



6712-01

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 54

[WC Docket No. 17-310; FCC 17-164]

Promoting Telehealth in Rural America

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: In this document, the Federal Communications Commission (Commission) proposes measured steps as part of a Notice of Proposed Rulemaking and Order to ensure that rural healthcare providers get the support they need while guarding against waste, fraud, and abuse, considers a series of measures to ensure the Rural Health Care (RHC) Program operates efficiently and considers the appropriate size of the funding cap. The Commission takes targeted, immediate action in the Order section of the item to mitigate the impact of the existing RHC Program cap on rural healthcare providers in funding year (FY) 2017. Because the Order section does not establish any final rules, we do not incorporate the Order section in this document.

DATES: Comments are due **[INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]**, and reply comments are due on or before **[INSERT DATE 45 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]**. If you anticipate that you will be submitting comments, but find it difficult to do so within the period of time allowed by this document, you should advise the contact listed below as soon as possible.

ADDRESSES: You may submit comments, identified by WC Docket No. 17-310, by any of the following methods:

- Federal eRulemaking Portal: <http://www.regulations.gov>. Follow the instructions for submitting comments.

- Federal Communications Commission’s Web Site: <http://apps.fcc.gov/ecfs/>. Follow the instructions for submitting comments.
- People with Disabilities: Contact the FCC to request reasonable accommodations (accessible format documents, sign language interpreters, CART, etc.) by e-mail: FCC504@fcc.gov or phone: (202) 418-0530 or TTY: (202) 418-0432.

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

FOR FURTHER INFORMATION CONTACT: Radhika Karmarkar, Wireline Competition Bureau, (202) 418-7400 or TTY: (202) 418-0484.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission’s Notice of Proposed Rulemaking (NPRM) in WC Docket No. 17-310; FCC 17-164, adopted on December 14, 2017 and released on December 18, 2017. The full text of this document is available for public inspection during regular business hours in the FCC Reference Center, Room CY-A257, 445 12th Street SW., Washington, DC 20554 or at the following Internet address: https://apps.fcc.gov/edocs_public/attachmatch/FCC-17-164A1.pdf.

I. INTRODUCTION

1. In this Notice of Proposed Rulemaking (NPRM), the Commission proposes measured steps to ensure that rural healthcare providers get the support they need while guarding against waste, fraud, and abuse. The Commission considers a series of measures to ensure the Rural Health Care (RHC) Program operates efficiently and in the appropriate size of the funding cap.

2. As technology and telemedicine assume an increasingly critical role in healthcare delivery, a well-designed RHC Program 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.” Over the last seven years, over 80 rural hospitals have closed and hundreds more

are at risk of closing. On a per capita basis, there are far fewer doctors in rural areas than in urban areas. In sum, “rural hospitals are facing one of the great slow-moving crises in American health care.”

3. 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.

4. 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. 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. Additionally, in Texas, the Connect2Health Task Force emphasized how broadband-enabled health technologies can improve access to mental health care.

5. 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, demand for RHC Program support is anticipated to exceed available program funding, leaving healthcare providers to potentially pay more for service than expected. Unfortunately, part of that growth is due to an increase in waste, fraud, and abuse in the RHC Program. Further, the Telecommunications (Telecom) Program, a component of the RHC Program, has not been significantly reviewed or revised since its

inception in 1997.

II. NOTICE OF PROPOSED RULEMAKING

A. Addressing RHC Program Funding Levels

1. Revisiting the RHC Program Funding Cap

6. The current cap on the RHC Program has remained at \$400 million since its inception in 1997. 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 the Commission examines 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 Healthcare Connect Fund (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.

7. The Commission seeks comment on increasing the cap for the RHC Program and whether to retroactively increase the cap for FY 2017. Looking ahead, beyond FY 2017, by how much should the Commission 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 the Commission 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. Another consideration, however, is whether potential waste in the Telecom Program (which the Commission discusses in more depth below) has contributed to the RHC Program reaching the cap sooner than anticipated—when the Commission adopted the HCF Program in 2012, it did not expect the RHC Program to reach the cap in the foreseeable future. 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. 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. How should advances in medical services delivered over communications services impact the Commission's evaluation of the cap? The Commission asks 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. What other factors should the Commission consider before increasing the cap? Should the Commission consider the universe of potential rural healthcare providers and estimate the average or median support needed? How should the Commission 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? The Commission recognizes 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. The Commission seeks comment on how the Commission should evaluate this trade off as it considers the appropriate funding level.

8. Additionally, within the RHC Program, multiyear commitments and upfront costs are capped within the HCF Program to \$150 million per funding year. The Commissions 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.

9. Finally, the funding caps for some of the other federal universal service support programs incorporate inflation adjustments. Commenters, likewise, argue that the RHC Program cap should be adjusted annually for inflation. The Commission seeks 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.

10. The Commission also seeks comment on whether to roll over unused funds committed in one funding year into a subsequent funding year. The Commission seeks comment on the types of unused funds from a given funding year to roll over to subsequent funding years. For example, the Commission proposes to include in any roll over mechanism unused or released funds the Universal Service Administrative Company (USAC) previously held in reserve for appeals and any funds committed to a healthcare provider but not used by the healthcare provider. The Commission seeks 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 the Commission 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? The Commission notes that, in the E-rate Program, all unused funding from previous funding years is made available for subsequent funding years.

11. The Commission also seeks comment on how to best distribute the roll over funds across the RHC Program. 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

12. 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. 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, and can create unexpected financial difficulties for

healthcare providers, especially in highly remote areas. The Commission seeks comment on whether to consider changes in how to prioritize the funding of eligible RHC Program requests. Below, the Commission discusses a number of prioritization approaches, some of which could be combined to more efficiently distribute funds.

13. At the outset, the Commission notes that section 254(b) of the Act requires that to 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 the Commission could adopt to further a prioritization plan? Are there prioritization methods other than those described below that the Commission should consider? Is proration, itself a method of prioritization, preferable to some alternate form of prioritization?

