

Before the
Federal Communications Commission
Washington, D.C. 20554

In the Matter of
Promoting Telehealth in Rural America
WC Docket No. 17-310

NOTICE OF PROPOSED RULEMAKING AND ORDER

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By the Commission: Chairman Pai and Commissioners Clyburn, O’Rielly, Carr, and Rosenworcel issuing separate statements.

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I. INTRODUCTION

1. As technology and telemedicine assume an increasingly critical role in healthcare delivery,¹ a well-designed Rural Health Care (RHC) Program² is more vital than ever. Trends suggest that rural communities across the country are falling behind when it comes to the availability of high-quality healthcare. Indeed, the American Hospital Association (AHA) reports that “obtaining access to care in rural America is a significant challenge.”³ Over the last seven years, over 80 rural hospitals have closed and hundreds more are at risk of closing.⁴ On a per capita basis, there are far fewer doctors in rural

¹ The American Telemedicine Association (ATA) estimates that 25 million Americans will have benefitted from the use of telemedicine this year. *See generally* ATA Connect2Health Comments, GN Docket No. 16-46, at 2 (filed May 24, 2017) (ATA defines telemedicine as “the use of telecommunications technology tools to provide patient care. This is an intentionally broad description that covers an array of applications sometimes labeled as telehealth, e-health, mHealth and connected health.”). Healthcare facilities are increasingly relying on broadband-enabled services. *See* American Hospital Association (AHA) Connect2Health Comments, GN Docket No. 16-46, at 10 (filed May 23, 2017). AHA states that 65 percent of hospitals have implemented telehealth and the Office of the National Coordinator for Health IT reports that nearly five out of every six hospitals have adopted a basic electronic health records system. *See* AHA Connect2Health Comments at 10; Office of the National Coordinator for Health Information Technology, HealthIT Dashboard, <https://dashboard.healthit.gov/evaluations/data-briefs/non-federal-acute-care-hospital-ehr-adoption-2008-2015.php> (last visited Nov. 17, 2017) (Note, however, that there is an urban-rural disequilibrium—the percentage of hospitals that have adopted electronic health records in rural areas lags behind their urban counterparts).

² In this item, we refer to the Telecommunications Program (Telecom) and the Healthcare Connect Fund (HCF) Program collectively as the “RHC Program.”

³ AHA Connect2Health Comments at 4. According to AHA, the number of rural hospitals is in decline and there are insufficient medical professionals to meet demand. *Id.* at 4-5.

⁴ *See* NC Rural Health Research Program, 82 Rural Hospital Closures: Jan. 2010 – Present, <http://www.shepscenter.unc.edu/programs-projects/rural-health/rural-hospital-closures/> (last visited Nov. 17, 2017); Caitlin Ostroff and Ciara Bri’ d Frisbie, *Millions of Americans Live Nowhere Near a Hospital, Jeopardizing Their Lives*, CNN (Aug. 3, 2017), <http://www.cnn.com/2017/08/03/health/hospital-deserts/index.html> (last visited Nov. 17, 2017).

areas than in urban areas.⁵ In sum, “rural hospitals are facing one of the great slow-moving crises in American health care.”⁶

2. By improving rural healthcare provider access to modern communications services, the RHC Program can help in overcoming some of the obstacles to healthcare delivery faced in isolated communities. Through broadband-enabled technology, a rural clinic can transmit an x-ray in a matter of seconds to a radiologist located thousands of miles away. Via video-conferencing, a woman with a high-risk pregnancy has access to the type of pre-natal care that enables her baby to be delivered much closer to term. This in turn leads to fewer days in the Neonatal Intensive Care Unit for the baby and potentially places the child and family on a more positive future trajectory. With a high-speed data connection, a surgeon can perform an emergency procedure remotely. In places where the nearest pharmacist is a plane ride away, vending machine-like devices can dispense prescription medications.

3. The efforts by the Commission’s Connect2HealthFCC (Connect2Health) Task Force have illustrated the significant impact communications services can have on addressing the healthcare needs of persons living in rural and underserved areas, and how communities are leveraging broadband-enabled health technologies to improve access to health and care throughout the country.⁷ For example, in Mississippi, the Connect2Health Task Force highlighted the positive impact of public-private partnerships on health outcomes and how broadband-enabled health technologies have made a difference to diabetes patients in Mississippi.⁸ Additionally, in Texas, the Connect2Health Task Force emphasized how broadband-enabled health technologies can improve access to mental health care.⁹

4. It is therefore crucial that the benefits of the RHC Program are fully realized across the nation. But current RHC Program rules and procedures may be holding back the promise of the RHC Program for the rural healthcare providers that need it most. For the second funding year (FY) in a row,¹⁰ demand for RHC Program support is anticipated to exceed available program funding, leaving healthcare providers to potentially pay more for service than expected.¹¹ Unfortunately, part of that growth is due to

⁵ See Olga Khazan, *Why Are There So Few Doctors in Rural America*, The Atlantic (Aug. 28, 2014), <https://www.theatlantic.com/health/archive/2014/08/why-wont-doctors-move-to-rural-america/379291/> (last visited Nov. 17, 2017).

⁶ Anna Gorman, *Healthcare’s New Rural Frontier*, Politico (Apr. 12, 2017), <https://www.politico.com/agenda/story/2017/04/rural-healthcare-idaho-lost-rivers-000394> (last visited Nov. 17, 2017).

⁷ See FCC, FCC Initiatives, Connect2HealthFCC, <https://www.fcc.gov/about-fcc/fcc-initiatives/connect2healthfcc> (last visited Dec. 11, 2017); *FCC Seeks Comment and Data on Actions to Accelerate Adoption and Accessibility of Broadband-enabled Health Care Solutions and Advanced Technologies*, GN Docket No. 16-46, Public Notice, 32 FCC Rcd 3660 (2017) (Connect2Health PN); FCC, FCC Initiatives, Connect2HealthFCC, *Beyond the Beltway Series*, <https://www.fcc.gov/health/beyond-beltway-series> (last visited Dec. 11, 2017) (Beyond the Beltway).

⁸ FCC, FCC Initiatives, Connect2HealthFCC, *Faces of Connected Care – The Mississippi Story*, <https://www.fcc.gov/faces-connected-care-mississippi-story> (last visited Dec. 11, 2017).

⁹ See *Beyond the Beltway*.

¹⁰ FYs run from July 1 through June 30 of the subsequent calendar year. See 47 CFR §54.675(b). For example, FY 2017 runs from July 1, 2017 through June 30, 2018.

¹¹ See *Wireline Competition Bureau Provides a Filing Window Period Schedule For Funding Requests Under the Telecommunications Program and the Healthcare Connect Fund*, Public Notice, WC Docket No. 02-60, 31 FCC Rcd 9588 (WCB 2016) (August 2016 Filing Window PN); USAC, *Rural Health Care Program, Telecommunications Program, Filing Windows for FY 2016*, <http://www.usac.org/rhc/tools/2016-filing-windows.aspx> (last visited Nov. 17, 2017) (FY 2016 Filing Windows and Pro-rata Information) (stating that all qualifying FY 2016 funding requests received during the September 1 – November 30 filing window period will be prorated at 92.5 percent (reduction of 7.5 percent)).

an increase in waste, fraud, and abuse in the RHC Program.¹² Further, the Telecom Program, a component of the RHC Program, has not been significantly reviewed or revised since its inception in 1997.¹³ Accordingly, in this Notice of Proposed Rulemaking (NPRM), we propose measured steps to ensure that rural healthcare providers get the support they need while guarding against waste, fraud, and abuse. We consider a series of measures to ensure the RHC Program operates efficiently and we consider the appropriate size of the funding cap.¹⁴ We also take targeted, immediate action in the attached Order to mitigate the impact of the existing RHC Program cap on rural healthcare providers in FY 2017.

II. BACKGROUND

5. In the Telecommunications Act of 1996 (1996 Act), Congress recognized the value of providing rural healthcare providers with “an affordable rate for the services necessary for the provision of telemedicine and instruction relating to such services.”¹⁵ Based on this legislative mandate, the Commission established the two components of the RHC Program—the Telecom Program and the HCF Program—and capped the size of the RHC Program at \$400 million per funding year.¹⁶ Through the RHC Program, the Commission has sought to support eligible healthcare providers in their delivery of essential healthcare services to families and individuals living and working in rural and remote parts of the country.¹⁷

6. The Commission established the Telecom Program in 1997, pursuant to section 254(h)(1)(A) of the Act, to subsidize the difference between urban and rural rates for telecommunications services.¹⁸ Under the Telecom Program, eligible rural healthcare providers can obtain rates on telecommunications services in rural areas that are reasonably comparable to rates charged for similar services in corresponding urban areas.¹⁹ There have been no significant changes to the Telecom Program in the two decades since it was first established.

¹² See, e.g., *Network Services Solutions, LLC, Scott Madison*, Amendment to Notice of Apparent Liability for Forfeiture and Order, 32 FCC Rcd 5169 (2017) (*NSS NAL*).

¹³ See *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776, 9093-9161 paras. 608-749 (1997) (*Universal Service First Report and Order*) (subsequent history omitted); 47 U.S.C. § 254(h)(1)(A).

¹⁴ See 47 CFR § 54.675(a) (“The aggregate annual cap on federal universal service support for health care providers shall be \$400 million per funding year, of which up to \$150 million per funding year will be available to support upfront payments and multi-year commitments under the [HCF Program].”).

¹⁵ S. Conf. Rep. No. 104-230 at 133 (1996). See also Telecommunications Act of 1996, Pub. L. No. 104-104, 110 Stat. 56 (1996). The 1996 Act amended the Communications Act of 1934 (Communications Act or Act).

¹⁶ See 47 CFR § 54.675(a); *supra* n.14.

¹⁷ See *Universal Service First Report and Order*, 12 FCC Rcd 8776; *Rural Health Care Mechanism*, WC Docket No. 02-60, Report and Order, Order on Reconsideration and Further Notice of Proposed Rulemaking, 18 FCC Rcd 24546 (2003) (*2003 RHC Order*); *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 19 FCC Rcd 24580 (2004); *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 21 FCC Rcd 11111 (2006); *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 27 FCC Rcd 16678 (2012) (*HCF Order*).

¹⁸ See 47 U.S.C. § 254(h)(1)(A); *Universal Service First Report and Order*, 12 FCC Rcd at 9093-9161, paras. 608-749.

¹⁹ See 47 U.S.C. § 254(h)(1)(A).

7. In 2012, the Commission established the HCF Program, pursuant to section 254(h)(2)(A) of the Act.²⁰ The HCF Program provides a flat 65 percent discount on an array of communications services. These services include Internet access, dark fiber, business data, traditional DSL, and private carriage services. With the HCF Program, the Commission intended to promote the use of broadband services and facilitate the formation of healthcare provider consortia.²¹ The Commission promoted the consortia model recognizing the increasing need for rural healthcare providers to have access to specialists who are often located in urban areas, as well as the advent of certain communications-based trends in healthcare delivery, such as the move towards electronic health records.

8. Although the RHC Program has historically spent less than its Commission-established cap, we have recently seen a dramatic increase in both the number of funding requests and their overall dollar value. For example, when the Commission instituted the HCF Program in 2012, it anticipated that with this new program the total RHC Program demand would grow to \$235 million within five years.²² Yet, in FY 2016, demand exceeded the RHC Program's \$400 million cap by approximately \$20 million. Figure 1 below depicts the steady rise in funding commitments in the various RHC Programs in recent years.²³

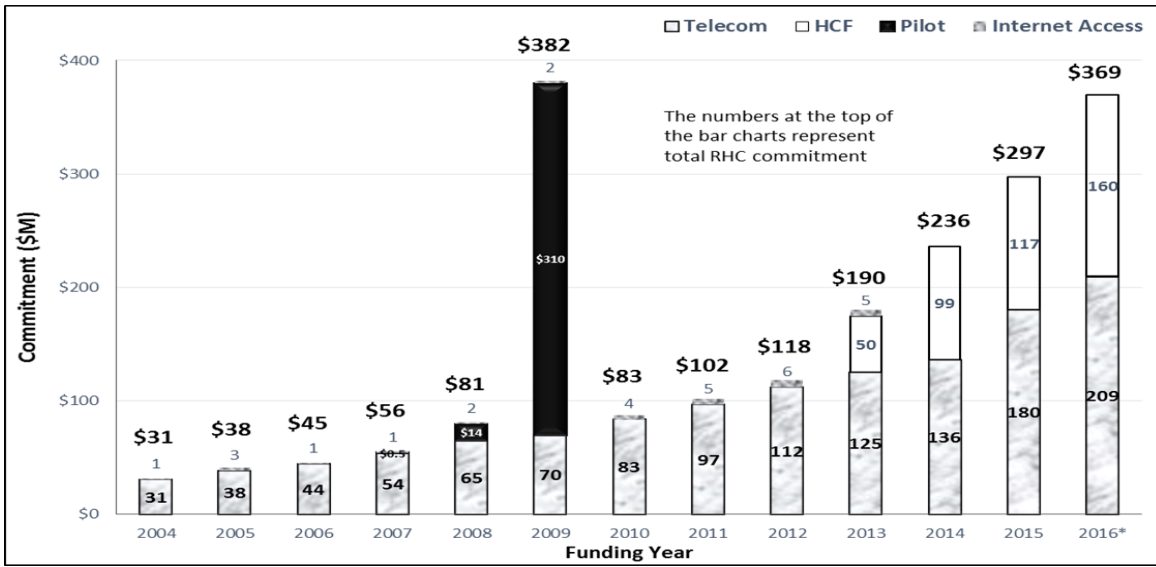
²⁰ See 47 U.S.C. § 254(h)(2)(A); *HCF Order*, 27 FCC Rcd 16678.

²¹ The HCF Program replaced the existing Internet Access Program, also enacted pursuant to section 254(h)(2)(A), which provided healthcare providers with a 25 percent discount for Internet access service. See *HCF Order*, 27 FCC Rcd 16681, n.9.

²² See *HCF Order*, 27 FCC Rcd at 16723-24, para. 98.

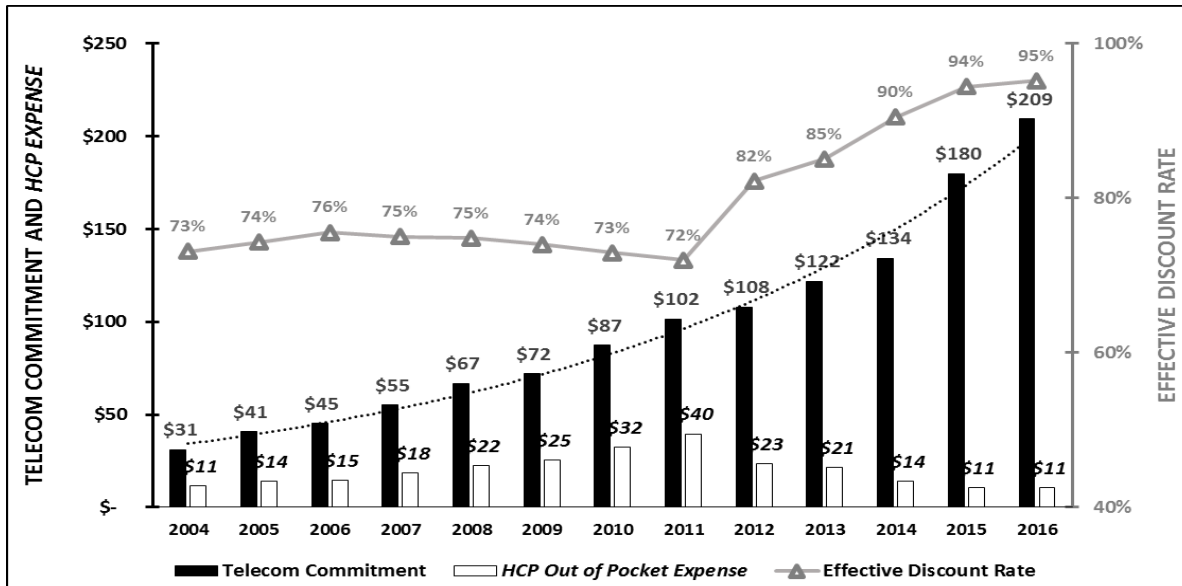
²³ The following charts are based on RHC Program data obtained from the Universal Service Administrative Company (USAC) by the Wireline Competition Bureau (Bureau) staff. As used here and throughout this NPRM, the "discount rate" is the percentage by which the healthcare provider's rural rate must be reduced to be equivalent to the urban rate for similar services, and is the amount of support provided to the service provider under the Telecom Program. Essentially, it is the difference between the relevant rural rate and the urban rate, divided by the healthcare provider's rural rate. We note that the data underlying the charts contained in this NPRM were collected at a later time than much of the demand and commitment data currently posted on USAC's website. Consequently, there may be slight variations between numbers included in this NPRM and those on USAC's website.

Fig. 1: RHC Program Commitment Trend (FYs 2004 – 2016)²⁴



9. The HCF Program has seen significant growth in demand in recent years, as healthcare providers, and particularly consortia of healthcare providers, have subscribed to the HCF Program in growing numbers. Of particular concern, however, has been the recent growth in the Telecom Program. As Figure 2 demonstrates, the Telecom Program more than doubled in size from FY 2011 to FY 2016, from approximately \$102 million to approximately \$209 million. As total commitments from the Telecom Program increased, however, the healthcare provider’s out-of-pocket expenses decreased, from approximately \$40 million in FY 2011 to approximately \$11 million in FY 2016.

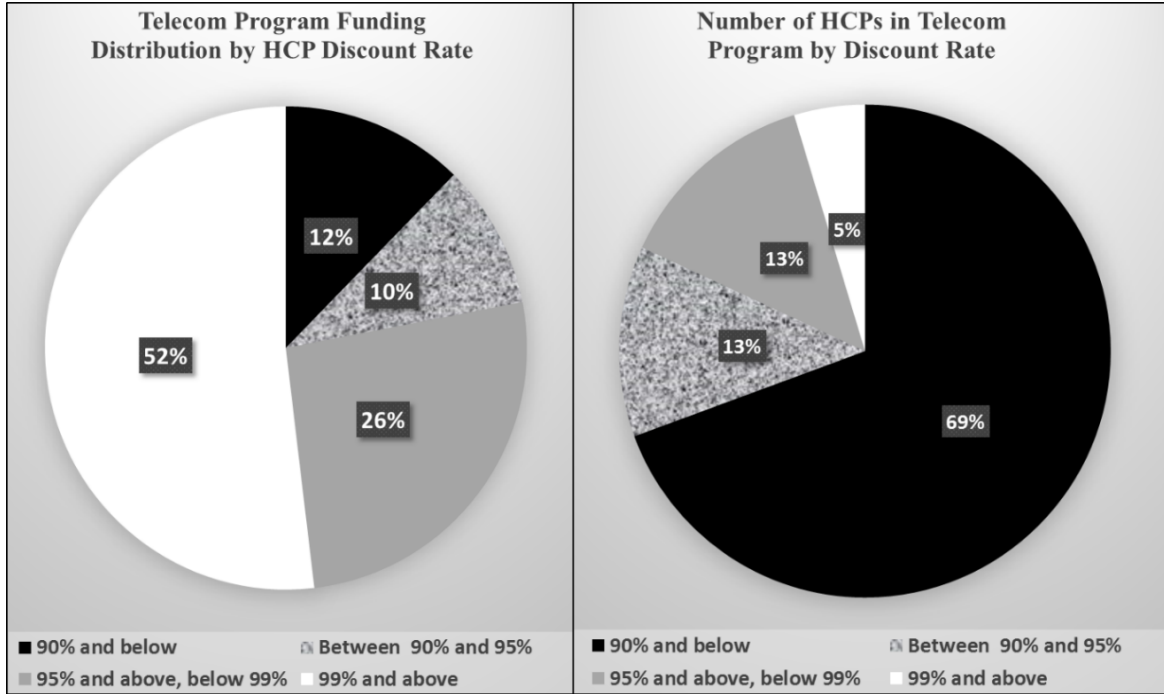
Fig. 2: Telecom Program Commitment and Healthcare Provider Out of Pocket Expense with Discount Rate



²⁴ FY 2016 commitments shown are un-prorated amounts; while prorated FY 2016 commitments were \$200 million in the Telecom Program and \$152 million in the HCF Program. Also, committed amounts shown do not include FY 2016 administrative expenses of \$13 million and reserves for appeals of \$35 million.

10. Further, as Figure 3 demonstrates, recent trends show an increasing concentration of RHC Program funding among a small number of extremely high-support healthcare providers in the Telecom Program. Between FY 2013 and FY 2016, the number of healthcare providers in the Telecom Program declined by more than 36 percent, but the amount of funding dollars committed during this period increased by 67.2 percent. On a per healthcare provider basis, Telecom Program commitments grew from an average of \$32,000 in FY 2013 to \$81,000 in FY 2016, an increase of 153 percent in just three years. In FY 2016, 5 percent of the healthcare providers in the Telecom Program received 52 percent, or \$108 million, of the un-prorated Telecom Program support commitments, as shown in Figure 3.

Fig. 3: FY 2016 Telecom Program Funding Distribution Among Healthcare Providers



11. Unsurprisingly, discount rates are correlated with pricing in the Telecom Program. Because the effective discount rate results from dividing the difference in the rural and urban rates by the rural rate, we would expect this relationship.²⁵ Figures 4 and 5 show this relationship in the data for 5 Mbps Multiprotocol Label Switching (MPLS) service and 1.5 Mbps satellite service respectively.

²⁵ The discount rate (D) is calculated as $D = (R - U)/R$, where R is the rural rate and U is the urban rate.

Fig. 4: FY 2015 Urban Rates and Telecom Program Funding for 5 Mbps MPLS Service

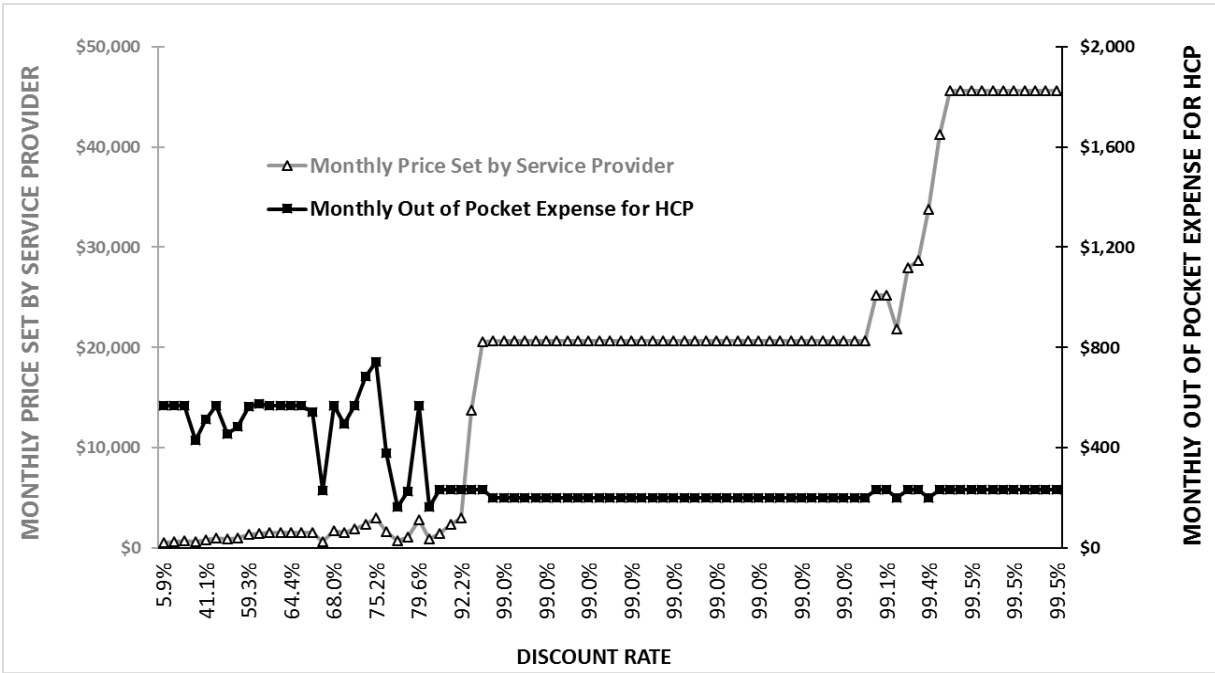
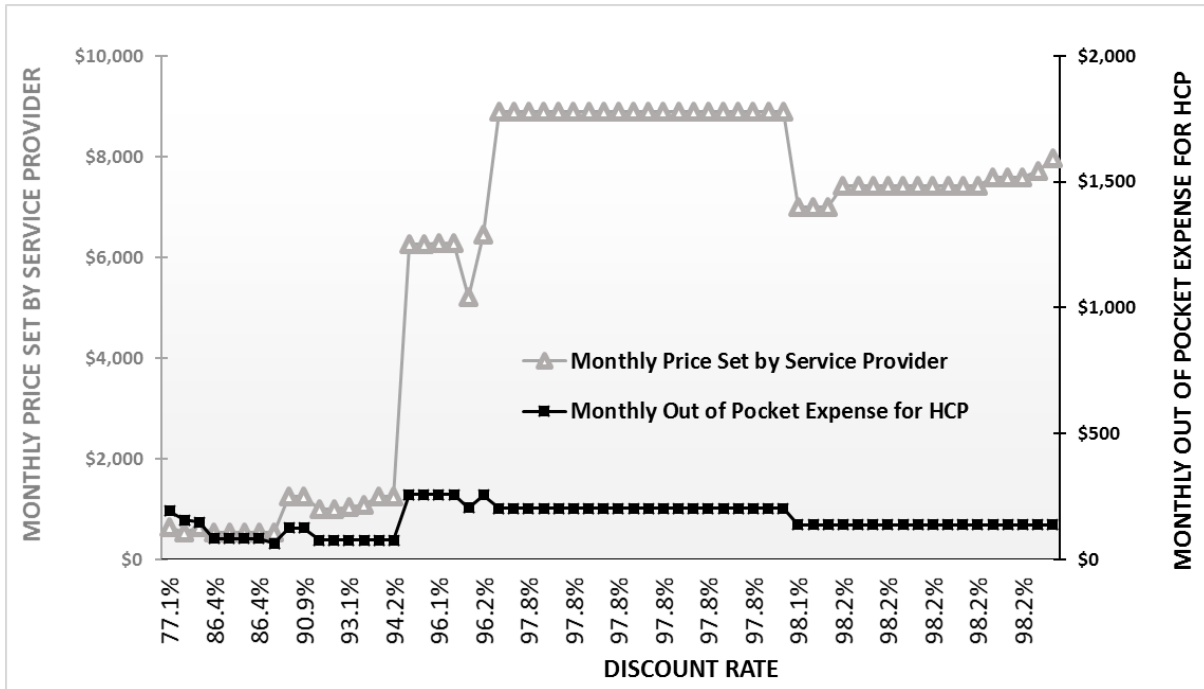


Fig. 5: FYs 2013-2015 Urban Rates and Telecom Program Funding for 1.5 Mbps Satellite Service



12. Almost one third of all RHC Program funding goes to healthcare providers and service providers in Alaska, with approximately \$119 million in funding in FY 2016 from the Telecom Program alone. Moreover, Alaska healthcare providers spent just \$2.4 million for service in FY 2016, making the average discount rate in Alaska 98 percent, with a number of healthcare providers eligible under current RHC Program rules for a discount rate above 99 percent. Elsewhere, healthcare providers received an average discount of 91 percent.

13. These data suggest a lack of price sensitivity that results in a concentration of more Telecom Program support toward fewer, high-discount healthcare providers. As the Commission has observed about the Telecom Program: A healthcare provider “using the rural-urban differential pays only the urban rate, so it has little incentive to control the overall cost of the service (i.e., the rural rate). Any increases in the overall cost of the service are borne directly by the Fund, which pays the difference between the urban and rural rates.”²⁶

14. One result of demand exceeding the RHC Program’s \$400 million cap in FY 2016 is that for the first time USAC had to prorate funding for some FY 2016 funding requests in accordance with the Commission’s rules.²⁷ The Commission sought to mitigate the impact of the proration for healthcare providers in remote Alaskan areas for which the impact was especially severe in the *Alaska Waiver Order* where, *inter alia*, we permitted the service providers of these healthcare providers to reduce the price of service while holding constant the prorated support amount.²⁸ In FY 2017, demand is again expected to surpass the \$400 million cap, which will potentially require proration of funding requests, possibly at a level higher than the FY 2016 proration.

III. NOTICE OF PROPOSED RULEMAKING

A. Addressing RHC Program Funding Levels

1. Revisiting the RHC Program Funding Cap

15. The current cap on the RHC Program has remained at \$400 million since its inception in 1997.²⁹ RHC Program demand, however, exceeded the cap in FY 2016 and is expected to exceed the cap in FY 2017 and in future years. The proration that comes with capped funding may be especially hard on small, rural healthcare providers with limited budgets, and so we examine whether a cap of \$400 million is an appropriate level of funding for the RHC Program going forward. Since the time the cap was set, the RHC Program has grown and changed and now, under the HCF Program, covers more services than its predecessor program. With this change in RHC Program eligibility comes an increased demand for services. Likewise, advances in technology have improved telehealth and telemedicine capabilities and with it a need for expanded bandwidth.

16. We seek comment on increasing the cap for the RHC Program and whether we should retroactively increase the cap for FY 2017. Looking ahead, beyond FY 2017, by how much should we increase the cap? Likewise, what would be an appropriate increase for FY 2017? One metric would be to consider what the cap would have been if adjusted by inflation since its adoption. If we had adjusted the \$400 million cap annually for inflation since 1997, based on the GDP-CPI (which the E-rate Program uses to adjust its cap), the RHC Program cap would have been approximately \$571 million for FY 2017.³⁰ Another consideration, however, is whether potential waste in the Telecom Program (which we discuss in more depth below) has contributed to the RHC Program reaching the cap sooner than anticipated—when

²⁶ See *HCF Order*, 27 FCC Rcd 16678, 16718, para. 87.

²⁷ See 47 CFR § 54.675(f); *August 2016 Filing Window PN*; USAC, Rural Health Care Program, Healthcare Connect Fund Program, Funding Information, Pro-rata Factor for FY 2016, <http://www.usac.org/rhc/funding-information/default.aspx?pgm=hcc> (last visited Nov. 17, 2017).

