

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

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

REPORT AND ORDER

Adopted: June 19, 2018

Released: June 25, 2018

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

I. INTRODUCTION

1. Technology and telemedicine have assumed an increasingly important role in health care delivery, particularly in rural and remote areas of the country. For Americans living in rural and isolated areas, doctor shortages and hospital closures are endemic, and obtaining access to high-quality health care is a constant challenge. Broadband greatly changes that equation, however, by enabling a wide range of telemedicine services—from specialists providing consultations via video conferencing to radiologists remotely reading X-rays via high-speed connectivity. Today, we take steps to help ensure that health care providers participating in the Commission’s Rural Health Care (RHC) Program can continue providing these and other essential telemedicine services to their communities.

2. In 1996, Congress recognized the value of providing rural health care providers with “an affordable rate for the services necessary for the provision of telemedicine,”¹ and the Commission established the RHC Program the following year.² At that time, the Commission capped RHC Program funding at \$400 million annually,³ and for many years, the \$400 million funding cap was sufficient to fulfill Program demand. More recently, however, funding requests for high-speed broadband from health care providers have outpaced the RHC Program funding cap, placing a strain on the Program’s ability to increase access to broadband for health care providers, particularly in rural areas, and foster the deployment of broadband health care networks.⁴ Further, rural health care providers face imminent financial hardship in funding year (FY) 2017 due to the significant, automatic proration of their funding

¹ Telecommunications Act of 1996, Pub. L. No. 104-104, 110 Stat. 56 (1996) (1996 Act). The 1996 Act amended the Communications Act of 1934 (Communications Act or Act). See S. Conf. Rep. No. 104-230 at 133 (1996); 47 U.S.C. §§ 254(b)(3), (h)(1)(A), (h)(2)(A).

² See *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776 (1997) (*Universal Service First Report and Order*) (subsequent history omitted). The RHC Program currently includes the Telecommunications Program, which provides support for telecommunications services, and the Healthcare Connect Fund (HCF) Program, which provides support for broadband connectivity.

³ 47 CFR § 54.675(a). The \$400 million annual cap applies to funding commitments. See *Universal Service First Report and Order* at 9143-44, paras. 710-13. Of the \$400 million, \$150 million per funding year is available to support upfront payments and multi-year commitments under the HCF Program. See *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 27 FCC Rcd 16678, 16764-65, para. 190 (2012) (*HCF Order*).

⁴ *HCF Order*, 27 FCC Rcd at 16695, para. 32.

requests pursuant to RHC Program rules.⁵ These funding reductions have forced providers to assume additional costs of providing critical health care services to their communities.⁶

3. Given rural health care providers' urgent need for funding, we take immediate action in this Report and Order to address the current funding shortfall in the RHC Program, including by raising the annual Program funding cap to \$571 million and applying it to the current funding year to fully fund eligible funding requests for FY 2017.⁷ We take this action consistent with our goal of ensuring that rural health care providers are able to get the funding they need from the RHC Program. At the same time, we are mindful of the need to guard against Program waste, fraud, and abuse to ensure that this funding is being spent appropriately. We remain committed to this goal and for that reason, have proposed and sought comment in this proceeding on measures to ensure compliance and to reduce waste, fraud, and abuse in the RHC Program.⁸

II. BACKGROUND

4. When the Commission established the RHC Program in 1997, it capped funding for the Program at \$400 million per funding year.⁹ At that time, the RHC Program consisted entirely of the Telecommunications Program, which permits eligible health care providers to apply for discounts to defray the high cost of eligible telecommunications services in rural areas.¹⁰ Specifically, the Telecommunications Program pays the difference between the rate urban users of a telecommunications service pay and the "rural rate," determined either by (1) the average of rates that carrier charges to non-health care providers in the area, (2) the average of rates charged by other carriers in that area, or (3) a

⁵ See 47 CFR 54.675(f); USAC, Rural Health Care Program, Funding Commitments, <https://www.usac.org/rhc/tools/funding-commitments/default.aspx?pgm=hcc> (last visited June 6, 2018) (FY 2017 Funding Information).

⁶ See *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 32 FCC Rcd 5463, 5464, para. 5 (2017) (*Alaska Order*) (acknowledging that rural health care providers may be required to absorb larger portions of the cost of services due to the proration of funding requests, potentially leading to service disruptions and public health consequences); see also USAC, Rural Health Care Program, Funding Commitments, FY2016 Funding Information, <https://www.usac.org/rhc/tools/funding-commitments/archive/default.aspx> (last visited June 6, 2018) (FY 2016 Funding Information); FY 2017 Funding Information.

⁷ Funding years run from July 1 through June 30 of the subsequent calendar year. 47 CFR § 54.675(b). Due to the relief provided by this Order, which fully funds eligible funding requests for FY 2017, we dismiss the Schools, Health & Libraries Broadband Coalition (SHLB) Petition as moot. See Emergency Petition for Waiver of the Rural Health Care Program Funding Cap Pending Conclusion of the Open Rulemaking by the Schools, Health & Libraries Broadband Coalition, WC Docket No. 17-310, at 2 (filed Apr. 3, 2018) (SHLB Petition) (urging the Commission to waive section 54.675(a) of the Commission's rules and fully fund eligible applications for FY 2017). We also dismiss as moot other petitions which urge the Commission to raise the FY 2017 funding cap. See Petition for Waiver of USAC Funding Cap for 2017 by Bristol Bay Area Health Corporation, WC Docket No. 02-60 (filed Apr. 2, 2018) (requesting that the Commission waive section 54.675(a) of its rules and direct USAC to fully fund Bristol Bay's FY 2017 applications without proration); Petition for Waiver of USAC Funding Cap for 2017 by Council of Athabaskan Tribal Government (CATG), WC Docket No. 02-60 (filed Apr. 9, 2018) (requesting that the Commission waive section 54.675(a) of its rules and direct USAC to fully fund CATG's FY 2017 applications for support); Petition for Waiver of USAC Funding Cap for 2017 by Advanced Data Solutions, WC Docket No. 02-60 (filed May 15, 2018) (on behalf of Frontier Community Services, Central Peninsula Hospital, Cordova Community Medical Center, Camai Community Health Center, IHS/ABQ Alamo Health Center, and Kenaitze Indian Tribe-Dena'ina Wellness Center) (asking that RHC Program rules be waived and required actions be taken to fully fund FY 2017 applications for support).

⁸ See generally *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Notice of Proposed Rulemaking and Order, 32 FCC Rcd 10631 (2017) (*2017 NPRM and Order*).

⁹ See *Universal Service First Report and Order*, 12 FCC Rcd at 9093-9161, paras. 608-749; 47 CFR § 54.675(a).

¹⁰ See *Universal Service First Report and Order*, 12 FCC Rcd at 9093-9161, paras. 608-749.

cost study, including an itemization of costs, submitted to either the Commission or a state commission for approval.¹¹ The \$400 million funding cap adopted for the RHC Program represented the Commission's view at that time of the estimated maximum demand for the Program's first year, given that it did not have historical data from which it could calculate the number of health care providers that would participate in the Program and the services they would purchase.¹² In the absence of such data, the Commission based the RHC Program funding cap on what it would cost if every eligible health care provider requested the maximum amount of service then eligible for support, which it estimated to total \$366 million in support for approximately 12,000 eligible health care providers.¹³ The Commission also assumed that all 12,000 health care providers would purchase limited toll-free access to an Internet service provider at a cost of \$26 million,¹⁴ that rates for service would be higher in rural areas, and that the RHC Program would fund distance-based charges for 100 miles per provider.¹⁵ In all, the Commission arrived at a \$400 million funding cap.