14. The Commission also seeks comment on the mechanics of how to distribute funding if a prioritization system is adopted. For example, would the Commission fully fund the requests at 100 percent (or some other percentage), starting with the requests that meet its highest prioritization criteria and then proceed through the prioritization tiers at 100 percent funding (or the chosen percentage), until funds are depleted? Or, should the Commission 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?

15. Prioritizing Based on Rurality or Remoteness. The Commission first seeks comment on whether to 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, should the Commission 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?

16. 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 the Commission prioritize funding requests based on the varied levels of rurality contained in its current definition of “rural area,” with the highest priority given to the healthcare providers in the most rural areas? Likewise, should the Commission consider the rurality of a healthcare provider in the HCF Program under section 254(h)(2)(A) when prioritizing funds?

17. 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.

18. The Commission seeks 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 the Commission decides whether to target scarce RHC Program funds to the most rural areas?

19. The Commission 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 the Commission use to determine the rurality of a consortium, and thus the prioritization of its request if the consortium has rural and urban healthcare providers? Would the Commission balance or average the number of rural healthcare providers with the urban healthcare providers? Or would the Commission

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 the Commission 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?

20. The Commission also seeks comment on whether to 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. These eligible counties are located in eleven states. 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. 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." 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. 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." The Commission seeks 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, the Commission seeks

comment on whether it's a need to safeguard the HCF Program under GCI's proposal. The Commission also seeks comment on other ways to alleviate the burden of proration in extremely rural high cost areas.

21. Alternatively, the Commission seeks comment on whether to modify its current definition of the term "rural area" or adopt a new definition entirely. Does the definition of rural area in §54.600(b) of the Commission's rules meet the needs of the RHC Program for purposes of prioritization? 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 sense to prioritize the extremely high cost census blocks identified as eligible for Remote Areas Fund funding for RHC Program prioritization? Finally, are there alternative definitions of "rural" the Commission should consider enhancing the efficiency of the RHC Program?

22. Prioritizing Based on Type of Service. The Commission seeks 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? Is the Commission 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?

23. 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 the Commission prioritize one RHC Program over the other? Currently, the Commission's rules provide for equal treatment of the two programs when the cap is exceeded, for purposes of prorating support. The Commission also notes that section 254(h)(2)(A) of the Act requires the Commission to establish competitively neutral rules for healthcare provider access to advanced telecommunications and information services to the extent "economically reasonable." 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. The Commission seeks comment on the relevance of these and other statutory provisions to the Commission's options for prioritizing support. The Commission also seeks 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.

24. Prioritizing Based on Economic Need or Healthcare Professional Shortages. The Commission seeks 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. If so, would Medicaid eligibility be an appropriate measure of economic need? Would Medicaid eligibility be an appropriate measure to use to prioritize funds to maximize the efficiency of the Commission's funding dollars? Is there another metric of economic need that would be more appropriate? If the Commission prioritize funding based on economic need of the population served by the healthcare provider, how would consortia be handled?

25. The Commission also seeks comment on whether to 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. The Commission seeks comment on whether prioritizing funding requests based on the designations by the HRSA would better serve its goal of using each funding dollar to its maximum benefit. If the Commission were to use these designations, would it also be required to 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

26. Recognizing that the primary emphasis of the RHC Program is to defray the cost of supported services for rural healthcare providers, the Commission seeks comment in this section on several proposals to direct proportionally more funding to rural healthcare providers, including healthcare providers on rural Tribal lands.

27. Rural Healthcare Providers in HCF Program. Currently, the HCF Program provides support for non-rural healthcare providers in majority-rural consortia. 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 (78 FR 13935, March 1, 2013), that non-rural healthcare provider participation may confer benefits upon affiliated rural healthcare providers, including lower broadband costs, access to medical specialists, administrative support, and technical expertise. The Commission agrees 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.

28. First, the Commission seeks 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. 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. The Commission seeks comment on whether the current “majority rural” threshold accurately reflects the needs of rural healthcare providers, and whether to 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?

29. Second, the Commission seeks comment on elimination of the three-year grace period during which HCF consortia may come into compliance with the “majority rural” requirement. 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. If commenters propose that the Commission establishes a grace period of less than three years, what period would be appropriate, and why?

30. Finally, the Commission seeks 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, the Commission does 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. Should non-rural healthcare provider support be limited to only those healthcare providers directly providing healthcare-related services to rural areas? Or, should the Commission 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?

31. Rural Tribal Healthcare Providers in Telecom and HCF Programs. Given emphasis on targeting more support to rural healthcare providers and healthcare providers on rural Tribal lands, the Commission seeks comment from Tribal governments in particular on whether any of the proposals here would impact Tribal populations and, if so, how. Additionally, the Commission seeks 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

32. In light of the pricing increases and shrinking out-of-pocket costs borne by healthcare providers, the Commission 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 purchases and the Commission believes 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, the Commission seeks to ensure that, by improving efficiency, and not restricting 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

33. To ensure that limited funding is distributed efficiently, the Commission proposes to

establish objective benchmarks to identify outlier funding requests, using information already provided by Telecom Program participants to USAC. The Commission seeks 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 the Commission’s proposal, outlier funding requests that exceed the benchmark will be subject to enhanced review by USAC before issuing commitments. Then, the Commission seeks comment on the measures to use in evaluating those outlier requests for funding support.

a. Identifying Healthcare Providers with Particularly High Support Levels

34. 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. A discount rate benchmark identifies those healthcare providers paying a smaller share of 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, the Commission seeks 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.

35. Specifically, the Commission seeks 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.

36. 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). The Commission seeks comment on the appropriate level of this discount rate cutoff.