²⁸ See *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 32 FCC Rcd 5463, 5465, para. 9 (2017) (*Alaska Waiver Order*).

²⁹ See *Universal Service First Report and Order*, 12 FCC Rcd at 9140-41, para. 704 (establishing a \$400 million rural healthcare support cap).

³⁰ The annual GDP price index increased from 78.088 in 1998 to 111.419 in 2016, an increase of 42.7 percent. See National Income and Product Accounts Table, Bureau of Economic Analysis, Table 1.1.4, available at <https://www.bea.gov/iTable/iTable.cfm?reqid=19&step=2#reqid=19&step=2&isuri=1&1921=survey> (last visited Nov. 17, 2017).

the Commission adopted the HCF Program in 2012, it did not expect the RHC Program to reach the cap in the foreseeable future.³¹ Growth in the Telecom Program has outpaced inflation since the HCF Program was adopted. Since 2011, inflation-based demand for the Telecom Program would have increased from \$102 million to approximately \$110 million in FY 2016.³² In that case, total RHC Program demand for FY 2016 would have been \$270 million, including \$160 million in actual HCF Program demand. Does this fact argue against a cap increase or to moderate any such increase? Further, some commenters argue that the current scope of the RHC Program and advances in telehealth and telemedicine warrant a further increase in the cap.³³ How should advances in medical services delivered over communications services impact our evaluation of the cap? We ask that commenters provide data in the record regarding the current state of the telehealth market, specifically data on the types of telehealth services used by Program participants, the bandwidth required for such services, and any trends in services that will likely impact the needs of rural healthcare providers in the telehealth arena in the near future.³⁴ What other factors should we consider before increasing the cap? Should we consider the universe of potential rural healthcare providers and estimate the average or median support needed? How should we factor the impact of an increased cap on other programs within the Universal Service Fund (USF or Fund) and on the consumers that ultimately will pay for any increases? We recognize that any increase in Program expenditures must be paid for with contributions from ratepayers and that the Commission must carefully balance the need to meet universal service support demands against the effects of a greater contribution burden. We seek comment on how the Commission should evaluate this trade off as it considers the appropriate funding level.

17. Additionally, within the RHC Program, multiyear commitments and upfront costs are capped within the HCF Program to \$150 million per funding year. We seek comment on whether the \$150 million cap for multiyear commitments and upfront costs within the HCF Program should also be adjusted—*i.e.*, increased, eliminated, or modified in some other way.³⁵

18. Finally, the funding caps for some of the other federal universal service support programs incorporate inflation adjustments.³⁶ Commenters, likewise, argue that the RHC Program cap should be adjusted annually for inflation.³⁷ We seek comment on whether to adopt a similar mechanism here to automatically increase the RHC Program caps for inflation and, if so, what form such a mechanism should take.³⁸

³¹ See *HCF Order*, 27 FCC Rcd at 16823, paras. 367-68 (stating that it would take some time for HCF consortia to develop and anticipating savings from migration of Telecom Program participants to HCF Program).

³² The annual GDP price index rose from 103.315 in 2011 to 111.419 in 2016, an increase of 7.8 percent. See *id.*

³³ See, e.g., Letter from Karen Brinkmann, Counsel to Alaska Communications Systems, to Marlene Dortch, FCC, WC Docket No. 02-60, at 4 (filed June 9, 2017) (ACS June 9 *Ex Parte* Letter); SHLB Connect2Health Comments, GN Docket No. 16-46, at 7, n.11 (filed May 24, 2017) (SHLB Connect2Health Comments).

³⁴ See Letter from Jeffrey Mitchell, Counsel to Schools, Health and Libraries Broadband Coalition, to Marlene Dortch, FCC, WC Docket Nos. 02-60, 17-310 (filed Dec. 6, 2017) (SHLB *Ex Parte*).

³⁵ See *id.*

³⁶ See 47 CFR § 54.507(a)(1) (“In funding year 2016 and subsequent funding years, the \$3.9 billion funding cap on federal universal service support for schools and libraries shall be automatically increased annually to take into account increases in the rate of inflation”).

³⁷ See, e.g., ACS June 9 *Ex Parte* Letter at 4; Richard Cameron, Counsel to Alaska Communications, to Marlene Dortch, FCC, WC Docket No. 02-60, at 2 (filed July 24, 2017) (ACS July 24 *Ex Parte* Letter).

³⁸ The E-rate Program uses the Gross Domestic Product Chain-type Price Index (GDP-CPI). See 47 CFR § 54.507(a)(2); National Income and Product Accounts Table, Bureau of Economic Analysis, Table 1.1.4, available at <https://www.bea.gov/iTable/iTable.cfm?reqid=19&step=2#reqid=19&step=2&isuri=1&1921=survey> (last visited Nov. 17, 2017), maintained by the Bureau of Economic Analysis of the Department of Commerce. The

(continued...)

19. We also seek comment on whether we should roll over unused funds committed in one funding year into a subsequent funding year.³⁹ We seek comment on the types of unused funds from a given funding year to roll over to subsequent funding years. For example, we propose to include in any roll over mechanism unused or released funds USAC previously held in reserve for appeals and any funds committed to a healthcare provider but not used by the healthcare provider. We seek comment on specific limitations that should apply to funds that are rolled over. Should roll over funding be limited to RHC funding requests received only for the next funding year? Or, may unused funds from one year be rolled over to multiple funding years until they are ultimately disbursed? In the latter case, should we establish separate caps on the amount that may be rolled over from a single funding year, as well as the cumulative amount of roll over funding? We note that, in the E-rate Program, all unused funding from previous funding years is made available for subsequent funding years.⁴⁰

20. We also seek comment on how to best distribute the roll over funds across the RHC Program.⁴¹ Should roll over funds first be used to defray the impact on, for example, individual rural healthcare providers with any remaining unused funds being used for rural consortia applicants? What are the material differences between individual healthcare providers and those participating in a consortium?

2. Prioritizing Funding if Demand Reaches the Cap

21. In 2012, the Commission considered whether to adopt a mechanism by which to prioritize funding if demand exceeded the \$400 million funding cap. Given the funding levels at that time, however, the Commission determined that the existing rule requiring proration would be sufficient while it conducted further proceedings regarding prioritization.⁴² The recent growth in RHC Program demand and the uncertainty associated with possible proration makes it difficult for healthcare providers to make service selections and telehealth plans,⁴³ and can create unexpected financial difficulties for healthcare providers, especially in highly remote areas.⁴⁴ We seek comment on whether we should consider changes in how we prioritize the funding of eligible RHC Program requests. Below, we discuss a number of prioritization approaches, some of which could be combined to more efficiently distribute funds.

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Commission has previously concluded that the GDP-CPI reasonably estimates inflation of carrier costs and the GDP-CPI has been used by the Commission for other carrier accounting and reporting purposes. *Schools and Libraries Universal Service Support Mechanism*, Sixth Report and Order, 25 FCC Rcd 18762, 18782, para. 39 (2010) (citing *Reform of Filing Requirements and Carrier Classifications*, Order and Notice of Proposed Rulemaking, 11 FCC Rcd 11716, 11721-22, para. 10 (1996)).

³⁹ The E-rate Program currently uses a mechanism for unused funds that ensures funds committed to an E-rate participant and collected from contributors is used in future years to reduce E-rate program demand. See 47 CFR § 54.507(a)(5).

⁴⁰ See 47 CFR § 54.507(a)(5) (“All funds collected that are unused shall be carried forward into subsequent funding years for use in the schools and libraries support mechanism in accordance with the public interest and notwithstanding the annual cap.”).

⁴¹ See SHLB *Ex Parte*.

⁴² *HCF Order*, 27 FCC Rcd at 16822-3, para. 367.

⁴³ See, e.g., Letter from John Nakahata, Counsel to General Communications, Inc., to Marlene H. Dortch, Secretary, FCC, WC Docket No. 02-60, at 1 (filed Sept. 1, 2017); Schools, Health & Libraries Broadband Coalition (SHLB) Petition for Rulemaking, WC Docket No. 02-60, at 30-31 (filed Dec. 7, 2015) (SHLB Petition).

⁴⁴ *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 2017 WL 2844012 (rel. Jun. 30, 2017) (waiving rules on a one-time basis to assist remote Alaskan healthcare providers impacted by the 2016 proration), (*Alaska Waiver Order*), *pet. for recon. pending*.

22. At the outset, we note that section 254(b) requires that we preserve and advance universal service by establishing, among other things, access to advanced telecommunications for health care and specific and predictable support mechanisms. By adopting a prioritization plan, would the RHC Program disbursements be more specific and predictable when demand exceeds the cap? Are there additional principles we could adopt to further a prioritization plan? Are there prioritization methods other than those described below that we should consider? Is proration, itself a method of prioritization, preferable to some alternate form of prioritization?

23. We also seek comment on the mechanics of how we would distribute funding if a prioritization system is adopted. For example, would we fully fund the requests at 100 percent (or some other percentage), starting with the requests that meet our highest prioritization criteria and then proceed through the prioritization tiers at 100 percent funding (or the chosen percentage), until funds are depleted? Or, should we fund the highest prioritization requests at, for example, 100 percent, and the requests at the next prioritization tier at, for example, 95 percent, with decreasing support as the prioritization declines? Are there other ways to distribute funding based on an adopted prioritization system that would maximize the efficient use of RHC Program support?

24. *Prioritizing Based on Rurality or Remoteness.* We first seek comment on whether we could prioritize requests from healthcare providers based on the rurality or the remoteness of the area served by an eligible healthcare provider. Given the directive from Congress to support eligible rural healthcare providers,⁴⁵ should we consider using gradations of rurality to prioritize funding requests, ranking areas as extremely rural, rural, less rural, and urban, and prioritizing Program support first to the most rural areas?

25. The Act does not define the terms “rural” or “rural area.” The RHC Program, however, employs a definition of “rural area” that relies upon a healthcare provider’s location relative to the Census Bureau’s Core Based Statistical Area designations. Does section 254(h)(1)(A) of the Act, which requires that rates for telecommunications services for healthcare providers serving rural areas be comparable to urban rates, permit the Commission to consider how rural a given healthcare provider’s site is in determining how much funding to allocate to that healthcare provider? Could we prioritize funding requests based on the varied levels of rurality contained in our current definition of “rural area,” with the highest priority given to the healthcare providers in the most rural areas? Likewise, should we consider the rurality of a healthcare provider in the HCF Program under section 254(h)(2)(A) when prioritizing funds?

26. Using FY 2016 data, approximately 3,500 healthcare providers received approximately \$165 million (or about 53 percent) of the commitments in the extremely rural areas, approximately 1,580 healthcare providers received approximately \$41 million (or about 13 percent) of the commitments in rural areas, and approximately 1,870 healthcare providers received approximately \$50 million (or about 16 percent) of the commitments in less rural areas.

27. We seek comment on the value this proposal would provide. Would this approach or a similar approach focus RHC Program dollars to areas in greatest need of access to health care? Are there other factors to consider as we decide whether to target scarce RHC Program funds to the most rural areas?

28. We also must explore how to handle requests for funding from consortia under the HCF Program. Consortia allow diverse healthcare providers to pool resources and expertise in order to access high-capacity broadband at affordable prices; the participation of urban-based healthcare providers in the consortia can provide value to the rural healthcare providers. What factors would we use to determine the rurality of a consortium, and thus the prioritization of its request if the consortium has rural and urban

⁴⁵ *HCF Order*, 27 FCC Rcd at 16683, para. 5 (citing S. Report No. 104-230 at 133 (1996); 47 U.S.C. § 254(b)(3), (h)).

healthcare providers? Would we balance or average the number of rural healthcare providers with the urban healthcare providers? Or would we consider the interdependence between the healthcare providers say, for example, if a highly skilled urban healthcare provider supported a number of extremely rural healthcare providers versus a consortium of healthcare providers where the rurality of the member healthcare providers did not vary greatly? Alternatively, could we consider the rurality of the individual healthcare provider for prioritization purposes? Would healthcare providers in the same consortium serving areas with different gradations of rurality receive different levels of prioritization?

29. We also seek comment on whether we should adopt the approach of the Department of Veterans Affairs' (VA) Highly Rural Transportation Grant program as a proxy for rurality in the RHC Program. This VA program provides veterans who live in highly rural counties, defined as counties with fewer than seven people per square mile, with free transportation to VA or VA-authorized health care facilities.⁴⁶ These eligible counties are located in eleven states.⁴⁷ GCI identifies these areas as "Highly Rural" and proposes that funding requests for healthcare providers in Highly Rural areas be prioritized over other funding requests in both the Telecom and HCF Programs.⁴⁸ Under this proposal, however, if demand exceeds the RHC Program cap and proration is required, GCI proposes to require Highly Rural healthcare providers to pay a minimum amount that increases each year over five years to "bring greater fiscal discipline to the Telecommunications Program so that Highly Rural priority will not unduly restrict support outside of Highly Rural communities."⁴⁹ Under GCI's proposal, additional costs of service to healthcare providers in these "Highly Rural" areas would be limited in FY 2018 to the higher of the urban rate or one percent of the rural rate. In FY 2019 through FY 2022, the amount that highly rural healthcare providers would pay would increase by one percent per year, so that in FY 2019 they would pay two percent of the rural rate, in FY 2020 three percent, and so on up to a maximum contribution of five percent in FY 2022.⁵⁰ GCI argues that "[p]hased-in increased contributions for Highly Rural healthcare providers in [the] Telecom Program addresses concerns about sufficient 'skin in the game' to hold down costs."⁵¹ We seek comment on this proposal and whether one percent of the rural rate (or the urban rate, whichever is higher) is the appropriate minimum payment amount and whether one percent incremental increases and the five percent cap are appropriate. Further, we seek comment on whether we need to safeguard the HCF Program under GCI's proposal. We also seek comment on other ways to alleviate the burden of proration in extremely rural high cost areas.

30. Alternatively, we seek comment on whether we should modify our current definition of the term "rural area" or adopt a new definition entirely. Does the definition of rural area in section 54.600(b) of our rules meet the needs of the RHC Program for purposes of prioritization?⁵² Would the definitions of "rural" as used in the Connect America Fund Program, the E-rate Program, or the Lifeline Program better target the most rural areas than the current RHC Program definition? Would it make

⁴⁶ See Highly Rural Transportation Grants, https://www.va.gov/healthbenefits/vtp/highly_rural_transportation_grants.asp (last visited Nov. 17, 2017).

⁴⁷ *Id.* (North Dakota, South Dakota, Washington, Nevada, California, Texas, Maine, Montana, Idaho, Oregon, Alaska).

⁴⁸ Letter from John Nakahata, Counsel to GCI, to Marlene Dortch, FCC, WC Docket No. 02-60, at i (filed Nov. 2, 2017) (GCI Nov. 2 *Ex Parte*) ("In Alaska, the consolidated city-boroughs of Anchorage and Juneau and the Fairbanks North Star borough would not be 'Highly Rural'; the remainder of the state would be"). GCI also states that "[p]reliminary analysis from the Brattle Group suggests that nationwide approximately \$131 million was committed to Highly Rural Areas in FY 2016." *Id.*

⁴⁹ *Id.*

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² Section 54.600(b) of our rules employs the Core Based Statistical Concept to define rural. 47 CFR § 54.600(b).

sense to prioritize the extremely high cost census blocks identified as eligible for Remote Areas Fund funding for RHC Program prioritization?⁵³ Finally, are there alternative definitions of “rural” we should consider to enhance the efficiency of the RHC Program?

31. *Prioritizing Based on Type of Service.* We seek comment on whether to prioritize distribution of funds based on type of funding request. The RHC Program supports telecommunications services, advanced telecommunications and information services, and infrastructure. Healthcare providers may request funding for the monthly costs of telecommunications or information services, or for one-time upfront costs such as for infrastructure. Would prioritizing the funding request based on whether the request is for a recurring cost or a one-time infrastructure cost advance the goals of the RHC Program? Does one type of support, such as monthly recurring costs or one-time, upfront costs, have a greater impact in rural areas? Are there other meaningful distinctions to make between types of services, such as prioritizing broadband services of a certain speed or type over voice services? Are we limited by the statutory language of section 254(h)(1)(A) and/or section 254(h)(2)(A) of the Act in prioritizing funding requests based on the type of service requested?⁵⁴

32. *Prioritizing Based on RHC Program.* The Telecom Program and HCF Program have similar, but slightly different focuses. One, the Telecom Program, seeks to improve healthcare providers' access to telecommunications services by discounting the rural rate for service to match the urban rate, making access more affordable for the rural healthcare provider; the other, the HCF Program, seeks to expand access to affordable broadband for healthcare providers, especially in rural areas, and encourages the creation of state and regional broadband health care networks. Should we prioritize one RHC Program over the other? Currently, our rules provide for equal treatment of the two programs when the cap is exceeded, for purposes of prorating support. We also note that section 254(h)(2)(A) requires the Commission to establish competitively neutral rules for healthcare provider access to advanced telecommunications and information services to the extent “economically reasonable.”⁵⁵ Some entities nevertheless have argued that funding for the Telecom Program is mandatory and that the Commission therefore is required to fund Telecom Program requests in their entirety before funding HCF Program requests.⁵⁶ We seek comment on the relevance of these and other statutory provisions to the Commission's options for prioritizing support. We also seek comment on how prioritizing one program over the other might affect funding between the two programs and how it would, or would not, lead to an efficient use of the RHC Program's funding and accomplish Congress's goals for this universal service support program.

33. *Prioritizing Based on Economic Need or Healthcare Professional Shortages.* We seek comment on whether the RHC Program should likewise take into consideration the economic need of the population served by the healthcare provider when prioritizing disbursements.⁵⁷ If so, would Medicaid

⁵³ *Connect America Fund, ETC Annual Reports and Certifications, Rural Broadband Experiments*, WC Docket Nos. 10-90, 14-58, 14-529, Report and Order, 31 FCC Rcd 5949, 6018-20, paras. 195 *et seq.* (2016).

⁵⁴ See 47 U.S.C. §§ 254(h)(1)(A), (h)(2)(A).

⁵⁵ See 47 U.S.C. § 254(h)(2)(A).

⁵⁶ 47 U.S.C. §§ 254(h)(1)(A), (h)(2)(A). See, e.g., Letter from Geoff Strommer, Counsel to Tribal Organizations in Alaska, to Chairman Ajit Pai and Commissioners, FCC, WC Docket No. 02-60, at 1 (filed Aug. 15, 2017) (arguing that section 254(h)(1)(A) of the Telecommunications Act of 1996 is an entitlement mandate and that a cap is not authorized by Congress).

⁵⁷ The E-rate Program prioritizes funding based on economic need of the children as the determinant. 47 CFR § 54.505(c).

eligibility be an appropriate measure of economic need?⁵⁸ Would Medicaid eligibility be an appropriate measure to use to prioritize funds to maximize the efficiency of our funding dollars? Is there another metric of economic need that would be more appropriate? If we prioritize funding based on economic need of the population served by the healthcare provider, how would we handle consortia?

34. We also seek comment on whether we should prioritize funding to areas with health care professional shortages. Telemedicine and telehealth can be a valuable resource where a shortage of health professionals is present. For example, using telemedicine and telehealth, rural healthcare providers that may be understaffed or lack highly skilled health professionals can connect with medical professionals and specialists located elsewhere to provide care to the patient and avoid the need and expense of either the patient or professional traveling to the other. The Health Resources and Services Administration (HRSA) currently identifies Health Professional Shortage Areas (HPSA), based on geographic area, population groups and facilities; Medically Underserved Areas and Medically Underserved Populations (MUA/P), which identify geographic areas and populations with a lack of access to primary care services; and state identified rural health care clinics that do not otherwise qualify for HPSA or MUA/P designation.⁵⁹ We seek comment on whether prioritizing funding requests based on the designations by the HRSA would better serve our goal of using each funding dollar to its maximum benefit. If we were to use these designations, would we be required to also consider whether the persons served by the healthcare provider lived in rural areas to satisfy the requirements of section 254(h)(1)(A) of the Act? Would this overlay of HRSA designations on the rural areas focus funding on the areas of the country that most need access to health care? Would this target the RHC Program funding to its most efficient use?

3. Targeting Support to Rural and Tribal Healthcare Providers

35. Recognizing that the primary emphasis of the RHC Program is to defray the cost of supported services for *rural* healthcare providers,⁶⁰ we seek comment in this section on several proposals to direct proportionally more funding to rural healthcare providers, including healthcare providers on rural Tribal lands.⁶¹

36. *Rural Healthcare Providers in HCF Program.* Currently, the HCF Program provides support for non-rural healthcare providers in majority-rural consortia.⁶² Although the HCF Program places an emphasis on increasing broadband access to healthcare providers that serve rural areas, the Commission recognized in the *HCF Order* that non-rural healthcare provider participation may confer benefits upon affiliated rural healthcare providers, including lower broadband costs, access to medical

⁵⁸ We note that Medicaid eligibility rules differ between states but are based on income, household size, disability, family status, and other factors.

⁵⁹ See HRSA: Types of Designations, <https://bhw.hrsa.gov/shortage-designation/types> (last visited Nov. 17, 2017).

⁶⁰ See 47 U.S.C. §§ 254(b), (h)(1)(A), (h)(2)(A).

⁶¹ See, e.g., SHLB Petition at 5-19 (requesting, among other things, a higher HCF discount percentage for rural healthcare providers); NOSORH Comments, GN Docket No. 16-46, at 2-3 (May 25, 2017) (arguing that “frontier providers with the lowest broadband capacity” should be afforded the “highest priority” in the RHC Programs); OKPCA Comments, GN Docket No. 16-46, at 2 (June 8, 2017) (seeking “full funding for Federally Qualified Health Centers and other health care providers that are clearly eligible under a plain reading of the statute”); ACS Comments, GN Docket No. 16-46, at 3, 12 (May 25, 2017); NRHA Comments, GN Docket No. 16-46, at 3 (May 23, 2017); ATA Comments, GN Docket No. 16-46, at 9 (May 24, 2017) (asking that the RHC Programs “continue to target the most rural health facilities that are faced with extreme costs”); IPCA Comments, GN Docket No. 16-46, at 2 (May 25, 2017); Seward Community Health Center Comments, GN Docket No. 16-46, at 1 (May 23, 2017); Alaska PCA Comments, GN Docket No. 16-46, at 1 (May 25, 2017).

⁶² See 47 CFR § 54.630(b).

specialists, administrative support, and technical expertise.⁶³ We agree that non-rural healthcare provider participation in HCF consortia benefits rural healthcare providers and patients, and therefore propose the measures below to promote continued non-rural healthcare providers' participation yet still direct the greater part of HCF Program support to rural healthcare providers.

37. First, we seek comment on increasing the HCF Program consortia "majority rural" healthcare provider requirement from a "more than 50 percent rural healthcare providers" threshold to some higher percentage.⁶⁴ As of November 2017, 27 HCF consortia were required to meet the existing "majority rural" requirement and had rural healthcare provider percentages ranging from 45 to 100 percent, with an average of 79 percent rural healthcare providers.⁶⁵ We seek comment on whether the current "majority rural" threshold accurately reflects the needs of rural healthcare providers, and whether we should increase the minimum percentage of rural healthcare providers in HCF consortia. If so, what might be an appropriate percentage? What would be the practical implications of an increase in the percentage of rural healthcare providers necessary in a consortium?

38. Second, we seek comment on elimination of the three-year grace period during which HCF consortia may come into compliance with the "majority rural" requirement.⁶⁶ As of November 2017, of the 160 HCF consortia that were still within the three-year grace period for "majority rural" compliance, 143, or 89 percent, already had met the requirement and had rural healthcare provider percentages ranging from 55 to 100 percent, with an average of 81 percent rural healthcare providers.⁶⁷ If commenters propose that we establish a grace period of less than three years, what period would be appropriate, and why?

39. Finally, we seek comment on whether to require a direct healthcare-service relationship between an HCF consortium's non-rural and rural healthcare providers that receive Program support. Currently, we do not require a consortium's non-rural healthcare providers to provide clinical care or other healthcare-related services to patients of their affiliated rural healthcare providers.⁶⁸ Should non-rural healthcare provider support be limited to only those healthcare providers directly providing healthcare-related services to rural areas? Or, should we provide HCF support to some percentage of each consortium's non-rural healthcare providers that do not provide healthcare services to rural areas, recognizing that, among other things, many non-rural healthcare providers provide significant non-healthcare-related benefits to affiliated rural healthcare provider consortia members, such as consortium formation and leadership; administrative resources; and greater bargaining power with service providers?⁶⁹

40. *Rural Tribal Healthcare Providers in Telecom and HCF Programs.* Given our emphasis on targeting more support to rural healthcare providers and healthcare providers on rural Tribal lands, we seek comment from Tribal governments in particular on whether any of our proposals here would impact

⁶³ See *HCF Order*, 27 FCC Rcd at 16696, 16705-07, paras. 34, 60.

⁶⁴ See 47 CFR § 54.630(b); see also *HCF Order*, 27 FCC Rcd at 16707, para. 61.

⁶⁵ Derived from USAC-provided data. See USAC Website, Rural Health Care, Healthcare Connect Fund, Commitment Search Tool, <https://rhc.usac.org/hcf/public/CommitmentSearch.htm> (last visited Nov. 17, 2017). We note that a consortium's non-rural healthcare providers exceeding the allowed non-rural percentage do not receive RHC support. See 47 CFR § 54.630(b).

⁶⁶ See *HCF Order*, 27 FCC Rcd at 16707, para. 61.

⁶⁷ Derived from USAC-provided data. See USAC Website, Rural Health Care, Healthcare Connect Fund, Commitment Search Tool, <https://rhc.usac.org/hcf/public/CommitmentSearch.htm> (last visited Nov. 17, 2017).

⁶⁸ See 47 CFR § 54.630(b).

⁶⁹ *HCF Order*, 27 FCC Rcd at 16705-07, para. 60.

Tribal populations and, if so, how.⁷⁰ Additionally, we seek comment on what measures would help ensure that adequate Telecom and HCF Program support is directed toward healthcare providers on rural Tribal lands.

B. Promoting Efficient Operation of the RHC Program to Prevent Waste, Fraud, and Abuse

41. In light of the pricing increases and shrinking out-of-pocket costs borne by healthcare providers, we next turn to the issue of inadequate price-sensitivity in the Telecom Program. In the *HCF Order*, the Commission stated that reforms to the Telecom Program could provide greater incentives for healthcare providers to make more cost-efficient service purchases⁷¹ and we believe promoting price-sensitivity and encouraging healthcare providers to make more efficient purchasing decisions is particularly important considering growth in the RHC Program. Efficiency entails both ensuring that limited Telecom Program funding is directed to healthcare providers that need it and encouraging healthcare providers to be price sensitive in choosing services and carriers. One goal of the Telecom Program is to reduce the effect of healthcare providers' location on the effective (out-of-pocket) price of available services. If incentives were well aligned, healthcare providers receiving support would choose the same service levels that an identical urban counterpart would purchase under the circumstances. At the same time, we seek to ensure that, by improving efficiency, we do not restrict necessary funding for those healthcare providers whose service costs are legitimately high due to their unique geography and topography.

1. Controlling Outlier Costs in the Telecom Program

42. To ensure that limited funding is distributed efficiently, we propose to establish objective benchmarks to identify outlier funding requests, using information already provided by Telecom Program participants to USAC. We seek comment on whether establishing an objective benchmark to identify those outlying funding requests will provide greater transparency for RHC Program participants and clearer guidance to USAC. Under our proposal, outlier funding requests that exceed the benchmark will be subject to enhanced review by USAC before issuing commitments. Then, we seek comment on the measures to use in evaluating those outlier requests for funding support.

a. Identifying Healthcare Providers with Particularly High Support Levels

43. Under section 254(h)(1)(A) of the Act, rural healthcare providers pay discounted rates for telecommunications services that are "reasonably comparable" to rates charged for "similar services" in urban areas.⁷² A discount rate benchmark identifies those healthcare providers paying a smaller share of

⁷⁰ For the purposes of this NPRM, we define "Tribal lands" as any federally-recognized Indian tribe's reservation, pueblo or colony, including former reservations in Oklahoma, Alaska Native regions established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688), and Indian allotments. The term "Tribe" means any American Indian or Alaska Native Tribe, Band, Nation, Pueblo, Village or Community which is acknowledged by the Federal government to have a government-to-government relationship with the United States and is eligible for the programs and services established by the United States. *See Statement of Policy on Establishing a Government-to-Government Relationship with Indian Tribes*, 16 FCC Rcd 4078, 4080 (2000). Thus, "Tribal lands" includes American Indian Reservations and Trust Lands, Tribal Jurisdiction Statistical Areas, Tribal Designated Statistical Areas, and Alaska Native Village Statistical Areas, as well as the communities situated on such lands. This would also include the lands of Native entities receiving Federal acknowledgement or recognition in the future. Although Native Hawaiians are not currently members of federally-recognized Tribes, we also seek comment on whether any of our proposals here would impact Native Hawaiian populations.

⁷¹ *HCF Order*, 27 FCC Rcd 16678, 16815, para. 343. *See also* Letter from Richard E. Wiley to Marlene Dortch, FCC, WC Docket No. 17-310 (filed Dec. 8, 2017).

⁷² 47 U.S.C. § 254(h)(1)(A).

the costs toward their selected services. For example, some healthcare providers in the Telecom Program receive discounts in excess of 99 percent and therefore contribute less than one percent of the price of services. In contrast, a healthcare provider with a discount rate of 75 percent, for example, pays one fourth of the service costs. Since high discount rates will tend to suggest high differentials between the rural and urban rates, we seek comment on using the discount rate to establish a benchmark based on data from the preceding funding year, and a rebuttable presumption that Telecom Program support levels above the benchmark will not result in rates that meet the Act's "reasonably comparable" standard.⁷³

44. Specifically, we seek comment on establishing a benchmark based on the discount rates in the Telecom Program, which USAC would use to identify outlying high-support requests. One approach would make the benchmark discount rate equal to the lowest discount rate from among the five percent of healthcare providers receiving the highest discount rates in the immediately preceding funding year—in 2016, five percent of healthcare providers got discounts of 99 percent or more and received more than 52 percent of all Telecom Program funding. Each year, USAC would publish this benchmark well in advance of the filing window period to assist service providers in making bids and rural healthcare providers in making service selections. This approach could limit the pool of applicants the rate applies to while maximizing its impact—but the benchmark would change significantly year to year.

