service Provider Contact Person's Phone #				
25 Service Provider Contact Person Email				
26 Circuit Start Location				
27 Circuit Termination Location				

IF YOU ARE REQUESTING SUPPORT FOR MILEAGE-BASED CHARGES, COMPLETE BLOCK 5 ONLY AND SKIP BLOCK 6. (PLEASE SEE INSTRUCTIONS). IF YOU ARE REQUESTING SUPPORT BASED ON URBAN/RURAL RATE COMPARISON, SKIP BLOCK 5 AND COMPLETE ONLY BLOCK 6. YOUR APPLICATION CANNOT BE PROCESSED IF BOTH BLOCKS ARE COMPLETED.

Block 5: Mileage-based Charge Discount Request

Complete this block if you are seeking support for mileage (distance-based) charges only. Do not enter any other charges in this block. You may to ask your service provider representative to provide this informa

36 Billed Circuit Miles				
37 Monthly Mileage Charges (Exclude Channel Termination chgs, etc.)				
38 Cost per Mile per Month				

If Line 33 equals Line 37, please ensure that ONLY mileage-related charges are included in Line 37. (See instructions.)

Block 6: Comprehensive Rate Comparison Request

Complete Block 6 if you have not completed Block 5 and are requesting support for all elements of your telecommunications service necessary fo the provision of health care. The information in this block will establish the difference between the urban and rural rates for your requested service. Please call RHCD at 1-800-229-5476 if you need assistance.

39 One-time Urban Rate Charge (in selected large city)				
40 One-time Rural Rate Charge (in city where HCP is located)				
41 Monthly Urban Rate (in selected large city). From RHCD web site: ☐ or Other rate documentation attached: ☐				

If your circuit includes charges for mileage over the Maximum Allowable Dist., (Line 19), please complete Lines 42 to 44. Otherwise, skip to l

42 Billed Circuit Miles				
43 Monthly Mileage Based Charges				
44 Cost per Mile per Month				

Block 7: Bid Documentation

45 Did you receive any bids in response to the Form 465 Request for Services posted on the RHCD website? ☐ Yes ☐ No
If you checked yes, copies of the bids MUST be mailed to RHCD.

Block 8: Certification

46 ☐ I certify that the above named entity has considered all bids received and selected the most cost-effective method of providing the requested service or services. The "most cost-effective service" is defined in the Universal Service Order as the service available at the lowest cost after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems necessary for the service to adequately transmit the health care services required by the health care provider.

47 ☐ Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or consortium that I am representing satisfies all of the requirements herein and will abide by all of the relevant requirements, including all applicable FCC rules, with respect to universal service benefits provided under 47 U.S.C. Sec. 254. I understand that any letter from RHCD that erroneously states that funds will be made available for the benefit of the applicant may be subject to rescission.

48 ☐ I hereby certify that the billed entity will maintain complete billing records for the service for five years.

49 ☐ I certify that I am authorized to submit this request on behalf of the above-named Billed Entity and HCP, and that I have examined this form and attachments and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.

Form 466-A

FCC Form **466 - A**

Health Care Providers Universal Service

Internet Service Funding Request and Certification Form

(And Advanced Services Funding Request and Certification for Entirely Rural States)

Approval by OMB 3060—0804

The Deadline to submit this Form is the June 30th End of the Funding Year. Estimated time per response: 1 hour

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

Block 1: HCP Information

1 HCP Name		2 HCP Number
3 Form 465 Application #	4 Consortium Name (If any)	

Block 2: Bill Payer Information

5 Billed Entity Name		6 Billed Entity's FCC RN	
7 Contact Name			
8 Address Line 1			
9 Address Line 2			
10 City		11 State	12 Zip
13 Contact Phone #	14 Fax #	15 E-Mail	

Block 3: Funding Year Information

16 Funding Year - Check only one box

[x] Year 2010 (7/1/2010-6/30/2011) [ ] Year 2011 (7/1/2011-6/30/2012) [ ] Year 2012 (7/1/2012-6/30/2013)

Block 4: Service Information

17 Give a brief description of the service for which support is requested:

18 Percentage of HCP's service used for the provision of health care. (If less than 100%, please explain.)

19 Location where service is provided:

20 Service Provider Name

21 Service Provider Identification Number (SPIN)		22 Billing Account Number
23 Contract Number (NA if no contract)		24 Date contract signed or service selected
25 Contract Expiration Date (NA if no contract)		26 Expected Service Start Date

27 Were bids received in response to Form 465? [ ] Yes [ ] No If yes, submit copies.

Block 5: Cost of Service

28 Installation Charge (If applicable)	29 Monthly rate charge (Enclose documentation)

Block 6: Certification

30 [ ] I certify that the above named entity has considered all bids received and selected the most cost-effective method of providing the requested service or services. The "most cost-effective service" is defined in the Universal Service Order as the service available at the lowest cost after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems necessary for the service to adequately transmit the health care services required by the health care provider.