37. 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 the Commission consider setting benchmarks directly based on the service costs? For instance, should the Commission 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

38. In this section, the Commission addresses what steps to take when a healthcare provider's request in the Telecom Program exceeds the established benchmark. The Commission's 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

39. The Commission proposes 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. And under current rules, urban rates are set as “no higher than the highest tariffed or publicly-available rate charged to a commercial customer for a functionally similar service in any city with a population of 50,000 or more in that state.”

40. As a first step, the Commission seeks 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. The Commission seeks comment on limiting the rural rate to what can be cost-justified as one form of enhanced review of rural rates.

41. If the Commission adopts 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 wholesaler—should the Commission look beyond those discounts in selecting a maximum markup? The Commission seeks comment on this approach and especially solicit examples of how similar reviews have been conducted in other contexts. For example, should the Commission 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? Should the Commission continue to incorporate updates to the items in the [High Cost Public Notice](#) (FCC 15-133, [rel. Oct. 19, 2015](#))? To ensure that support is limited to “telecommunications services which are necessary for the provision of health care services,” the

Commission seeks comment on whether to adapt the “used or useful” standard 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.” For example, should the Commission 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?

42. Commenters should discuss whether this proposal should replace the current comprehensive support calculation in §54.607(b) of the Commission’s rules. The Commission also seeks comment on the costs and benefits of carrying out this approach. In addition, commenters should discuss how this enhanced review would interact with other reforms discussed below, such as proposals for calculating the urban and rural rates.

43. As an alternative first step, the Commission seeks comment on USAC limiting the rural rate to the lowest market rate it can find for identical or similar services in the rural area. The Commission expects 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?

44. Second, the Commission seeks 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 the Commission consider in evaluating this option?

45. Alternatively, the Commission seeks 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. The Commission also seeks 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?

46. Which of these approaches will best balance the Commission's goals of fairness and efficiency? Are there alternative approaches the Commission 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

47. As an alternative to enhanced review, the Commission seeks 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. The Commission seeks comment on this alternative, including on associated issues such as the appropriate geographic unit to which to apply it.

48. The Commission also seeks comment on an alternative proposal in which to 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, 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.

49. The Commission seeks comment on whether this approach provides helpful incentives for healthcare providers to seek the lowest costs for services. The Commission also seeks 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 the Commission consider in grouping healthcare providers in order to best compare their spending or service levels? For example, if the Commission distinguishes between healthcare providers by size, should the Commission measure size by patient capacity, actual patient numbers, staff levels, or some other measure? What service features should the Commission use for grouping similar healthcare providers? Are the features in similar services proposal appropriate, or should the Commission include additional features for purposes of this proposal?

50. The Commission believes the approaches discussed above meet the 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. The Commission seeks 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

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

a. Calculating Urban and Rural Rates

52. The Commission proposes more detailed requirements about how the urban and rural rates are determined in the Telecom Program to minimize potential variances and rate manipulation. The Commission believes 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.

53. The subsidy provided to the service provider is based on the difference between the “urban rate” and the “rural rate.” 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.” 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 that rural area . . . by other carriers.” 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.

54. The Commission recognizes 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. The Commission is 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).

55. Nevertheless, the Commission appreciates that reliance on publicly available rate data leads to greater transparency. To address the issue about the paucity of rate data in rural areas, the Commission offers several proposals. Going forward, rather than distinguishing between the rates of the healthcare provider's selected service provider and the rates of other service providers, 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 the Commission should consider adding? Should the Commission 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 the Commission 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, the Commission proposes, 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 the Commission seeks to minimize the service provider's ability to offer an unjustified, high rural rate. To this end, should the Commission 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? The Commission also seeks 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.

56. The Commission also seeks comment on whether to retain §54.609(d) of the rules, 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 the Commission's proposals to reform the rules for calculating the rural rate, along with the proposals for competitive bidding reform, §54.609(d) of the Commission's rules may no longer be necessary. The Commission's 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 unnecessary limitations to §54.609(d) of the rules on support available for satellite service where terrestrial service is also available. If the Commission retains §54.609(d) of the rules, should the Commission 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? 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 the Commission were to modify §54.609(d) of the rules in the manner suggested by ACS, should the Commission 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?

57. The Commission likewise seeks comment on whether to retain the cost-based support mechanism in §54.609(b) of the rules. Currently, service providers may propose a rural rate, supported by the service provider's itemized costs of providing the requested service. 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, the Commission seeks comment on whether the rule would continue to benefit service providers that may believe that rural rates calculated consistent with its 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?

58. The Commission also proposes to modify its 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). 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. Requiring a rate average would eliminate this incentive.

59. The Commission next explores 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. The Commission seeks 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. The Commission believes 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. The Commission seeks comment on this approach.

60. Nevertheless, having the carrier, the entity with the most to gain financially, provide the rate information may promote incentives that are not aligned with the Commission’s goals of efficiency in the RHC Program. To remove concerns about misaligned incentives and provide greater transparency in the Telecom Program review process, the Commission seeks 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. The Commission seeks 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?

61. The Commission must next define the geographic contours of rural and urban areas for the purpose of determining the urban and rural rates. The Commission believes that averaging rates within state rural areas containing similar cost attributes is consistent with the goal of section 254(h)(1)(A) of the Act to ensure that healthcare providers in rural and urban areas pay reasonably comparable rates. The Commission seeks comment on that belief. Consistent with that approach, the Commission proposes 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. The Commission seeks examples of such appropriate rural areas. The Commission also seeks comment on methods to ensure services are averaged with similarly rural services. Should the Commission 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. What data sources could the Commission look to in order to ensure healthcare providers and service providers are only using rates from like rural areas when calculating the discount? Should the Commission consider using types of rural areas that align with the prioritization tiers discussed below? Would establishing rural areas in this manner result in appropriate rates and discounts for RHC Program participants? The Commission seeks comment on any other approaches consistent with the statute.

62. As for urban areas, should the Commission 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? Given the increased availability of telecommunications services in smaller cities, should the Commission modify the city population size used to generate the urban rate? The Commission seeks comment on methods to identify the appropriate urban rate for discount calculation.