5. In 2012, the Commission expanded the RHC Program to include the Healthcare Connect Fund (HCF) Program, which provides a flat 65 percent discount for the cost of broadband services and facilities.¹⁶ In that order, the Commission adopted three new goals for the RHC Program: (1) increase access to broadband for health care providers, particularly those serving rural areas; (2) foster development and deployment of broadband health care networks; and (3) reduce the burden on the Universal Service Fund (USF) by maximizing the cost-effectiveness of the health care support mechanisms.¹⁷ The Commission did not, however, increase the \$400 million funding cap,¹⁸ which has remained the same since the RHC Program's inception in 1997.¹⁹

6. From 1997 to FY 2016, RHC Program demand fell far short of the \$400 million funding cap. In fact, with the exception of FY 2009, Program commitments did not exceed \$100 million until FY 2011, and did not exceed \$200 million until FY 2014.²⁰ After the HCF Program was created, total RHC Program demand began to increase in response to the growing importance of broadband networks in health care delivery, especially in rural areas, and the additional opportunities for funding opened by the

¹¹ See 47 CFR §§ 54.605 (describing how to calculate the urban rate in detail), 54.607 (describing how to calculate the rural rate in detail), 54.609 (describing how to calculate support in detail).

¹² *Id.* at 9140, para. 704. The Commission acknowledged that "it is difficult to estimate costs given that technologies are developing rapidly and demand is inherently difficult to predict." *Id.*

¹³ *Id.* at 9141-42, paras. 706-707.

¹⁴ *Id.* at 9142-43, para. 708.

¹⁵ See *id.* at 9141-42, paras. 706-707 & n.1847 (noting that the record reflected that the average distance to a "point-of-presence" for telemedicine grantees of the Department of Health and Human Services, Office for Human Research Protections, was 99.8 miles and that the responses to survey forms received by the Commission indicated the average distance to the nearest city of population equal to or greater than 50,000 was 118 miles). The Commission survey was not drawn from a scientifically selected or statistically accurate sample. *Id.*

¹⁶ See *HCF Order*, 27 FCC Rcd at 16717-20, 16728-65 paras. 83-93, 105-92; 47 CFR §§ 54.634, 54.633-639.

¹⁷ *HCF Order*, 27 FCC Rcd at 16695, para. 32.

¹⁸ In the 2012 *HCF Order*, the Commission estimated that total demand for the RHC Program in FY 2017 would be approximately \$235 million. *Id.* at 16724, para. 98.

¹⁹ See 47 CFR § 54.675(a).

²⁰ See 2017 *NPRM and Order*, 32 FCC Rcd at 10636, Fig. 1. The large increase in funding in FY 2009 reflects commitments made in connection with the 2006 RHC Pilot Program, established to provide funding to support state or regional broadband networks designed to bring the benefits of innovative telehealth and telemedicine to the neediest areas of the country. See *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 21 FCC Rcd 11111, para. 1 (2006) (*Pilot Program Order*).

HCF Program. Total net program demand increased to approximately \$377 million by FY 2015,²¹ and increased to approximately \$407 million in FY 2016.²² In FY 2017, RHC Program net demand increased to approximately \$521 million.²³ The Program's growth is largely attributable to the expansion of services and entities eligible for RHC Program support over the last five years, as well as advances in telehealth technology that require greater bandwidths.²⁴ Our expectation is that Program demand will continue to grow as reliance on technology used for health care delivery increases.²⁵

7. Pursuant to RHC Program rules, when Program demand exceeds the annual funding cap, the Program administrator, the Universal Service Administrative Company (USAC), is required to prorate funding requests to ensure that total commitments approved for that funding year do not exceed the funding cap.²⁶ The impact of this proration can be severe for rural health care providers and the communities they serve,²⁷ and that severity increases as the margin between Program demand and the funding cap grows. In FY 2016, demand exceeded the cap by approximately \$20 million and USAC applied a proration factor of 92.5 percent to eligible funding requests filed during the second filing window (i.e., funding for the eligible costs of the requested services was reduced by 7.5 percent).²⁸ In FY 2017, demand exceeded the funding cap by approximately \$121 million and USAC applied a proration factor of 84.4 percent for individual health care providers and 74.5 percent for consortia (i.e., funding for the eligible costs of the requested services was reduced by 15.6 and 25.5 percent, respectively).²⁹

8. The Commission has recognized that these funding reductions may impede the ability of rural health care providers to provide essential health care services in their rural communities or require them to scale back service offerings or quality, and that these consequences could be particularly severe

²¹ See *Wireline Competition Bureau Provides a Filing Window Period Schedule for Funding Requests Under the Telecommunications Program and the Healthcare Connect Fund*, WC Docket No. 02-60, Public Notice, 31 FCC Rcd 9588, 9589, para. 3 (WCB 2016); USAC, Rural Health Care Program, Funding Commitments, Funding Commitments Archive, <https://www.usac.org/rhc/tools/funding-commitments/archive/funding-commitments-archive.aspx> (last visited June 6, 2018).

²² See FY 2016 Funding Information. Net demand is the total demand for RHC Program funding requests received during the filing window after USAC review. USAC, Rural Health Care Program, Funding Commitments, Glossary of Terms, <https://www.usac.org/rhc/tools/funding-commitments/glossary-terms.aspx> (last visited June 6, 2018).

²³ See FY 2017 Funding Information.

²⁴ See *2017 NPRM and Order*, 32 FCC Rcd at 10639, para. 15; see also *Rural Health Care Mechanism*, WC Docket No. 02-60, Memorandum Opinion and Order, 32 FCC Rcd 5260 (2018) (*Skilled Nursing Facilities Order*) (amending the Commission's rules to include skilled nursing facilities as an eligible health care provider consistent with the Act).

²⁵ See, e.g., JT Ripton and Stefan Winkler, *How Technology is Transforming Treatment in Rural Communities*. (Apr. 8, 2016), <https://www.beckershospitalreview.com/healthcare-information-technology/how-telemedicine-is-transforming-treatment-in-rural-communities.html> (last visited June 6, 2018).

²⁶ See 47 CFR § 54.675(f). Although, as discussed below, this Report and Order eliminates proration reductions for approved FY 2017 commitments, the Commission's proration rules remain in effect.

²⁷ See *Alaska Order*, 32 FCC Rcd at 5464, para. 5 (acknowledging that health care providers may be required to absorb larger portions of the cost of services due to the proration of funding requests, potentially leading to service disruptions and public health consequences). In the *Alaska Order*, the Commission attempted to mitigate the impact of the proration for health care providers in remote Alaskan areas where the impact was especially severe by permitting the service providers for those health care providers to reduce the price of service while holding constant the prorated support amount. *Id.* at 5465, para. 9.

²⁸ See FY 2016 Funding Information.

²⁹ See FY 2017 Funding Information. We note that the 84.4 percent proration factor applied to individual health care providers was assessed after USAC implemented the Commission's direction to carry forward unused funds from prior funding years to mitigate the effects of proration for individual health care providers in FY 2017. See *2017 NPRM and Order*, 32 FCC Rcd at 10667-8, para. 109.

for small, rural health care providers with limited budgets.³⁰ In December 2017, the Commission thus sought comment on a variety of measures to address the issue of RHC Program demand significantly exceeding the \$400 million funding cap.³¹

III. DISCUSSION

9. In this Report and Order, we adopt measures to address the increased demand for funding from the RHC Program and thereby promote health care delivery and telemedicine in rural America. Specifically, we (1) increase the annual RHC Program funding cap to \$571 million and apply it to FY 2017; (2) decide to annually adjust the RHC Program funding cap to reflect inflation, beginning with FY 2018; and (3) establish a process to carry-forward unused funds from past funding years for use in future funding years. The actions we take today will provide rural health care providers with a sufficient and more predictable source of universal service funding to deliver vital telemedicine services to their communities.