45. Another approach would require USAC to set a fixed benchmark (such as 90 percent or 99 percent) that would remain either static from year to year or change gradually over time (such as a 99 percent initial benchmark that decreases 1 percent each year and stops at 90 percent). We seek comment on the appropriate level of this discount rate cutoff.

46. Should the benchmark also incorporate other considerations, such as the overall size of a healthcare provider's funding request? Should the benchmark be calculated on a nationwide basis or per state? Commenters should also discuss other measures that may be useful benchmarks. Alternatively, since high discount rates may reflect in large part unusually high rural rates, should we consider setting benchmarks directly based on the service costs? For instance, should we look at those rural rates for service that are above a certain percentile when compared to rural rates contained in all funding requests, possibly normalized by some characteristic of the healthcare providers? How would such a benchmark be implemented?

b. Funding Requests that Exceed the Benchmark

47. In this section, we address what steps to take when a healthcare provider's request in the Telecom Program exceeds the established benchmark. Our objective is to make service providers and healthcare providers more sensitive to price in an effort to reduce unnecessary spending while at the same time allowing for support in accordance with the Act. The proposals below are intended to incentivize healthcare providers to consider costs more carefully and, thereby, ensure a more efficient use of scarce RHC Program funds.

(i) Enhanced Review for Outlier Funding Requests

48. We propose that a funding request that exceeds the relevant benchmark be subject to a two-step enhanced review—one to determine whether the rural rate is improperly high and another to determine whether the urban rate is improperly low. Under current rules, a carrier is supposed to calculate the rural rate by taking its own "average of the rates actually being charged to commercial customers" in the relevant area, looking to the rates charged by other carriers or costs only as a secondary approach.⁷⁴ And under current rules, urban rates are set as "no higher than the highest tariffed or

⁷³ We note that USAC will need to review not only the healthcare providers' documentation, but also documentation from the healthcare providers' service provider, and possibly any consultants that have worked on behalf of the service provider or healthcare provider during the competitive bidding and service selection processes.

⁷⁴ 47 CFR § 54.607.

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.”⁷⁵

49. As a first step, we seek comment on requiring the carrier to justify the underlying costs in the rural rate presented in the funding request, including the costs materially affecting the price of each feature that the healthcare provider included in its Request for Proposal (RFP). Under this approach, USAC would limit the acceptable rural rate associated with the funding request to those specific costs plus a reasonable rate of return. That allowable return on the rate set for rate-of-return carriers is currently 10.75 percent, and is set to decline by 0.25 percent annually until 2021, when it will be 9.75 percent.⁷⁶ We seek comment on limiting the rural rate to what can be cost-justified as one form of enhanced review of rural rates.

50. If we adopt this approach, what information should the service provider be required to submit to justify costs? Which features, if different from those being analyzed under the enhanced similarity review, should be included? Should such a cost review limit the mark up that resellers can impose on resold services? In the past, the Commission has suggested that a wholesale discount of 17 percent to 25 percent would reasonably reflect the avoided costs of a wholesaler⁷⁷—should we look beyond those discounts in selecting a maximum markup?⁷⁸ We seek comment on this approach and especially solicit examples of how similar reviews have been conducted in other contexts. For example, should we incorporate the Commission’s recent non-exhaustive list of expenses that should not be included in the cost base for rate-of-return carriers into the cost study analysis proposed here?⁷⁹ Should we continue to incorporate updates to the items in the *High Cost Public Notice*? To ensure that support is limited to “telecommunications services which are necessary for the provision of health care services,”⁸⁰ we seek comment on whether we should adapt the “used or useful” standard⁸¹ from the High-Cost context to this proposed cost review? As the Commission has noted, plant that is actually being used to send signals to customers is “used and useful.”⁸² For example, should we adapt that test to the review of a service that exceeds the healthcare provider’s minimum needs? In that case, should USAC limit support to a return on only the costs needed to provide the healthcare provider’s minimum needs?

51. Commenters should discuss whether this proposal should replace the current comprehensive support calculation in section 54.607(b) of our rules.⁸³ We also seek comment on the costs and benefits of carrying out this approach. In addition, commenters should discuss how this

⁷⁵ 47 CFR § 54.605.

⁷⁶ See *Connect America Fund*, Report and Order, Order and Order on Reconsideration, and Further Notice of Proposed Rulemaking, 31 FCC Rcd 3087, 3212, para. 326 (2016).

⁷⁷ 47 CFR § 51.611.

⁷⁸ A 17 percent discount would translate into a 20.4 percent markup (1 / 0.83). A 25 percent discount would translate into a 33.3 percent markup (1 / 0.75).

⁷⁹ *All Universal Service High-Cost Support Recipients are Reminded that Support must be Used for its Intended Purpose*, Public Notice, FCC 15-133 (Oct. 19, 2015) (*High Cost Public Notice*).

⁸⁰ 47 U.S.C. § 254(h)(1)(A).

⁸¹ See *AT&T Application for Review; Sandwich Isles Commc’ns, Inc. Petition for Declaratory Ruling*, Memorandum Opinion and Order, 31 FCC Rcd 12977, 12981, para. 10 (2016) (Property is considered used and useful if it is “necessary to the efficient conduct of a utility’s business, presently or within a reasonable future period.” (citation omitted)).

⁸² *Id.* at para. 11. The “equitable considerations” that sometimes justify investments beyond current capacity, *id.* at para. 13, are not present here, as the Telecom Program is limited to presently available services.

⁸³ See 47 CFR § 54.609(a)(2).

enhanced review would interact with other reforms discussed below, such as proposals for calculating the urban and rural rates.

52. As an alternative first step, we seek comment on USAC limiting the rural rate to the lowest market rate it can find for identical or similar services in the rural area. We expect that USAC would examine at least the commercial rates that the carrier itself used in creating an average rural rate in evaluating the lowest cost option, as well as the rates charged by other service providers for commercial customers and any other rates for such services that USAC can find. What would be the impact of such an approach? What data sources should USAC look to in determining other commercial rates in the rural area?

53. Second, we seek comment on USAC setting the urban rate based on the highest urban rate for an identical or similar service in any city of 50,000 or more in that state. Such a change would take the ability to set the urban rate out of the hands of a carrier that might be seeking to compete for a rural healthcare provider by offering an artificially low urban rate. What factors should we consider in evaluating this option?

54. Alternatively, we seek comment on requiring USAC to conduct a detailed review of the healthcare provider's funding request to ensure that the rural and urban services being compared are sufficiently similar. USAC's analysis would include a feature-by-feature review of the similarity between the requested rural services and their urban counterparts, as well as the similarity between the services being provided in comparable rural areas. USAC's similarity review would be based on the service information contained in the documents supporting the healthcare provider's funding request. We also seek comment on how to best address those support requests that do not satisfy the similar services stage of the enhanced review inquiry. Should USAC deny those funding requests outright, or allow healthcare providers and their service providers to recalculate and reapply with a revised urban rate?

55. Which of these approaches will best balance our goals of fairness and efficiency? Are there alternative approaches we should consider? What burdens would each of the enhanced review options have on rural healthcare providers, their carriers, and USAC? What options would lead to the best incentives for rural healthcare providers to choose cost-effective options? Would any of the options be particularly efficient at ferreting out waste, fraud, and abuse in the RHC Program? Would any of the options be sufficient to encourage carriers to bid to serve rural healthcare providers at rural-urban differentials that would be low enough to avoid the enhanced review?

(ii) Capping Funding Requests That Exceed the Benchmark

56. As an alternative to enhanced review, we seek comment on capping high-support funding requests in the Telecom Program to ensure efficient distribution of funding to the greatest number of healthcare providers. Under this alternative, healthcare providers whose support requests exceed the proposed benchmark would be conclusively deemed to be requesting service at rates that are not reasonably comparable to those charged for similar services in urban areas, and support would be capped at the benchmark. Carriers are limited under the Act to receive only the difference between rural rates and reasonably comparable rates in urban areas for similar services.⁸⁴ We seek comment on this alternative, including on associated issues such as the appropriate geographic unit to which to apply it.

57. We also seek comment on an alternative proposal in which we would establish discount rate tiers that would provide diminishing support to healthcare providers as their service costs increase relative to similar healthcare providers. To provide certainty to healthcare providers, these tiers would be established each year based on the preceding funding year's participant data. Under this "soft" funding cap approach, healthcare providers would be grouped based on specific, identified factors such as entity size, geographic location, and purchased services. For example, within each healthcare provider group,

⁸⁴ 47 U.S.C. § 254(h)(1)(A).

the Telecom Program could fully fund the urban–rural rate difference if the cost of the requested service falls at or below the 25th percentile of spending for the relevant group. For requests with costs in the second-lowest quartile between the 25th percentile and the median for the group, funding would be substantial but less than the full urban–rural rate difference, and funding would decrease accordingly for succeeding quartiles above the median cost. Thus, under this marginal “soft” funding cap approach, only healthcare providers’ marginal spending increases relative to similar healthcare providers will be subject to diminishing support.

58. We seek comment on whether this approach provides helpful incentives for healthcare providers to seek the lowest costs for services. We also seek comment on how it can best be implemented. Is quartile of healthcare provider eligible service spending the best way to establish marginal support tiers? What level of marginal support for each tier will provide the most efficient reduction? What factors should we consider in grouping healthcare providers in order to best compare their spending or service levels? For example, if we distinguish between healthcare providers by size, should we measure size by patient capacity, actual patient numbers, staff levels, or some other measure? What service features should we use for grouping similar healthcare providers? Are the features in our similar services proposal appropriate, or should we include additional features for purposes of this proposal?

59. We believe the approaches discussed above meet our efficiency goals because they ensure that healthcare providers—even those receiving particularly high levels of support—will continue to receive support for necessary telecommunications services under the Telecom Program while also realigning healthcare providers’ incentives to select services and carriers more efficiently. We seek comment on how these various proposals help align healthcare providers’ incentives to select services and carriers efficiently, thereby promoting these efficiency goals for the Program.

2. Reforming the Rules for Calculating Support in the Telecom Program

60. In accordance with the goal of calculating funding disbursements in a consistent and transparent manner and minimizing excessive RHC Program spending, we next seek to reduce opportunities for manipulating the rural and urban rates in the Telecom Program more generally.

a. Calculating Urban and Rural Rates

61. We propose more detailed requirements about how the urban and rural rates are determined in the Telecom Program to minimize potential variances and rate manipulation. We believe these changes will ultimately reduce the burden on healthcare providers and service providers to calculate urban and rural rates, and the need for USAC to engage in detailed rate reviews.

62. The subsidy provided to the service provider is based on the difference between the “urban rate”⁸⁵ and the “rural rate.”⁸⁶ The concepts of urban rate and rural rate are defined in the Commission’s rules. Pursuant to the rules, the rural rate is calculated in one of three ways. In the first instance, the rural rate is “the average of the rates actually being charged to commercial customers, other than [healthcare providers], for identical or similar services provided by the telecommunications carrier providing the service in the rural area in which the [healthcare provider] is located.”⁸⁷ If the service provider is not providing an identical or similar service in the rural area, then the rural rate should be “the average of the tariffed and other publicly available rates . . . charged for the same or similar services in

⁸⁵ See 47 CFR § 54.605 (describing how to determine the urban rate).

⁸⁶ See 47 CFR § 54.607 (describing how to determine the rural rate).

⁸⁷ See 47 CFR § 54.607(a).

that rural area . . . by other carriers.”⁸⁸ If there are no tariffed or publicly available rates for such services in that rural area, then the Commission’s rules provide a mechanism for deriving a cost-based rate.

63. We recognize that there are often few customers of a size comparable to the healthcare provider in the rural area and often even fewer service providers. This circumstance may make it difficult to develop an average rate consistent with the Commission’s rules for determining the rural rate. We are moreover concerned that, at times, permitting service providers to put forward rural rates based only on their own rates to other rural customers may artificially inflate the rural rate by excluding other service providers’ service rates to rural customers for functionally similar services. This situation also risks conflating the rural rate concept with the carrier’s own price for providing service, and opens the door to potentially boundless rural rate increases, and difficult-to-detect abuse. Moreover, healthcare providers may have little incentive to check service provider pricing (since rural healthcare providers pay the urban rate no matter what the differential under current rules).

64. Nevertheless, we appreciate that reliance on publicly available rate data leads to greater transparency. To address the issue about the paucity of rate data in rural areas, we offer several proposals. Going forward, rather than distinguishing between the rates of the healthcare provider’s selected service provider⁸⁹ and the rates of other service providers,⁹⁰ the rural rate would be the average of *all* publicly available rates charged for the “same or similar services” in the rural area in which the healthcare provider is located. This average of all publicly available rates would include the service provider’s own rates to other non-healthcare provider customers, as well as tariffed rates in the rural area, and undiscounted rates offered to schools and libraries in the rural area via the E-rate Program. Are there other sources of publicly available rate information that we should consider adding? Should we retain the inclusion of tariffed rates in the calculation of the rural rate? Is there a risk that service providers may be able to file tariffs with artificially high rates in order to increase the rural rate? If so, can we mitigate that risk by limiting the use of tariffed rates to services actually being provided to at least one non-healthcare provider commercial customer in the rural area? In addition, we propose, in the event the only available rates in the healthcare provider’s rural area are the service provider’s own rates, to require the service provider to calculate a rural rate based on publicly available rates in another comparable rural area in the healthcare provider’s state where at least one other service provider offers publicly available rates for functionally similar services. Through this proposal we seek to minimize the service provider’s ability to offer an unjustified, high rural rate. To this end, should we direct USAC to substitute publicly available rates it is aware of in the healthcare provider’s rural area if those rates are lower than the rate average submitted by the healthcare provider? We also seek comment on whether USAC should establish a database containing all the rate information submitted each year. If so, in subsequent years the rural rate could be based on an average of the rates in the rural area from the preceding year.

65. We also seek comment on whether to retain section 54.609(d) of the rules,⁹¹ which provides that healthcare providers may receive support for satellite service even if there is a functionally equivalent terrestrial service in the healthcare provider’s rural area, but such support may not exceed the amount of support that would be available for the relevant terrestrial service. In light of our proposals to reform the rules for calculating the rural rate, along with our proposals for competitive bidding reform, section 54.609(d) may no longer be necessary. Our rural rate proposal, for example, would place a check on the service provider’s rate by requiring the rural rate be calculated by taking an average of publicly available rates including at least one other service provider in addition to the healthcare provider’s service provider. Using a competitive service provider’s rate to limit support to a healthcare provider may make

⁸⁸ See 47 CFR § 54.607(b).

⁸⁹ 47 CFR § 54.607(a).

⁹⁰ 47 CFR § 54.607(b).

⁹¹ 47 CFR § 54.609(d).

unnecessary section 54.609(d)'s limitation on support available for satellite service where terrestrial service is also available. If we do retain section 54.609(d) of the rules, should we modify that provision, based on Alaska Communications Systems' (ACS) suggestion, to cap support at the lower of the satellite service rate or the terrestrial service rate where both services are available?⁹² Is it the case that the prices for satellite and terrestrial services diverge greatly only in Alaska, or does this occur in other parts of the country as well? If we were to modify 54.609(d) in the manner suggested by ACS, should we require all healthcare providers to provide rate information about both satellite and terrestrial services, or should there be some criteria for determining when such a comparison is required?

66. We likewise seek comment on whether we should retain the cost-based support mechanism in section 54.609(b) of the rules.⁹³ Currently, service providers may propose a rural rate, supported by the service provider's itemized costs of providing the requested service.⁹⁴ The above proposals would reduce the chance that there are no publicly available rates to use in calculating a rural rate for a service. Nevertheless, we seek comment on whether the rule would continue to benefit service providers that may believe that rural rates calculated consistent with our proposal above are unfair. Are there alternatives that would ensure that the rural rate was calculated in a manner such that establishing a cost-based rural rate would not be necessary?

67. We also propose to modify our rules regarding the calculation of the urban rate. Under the current rules, the urban rate can be "no higher than the highest tariffed or publicly-available rate... for a functionally similar service" offered in a city in that state of 50,000 or more at a distance no greater than the standard urban distance (SUD).⁹⁵ Basing the urban rate on only one rate example may lead to "cherry-picking" and a search for the lowest possible rate regardless of whether this rate is representative of the *average* urban rate for a similar service. This incentive to find the lowest possible urban rate so as to maximize the discount contributes to excessive Telecom Program spending.⁹⁶ Requiring a rate average would eliminate this incentive.

68. We next explore the best sources for the various rate data required to calculate the average rates and the discount. While the healthcare provider currently submits urban and rural rate data along with its application, healthcare providers may obtain these rates from carriers, third party consultants or through other means. We seek comment on standardizing this process by having the healthcare provider's service provider give the healthcare provider the urban and rural rates and averages for the relevant urban and rural areas, along with rate documentation to the healthcare provider. The healthcare provider would then file that documentation with its application. We believe the service provider can most easily access the rate information and this approach will ease the burden on healthcare providers and USAC to compare urban and rural rates from difference sources. We seek comment on this approach.

69. Nevertheless, having the carrier, the entity with the most to gain financially, provide the rate information may promote incentives that are not aligned with our goals of efficiency in the RHC

⁹² See, e.g., Letter from Richard Cameron, Counsel for Alaska Communications, to Marlene Dortch, FCC, WC Docket No. 02-60 at 1-2 (filed Nov. 13, 2017).

⁹³ 47 CFR § 54.607(b) ("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.").

⁹⁴ 47 CFR § 54.607(b)(1).

⁹⁵ 47 CFR § 54.605.

⁹⁶ See, e.g., *NSS NAL*, 31 FCC Rcd at 12277, para. 104 (alleging company submitted fraudulent rates to increase the amount of support NSS received from the Fund as a result of the RHC Telecom Program's funding formula).

Program. To remove concerns about misaligned incentives and provide greater transparency in the Telecom Program review process, we seek comment on whether USAC should collect and make available the relevant urban and rural rate data, rather than the service provider. Under this approach, for each relevant urban and rural area, USAC would collect and aggregate the prior year's Telecom Program and E-rate rate data as well as any other publicly available rate data. USAC would post this rate data on its website. At the time of application, a healthcare provider's service provider would develop an average rural and urban rate for the relevant service based on a combination of its own price data and that found on USAC's website. We seek comment on this idea and ask how USAC can best accumulate reliable rate information. How would this approach work in the event there is no data, or insufficient data, from the preceding year for the rural area in which the healthcare provider is located and/or the relevant urban area?

70. We must next define the geographic contours of rural and urban areas for the purpose of determining the urban and rural rates. We believe that averaging rates within state rural areas containing similar cost attributes is consistent with the goal of section 254(h)(1)(A) to ensure that healthcare providers in rural and urban areas pay reasonably comparable rates. We seek comment on that belief. Consistent with that approach, we propose to establish an appropriate rural definition for the RHC Program that is simple to understand and apply. The rural area must be completely enclosed by a state and should contain enough telecommunications service offerings to calculate a meaningful average rural rate. We seek examples of such appropriate rural areas. We also seek comment on methods to ensure services are averaged with similarly rural services. Should we consider establishing tiers of rurality so average rates in the most rural areas will not be reduced by including rates from only slightly rural areas? The relevant rural area could be defined by the boundaries of the tier in which the healthcare provider is located and the rural rate would be the average of the rates of "similar services" within that boundary.⁹⁷ What data sources could we look to in order to ensure healthcare providers and service providers are only using rates from like rural areas when calculating the discount? Should we consider using types of rural areas that align with the prioritization tiers discussed below?⁹⁸ Would establishing rural areas in this manner result in appropriate rates and discounts for RHC Program participants? We seek comment on any other approaches consistent with the statute.

71. As for urban areas, should we continue to follow the approach currently set forth in the Commission's rules, whereby the urban rate is based on rate data from any city in the relevant state with a population of 50,000 or more?⁹⁹ Given the increased availability of telecommunications services in smaller cities, should we modify the city population size used to generate the urban rate? We seek comment on methods to identify the appropriate urban rate for discount calculation.

72. Finally, we seek comment on whether, in lieu of using rate averaging we should instead adopt a median-based approach.¹⁰⁰ Might such an approach, rather than an average-based approach, limit

⁹⁷ A healthcare provider located in a type of rural area defined by the Commission would calculate its rural rate by averaging all similar services in that rural area.

⁹⁸ These three tiers are defined by the three different sub-areas in the current definition of rural area in our rules, with the most rural sub-area listed first. *See* 47 CFR § 54.600 (b) (defining rural area as either (1) "an area that is entirely outside of a Core Based Statistical Area"; OR (2) "is within a Core Based Statistical Area that does not have any Urban Area with a population of 25,000 or greater"; OR (3) "is in a Core Based Statistical Area that contains an Urban Area with a population of 25,000 or greater, but is within a specific census tract that itself does not contain any part of the Place or Urban Area with a population of greater than 25,000.").

⁹⁹ 47 CFR § 54.605(a).

¹⁰⁰ For example, assume USAC's rate information showed that in the healthcare provider's rural area, there were five other services in the same bandwidth tier as the healthcare provider's service (\$10, \$95, \$100, \$120 and \$180) and the carrier serving the healthcare provider submitted information showing that it was also providing two similar services in the same rural area for \$75 and \$300. The rate would be the median of these seven prices, or \$100.

the effect of very high and low rates?

b. Defining Similar Services

73. To limit possible waste and modernize our rules to reflect services actually purchased by healthcare providers today, we seek comment on services supported by the Program. We first seek comment on changes to the Commission's interpretation of "similar services." Under section 254(h)(1)(A), and the Commission's rules, carriers are permitted to receive reimbursement for the difference between the urban and average rural rates for "similar services."¹⁰¹ In 2003, the Commission concluded that services are "similar" under 254(h)(1)(A) if they are "*functionally* similar as viewed from the perspective of the end user."¹⁰² To implement this standard, the Commission established a voluntary "safe harbor" whereby a healthcare provider could claim that two services are similar if they both fall within one of five speed tiers (the highest tier grouped all services at 50 Mbps and above) and are either symmetrical or asymmetrical.¹⁰³ Although the Commission anticipated updating these tiers to account for market changes and to "reflect technological developments," the tiers have not been updated since 2003. Our experience with the RHC Program shows that having a voluntary safe-harbor system based on speed tiers that do not reflect current healthcare provider service needs has led to significant variability in how the "similar services" analysis is conducted and is a potential source of waste.

74. The current safe-harbor healthcare providers and service providers use when calculating urban and rural rate determinations may be contributing to RHC Program waste as it allows healthcare providers and service providers to rely on services that are in fact materially different. For example, due to the highest tier grouping all bandwidths of 50 Mbps or higher, in determining the applicable discount rate for a 60 Mbps service under the safe-harbor, the average rural rate could be set based on rates for two services at 200 Mbps and three services at 500 Mbps, all of which are priced significantly higher than the undiscounted price for the 60 Mbps service. The healthcare provider could also select an urban rate based on the price of a 50 Mbps service. These services, however, are unlikely to be "*functionally* similar as viewed from the perspective of the end user" given the huge disparity between a 50 Mbps service and a 300 Mbps service. Yet the safe-harbor tiers currently permit a comparison of these services when calculating the discount for the service ordered.

75. Going forward, we propose to retain the concept of "*functionally* similar as viewed from the perspective of the end user," and require healthcare providers to analyze similarity under specific criteria.¹⁰⁴ First, we propose to retain the concept of bandwidth tiers from the current safe-harbor framework, but update the speeds to ensure that each tier includes only bandwidths in a range that are "*functionally* similar as viewed from the perspective of the end user." As with the existing safe-harbor, each tier will be made up of bandwidths within a specific range and any service within that range will be considered "similar" for purposes of the bandwidth criterion.

76. Next, we seek comment on how the bandwidth tiers should be established and updated. We propose that the bandwidth tiers be set by reference to the healthcare providers' requested bandwidth in each instance. For example, the tier for a healthcare provider requesting a 50 Mbps service would include all services within 30 percent of 50 Mbps (*i.e.*, 35 Mbps to 65 Mbps), where the average rural rate would be the average rate of all services within this 30 percent bandwidth range in the relevant rural area. All services within the stated percentage above or below the bandwidth requested by the healthcare provider would be considered "similar" for purposes of the bandwidth criteria. Under this approach, there

¹⁰¹ See 47 U.S.C. § 254(h)(1)(A); *HCF Order*, 27 FCC Rcd at 16718, para. 87.

¹⁰² See *2003 RHC Order*, 18 FCC Rcd at 24563, para. 33 (emphasis in original).

¹⁰³ See *id.*, para. 34.

¹⁰⁴ By functionally similar from the perspective of the end user, we mean these services offer features and functions that provide a similar user experience.

would be no need to update the bandwidth tiers over time. If we adopt this approach, what is an appropriate percentage to establish the range? Should this percentage vary depending on the bandwidth requested? Should we use something besides a percentage? In the alternative, we seek comment on resetting the current bandwidth tiers at higher bandwidths and updating those tiers periodically over time based on common bandwidths for which healthcare providers seek funding. For example, one bandwidth tier could consist of all services in a rural area with bandwidth speeds between 1 Gbps and 2 Gbps.

77. We also seek comment on other criteria we could use to establish “similar services.” For example, should packetization be a criterion? Packetized services can provide traffic prioritization and can be purchased in more granular bandwidth increments than non-packetized, TDM-based services.¹⁰⁵ Do these differences mean that packetized and non-packetized services cannot be “functionally similar as viewed from the perspective of the end user?”

78. In addition, as we explore revisiting the service tiers, should the Commission consider adopting a minimum bandwidth requirement? What about minimum requirements for other service characteristics? Would any minimum requirements be appropriate for the Telecom or the HCF Programs? We seek comment on whether to do so and, if so, appropriate minimum levels. Also, could a list of services eligible for support under each of the RHC Programs be useful?¹⁰⁶ Further, we seek comment on supporting services that have not traditionally received support in the RHC Program. For example, under the statute, could we support patient home monitoring services?¹⁰⁷ We note the statute defines “health care provider” as one of the following entities: 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; skilled nursing facilities; and consortia of those entities.¹⁰⁸ How would support for patient home monitoring or any other service not currently supported comply with the statute given the definition of health care provider? If allowable under the statute, how would the support mechanism work vis-à-vis our proposed support calculation and competitive bidding rules?

c. Eliminating Distance-Based Analysis

79. We next propose to eliminate the distance-based support approach considering its limited use and the administrative benefits that result from using one standardized support calculation methodology. Under the current rules, carrier support is based on an urban/rural rate comparison or, if the offered service includes an explicit distance-based charge, USAC will provide support for distance-based charges up to the maximum allowable distance (MAD) equal to the distance of the requested service as calculated in the service’s distance-based charge minus the SUD.¹⁰⁹ The SUD is the average of the longest diameters of all cities with a population of 50,000 people or more in a state.¹¹⁰ The MAD is the distance from the healthcare provider to the farthest point on the jurisdictional boundary of the city in that

¹⁰⁵ See *Business Data Services in an Internet Protocol Environment*, Report and Order, 31 FCC Rcd 3459, 3470, para. 26 (2017) (*BDS Order*) (discussing the increasing complexity of services incorporating high capacity transmission).

¹⁰⁶ See *SHLB Ex Parte*.

¹⁰⁷ *Id.* See also Letter from Karen Brinkman, Counsel for Alaska Communications, to Marlene Dortch, FCC, WC Docket No. 17-310 (filed Dec. 7, 2017).

¹⁰⁸ See 47 U.S.C. § 254(h)(7)(B).

¹⁰⁹ See 47 CFR §§ 54.605-609.

¹¹⁰ See 47 CFR §§ 54.605(c), 54.625(a).

state with the largest population.¹¹¹ The healthcare provider must pay for any distance-based charges incurred for mileage greater than the MAD.¹¹² The per-mile charge 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 over the SUD.”¹¹³ Despite these detailed rules, virtually no healthcare providers use a distance-based approach.¹¹⁴

80. We propose to eliminate any consideration of a distance-based approach. Based on the low use of this methodology, we believe it is no longer necessary to use as a proxy for the appropriate support amount. We also believe eliminating this option will reduce the administrative burden on USAC by eliminating the need to manage two separate rate methodologies. Moreover, eliminating this option and focusing support on urban/rural rate comparisons, particularly in conjunction with some of the changes on which we seek comment elsewhere in this item, will also simplify the application process for healthcare provider and service providers. We seek comment on removing the distance-based approach.

81. In the absence of a distance-based approach, should there be some other method to determine rates for supported telecommunications services in those limited cases where “similar” urban and rural services cannot be found to generate a discount rate? Under our current rules, carriers may submit a “cost-based rate” to the Commission or state (for intrastate services) if they cannot find similar services to use in calculating the rural rate.¹¹⁵ If we eliminate a distance-based approach, could the enhanced review described above be used in lieu of the current cost-based approach? If, after conducting such a review, USAC deemed the costs to be justified, would such an approach provide sufficient safeguards to enable the Commission to find the rural rate “reasonably comparable” to an urban rate? We seek comment on these proposals.

3. Defining the “Cost-Effectiveness” Standard Across the RHC Programs

82. To receive funding for eligible services under the Telecom and HCF Programs, applicants must conduct a competitive bidding process and select the most “cost-effective” service offering. In each Program, “cost-effective” is the “method that costs the least after consideration of the features, quality of transmission, reliability, and other factors that the applicant deems relevant to choosing a method of providing the required health care services.”¹¹⁶ The ability to look at “features, quality of transmission, reliability, and other factors” places virtually no limitation on how healthcare providers make their service selections. Moreover, healthcare providers need not provide much detail about their service needs when posting their requests for services, nor do they need to provide detailed information to potential bidders about how they will score responsive bids. This lack of transparency about the healthcare provider’s needs and its anticipated vendor selection process, may lead to inefficiencies in the competitive bidding process.

83. As a result, under the current system, a healthcare provider could post a request for services merely stating that it seeks a connection between points A and B to transmit voice and video. In response to this request for services, the healthcare provider could receive two bids—one offering 100 Mbps service for \$10 a month and the second offering 1 Gbps service for \$100 a month but with additional features such as additional bandwidth or others not specified in the request. Under the current

¹¹¹ See 47 CFR § 54.625(a).

¹¹² See 47 CFR § 54.625(c).

¹¹³ 54.608(a)(1)(ii).

¹¹⁴ Based on USAC’s review of its records, fewer than 100 funding requests in FY 2015 and FY 2016 combined used this approach.

¹¹⁵ See 47 CFR § 54.605(b).