63. Finally, the Commission seeks comment on whether, in lieu of using rate averaging to instead adopt a median-based approach. Might such an approach, rather than an average-based approach, limit the effect of very high and low rates?

b. Defining Similar Services

64. To limit possible waste and modernize the rules to reflect services actually purchased by healthcare providers, the Commission seeks comment on services supported by the Program. The Commission first seeks comment on changes to the Commission's interpretation of "similar services." Under section 254(h)(1)(A) of the Act, and the Commission's rules, carriers are permitted to receive reimbursement for the difference between the urban and average rural rates for "similar services." In 2003, the Commission concluded that services are "similar" under 254(h)(1)(A) of the Act if they are "functionally similar as viewed from the perspective of the end user." 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. 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. The Commission's experiences 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.

65. 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.

66. Going forward, the Commission proposes 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. First, the Commission proposes 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.

67. Next, the Commission seeks comment on how the bandwidth tiers should be established and updated. The Commission proposes 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 would be no need to update the bandwidth tiers over time. If the Commission adopts this approach, what is an appropriate percentage to establish the range? Should this percentage vary depending on the bandwidth requested? Should the Commission use something

besides a percentage? In the alternative, the Commission seeks 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.

68. The Commission also seeks comment on other criteria to 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. Do these differences mean that packetized and non-packetized services cannot be “functionally similar as viewed from the perspective of the end user?”

69. In addition, as the Commission explores 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? The Commission seeks 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? Further, the Commission seeks comment on supporting services that have not traditionally received support in the RHC Program. For example, under the statute, could the Commission support patient home monitoring services? The Commission notes 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. 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 the Commission’s proposed support calculation and competitive bidding rules?

c. Eliminating Distance-Based Analysis

70. The Commission next proposes 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. The SUD is the average of the longest diameters of all cities with a population of 50,000 people or more in a state. The MAD is the distance from the healthcare provider to the farthest point on the jurisdictional boundary of the city in that state with the largest population. The healthcare provider must pay for any distance-based charges incurred for mileage greater than the MAD. 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." Despite these detailed rules, virtually no healthcare providers use a distance-based approach.

71. The Commission proposes to eliminate any consideration of a distance-based approach. Based on the low use of this methodology, the Commission believes it is no longer necessary to use as a proxy for the appropriate support amount. The Commission also believes 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 the Commission seeks comment elsewhere in this item, will also simplify the application process for healthcare provider and service providers. The Commission seeks comment on removing the distance-based approach.

72. 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 the Commission's 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. If the Commission eliminates 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? The Commission seeks comment on these proposals.

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

73. 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.” 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.

74. 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 “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.

75. The Commission seeks comment on ways to minimize opportunities for this type of waste. For example, the Commission seeks 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 the Commission 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 the Commission’s other competitive bidding requirements, provide a sufficient safeguard against wasteful spending and allow for flexibility in the bid evaluation to reflect the differing needs of healthcare providers? Should the Commission 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 the Commission provide more guidance for healthcare providers in how they structure their vendor selection and evaluation processes? The Commission seeks comment and solicits information about other systems or procedures to employ improving the competitive bidding process in the RHC Program.

C. Improving Oversight of the RHC Program

76. Below, the Commission explores proposals to simplify and streamline various RHC Program requirements to improve the stakeholder experience and ease administrative burdens. The Commission believes 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

77. In this section, the Commission seeks comment on several proposals to minimize waste, fraud, and abuse in the Telecom and HCF Programs. In particular, the Commission proposes to revise RHC Program rules to codify requirements for consultants or anyone acting on behalf of RHC Program

applicants as well as gift restrictions. The Commission anticipates that the measures proposed here, if codified in the Commission's rules, will assist in its 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

78. To harmonize the Commission's rules under the Telecom and HCF Programs regarding consultants, the Commission proposes 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. 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. 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, the Commission proposes 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. Should the Commission 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? Should the Commission also require the applicant to describe the relationship it has with the consultant or other outside expert providing the assistance?

79. 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). 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. The Commission seeks 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. The Commission also seeks 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 the Commission also hold healthcare providers and service providers accountable for the actions of their consultants or outside experts should 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

80. 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. 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. The Commission proposes 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.

81. The E-rate Program gift rules are consistent with the gift rules applicable to federal agencies, which permit only certain de minimis gifts. 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. 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. 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.

82. The Commission proposes to codify these rules for the RHC Program and seeks comment on this proposal. Specifically, the Commission seeks 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? 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?

83. Regarding the applicability of gift restrictions in the RHC Program, the Commission seeks comment on which entities should be subject to such restrictions. 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 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?

84. The Commission also seeks 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 the Commission 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 the Commission 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? The Commission reminds commenters that any gift restrictions to adopt will apply in addition to the applicant and service provider's state and local restrictions regarding gifts.

c. Harmonizing Invoicing Deadlines

85. The Commission proposes to adopt a new rule establishing the same invoicing deadline for the Telecom Program as that applicable to the HCF Program. 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.

86. To alleviate further inefficiencies with respect to the disbursement process, the

Commission proposes to adopt a firm invoice filing deadline for Telecom Program participants, similar to the invoicing deadline adopted in the HCF Program. In particular, the Commission seeks comment on whether to 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 the Commission's 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. The Commission seeks comment on whether there are other ways to eliminate delays and lack of response from service providers in submitting invoices to USAC. The Commission invites commenters to also address the appropriate consequences should the service provider fail to submit an invoice to USAC in a timely manner.

2. Streamlining the RHC FCC Forms Application Process

87. The Commission seeks 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. 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.

88. As one means to streamline and improve the efficiency of the application process, while also reducing the administrative burden upon applicants, the Commission proposes condensing the RHC Program application process to use fewer online FCC Forms. The Commission proposes 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. The Commission seeks 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? The Commission welcomes 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.