A. Raising the RHC Program Funding Cap

10. *Background.* In the *2017 NPRM and Order*, the Commission sought comment on whether to increase the RHC Program's \$400 million annual funding cap and how to determine the appropriate funding cap level.³² The Commission explained that one metric would be to consider what the cap would have been if adjusted by inflation since its adoption.³³ It therefore sought comment on whether to establish a new RHC Program funding cap based on the expected level had the Commission initiated an annual inflation adjustment in 1997 using the gross domestic product chain-type price index (GDP-CPI).³⁴ The Commission also sought comment on whether to apply any increased funding cap to FY 2017.³⁵

³⁰ *2017 NPRM and Order*, 32 FCC Rcd at 10639, para. 15; *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, Order on Reconsideration and Further Notice of Proposed Rulemaking, 18 FCC Rcd 24546, 24550, para. 6 (2003) (noting that the RHC Program “has facilitated the delivery of medical services to people who would otherwise have to wait for care, go without it, or take long and expensive journeys across difficult terrain to find help”). See also SHLB Petition at 2. In its request, SHLB urges the Commission to waive the RHC Program cap and fully fund eligible funding requests to avoid extreme financial hardship to eligible health care providers across the nation. Numerous entities have filed letters in support of the SHLB Petition. See, e.g., Letter from Jennifer Youngberg, Peninsula Community Health Services of Alaska, to Marlene Dortch, FCC, WC Docket No. 17-310 (filed Apr. 11, 2018); Letter from Rosemarie D. Parks, Southeast Health District, to Marlene Dortch, FCC, WC Docket No. 17-310 (filed Apr. 16, 2018); Letter from Becky Hultberg, Alaska State Hospital & Nursing Home Association, to Marlene Dortch, FCC, WC Docket No. 17-310 (filed Apr. 16, 2018); Letter from Bob Wattam, Central Peninsula Hospital, to Marlene Dortch, FCC, WC Docket No. 17-310 (filed Apr. 18, 2018); Letter from Charleen Fisher, Council of Athabaskan Tribal Governments (CATG), to Marlene Dortch, FCC, WC Docket No. 17-310 (filed Apr. 23, 2018); Letter from Holly Smith, Canyonlands Healthcare, to Marlene Dortch, FCC, WC Docket No. 17-310 (filed May 7, 2018). As noted in note 7, *supra*, we dismiss the SHLB Petition as moot due to the relief provided by this Report and Order.

³¹ *2017 NPRM and Order*, 32 FCC Rcd at 10639-41, paras. 16-20.

³² *Id.* at 10639-40, para. 16.

³³ *Id.*

³⁴ *Id.* See U.S. Department of Labor, Bureau of Labor Statistics, Monthly Labor Review, *Comparing the Consumer Price Index with the Gross Domestic Product Price Index and Gross Domestic Product Implicit Price Deflator* (Mar. 2016), <https://www.bls.gov/opub/mlr/2016/article/comparing-the-cpi-with-the-gdp-price-index-and-gdp-implicit-price-deflator.htm> (Comparing Consumer Price Index with GDP Price Index).

³⁵ *2017 NPRM and Order*, 32 FCC Rcd at 10639-40, para. 16.

11. The majority of commenters agree that the Commission should raise the RHC Program funding cap.³⁶ Of those commenters, most argue that setting the cap at \$571 million, the level it would be had the Program been indexed for inflation since its inception, is a sufficient and appropriate metric for establishing a new funding cap today.³⁷ Some commenters instead argue that the cap should be raised beyond \$571 million to account for the expansion of eligible services and entities since the Program's inception, as well as advances in telehealth capabilities and technologies, and increased broadband requirements.³⁸ Other commenters contend that the GDP-CPI index does not sufficiently represent Program demand because the costs of providing health care services have historically outpaced inflation,³⁹ or they assert that the funding cap should simply be doubled to \$800 million to account for inflation, the increased number of eligible entities, and advances in technology.⁴⁰

12. Additionally, some parties assert that the Commission's analysis in setting the original cap of \$400 million was arbitrary or based on incorrect estimates of the number of qualifying rural health care providers.⁴¹ Despite this, these commenters advocate raising the annual funding cap based on the broadband communications requirements for health care providers, the increased demand for the services that such broadband can support, other potential sources of funding of rural health care broadband needs,⁴² or indexing the \$400 million cap to GDP-CPI.⁴³

³⁶ See, e.g., American Telemedicine Association (ATA) 2017 NPRM Comments at 2; American Hospital Association (AHA) 2017 NPRM Comments at 8-9; American Academy of Family Physicians (AAFP) 2017 NPRM Comments at 1; Healthcare Information and Management Systems Society 2017 NPRM Comments at 4.

³⁷ See, e.g., Alaska Communications Systems Group, Inc. (ACS) 2017 NPRM Comments at 11; AAFP 2017 NPRM Comments at 1; Alaska State Hospital & Nursing Home Association (ASHNHA) 2017 NPRM Comments at 1; Community Connection 2017 NPRM Comments at 1; Cross Road Health (CRH) 2017 NPRM Comments at 2; Kodiak Area Native Association (KANA) 2017 NPRM Comments at 1; Kellogg & Sovereign Consulting, LLC (KSLLC) 2017 NPRM Reply Comments at 2.

³⁸ See, e.g., General Communication, Inc. (GCI) 2017 NPRM Comments at 18, 21 (arguing that adjusting the cap for inflation, alone, is insufficient, and that the Commission should establish an appropriate cap by considering the actual number of eligible health care providers, advances in medical services, the communication services needed to deliver these medical services, and the market-driven prices of the underlying communications services); Alaska Primary Care Association (APCA) 2017 NPRM Comments at 2; National Association of Community Health Centers (NACHC) 2017 NPRM Comments at 2; Community Connection 2017 NPRM Comments at 1; California Primary Care Association (CPCA) 2017 NPRM Comments at 1; Florida Association of Community Health Centers, Inc. (FACHC) 2017 NPRM Comments at 1; Texas Association of Community Health Centers (TACHC) 2017 NPRM Reply Comments at 1.

³⁹ See, e.g., Franciscan Health Alliance and Parkview Health Systems (FHA-PHS) 2017 NPRM Comments at 8 (recommending use of the CPI-Medical index); SHLB 2017 NPRM Reply Comments at 3 (recommending use of the CPI-Medical index). See also ADTRAN, Inc. (ADTRAN) 2017 NPRM Comments at 5 (advocating for an unspecified index that reflects broadband equipment costs); ATA 2017 NPRM Comments at 2 (advocating for an unspecified index that reflects the difference between rural and non-rural broadband connection costs).

⁴⁰ See, e.g., SHLB 2017 NPRM Comments at 14; Alaska Native Health Board 2017 NPRM Comments at 6; Bristol Bay Area Health Corporation 2017 NPRM Comments at 6; College of Healthcare Information Management Executives 2017 NPRM Comments at 1; FHA-PHS 2017 NPRM Comments at 7; KSLLC 2017 NPRM Reply Comments at 6; ACS 2017 NPRM Comments at 12-13 (recommending a budget of \$900-\$999 million in light of inflation and also legal and technological advances).