31	☐	Pursuant to 47 C.F.R. Secs. 54.601 and 54.603, I certify that the HCP or consortium that I am representing satisfies all of the requirem herein and will abide by all of the relevant requirements, including all applicable FCC rules, with respect to universal service benefits provided under 47 U.S.C. Sec. 254. I understand that any letter from RHCD that erroneously states that funds will be made available for the benefit of the applicant may be subject to rescission.
32	☐	I hereby certify that the billed entity requesting reduced rates will maintain complete records for the service for five years.
33	☐	I certify that I am authorized to submit this request on behalf of the above-named Billed Entity and HCP, and that I have examined this form and attachments and that to the best of my knowledge, information, and belief, all statements of fact contained herein are true.

34 Signature	35 Date
36 Printed name of authorized person	37 Title or position of authorized person
38 Employer of authorized person	39 Employer's FCC RN

Please remember:

- An applicant may not file a Form 466-A until after signing the contract or otherwise selecting a service provider
- **The HCP or its authorized representative must wait at least 28 days from the Form 465 posting date before signing the contract or otherwise selecting a service provider.**
- You must be authorized to provide the information required by Form 466-A on behalf of the HCP, and you must sign and date the form.
- **Provide data for all items that apply. Attach additional sheets if necessary. Any attachments to Form 466-A must be clearly labe**

Persons willfully making false statements on this form can be punished by fine or forfeiture under the Communications Act, 47 U.S.C. Secs. 502, 503(b), or fine or imprisonment under Title 18 of the United States Code, 18 U.S.C. Sec. 1001.

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

Part 3 of the Commission's Rules authorize the FCC to request the information on this form. The data reported will be used to ensure that health care providers have selected the most cost-effective method of providing the requested services as set forth in 47 C.F.R. § 54.603(b)(4). The information will be used by the Universal Service Administrative Company and/or the staff of the Federal Communications Commission, to evalua this form, to provide information for enforcement and rulemaking proceedings and to maintain a current inventory of applicants, health care providers, billed entities, and service providers. No authorization can be granted unless all information requested is provided. Failure to provide requested information will delay the processing of the application or result in the application being returned without action. Information requested by this form will be available for public inspection. Your response is required to obtain the requested authorization.

The public reporting for this collection of information is estimated to average 1 hour per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the required data, and completing and reviewing the collection of information. If you have any comments on this burden estimate, or how we can improve the collection and reduce the burden it causes you, please write to the Federal Communications Commission, AMD-PERM, Paperwork Reduction Act Project (3060-0804), Washington, DC 20554. We will also accep your comments regarding the Paperwork Reduction Act aspects of this collection via the Internet if you send them to pra@fcc.gov. PLEASE DO NOT SEND YOUR RESPONSE TO THIS ADDRESS.

Remember - You are not required to respond to a collection of information sponsored by the Federal government, and the government may not conduct or sponsor this collection, unless it displays a currently valid OMB control number or if we fail to provide you with this notice. This collection has been assigned an OMB control number of 3060-0804.

THE FOREGOING NOTICE IS REQUIRED BY THE PRIVACY ACT OF 1974, PUBLIC LAW 93-579, DECEMBER 31, 1974, 5 U.S.C. 552a(e)(3) AND THE PAPEWORK REDUCTION ACT OF 1995, PUBLIC LAW 104-13, OCTOBER 1, 1995, 44 U.S.C. SECTION 3507.

This form should be submitted to:
Rural Health Care Division
30 Lanidex Plaza West, P.O.Box 685
Parsippany NJ 07054-0685

Form 467

FCC Form **467**	**Health Care Providers Universal Service** ***Connection Certification***	Approval by OMB 3060—0804

Estimated time per response: .5 hour

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

The Connection Certification (Form 467) is the means by which an HCP informs RHCD that the service provider(s) has turned on the service(s) for which the HCP is seeking reduced rates under the universal service support mechanism. Form 467 must also be used to notify RHCD that a supported service was disconnected or that the service was not or will not be turned on during the funding year.

An applicant must submit one Form 467 for each Form 466 or Form 466-A that it previously submitted to RHCD.