89. SHLB suggests the Commission improve the processing of consortia applications and find ways to speed the processing of the various FCC HCF Forms and streamline the treatment of individual health care sites. Because the SHLB filings did not contain specific suggestions, and due to changes in the RHC Program procedures after the recent increase in demand, the Commission seeks 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 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

90. In this section, the Commission seeks comment on a number of proposals to bolster competitive bidding rules in the Telecom Program. These proposals are consistent with the Commission's 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

91. To enhance RHC Program transparency and increase administrative efficiency, the Commission proposes to align the “fair and open” competitive bidding standard applied in each Program. Although this standard is codified under HCF Program rules, 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.” For consistency purposes, the Commission now seeks to codify this standard under the Telecom Program as well. Because the Commission is merely proposing to codify an existing requirement, RHC Program participants that are already complying with the Commission’s competitive bidding rules should not be impacted. The Commission seeks comment on this proposal. The Commission also proposes 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. The Commission seeks comment on this proposal.

b. Aligning Competitive Bidding Exemptions in Both RHC Programs

92. The Commission proposes 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. The Commission seeks comment on whether to 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. With the exception of “evergreen” contracts, none of these exemptions apply in the Telecom Program. The Commission therefore seeks comment on whether to apply these exemptions, or variants thereof, to the Telecom Program. The Commission also seeks comment on whether other situations may warrant a competitive bidding exemption. In addition, to improve uniformity across both Programs, the Commission proposes to codify the existing “evergreen” contract exemption in the Telecom Program. The Commission seeks comment on this proposal.

c. Requiring Submission of Documentation with Requests for Services

93. The Commission next proposes 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). 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. The Commission has 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. The Commission therefore proposes 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). The Commission seeks comment on this proposal and whether requiring such information would be burdensome for applicants. For administrative ease, should the Commission 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

94. The Commission also proposes 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), a copy of its signed service contract, and copies of all bids received in response to its request for services. 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. While this requirement is codified in the Commission's rules for the HCF Program, there is no analogous rule under the Telecom Program. Therefore, to improve uniformity and transparency across both Programs, the Commission proposes to codify the existing requirement that applicants provide supporting documentation with their funding requests in the Telecom Program. The Commission seeks comment on this proposal and, in particular, whether to require applicants to provide additional documentation contemporaneously with their funding requests. For example, the Commission proposes 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. The Commission seeks 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? The Commission also seeks comment on whether to 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

95. As the Commission seeks to better monitor RHC Program effectiveness, the Commission seeks 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 their supported communications services. Currently, consistent with the requirements in the HCF Order, only healthcare providers participating in HCF consortia are required to report annually about the telehealth applications they provide over their supported connections. Understanding how all RHC participants use their supported communications services would provide information about the role of the RHC Program in delivering telehealth services to rural areas. 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? The Commission seeks 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? 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

96. 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. 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. 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.

97. The Commission proposes to continue with the filing window periods process established by the Bureau and USAC for administering RHC Program funds. The Commission believes this process furthers its 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. The Commission seeks comment on this proposal. The Commission seeks comment on any specific concerns regarding the current process and how to potentially adjust the current process to better align with applicants' business needs and filing schedules. The Commission also seeks 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 and administratively manageable.

III. PROCEDURAL MATTERS

A. Initial Regulatory Flexibility Analysis

98. As required by the Regulatory Flexibility Act of 1980, as amended, 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. 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. In addition, the NPRM and IRFA (or summaries thereof) will be published in the Federal Register.

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

99. 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.

2. Legal Basis

100. The legal basis for the NPRM is contained in sections 1 through 4, 201 through 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.

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

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

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

102. Small Businesses, Small Organizations, Small Governmental Jurisdictions. The Commission's actions, over time, may affect small entities that are not easily categorized at present. The Commission therefore describes here, at the outset, three broad groups of small entities that could be directly affected herein. 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. These types of small businesses represent 99.9 percent of all businesses in the United States which translates to 28.8 million businesses.

103. 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." 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).

104. 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." U.S. Census Bureau data from the 2012 Census of Governments indicates that there were 90,056 local governmental jurisdictions consisting of general purpose governments and special purpose governments in the United States. Of this number there were 37, 132 General purpose governments (county, municipal and town or township) with populations of less than 50,000 and 12,184 Special purpose governments (independent school districts and special districts) 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. Based on this data the Commission estimates that at least 49,316 local government jurisdictions fall in the category of "small governmental jurisdictions."

105. 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.

a. Healthcare Providers

106. 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. The SBA has created a size standard for this industry, which is annual receipts of \$11 million or less. According to 2012 U.S. Economic Census, 152,468 firms operated throughout the entire year in this industry. Of that number, 147,718 had annual receipts of less than \$10 million, while 3,108 firms had annual receipts between \$10 million and \$24,999,999. Based on this data, the Commission concludes that a majority of firms operating in this industry are small under the applicable size standard.

107. 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. The SBA has established a size standard for businesses in this industry, which is annual receipts of \$11 million dollars or less. The U.S. Economic Census indicates that 8,809 firms operated throughout the entire year in this industry. 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. Based on this data, the Commission concludes that a majority of firms in this industry are small under the applicable standard.

108. 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. The SBA has established a size standard for that industry of annual receipts of \$7.5 million or less. The 2012 U.S. Economic Census indicates that 115,268 firms operated in the dental industry throughout the entire year. 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. Based on this data, the Commission concludes that a majority of business in the dental industry are small under the applicable standard.

109. 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 facilities of others, such as hospitals or HMO medical centers. The SBA has established a size standard for this industry, which is annual receipts of \$7.5 million or less. The 2012 U.S. Economic Census statistics show that in 2012, 33,940 firms operated throughout the entire year. 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. Based on that data, the Commission concludes that a majority of chiropractors are small.