¹¹⁶ See 47 CFR §§ 54.603(b)(4), 54.642(c).

“cost-effectiveness” standard and vendor selection process, the healthcare provider can select the 1 Gbps service even if its basic communications needs could have been met by the cheaper 100 Mbps service. The healthcare provider can simply state that the 1 Gbps service was the most “cost-effective” after including the additional features in its consideration. Nevertheless, selecting services that exceed the healthcare provider’s needs is a waste of RHC Program funds. Such selections are particularly troubling at a time when the RHC Program is already having difficulty meeting the funding needs of healthcare providers.

84. We seek comment on ways to minimize opportunities for this type of waste. For example, we seek comment on whether narrowing the current definition of “cost effectiveness” could help to prevent such wasteful spending as well as give healthcare providers more structure as they develop their bid evaluation processes. Should we define “cost-effectiveness” in both Programs as the lowest-price service that meets the minimum requirements for the products and services that are essential to satisfy the communications needs of the applicant? Would this standard, combined with our other competitive bidding requirements,¹¹⁷ provide a sufficient safeguard against wasteful spending and allow for flexibility in the bid evaluation to reflect the differing needs of healthcare providers? Should we require healthcare providers to be more specific about their communications service needs in their RFPs and/or requests for services, including a description of what the minimum requirements are to meet those needs and to list the specific evaluation criteria in their RFPs and/or requests for services to provide more transparency in the bidding process? Should we provide more guidance for healthcare providers in how they structure their vendor selection and evaluation processes? We seek comment and solicit information about other systems or procedures we could employ to improve the competitive bidding process in the RHC Program.

C. Improving Oversight of the RHC Program

85. Below, we explore proposals to simplify and streamline various RHC Program requirements to improve the stakeholder experience and ease administrative burdens. We believe these proposals will facilitate smoother and swifter funding determinations, while minimizing the opportunity for waste, fraud, and abuse.

1. Establishing Rules on Consultants, Gifts, and Invoicing Deadlines

86. In this section, we seek comment on several proposals to minimize waste, fraud, and abuse in the Telecom and HCF Programs. In particular, we propose to revise RHC Program rules to codify requirements for consultants or anyone acting on behalf of RHC Program applicants as well as gift restrictions. We anticipate that the measures we propose here, if codified in the Commission’s rules, will assist in our continuing effort to ensure that the Fund is being used by applicants as Congress intended and will deter RHC Program participants from engaging in improper conduct.

a. Establishing Rules on the Use of Consultants

87. To harmonize the Commission’s rules under the Telecom and HCF Programs regarding consultants, we propose to adopt specific requirements that will give consultants well-defined boundaries as they guide applicants through the RHC Program funding process. Under HCF Program rules, applicants are required to identify, through a “declaration of assistance,” any consultants, service providers, or any other outside experts who aided in the preparation of their applications.¹¹⁸ These disclosures facilitate the ability of USAC, the Commission, and law enforcement officials to identify and prosecute individuals who manipulate the competitive bidding process or engage in other illegal acts.

¹¹⁷ See 47 CFR §§ 54.603, 54.642.

¹¹⁸ See 47 CFR § 54.642(e)(3) (requiring applicants to submit a “Declaration of Assistance” with their Requests for Services identifying each and every consultant, vendor, and other outside expert, whether paid or unpaid, who aided in the preparation of their applications).

Currently, applicants participating in the Telecom Program are not required to make similar disclosures. Therefore, to align RHC Program requirements regarding the use of consultants, we propose to adopt a new rule in the Telecom Program containing a similar “declaration of assistance” requirement for Telecom Program applicants and seek comment on this proposal.¹¹⁹ Should we also require service providers to disclose the names of any consultants or third parties who helped them identify the healthcare provider’s RFP or helped them to connect with the healthcare provider in some other way? Would requiring the consultant or outside expert to obtain a unique consultant registration number from USAC, as is the current practice in the E-rate Program, be a more effective way of identifying those individuals providing consulting services to RHC Program participants?¹²⁰ Should we also require the applicant to describe the relationship it has with the consultant or other outside expert providing the assistance?

88. Other than the “declaration of assistance” requirement for HCF Program participants, the Commission has not adopted detailed rules regarding consultant participation in the RHC Program. USAC procedures, however, subject consultants to the same prohibitions as the applicant itself with respect to the competitive bidding process. In particular, USAC procedures prohibit consultants or outside experts who have an ownership interest, sales commission arrangement, or other financial stake with respect to a bidding service provider from performing any of the following functions on behalf of the applicant: (1) preparing, signing, or submitting the FCC Form 461 or FCC Form 465 or supporting documentation; (2) serving as consortium leaders or another point of contact on behalf of a healthcare provider; (3) preparing or assisting in the development of the competitive bidding evaluation criteria; or (4) participating in the bid evaluation or service provider selection process (except in their role as potential providers).¹²¹ The purpose of these procedures is to ensure that consultants or outside experts do not undermine the competitive bidding process by simultaneously acting on behalf of the healthcare provider and the service provider. These procedures are essential in order to ensure the integrity of the competitive bidding process, to ensure that the competitive bidding process has been conducted in a fair and open manner, and in order to prevent waste, fraud, and abuse. We seek comment on whether to require healthcare providers and service providers to certify on the appropriate form that the consultants or outside experts they hire have complied with RHC Program rules, including fair and open competitive bidding. We also seek comment on whether to require healthcare providers and service providers to certify that the consultants and outside experts they hire do not have an ownership interest, sales commission arrangement, or other financial stake in the vendor chosen to provide the requested services. Should we also hold healthcare providers and service providers accountable for the actions of their consultants or outside experts should we find that those consultants or experts have engaged in improper conduct? Are there other measures not mentioned here that would improve the Commission’s and USAC’s ability to ensure consultant and outside expert participation comports with the requirements of the RHC Program?

b. Establishing Consistent Gift Restrictions

89. Under E-rate Program rules, specific restrictions apply with respect to the receipt of gifts by applicants from service providers participating in or seeking to participate in the E-rate Program.¹²²

¹¹⁹ See *infra* Appendix A.

¹²⁰ See, e.g., USAC, Schools and Libraries Program, Competitive Bidding, Consultant Registration Numbers, <http://www.usac.org/sl/applicants/step01/consultant-registration-numbers.aspx> (last visited Nov. 17, 2017) (providing the process for obtaining a consultant registration number in the E-rate Program).

¹²¹ See USAC, Rural Health Care Program, Healthcare Connect Fund Program, Consortia, Consultants, <http://www.usac.org/rhc/healthcare-connect/Consortia/consultants.aspx> (last visited Nov. 17, 2017).

¹²² See *Schools and Libraries Universal Service Support Mechanism and A National Broadband Plan for Our Future*, Sixth Report and Order, CC Docket No. 02-6, 25 FCC Rcd 18762, 18800-802, paras. 87-90 (2010); 47 CFR § 54.503(d)(1).

Although there is no specific rule in the RHC Program, a gift from a service provider to an RHC applicant is nonetheless considered to be a violation of the Commission's competitive bidding rules because it undermines the integrity of the competitive bidding process. We propose to codify this requirement by adding for the RHC Program a gift rule that is similar to the codified rule in the E-rate Program.¹²³

90. The E-rate Program gift rules are consistent with the gift rules applicable to federal agencies, which permit only certain *de minimis* gifts.¹²⁴ Generally, federal rules prohibit a federal employee from directly or indirectly soliciting or accepting a gift (i.e., anything of value, including meals, tickets to sporting events, or trips) from someone who does business with his or her agency or accepting a gift given as a result of the employee's official position.¹²⁵ Two exceptions to this rule include (1) modest refreshments that are not offered as part of a meal (e.g., coffee and donuts provided at a meeting) and items with little intrinsic value solely for presentation (e.g., certificates and plaques); and (2) items that are worth \$20 or less, as long as those items do not exceed \$50 per employee from any one source per calendar year.¹²⁶ Like the federal rules, E-rate Program rules also include an exception for gifts to family members and personal friends when those gifts are made using personal funds of the donor (without reimbursement from an employer) and are not related to a business transaction or business relationship.¹²⁷

91. We propose to codify these rules for the RHC Program and seek comment on this proposal.¹²⁸ Specifically, we seek comment on whether the codified E-rate gift restrictions are suitable for the RHC Program. Do they provide sufficient guidance about the appropriateness of a particular offering or gift? Do they offer a fair balance between prohibiting gifts that may compromise a procurement process and acknowledging the realities of professional interactions? Are there other gift restrictions that should be considered for the RHC Program?¹²⁹ If so, what are they and under what conditions should they apply or be applied? Should service providers be allowed to make charitable donations to healthcare providers participating in the RHC Program? If so, what parameters should be in place for allowing such donations?

92. Regarding the applicability of gift restrictions in the RHC Program, we seek comment on which entities should be subject to such restrictions.¹³⁰ Should they apply to both applicants *and* service providers participating in or seeking to participate in the RHC Program? Should they apply to consultants and their employees, as well as to family members of the consultants and employees? Should they also

¹²³ See 47 CFR § 54.503(d)(1).

¹²⁴ *Id.*

¹²⁵ See 5 CFR §§ 2635.201-205.

¹²⁶ See 5 CFR § 2635.203(b).

¹²⁷ See 47 CFR § 54.503(d)(3).

¹²⁸ See *infra* Appendix A.

¹²⁹ Note that in the HCF Program, only funds from an eligible source will apply towards a participant's required contribution. A service provider is not an eligible source of such funding. See *HCF Order*, 27 FCC Rcd 16678, 16724-25, para. 99.

¹³⁰ In the E-rate Program, the gift restriction applies to "individuals on the governing boards of a school, library, or consortium, as well as to all employees, officers, representatives, agents, consultants or independent contractors of such entities involved on behalf of such school, library, or consortium with the E-rate Program, including individuals who prepare, approve, sign or submit E-rate applications, or other forms related the E-rate Program, or who prepare bids, communicate or work with E-rate service providers, E-rate consultants, or with USAC, as well as any staff of such entities responsible for monitoring compliance with the E-rate Program." See 47 CFR § 54.503(d)(2)(i). The restrictions also apply to service providers, including all individuals who are on the governing boards of such an entity (such as board of directors), and all employees, officers, representatives, agents, or independent contractors of such entities. See 47 CFR § 54.503(d)(2)(ii).

apply to healthcare providers that may be part of a consortium but are not eligible to receive RHC Program support? Are there any challenges to applying a gift restriction in this manner? If so, what are the challenges and how could they be addressed or minimized?

93. We also seek comment on when gift restrictions should apply. Should they be triggered only during the time period that an applicant's competitive bidding process is taking place (i.e., the 28-day period after an FCC Form 461, FCC Form 465, or RFP is posted) or should they also apply outside of the bidding period (i.e., before and/or after such forms or documents are posted)? Should we require applicants and anyone acting on behalf of applicants to certify that they have not solicited or accepted a gift or any other thing of value from their selected service provider or any other service provider participating in their competitive bidding process? Should we also require service providers to certify that they have not offered or provided a gift or any other thing of value to the applicant for which it will provide services? We remind commenters that any gift restrictions we adopt will apply in addition to the applicant and service provider's state and local restrictions regarding gifts.

c. Harmonizing Invoicing Deadlines

94. We propose to adopt a new rule establishing the same invoicing deadline for the Telecom Program as that applicable to the HCF Program.¹³¹ Currently, there is no deadline in the Telecom Program for service providers to complete and submit their online invoices to USAC. Consequently, over the years, USAC has often had to contact applicants and service providers to encourage them to complete and submit their invoices. Allowing service providers to submit invoices whenever they choose has compromised USAC's ability to administer the Telecom Program's disbursement process efficiently and effectively and has forced USAC to keep committed but undisbursed funding on its books for excessively long periods of time.

95. To alleviate further inefficiencies with respect to the disbursement process, we propose to adopt a firm invoice filing deadline for Telecom Program participants, similar to the invoicing deadline adopted in the HCF Program.¹³² In particular, we seek comment on whether we should require service providers in the Telecom Program to submit all invoices to USAC within six months (180 days) of the end date of the time period covered by the funding commitment. In our experience, the HCF Program invoicing deadline has resulted in more efficient administration of the HCF Program's disbursement process, as well as faster funding timetables. It also provides specific guidance to applicants and service providers when submitting applications for universal service support. We seek comment on whether there are other ways to eliminate delays and lack of response from service providers in submitting invoices to USAC. We invite commenters to also address the appropriate consequences should the service provider fail to submit an invoice to USAC in a timely manner.

¹³¹ See 47 CFR § 54.645(b) (requiring all HCF Program invoices to be received by USAC within six months (180 days) of the end of the funding commitment). For example, for FY 2016 funding commitments ending on June 30, 2017, the FCC Form 463 (Invoice and Request for Disbursement Form) must be submitted by the applicant to USAC, after approval by the service provider, by December 31, 2017.

¹³² *Id.*

2. Streamlining the RHC FCC Forms Application Process

96. We seek comment on ways to streamline the data collection requirements as part of the FCC Forms for the RHC Program. Currently, the HCF and Telecom Programs each have their own online forms to collect information, leading to a total of seven FCC Forms.¹³³ The use of multiple online forms for the RHC Program can cause confusion on the part of applicants and reduces the administrative efficiency of the application process. Applicants often must familiarize themselves with two sets of fairly intricate filing requirements. This complexity may lead many applicants to hire outside consultants to assist them in submitting the necessary information to seek funding under the RHC Program every year.

97. As one means to streamline and improve the efficiency of the application process, while also reducing the administrative burden upon applicants, we propose condensing the RHC Program application process to use fewer online FCC Forms. We propose to use four forms—Eligibility Form, Request for Services Form, Request for Funding Form, and Invoicing/Funding Disbursement Form. Applicants could use the same online form whether applying under the Telecom or HCF Programs by indicating on each online form under which RHC Program they seek funding for services. Applicants thus would no longer have to switch between the online forms when applying for services under both the HCF and Telecom Programs. We seek comment on the feasibility of this proposal and whether certain data fields on the current online FCC Forms could impede this approach to simplify the application process. Also, are there data elements requested on the online forms that, in applicants' view, are no longer needed? We welcome alternative proposals to streamline the RHC FCC Forms application process to alleviate the burden upon applicants. Commenters should be detailed in their proposals as to which data elements should be eliminated and those that should continue to apply.

98. SHLB suggests the Commission improve the processing of consortia applications¹³⁴ and find ways to speed the processing of the various FCC HCF Forms and streamline the treatment of individual health care sites.¹³⁵ Because the SHLB filings did not contain specific suggestions,¹³⁶ and due to changes in the RHC Program procedures after the recent increase in demand,¹³⁷ we seek comment here on how to improve the processing of consortia applications. What are the obstacles faced by commenters when filing consortia applications? From the applicants' perspective, what are the reasons for the delay in the review and processing of consortia applications? Are there ways in which the Commission can, in the instant rulemaking, facilitate USAC's ability to process consortia applications more quickly? Commenters should provide specific examples of the problems they encounter during the consortia application review process. At the same time, the Commission has directed USAC to ensure that funding

¹³³ There are currently four online FCC Forms used for the HCF Program – FCC Form 460 (Description of Eligibility and Registration), FCC Form 461 (Description of Request for Services), FCC Form 462 (Description of Request for Funding), and FCC Form 463 (Description of Request for Funding Disbursement). See USAC, Rural Healthcare Program, Healthcare Connect Fund Program, Forms, <http://www.usac.org/rhc/healthcare-connect/tools/forms/default.aspx> (last visited Nov. 17, 2017). There are currently three online FCC Forms used for the Telecom Program – FCC Form 465 (Description of Eligibility and Request for Services), FCC Form 466 (Description of Request for Funding), and FCC Form 467 (Description of Request for Funding Disbursement). See USAC, Rural Healthcare Program, Telecommunications Program, Forms, <http://www.usac.org/rhc/telecommunications/tools/forms/default.aspx> (last visited Nov. 17, 2017).

¹³⁴ SHLB Connect2Health Comments, GN Docket No. 16-46, at 9 (filed May 24, 2017) (SHLB Connect2Health Comments).

¹³⁵ *Id.* See Alaska Communications Connect2Health Comments, GN Docket No. 16-46, at 3, 11 (filed May 24, 2017) (recommending that the Commission increase the transparency and speed of the USAC review process for RHC funding, so that applicants and service providers can receive more timely funding decisions).

¹³⁶ See SHLB Connect2Health Comments at 9.

¹³⁷ See *August 2016 Filing Window PN*, 31 FCC Rcd 9588.

is disbursed to eligible recipients for eligible services. Thus, any suggestions provided should account for the Commission's need to balance administrative efficiency with protecting against waste, fraud, and abuse.

3. Applying Lessons Learned from the HCF Program to the Telecom Program

99. In this section, we seek comment on a number of proposals to bolster competitive bidding rules in the Telecom Program. These proposals are consistent with our goals to simplify the application and disbursement process for applicants and service providers, while also reducing the complexity of administering the Programs. Greater harmonization of the codified rules applying to both RHC Programs will also make the establishment of one set of application forms simpler. In some cases, this alignment of rules involves merely the codification of requirements that were laid out in preceding orders and, thus, should not be viewed as a change in applicant obligations.

a. Aligning the "Fair and Open" Competitive Bidding Standard

100. To enhance RHC Program transparency and increase administrative efficiency, we propose to align the "fair and open" competitive bidding standard applied in each Program.¹³⁸ Although this standard is codified under HCF Program rules,¹³⁹ it is not codified under the Telecom Program, although numerous Commission orders state that an applicant must conduct a fair and open competitive bidding process prior to submitting a request for funding, and indeed, a process that is not "fair and open" is inherently inconsistent with "competitive bidding."¹⁴⁰ For consistency purposes, we now seek to codify this standard under the Telecom Program as well. Because we are merely proposing to codify an existing requirement, RHC Program participants that are already complying with our competitive bidding rules should not be impacted. We seek comment on this proposal. We also propose to apply the "fair and open" standard to all participants under each RHC Program, including applicants, service providers, and consultants, and require them to certify compliance with the standard. We seek comment on this proposal.

b. Aligning Competitive Bidding Exemptions in Both RHC Programs

101. We propose to harmonize the Commission's rules that exempt certain applicants from the competitive bidding requirements in the Telecom and HCF Programs. Applicants qualifying for an exemption are not required to initiate a bidding process by preparing and posting an FCC Form 461 (in the HCF Program) or an FCC Form 465 (in the Telecom Program). Instead, qualifying applicants may proceed directly to filing a funding request in each respective Program. We seek comment on whether we should apply the following HCF Program competitive bidding exemptions to the Telecom Program: (1) applicants who are purchasing services and/or equipment from master services agreements (MSAs) negotiated by federal, state, Tribal, or local government entities on behalf of such applicants; (2) applicants purchasing services and/or equipment from an MSA that was subject to the HCF and Pilot Programs competitive bidding requirements; (3) applicants seeking support under a contract that was deemed "evergreen" by USAC; and (4) applicants seeking support under an E-rate contract that was competitively bid consistent with E-rate Program rules.¹⁴¹ With the exception of "evergreen" contracts,¹⁴²

¹³⁸ See 47 CFR §§ 54.603, 54.642.

¹³⁹ See 47 CFR § 54.642(b) (requiring all entities participating in the HCF Program to conduct a fair and open competitive bidding process).

¹⁴⁰ See, e.g., *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776, (1997) (subsequent history omitted) (requiring competitive bidding processes such that no bidders receive an unfair advantage).

¹⁴¹ See 47 CFR § 54.642(h).

¹⁴² Note that the existing "evergreen" contract exemption is not currently codified under Telecom Program rules. To be considered "evergreen," the multi-year contract must meet the following criteria: (1) both parties are identified;

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none of these exemptions apply in the Telecom Program. We therefore seek comment on whether to apply these exemptions, or variants thereof, to the Telecom Program. We also seek comment on whether other situations may warrant a competitive bidding exemption. In addition, to improve uniformity across both Programs, we propose to codify the existing “evergreen” contract exemption in the Telecom Program. We seek comment on this proposal.

c. Requiring Submission of Documentation with Requests for Services

102. We next propose rules in the Telecom Program regarding the submission of competitive bidding documentation during the application process. Currently, after selecting a service provider in the Telecom Program, the applicant must submit to USAC paper copies of bids it received in response to its request for services (i.e., FCC Form 465).¹⁴³ Under the rules applicable to the HCF Program, however, the applicant must submit as part of its request for services (i.e., FCC Form 461 or RFP, if applicable) certifications attesting to RHC Program compliance, bid evaluation criteria and a matrix demonstrating how it will choose a service provider, a declaration of assistance, and an RFP and network plan, if applicable.¹⁴⁴ We have found that requiring HCF Program applicants to provide this information up front with their requests for services makes the bid evaluation process more transparent for service providers seeking to bid and for USAC to review. Incorporating this requirement in the Telecom Program will likely yield similar benefits. We therefore propose to require Telecom Program applicants to provide, contemporaneously with their requests for services (i.e., FCC Forms 465 and/or RFPs), certifications attesting to their compliance with Telecom Program rules, bid evaluation criteria and worksheets demonstrating how they will select a service provider, and a declaration of assistance (if applicable). We seek comment on this proposal and whether requiring such information would be burdensome for applicants. For administrative ease, should we revise the request for services forms in both Programs to include a scoring matrix for applicants to use in their vendor evaluations? Is there other documentation that should be included with the applicant’s request for services to ensure that a fair and open procurement will take place?

d. Requiring Submission of Documentation with Funding Requests

103. We also propose to change Telecom Program requirements regarding the types of documents that must accompany the applicant’s funding requests. In the Telecom Program, the applicant must submit with its funding request (i.e., FCC Form 466) proof of the rural rate or cost of service, proof of the urban rate (if the applicant uses an urban rate other than what is posted on USAC’s website),¹⁴⁵ a copy of its signed service contract, and copies of all bids received in response to its request for services.¹⁴⁶

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(2) the healthcare provider has signed and dated the contract; (3) the contract specifies the type and terms of services; (4) the contract has a specified duration; (5) the contract specifies the cost of services to be provided; and (6) the contract includes the physical addresses or other identifying information of the healthcare providers purchasing from the contract. See USAC, Rural Health Care, Evergreen Contracts, <http://www.usac.org/rhc/telecommunications/health-care-providers/evergreen-contracts.aspx> (last visited Nov. 17, 2017).

¹⁴³ See 47 CFR § 54.603(b)(4).

¹⁴⁴ See 47 CFR § 54.642(e).

¹⁴⁵ Above, we seek comment on our proposal to revise the urban and rural pricing information that healthcare providers must submit with their Telecom Program applications. This includes a proposal to require the winning bidder, not the healthcare provider, to provide the relevant pricing information to the healthcare provider as part of their bid response.

¹⁴⁶ See USAC, Rural Health Care, Telecommunications Program, Documentation, <http://www.usac.org/rhc/telecommunications/health-care-providers/documentation.aspx> (last visited Nov. 17, 2017) (Telecom Program Documentation).

Similarly, in the HCF Program, the applicant must submit with its funding request (i.e., FCC Form 462) certain certifications attesting to its compliance with HCF Program rules, a copy of its signed service contract, competitive bidding documentation, cost allocations, and other documentation for consortium applicants, if applicable.¹⁴⁷ While this requirement is codified in the Commission's rules for the HCF Program,¹⁴⁸ there is no analogous rule under the Telecom Program. Therefore, to improve uniformity and transparency across both Programs, we propose to codify the existing requirement that applicants provide supporting documentation with their funding requests in the Telecom Program.¹⁴⁹ We seek comment on this proposal and, in particular, whether we should also require applicants to provide additional documentation contemporaneously with their funding requests. For example, we propose to require applicants to provide: (1) certifications from applicants attesting to their compliance with Telecom Program rules; and, (2) competitive bidding documentation, including winning and losing bids, bid evaluation worksheets, memos, meeting minutes or similar documents related to the vendor selection, and copies of any correspondence with vendors prior to and during the bidding, evaluation, and award phases of the process. Requiring this documentation for both RHC Programs facilitates USAC's ability to determine whether the healthcare provider abided by its evaluation criteria in reviewing bids and ultimately selected the most cost-effective service provider. This documentation also provides USAC with greater means to ensure and verify that Program participants are not engaging in fraudulent conduct, such as pre-bidding negotiations with potential service providers, or otherwise violating the Commission's competitive bidding rules, such as failing to comply with the 28-day waiting period.¹⁵⁰ We seek comment on whether this requirement would be burdensome for applicants. Is there other supporting documentation that should be included with the applicant's request for funding to ensure that a fair and open procurement took place? We also seek comment on whether we should require service providers to certify on each invoice submission that they have reviewed and complied with all applicable requirements for the program, including the applicable competitive bidding requirements.

e. Unifying Data Collection on RHC Program Support Impact

104. As we seek to better monitor RHC Program effectiveness, we seek comment here on whether all RHC Program participants should report on the telehealth applications (e.g., tele-psychiatry, tele-stroke, transmission of EHRs, etc.) they provide over their supported communications services. Currently, consistent with the requirements in the *HCF Order*,¹⁵¹ only healthcare providers participating in HCF consortia are required to report annually about the telehealth applications they provide over their supported connections.¹⁵² Understanding how all RHC participants use their supported communications

¹⁴⁷ See 47 CFR § 54.643 (requiring applicants to submit with their funding request certifications attesting to HCF Program compliance, service contracts, competitive bidding documentation (including winning and losing bids, bid evaluation sheets, and memos), cost allocations, and additional documentation for consortiums).

¹⁴⁸ *Id.*

¹⁴⁹ See Telecom Program, Documentation (requiring applicants to provide proof of the rural rate or cost of service, proof of the urban rate (if the applicant uses an urban rate other than what is posted on USAC's website), a copy of the service contract, and copies of all bids received).

¹⁵⁰ See, e.g., *NSS NAL*, 31 FCC Rcd 12238 (determining, after reviewing healthcare provider competitive bidding documentation, that Network Services Solutions, LLC, apparently violated the Commission's competitive bidding requirements by assisting healthcare providers in preparing their FCC Forms 465, manipulating the 28-day competitive bidding period, and creating numerous *post facto* bid matrices to justify contract awards).

¹⁵¹ See *HCF Order*, 27 FCC Rcd 16678, 16807-16809, paras. 316-322; *Wireline Competition Bureau Addresses Funding Year 2014 Healthcare Connect Fund Consortia Annual Reports Requirements*, WC Docket No. 02-60, Public Notice, 30 FCC Rcd 9894 (WCB 2015).

¹⁵² See USAC, Rural Health Care, Healthcare Connect Fund Program, Consortia, Step 9: Submit Annual Report, <http://www.usac.org/rhc/healthcare-connect/consortia/step09/default.aspx> (last visited Nov. 17, 2017) (requiring HCF consortia to report on an annual basis whether its supported connections are being used for telemedicine,

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services would provide information about the role of the RHC Program in delivering telehealth services to rural areas.¹⁵³ In addition, although USAC does currently obtain some information through the Telecom and HCF application process about the types of services, bandwidths, and prices associated with RHC Program participants, might it be useful to require RHC Program participants to report on this information in a way that more directly correlates to the telehealth applications for which the communications services will be used? We seek comment on incorporating lessons learned by the Connect2Health Task Force that could guide us in understanding future telehealth trends. Would it be useful, from a transparency perspective, to make this and any other information provided to USAC available to RHC Program participants?¹⁵⁴ Moreover, would it be beneficial to see whether there are correlations between certain telehealth applications and certain communications services? Might awareness of such correlations, or lack thereof, facilitate decisions by this Commission and other policymakers in the future?

4. Managing Filing Window Periods

105. In light of RHC Program growth and the potential for FY 2016 demand to exceed the \$400 million cap before the end of FY 2016, the Bureau established multiple filing window periods for FY 2016 and beyond, consistent with the Commission's rules.¹⁵⁵ By establishing multiple filing window periods, the Bureau provided a mechanism for USAC to more efficiently administer the RHC Program and process requests while providing an incentive for applicants to timely submit their requests for funding.¹⁵⁶ Additionally, the Bureau found that filing window periods provide a greater opportunity for healthcare providers to receive at least some support rather than none at all, even when demand exceeds the cap.¹⁵⁷

106. We propose to continue with the filing window periods process established by the Bureau and USAC for administering RHC Program funds.¹⁵⁸ We believe this process furthers our goals of supporting health care delivery in as many parts of rural America as possible and provides USAC with a mechanism to more efficiently manage the application process.¹⁵⁹ We seek comment on this proposal. We seek comment on any specific concerns regarding the current process and how we may potentially adjust the current process to better align with applicants' business needs and filing schedules. We also seek comment on whether there is a more efficient way to manage requests for funding when the demand exceeds, or is likely to exceed, the funding cap. Commenters proposing an alternative to the current process should ensure that any alternative process distributes funding in a manner that is both equitable

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exchange of electronic health records (EHRs), participation in a health information exchange, remote training, and/or other telehealth applications).

¹⁵³ This information will also enable us to measure progress we have made toward our stated performance goals for the health care universal service support mechanism. These performance goals include: (1) increasing access to broadband for HCPs, particularly those serving rural areas; (2) fostering the development and deployment of broadband health care networks; and (3) reducing the burden on the universal service fund by maximizing the cost-effectiveness of the health care support mechanism. *See HCF Order*, 27 FCC Rcd 16678, 16695, para. 32.

¹⁵⁴ *See SHLB Ex Parte*.

¹⁵⁵ *See* 47 CFR § 54.675(c)(2); *August 2016 Filing Window PN*, 31 FCC Rcd 9588; FY 2016 Filing Windows and Pro-rata Information.

¹⁵⁶ *See August 2016 Filing Window PN*, 31 FCC Rcd at 9590-91, at 3.

¹⁵⁷ *Id.*; FY 2016 Filing Windows and Pro-rata Information.

¹⁵⁸ *See* FY 2016 Filing Windows and Pro-rata Information; USAC, Rural Health Care Program, Telecommunications Program, Filing Window Period for FY 2017, <http://www.usac.org/rhc/tools/additional-filing-windows.aspx> (last visited Nov. 17, 2017).