Block 1: HCP Information

1 HCP Name

2 Consortium Name

3 HCP Number

Block 2: Funding Year Information

4 Funding Year - Check only one box

[ ] Year 2007 (7/1/2007-6/30/2008) [ ] Year 2008 (7/1/2008-6/30/2009) [x] Year 2009 (7/1/2009-6/30/2010)

Block 3: Action Taken

5 By filing this form, the HCP or its authorized representative is (check one):

[ ] Confirming the connection of a telecommunications or Internet service for which the HCP has requested a discount and is confirming the accuracy of all information previously filed with RHCD regarding this service; or

[ ] Notifying RHCD of the disconnection of a discounted service. Date of Disconnection (mm/dd/yyyy)____________________

[ ] Informing RHCD that service was not (or will not be) turned on during the funding year

Block 4: Connection Information

6 Funding Request Number				
7 Service Provider Name				
8 Service Provider Identification Number (SPIN)				
9 Billing Account Number				
10 Type of Telecommunications Service & Circuit Bandwidth or "Internet" for Internet service.				
11 Actual Service Start Date (date service began)				
12 End of Service Date (date service was or will be turned off)				

Block 5: Certification

13 [ ] I certify that the service identified above has been or is being provided to the above-named health care provider. I certify that the universal service credit will be applied to the telecommunications service or Internet billing account of the HCP or the billed entity as directed by the HCP. I certify that I am authorized to submit this request on behalf of the above-named HCP, and that I have examined this request and that to the best of my knowledge, information and belief, all statements of fact contained herein are true.

Sample Support Schedule

HCP Support Schedule

Funding Year: 2005 **HCP #:** 12345 **FRN:** 12300 **Billing Account Number:** 589764

HCP Name: ABC Health Care.
HCP Address: 8 Main Street
Window Rock, AZ 86515

HCP Mailing Organization and Address:
RHC East.
9 College Avenue
Phoenix, AZ 85086

Support Start Date: 7/1/2005
Support End Date: 6/30/2006
Non-Recurring Support: $0.00
Monthly Recurring Support: $210.00

Service: T1 – 1544 Kbps
SPIN: 143004567
Telco: Smith Telco

Note: first and last month's support was prorated for monthly recurring support based on the number of days the service was in place (Support Start and End Date).
Non-recurring support was applied to the first month's support.

Support Date	Support Amount
7/2004	$210.00
8/2004	$210.00
9/2004	$210.00
10/2004	$210.00
11/2004	$210.00
12/2004	$210.00
1/2005	$210.00
2/2005	$210.00
3/2005	$210.00
4/2005	$210.00
5/2005	$210.00
6/2005	$210.00
Total	$2,520.00

10/12/2005

Appendix D: Estimate of Rural Health Care Program Reimbursement for Wyoming FCC Grant Participants

There are two methods for calculating reimbursement of eligible charges: mileage based and urban vs. rural comparison reimbursement. The circuits being supplied through the FCC grant are Asynchronous Transfer Mode (ATM)[44] circuits, and as such are virtual circuits. According to a representative of the telecommunications provider, since these circuits operate virtually, the mileage based reimbursement method discussed earlier would not be applicable.

In the comparative rate method, HCPs make a comparison between urban and rural rates for similar services in their state, and calculate support equal to the difference between what they pay (the rural rate) and what they would pay if they were receiving the service in the largest city with a population of 50,000 or more in their state (the urban rate). Both monthly recurring service charges and one-time installation charges are eligible for reimbursement.

Cost data for the calculation was supplied by the FCC network vendor, based on actual contract charges. The explanation below is for the spreadsheet shown in Table 5 at the end of this appendix.

The columns labeled "Facility Name" and "Location" identity the site and the city in which it is located. The "yes" or "no" data in the column labeled "Not for Profit?" was taken from the FCC Rural Health Care Pilot Program grant application. The "yes" or "no" response in the "Rural?" column is based on the site's home county using the city in the "Location" column to identify the county. The site's home county determines if the site is rural or urban. With the exception of Laramie and Natrona counties and most of Albany County, Wyoming is considered rural.

If a site is both not-for-profit and rural, it is eligible for reimbursement and the calculation continues.

The column labeled "ATM Access" identifies the type of service, either as a single T-1 line or a dual T-1 line.

The next five columns pertain to Monthly Recurring Charges (MRC), as follows:

- "Qwest MRC" - MRCs of the primary contractor (Qwest) by location and service type, as per contract;
- "Independ MRC" - MRCs for any independent contractors used by the primary contractor, as per contract;
- "Total MRC" – the sum of the Qwest MRC and Independ MRC amounts;
- "Urban MRC" – the lowest Total MRC for similar services statewide, for sites included in the contract;
- "Estimated Reimb. MRC"- the estimated amount of monthly reimbursement for eligible services by site, as explained below.