110. 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. The SBA has established a size standard for businesses operating in this industry, which is annual receipts of \$7.5 million or less. The 2012 Economic Census indicates that 18,050 firms operated the entire year. 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. Based on this data, the Commission concludes that a majority of optometrists in this industry are small.

111. 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. The SBA has created a size standard for this industry, which is annual receipts of \$7.5 million or less. The 2012 U.S. Economic Census indicates that 16,058 firms operated throughout the entire year. 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. Based on this data, the Commission concludes that a majority of mental health practitioners who do not employ physicians are small.

112. 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. The SBA has established a size standard for this industry, which is annual receipts of \$7.5 million or less. The 2012 U.S. Economic Census indicates that 20,567 firms in this industry operated throughout the entire year. 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. Based on this data, the Commission concludes that a majority of businesses in this industry are small.

113. 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. The SBA has established a size standard for businesses in this industry, which is annual receipts of \$7.5 million or less. The 2012 U.S. Economic Census indicates that 7,569 podiatry firms operated throughout the entire year. Of that number, 7,545 firms had annual receipts of less than \$5 million, while 22 firms had annual receipts between \$5 million and \$9,999,999. Based on this data, the Commission concludes that a majority of firms in this industry are small.

114. 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. The SBA has established a size standard for this industry, which is annual receipts of \$7.5 million or less. The 2012 U.S. Economic Census indicates that 11,460 firms operated throughout the entire year. 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. Based on this data, the Commission concludes the majority of firms in this industry are small.

115. 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. The SBA has established a size standard for this industry, which is annual receipts of \$11 million or less. The 2012 Economic Census indicates that 1,286 firms in this industry operated throughout the entire year. 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. Based on this data, the Commission concludes that the majority of firms in this industry are small.

116. 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. The SBA has established a size standard for this industry, which is \$15 million or less in annual receipts. The 2012 U.S. Economic Census indicates that 4,446 firms operated throughout the entire year. 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. Based on this data, the Commission concludes that a majority of firms in this industry are small.

117. 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. The SBA has established a size standard for this industry, which is \$32.5 million or less in annual receipts. The 2012 U.S. Economic Census indicates that 14 firms in this industry operated throughout the entire year. 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. Based on this data, the Commission concludes that approximately one-third

of the firms in this industry are small.

118. 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. The SBA has established a size standard for this industry, which is annual receipts of \$15 million or less. The 2012 U.S. Economic Census indicates that 3,595 firms in this industry operated throughout the entire year. Of that number, 3,222 firms had annual receipts of less than \$10 million, while 289 firms had annual receipts between \$10 million and \$24,999,999. Based on this data, the Commission concludes that a majority of firms in this industry are small.

119. 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. The SBA has established a size standard for this industry, which is annual receipts of \$20.5 million or less. The 2012 U.S. Economic Census indicates that 4,903 firms operated in this industry throughout the entire year. 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. Based on this data, the Commission concludes that a majority of firms in this industry are small.

120. 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.

The SBA has established a size standard for this industry, which is annual receipts of \$32.5 million or less. The 2012 U.S. Economic Census indicates that 314 firms operated in this industry throughout the entire year. 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. Based on this data, the Commission concludes that approximately three-quarters of firms that operate in this industry are small.

121. 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). The SBA has established a size standard for this industry, which is annual receipts of \$15 million or less. The 2012 U.S. Economic Census indicates that 2,429 firms operated in this industry throughout the entire year. 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. Based on this data, the Commission concludes that a majority of the firms in this industry are small.

122. 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. The SBA has established a size standard for this industry, which is annual receipts of \$32.5 million or less. The 2012 U.S. Economic Census indicates that 2,599 firms operated in this industry throughout the entire year. 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. Based on this data, the Commission concludes that a majority of firms that operate in this industry are small.

123. 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. The SBA has established size standard for this industry, which is annual receipts of \$15 million or less. The 2012 U.S. Economic Census indicates that 4,209 firms operated in

this industry throughout the entire year. 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. Based on this data, the Commission concludes that a majority of firms that operate in this industry are small.

124. 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 therapy; dietary and nutritional services; speech therapy; audiology; and high-tech care, such as intravenous therapy. The SBA has established a size standard for this industry, which is annual receipts of \$15 million or less. The 2012 U.S. Economic Census indicates that 17,770 firms operated in this industry throughout the entire year. 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. Based on this data, the Commission concludes that a majority of firms that operate in this industry are small.

125. 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. The SBA has established a size standard for this industry, which is annual receipts of \$15 million or less. The 2012 U.S. Economic Census indicates that 2,984 firms operated in this industry throughout the entire year. 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. Based on this data, the Commission concludes that a majority of firms in this industry are small.

126. Kidney Dialysis Centers. This U.S. industry comprises establishments with medical staff primarily engaged in providing outpatient kidney or renal dialysis services. The SBA has established a size standard for this industry, which is annual receipts of \$38.5 million or less. The 2012 U.S. Economic Census indicates that 396 firms operated in this industry throughout the entire year. 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. Based on this data, the Commission concludes that a majority of firms in this industry are small.

127. 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. The SBA has established a size standard for this industry, which is annual receipts of \$38.5 million or less. The 2012 U.S. Economic Census indicates that 2,800 firms operated in this industry throughout the entire year. 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. Based on this data, the Commission concludes that approximately one-quarter of firms in this industry are small.

128. 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. The SBA has established a size standard for this industry, which is annual receipts of \$38.5 million or less. The 2012 U.S. Economic Census indicates that 404

firms operated in this industry throughout the entire year. 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. Based on this data, the Commission concludes that more than one-half of the firms in this industry are small.

129. 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 (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. The SBA has established a size standard for this industry, which is annual receipts of \$38.5 million or less. The 2012 U.S. Economic Census indicates that 346 firms operated in this industry throughout the entire year. 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. Based on this data, the Commission concludes that more than one-half of the firms in this industry are small.