¹⁵⁹ *See* 47 U.S.C. §§ 254(h)(2)(A), (h)(1)(A).

and administratively manageable.¹⁶⁰

IV. ORDER

107. In the NPRM, we propose several steps that will ensure rural healthcare providers are able to get the support they need from the RHC Program while also reducing waste, fraud, and abuse in the RHC Program to ensure that federal funds are being properly spent. We recognize, however, that the effect of those proposals will not benefit the FY 2017 funding requests. If there is a proration in FY 2017, most RHC Program participants will have faced back to back cuts in their funding requests. Being mindful of the vital services RHC Program healthcare providers make available in their communities, we seek in this Order to bring some immediate relief in the event of a proration in FY 2017. Specifically, we carry forward for use in FY 2017 any available RHC Program funds from prior funding years and, on a one-time basis, commit these funds to rural healthcare providers participating in the RHC Program for FY 2017. We also permit service providers to reduce the cost of service to all healthcare providers.

108. We find that the anticipated hardship that would be imposed on healthcare providers from proration in FY 2017 justifies good cause for waiver of certain rules to effectuate this relief. Generally, the Commission may waive its rules for “good cause shown.”¹⁶¹ The Commission may exercise its discretion to waive a rule where (a) the particular facts make strict compliance inconsistent with the public interest, (b) special circumstances warrant a deviation from the general rule, and (c) such deviation will serve the public interest.¹⁶² In making these determinations, the Commission may consider evidence of hardship, equity, and more effective implementation of overall policy on an individual basis.¹⁶³

A. Carrying Forward of Unused RHC Program Funds for FY 2017

109. We first waive section 54.675(a) of our rules to permit USAC to commit up to the amount of any unused funds carried forward from prior years to the RHC Program funding to reduce the proration for individual rural healthcare providers in both the Telecom and HCF Programs for FY 2017.¹⁶⁴ To effectuate this waiver, we direct USAC to put unused RHC Program funding available at the time of proration into the RHC Program for FY 2017 to lower or eliminate the proration factor first for all qualifying funding requests from non-consortia rural healthcare providers. In the event there are funds remaining, USAC should then lower the proration factor for qualifying funding requests from consortia. We disagree with parties who argue that we should apply funding to all healthcare providers equally.¹⁶⁵ Individual rural healthcare providers generally do not have the advantages of bargaining power or the economies of scale in purchasing services that consortia have and so likely would be at risk of greater harm from the proration.¹⁶⁶ Moreover, this approach is administratively efficient because of the inherent

¹⁶⁰ See *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Third Report and Order, 12 FCC Rcd 22485 (1997) (*Third Report and Order*).

¹⁶¹ 47 CFR § 1.3; *Northeast Cellular Telephone Co. v. FCC*, 897 F.2d 1164, 1166 (D.C. Cir. 1990) (*Northeast Cellular*).

¹⁶² *Northeast Cellular*, 897 F.2d at 1166.

¹⁶³ *WAIT Radio v. FCC*, 418 F.2d 1153, 1159 (D.C. Cir. 1969); *Northeast Cellular*, 897 F.2d at 1166.

¹⁶⁴ 47 CFR 54.675(a).

¹⁶⁵ *SHLB Ex Parte*; Letter from Gary Green, Consultant to MiCTA, to Marlene Dortch, FCC, WC Docket No. 17-310 (filed Dec. 9, 2017) (*MiCTA Ex Parte*). MiCTA argues that any carried over funds should be distributed to consortia members because discount rates are lower in the HCF Program than the Telecom Program. *MiCTA Ex Parte*. Funds carried over pursuant to this order are, however, available to individual applicants in both programs.

¹⁶⁶ *HCF Order*, 27 FCC Rcd at 16703, 16706, 16764, paras. 54, 60, 189 (consortium “bulk buying,” combined with competitive bidding and multi-year funding commitments, gave Pilot projects lower rates than would otherwise have been possible); *Wireline Competition Bureau Interim Evaluation of Rural Health Care Pilot Program*, WC Docket

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difficulty of distinguishing between urban and rural consortia members. We also waive our rules to the extent described herein to create a path for healthcare providers seeking support in FY 2017 to benefit from any voluntary price reduction(s) that their service providers elect to undertake for services based on qualifying funding requests submitted during the filing window period for FY 2017.¹⁶⁷ In this way, we endeavor to reduce the financial impact on healthcare providers for FY 2017, where demand has again exceeded the \$400 million cap.¹⁶⁸

110. We find it is in the public interest to allow USAC to apply any unused funding from prior years to FY 2017 to enable USAC to provide more support first to qualifying funding requests from individual rural healthcare providers, then to consortia.¹⁶⁹ Due to the unique circumstances presented by the impact of proration on healthcare providers, we believe this limited waiver is appropriate and in the public interest. The need to prorate RHC Program support in FY 2016—for the first-time ever—placed an unexpected new payment obligation on healthcare providers. Prorating support again in FY 2017 could further exacerbate this impact on healthcare providers.

B. Allowing Voluntary Price Reduction by Service Providers

111. In the *Alaska Waiver Order*, we recognized the severe impact the FY 2016 proration had in remote Alaska and sought to lessen the financial burden of remote Alaskan healthcare providers by permitting their service providers to voluntarily reduce the price of service. Even with the *Alaska Waiver Order*, however, remote Alaskan healthcare providers, as well as healthcare providers across the country, likely had to contribute more to the cost of service than they had originally budgeted.¹⁷⁰ Consequently, we waive our rules to the extent described herein to create a path for healthcare providers seeking support in FY 2017 to benefit from any voluntary price reduction(s) that their service providers elect to undertake for services based on qualifying funding requests submitted during the filing window period for FY 2017.¹⁷¹ Accordingly, we direct the Bureau and USAC to take any steps necessary to implement this Order.

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No. 02-60, *Staff Report*, 27 FCC Rcd 9387, 9392-93, 9436-37, paras. 4, 81-83 (WCB 2012) (consortium purchasing power led to lower prices for Pilot projects).

¹⁶⁷ See *Alaska Waiver Order*, 32 FCC Rcd 5463.

¹⁶⁸ See 47 U.S.C. § 254(b)(5) (stating that “[t]here should be specific, *predictable* and sufficient Federal and State mechanisms to preserve and advance universal service”) (emphasis added).

¹⁶⁹ See, e.g., GCI Nov. 2 *Ex Parte* Letter (arguing that proration reductions for healthcare providers in extremely high cost areas create “substantial and unmanageable uncertainty with respect to the amount that the healthcare providers will themselves have to pay for critical telecommunications services”); Letter from Victor Joseph, Tanana Chiefs Conference, to Chairman Pai and Commissioners, FCC, WC Docket No. 02-60, (filed May 19, 2017) (proration reductions in support cannot be recouped in service rates, directly impact patient programs due to cuts in personnel, programs, and direct health services, and require other grant money be reallocated to cover the reduction); Letter from Rosalie Nadeau, Akeela, to Chairman Pai and Commissioners, FCC, WC Docket No. 02-60 (filed May 1, 2017) (proration reduction in support could result in programs closing and staff reduction, which would jeopardize other grant based funding and could cause Akeela to close).

¹⁷⁰ See, e.g., ACS July 24 *Ex Parte* Letter at 2 (arguing that “[p]roration of funding commitments causes great hardships for rural health care providers in Alaska”); ACS June 9 *Ex Parte* Letter at 3 (noting that “service reductions [] may be necessary as a result of these *pro-rata* cuts”).

¹⁷¹ See *Alaska Waiver Order* (waiving, *sua sponte*, the Commission’s rules to assist remote Alaskan healthcare providers impacted by the RHC Program pro-ration in FY 2016). At the same time, we direct USAC to modify any of its processes (e.g., to receive information regarding a price revision) to the extent necessary to execute this waiver. For purposes of Program administration and integrity, this waiver shall be time-limited. Parties shall have 90 days from the date of a healthcare provider’s funding commitment decision letter to take advantage of the relief provided herein.

112. We also waive our rules to allow service providers to voluntarily¹⁷² reduce their rates for qualifying FY 2017 requests, in the event of proration, while holding constant the prorated support amount contained in the healthcare providers' funding commitment letters. Because USAC will continue to provide the support amount contained in the healthcare providers' funding commitment letters, any reduction in the service provider's price will automatically reduce unexpected cost burdens imposed on the healthcare provider due to any FY 2017 proration. While the healthcare provider must continue to contribute its original obligation towards the supported service,¹⁷³ the financial benefit of a service provider's cost reduction will flow directly to the healthcare provider. Put simply, by holding constant the previously committed RHC Program support amount, we create a voluntary path for service providers to help minimize the impact of a FY 2017 proration. This waiver operates in the same manner as the waiver granted by the Commission earlier this year covering Alaska-based participants in the RHC Program.¹⁷⁴

113. Elsewhere in this document, we are considering whether to adjust the cap in the future. In the interim, we find that a waiver is necessary for FY 2017 to remove any regulatory obstacles that could otherwise prevent a service provider from voluntarily reducing its service price(s) to the benefit of healthcare providers. Specifically, to implement this approach, we waive our support calculation rules that would otherwise be triggered by a reduction in service price.¹⁷⁵ We waive any other requirement, to the extent necessary, in these special circumstances to effectuate the relief granted, including restrictions on ineligible sources of funding,¹⁷⁶ certification requirements,¹⁷⁷ proration requirements to the extent any

¹⁷² See Letter from Michael Jacobs, ITTA, to Marlene Dortch, FCC, WC Docket No. 17-310 (filed Dec. 7, 2017) and Letter from Kevin G. Rupy, USTelecom to Marlene Dortch, FCC, WC Docket No. 17-310 (filed Dec. 7, 2017) (asking the Commission to emphasize the voluntary nature of any price reductions by service providers).

¹⁷³ This relief remains bounded by a healthcare provider's requirement to contribute, at a minimum, the applicable urban rate (for the Telecom Program) or its original 35 percent share of costs against its qualifying funding request (for the HCF Program). In other words, the floor established by the healthcare provider's original payment expectation absent proration will remain in place.

¹⁷⁴ See *Alaska Waiver Order*.

¹⁷⁵ Section 54.607 of our rules specifies how a service provider's rural rate is to be determined and justified. A service provider may be concerned that lowering its price, even pursuant to the terms of the instant order, might imply that the rate contained in a healthcare provider's previously submitted funding request was not derived in conformance with section 54.607 of our rules. Consequently, we waive section 54.607 of our rules only to the extent that a price reduction consistent with this order should not in and of itself be treated as evidence that the initial rural rate submitted by the healthcare provider violated section 54.607. See 47 CFR § 54.607. Section 54.609 sets forth options by which universal service support under the Telecom Program is to be calculated. See 47 CFR § 54.609. To the extent that a price adjustment made, pursuant to the instant order would necessitate a commensurate change in the support amount, we waive this requirement to the extent necessary to hold a carrier's support amount constant.

¹⁷⁶ Section 54.633(b) makes clear that "direct payments from vendors or other service providers" are considered to be ineligible funding sources in connection with a healthcare provider's contribution toward eligible expenses. See 47 CFR § 54.633(b). While we do not waive a healthcare provider's contribution requirement, to the extent a pricing adjustment by the service provider might be construed as a payment from an ineligible source, we waive this rule for the narrow purposes described herein. Similarly, section 54.643(a)(6)(iii) requires a consortium applicant to provide "evidence of a viable source for the undiscounted portion of supported costs." See 47 CFR § 54.633(a)(6)(iii). Here again, to remove any doubt on behalf of service providers about the permissibility of offering a pricing adjustment, we waive this rule for the narrow purposes described herein.

In addition, sections 54.603 and 54.642 set forth the competitive bidding requirements for the Telecom and HCF Programs, including the fair and open bidding requirements for HCF. See 47 CFR §§ 54.603, 642. To the extent a reduction in the amount owed by the healthcare provider is inconsistent with our competitive bidding requirements,

(continued...)

interpretation of that rule might suggest the need to prorate the newly lowered price,¹⁷⁸ and restrictions on evergreen contracts.¹⁷⁹ We also waive the E-rate lowest corresponding price rule, but only to the extent necessary to prevent any price reductions exercised pursuant to this order from setting the lowest corresponding price for E-rate purposes.¹⁸⁰ Finally, we direct the Bureau and USAC to take any steps necessary to implement this order.

114. We conclude that any potential cost to the RHC Program that could result from this Order will be minor and is outweighed by the benefits of our action. The relief in the form of additional funding for FY 2017 is based on funds available from previous years. Thus, no new funds are being collected to afford this relief. With regard to allowing service providers to reduce their prices, to the extent the Fund could otherwise benefit from reductions in universal support outlays corresponding to a service provider's voluntary price reduction, we find the impact to be controlled and within reasonable bounds—that is, normally a reduction in the price of service would be accompanied by a corresponding reduction in support; here, however, although we permit a voluntary reduction in the price of service, we hold the support constant. The pathway set forth in this order is voluntary in nature. Moreover, any impact to the Fund will be further mitigated because we retain the healthcare provider's obligation to contribute its previously committed share of HCF costs or the urban rate, as applicable.

115. We reiterate that we remain committed to the integrity of the RHC Program, to guarding against waste, fraud, and abuse, and to ensuring that funds disbursed through the RHC Program are used for appropriate purposes. Notwithstanding any voluntary pricing reduction undertaken pursuant to this order, service providers and healthcare providers will remain subject to all of our rules relative to justifying the original funding commitment. Our action here does not affect the authority of the

(Continued from previous page) _____

including our “fair and open” requirements, we waive those requirements, provided there is no *quid pro quo* involved.

¹⁷⁷ Section 54.645(b) requires a health care consortium leader or healthcare provider and its vendor to certify to the accuracy of invoices submitted to the Administrator. *See* 47 CFR § 54.645(b). We recognize that, depending on billing and reconciliation processes, a service provider and/or healthcare provider may not be positioned to certify the accuracy of invoices filed with the Administrator in the event of a price adjustment. As a result, we waive our invoicing certification rule for the narrow purpose of providing the path to relief described herein.

¹⁷⁸ Section 54.675(f) sets forth the process by which pro rata reductions to RHC Program support are to be undertaken in the event total demand during a filing window period exceeds the total remaining support available for a funding year. *See* 47 CFR § 54.675(f). We waive this rule to the extent that any interpretation of the rule might suggest the need to prorate the newly lowered price.

¹⁷⁹ Section 54.642(h)(4) sets forth guidance as to the designation of certain contracts as “evergreen” for RHC Program support purposes. *See* 47 CFR §§ 54.642(h)(4). The benefit of having a contract be deemed “evergreen” is that the same contract may be used in subsequent years without being rebid for the life of the contract. Typically, a contract modification must undergo additional competitive bidding if the modification is a “cardinal change” or exceeds the scope of the original contract, even if the contract has been deemed evergreen. To the extent a pricing adjustment consistent with the terms of the instant order is considered a “cardinal change” that might have necessitated the contract to be rebid, we provide a limited one-time waiver to our evergreen contract requirements with regard to any such price change. We note, however, that any changes to a previously deemed evergreen contract that are made as a result of the instant waiver are only permissible in the context described in this order. In future funding years, determinations about whether a “cardinal change” has been made to a previously deemed evergreen contract will be based on the original contract.

¹⁸⁰ *See* 47 CFR § 54.511(b). *See also* 47 CFR § 54.500. Section 54.511(b) of our rules concerns the Schools and Libraries Program and prohibits “[p]roviders of eligible services” from submitting bids to or charging schools or libraries “a price above the lowest corresponding price.” We waive this requirement to the extent necessary to prevent any price reductions exercised pursuant to this order from setting the lowest corresponding price for E-rate purposes.

Commission or USAC to conduct audits or investigations to determine compliance with RHC Program rules and requirements. Because audits or investigations may provide information showing that a beneficiary or service provider failed to comply with the statute or Commission rules, such proceedings can reveal instances in which universal service funds were improperly disbursed or in a manner inconsistent with the statute or the Commission's rules. To the extent we find that funds were not used properly, we will require USAC to recover such funds through its normal processes. Further, we recognize that we may need to closely examine, through the audit process, subsequent years' funding requests of service providers and healthcare providers who avail themselves of the relief in this order to deter fraud or abuse that may occur from year-to-year in connection with the reduction in service price. We retain the discretion to evaluate the use of monies disbursed through the RHC Program and to determine on a case-by-case basis whether waste, fraud, or abuse of Program funds occurred and whether recovery is warranted. We will continue to aggressively pursue instances of waste, fraud, or abuse under our own procedures and in cooperation with law enforcement agencies.

116. Finally, with respect to service providers who provide reduced prices for their services pursuant to this Order, we forbear from the application of section 203 of the Communications Act and any regulations stemming therefrom, to the extent they might conflict with this one-time price reduction.¹⁸¹ Under section 10 of the 1996 Act, the Commission is required to forbear from any statutory provision or regulation if it determines that: (1) enforcement of the regulation is not necessary to ensure that the telecommunications carrier's charges, practices, classifications, or regulations are just, reasonable, and not unjustly or unreasonably discriminatory; (2) enforcement of the regulation is not necessary to protect consumers; and (3) forbearance from applying such provision or regulation is consistent with the public interest.¹⁸² In making this public interest determination, the Commission must also consider, pursuant to section 10(b), "whether forbearance from enforcing the provision or regulation will promote competitive market conditions."¹⁸³ In light of the unique circumstances presented by the impact of recent proration under the RHC Program on certain healthcare providers, we conclude that forbearance from a carrier's obligations under tariff is warranted under the section 10 criteria.

117. Pursuant to this Order, service providers are permitted to offer healthcare providers a reduced price for service in FY 2017. We thus find that no purpose is served by requiring compliance with those tariffing requirements that impede a service provider's ability to give impacted healthcare providers voluntary price reductions on this limited basis. In fact, strict enforcement of the tariffing requirements could hurt rather than protect consumers, by potentially limiting the types of medical services healthcare providers can deliver to these already isolated communities. By providing such price reductions, service providers help to minimize the financial burden upon healthcare providers that may not otherwise be able to afford such services while the support amount provided by the Fund remains constant. We therefore find that this limited forbearance from the tariff requirements is consistent with the public interest. Accordingly, we forbear from the application of section 203 and any regulations stemming therefrom with respect to service providers who offer price reductions under this Order.

¹⁸¹ See 47 U.S.C. § 203 (specifying, among other obligations, that every common carrier, except connecting carriers, shall file with the Commission tariffs for its interstate common carrier services).

¹⁸² 47 U.S.C. § 160(a). Congress enacted this section to give the Commission the authority to forbear from enforcing statutes and regulations that are no longer "current and necessary in light of changes in the industry." 141 Cong. Rec. S7893 (June 7, 1995) (remarks of Sen. Pressler). Under the statute, the Commission has the authority to forbear from applying regulation on its own motion, as well as in response to a petition for forbearance. See *Appropriate Framework for Broadband Access to the Internet over Wireline Facilities*, CC Docket No. 02-33 et al., Report and Order and Notice of Proposed Rulemaking, 20 FCC Rcd 14853, 14901, para. 90 (2005), *aff'd sub nom. Time Warner Telecom, Inc. v. FCC*, 507 F.3d 205 (3d Cir. 2007) (forbearing, on the Commission's own motion, from applying tariffing requirements to certain providers of wireline broadband Internet access service).

¹⁸³ 47 U.S.C. § 160(b).

V. PROCEDURAL MATTERS

A. Initial Regulatory Flexibility Analysis

118. As required by the Regulatory Flexibility Act of 1980, as amended,¹⁸⁴ the Commission has prepared an Initial Regulatory Flexibility Analysis (IRFA) for the Notice of Proposed Rulemaking (NPRM), of the possible significant economic impact on a substantial number of small entities by the policies and rules proposed in this NPRM. The IRFA is in Appendix B. Written public comments are requested on this IRFA. Comments must be identified as responses to the IRFA and must be filed by the deadlines for comments on the NPRM. The Commission will send a copy of the NPRM, including this IRFA, to the Chief Counsel for Advocacy of the Small Business Administration.¹⁸⁵ In addition, the NPRM and IRFA (or summaries thereof) will be published in the Federal Register.¹⁸⁶

B. Initial Paperwork Reduction Act Analysis

119. The NPRM seeks comment on a potential new or revised information collection requirement. If the Commission adopts any new or revised information collection requirement, the Commission will publish a separate notice in the Federal Register inviting the public to comment on the requirement, as required by the Paperwork Reduction Act of 1995, Public Law 104-13 (44 U.S.C. §§ 3501-3520). In addition, pursuant to the Small Business Paperwork Relief Act of 2002, Public Law 107-198, 44 U.S.C. § 3506(c)(4), the Commission seeks specific comment on how it might “further reduce the information collection burden for small business concerns with fewer than 25 employees.”

C. Other Procedural Matters

1. Ex Parte Rules

120. *Permit-But-Disclose*. The proceeding shall be treated as a “permit-but-disclose” proceeding in accordance with the Commission’s *ex parte* rules.¹⁸⁷ Persons making *ex parte* presentations must file a copy of any written presentation or a memorandum summarizing any oral presentation within two business days after the presentation (unless a different deadline applicable to the Sunshine period applies). Persons making oral *ex parte* presentations are reminded that memoranda summarizing the presentation must (1) list all persons attending or otherwise participating in the meeting at which the *ex parte* presentation was made, and (2) summarize all data presented and arguments made during the presentation. If the presentation consisted in whole or in part of the presentation of data or arguments already reflected in the presenter’s written comments, memoranda or other filings in the proceeding, the presenter may provide citations to such data or arguments in his or her prior comments, memoranda, or other filings (specifying the relevant page and/or paragraph numbers where such data or arguments can be found) in lieu of summarizing them in the memorandum. Documents shown or given to Commission staff during *ex parte* meetings are deemed to be written *ex parte* presentations and must be filed consistent with rule 1.1206(b). In proceedings governed by rule 1.49(f) or for which the Commission has made available a method of electronic filing, written *ex parte* presentations and memoranda summarizing oral *ex parte* presentations, and all attachments thereto, must be filed through the electronic comment filing system available for that proceeding, and must be filed in their native format (e.g., .doc, .xml, .ppt, searchable .pdf). Participants in this proceeding should familiarize themselves with the Commission’s *ex parte* rules.

¹⁸⁴ See 5 U.S.C. § 603.

¹⁸⁵ See 5 U.S.C. § 603(a).

¹⁸⁶ See *id.*

¹⁸⁷ 47 CFR §§ 1.1200 *et seq.*

2. Comment Filing Procedures

121. *Comments and Replies.* We invite comment on the issues and questions set forth in the NPRM and IRFA contained herein. Pursuant to sections 1.415 and 1.419 of the Commission's rules, 47 CFR §§ 1.415, 1.419, interested parties may file comments and reply comments on or before the dates indicated on the first page of this document. Comments may be filed using the Commission's Electronic Comment Filing System (ECFS). See *Electronic Filing of Documents in Rulemaking Proceedings*, 63 FR 24121 (1998).

- Electronic Filers: Comments may be filed electronically using the Internet by accessing the ECFS: <http://apps.fcc.gov/ecfs/>.
- Paper Filers: Parties who choose to file by paper must file an original and one copy of each filing. If more than one docket or rulemaking number appears in the caption of this proceeding, filers must submit two additional copies for each additional docket or rulemaking number.

Filings can be sent by hand or messenger delivery, by commercial overnight courier, or by first-class or overnight U.S. Postal Service mail. All filings must be addressed to the Commission's Secretary, Office of the Secretary, Federal Communications Commission.

- All hand-delivered or messenger-delivered paper filings for the Commission's Secretary must be delivered to FCC Headquarters at 445 12th St., SW, Room TW-A325, Washington, DC 20554. The filing hours are 8:00 a.m. to 7:00 p.m. All hand deliveries must be held together with rubber bands or fasteners. Any envelopes and boxes must be disposed of before entering the building.
- Commercial overnight mail (other than U.S. Postal Service Express Mail and Priority Mail) must be sent to 9050 Junction Drive, Annapolis Junction, MD 20701.
- U.S. Postal Service first-class, Express, and Priority mail must be addressed to 445 12th Street, SW, Washington DC 20554.

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

123. In addition, one copy of each paper filing must be sent to each of the following: (1) the Commission's duplicating contractor, Best Copy and Printing, Inc., 445 12th Street, SW, Room CY-B402, Washington, DC 20554; website: www.bcpiweb.com; phone: (800) 378-3160; (2) Radhika Karmarkar, Telecommunications Access Policy Division, Wireline Competition Bureau, 445 12th Street, SW, Room 5-A317, Washington, DC 20554; e-mail: Radhika.Karmarkar@fcc.gov and (3) Charles Tyler, Telecommunications Access Policy Division, Wireline Competition Bureau, 445 12th Street, SW, Room 5-A452, Washington, DC 20554; e-mail: Charles.Tyler@fcc.gov.

124. Filing and comments are also available for public inspection and copying during regular business hours at the FCC Reference Information Center, Portals II, 445 12th Street, SW, Room CY-A257, Washington, DC 20554. Copies may also be purchased from the Commission's duplicating contractor, BCPI, 445 12th Street, SW, Room CY-B402, Washington, DC 20554. Customers may contact BCPI through its website: www.bcpi.com, by e-mail at fcc@bcpiweb.com, by telephone at (202) 488-5300 or (800) 378-3160 or by facsimile at (202) 488-5563.

125. Comments and reply comments must include a short and concise summary of the substantive arguments raised in the pleading. Comments and reply comments must also comply with section 1.49 and all other applicable sections of the Commission's rules. We direct all interested parties

to include the name of the filing party and the date of the filing on each page of their comments and reply comments. All parties are encouraged to utilize a table of contents, regardless of the length of their submission. We also strongly encourage parties to track the organization set forth in the NPRM in order to facilitate our internal review process.

126. For additional information on this proceeding, contact Radhika Karmarkar (202) 418-1523 in the Telecommunications Access Policy Division, Wireline Competition Bureau.

VI. ORDERING CLAUSES

127. ACCORDINGLY, IT IS ORDERED, that pursuant to the authority contained in sections 1-4, 254, and 403 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151-154, 254, and 403, and sections 0.91, 0.921, and 1.3 of the Commission's rules, 47 CFR §§ 0.91, 0.0291, and 1.3 that this Order is ADOPTED.

128. IT IS FURTHER ORDERED, pursuant to the authority contained in sections 1-4 and 254 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151-154 and 254, and sections 0.91, 0.291, and 1.3 of the Commission's rules, 47 CFR. §§ 0.91, 0.291, and 1.3, that sections 54.511(b), 54.603, 54.607(b), 54.609, 54.633(b), 54.642, 54.643(a)(6)(iii), 54.645(b), 54.675(a), 54.675(f) of the Commission's rules, 47 CFR §§ 54.511(b), 54.603, 54.607(b), 54.609, 54.633(b), 54.642, 54.643(a)(6)(iii), 54.645(b), 54.675(a) and 54.675(f) ARE WAIVED to the limited extent provided herein.

129. IT IS FURTHER ORDERED that, pursuant to the authority contained in sections 1 through 4, 201-205, 254, 303(r), and 403 of the Communications Act of 1934, as amended by the Telecommunications Act of 1996, 47 U.S.C. §§ 151 through 154, 201 through 205, 254, 303(r), and 403, this Notice of Proposed Rulemaking IS ADOPTED.

130. IT IS FURTHER ORDERED that, pursuant to applicable procedures set forth in sections 1.415 and 1.419 of the Commission's rules, 47 CFR. §§ 1.415, 1.419, interested parties may file comments on this Notice of Proposed Rulemaking on or before 30 days from publication of this item in the Federal Register, and reply comments on or before 60 days from publication of this item in the Federal Register.

131. IT IS FURTHER ORDERED that the Commission's Consumer and Governmental Affairs Bureau, Reference Information Center, SHALL SEND a copy of this Notice of Proposed Rulemaking, including the Initial Regulatory Flexibility Analysis, to the Chief Counsel for Advocacy of the Small Business Administration.

FEDERAL COMMUNICATIONS COMMISSION

Marlene H. Dortch
Secretary

APPENDIX A

PROPOSED RULES

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

PART 54 – UNIVERSAL SERVICE

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

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

2. Revise Subpart G headings to read as follows:

DEFINED TERMS AND ELIGIBILITY

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

TELECOMMUNICATIONS PROGRAM

- § 54.603 Competitive bidding and certification requirements and exemptions.
- § 54.604 Consortia, telecommunications services, and existing contracts.
- § 54.605 Determining the urban rate.
- § 54.607 Determining the rural rate.
- § 54.609 Calculating support.
- § 54.610 Funding Commitments.
- § 54.611 Payment Process.
- § 54.613 Limitations on supported services for rural health care providers.
- § 54.615 Obtaining services.
- § 54.619 Audits and recordkeeping.
- § 54.623 Annual filing and funding commitment requirement.
- § 54.625 Support for services beyond the maximum supported distance for rural health care providers.

HEALTHCARE CONNECT FUND

- § 54.630 Eligible recipients.
- § 54.631 Designation of consortium leader.
- § 54.632 Letters of agency (LOA).
- § 54.633 Health care provider contribution.
- § 54.634 Eligible services.
- § 54.635 Eligible equipment.
- § 54.636 Eligible participant-constructed and owned network facilities for consortium applicants.
- § 54.637 Off-site data centers and off-site administrative offices.
- § 54.638 Upfront payments.
- § 54.639 Ineligible expenses.
- § 54.640 Eligible vendors.
- § 54.642 Competitive bidding requirement and exemptions.

§ 54.643	Funding commitments.
§ 54.644	Multi-year commitments.
§ 54.645	Payment process.
§ 54.646	Site and service substitutions.
§ 54.647	Data collection and reporting.
§ 54.648	Audits and recordkeeping.
§ 54.649	Certifications.

GENERAL PROVISIONS

§ 54.671	Resale.
§ 54.672	Duplicate support.
§ 54.675	Cap.
§ 54.679	Election to offset support against annual universal service fund contribution.
§ 54.680	Validity of electronic signatures.

3. Amend § 54.603 by revising paragraphs (a) and (b) and adding new paragraphs (c), (d), (e), (f), (g), (h), and (i) to read as follows:

§ 54.603 Competitive bidding and certification requirements and exemptions.

(a) *Competitive bidding requirement.* All applicants are required to engage in a competitive bidding process for services eligible for universal service support under the Telecommunications Program consistent with the requirements set forth in this subpart, unless they qualify for an exemption in paragraph (i) of this subpart. Applicants may engage in competitive bidding even if they qualify for an exemption. Applicants who utilize a competitive bidding exemption may proceed directly to filing a funding request as described in § 54.610.