[44] http://en.wikipedia.org/wiki/ATM_NIC

The actual calculation is made by comparing the rural and urban costs by eligible site to the rural costs by site for both the MRC and the installation costs.

For example, site #3 in the worksheet is eligible for reimbursement since it is both rural and not-for profit. It has an anticipated T-1 connection, with an MRC of $821.60. The lowest Total MRC for a single T-1 included under the contract is $345.60 (see site #19 for example), and the lowest Total MRC for a dual T-1 is $680.40 (see site #4 for example).

The estimated MRC reimbursement is calculated below.

Rural monthly ($821.60) – Urban monthly ($345.60) = $476.00

The next five columns pertain to installation charges or Non-Recurring Charges (NRC), as follows:

- "Qwest NRC" – installation charges for the primary contractor (Qwest) by location and service type, as per contract;
- "Independ NRC" – installation charges for any independent contractors used by the primary contractor,as per contract;
- "Total NRC" – the sum of the Qwest NRC and Independent NRC amounts;
- "Urban NRC" – the lowest Total NRC for similar services for sites included in the contract;
- "Estimated Reimb. NRC"- the estimated amount of one-time reimbursement for installation costs by site.

Using site #3 again as an example, the Total NRC is $2,660.00 and the Urban NRC is $660.00. The lowest Total NRC for a single T-1 included under the contract is $1,016.00 (see site #15 for example), and the lowest Total MRC for a dual T-1 is $1,335.00 (see site #7 for example).

The estimated MRC reimbursement is calculated below.

Rural install ($2,660.00) – Urban install ($1,016.00) = $1,644.00 (one time only)

In this case, the rural HCP would receive ongoing monthly support of $476.00 and a one-time installation support of $1,644.00.