⁴¹ See ADTRAN 2017 NPRM Comments at 4 (arguing that the \$400 million cap "is a somewhat arbitrary number selected back in 1997 as a 'best guess' on needs"); Western New York Rural Area Health Center, Inc. (WNY R-AHEC) 2017 NPRM Comments at 1 (arguing that the \$400 million cap "was based on grossly incorrect estimates of the number of qualifying rural health care providers").

⁴² ADTRAN 2017 NPRM Comments at 4.

13. *Discussion.* We conclude that raising the RHC Program funding cap is necessary to address current and future demand for supported services by health care providers.⁴⁴ Raising the funding cap to \$571 million responds to the significant increase in RHC Program demand resulting from the expansion of eligible services and entities since the Program's creation, as well as the advances in technology that often require higher bandwidth (e.g., higher-speed bandwidth, less latency, and diverse routing) than was contemplated by the Commission when it established a \$400 million cap for the Program in 1997.⁴⁵ We also find that increasing the funding cap to what it would have been if indexed annually for inflation since the inception of the Program, using the GDP-CPI index, ensures that RHC Program funding is sufficient to meet current demand,⁴⁶ while also minimizing the increased costs of funding, which are imposed on USF contributors and generally passed on to consumers. In addition, adjusting the funding cap to account for inflation over the past 20 years maintains the purchasing power in today's dollars that health care providers held when the RHC Program was first instituted. On these bases, we raise the RHC Program annual funding cap from \$400 million to \$571 million.⁴⁷

14. We disagree with those commenters who advocate doubling the RHC Program funding cap to \$800 million at this time.⁴⁸ The \$171 million increase in the annual funding cap that we adopt today exceeds the current demand of \$521 million,⁴⁹ and commenters fail to provide reliable data justifying a \$400 million increase.⁵⁰ Moreover, we believe that adopting such a substantial increase at this time is especially imprudent given our concerns in this proceeding about whether potential waste in the

(Continued from previous page)

⁴³ WNY R-AHEC 2017 NPRM Comments at 1 (favoring increasing the original cap for the RHC program by GDP-CPI, but noting that the pace of technology adoption is increasing exponentially).

⁴⁴ We defer the question of whether to raise the \$150 million cap for multi-year commitments and upfront payments at this time. Although three commenters argued generally for an increase, *see* AANP 2017 NPRM Comments at 2; Christus 2017 NPRM Comments at 3; Illinois Rural HealthNet 2017 NPRM Comments at 2, funding requests have not exceeded this internal \$150 million cap. We plan to consider whether to increase the internal \$150 million cap at a future time, once we have the historical data to determine if such action is necessary and the impact that raising or not the raising the internal cap would have on the functioning of the RHC Program.

⁴⁵ As mentioned above, the Commission established the \$400 million funding cap for the RHC Program based on an assumption that all eligible health care providers would purchase services at a maximum speed of 1.544 Mbps. *See supra* Section II. Today, the RHC Program supports services that require much higher bandwidths, as well as high degrees of network performance and reliability. *See, e.g.,* GCI 2017 NPRM Comments at 18-21; APCA 2017 NPRM Comments at 2; NACHC 2017 NPRM Comments at 2; Community Connection 2017 NPRM Comments at 1; CPCA 2017 NPRM Comments at 1; FACHC 2017 NPRM Comments at 1; TACHC 2017 NPRM Reply Comments at 1.

⁴⁶ We note that GDP-CPI is the inflation index used to adjust the funding cap for the Schools and Libraries Support Mechanism (E-Rate) Program. *See* 47 CFR § 54.507(a)(1)-(3). Many commenters support harmonizing the use of GDP-CPI between the two programs. *See, e.g.,* APCA 2017 NPRM Comments at 6; NACHC 2017 NPRM Comments at 6; CATC 2017 NPRM Comments at 5; CPCA 2017 NPRM Comments at 1; FACHC 2017 NPRM Comments at 1.

⁴⁷ The GDP-CPI averaged over four quarters increased 42.7 percent from 78.088 in 1997 to 111.419 in 2016. Thus, the inflation-adjusted new cap for the RHC Program increases from \$400,000 in 1998 to \$570,735,580 in 2017, which we round to \$571 million. *See* U.S. Bureau of Economic Analysis, Gross Domestic Product: Chain-type Price Index (GDPCTPI), retrieved from FRED, Federal Reserve Bank of St. Louis, <https://fred.stlouisfed.org/series/GDPCTPI> (last visited June 6, 2018).

⁴⁸ *See supra* note 41.

⁴⁹ *See* FY 2017 Funding Information.

⁵⁰ *See, e.g.,* SHLB 2017 NPRM Comments at 12-14 (arguing that the RHC Program funding cap should be doubled based on an unsubstantiated estimate that the number of health care providers potentially eligible for Program support has more than doubled since the inception of the Program).

RHC Telecommunications Program has contributed to reaching the cap sooner than anticipated⁵¹ and what steps we should take to reduce such waste.

15. Accordingly, we conclude that increasing the cap to \$571 million strikes the appropriate balance between ensuring adequate funding for vital telehealth services while minimizing the burden placed on USF contributors and consumers. As necessary, the Commission will assess the need for any future increases in the cap to ensure that the RHC Program is sufficiently funded to achieve the Program's goals of increasing access to broadband for health care providers, particularly in rural areas, and fostering the deployment of broadband health care networks.⁵² For these reasons, we are not persuaded by the arguments submitted by SHLB, ACS, and others that raising the cap to \$571 million is insufficient to address RHC Program demand.⁵³ By raising the cap by \$171 million and taking the other steps discussed in this Report and Order (i.e., indexing the cap to reflect inflation and adopting a carry-forward process for unused funding), we are addressing the substantial increase in RHC Program demand.

16. We are also unpersuaded by AT&T's arguments that until the Commission fundamentally reforms the Telecommunications Program, it is premature to consider increasing the annual RHC Program funding cap.⁵⁴ In light of the current funding shortfall in the RHC Program, we believe that raising the funding cap to \$571 million now is necessary to ensure that sufficient funding is available for eligible health care providers to maintain their current network connections and telehealth services, and to provide additional certainty as health care providers consider their future bandwidth needs. We do, however, agree with AT&T and other commenters that managing waste, fraud, and abuse in the RHC Program is essential to ensuring efficient Program disbursements, and that the Commission should consider additional measures to ensure Program compliance.⁵⁵ For that very reason, the *2017 NPRM and Order* proposed and sought comment on measures to control outlier costs and reform support calculations in the Telecommunications Program, improve competitive bidding, and establish more effective oversight of the RHC Program.⁵⁶

17. In addition to raising the annual RHC Program funding cap, we address the immediate needs of participating health care providers by applying the increased cap to the current funding year (FY 2017). Given the significant financial hardship faced by rural health care providers due to the scarcity of Program funding and the substantial proration of FY 2017 funding requests, it is incumbent on the Commission to make available the additional funding in this funding year. This decision will eliminate the need to prorate the amount of qualified FY 2017 funding requests and relieve rural health care providers of burdensome service cost increases resulting from the required proration.

⁵¹ See *2017 NPRM*, 32 FCC Rcd at 10639-40, para. 16.

⁵² See *HCF Order*, 27 FCC Rcd at 16695, para. 32.