(b) *Fair and open process.* (1) All entities participating in the Telecommunications Program, including vendors, must conduct a fair and open competitive bidding process, consistent with all applicable requirements.

(2) Vendors who intend to bid to provide supported services to a health care provider may not simultaneously help the health care provider choose a winning bid. Any vendor who submits a bid, and any individual or entity that has a financial interest in such a vendor, is prohibited from: preparing, signing or submitting an applicant's request for services or supporting documentation; serving as the point of contact on behalf of the applicant; being involved in setting bid evaluation criteria; or participating in the bid evaluation or vendor selection process (except in their role as potential vendors).

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

(4) An applicant may not have a relationship, financial interest, or ownership interest with a service provider that would unfairly influence the outcome of a competition or furnish the service provider with inside information.

(5) An applicant may not turn over its responsibility for ensuring a fair and open competitive bidding process to a service provider or anyone working on behalf of a service provider.

(6) An employee or board member of the applicant may not serve on any board of any type of service provider that participates in the RHC Programs.

(7) An applicant may not accept or solicit, and a service provider may not offer or provide, any gift or other thing of value to employees or board members of the applicant, or anyone acting on the applicant's behalf.

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

(c) *Cost-effective.* For purposes of the Telecommunications Program, "cost-effectiveness" is defined as the lowest-price service that meets the minimum requirements for the products and services that are essential to satisfy the communications needs of the applicant.

(d) *Bid evaluation criteria.* Applicants must develop evaluation criteria and demonstrate how the applicant will choose the most cost-effective bid before submitting a Request for Services. The applicant must specify on its bid evaluation worksheet and/or scoring matrix what its minimum requirements are for each of those criteria. The applicant must record on the bid evaluation worksheet or matrix each service provider's proposed service levels for the established criteria. After reviewing the bid submissions and identifying the bids that satisfy the applicant's minimum requirements, the applicant must then select the service provider that costs the least.

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

(1) Form 465, including certifications. The applicant must provide the Form 465 and the following certifications as part of the request for services:

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

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

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

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

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

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

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

(viii) The applicant has reviewed all applicable requirements for the Telecommunications Program and will comply with those requirements.

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

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

(f) *Public posting by the Administrator.* The Administrator shall post the applicant's Form 465 and bid evaluation criteria on its website.

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

(1) *Selection of the most "cost-effective" bid and contract negotiation.* Each applicant is required to certify to the Administrator that the selected bid is, to the best of the applicant's knowledge, the most cost-effective option available. Applicants are required to submit the documentation listed in § 54.610 to support their certifications.

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

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

(2) For purposes of this paragraph: (i) The terms "health care provider" or "consortium" shall include all individuals who are on the governing boards of such entities and all employees, officers, representatives, agents, consultants or independent contractors of such entities involved on behalf of such health care provider or consortium with the Rural Health Care Program, including individuals who prepare, approve, sign or submit RHC Program applications, or other forms related to the RHC Program, or who prepare

bids, communicate or work with RHC Program service providers, consultants, or with USAC, as well as any staff of such entities responsible for monitoring compliance with the RHC Program; and

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

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

(i) Are motivated solely by a personal relationship,

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

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

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

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

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

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

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

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

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

(C) Specifies the term of the contract;

- (D) Specifies the cost of services to be provided; and
 - (E) Includes the physical location or other identifying information of the health care provider sites purchasing from the contract.
- (iii) Participants may exercise voluntary options to extend an evergreen contract without undergoing additional competitive bidding if:
- (A) The voluntary extension(s) is memorialized in the evergreen contract;
 - (B) The decision to extend the contract occurs before the participant files its funding request for the funding year when the contract would otherwise expire; and
 - (C) The voluntary extension(s) do not exceed five years in the aggregate.

4. Add § 54.610 to read as follows:

§ 54.610 Funding Commitments.

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

(1) *Request for funding.* The applicant shall submit a Request for Funding (Form 466) to identify the service; urban and rural rates; vendor(s); and date(s) of vendor selection.

(2) *Certifications.* The applicant must provide the following certifications as part of the Request for Funding: (i) The person signing the application is authorized to submit the application on behalf of the applicant and has examined the form and all attachments, and to the best of his or her knowledge, information, and belief, all statements of fact contained therein are true.

(ii) Each vendor selected is, to the best of the applicant’s knowledge, information and belief, the most cost-effective vendor available, as defined in §54.603.

(iii) All Telecommunications Program support will be used only for eligible health care purposes.

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

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

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

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

(viii) The applicant conducted a fair and open competitive bidding process, as described in §54.603.

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

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

5. Add § 54.611 to read as follows:

§ 54.611 Payment Process.

(a) The applicant must submit Form 467 to the Administrator confirming the service start date, the service end or disconnect date, or whether the service was never turned on.

(b) Upon receipt of the form, the Administrator shall generate a health care support schedule, which the service provider shall use to determine how much credit the applicant will receive for the services. The service provider must apply the credit to the applicant's bill during the next possible billing cycle and submit an online invoice to the Administrator. The service provider must certify on the invoice that it has reviewed all applicable requirements for the program, including the competitive bidding requirements described in § 54.603, and has complied with those requirements.

(c) Before the Administrator may process and pay an invoice, it must receive a completed Form 467 from the health care provider and an invoice from the service provider. All invoices must be received by the Administrator within six months (180 days) of the end date of the time period covered by the funding commitment.

6. Amend § 54.642 by:

- a. Revising paragraphs (b)(1), (b)(2), (b)(4) and adding paragraph (b)(5) through (b)(8),
- b. Revising paragraphs (c), (d),
- c. Revising paragraphs (e)(1)(iv), (e)(2), (e)(3),
- d. Revising paragraph (g)(1), and
- e. Adding paragraph (i)

The revisions and additions read as follows:

§ 54.642 Competitive bidding and certification requirements.

* * * * *

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

(2) Vendors who intend to bid to provide supported services to a health care provider may not simultaneously help the health care provider choose a winning bid. Any vendor who submits a bid, and any individual or entity that has a financial interest in such a vendor, is prohibited from: preparing, signing or submitting an applicant's request for services or supporting documentation; serving as the point of contact on behalf of the applicant; being involved in setting bid evaluation criteria; or participating in the bid evaluation or vendor selection process (except in their role as potential vendors).

(3) * * *

(4) An applicant may not have a relationship, financial interest, or ownership interest with a service provider that would unfairly influence the outcome of a competition or furnish the service provider with inside information.

(5) An applicant may not turn over its responsibility for ensuring a fair and open competitive bidding process to a service provider or anyone working on behalf of a service provider.

(6) An employee or board member of the applicant may not serve on any board of any type of service provider that participates in the RHC Programs.

(7) An applicant may not accept or solicit, and a service provider may not offer or provide, any gift or other thing of value to employees or board members of the applicant, or anyone working on the applicant's behalf.

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

(c) *Cost-effective.* For purposes of the Healthcare Connect Fund Program, "cost-effectiveness" is defined as the lowest-price service that meets the minimum requirements for the products and services that are essential to satisfy the communications needs of the applicant.

(d) *Bid evaluation criteria.* Applicants must develop evaluation criteria and demonstrate how the applicant will choose the most cost-effective bid before submitting a request for services. The applicant must specify on its bid evaluation worksheet and/or scoring matrix what its minimum requirements are for each of those criteria. The applicant must record on the bid evaluation worksheet or matrix each service provider's proposed service levels for the established criteria. After reviewing the bid submissions and identifying the bids that satisfy the applicant's minimum requirements, the applicant must then select the service provider that costs the least.

(e) * * *

(1) * * *

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

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

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

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

(v) All Healthcare Connect Fund Program support will be used solely for purposes reasonably related to the provision of health care service or instruction that the healthcare provider 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.

(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 healthcare provider.

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

(viii) The applicant has reviewed all applicable requirements for the Healthcare Connect Fund Program and will comply with those requirements.

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

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

* * * * *

(g) * * *

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

* * * * *

(i) *Gift restrictions.* (1) Subject to paragraphs (i)(3) and (i)(4) of this section, an eligible health care provider or consortium that includes eligible health care providers and/or other eligible entities may not

directly or indirectly solicit or accept any gift, gratuity, favor, entertainment, loan, or any other thing of value from a service provider participating in or seeking to participate in the rural health care universal service program. No such service provider shall offer or provide any such gift, gratuity, favor, entertainment, loan, or other thing of value except as otherwise provided herein. Modest refreshments not offered as part of a meal, items with little intrinsic value intended solely for presentation, and items worth \$20 or less, including meals, may be offered or provided, and accepted by any individuals or entities subject to this rule, if the value of these items received by any individual does not exceed \$50 from any one service provider per funding year. The \$50 amount for any service provider shall be calculated as the aggregate value of all gifts provided during a funding year by the individuals specified in paragraph (i)(2)(ii) of this section.

(2) For purposes of this paragraph: (i) The terms “health care provider or consortium” shall include all individuals who are on the governing boards of such entities and all employees, officers, representatives, agents, consultants or independent contractors of such entities involved on behalf of such health care provider or consortium with the Rural Health Care Program, including individuals who prepare, approve, sign or submit RHC Program applications, or other forms related to the RHC Program, or who prepare bids, communicate or work with RHC Program service providers, consultants, or with USAC, as well as any staff of such entities responsible for monitoring compliance with the RHC Program; and

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

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

(i) Are motivated solely by a personal relationship,

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

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

(4) Any service provider may make charitable donations to an eligible health care provider or consortium that includes eligible health care providers in the support of its programs as long as such contributions are not directly or indirectly related to RHC Program procurement activities or decisions and are not given by service providers to circumvent competitive bidding and other RHC Program rules, including those in section 54.633 of this Part, requiring health care providers to contribute 35 percent of the total cost of all eligible expenses.

7. Amend § 54.643 by adding paragraph (a)(2)(viii) and by revising paragraph (a)(4) to read as follows:

§ 54.643 Funding Commitments.

(a) * * *

(2)(i)-(vii) * * *

(viii) The applicant conducted a fair and open competitive bidding process, as described in §54.642.

(3) * * *

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

* * * * *

8. Amend § 54.645 by revising paragraph (b) to read as follows:

§ 54.645 Payment Process.

* * * * *

(b) Before the Administrator may process and pay an invoice, both the Consortium Leader (or health care provider, if participating individually) and the vendor must certify that they have reviewed the document and that it is accurate. The service provider must certify on the invoice that it has reviewed all applicable requirements for the program, including the competitive bidding requirements described in § 54.642, and has complied with those requirements. All invoices must be received by the Administrator within six months (180 days) of the end date of the time period covered by the funding commitment.

APPENDIX B**Initial Regulatory Flexibility Analysis**

1. As required by the Regulatory Flexibility Act of 1980, as amended (RFA),¹⁸⁸ the Commission has prepared this Initial Regulatory Flexibility Analysis (IRFA) of the possible significant economic impact on a substantial number of small entities by the policies and rules proposed in the Notice of Proposed Rulemaking (NPRM). Written comments are requested on this IRFA. Comments must be identified as responses to the IRFA and must be filed by the deadlines for comments on the NPRM provided on the first page of the item. The Commission will send a copy of the NPRM, including this IRFA, to the Chief Counsel for Advocacy of the Small Business Administration (SBA).¹⁸⁹ In addition, the NPRM and IRFA (or summaries thereof) will be published in the Federal Register.¹⁹⁰

A. Need for, and Objectives of, the Proposed Rules

2. Through this NPRM, the Commission seeks to improve the Rural Health Care (RHC) Program's capacity to distribute telecommunications and broadband support to health care providers—especially small, rural healthcare providers (HCPs)—in the most equitable, effective, efficient, clear, and predictable manner as possible. Telemedicine has become an increasingly vital component of healthcare delivery to rural Americans and, in Funding Year (FY) 2016, for the first time in the RHC Program's twenty-year history, demand for support exceeded the \$400 million annual cap which necessitated reduced, *pro rata* distribution of support. In light of the significance and scarcity of RHC Program support, the Commission proposes and seeks comment on several measures to most effectively meet HCPs' needs while responsibly stewarding the RHC Program's limited funds.

B. Legal Basis

3. The legal basis for the NPRM is contained in sections 1 through 4, 201-205, 254, 303(r), and 403 of the Communications Act of 1934, as amended by the Telecommunications Act of 1996, 47 U.S.C. §§ 151 through 154, 201 through 205, 254, 303(r), and 403.

C. Description and Estimate of the Number of Small Entities to Which the Proposed Rules Will Apply

4. The RFA directs agencies to provide a description of and, where feasible, an estimate of the number of small entities that may be affected by the proposed rules, if adopted.¹⁹¹ The RFA generally defines the term “small entity” as having the same meaning as the terms “small business,” “small organization,” and “small governmental jurisdiction.”¹⁹² In addition, the term “small business” has the same meaning as the term “small business concern” under the Small Business Act.¹⁹³ A small business

¹⁸⁸ 5 U.S.C. § 603. The RFA, 5 U.S.C. §§ 601–612, has been amended by the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA), Pub. L. No. 104-121, Title II, 110 Stat. 857 (1996).

¹⁸⁹ See 5 U.S.C. § 603(a).

¹⁹⁰ See *id.*

¹⁹¹ 5 U.S.C. § 603(b)(3).

¹⁹² 5 U.S.C. § 601(6).

¹⁹³ 5 U.S.C. § 601(3) (incorporating by reference the definition of “small business concern” in 15 U.S.C. § 632). Pursuant to the RFA, the statutory definition of a small business applies “unless an agency, after consultation with the Office of Advocacy of the Small Business Administration and after opportunity for public comment, establishes one or more definitions of such term which are appropriate to the activities of the agency and publishes such definition(s) in the Federal Register.” 5 U.S.C. § 601(3).

concern is one that: (1) is independently owned and operated; (2) is not dominant in its field of operation; and (3) satisfies any additional criteria established by the Small Business Administration (SBA).¹⁹⁴

5. *Small Businesses, Small Organizations, Small Governmental Jurisdictions.* Our actions, over time, may affect small entities that are not easily categorized at present. We therefore describe here, at the outset, three broad groups of small entities that could be directly affected herein.¹⁹⁵ First, while there are industry specific size standards for small businesses that are used in the regulatory flexibility analysis, according to data from the SBA's Office of Advocacy, in general a small business is an independent business having fewer than 500 employees.¹⁹⁶ These types of small businesses represent 99.9% of all businesses in the United States which translates to 28.8 million businesses.¹⁹⁷

6. Next, the type of small entity described as a "small organization" is generally "any not-for-profit enterprise which is independently owned and operated and is not dominant in its field."¹⁹⁸ Nationwide, as of Aug 2016, there were approximately 356,494 small organizations based on registration and tax data filed by nonprofits with the Internal Revenue Service (IRS).¹⁹⁹

7. Finally, the small entity described as a "small governmental jurisdiction" is defined generally as "governments of cities, counties, towns, townships, villages, school districts, or special districts, with a population of less than fifty thousand."²⁰⁰ U.S. Census Bureau data from the 2012 Census of Governments²⁰¹ indicates that there were 90,056 local governmental jurisdictions consisting of general purpose governments and special purpose governments in the United States.²⁰² Of this number there were 37,132 General purpose governments (county²⁰³, municipal and town or township²⁰⁴) with populations of

¹⁹⁴ See 15 U.S.C. § 632.

¹⁹⁵ See 5 U.S.C. § 601(3)-(6).

¹⁹⁶ See SBA, Office of Advocacy, "Frequently Asked Questions, Question 1 – What is a small business?" https://www.sba.gov/sites/default/files/advocacy/SB-FAQ-2016_WEB.pdf (June 2016)

¹⁹⁷ See SBA, Office of Advocacy, "Frequently Asked Questions, Question 2- How many small business are there in the U.S.?" https://www.sba.gov/sites/default/files/advocacy/SB-FAQ-2016_WEB.pdf (June 2016).

¹⁹⁸ 5 U.S.C. § 601(4).

¹⁹⁹ Data from the Urban Institute, National Center for Charitable Statistics (NCCS) reporting on nonprofit organizations registered with the IRS was used to estimate the number of small organizations. Reports generated using the NCCS online database indicated that as of August 2016 there were 356,494 registered nonprofits with total revenues of less than \$100,000. Of this number 326,897 entities filed tax returns with 65,113 registered nonprofits reporting total revenues of \$50,000 or less on the IRS Form 990-N for Small Exempt Organizations and 261,784 nonprofits reporting total revenues of \$100,000 or less on some other version of the IRS Form 990 within 24 months of the August 2016 data release date. See <http://nccsweb.urban.org/tablewiz/bmf.php> where the report showing this data can be generated by selecting the following data fields: Show: "Registered Nonprofit Organizations"; By: "Total Revenue Level (years 1995, Aug to 2016, Aug)"; and For: "2016, Aug" then selecting "Show Results."

²⁰⁰ 5 U.S.C. § 601(5).

²⁰¹ See 13 U.S.C. § 161. The Census of Government is conducted every five (5) years compiling data for years ending with "2" and "7". See also Program Description Census of Government <https://factfinder.census.gov/faces/affhelp/jsf/pages/metadata.xhtml?lang=en&type=program&id=program.en.CO G#>.

²⁰² See U.S. Census Bureau, 2012 Census of Governments, Local Governments by Type and State: 2012 - United States-States. <https://factfinder.census.gov/bkmk/table/1.0/en/COG/2012/ORG02.US01>. Local governmental jurisdictions are classified in two categories - General purpose governments (county, municipal and town or township) and Special purpose governments (special districts and independent school districts).

²⁰³ See U.S. Census Bureau, 2012 Census of Governments, County Governments by Population-Size Group and State: 2012 - United States-States. <https://factfinder.census.gov/bkmk/table/1.0/en/COG/2012/ORG06.US01>. There were 2,114 county governments with populations less than 50,000.

less than 50,000 and 12,184 Special purpose governments (independent school districts²⁰⁵ and special districts²⁰⁶) with populations of less than 50,000. The 2012 U.S. Census Bureau data for most types of governments in the local government category shows that the majority of these governments have populations of less than 50,000.²⁰⁷ Based on this data we estimate that at least 49,316 local government jurisdictions fall in the category of “small governmental jurisdictions.”²⁰⁸

8. Small entities potentially affected by the proposals herein include eligible rural non-profit and public health care providers and the eligible service providers offering them services, including telecommunications service providers, Internet Service Providers (ISPs), and vendors of the services and equipment used for dedicated broadband networks.²⁰⁹

1. Healthcare Providers

9. *Offices of Physicians (except Mental Health Specialists)*. This U.S. industry comprises establishments of health practitioners having the degree of M.D. (Doctor of Medicine) or D.O. (Doctor of Osteopathy) primarily engaged in the independent practice of general or specialized medicine (except psychiatry or psychoanalysis) or surgery. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.²¹⁰ The SBA has created a size standard for this industry, which is annual receipts of \$11 million or less.²¹¹ According to 2012 U.S. Economic Census, 152,468 firms operated throughout the entire year in this industry.²¹² Of that number, 147,718 had annual receipts of less than \$10 million, while 3,108 firms

(Continued from previous page) _____

²⁰⁴ See U.S. Census Bureau, 2012 Census of Governments, Subcounty General-Purpose Governments by Population-Size Group and State: 2012 - United States – States. <https://factfinder.census.gov/bkmk/table/1.0/en/COG/2012/ORG07.US01>. There were 18,811 municipal and 16,207 town and township governments with populations less than 50,000.

²⁰⁵ See U.S. Census Bureau, 2012 Census of Governments, Elementary and Secondary School Systems by Enrollment-Size Group and State: 2012 - United States-States. <https://factfinder.census.gov/bkmk/table/1.0/en/COG/2012/ORG11.US01>. There were 12,184 independent school districts with enrollment populations less than 50,000.

²⁰⁶ See U.S. Census Bureau, 2012 Census of Governments, Special District Governments by Function and State: 2012 - United States-States. <https://factfinder.census.gov/bkmk/table/1.0/en/COG/2012/ORG09.US01>. The U.S. Census Bureau data did not provide a population breakout for special district governments.

²⁰⁷ See U.S. Census Bureau, 2012 Census of Governments, County Governments by Population-Size Group and State: 2012 - United States-States - <https://factfinder.census.gov/bkmk/table/1.0/en/COG/2012/ORG06.US01>; Subcounty General-Purpose Governments by Population-Size Group and State: 2012 - United States-States - <https://factfinder.census.gov/bkmk/table/1.0/en/COG/2012/ORG07.US01>; and Elementary and Secondary School Systems by Enrollment-Size Group and State: 2012 - United States-States. <https://factfinder.census.gov/bkmk/table/1.0/en/COG/2012/ORG11.US01>. While U.S. Census Bureau data did not provide a population breakout for special district governments, if the population of less than 50,000 for this category of local government is consistent with the other types of local governments the majority of the 38, 266 special district governments have populations of less than 50,000.

²⁰⁸ *Id.*

²⁰⁹ 47 CFR §§ 54.601, 54.621.

²¹⁰ See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621111 “Offices of Physicians (except Mental Health Specialists)” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621111&search=2012+NAICS+Search&search=2012>.

²¹¹ 13 CFR § 121.201, NAICS Code 621111.

²¹² U.S. Census Bureau, 2012 Economic Census of the United States, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 621111, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~621111.

had annual receipts between \$10 million and \$24,999,999.²¹³ Based on this data, we conclude that a majority of firms operating in this industry are small under the applicable size standard.

10. *Offices of Physicians, Mental Health Specialists.* This U.S. industry comprises establishments of health practitioners having the degree of M.D. (Doctor of Medicine) or D.O. (Doctor of Osteopathy) primarily engaged in the independent practice of psychiatry or psychoanalysis. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.²¹⁴ The SBA has established a size standard for businesses in this industry, which is annual receipts of \$11 million dollars or less.²¹⁵ The U.S. Economic Census indicates that 8,809 firms operated throughout the entire year in this industry.²¹⁶ Of that number 8,791 had annual receipts of less than \$10 million, while 13 firms had annual receipts between \$10 million and \$24,999,999.²¹⁷ Based on this data, we conclude that a majority of firms in this industry are small under the applicable standard.

11. *Offices of Dentists.* This U.S. industry comprises establishments of health practitioners having the degree of D.M.D. (Doctor of Dental Medicine), D.D.S. (Doctor of Dental Surgery), or D.D.Sc. (Doctor of Dental Science) primarily engaged in the independent practice of general or specialized dentistry or dental surgery. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers. They can provide either comprehensive preventive, cosmetic, or emergency care, or specialize in a single field of dentistry.²¹⁸ The SBA has established a size standard for that industry of annual receipts of \$7.5 million or less.²¹⁹ The 2012 U.S. Economic Census indicates that 115,268 firms operated in the dental industry throughout the entire year.²²⁰ Of that number 114,417 had annual receipts of less than \$5 million, while 651 firms had annual receipts between \$5 million and \$9,999,999.²²¹ Based on this data, we conclude that a majority of business in the dental industry are small under the applicable standard.

12. *Offices of Chiropractors.* This U.S. industry comprises establishments of health practitioners having the degree of D.C. (Doctor of Chiropractic) primarily engaged in the independent practice of chiropractic. These practitioners provide diagnostic and therapeutic treatment of neuromusculoskeletal and related disorders through the manipulation and adjustment of the spinal column and extremities, and operate private or group practices in their own offices (e.g., centers, clinics) or in the

²¹³ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$11 million or less.

²¹⁴ See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621112 “Offices of Physicians, Mental Health Specialists”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621112&search=2012+NAICS+Search&search=2012>.

²¹⁵ 13 CFR § 121.201, NAICS Code 621112.

²¹⁶ U.S. Census Bureau, 2012 Economic Census of the United States, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 621112, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~621112.

²¹⁷ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$11 million or less.

²¹⁸ See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621210 “Offices of Dentists”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621210&search=2012+NAICS+Search&search=2012>.

²¹⁹ 13 CFR § 121.201, NAICS Code 621210.

²²⁰ U.S. Census Bureau, 2012 Economic Census of the United States, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 621210, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~621210.

²²¹ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$7.5 million or less.

facilities of others, such as hospitals or HMO medical centers.²²² The SBA has established a size standard for this industry, which is annual receipts of \$7.5 million or less.²²³ The 2012 U.S. Economic Census statistics show that in 2012, 33,940 firms operated throughout the entire year.²²⁴ Of that number 33,910 operated with annual receipts of less than \$5 million per year, while 26 firms had annual receipts between \$5 million and \$9,999,999.²²⁵ Based on that data, we conclude that a majority of chiropractors are small.

13. *Offices of Optometrists.* This U.S. industry comprises establishments of health practitioners having the degree of O.D. (Doctor of Optometry) primarily engaged in the independent practice of optometry. These practitioners examine, diagnose, treat, and manage diseases and disorders of the visual system, the eye and associated structures as well as diagnose related systemic conditions. Offices of optometrists prescribe and/or provide eyeglasses, contact lenses, low vision aids, and vision therapy. They operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers, and may also provide the same services as opticians, such as selling and fitting prescription eyeglasses and contact lenses.²²⁶ The SBA has established a size standard for businesses operating in this industry, which is annual receipts of \$7.5 million or less.²²⁷ The 2012 Economic Census indicates that 18,050 firms operated the entire year.²²⁸ Of that number, 17,951 had annual receipts of less than \$5 million, while 70 firms had annual receipts between \$5 million and \$9,999,999.²²⁹ Based on this data, we conclude that a majority of optometrists in this industry are small.

14. *Offices of Mental Health Practitioners (except Physicians).* This U.S. industry comprises establishments of independent mental health practitioners (except physicians) primarily engaged in (1) the diagnosis and treatment of mental, emotional, and behavioral disorders and/or (2) the diagnosis and treatment of individual or group social dysfunction brought about by such causes as mental illness, alcohol and substance abuse, physical and emotional trauma, or stress. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.²³⁰ The SBA has created a size standard for this industry, which is annual receipts of \$7.5 million or less.²³¹ The 2012 U.S. Economic Census indicates that 16,058 firms operated

²²²See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621310 “Offices of Chiropractors”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621310&search=2012+NAICS+Search&search=2012>. See also NAICS code 621310, 13 CFR § 121.201.

²²³ 13 CFR § 121.201, NAICS Code 621310.

²²⁴ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 621310, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~621310.

²²⁵ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$7.5 million or less.

²²⁶ See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621320 “Offices of Optometrists”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621320&search=2012+NAICS+Search&search=2012>.

²²⁷ 13 CFR § 121.201, NAICS code 621320.

²²⁸ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 621320, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~621320.

²²⁹*Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$7.5 million or less.

²³⁰ See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621330 “Offices of Mental Health Practitioners (except Physicians)”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621330&search=2012+NAICS+Search&search=2012>.

²³¹ 13 CFR § 121.201 NAICS Code 621330.

throughout the entire year.²³² Of that number, 15,894 firms received annual receipts of less than \$5 million, while 111 firms had annual receipts between \$5 million and \$9,999,999.²³³ Based on this data, we conclude that a majority of mental health practitioners who do not employ physicians are small.

15. *Offices of Physical, Occupational and Speech Therapists and Audiologists.* This U.S. industry comprises establishments of independent health practitioners primarily engaged in one of the following: (1) providing physical therapy services to patients who have impairments, functional limitations, disabilities, or changes in physical functions and health status resulting from injury, disease or other causes, or who require prevention, wellness or fitness services; (2) planning and administering educational, recreational, and social activities designed to help patients or individuals with disabilities, regain physical or mental functioning or to adapt to their disabilities; and (3) diagnosing and treating speech, language, or hearing problems. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.²³⁴ The SBA has established a size standard for this industry, which is annual receipts of \$7.5 million or less.²³⁵ The 2012 U.S. Economic Census indicates that 20,567 firms in this industry operated throughout the entire year.²³⁶ Of this number, 20,047 had annual receipts of less than \$5 million, while 270 firms had annual receipts between \$5 million and \$9,999,999.²³⁷ Based on this data, we conclude that a majority of businesses in this industry are small.

16. *Offices of Podiatrists.* This U.S. industry comprises establishments of health practitioners having the degree of D.P.M. (Doctor of Podiatric Medicine) primarily engaged in the independent practice of podiatry. These practitioners diagnose and treat diseases and deformities of the foot and operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.²³⁸ The SBA has established a size standard for businesses in this industry, which is annual receipts of \$7.5 million or less.²³⁹ The 2012 U.S. Economic Census indicates that 7,569 podiatry firms operated throughout the entire year.²⁴⁰ Of that number, 7,545 firms had annual receipts of less than \$5 million, while 22 firms had annual receipts between \$5 million and

²³² U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 621330, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~621330.

²³³ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$7.5 million or less.

²³⁴ See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621340 “Offices of Physical, Occupational and Speech Therapists and Audiologists”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621340&search=2012+NAICS+Search&search=2012>.

²³⁵ 13 CFR § 121.201, NAICS Code 621340.

²³⁶ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 621340, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~621340.

²³⁷ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$7.5 million or less.

²³⁸ See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621391 “Offices of Podiatrists”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621391&search=2012+NAICS+Search&search=2012>.

²³⁹ 13 CFR § 121.201, NAICS Code 621391.

²⁴⁰ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 621391, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~621391.

\$9,999,999.²⁴¹ Based on this data, we conclude that a majority of firms in this industry are small.

17. *Offices of All Other Miscellaneous Health Practitioners.* This U.S. industry comprises establishments of independent health practitioners (except physicians; dentists; chiropractors; optometrists; mental health specialists; physical, occupational, and speech therapists; audiologists; and podiatrists). These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.²⁴² The SBA has established a size standard for this industry, which is annual receipts of \$7.5 million or less.²⁴³ The 2012 U.S. Economic Census indicates that 11,460 firms operated throughout the entire year.²⁴⁴ Of that number, 11,374 firms had annual receipts of less than \$5 million, while 48 firms had annual receipts between \$5 million and \$9,999,999.²⁴⁵ Based on this data, we conclude the majority of firms in this industry are small.

18. *Family Planning Centers.* This U.S. industry comprises establishments with medical staff primarily engaged in providing a range of family planning services on an outpatient basis, such as contraceptive services, genetic and prenatal counseling, voluntary sterilization, and therapeutic and medically induced termination of pregnancy.²⁴⁶ The SBA has established a size standard for this industry, which is annual receipts of \$11 million or less.²⁴⁷ The 2012 Economic Census indicates that 1,286 firms in this industry operated throughout the entire year.²⁴⁸ Of that number 1,237 had annual receipts of less than \$10 million, while 36 firms had annual receipts between \$10 million and \$24,999,999.²⁴⁹ Based on this data, we conclude that the majority of firms in this industry are small.