Table 5. Estimate of Reimbursement for Current FCC Pilot Program Participants

Facility Name	City	Not for Profit?	Rural?	ATM Access	Qwest MRC	Independ MRC	Total MRC	Urban MRC	Estimated Reimb. MRC	Qwest NRC	Independ NRC	Total NRC	Urban NRC	Estimated Reimb. NRC
	Lowest Total MRC for T-1				$345.60									
	Lowest Total MRC for 2xT-1				$680.40									
	Lowest Total NRC for T-1				$1,016.00									
	Lowest Total NRC for 2xT-1				$1,335.00									
University of Wyoming	Laramie	Yes	No	OC3	1,968.80		1,968.80			1,300.00				
Big Horn Clinic - Hot Springs County Memorial Hosp	Basin	Yes	Yes	T-1	376.80	449.46	826.26	345.60	480.66	660.00	356.00	1,016.00	1,016.00	0.00
Bridger Valley Family Practice	Lyman	No	Yes	T-1	421.35	400.25	821.60			660.00	2,000.00	2,660.00		
Campbell County Memorial Hospital	Gillette	Yes	Yes	2xT-1	680.40		680.40	680.40	0.00	1,860.00		1,860.00	1,335.00	525.00
Crook County Medical Services District	Sundance	Yes	Yes	T-1	380.04	652.60	1,032.64	345.60	687.04	660.00	475.00	1,135.00	1,016.00	119.00
Evanston Regional Hospital	Evanston	No	Yes	2xT-1	680.40		680.40			1,860.00		1,860.00		
Hot Springs County Memorial Hospital	Thermopolis	Yes	Yes	2xT-1	1,140.78	532.06	1,672.84	680.40	992.44	860.00	475.00	1,335.00	1,335.00	0.00
Hulett Clinic	Hulett	Yes	Yes	T-1	577.48	376.28	953.76	345.60	608.16	660.00	475.00	1,135.00	1,016.00	119.00
Ivinson Memorial Hospital	Laramie	Yes	No	2xT-1	680.40		680.40			1,860.00		1,860.00		
Johnson County Healthcare Center	Buffalo	Yes	Yes	2xT-1	680.40		680.40	680.40	0.00	1,860.00		1,860.00	1,335.00	525.00
Memorial Hospital of Carbon County	Rawlins	Yes	Yes	2xT-1	680.40		680.40	680.40	0.00	1,860.00		1,860.00	1,335.00	525.00
Memorial Hospital of Converse County	Douglas	Yes	Yes	2xT-1	680.40		680.40	680.40	0.00	1,860.00		1,860.00	1,335.00	525.00
Moorcroft Clinic	Moorcroft	Yes	Yes	T-1	467.25	267.04	734.29	345.60	388.69	660.00	475.00	1,135.00	1,016.00	119.00
Mountain View Clinic	Mountain View	No	Yes	T-1	407.99	396.71	804.70			660.00	2,000.00	2,660.00		
North Big Horn County Hospital District	Lovell	Yes	Yes	T-1	376.80	449.46	826.26	345.60	480.66	660.00	356.00	1,016.00	1,016.00	0.00
Platte Valley Medical Clinic	Saratoga	Yes	Yes	T-1	323.34	440.23	763.57	345.60	417.97	660.00	2,000.00	2,660.00	1,016.00	1,644.00
Powell Valley Healthcare	Powell	Yes	Yes	2xT-1	680.40		680.40	680.40	0.00	1,860.00		1,860.00	1,335.00	525.00
South Big Horn County Hospital District	Basin	Yes	Yes	T-1	376.80	449.46	826.26	345.60	480.66	660.00	356.00	1,016.00	1,016.00	0.00
South Lincoln Medical Center	Kemmerer	Yes	Yes	T-1	345.60		345.60	345.60	0.00	1,160.00		1,160.00	1,016.00	144.00
Star Valley Medical Center	Afton	Yes	Yes	T-1	345.60		345.60	345.60	0.00	1,160.00		1,160.00	1,016.00	144.00
University of Wyoming College of Health Sciences	Laramie	Yes	No	2xT-1	680.40		680.40			1,860.00		1,860.00		
West Park Hospital	Cody	Yes	Yes	2xT-1	680.40		680.40	680.40	0.00	1,860.00		1,860.00	1,335.00	525.00
West Park Hospital Cathcart Medical Office Building	Cody	Yes	Yes	T-1	345.60		345.60	345.60	0.00	1,160.00		1,160.00	1,016.00	144.00
Weston County Health Services	Newcastle	Yes	Yes	T-1	700.80	385.48	1,086.28	345.60	740.68	660.00	475.00	1,135.00	1,016.00	119.00
Wyoming State Hospital	Evanston	Yes	Yes	2xT-1	680.40		680.40	680.40	0.00	1,860.00		1,860.00	1,335.00	525.00
Big Horn Basin Counseling Service	Basin	Yes	Yes	T-1	376.80	449.46	826.26	345.60	480.66	660.00	356.00	1,016.00	1,016.00	0.00
Big Horn Basin Counseling Service	Lovell	Yes	Yes	T-1	376.80	449.46	826.26	345.60	480.66	660.00	356.00	1,016.00	1,016.00	0.00
Carbon County Counseling Center	Rawlins	Yes	Yes	T-1	345.60		345.60	345.60	0.00	1,160.00		1,160.00	1,016.00	144.00
Central Wyoming Counseling Center	Casper	Yes	No	T-1	345.60		345.60			1,160.00		1,160.00		
Fremont Counseling Center: Lander	Lander	Yes	Yes	T-1	345.60		345.60	345.60	0.00	1,160.00		1,160.00	1,016.00	144.00
Fremont Counseling Center: Riverton	Riverton	Yes	Yes	T-1	345.60		345.60	345.60	0.00	1,160.00		1,160.00	1,016.00	144.00
High Country Counseling and Resource Centers	Afton	Yes	Yes	T-1	345.60		345.60	345.60	0.00	1,160.00		1,160.00	1,016.00	144.00
High Country Counseling and Resource Centers	Kemmerer	Yes	Yes	T-1	345.60		345.60	345.60	0.00	1,160.00		1,160.00	1,016.00	144.00
High Country Counseling and Resource Centers	Pinedale	Yes	Yes	T-1	691.69	46.95	738.64	345.60	393.04	660.00	475.00	1,135.00	1,016.00	119.00
Jackson Hole Community Counseling Cneter	Jackson	Yes	Yes	T-1	345.60		345.60	345.60	0.00	1,160.00		1,160.00	1,016.00	144.00
Northern Wyoming Mental Health Center: Buffalo	Buffalo	Yes	Yes	T-1	345.60		345.60	345.60	0.00	1,160.00		1,160.00	1,016.00	144.00
Northern Wyoming Mental Health Center: Sheridan	Sheridan	Yes	Yes	T-1	345.60		345.60	345.60	0.00	1,160.00		1,160.00	1,016.00	144.00
Northern Wyoming Mental Health Center: Sundance	Sundance	Yes	Yes	T-1	380.04	652.60	1,032.64	345.60	687.04	660.00	475.00	1,135.00	1,016.00	119.00
Northern Wyoming Mental Health Center: Newcastle	Newcastle	Yes	Yes	T-1	700.80	385.48	1,086.28	345.60	740.68	660.00	475.00	1,135.00	1,016.00	119.00
Northern Wyoming Mental Health Center: Supported Independence Program	Sheridan	Yes	Yes	T-1	345.60		345.60	345.60	0.00	1,160.00		1,160.00	1,016.00	144.00
Yellowstone Behavioral Health Center	Cody	Yes	Yes	T-1	345.60		345.60	345.60	0.00	1,160.00		1,160.00	1,016.00	144.00
					$21,686.76	$6,782.98	$28,469.74	$14,428.80	$8,059.04	$46,900.00	$11,580.00	$57,180.00	$37,096.00	$8,024.00