⁵³ SHLB *2017 NPRM* Comments at 12-14; ACS *2017 NPRM* Comments at 12-13 (arguing that a new annual funding cap should account for legal changes (e.g., mandatory electronic health record-keeping requirements) and advances in technology that demand high-speed bandwidth, security, and diverse routing); Peninsula Community Health Services of Alaska *2017 NPRM* Comments at 18-20 (arguing that simply adjusting the annual funding cap for inflation is insufficient because of increased technology and telecommunications demands, advances in telemedicine capabilities, changes in patient standards of care and new demands from skilled nursing facilities); KSLLC *2017 NPRM* Comments at 6 (arguing that the annual funding cap should be increased to \$800 million and indexed to inflation).

⁵⁴ See AT&T *2017 NPRM* Reply Comments at 16; see also USTelecom *2017 NPRM* Comments at 11-12 (arguing that once the Telecom Program is reformed "in the lower 48, there may be no need for any increase in Telecom Program funding outside of Alaska"). But see TeleQuality *2017 NPRM* Comments at 4 (arguing that the pressure on the cap is not attributable to waste, fraud, and abuse but to the realities and needs of the provision of modern health care and increased broadband capabilities that are required to implement essential technological advances).

⁵⁵ See AT&T *2017 NPRM* Reply Comments at 16; USTelecom *2017 NPRM* Comments at 12-22.

⁵⁶ *2017 NPRM and Order*, 32 FCC Rcd at 10647-66, Section III.B & Section III.C.

18. None of the commenters who support raising the annual funding cap oppose applying the funding cap to FY 2017.⁵⁷ In the *2017 NPRM and Order*, the Commission sought comment on whether to raise the funding cap, and whether the funding cap should be increased for FY 2017 to address the financial distress that can result from the proration of funding requests.⁵⁸ The Commission anticipated that demand would exceed the funding cap in FY 2017,⁵⁹ potentially at a level requiring a deeper proration than required in FY 2016,⁶⁰ and recognized that the “proration that comes with capped funding may be especially hard on small, rural healthcare providers with limited budgets”⁶¹ USAC has since announced and applied a significant proration factor for FY 2017, and the hardship anticipated by the Commission has been reflected in petitions for relief and correspondence filed in the RHC Program dockets.⁶² We conclude that the public health consequences that could result from rural health care providers receiving reduced funding as a result of the proration of their funding requests in FY 2017 weighs in favor of increasing the FY 2017 RHC Program cap to the \$571 million level as adopted by this Report and Order.

19. By taking this action, we make significant funding available to issue commitments for the full amount approved for FY 2017 funding requests prior to proration.⁶³ We direct USAC to collect the additional funds needed to fully fund FY 2017 demand over the next two quarters in accordance with our standard process for calculating and announcing the quarterly contribution factor to reduce the impact on ratepayers. We further direct USAC to take any other steps necessary to reverse the proration of approved FY 2017 funding requests, consistent with this Report and Order.

B. Instituting an Annual Inflation Adjustment

20. *Background.* In addition to whether and how to raise the RHC Program annual funding cap, the *2017 NPRM and Order* sought comment on whether the cap should be adjusted annually for inflation.⁶⁴ The Commission noted that other universal service support mechanisms use the GDP-CPI inflation index to adjust funding caps,⁶⁵ and inquired whether the RHC Program cap should also be

⁵⁷ See, e.g., ACS *2017 NPRM* Comments at 11; AAFP *2017 NPRM* Comments at 1; ASHNHA *2017 NPRM* Comments at 1; Community Connection *2017 NPRM* Comments at 1; CRH *2017 NPRM* Comments at 2; KANA *2017 NPRM* Comments at 1; KSLLC *2017 NPRM* Reply Comments at 2. Commenters that oppose raising the cap before further reforms are made to the RHC Program do not specifically oppose raising the cap for FY 2017. AT&T *2017 NPRM* Comments at 16; USTelecom *2017 NPRM* Comments at 8-12.

⁵⁸ See *2017 NPRM and Order*, 32 FCC Rcd at 10639-40, paras. 15-16.

⁵⁹ *Id.* at 10639, para. 14.

⁶⁰ *Id.*

⁶¹ See *id.* at 10639, para. 15.

⁶² In its Petition, SHLB describes the impact of the FY 2017 proration as immediate, irreparable, and severe, noting that the magnitude of the funding cuts so late in the health care providers’ budget year will adversely affect their ability to provide vital telehealth services. See SHLB Petition at 6-10; see also Letter from Debra Shelor, Tri-Area Community Health, to Marlene Dortch, FCC, WC Docket No. 17-310 (filed May 11, 2018); Letter from Richard D. Shinn, Virginia Community Healthcare Association, to Marlene Dortch, FCC, WC Docket No. 17-310 (filed May 10, 2018); Letter from Rick Groves, Chambers Health, to Marlene Dortch, FCC, WC Docket No. 17-310 (filed May 4, 2018).

⁶³ Demand for FY 2017 RHC Program funding is approximately \$521 million. See FY 2017 Funding Information. In increasing the RHC Program funding cap for FY 2017 to \$571 million, we make no finding as to the ultimate eligibility of the services requested by FY 2017 funding requests or whether the health care providers’ applications comply with RHC Program rules.

⁶⁴ See *2017 NPRM and Order*, 32 FCC Rcd at 10640, para. 18.

⁶⁵ See, e.g., 47 CFR § 54.507(a)(1)-(3) (providing for annual adjustment of the \$3.9 billion funding cap for the E-Rate Program based on the GDP-CPI index); 47 CFR § 32.9000 (defining mid-sized incumbent local exchange carrier with annual revenue indexed for inflation as measured by the GDP-CPI); 47 CFR § 36.603(c). See also

adjusted annually on the same basis.⁶⁶ Commenters that support raising the RHC Program funding cap to the level that it would be had it been indexed for inflation using GDP-CPI since the inception of the Program also support adjusting the cap for inflation in future funding years.⁶⁷

21. *Discussion.* We adopt a rule today that, beginning in FY 2018, the RHC Program funding cap will be adjusted annually for inflation using the GDP-CPI inflation index.⁶⁸ By itself, raising the cap does not create the flexibility necessary to ensure that rural health care providers have affordable access to telecommunications and broadband services in the event of future price inflation. Accordingly, we must also institute an annual inflation adjustment to ensure that the RHC Program maintains consistent purchasing power without unreasonably increasing the size of the USF and increasing the USF contribution charges that are ultimately passed through to consumers.

22. We conclude that it is appropriate to rely upon the GDP-CPI index for the RHC Program's inflation adjustment. There is no index that specifically examines the cost of services funded under the RHC Program.⁶⁹ Given that GDP-CPI is the same index the Commission uses to inflation-adjust the E-Rate Program cap, the high-cost loop support mechanism cap,⁷⁰ and in other contexts to estimate inflation of carrier costs,⁷¹ we conclude that it is reasonable to use the GDP-CPI to approximate the impact of inflation on RHC Program supported services.⁷² In the event of periods of deflation, we will maintain the prior-year cap to maintain predictability.⁷³

23. To compute the annual inflation adjustment, the percentage increase in the GDP-CPI

(Continued from previous page)

Schools and Libraries Universal Service Support Mechanism, CC Docket No. 02-6, Sixth Report and Order, 25 FCC Rcd 18762, 18782, para. 36 (2010) (*E-Rate Sixth Report and Order*).

⁶⁶ See *2017 NPRM and Order*, 32 FCC Rcd at 10640, para. 18.

⁶⁷ See, e.g., *CAH 2017 NPRM Comments* at 1; *CPC 2017 NPRM Comments* at 1; *FACHC 2017 NPRM Comments* at 1; *GCI 2017 NPRM Comments* at 21-22; *TeleQuality 2017 NPRM Comments* at 4; *Yukon-Kuskokwim Health Corporation (YKHC) 2017 NPRM Comments* at 3.