19. *Outpatient Mental Health and Substance Abuse Centers.* This U.S. industry comprises establishments with medical staff primarily engaged in providing outpatient services related to the diagnosis and treatment of mental health disorders and alcohol and other substance abuse. These establishments generally treat patients who do not require inpatient treatment. They may provide a counseling staff and information regarding a wide range of mental health and substance abuse issues and/or refer patients to more extensive treatment programs, if necessary.²⁵⁰ The SBA has established a

²⁴¹*Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$7.5 million or less.

²⁴² See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621399 “Offices of All Other Miscellaneous Health Practitioners”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621399&search=2012+NAICS+Search&search=2012>.

²⁴³ 13 CFR § 121.201, NAICS Code 621399.

²⁴⁴ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 621399, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~621399.

²⁴⁵*Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$7.5 million or less.

²⁴⁶ See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621410 “Family Planning Centers”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621410&search=2012+NAICS+Search&search=2012>.

²⁴⁷ 13 CFR § 121.201, NAICS Code 621410.

²⁴⁸ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 621410, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~621410.

²⁴⁹*Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$11 million or less.

²⁵⁰ See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621420 “Outpatient Mental Health and Substance Abuse Centers”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621420&search=2012+NAICS+Search&search=2012>.

size standard for this industry, which is \$15 million or less in annual receipts.²⁵¹ The 2012 U.S. Economic Census indicates that 4,446 firms operated throughout the entire year.²⁵² Of that number, 4,069 had annual receipts of less than \$10 million while 286 firms had annual receipts between \$10 million and \$24,999,999.²⁵³ Based on this data, we conclude that a majority of firms in this industry are small.

20. *HMO Medical Centers.* This U.S. industry comprises establishments with physicians and other medical staff primarily engaged in providing a range of outpatient medical services to the health maintenance organization (HMO) subscribers with a focus generally on primary health care. These establishments are owned by the HMO. Included in this industry are HMO establishments that both provide health care services and underwrite health and medical insurance policies.²⁵⁴ The SBA has established a size standard for this industry, which is \$32.5 million or less in annual receipts.²⁵⁵ The 2012 U.S. Economic Census indicates that 14 firms in this industry operated throughout the entire year.²⁵⁶ Of that number, 5 firms had annual receipts of less than \$25 million, while 1 firm had annual receipts between \$25 million and \$99,999,999.²⁵⁷ Based on this data, we conclude that approximately one-third of the firms in this industry are small.

21. *Freestanding Ambulatory Surgical and Emergency Centers.* This U.S. industry comprises establishments with physicians and other medical staff primarily engaged in (1) providing surgical services (e.g., orthoscopic and cataract surgery) on an outpatient basis or (2) providing emergency care services (e.g., setting broken bones, treating lacerations, or tending to patients suffering injuries as a result of accidents, trauma, or medical conditions necessitating immediate medical care) on an outpatient basis. Outpatient surgical establishments have specialized facilities, such as operating and recovery rooms, and specialized equipment, such as anesthetic or X-ray equipment.²⁵⁸ The SBA has established a size standard for this industry, which is annual receipts of \$15 million or less.²⁵⁹ The 2012 U.S. Economic Census indicates that 3,595 firms in this industry operated throughout the entire year.²⁶⁰ Of that number, 3,222 firms had annual receipts of less than \$10 million, while 289 firms had annual receipts between \$10

²⁵¹ 13 CFR § 121.201 NAICS Code 621420.

²⁵² U.S. Census Bureau, *2012 Economic Census of the United States, Table EC1262SSSZ4, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 621420, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~621420.

²⁵³ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$15 million or less.

²⁵⁴ See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621491 “HMO Medical Centers”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621491&search=2012+NAICS+Search&search=2012>.

²⁵⁵ 13 CFR § 121.201 NAICS code 621491.

²⁵⁶ U.S. Census Bureau, *2012 Economic Census of the United States, Table EC1262SSSZ4, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 621491, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~621491.

²⁵⁷ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$32.5 million or less.

²⁵⁸ See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621493 “Freestanding Ambulatory Surgical and Emergency Centers”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621493&search=2012+NAICS+Search&search=2012>.

²⁵⁹ 13 CFR § 121.201 NAICS Code 621493.

²⁶⁰ U.S. Census Bureau, *2012 Economic Census of the United States, Table EC1262SSSZ4, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 621493, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~621493.

million and \$24,999,999.²⁶¹ Based on this data, we conclude that a majority of firms in this industry are small.

22. *All Other Outpatient Care Centers.* This U.S. industry comprises establishments with medical staff primarily engaged in providing general or specialized outpatient care (except family planning centers, outpatient mental health and substance abuse centers, HMO medical centers, kidney dialysis centers, and freestanding ambulatory surgical and emergency centers). Centers or clinics of health practitioners with different degrees from more than one industry practicing within the same establishment (i.e., Doctor of Medicine and Doctor of Dental Medicine) are included in this industry.²⁶² The SBA has established a size standard for this industry, which is annual receipts of \$20.5 million or less.²⁶³ The 2012 U.S. Economic Census indicates that 4,903 firms operated in this industry throughout the entire year.²⁶⁴ Of this number, 4,269 firms had annual receipts of less than \$10 million, while 389 firms had annual receipts between \$10 million and \$24,999,999.²⁶⁵ Based on this data, we conclude that a majority of firms in this industry are small

23. *Blood and Organ Banks.* This U.S. industry comprises establishments primarily engaged in collecting, storing, and distributing blood and blood products and storing and distributing body organs.²⁶⁶ The SBA has established a size standard for this industry, which is annual receipts of \$32.5 million or less.²⁶⁷ The 2012 U.S. Economic Census indicates that 314 firms operated in this industry throughout the entire year.²⁶⁸ Of that number, 235 operated with annual receipts of less than \$25 million, while 41 firms had annual receipts between \$25 million and \$49,999,999.²⁶⁹ Based on this data, we conclude that approximately three-quarters of firms that operate in this industry are small.

24. *All Other Miscellaneous Ambulatory Health Care Services.* This U.S. industry comprises establishments primarily engaged in providing ambulatory health care services (except offices of physicians, dentists, and other health practitioners; outpatient care centers; medical and diagnostic laboratories; home health care providers; ambulances; and blood and organ banks).²⁷⁰ The SBA has

²⁶¹ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$15 million or less.

²⁶² See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621498 “All Other Outpatient Care Centers”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621498&search=2012+NAICS+Search&search=2012>.

²⁶³ 13 CFR § 121.201 NAICS Code 621498.

²⁶⁴ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 621498, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621498.

²⁶⁵ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$20.5 million or less.

²⁶⁶ See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621991 “Blood and Organ Banks”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621991&search=2012+NAICS+Search&search=2012>.

²⁶⁷ 13 CFR § 121.201 NAICS Code 621991.

²⁶⁸ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 621991, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621991.

²⁶⁹ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$32.5 million or less.

²⁷⁰ See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621999 “All Other Miscellaneous Ambulatory Health Care Services”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621999&search=2012+NAICS+Search&search=2012>.

established a size standard for this industry, which is annual receipts of \$15 million or less.²⁷¹ The 2012 U.S. Economic Census indicates that 2,429 firms operated in this industry throughout the entire year.²⁷² Of that number, 2,318 had annual receipts of less than \$10 million, while 56 firms had annual receipts between \$10 million and \$24,999,999.²⁷³ Based on this data, we conclude that a majority of the firms in this industry are small.

25. *Medical Laboratories.* This U.S. industry comprises establishments known as medical laboratories primarily engaged in providing analytic or diagnostic services, including body fluid analysis, generally to the medical profession or to the patient on referral from a health practitioner.²⁷⁴ The SBA has established a size standard for this industry, which is annual receipts of \$32.5 million or less.²⁷⁵ The 2012 U.S. Economic Census indicates that 2,599 firms operated in this industry throughout the entire year.²⁷⁶ Of this number, 2,465 had annual receipts of less than \$25 million, while 60 firms had annual receipts between \$25 million and \$49,999,999.²⁷⁷ Based on this data, we conclude that a majority of firms that operate in this industry are small.

26. *Diagnostic Imaging Centers.* This U.S. industry comprises establishments known as diagnostic imaging centers primarily engaged in producing images of the patient generally on referral from a health practitioner.²⁷⁸ The SBA has established size standard for this industry, which is annual receipts of \$15 million or less.²⁷⁹ The 2012 U.S. Economic Census indicates that 4,209 firms operated in this industry throughout the entire year.²⁸⁰ Of that number, 3,876 firms had annual receipts of less than \$10 million, while 228 firms had annual receipts between \$10 million and \$24,999,999.²⁸¹ Based on this data, we conclude that a majority of firms that operate in this industry are small.

27. *Home Health Care Services.* This U.S. industry comprises establishments primarily engaged in providing skilled nursing services in the home, along with a range of the following: personal care services; homemaker and companion services; physical therapy; medical social services; medications; medical equipment and supplies; counseling; 24-hour home care; occupation and vocational

²⁷¹ 13 CFR § 121.201 NAICS Code 621999.

²⁷² U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 621999, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~621999.

²⁷³ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$15 million or less.

²⁷⁴ See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621511 “Medical Laboratories”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621511&search=2012+NAICS+Search&search=2012>.

²⁷⁵ 13 CFR § 121.201 NAICS Code 621511.

²⁷⁶ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 621511, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~621511.

²⁷⁷ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$32.5 million or less.

²⁷⁸ See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621512 “Diagnostic Imaging Centers”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621512&search=2012+NAICS+Search&search=2012>.

²⁷⁹ 13 CFR § 121.201 NAICS Code 621512.

²⁸⁰ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 621512, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~621512.

²⁸¹ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$15 million or less.

therapy; dietary and nutritional services; speech therapy; audiology; and high-tech care, such as intravenous therapy.²⁸² The SBA has established a size standard for this industry, which is annual receipts of \$15 million or less.²⁸³ The 2012 U.S. Economic Census indicates that 17,770 firms operated in this industry throughout the entire year.²⁸⁴ Of that number, 16,822 had annual receipts of less than \$10 million, while 590 firms had annual receipts between \$10 million and \$24,999,999.²⁸⁵ Based on this data, we conclude that a majority of firms that operate in this industry are small.

28. *Ambulance Services.* This U.S. industry comprises establishments primarily engaged in providing transportation of patients by ground or air, along with medical care. These services are often provided during a medical emergency but are not restricted to emergencies. The vehicles are equipped with lifesaving equipment operated by medically trained personnel.²⁸⁶ The SBA has established a size standard for this industry, which is annual receipts of \$15 million or less.²⁸⁷ The 2012 U.S. Economic Census indicates that 2,984 firms operated in this industry throughout the entire year.²⁸⁸ Of that number, 2,926 had annual receipts of less than \$15 million, while 133 firms had annual receipts between \$10 million and \$24,999,999.²⁸⁹ Based on this data, we conclude that a majority of firms in this industry are small.

29. *Kidney Dialysis Centers.* This U.S. industry comprises establishments with medical staff primarily engaged in providing outpatient kidney or renal dialysis services.²⁹⁰ The SBA has established a size standard for this industry, which is annual receipts of \$38.5 million or less.²⁹¹ The 2012 U.S. Economic Census indicates that 396 firms operated in this industry throughout the entire year.²⁹² Of that number, 379 had annual receipts of less than \$25 million, while 7 firms had annual receipts between \$25 million and \$49,999,999.²⁹³ Based on this data, we conclude that a majority of firms in this industry are small.

²⁸² See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621610 “Home Health Care Services”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621610&search=2012+NAICS+Search&search=2012>.

²⁸³ 13 CFR § 121.201 NAICS Code 621610.

²⁸⁴ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 621610, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~621610.

²⁸⁵*Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$15 million or less.

²⁸⁶ See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621910 “Ambulance Services”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621910&search=2012+NAICS+Search&search=2012>.

²⁸⁷ 13 CFR § 121.201 NAICS Code 621910.

²⁸⁸ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 621910, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~621910.

²⁸⁹ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$15 million or less.

²⁹⁰ See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621492 “Kidney Dialysis Centers”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621492&search=2012+NAICS+Search&search=2012>.

²⁹¹ 13 CFR § 121.201 NAICS Code 621492.

²⁹² U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 621492, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~621492.

²⁹³*Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$38.5 million or less.

30. *General Medical and Surgical Hospitals.* This U.S. industry comprises establishments known and licensed as general medical and surgical hospitals primarily engaged in providing diagnostic and medical treatment (both surgical and nonsurgical) to inpatients with any of a wide variety of medical conditions. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements. These hospitals have an organized staff of physicians and other medical staff to provide patient care services. These establishments usually provide other services, such as outpatient services, anatomical pathology services, diagnostic X-ray services, clinical laboratory services, operating room services for a variety of procedures, and pharmacy services.²⁹⁴ The SBA has established a size standard for this industry, which is annual receipts of \$38.5 million or less.²⁹⁵ The 2012 U.S. Economic Census indicates that 2,800 firms operated in this industry throughout the entire year.²⁹⁶ Of that number, 877 has annual receipts of less than \$25 million, while 400 firms had annual receipts between \$25 million and \$49,999,999.²⁹⁷ Based on this data, we conclude that approximately one-quarter of firms in this industry are small.

31. *Psychiatric and Substance Abuse Hospitals.* This U.S. industry comprises establishments known and licensed as psychiatric and substance abuse hospitals primarily engaged in providing diagnostic, medical treatment, and monitoring services for inpatients who suffer from mental illness or substance abuse disorders. The treatment often requires an extended stay in the hospital. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements. They have an organized staff of physicians and other medical staff to provide patient care services. Psychiatric, psychological, and social work services are available at the facility. These hospitals usually provide other services, such as outpatient services, clinical laboratory services, diagnostic X-ray services, and electroencephalograph services.²⁹⁸ The SBA has established a size standard for this industry, which is annual receipts of \$38.5 million or less.²⁹⁹ The 2012 U.S. Economic Census indicates that 404 firms operated in this industry throughout the entire year.³⁰⁰ Of that number, 185 had annual receipts of less than \$25 million, while 107 firms had annual receipts between \$25 million and \$49,999,999.³⁰¹ Based on this data, we conclude that more than one-half of the firms in this industry are small.

32. *Specialty (Except Psychiatric and Substance Abuse) Hospitals.* This U.S. industry consists of establishments known and licensed as specialty hospitals primarily engaged in providing diagnostic, and medical treatment to inpatients with a specific type of disease or medical condition

²⁹⁴ See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 622110 “General Medical and Surgical Hospitals”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=622110&search=2012+NAICS+Search&search=2012>.

²⁹⁵ 13 CFR § 121.201 NAICS Code 622110.

²⁹⁶ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 622110, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~622110.

²⁹⁷*Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$38.5 million or less.

²⁹⁸ See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 622210 “Psychiatric and Substance Abuse Hospitals”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=622210&search=2012+NAICS+Search&search=2012>.

²⁹⁹ 13 CFR § 121.201 NAICS Code 622210.

³⁰⁰ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 622210, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~622210.

³⁰¹*Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$38.5 million or less.

(except psychiatric or substance abuse). Hospitals providing long-term care for the chronically ill and hospitals providing rehabilitation, restorative, and adjustive services to physically challenged or disabled people are included in this industry. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements. They have an organized staff of physicians and other medical staff to provide patient care services. These hospitals may provide other services, such as outpatient services, diagnostic X-ray services, clinical laboratory services, operating room services, physical therapy services, educational and vocational services, and psychological and social work services.³⁰² The SBA has established a size standard for this industry, which is annual receipts of \$38.5 million or less.³⁰³ The 2012 U.S. Economic Census indicates that 346 firms operated in this industry throughout the entire year.³⁰⁴ Of that number, 146 firms had annual receipts of less than \$25 million, while 79 firms had annual receipts between \$25 million and \$49,999,999.³⁰⁵ Based on this data, we conclude that more than one-half of the firms in this industry are small.

33. *Emergency and Other Relief Services.* This industry comprises establishments primarily engaged in providing food, shelter, clothing, medical relief, resettlement, and counseling to victims of domestic or international disasters or conflicts (e.g., wars).³⁰⁶ The SBA has established a size standard for this industry which is annual receipts of \$32.5 million or less.³⁰⁷ The 2012 U.S. Economic Census indicates that 541 firms operated in this industry throughout the entire year.³⁰⁸ Of that number, 509 had annual receipts of less than \$25 million, while 7 firms had annual receipts between \$25 million and \$49,999,999.³⁰⁹ Based on this data, we conclude that a majority of firms in this industry are small

2. Providers of Telecommunications and Other Services

a. Telecommunications Service Providers

34. *Incumbent Local Exchange Carriers (LECs).* Neither the Commission nor the SBA has developed a small business size standard specifically for incumbent local exchange services. The closest applicable NAICS Code category is Wired Telecommunications Carriers and under the SBA size standard, such a business is small if it has 1,500 or fewer employees.³¹⁰ U.S. Census Bureau data for 2012

³⁰² See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 622310 “Specialty (Except Psychiatric and Substance Abuse) Hospitals”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=622310&search=2012+NAICS+Search&search=2012>.

³⁰³ 13 CFR § 121.201 NAICS Code 622310.

³⁰⁴ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 622310, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~622310.

³⁰⁵ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$38.5 million or less.

³⁰⁶ See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 624230 “Emergency and Other Relief Services”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=624230&search=2012+NAICS+Search&search=2012>.

³⁰⁷ 13 CFR § 121.201, NAICS Code 624230.

³⁰⁸ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS code 624230, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics~624230.

³⁰⁹ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$32.5 million or less.

³¹⁰ See, 13 CFR § 121.201. The Wired Telecommunications Carrier category formerly used the NAICS code of 517110. As of 2017 the U.S. Census Bureau definition shows the NAICS code as 517311 for Wired

(continued...)

indicates that 3,117 firms operated during that year. Of this total, 3,083 operated with fewer than 1,000 employees.³¹¹ Consequently, the Commission estimates that most providers of incumbent local exchange service are small businesses that may be affected by our actions. According to Commission data, one thousand three hundred and seven (1,307) Incumbent Local Exchange Carriers reported that they were incumbent local exchange service providers.³¹² Of this total, an estimated 1,006 have 1,500 or fewer employees.³¹³ Thus using the SBA's size standard the majority of Incumbent LECs can be considered small entities.

35. *Interexchange Carriers (IXCs)*. Neither the Commission nor the SBA has developed a definition of small entities specifically applicable to providers of interexchange services (IXCs). The closest NAICS Code category is Wired Telecommunications Carriers and the applicable size standard under SBA rules consists of all such companies having 1,500 or fewer employees.³¹⁴ U.S. Census Bureau data for 2012 indicates that 3,117 firms operated during that year.³¹⁵ Of that number, 3,083 operated with fewer than 1,000 employees.³¹⁶ According to internally developed Commission data, 359 companies reported that their primary telecommunications service activity was the provision of interexchange services.³¹⁷ Of this total, an estimated 317 have 1,500 or fewer employees.³¹⁸ Consequently, the Commission estimates that the majority of interexchange service providers that may be affected are small entities.

36. *Competitive Access Providers*. Neither the Commission nor the SBA has developed a definition of small entities specifically applicable to competitive access services providers (CAPs). The closest applicable definition under the SBA rules is Wired Telecommunications Carriers and under the size standard, such a business is small if it has 1,500 or fewer employees.³¹⁹ U.S. Census Bureau data for 2012 indicates that 3,117 firms operated during that year.³²⁰ Of that number, 3,083 operated with

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Telecommunications Carriers. See, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517311&search=2017>.

³¹¹ *Id.*

³¹² See *Trends in Telephone Service*, Federal Communications Commission, Wireline Competition Bureau, Industry Analysis and Technology Division at Table 5.3 (Sept. 2010) (*Trends in Telephone Service*).

³¹³ *Id.*

³¹⁴ See, 13 CFR § 121.201. The Wired Telecommunications Carrier category formerly used the NAICS code of 517110. As of 2017 the U.S. Census Bureau definition shows the NAICS code as 517311 for Wired Telecommunications Carriers. See, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517311&search=2017>.

³¹⁵ See U.S. Census Bureau, *2012 Economic Census of the United States*, Table No. EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms: 2012* (517110 Wired Telecommunications Carriers). https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5//naics~517110.

³¹⁶ *Id.*

³¹⁷ See *Trends in Telephone Service*, Federal Communications Commission, Wireline Competition Bureau, Industry Analysis and Technology Division at Table 5.3 (Sept. 2010) (*Trends in Telephone Service*).

³¹⁸ *Id.*

³¹⁹ See, 13 CFR § 121.201. The Wired Telecommunications Carrier category formerly used the NAICS code of 517110. As of 2017 the U.S. Census Bureau definition shows the NAICS code as 517311 for Wired Telecommunications Carriers. See, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517311&search=2017>.

³²⁰ See U.S. Census Bureau, *2012 Economic Census of the United States*, Table No. EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms: 2012* (517110 Wired Telecommunications Carriers). https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5//naics~517110.

fewer than 1,000 employees.³²¹ Consequently, the Commission estimates that most competitive access providers are small businesses that may be affected by our actions. According to Commission data the *2010 Trends in Telephone Report*, 1,442 CAPs and competitive local exchange carriers (competitive LECs) reported that they were engaged in the provision of competitive local exchange services.³²² Of these 1,442 CAPs and competitive LECs, an estimated 1,256 have 1,500 or few employees and 186 have more than 1,500 employees.³²³ Consequently, the Commission estimates that most providers of competitive exchange services are small businesses.

37. *Wired Telecommunications Carriers.* The U.S. Census Bureau defines this industry as “establishments primarily engaged in operating and/or providing access to transmission facilities and infrastructure that they own and/or lease for the transmission of voice, data, text, sound, and video using wired communications networks. Transmission facilities may be based on a single technology or a combination of technologies. Establishments in this industry use the wired telecommunications network facilities that they operate to provide a variety of services, such as wired telephony services, including VoIP services, wired (cable) audio and video programming distribution, and wired broadband internet services. By exception, establishments providing satellite television distribution services using facilities and infrastructure that they operate are included in this industry.”³²⁴ The SBA has developed a small business size standard for Wired Telecommunications Carriers, which consists of all such companies having 1,500 or fewer employees.³²⁵ U.S. Census data for 2012 shows that there were 3,117 firms that operated that year.³²⁶ Of this total, 3,083 operated with fewer than 1,000 employees.³²⁷ Thus, under this size standard, the majority of firms in this industry can be considered small.

38. *Wireless Telecommunications Carriers (except Satellite).* This industry comprises establishments engaged in operating and maintaining switching and transmission facilities to provide communications via the airwaves. Establishments in this industry have spectrum licenses and provide services using that spectrum, such as cellular services, paging services, wireless internet access, and wireless video services.³²⁸ The appropriate size standard under SBA rules is that such a business is small if it has 1,500 or fewer employees.³²⁹ For this industry, U.S. Census Bureau data for 2012 shows that there were 967 firms that operated for the entire year.³³⁰ Of this total, 955 firms had employment of 999

³²¹ *Id.*

³²² See Federal Communications Commission, Wireline Competition Bureau, Industry Analysis and Technology Division, Trends in Telephone Service at Table 5.3, page 5.5 (Sept. 2010) (*Trends in Telephone Service*), https://apps.fcc.gov/edocs_public/attachmatch/DOC-301823A1.pdf.

³²³ *Id.*

³²⁴ See 13 CFR § 120.201. The Wired Telecommunications Carrier category formerly used the NAICS code of 517110. As of 2017 the U.S. Census Bureau definition shows the NAICS code as 517311 for Wired Telecommunications Carriers. See, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517311&search=2017>.

³²⁵ *Id.*

³²⁶ See U.S. Census Bureau, *2012 Economic Census of the United States*, Table No. EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms: 2012* (517110 Wired Telecommunications Carriers). https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5//naics~517110.

³²⁷ *Id.*

³²⁸ NAICS Code 517210. See <https://factfinder.census.gov/faces/affhelp/jsf/pages/metadata.xhtml?lang=en&type=ib&id=ib.en/ECN.NAICS2012.517210>.

³²⁹ 13 CFR § 121.201, NAICS code 517210.

³³⁰ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1251SSSZ5, *Information: Subject Series: Estab and Firm Size: Employment Size of Firms for the U.S.: 2012 NAICS Code 517210* (rel. Jan. 8, 2016). https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5//naics~517210.

or fewer employees and 12 had employment of 1000 employees or more.³³¹ Thus under this category and the associated size standard, the Commission estimates that the majority of wireless telecommunications carriers (except satellite) are small entities.

39. The Commission's own data—available in its Universal Licensing System—indicate that, as of October 25, 2016, there are 280 Cellular licensees that will be affected by our actions today.³³² The Commission does not know how many of these licensees are small, as the Commission does not collect that information for these types of entities. Similarly, according to internally developed Commission data, 413 carriers reported that they were engaged in the provision of wireless telephony, including cellular service, Personal Communications Service (PCS), and Specialized Mobile Radio (SMR) Telephony services.³³³ Of this total, an estimated 261 have 1,500 or fewer employees, and 152 have more than 1,500 employees.³³⁴ Thus, using available data, we estimate that the majority of wireless firms can be considered small.

40. *Wireless Telephony.* Wireless telephony includes cellular, personal communications services, and specialized mobile radio telephony carriers. The closest applicable SBA category is Wireless Telecommunications Carriers (except Satellite)³³⁵ and the appropriate size standard for this category under the SBA rules is that such a business is small if it has 1,500 or fewer employees.³³⁶ For this industry, U.S. Census Bureau data for 2012 shows that there were 967 firms that operated for the entire year.³³⁷ Of this total, 955 firms had fewer than 1,000 employees and 12 firms has 1000 employees or more.³³⁸ Thus under this category and the associated size standard, the Commission estimates that a majority of these entities can be considered small. According to Commission data, 413 carriers reported that they were engaged in wireless telephony.³³⁹ Of these, an estimated 261 have 1,500 or fewer employees and 152 have more than 1,500 employees.³⁴⁰ Therefore, more than half of these entities can be considered small.

41. *Satellite Telecommunications.* This category comprises firms “primarily engaged in providing telecommunications services to other establishments in the telecommunications and broadcasting industries by forwarding and receiving communications signals via a system of satellites or

³³¹ *Id.* Available census data does not provide a more precise estimate of the number of firms that have employment of 1,500 or fewer employees; the largest category provided is for firms with “1000 employees or more.”

³³² See <http://wireless.fcc.gov/uls>. For the purposes of this IRFA, consistent with Commission practice for wireless services, the Commission estimates the number of licensees based on the number of unique FCC Registration Numbers.

³³³ See Federal Communications Commission, Wireline Competition Bureau, Industry Analysis and Technology Division, Trends in Telephone Service at Table 5.3 (Sept. 2010) (*Trends in Telephone Service*), https://apps.fcc.gov/edocs_public/attachmatch/DOC-301823A1.pdf.

³³⁴ See *id.*

³³⁵ 13 CFR § 121.201, NAICS code 517210.

³³⁶ *Id.*

³³⁷ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1251SSSZ5, Information: Subject Series: Estab and Firm Size: Employment Size of Firms for the U.S.: 2012 NAICS Code 517210 (rel. Jan. 8, 2016). https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5/naics~517210.

³³⁸ *Id.* Available census data do not provide a more precise estimate of the number of firms that have employment of 1,500 or fewer employees; the largest category provided is for firms with “1000 employees or more.”

³³⁹ See Federal Communications Commission, Wireline Competition Bureau, Industry Analysis and Technology Division, Trends in Telephone Service at Table 5.3 (Sept. 2010) (*Trends in Telephone Service*), https://apps.fcc.gov/edocs_public/attachmatch/DOC-301823A1.pdf.

³⁴⁰ *Id.*

reselling satellite telecommunications.”³⁴¹ Satellite telecommunications service providers include satellite and earth station operators. The category has a small business size standard of \$32.5 million or less in average annual receipts, under SBA rules.³⁴² For this category, U.S. Census Bureau data for 2012 shows that there were a total of 333 firms that operated for the entire year.³⁴³ Of this total, 299 firms had annual receipts of less than \$25 million.³⁴⁴ Consequently, we estimate that the majority of satellite telecommunications providers are small entities.

42. *All Other Telecommunications.* The “All Other Telecommunications” category is comprised of establishments that are primarily engaged in providing specialized telecommunications services, such as satellite tracking, communications telemetry, and radar station operation.³⁴⁵ This industry also includes establishments primarily engaged in providing satellite terminal stations and associated facilities connected with one or more terrestrial systems and capable of transmitting telecommunications to, and receiving telecommunications from, satellite systems.³⁴⁶ Establishments providing Internet services or voice over Internet protocol (VoIP) services via client-supplied telecommunications connections are also included in this industry.³⁴⁷ The SBA has developed a small business size standard for “All Other Telecommunications,” which consists of all such firms with gross annual receipts of \$32.5 million or less.³⁴⁸ For this category, U.S. Census Bureau data for 2012 shows that there were 1,442 firms that operated for the entire year.³⁴⁹ Of these firms, a total of 1,400 had gross annual receipts of less than \$25 million and 42 firms had gross annual receipts of \$25 million to \$49, 999,999.³⁵⁰ Thus, the Commission estimates that a majority of “All Other Telecommunications” firms potentially affected by our action can be considered small.

b. Internet Service Providers

43. *Internet Service Providers (Broadband).* Broadband Internet service providers include wired (e.g., cable, DSL) and VoIP service providers using their own operated wired telecommunications infrastructure fall in the category of Wired Telecommunication Carriers.³⁵¹ Wired Telecommunications Carriers are comprised of establishments primarily engaged in operating and/or providing access to transmission facilities and infrastructure that they own and/or lease for the transmission of voice, data, text, sound, and video using wired telecommunications networks. Transmission facilities may be based on

³⁴¹ U.S. Census Bureau, 2017 NAICS Definitions, “517410 Satellite Telecommunications”; <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=517410&search=2017+NAICS+Search&search=2017>.

³⁴² 13 CFR § 121.201, NAICS code 517410.

³⁴³ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1251SSSZ4, Information: Subject Series - Estab and Firm Size: Receipts Size of Firms for the United States: 2012, NAICS code 517410 https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ4/naics~517410.

³⁴⁴ *Id.*

³⁴⁵ See U.S. Census Bureau, 2017 NAICS Definitions, NAICS Code “517919 All Other Telecommunications”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=517919&search=2017+NAICS+Search&search=2017>.