Appendix E. Overview of the FCC National Broadband Plan

Overview

In March 2010, the FCC released the congressionally mandated National Broadband Plan. The Plan includes a detailed strategy for "… achieving affordability and maximizing use of broadband to advance…" a number of areas, including healthcare.[45]

The Plan addresses its goals through four major initiatives:

1. Design policies to ensure robust competition and, as a result maximize consumer welfare, innovation and investment.
2. Ensure efficient allocation and management of assets government controls or influences, such as spectrum, poles, and rights-of-way, to encourage network upgrades and competitive entry.
3. Reform current universal service mechanisms to support deployment of broadband and voice in high-cost areas; and ensure that low-income Americans can afford broadband; and in addition, support efforts to boost adoption and utilization.
4. Reform laws, policies, standards and incentives to maximize the benefits of broadband in sectors government influences significantly, such as public education, health care and government operations.[46]

While there are some wireless network related recommendations that may impact Wyoming healthcare providers in item 2 above, the bulk of the healthcare related impacts would be included in item 3. Specifically, the recommendations related to item 3 address the following:

- Help ensure health care providers have access to affordable broadband by transforming the FCC's Rural Health Care Program;
- Create incentives for adoption by expanding reimbursement for e-care;
- Remove barriers to e-care by modernizing regulations like device approval, credentialing, privileging and licensing;
- Drive innovative applications and advanced analytics by ensuring patients have control over their health data and ensuring interoperability of data.[47]

The healthcare-related recommendations are outlined in Chapter 10 of the Plan. With its recommendations, the FCC moves beyond a telecommunications focus, and looks for ways to support the larger national agenda of improving healthcare outcomes, especially through the consistent, meaningful use of Healthcare Information Technology.

> Broadband is not a panacea. However, there is a developing set of broadband-enabled solutions that can play an important role in the transformation required to address these issues. These solutions, usually grouped under the name health information technology, offer the potential to improve health care outcomes while simultaneously controlling costs and extending the reach of the limited pool of health care professionals. Furthermore, as a major area of innovation and entrepreneurial

[45] FCC National Broadband Plan, Executive Summary, http://www.broadband.gov/plan/executive-summary/
[46] FCC National Broadband Plan, Executive Summary, http://www.broadband.gov/plan/executive-summary/
[47] FCC National Broadband Plan, Executive Summary, http://www.broadband.gov/plan/executive-summary/

activity, the health IT industry can serve as an engine for job creation and global competitiveness.

This chapter's recommendations aim to encourage maximum utilization of these solutions. In its traditional role, the FCC would evaluate this challenge primarily through a network connectivity perspective. However, it is the ecosystem of networks, applications, devices and individual actions that drives value, not just the network itself. It is imperative to focus on adoption challenges, and specifically the government decisions that influence the system in which private actors operate, if America is to realize the enormous potential of broadband-enabled health IT.[48]

Plan Recommendations

The following outlines Plan recommendations that address telehealth generally as well as specific recommendations that may impact the Rural Health Care Program. These are taken from Chapter 10 of the Plan.

Recommendation 10.1: Congress and the Secretary of Health and Human Services (HHS) should consider developing a strategy that documents the proven value of e-care technologies, proposes reimbursement reforms that incent their meaningful use and charts a path for their widespread adoption.

- HHS should identify e-care applications whose use could be immediately incented through outcomes-based reimbursement.
- When testing new payment models, HHS should explicitly include e-care applications and evaluate their impact on the models. Where proven and scalable, these alternative payment models would provide an additional solution for incenting e-care.
- For nascent e-care applications, HHS should support further pilots and testing that review their suitability for reimbursement.
- As outcomes-based payment reform is developed, CMS should seek to proactively reimburse for e-care technologies under current payment models.

Recommendation 10.2: Congress, states and the Centers for Medicare & Medicaid Services (CMS) should consider reducing regulatory barriers that inhibit adoption of health IT solutions.