130. 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). The SBA has established a size standard for this industry which is annual receipts of \$32.5 million or less. The 2012 U.S. Economic Census indicates that 541 firms operated in this industry throughout the entire year. 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. Based on this data, the Commission concludes that a majority of firms in this industry are small

b. Providers of Telecommunications and Other Services

(i) Telecommunications Service Providers

131. 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. U.S. Census Bureau data for 2012 indicates that 3,117 firms operated during that year. Of this total, 3,083 operated with fewer than 1,000 employees. Consequently, the Commission estimates that most providers of incumbent local exchange service are small businesses that may be affected by its 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. Of this total, an estimated 1,006 have 1,500 or fewer employees. Thus using the SBA's size standard the majority of Incumbent LECs can be considered small entities.

132. 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. U.S. Census Bureau data for 2012 indicates that 3,117 firms operated during that year. Of that number, 3,083 operated with fewer than 1,000 employees. According to internally developed Commission data, 359 companies reported that their primary telecommunications service activity was the provision of interexchange services. Of this total, an estimated 317 have 1,500 or fewer employees. Consequently, the Commission estimates that the majority of interexchange service providers that may be affected are small entities.

133. 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. U.S. Census Bureau data for 2012 indicates that 3,117 firms operated during that year. Of that number, 3,083 operated with fewer than

1,000 employees. Consequently, the Commission estimates that most competitive access providers are small businesses that may be affected by its actions. According to Commission data the 2010 Trends in Telephone Report (rel. September 30, 2010), 1,442 CAPs and competitive local exchange carriers (competitive LECs) reported that they were engaged in the provision of competitive local exchange services. 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. Consequently, the Commission estimates that most providers of competitive exchange services are small businesses.

134. 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.” 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. U.S. Census 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. Thus, under this size standard, the majority of firms in this industry can be considered small.

135. 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. The appropriate size standard under SBA rules is that such a business is small if it has 1,500 or fewer employees. For this industry, U.S. Census Bureau data for 2012 shows that there

were 967 firms that operated for the entire year. Of this total, 955 firms had employment of 999 or fewer employees and 12 had employment of 1000 employees or more. Thus under this category and the associated size standard, the Commission estimates that the majority of wireless telecommunications carriers (except satellite) are small entities.

136. 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 the Commission's actions. 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. Of this total, an estimated 261 have 1,500 or fewer employees, and 152 have more than 1,500 employees. Thus, using available data, the Commission estimates that the majority of wireless firms can be considered small.

137. 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) 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. For this industry, U.S. Census Bureau data for 2012 shows that there were 967 firms that operated for the entire year. Of this total, 955 firms had fewer than 1,000 employees and 12 firms has 1000 employees or more. 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. Of these, an estimated 261 have 1,500 or fewer employees and 152 have more than 1,500 employees. Therefore, more than half of these entities can be considered small.

138. 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

reselling satellite telecommunications.” 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. 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. Of this total, 299 firms had annual receipts of less than \$25 million. Consequently, the Commission estimates that the majority of satellite telecommunications providers are small entities.

139. 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. 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. Establishments providing Internet services or voice over Internet protocol (VoIP) services via client-supplied telecommunications connections are also included in this industry. 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. 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 and 42 firms had gross annual receipts of \$25 million to \$49, 999,999. Thus, the Commission estimates that a majority of “All Other Telecommunications” firms potentially affected by its action can be considered small.

(ii) Internet Service Providers

140. 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. 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 a single technology or a combination of technologies. The SBA size standard for this category classifies a business as small if it has 1,500 or fewer employees. 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. Consequently, under this size standard the majority of firms in this industry can be considered small.

141. 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. 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. Consequently, under this size standard a majority of firms in this industry can be considered small.

c. Vendors and Equipment Manufacturers

142. 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 less and “Other Communications Equipment Manufacturing” with a size standard of 750 employees or less.” 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. 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. For Other Communications Equipment Manufacturing, U.S. Census Bureau data for 2012 shows that 383

establishments operated for the year. Of that number 379 firms operated with fewer than 500 employees and 4 had 500 to 999 employees. Based on this data, the Commission concludes that the majority of Vendors of Infrastructure Development or “Network Buildout” are small.

143. 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.” The SBA size standard for Telephone Apparatus Manufacturing is all such firms having 1,250 or fewer employees. 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. Of this total, 262 had employment of under 1,000, and an additional 4 had employment of 1,000 to 2,499. Thus, under this size standard, the majority of firms can be considered small.

144. 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. Examples of products made by these establishments are: transmitting and receiving antennas, cable television equipment, GPS equipment, pagers, cellular phones, mobile communications equipment, and radio and television studio and broadcasting equipment. The SBA has established a small business size standard for this industry of 1,250 employees or less. U.S. Census Bureau data for 2012 shows that 841 establishments operated in this industry in that year. 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. Based on this data, the Commission concludes that a majority of manufacturers in this industry are small.

145. Other Communications Equipment Manufacturing. This industry comprises

establishments primarily engaged in manufacturing communications equipment (except telephone apparatus, and radio and television broadcast, and wireless communications equipment). 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. The SBA has established a size for this industry as all such firms having 750 or fewer employees. U.S. Census Bureau data for 2012 shows that 383 establishments operated in that year. Of that number 379 operated with fewer than 500 employees and 4 had 500 to 999 employees. Based on this data, the Commission concludes that the majority of Other Communications Equipment Manufacturers are small.

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

146. 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 the Commission's proposed requirements, however, the determination that its 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.

147. Provision of Rate Information in the Telecom Program. Because the service provider can most easily access rate information, the Commission proposes 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.

148. Application Documentation. The Commission proposes 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). The Commission seeks comment on this proposal and whether requiring such information

would be burdensome for applicants.

149. 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, the Commission proposes a new rule in the Telecom Program containing a "declaration of assistance" requirement similar to that in the HCF Program. The Commission also proposes a new rule establishing the same six-month invoicing deadline for the Telecom Program as that applicable in the HCF Program.