⁶⁸ See Appendix A, 47 CFR § 54.675(a)(1)-(2) as adopted herein.

⁶⁹ FHA-PHS argues that the cap should be adjusted for inflation using the CPI-Medical Index, which indicates that the cost of providing health care has outpaced inflation (i.e., the cost of health care has grown by an average of 3.5 percent over the last 20 years in contrast to the CPI, which has grown on an average by 2.2 percent). If the CPI-Medical Index was used to adjust the cap for inflation since the inception of the Program, the cap would be \$810.27 million today. See *FHA-PHS 2017 NPRM Comments* at 6-8; *SHLB 2017 NPRM Reply Comments* at 5 (supporting use of the CPI-Medical Index); see also *ACS 2017 NPRM Comments* at 12, n.12 (arguing that the appropriate measure of inflation is the Consumer Price Index for All Urban Consumers (CPI-U), which includes price changes in imported goods and services reflecting the fact that “telecom providers are purchasing most of their equipment from overseas manufacturers”). The CPI-Medical Index is comprised of two main components: (1) medical care services, which includes professional services, hospital and related services; and (2) health insurance and medical care commodities, which include medicinal drugs and medical equipment and supplies. See U.S. Department of Labor, Bureau of Labor Statistics, Consumer Price Index, *Measuring Price Change in CPI: Medical Care*, <https://www.bls.gov/cpi/factsheets/medical-care.htm> (last visited June 6, 2018). We reject FHA-PHS's argument because the RHC Program does not support the cost of medical care and medical care commodities but rather provides support for access to telecommunications so that rural health care providers may meet the health care needs of their communities. By indexing the cap to the GDP-CPI index as we do in the E-Rate Program, we move toward aligning the support provided by the RHC Program with the needs of rural health care providers.

⁷⁰ See, e.g., 47 CFR § 54.507(a)(1)-(3); 47 CFR § 54.303(c).

⁷¹ See 47 CFR § 32.9000 (defining mid-sized incumbent local exchange carrier with annual revenue indexed for inflation as measured by the GDP-CPI); *Reform of Filing Requirements and Carrier Classifications*, CC Docket No. 96-193, Order and Notice of Proposed Rulemaking, 11 FCC Rcd 11716, 11721-22, para. 10 (1996).

⁷² See Comparing Consumer Price Index with GDP Price Index.

⁷³ See *E-Rate Sixth Report and Order*, 25 FCC Rcd at 18782, para. 39.

from the previous year will be used. The increase shall be rounded to the nearest 0.1 percent. The increase in the inflation index will then be used to calculate the maximum amount of funding for the next RHC Program funding year which runs from July 1 to June 30. When the calculation of the yearly average GDP-CPI is determined, the Wireline Competition Bureau (Bureau) will publish a Public Notice in the Federal Register within 60 days announcing any increase in the annual funding cap based on the rate of inflation.⁷⁴ For FY 2018, based on GDP-CPI, the RHC Program funding cap will be \$581 million.⁷⁵

C. Adopting a Carry-Forward Process for the RHC Program

24. *Background.* In the *2017 NPRM and Order*, the Commission sought comment on whether to allow unused funds committed in one funding year to be carried forward to a subsequent funding year.⁷⁶ In fact, in the accompanying *Order*, the Commission directed that unused funds from prior years be carried forward to reduce the effect of proration for certain health care providers in FY 2017.⁷⁷ All those who commented on this issue supported the proposal that unused funds be carried forward for use in subsequent years.⁷⁸

25. *Discussion.* We find that, beginning in FY 2018, unused funds may be carried forward from previous years for use in subsequent funding years. Unused funds are the difference between the amount of funds collected, or made available for that particular funding year, and the amount of funds disbursed or to be disbursed for that funding year.⁷⁹ Funds carried forward from one funding year may be rolled over to multiple funding years until ultimately committed and disbursed. Considering the high demand for RHC Program funding, we conclude that this action is consistent with the goals of the RHC Program, aligns the RHC Program with the E-Rate Program's carry-forward process, and is in the public interest.

26. Additionally, as in the E-Rate Program, we will require USAC to provide quarterly estimates to the Commission regarding the amount of unused funds that will be available for carryover in subsequent years.⁸⁰ This requirement codifies USAC's existing reporting practice and reporting cycle. The quarterly estimate will also provide stakeholders of the RHC Program with general notice regarding the estimated amount of unused funds that may be made available in the subsequent year.

27. Further, we will make unused funds available annually in the second quarter of each calendar year for use in the next full funding year of the RHC Program. Based on the estimates provided by USAC, the Commission will announce a specific amount of unused funds from prior funding years to be carried forward to increase available funding for future funding years. This unused funding may be used to commit to eligible services in excess of the annual funding cap in the event demand in a given

⁷⁴ See Appendix A, 47 CFR § 54.675(a)(3) as adopted herein.

⁷⁵ The annual GDP-CPI increased from 111.419 in 2016 to 113.425 in 2017, an increase of 1.8 percent. Thus, the inflation-adjusted new cap would increase from \$571 million in 2017 to \$581,278,000 in 2018. See FRED Gross Domestic Product: Chain-type Price Index (GDPCTPI), Federal Reserve Bank of St. Louis, <https://fred.stlouisfed.org/series/GDPCTPI> (last visited June 6, 2018).

⁷⁶ *2017 NPRM and Order*, 32 FCC Red at 10641, para. 19.

⁷⁷ *Id.* at 10667-8, para. 109.

⁷⁸ See, e.g., ACS *2017 NPRM* Reply Comments at 18; AHA *2017 NPRM* Comments at 9; AT&T *2017 NPRM* Reply Comments at 18; CATG *2017 NPRM* Comments at 6; FHA *2017 NPRM* Comments at 8; USTelecom *2017 NPRM* Comments at 11.

⁷⁹ Such funds may include funds that are de-obligated due to a voluntary downward adjustment, funds that were committed but not disbursed, or funds reserved for appeals that were denied or for which an appeal was not ultimately filed.

⁸⁰ See Appendix A, 47 CFR § 54.675(a)(4) as adopted herein; see also 47 CFR § 54.507(a)(5) (requiring USAC to report to the Commission on a quarterly basis E-Rate funding that is unused from prior years).

year exceeds the cap, or it may be used to reduce collections for the RHC Program in a year when demand is less than the cap.⁸¹ The Bureau will announce the availability and amount of carryover funds during the second quarter of the calendar year.

28. Finally, we find it is in the public interest to carry forward unused funds for disbursement on an annual basis. Distribution of unused funds on an annual basis allows USAC to refine its calculation of available funds over four reporting quarters as the funding year progresses. We also believe that the timing of this process provides certainty regarding when unused funds will be carried forward for use in the RHC Program with minimal disruption to the administration of the Program.

IV. PROCEDURAL MATTERS

29. *Paperwork Reduction Act.* This document contains no new information collection requirements subject to the Paperwork Reduction Act of 1995 (PRA), Public Law 104-13. In addition, we note that pursuant to the Small Business Paperwork Relief Act of 2002, Public Law 107-198, *see* 44 U.S.C. 3506(c)(4), we previously sought specific comment on how the Commission might further reduce the information collection burden for small business concerns with fewer than 25 employees. We describe impacts that might affect small businesses, which includes most business with fewer than 25 employees, in the Final Regulatory Flexibility Analysis (FRFA) in Appendix B, *infra*.

30. *Congressional Review Act.* The Commission will send a copy of this Report and Order to Congress and the Government Accountability Office pursuant to the Congressional Review Act, *see* 5 U.S.C. 801(a)(1)(A).