³⁴⁶ *Id.*

³⁴⁷ *Id.*

³⁴⁸ 13 CFR 121.201; NAICS Code 517919.

³⁴⁹ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1251SSSZ4, Information: Subject Series - Estab and Firm Size: Receipts Size of Firms for the United States: 2012, NAICS code 517919, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ4/naics~517919.

³⁵⁰ *Id.*

³⁵¹ See, 13 CFR § 121.201. The Wired Telecommunications Carrier category formerly used the NAICS code of 517110. As of 2017 the U.S. Census Bureau definition show the NAICs code as 517311. See, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517311&search=2017>

a single technology or a combination of technologies.³⁵² The SBA size standard for this category classifies a business as small if it has 1,500 or fewer employees.³⁵³ U.S. Census Bureau data for 2012 shows that there were 3,117 firms that operated that year. Of this total, 3,083 operated with fewer than 1,000 employees.³⁵⁴ Consequently, under this size standard the majority of firms in this industry can be considered small.

44. *Internet Service Providers (Non-Broadband)*. Internet access service providers such as Dial-up Internet service providers, VoIP service providers using client-supplied telecommunications connections and Internet service providers using client-supplied telecommunications connections (e.g., dial-up ISPs) fall in the category of All Other Telecommunications. The SBA has developed a small business size standard for All Other Telecommunications which consists of all such firms with gross annual receipts of \$32.5 million or less.³⁵⁵ For this category, U.S. Census Bureau data for 2012 shows that there were 1,442 firms that operated for the entire year. Of these firms, a total of 1,400 had gross annual receipts of less than \$25 million.³⁵⁶ Consequently, under this size standard a majority of firms in this industry can be considered small.

c. Vendors and Equipment Manufacturers

45. *Vendors of Infrastructure Development or “Network Buildout.”* The Commission has not developed a small business size standard specifically directed toward manufacturers of network facilities. There are two applicable SBA categories in which manufacturers of network facilities could fall and each have different size standards under the SBA rules. The SBA categories are “Radio and Television Broadcasting and Wireless Communications Equipment” with a size standard of 1,250 employees or less³⁵⁷ and “Other Communications Equipment Manufacturing” with a size standard of 750 employees or less.³⁵⁸ U.S. Census Bureau data for 2012 shows that for Radio and Television Broadcasting and Wireless Communications Equipment firms 841 establishments operated for the entire year.³⁵⁹ Of that number, 828 establishments operated with fewer than 1,000 employees, 7 establishments operated with between 1,000 and 2,499 employees and 6 establishments operated with 2,500 or more employees.³⁶⁰ For Other Communications Equipment Manufacturing, U.S. Census Bureau data for 2012 shows that 383 establishments operated for the year.³⁶¹ Of that number 379 firms operated with fewer than 500 employees and 4 had 500 to 999 employees. Based on this data, we conclude that the majority of Vendors of Infrastructure Development or “Network Buildout” are small.

³⁵² *Id.*

³⁵³ *Id.*

³⁵⁴ http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ECN_2012_US_51SSSZ2&prodType=table.

³⁵⁵ 13 CFR § 121.201; NAICS Code 517919.

³⁵⁶ http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ECN_2012_US_51SSSZ4&prodType=table.

³⁵⁷ 13 CFR § 121.201, NAICS Code 334220.

³⁵⁸ 13 CFR § 121.201, NAICS Code 334290.

³⁵⁹ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012, NAICS Code 334220, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2//naics~334220.

³⁶⁰ *Id.*

³⁶¹ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012, NAICS Code 334290, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2//naics~334290.

46. *Telephone Apparatus Manufacturing.* This industry comprises establishments primarily engaged in manufacturing wire telephone and data communications equipment. These products may be standalone or board-level components of a larger system. Examples of products made by these establishments are central office switching equipment, cordless telephones (except cellular), PBX equipment, telephones, telephone answering machines, LAN modems, multi-user modems, and other data communications equipment, such as bridges, routers, and gateways.³⁶² The SBA size standard for Telephone Apparatus Manufacturing is all such firms having 1,250 or fewer employees.³⁶³ According to U.S. Census Bureau data for 2012, there were a total of 266 establishments in this category that operated for the entire year.³⁶⁴ Of this total, 262 had employment of under 1,000, and an additional 4 had employment of 1,000 to 2,499.³⁶⁵ Thus, under this size standard, the majority of firms can be considered small.

47. *Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing.* This industry comprises establishments primarily engaged in manufacturing radio and television broadcast and wireless communications equipment.³⁶⁶ Examples of products made by these establishments are: transmitting and receiving antennas, cable television equipment, GPS equipment, pagers, cellular phones, mobile communications equipment, and radio and television studio and broadcasting equipment.³⁶⁷ The SBA has established a small business size standard for this industry of 1,250 employees or less.³⁶⁸ U.S. Census Bureau data for 2012 shows that 841 establishments operated in this industry in that year.³⁶⁹ Of that number, 828 establishments operated with fewer than 1,000 employees, 7 establishments operated with between 1,000 and 2,499 employees and 6 establishments operated with 2,500 or more employees.³⁷⁰ Based on this data, we conclude that a majority of manufacturers in this industry are small.

48. *Other Communications Equipment Manufacturing.* This industry comprises

³⁶² U.S. Census Bureau, 2012 NAICS Definitions, “334210 Telephone Apparatus Manufacturing”; <https://factfinder.census.gov/faces/affhelp/jsf/pages/metadata.xhtml?lang=en&type=ib&id=ib.en./ECN.NAICS2012.334210#>.

³⁶³ 13 CFR § 121.201, NAICS code 334210.

³⁶⁴ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012, NAICS Code 334210, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2//naics~334210. The number of “establishments” is a less helpful indicator of small business prevalence in this context than would be the number of “firms” or “companies,” because the latter take into account the concept of common ownership or control. Any single physical location for an entity is an establishment, even though that location may be owned by a different establishment. Thus, the numbers given may reflect inflated numbers of businesses in this category, including the numbers of small businesses. In this category, the Census data for firms or companies only gives the total number of such entities for 2012, which was 250. *See also* https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG1//naics~334210.

³⁶⁵ *Id.* An additional 4 establishments had employment of 2,500 or more.

³⁶⁶ The NAICS Code for this service is 334220. 13 C.F.R 121.201. *See also* U.S. Census Bureau, 2012 NAICS Definitions, “334220 Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing” <https://factfinder.census.gov/faces/affhelp/jsf/pages/metadata.xhtml?lang=en&type=ib&id=ib.en./ECN.NAICS2012.334220#>.

³⁶⁷ *Id.*

³⁶⁸ 13 CFR § 121.201, NAICS Code 334220.

³⁶⁹ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012, NAICS Code 334220, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2//naics~334220.

³⁷⁰ *Id.*

establishments primarily engaged in manufacturing communications equipment (except telephone apparatus, and radio and television broadcast, and wireless communications equipment).³⁷¹ Examples of such manufacturing include fire detection and alarm systems manufacturing, Intercom systems and equipment manufacturing, and signals (e.g., highway, pedestrian, railway, traffic) manufacturing.³⁷² The SBA has established a size for this industry as all such firms having 750 or fewer employees.³⁷³ U.S. Census Bureau data for 2012 shows that 383 establishments operated in that year.³⁷⁴ Of that number 379 operated with fewer than 500 employees and 4 had 500 to 999 employees.³⁷⁵ Based on this data, we conclude that the majority of Other Communications Equipment Manufacturers are small.

D. Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements for Small Entities

49. The reporting, recordkeeping, and other compliance requirements proposed in this NPRM likely would positively and negatively financially impact both large and small entities, including healthcare providers and service providers, and any resulting financial burdens may disproportionately impact small entities given their typically more limited resources. In weighing the likely financial benefits and burdens of our proposed requirements, however, we have determined that our proposed changes would result in more equitable, effective, efficient, clear, and predictable distribution of RHC support, far outweighing any resultant financial burdens on small entity participants.

50. *Provision of Rate Information in the Telecom Program.* Because the service provider can most easily access rate information, we propose that both the rural and urban rates used in the discount calculation be provided by the service provider to the HCP and submitted by the HCP in its application.

51. *Application Documentation.* We propose to require Telecom Program applicants to provide, contemporaneously with their requests for services (*i.e.*, FCC Form 465 and/or RFPs), certifications attesting to their compliance with Telecom Program rules; bid evaluation criteria and worksheets demonstrating how they will select a service provider; and a declaration of assistance (if applicable). We seek comment on this proposal and whether requiring such information would be burdensome for applicants.

52. *Consultant and Invoicing Requirements.* To harmonize the Commission's rules under the Telecom and HCF Programs, and to ensure sufficient program oversight, efficiency, and certainty, we propose a new rule in the Telecom Program containing a "declaration of assistance" requirement similar to that in the HCF Program. We also propose a new rule establishing the same six-month invoicing deadline for the Telecom Program as that applicable in the HCF Program.

53. *Unifying Data Collection on RHC Program Support Impact.* As we seek to better monitor RHC Program effectiveness, we seek comment on whether all RHC Program participants should report on the telehealth applications (e.g., tele-psychiatry, tele-stroke, transmission of EHRs, etc.) they provide over the supported communications services. Currently, only healthcare providers participating in HCF consortia are required to report annually about the telehealth applications they provide over their supported connections.

³⁷¹ U.S. Census Bureau, 2017 NAICS Definitions, NAICS Code "334290 Other Communications Equipment Manufacturing"; <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=334290&search=2017+NAICS+Search&search=2017>.

³⁷² *Id.*

³⁷³ 13 CFR § 121.201, NAICS code 334290.

³⁷⁴ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012, NAICS Code 334290, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2//naics~334290.

³⁷⁵ *Id.*

E. Steps Taken to Minimize the Significant Economic Impact on Small Entities, and Significant Alternatives Considered

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

55. As indicated above, in this NPRM, while we propose several changes that could increase the economic burden on small entities, we also propose many changes that would streamline and simplify the application process; maximize efficient and fair distribution of support; and increase support for small entities relative to their larger counterparts, thereby decreasing the net economic burden on small entities. In the instances in which a proposed change would increase the financial burden on small entities, we have determined that the net financial and other benefits from such changes would outweigh the increased burdens on small entities.

56. *Addressing RHC Program Funding Levels.* To increase RHC program support, and thereby increase support available for rural, mostly small, healthcare providers, we seek comment on several measures, including whether to: (1) prospectively increase the \$400 million annual RHC Program support cap, such as *via* an inflation adjustment or some other method; (2) retroactively increase the FY 2017 RHC Program support cap; and (3) “roll over” unused funds committed in one funding year into a subsequent funding year.

57. *Prioritizing Funding if Demand Reaches the Cap.* To more appropriately target RHC support if demand exceeds the \$400 million annual cap, we seek comment on whether to prioritize funding requests from HCPs based on: rurality or remoteness of the area served; which Program (Telecom or HCF); type of services requested; economic need of the population served; and/or health care professional shortage area status.

58. *Targeting Support to Rural and Tribal HCPs.* Recognizing that the primary emphasis of the RHC Program is to defray the cost of supported services for *rural* HCPs, which most often are small HCPs, we seek comment on increasing the HCF Program consortia “majority rural” HCP requirement from a “more than 50 percent rural HCPs” threshold to some higher percentage. We also seek comment on eliminating the three-year grace period during which HCF consortia may come into compliance with the “majority rural” requirement. Additionally, we seek comment on requiring a direct healthcare-related relationship between a consortium’s non-rural and rural healthcare providers. And, we seek comment from Tribal governments in particular on whether these proposals would impact Tribal populations, and what other measures would help ensure that adequate Telecom and HCF Program support is directed toward rural HCPs on Tribal lands.

59. *Controlling Outlier Costs.* To ensure efficient and equitable funding distribution, we seek comment on establishing objective benchmarks to identify and scrutinize particularly high funding requests in the Telecom Program, using information already provided by participants to USAC. As an alternative to this proposed enhanced review, we seek comment on capping high-support funding requests in the Telecom Program to enable funding distribution to more HCPs.

60. *Rate Calculations.* To minimize potential rate variances and manipulations, we seek comment on establishing more detailed requirements about how the urban and rural rates are determined in the Telecom Program. We also propose to eliminate the Telecom Program’s distance-based support calculation approach in light of its limited use and the administrative benefits for HCPs and service providers that would result from using one standardized support calculation methodology.

61. *Defining “Cost Effective.”* To improve Program uniformity and safeguard against wasteful or abusive spending, we seek comment on defining “cost-effectiveness” in both Programs as the

“lowest-price service that meets the minimum requirements for the products and services that are essential to satisfy the communications needs of the applicant.”

62. *Clarification of Gift Prohibition.* To provide clarity to RHC Program participants and ensure a fair competitive bidding process, we propose to codify a gift rule similar to the E-rate Program rule, which, consistent with the gift rules applicable to federal agencies, permits only certain *de minimis* gifts from service providers to applicants. While gifts from service providers to RHC Program applicants already are considered to be violations of the Commission’s competitive bidding rules, we believe that codifying the existing gift prohibition will provide applicants and service providers with enhanced clarity and understanding of this safeguard on program integrity.

63. *Streamlining and Harmonizing the Application Process.* To streamline the application process and reduce the administrative burden upon applicants, we propose that applicants use consolidated forms for both the Telecom and HCP Programs (Eligibility, Request for Services, Request for Funding, and Invoicing/Funding Disbursement), instead of the current requirement that separate forms be used for each program. To harmonize the Commission’s Telecom and HCF Program rules and to ensure sufficient program oversight, efficiency, and certainty, we propose a new rule in the Telecom Program containing a “declaration of assistance” requirement similar to that in the HCF Program. We also propose a new rule establishing the same six-month invoicing deadline for the Telecom Program as that applicable in the HCF Program.

64. *Competitive Bidding Requirements.* To enhance RHC Program transparency and increase administrative efficiency, we propose to align the “fair and open” competitive bidding standard applied in each program by codifying this standard in the Telecom Program. While this standard is codified in HCF Program rules, it is not yet codified in Telecom Program rules, although numerous Commission orders clearly state that a Telecom Program applicant must conduct a fair and open competitive bidding process prior to submitting a funding request.

65. *Competitive Bidding Exemptions.* We propose to harmonize the Commission’s rules that exempt certain applicants from the competitive bidding requirements in the Telecom and HCF Programs. Currently, there are five exemptions to the HCF Program’s competitive bidding requirements: (1) applicants purchasing services and/or equipment from master services agreements (MSAs) negotiated by federal, state, Tribal, or local government entities on behalf of such applicants; (2) applicants purchasing services and/or equipment from an MSA that was subject to the HCF and Pilot Program competitive bidding requirements; (3) applicants seeking support under a contract deemed “evergreen” by USAC; and (4) applicants seeking support under an E-rate contract that was competitively bid consistent with E-rate Program rules. With the exception of “evergreen” contracts, none of these exemptions apply in the Telecom Program. We therefore seek comment on whether to apply these exemptions, or variants thereof, to the Telecom Program, and ask whether other situations may warrant competitive bidding exemptions. In addition, to improve uniformity across both Programs, we propose to codify the existing “evergreen” contract exemption in the Telecom Program.

66. *Competitive Bidding Documentation.* To harmonize the Telecom Program’s competitive bidding documentation requirements with those in the HCF Program, which should simplify the application process for HCPs and service providers, we propose to require Telecom Program applicants to provide, contemporaneously with their requests for services (*i.e.*, FCC Forms 465 and/or RFPs), certifications attesting to their compliance with Telecom Program rules; bid evaluation criteria and worksheets demonstrating how they will select a service provider; and a declaration of assistance (if applicable). We seek comment on this proposal and whether requiring such information would be burdensome for applicants.

67. *Funding Request Supporting Documentation.* To improve uniformity and transparency across both Programs, we propose to codify the existing requirement that applicants provide supporting documentation with their funding requests in the Telecom Program. While this requirement is codified in the Commission’s rules for the HCF Program, there is not yet an analogous rule under the Telecom Program.

68. *Funding Request Filing Windows.* In light of RHC Program growth and the potential for FY 2016 demand to exceed the \$400 million cap before the end of FY 2016, the Wireline Competition Bureau (Bureau) established multiple filing window periods for FY 2016 and beyond, consistent with the Commission's rules. By establishing multiple filing window periods, the Bureau provided a mechanism for USAC to more efficiently administer the Program and process requests while providing an incentive for applicants to timely submit their funding requests. Additionally, the Bureau found that filing window periods provide a greater opportunity for HCPs to receive at least some support rather than none at all, even when demand exceeds the cap. We propose to continue the filing-window process and believe that it furthers our goals of supporting health care delivery in as many parts of rural America as possible and more efficiently managing the application process.

69. *Companion Order to Carry Forward Unused Support and Allow Voluntary Price Reductions.* In addition to the NPRM's proposed changes that, if adopted, would minimize the net economic burden on small entities, we also take targeted, immediate action in the attached Order to mitigate the potential negative impact of the existing RHC Program annual support cap on rural, usually small, healthcare providers in FY 2017. Specifically, in the event of a proration of FY 2017 RHC support, we direct USAC to carry forward for use in FY 2017 any available RHC Program funds from prior funding years and, on a one-time basis, commit these funds to rural, typically small, healthcare providers participating in the RHC Program in FY 2017. The companion Order also permits, in the event of FY 2017 support proration, service providers to reduce their service prices charged to participating healthcare providers and thereby further minimize the negative financial impact of a FY 2017 proration on participating healthcare providers.

F. Federal Rules that May Duplicate, Overlap, or Conflict with the Proposed Rules

70. None.

**STATEMENT OF
CHAIRMAN AJIT PAI**

Re: *Promoting Telehealth in Rural America*, WC Docket No. 17-310.

Often in the early mornings, starting in the late 1970s, a urologist in the small town of Parsons, Kansas would hit the road. He would drive long distances across southeast Kansas to make sure that patients in surrounding small communities could see a specialist who could help them. That was my dad. And even into adulthood, I remain amazed at the road miles he's logged.

It's becoming harder to recruit doctors to serve rural communities. It's becoming harder to keep rural hospitals afloat. And so it's becoming harder for many rural patients to get health care—ironically, at a moment when vital signs for those patients and rural America generally are suggesting trouble.

That's what makes the combination of the Internet and rural medicine—call it telemedicine or telehealth if you like—so critical. With a broadband connection, health care providers in small-town America can deliver the same quality of health care as those in our nation's big cities.

The FCC can and does promote this potential. Our Rural Health Care program helps health care providers afford the connectivity that they need to better serve patients. But it's facing some real problems.

First, the program is oversubscribed. The yearly demand for funding now exceeds the annual spending cap. And second, there may be substantial waste, fraud, and abuse in the program. Recent enforcement activity has shown it is all too easy for unscrupulous companies to manipulate the system for their own profit at the expense of the American taxpayer and the rural health care providers that truly need support.

So in this *Notice*, we tackle two key issues: what size the program should be going forward, and how it can function more efficiently. Every dollar in this program needs to be stretched as far as possible to help those in need in places like Southeast Kansas.

Thank you to the staff who have worked on this item. Specifically, Dana Bradford, Regina Brown, Soumitra Das, MaryBeth DeLuca, Trent Harkrader, Radhika Karmarker, Dev Kori, Paul Lafontaine, Belford Lawson, Billy Layton, Jonathan Lechter, Travis Litman, Rick Mallen, Elizabeth McCarthy, Maura McGowan, Avis Mitchell, Kris Monteith, Linda Oliver, Ryan Palmer, Rakesh Patel, Carol Pomponio, Eric Ralph, Bill Richardson, Arielle Roth, David Sobotkin, Geoffrey Waldau, and Preston Wise.

**STATEMENT OF
COMMISSIONER MIGNON L. CLYBURN**

Re: *Promoting Telehealth in Rural America*, WC Docket No. 17-310.

When a patient is presenting symptoms of a stroke, physicians have a saying: “time is brain.” Minutes can make the difference between full recovery and severe, permanent damage. That is why the University of Virginia Hospital System has put telestroke functionality in ambulances. By ensuring life-saving treatment can begin immediately, the program ensures that strokes are caught at the absolute earliest possible time. This advanced technology would not have been deployed organically, according to the system’s Director of Telehealth. As the Director stated just a few months ago, “[a]bsent the Rural Healthcare program, our ability to provide these services would be severely constrained.”

Whether it is telepsychiatry solutions for individuals in need of help, or the enabling of remote radiology readings to promote and speed the quality of healthcare, the FCC’s Rural Healthcare program has been a key plank undergirding the modernization of healthcare delivery.

Unfortunately, as the FCC’s own Connect2Health Task Force has found, “[m]ost of the counties with the worst access to primary care physicians are also the least connected.” And this holds true both in urban and rural areas: that vulnerable urban grandmother who spends over two hours on the local bus system to see a doctor can benefit just as much from telehealth as her rural counterpart. We need to do better as a country, and that can start with a fresh look at our Rural Healthcare program.

Everyone stands to benefit if our Rural Healthcare program matches the needs of healthcare providers with the patients who rely on them. That means looking at everything from top-line funding levels to the nuts and bolts of program administration. The potential here is huge if we simultaneously reduce healthcare expenditures and improve patient outcomes, but we must get it right.

That is why I am pleased my colleagues agreed to include further lines of questioning in the Notice of Proposed Rulemaking. We expand the inquiry to seek comment on how we can incorporate what we have learned from our Connect2Health Task Force.

We look at how best to improve transparency, and on how to equitably administer the program in the event funding requests cause us to hit the cap again. And, we look to understand whether and how to support remote monitoring consistent with our statutory mandate.

I always say that we need to make the business case for each and every one of our policies. This Rural Health Care Program is one where making the business case is incredibly easy. The program saves lives, reduces costs, and results in a healthier nation. Telemedicine consults with high-risk mothers result in an almost 40% reduction in the amount of infant days in the NICU, and it is here, especially, where the value proposition is both precious and crystal clear.

This item has my enthusiastic support.

Thanks to the Wireline Competition Bureau for your thoughtful work on reforming the Rural Healthcare Fund. I look forward to continuing to engage with you as we move towards developing an Order that will be a major driver in improving access and outcomes when it comes to healthcare in America.

**STATEMENT OF
COMMISSIONER MICHAEL O'RIELLY**

Re: *Promoting Telehealth in Rural America*, WC Docket No. 17-310.

I welcome this proceeding to update the Rural Health Care program. I have seen firsthand the role that the program can play in promoting the health and safety of Americans in some of the most remote parts of the country. One of my first trips as a new Commissioner was to Alaska, a telemedicine pioneer and hot spot by necessity. As I traveled to isolated villages accessible only by air, I saw health aides use what I've called "technology triage" to assess patients and forward relevant health information to larger facilities in regional cities and Anchorage. Through this connectivity, many patients can be monitored and treated remotely. At other times, the information is used to determine whether a patient needs to be air lifted for treatment as far away as Seattle, which can come at great cost and health risk to the patient. This is how I envisioned the program working, but it was powerful to experience it in person and I wish more of our good staff could have the same opportunity. For this reason, I remain cautious when suggestions are made to take funding from a portion of the U.S. that is unlike any other in our Union.

While that experience helped illustrate the benefits of the program, I have also had a chance to witness its shortcomings. For years, regulators and recipients complained that the program was underutilized, meaning it didn't spend every last dollar allowed under a set budget cap. Therefore, a prior Commission expanded the program to include broadband and marketed the heck out of it. Pushing dollars out the door quickly took precedence over cost-effectiveness and, not surprisingly, spending increased rapidly. To be sure, most of this funding has been used for the intended purposes – to provide discounted connectivity to rural health care providers, improving access for more consumers. However, in some cases, it has been used to buy more capacity than what's actually needed, overbuild other rural providers, and connect sites that were not originally intended to be part of the program.

I implored the last Chairman to put a plan in place to address the spending increases, but my requests were ignored. Now, demand exceeds the cap and we are left playing catch up. However, that cannot be an excuse to spend more and reform later.

Fortunately, the Notice seeks comment on ways to root out inefficiencies and target support where it is needed most. Indeed, I am pleased to see cost-saving ideas from other programs included in this Notice. In particular, the item seeks comment on excluding certain expenses outright, examining whether services are "used and useful," and capping or limiting support that exceeds a specified threshold or reasonable comparability benchmark – issues I've spent a great deal of time on in the high-cost program. In fact, I think we are getting real close to announcing new limitations on the extraneous uses of ratepayer funding by rate-of-return providers. The item also seeks comment on prioritizing certain areas, including based on economic need, which sounds a lot like the means-testing concept that Commissioner Clyburn and I have urged the Commission to at least seek comment on in the high-cost program.

At the same time, the Notice does ask about increasing the spending cap above the current \$400 million. I have several concerns with such an approach. As a threshold matter, it is my hope that improving program efficiency and targeting of the funds will obviate or at least decrease the need for more of it.

In addition, there seems to be an underlying assumption by some that the budget should be set based solely on health care demand. That's simply not the right approach. We are not a health care agency and we really aren't even part of that realm. What we do through the Rural Health Care program can help provide savings on the health care side, but we do not have insight into that nor do we recoup any of the savings to help offset our costs. Our job, according to the statute, is to provide a *discount* to

help make *already available service* more affordable. Funding new networks that potentially overlap and undermine existing infrastructure is expensive and can be wasteful.

We have to keep in mind that the federal universal service program is already authorized to spend approximately *\$11 billion* per year. And, there is no shortage of requests for additional funding as recipients from each of the four programs have requested even more. Instead of looking holistically and finding the necessary offsets, the Commission has tended to increase funding at the expense of consumers.

It is time for the Commission to decide how much we reasonably and justifiably should take from ratepayers then set an overall budget for USF and individual program budgets accordingly. Just recently, some suggested that a separate Commission action was akin to a tax on consumers, but this actually is one, if not officially labeled as such. Hard working Americans and businesses are charged extra fees on their phone bills in order to fund these programs. There must be a limit on how much we are willing to take from them – no matter how meritorious the spending could be. So, let me be clear: I will be extremely reluctant to increase the budget of the Rural Health Care program in any final item without corresponding spending reductions elsewhere.

I thank the Chairman and staff for working with me to include additional questions on the impact of funding increases on consumers. I am also pleased that the Order makes clear that any price reductions undertaken by service providers to help address the current shortfall will be completely voluntary. I vote to approve.

**STATEMENT OF
COMMISSIONER BRENDAN CARR**

Re: *Promoting Telehealth in Rural America*, WC Docket No. 17-310.

At the FCC, we are focusing a lot of our efforts on closing the digital divide. One area where that divide is particularly stark is healthcare. Americans living in rural communities are falling behind when it comes to the availability of high-quality care. It is difficult to impossible to find specialists in many rural communities, and even basic care is often out of reach, as we see rural hospitals closing by the dozen across the country.

The FCC's Rural Health Care program can help make a difference. This program uses money that consumers pay into the Universal Service Fund to subsidize the costs of broadband and other connectivity that consumers in rural communities need for telemedicine and other advanced healthcare services.

But unfortunately, this program is not living up to its potential. Our rules and the incentives they create are not serving the best interests of rural healthcare providers, the communities that depend on them, or the consumers that pay into the Universal Service Fund.

At a time when the program is more important than ever to a growing number of rural communities, it has been heading in the wrong direction. In what is known as the telecom portion of the program, we've been spending more money to serve fewer and fewer healthcare institutions. Over the last three years, for example, the number of participants in the program dropped by 36% while requests for funding grew by more than 67%. This means that limited program dollars are starting to concentrate in a small number of healthcare providers that are receiving increasingly large subsidies. Indeed, in 2016, just 5% of the participating healthcare providers received more than half of the available support.

In addition to concentrating USF support in fewer communities, the program's trend lines are unsustainable for another reason. It does not encourage or incentivize prudent spending. The 5% of providers that now receive the lion's share of support are getting discounts of over 99% on their services. And the effective program discount has risen from 72% in 2011 to 95% last year. It is no surprise, then, that demand exceeded the program's budget for the first time in 2016 and that we are expecting to see the same outcome in 2017.

So I am glad that the Commission is launching this proceeding to review the program. It is important that our rules incentivize the wise and prudent spending of program funds, while ensuring that more Americans, regardless of where they live, have access to advanced telehealth services. As part of this inquiry, I am pleased that we are now seeking comment on whether to adopt speed or other service benchmarks to ensure that supported services can in fact be used to bring telehealth offerings to rural communities. With this and the range of other questions we tee up, I am confident that we can craft rules that will promote efficient purchasing decisions.

In the interim, I support our decision to provide some immediate relief to healthcare providers that could otherwise face unexpected costs if the program exceeds its budget cap again this year. By waiving our rules, we allow service providers to voluntarily reduce their rates, which can help ensure that rural communities continue to receive service.

Thanks to the staff of the Wireline Competition Bureau for your work on this item. It has my support and I look forward to reviewing the record as it develops.

**STATEMENT OF
COMMISSIONER JESSICA ROSENWORCEL**

Re: *Promoting Telehealth in Rural America*, WC Docket No. 17-310.

I've seen the future . . . through a pair of virtual reality goggles as alarms were blaring in my ears and supervising physicians were urging me to administer CPR in order to save a patient. I am not doctor, nor do I play one on television. But I got to see the future of medical care at the Simulation Training and Education Lab in Northwest Washington, where video game developers work hand-in-hand with researchers and clinicians to develop training for the MedStar health system. It turns out virtual reality can improve training by leaps and bounds, reducing real-world errors and improving patient outcomes. This is especially true for practitioners in rural and remote areas who lack the resources for regular in-person consultation and training with colleagues.

But virtual reality requires bandwidth—lots of it. Yet today, the Commission program dedicated to ensuring that bandwidth reaches rural health care providers is stretched thin and about to break. There's an honest reason for that. When this program got its start two decades ago, neither connectivity nor medicine looked much like they do today. Virtual reality, prescription vending machines controlled by doctors at a distance, and electronic health records were the stuff of science fiction. But as I saw at the lab in Washington, today it's become standard medical training and practice.

That is why I am pleased to support today's rulemaking. It examines how to future proof the Commission's Rural Healthcare Program. At the same time, it seeks comment on how to responsibly manage the program budget and, to this end, it asks important questions about prioritization. It also seeks comment on improving incentives to promote more efficient decision-making among funding recipients. I look forward to the record that develops. I also look forward to seeing how we can use this program to speed the way for the future of medical care. That would be good news for both patients and practitioners—especially in rural America.