150. Unifying Data Collection on RHC Program Support Impact. As the Commission seeks to better monitor RHC Program effectiveness, the Commission seeks 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.

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

151. 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."

152. As indicated above, in this NPRM, while the Commission proposes several changes that could increase the economic burden on small entities, the Commission also proposes 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, the Commission has determined that the net financial and other benefits from such changes would outweigh the increased burdens on small entities.

153. Addressing RHC Program Funding Levels. To increase RHC program support, and thereby increase support available for rural, mostly small, healthcare providers, the Commission seeks 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.

154. Prioritizing Funding if Demand Reaches the Cap. To more appropriately target RHC support if demand exceeds the \$400 million annual cap, the Commission seeks 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.

155. 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, the Commission seeks comment on increasing the HCF Program consortia “majority rural” HCP requirement from a “more than 50 percent rural HCPs” threshold to some higher percentage. The Commission also seeks comment on eliminating the three-year grace period during which HCF consortia may come into compliance with the “majority rural” requirement. Additionally, the Commission seeks comment on requiring a direct healthcare-related relationship between a consortium’s non-rural and rural healthcare providers. And, the Commission seeks 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.

156. Controlling Outlier Costs. To ensure efficient and equitable funding distribution, the Commission seeks 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, the Commission seeks comment on capping high-support funding requests in the Telecom Program to enable funding distribution to more HCPs.

157. Rate Calculations. To minimize potential rate variances and manipulations, the Commission seeks comment on establishing more detailed requirements about how the urban and rural rates are determined in the Telecom Program. The Commission also proposes 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.

158. Defining "Cost Effective." To improve Program uniformity and safeguard against wasteful or abusive spending, the Commission seeks 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."

159. Clarification of Gift Prohibition. To provide clarity to RHC Program participants and ensure a fair competitive bidding process, the Commission proposes 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, the Commission believes that codifying the existing gift prohibition will provide applicants and service providers with enhanced clarity and understanding of this safeguard on program integrity.

160. Streamlining and Harmonizing the Application Process. To streamline the application process and reduce the administrative burden upon applicants, the Commission proposes 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, the Commission proposes a new rule in the Telecom Program containing a "declaration of assistance" requirement similar to that in

the HCF Program. The Commission also proposes a new rule establishing the same six-month invoicing deadline for the Telecom Program as that applicable in the HCF Program.

161. Competitive Bidding Requirements. To enhance RHC Program transparency and increase administrative efficiency, the Commission proposes 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.

162. Competitive Bidding Exemptions. The Commission proposes 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. The Commission therefore seeks 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, the Commission proposes to codify the existing “evergreen” contract exemption in the Telecom Program.

163. 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, the Commission proposes 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). The Commission seeks comment on this proposal and whether requiring such information would be burdensome for applicants.

164. Funding Request Supporting Documentation. To improve uniformity and transparency across both Programs, the Commission proposes 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.

165. 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. The Commission proposes to continue the filing-window process and believe that it furthers its goals of supporting health care delivery in as many parts of rural America as possible and more efficiently managing the application process.

166. 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, the Commission also takes targeted, immediate action 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, the Commission directs 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. 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.

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

167. None.

B. Initial Paperwork Reduction Act Analysis

168. 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. Ex Parte Rules

169. Permit-But-Disclose. The proceeding shall be treated as a “permit-but-disclose” proceeding in accordance with the Commission’s ex parte rules. 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) of the rules. 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.

D. Comment Filing Procedures

170. Comments and Replies. The Commission invites comment on the issues and questions set forth in the NPRM and IRFA contained herein. Pursuant to §§ 1.415 and 1.419 of the Commission's rules, 47 CFR 1.415, 1.419, interested parties may file comments and reply comments on or before the dates indicated on the first page of this document. Comments 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.

171. *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).

172. 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.

173. 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.

174. Comments and reply comments must include a short and concise summary of the substantive arguments raised in the pleading. Comments and reply comments must also comply with

§1.49 and all other applicable sections of the Commission's rules. The Commission directs 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. The Commission also strongly encourages parties to track the organization set forth in the NPRM in order to facilitate its internal review process.

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

V. ORDERING CLAUSES

176. ACCORDINGLY, IT IS 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.

177. IT IS FURTHER ORDERED that, pursuant to applicable procedures set forth in §§ 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 **[INSERT DATE 30 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]**, and reply comments on or before **[INSERT DATE 60 DAYS AFTER DATE OF PUBLICATION IN THE FEDERAL REGISTER]**.

178. 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.

List of Subjects in 47 CFR Part 54

Communications common carriers, Reporting and record keeping requirements,
Telecommunications, Telephone.

FEDERAL COMMUNICATIONS COMMISSION.

Marlene H. Dortch,
Secretary.

Proposed Rules

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

PART 54 – UNIVERSAL SERVICE

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 § 54.603 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 section. 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:

(i) Preparing, signing or submitting an applicant's request for services or supporting documentation;

(ii) Serving as the point of contact on behalf of the applicant;

(iii) Being involved in setting bid evaluation criteria; or

(iv) 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; and

(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 (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.

3. 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; and

(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:

(i) Proof of the urban and rural rates;

(ii) Costs for which support is being requested; and

(iii) 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):

(i) Completed bid evaluation worksheets or matrices;

(ii) Explanation for any disqualified bids;

(iii) A list of people who evaluated bids (along with their title/role/relationship to the applicant organization);

(iv) Memos, board minutes, or similar documents related to the vendor selection/award;

(v) Copies of notices to winners; and

(vi) 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.

4. 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.

5. Amend § 54.642 by:

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

* * * * *

(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) * * *

(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 (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 § 54.633, requiring health care providers to contribute 35 percent of the total cost of all eligible expenses.

6. 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) * * *

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

* * * * *

(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.

* * * * *

7. 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.

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