31. *Regulatory Flexibility Act.* The Regulatory Flexibility Act of 1980 (RFA) requires that an agency prepare a regulatory flexibility analysis for notice and comment rulemakings, unless the agency certifies that “the rule will not, if promulgated, have a significant economic impact on a substantial number of small entities.” Accordingly, we have prepared a Final Regulatory Flexibility Analysis (FRFA) concerning the possible impact of the rule changes contained in the Report and Order on small entities. The FRFA is set forth in Appendix B. The Commission will send a copy of the Report and Order, including the FRFA below, in a report to be sent to Congress and the Government Accountability Office pursuant to the Small Business Regulatory Enforcement Fairness Act of 1996.⁸² In addition, the Commission will send a copy of the Report and Order, including the FRFA, to the Chief Counsel for Advocacy of the Small Business Administration. A copy of the Report and Order and FRFA (or summaries thereof) will also be published in the Federal Register.

32. *Effective Date of Report and Order.* We find good cause to make the rule changes herein effective upon publication in the Federal Register, pursuant to Section 553(d) of the Administrative Procedure Act.⁸³ Agencies determining whether there is good cause to make a new rule or rule revision take effect less than 30 days after Federal Register publication must balance the necessity for immediate implementation against principles of fundamental fairness that require that all affected persons be

⁸¹ *See* Appendix A, 47 CFR § 54.675(a)(4) as adopted herein (requiring unused funds to be carried forward into subsequent funding years in accordance with the public interest and notwithstanding the cap); Appendix A, 47 CFR § 54.675(a)(5) as adopted herein (providing that, on an annual basis, in the second quarter of each calendar year, all funds collected and unused from prior years shall be available for use in the next full funding year). Similar rules are codified in the E-Rate Program. *See* 47 CFR § 54.507(a)(5) (requiring unused funds to be carried forward into subsequent funding years in accordance with the public interest and notwithstanding the cap); 47 CFR § 54.507(a)(6) (providing that, on an annual basis, in the second quarter of each calendar year, all funds collected and unused from prior years shall be available for use in the next full funding year).

⁸² 5 U.S.C. § 801(a)(1)(A).

⁸³ 5 U.S.C. § 553(d)(3); 47 CFR § 1.427(b) (“For good cause found and published with the rule, any rule issued by the Commission may be made effective within less than 30 days from the time it is published in the Federal Register”).

afforded a reasonable time to prepare for the effective date of the new rule.⁸⁴ Making these rule changes effective upon publication in the Federal Register enables eligible health care providers to benefit from the increased funding cap for FY 2017, thereby avoiding the financial hardship caused by the proration of their funding commitments and the potential public health crises that could result. As noted earlier, the current reduction in funding may impede the ability of rural health care providers to provide essential health care services in their rural communities, or require them to scale back service offerings or quality, and these consequences could be particularly severe for small, rural health care providers with limited budgets.⁸⁵

33. Further, making these rule changes effective upon publication will not burden contributors or RHC Program participants. As a practical matter, contributors pass through their contribution obligations to their end users by a line item on the end user's invoice, which they update quarterly based on the contribution factor.⁸⁶ The additional funding required by this Report and Order to be applied to FY 2017 will be collected over the next two quarters in accordance with our regular course of business for calculating and announcing the quarterly contribution factor, thus requiring no additional or different administrative burden on contributors.⁸⁷ No additional time is needed for affected parties to prepare for the rules' effectiveness because USAC and interested parties have already applied for and processed the requests for funding for the current RHC Program year (FY 2017). Additionally, the rule change to increase the funding cap enables eligible health care providers to benefit from increased funding in the current funding year and does not oblige them to take any particular action. The rule changes that index the funding cap to inflation and carry forward unused funds do not impose any additional requirement on RHC Program participants and will be implemented by Commission staff and USAC during FY 2018. Thus, we find good cause to make these rule changes effective upon publication in the Federal Register.

V. ORDERING CLAUSES

34. Accordingly, IT IS ORDERED that, pursuant to sections 4(i)-(j), 201(b), and 254 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 154(i)-(j), 201(b), 254, this Report and Order IS ADOPTED.

35. IT IS FURTHER ORDERED that Part 54 of the Commission's rules, 47 CFR Part 54, is AMENDED as set forth in Appendix A, and such rules shall become effective immediately upon publication of this Report and Order in the Federal Register.

36. IT IS FURTHER ORDERED that, pursuant to the authority contained in sections 1-4 and 254 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151-154 and 254, and pursuant to section 1.3 and of the Commission's rules, 47 CFR § 1.3, that section 54.675 of the Commission's rules, 47 CFR § 54.675, IS WAIVED to the extent provided herein.

37. IT IS FURTHER ORDERED that, pursuant to the authority contained in sections 1-4 and 254 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151-154 and 254, the petitions for waiver filed by Schools, Health, and Libraries Broadband Coalition filed on April 3, 2018, Advanced Data Solutions (on behalf of Frontier Community Services, Central Peninsula Hospital, Cordova Community Medical Center, Camai Community Health Center, IHS/ABQ Alamo Health Center and

⁸⁴ *Omnipoint Corporation v. FCC*, 78 F.3d 620, 630 (D.C. Cir. 1996) (citing *United States v. Gavrilovic*, 551 F.2d 1099, 1105 (8th Cir. 1977)).

⁸⁵ See *supra* para. 8.

⁸⁶ See 47 CFR § 54.712(a) (authorizing contributors to recover federal universal service contribution costs from their customers); see also *High-Cost Universal Service Support; Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, WC Docket No. 05-337, Notice of Proposed Rulemaking, 23 FCC Rcd 1467, 1469, para. 4 note 10 (2008) (noting that providers almost always pass contribution obligations through to their customers).

⁸⁷ See *supra* para. 19.

Kenaitze Indian Tribe) filed on May 15, 2018, Bristol Bay Area Health Corporation filed on April 2, 2018, and Council of Athabascan Tribal Government filed on April 9, 2018 ARE DISMISSED AS MOOT.

38. IT IS FURTHER ORDERED that, pursuant to 5 U.S.C. § 801(a)(1)(A), the Commission SHALL SEND a copy of this Report and Order to Congress and to the Government Accountability Office pursuant to the Congressional Review Act.

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

FEDERAL COMMUNICATIONS COMMISSION

Marlene H. Dortch
Secretary

APPENDIX A

Final Rules

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

PART 54—UNIVERSAL SERVICE

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

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

2. Amend § 54.675 by revising paragraph (a) and adding paragraphs (a)(1) through (a)(5) to read as follows:

§54.675 Cap.

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

(1) Inflation increase. In funding year 2018 and the subsequent funding years, the \$571 million cap on federal universal support in the Rural Health Care Program shall be automatically increased annually to take into account increases in the rate of inflation as calculated in paragraph (a)(2) of this section.

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

(3) Public notice. When the calculation of the yearly average GDP-CPI is determined, the Wireline Competition Bureau shall publish a public notice in the FEDERAL REGISTER within 60 days announcing any increase of the annual funding cap based on the rate of inflation.

(4) Amount of unused funds. All funds collected that are unused shall be carried forward into subsequent funding years for use in the Rural Health Care Program in accordance with the public interest and notwithstanding the annual cap. The Administrator shall report to the Commission, on a quarterly basis, funding that is unused from prior years of the Rural Health Care Program.