- Credentialing and privileging;
- State licensing requirements;
- E-prescribing.

Recommendation 10.6: The FCC should replace the existing Internet Access Fund with a Health Care Broadband Access Fund.

- Support bundled services, such as telecommunications, broadband, broadband based internet access;
- Include both urban and rural providers, based on need;
- Increase program support levels;
- Simplify the application process.

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[48] FCC National Broadband Plan, Chapter 10, http://www.broadband.gov/plan/10-healthcare/

Recommendation 10.7: The FCC should establish a Health Care Broadband Infrastructure Fund to subsidize network deployment to health care delivery locations where existing networks are insufficient.

- Build upon the lessons learned in the FCC Rural Health Care Pilot Program for the Infrastructure Fund:
  - Continue the15% required match as in the FCC Pilot Program;
  - Allow excess capacity developed in the FCC Pilot Program infrastructure to be shared by other participants at incremental cost rather than fair share;[49]
  - Maintain existing FCC Pilot Program criteria such as sustainability, leveraging existing networks, and joining nationwide backbone networks.
- Focus on geographic areas which meet defined needs-based criteria such as the following:
  - Broadband infrastructure is insufficient or unaffordable:
  - Broadband network deployment is more affordable than purchase from existing carriers;
  - HCPs are not receiving viable service proposals from telecommunications providers.
- Simplify the application and administration process for eligible HCPs;
- For non-eligible HCPs, simplify the process to estimate their share of network deployment costs and joint infrastructure deployment projects.

Recommendation 10.8: The FCC should authorize participation in the Health Care Broadband Funds by long-term care facilities, off-site administrative offices, data centers and other similar locations. Congress should consider providing support for for-profit institutions that serve particularly vulnerable populations.

- Expand the definition of eligible HCPs to include those those institutions that have become integral in the delivery of care in the United States, and specifically include those entities cited in Recommendation 10.8 above;
- Look to the Office of the National Coordinator (ONC) for guidance on eligible HCPs as HIT evolves;
- Include for-profit entities as eligible HCPs where appropriate;
- Consider extension of the criteria for HITECH incentive eligibility to HCPs in the Health Care Broadband Fund.

Recommendation 10.9: To protect against waste, fraud and abuse in the Rural Health Care Program, the FCC should require participating institutions to meet outcomes-based performance measures to qualify for USF subsidies, such as HHS's meaningful use criteria.

- Align the FCC Health Care Program criteria with those of other federal programs to measure the efficient use of HIT, such as the Meaningful Use criteria developed by the federal Department of Health and Human Services (DHHS);
- Work with DHHS to develop outcome metrics to assess the FCC program's impact on broadband usage and delivery of medicine;
- Improve FCC program oversight to ensure proper use of funds and impact on broadband usage and delivery of medicine.

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[49] Fair share has been defined as a proportionate share of all costs, including trenching and rights-of-way. http://www.broadband.gov/plan/10-healthcare/

Plan Implementation Steps

Chapter 17 of the Plan outlines recommendations for Implementation and Benchmarks.[50]

There are competing views on how the FCC should proceed with implementation of the Plan recommendations. One thought is that the FCC should request Congress pass legislation authorizing the FCC to implement the specific recommendations. As second thought is that the FCC rely on its existing statutory authority, where applicable, to implement recommendations, and rely on Congressional action for those recommendations outside its existing authority. The FCC indicates it will consider both options as it moves forward.

Recommendation 17.2: The FCC should quickly publish a timetable of proceedings to implement plan recommendations within its authority, publish an evaluation of plan progress and effectiveness as part of the annual Section 706 Advanced Services Inquiry, create a Broadband Data Depository, and continue to utilize Broadband.gov as a public resource for broadband information.

- The FCC should quickly publish a timetable of proceedings for implementing broadband plan recommendations directed to the FCC:
    - Rural Healthcare Pilot Program deadlines have been extended;
    - The FCC has set a tentative target date of the third quarter 2010 for issuance of a Notice of Proposed Rulemaking (NPRM) to create a Health Care Infrastructure Fund to support deployment of dedicated health care networks to underserved areas and a Health Care Access Fund to connect hospitals and doctors.
- The Plan should be periodically reviewed and revised to reflect changing conditions;
- The FCC should also create a Broadband Data Depository on the Internet to give researchers and the public better access to the FCC's data;
- The FCC should also continue to utilize Broadband.gov for communicating with the public.

Once the NPRM is released, the FCC expects the process to continue as shown below:

- Comment period (30 to 90 days);
- FCC reply to comments
- Ex-parte presentations[51] (60 days);
- Order establishing rules.[52]

[50] FCC Broadband Plan, Implementation and Benchmarks, http://www.broadband.gov/plan/17-implementation-and-benchmarks/

[51] An ex parte presentation is any written or oral communication by an outside party to the Commission, or any Commission staff involved in decision making, directed to the merits or outcome of a proceeding and not served on (mailed or delivered to) all the parties to the proceeding (if written) or of which all the parties have not been given advance notice (if oral). http://www.fcc.gov/cgb/consumerfacts/howtocomment.html

[52] USAC: Notes from the Rural Health Care monthly conference call: April 8, 2010 http://www.universalservice.org/_res/documents/rhc/pdf/conference-calls/2010/040810minutes.pdf

Estimating Healthcare's Broadband Connectivity Needs

The Plan also attempts to estimate health care providers' broadband connectivity needs and the ability of the country's infrastructure to meet those needs. The following contains excerpts from Chapter 10 of the Plan.[53]

Health care providers' broadband needs are largely driven by the digital health-related data that is collected and exchanged. Figure 3 below shows the variation in file sizes for common health care file types.

Figure 3. Healthcare Data File Sizes

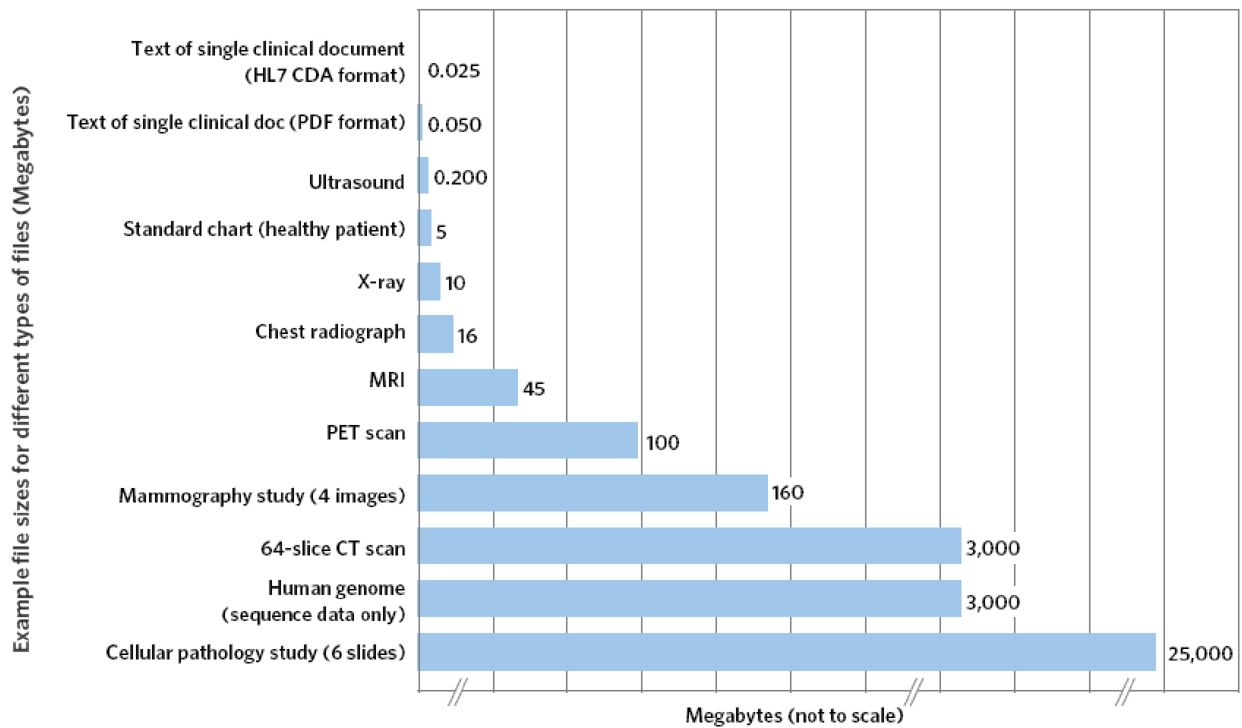

Figure 4 below provides the FCC estimate of needed broadband connectivity to meet current and short-term future needs of HCP, by type. These range from 4 MB/second for single physician practices to over 1GB/second for large medical centers.

[53] FCC National Broadband Plan, Chapter 10, http://www.broadband.gov/plan/10-healthcare/

Figure 4. FCC Estimate of Needed Broadband Connectivity

Exhibit 10-C: Required Broadband Connectivity and Quality Metrics (Actual)[80]