(5) Application of unused funds. On an annual basis, in the second quarter of each calendar year, all funds that are collected and that are unused from prior years shall be available for use in the next full funding year of the Rural Health Care Program in accordance with the public interest and notwithstanding the annual cap as described in paragraph (a) of this section.

APPENDIX B

Final Regulatory Flexibility Analysis

1. As required by the Regulatory Flexibility Act of 1980, as amended (RFA),¹ an Initial Regulatory Flexibility Analysis (IRFA) of the possible significant economic impact on a substantial number of small entities by the policies and rules was incorporated into the 2017 Notice of Proposed Rulemaking (NPRM).² Written comments were requested on this IRFA. This present Final Regulatory Flexibility Analysis (FRFA) conforms to the RFA.

A. Need for, and Objectives of, the Report and Order

2. Through this Report and Order, 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 health care providers—in the most equitable, effective, efficient, clear, and predictable manner as possible. Telemedicine has become an increasingly vital component of health care delivery to rural Americans and, in Funding Year (FY) 2016, for the first time in the RHC Program's twenty-year history, and then again in FY 2017, demand for support exceeded the \$400 million annual cap which necessitated reduced, *pro rata* distribution of support.³ In light of the significance and scarcity of RHC Program support, the Commission adopts several measures to most effectively meet health care providers' needs while responsibly stewarding the RHC Program's limited funds. Specifically, the Commission adopts rules that: (1) raise the annual RHC Program funding cap to \$571 million to apply to FY 2017; (2) adjust the annual RHC Program funding cap for inflation; and (3) establish a mechanism to carry-forward unused funds from past funding years for use in future funding years.

B. Summary of Significant Issues Raised by Public Comments in Response to the IRFA

3. There were no comments filed that specifically addressed the rules and policies proposed in the IRFA.

C. Response to Comments by the Chief Counsel for Advocacy of the Small Business Administration

4. The Chief Counsel did not file any comments in response to the proposed rules in this proceeding.

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

5. 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.⁴ The RFA generally defines the term "small entity" as having the same meaning as the terms "small business," "small organization," and "small governmental jurisdiction."⁵ In addition, the term "small business" has the same meaning as the term "small business concern" under the Small Business Act.⁶ A small business

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

² *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Notice of Proposed Rulemaking and Order, 32 FCC Rcd 10631 (2017).

³ See 47 CFR § 54.675(f).

⁴ 5 U.S.C. § 603(b)(3).

⁵ 5 U.S.C. § 601(6).

⁶ 5 U.S.C. § 601(3) (incorporating by reference the definition of "small business concern" in 15 U.S.C. § 632). Pursuant to the RFA, the statutory definition of a small business applies "unless an agency, after consultation with the Office of Advocacy of the Small Business Administration and after opportunity for public comment, establishes

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).⁷

6. *Small Businesses, Small Organizations, Small Governmental Jurisdictions.* Our actions, over time, may affect small entities that are not easily categorized at present. We therefore describe here, at the outset, three broad groups of small entities that could be directly affected herein.⁸ First, while there are industry specific size standards for small businesses that are used in the RFA, according to data from the SBA's Office of Advocacy, in general a small business is an independent business having fewer than 500 employees.⁹ These types of small businesses represent 99.9 percent of all businesses in the United States, which translates to 28.8 million businesses.¹⁰

7. 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."¹¹ Nationwide, as of August 2016, there were approximately 356,494 small organizations based on registration and tax data filed by nonprofits with the Internal Revenue Service (IRS).¹²

8. 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."¹³ U.S. Census Bureau data from the 2012 Census of Governments¹⁴ indicate that there were 90,056 local governmental jurisdictions consisting of general purpose governments and special purpose governments in the United States.¹⁵ Of this number, there were

(Continued from previous page) _____

one or more definitions of such term which are appropriate to the activities of the agency and publishes such definition(s) in the Federal Register." *Id.*

⁷ See 15 U.S.C. § 632.

⁸ See 5 U.S.C. § 601(3)-(6).

⁹ See SBA, Office of Advocacy, *Frequently Asked Questions*, Question 1: What is a small business?, https://www.sba.gov/sites/default/files/advocacy/SB-FAQ-2016_WEB.pdf (last visited June 6, 2018).

¹⁰ See SBA, Office of Advocacy, *Frequently Asked Questions*, Question 2: How many small businesses are there in the U.S.?, https://www.sba.gov/sites/default/files/advocacy/SB-FAQ-2016_WEB.pdf (last visited June 6, 2018).

¹¹ 5 U.S.C. § 601(4).

¹² Data from the Urban Institute, National Center for Charitable Statistics (NCCS) reporting on nonprofit organizations registered with the IRS was used to estimate the number of small organizations. Reports generated using the NCCS online database indicated that as of August 2016 there were 356,494 registered nonprofits with total revenues of less than \$100,000. Of this number, 326,897 entities filed tax returns with 65,113 registered nonprofits reporting total revenues of \$50,000 or less on the IRS Form 990-N for Small Exempt Organizations and 261,784 nonprofits reporting total revenues of \$100,000 or less on some other version of the IRS Form 990 within 24 months of the August 2016 data release date. See NCCS Web Tools, NCCS Nonprofits, <http://nccs.urban.org/sites/all/nccs-archive/html/tablewiz/tw.php> (last visited June 6, 2018) (where the report showing this data can be generated by selecting the following data fields: Report: "The Number and Finances of All Registered 501(c) Nonprofits"; Show: "Registered Nonprofit Organizations"; By: "Total Revenue Level (years 1995, Aug to 2016, Aug)"; and For: "2016, Aug" then selecting "Show Results").

¹³ 5 U.S.C. § 601(5).

¹⁴ See 13 U.S.C. § 161. The Census of Governments is conducted every five (5) years compiling data for years ending with "2" and "7." See U.S. Census Bureau, *Program Census of Governments*, <https://factfinder.census.gov/faces/affhelp/jsf/pages/metadata.xhtml?lang=en&type=program&id=program.en.COG#> (last visited June 6, 2018).

¹⁵ See U.S. Census Bureau, *2012 Census of Governments, Local Governments by Type and State: 2012 - United States-States*, <https://factfinder.census.gov/bkmk/table/1.0/en/COG/2012/ORG02.US01> (last visited June 6, 2018) (local governmental jurisdictions are classified in two categories - general purpose governments (county, municipal and town or township) and special purpose governments (special districts and independent school districts)).

37,132 General purpose governments (county,¹⁶ municipal and town or township¹⁷) with populations of less than 50,000 and 12,184 Special purpose governments (independent school districts¹⁸ and special districts¹⁹) with populations of less than 50,000. The 2012 U.S. Census Bureau data for most types of governments in the local government category show that the majority of these governments have populations of less than 50,000.²⁰ Based on this data we estimate that at least 49,316 local government jurisdictions fall in the category of “small governmental jurisdictions.”²¹

9. Small entities potentially affected by the reforms adopted herein include eligible non-profit and public health care providers and the eligible service providers offering them services, including telecommunications service providers, Internet Service Providers (ISPs), and vendors of the services and equipment used for dedicated broadband networks.²²

1. Health Care Providers

10. *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 health maintenance organization (HMO) medical centers.²³ The SBA has created a size standard for this industry, which is annual receipts of \$11 million or less.²⁴ According to 2012 U.S. Economic Census, 152,468 firms

¹⁶ See U.S. Census Bureau, *2012 Census of Governments, County Governments by Population-Size Group and State: 2012 - United States-States*, <https://factfinder.census.gov/bkmk/table/1.0/en/COG/2012/ORG06.US01> (last visited June 6, 2018) (2012 Census, County Governments by Population-Size Group and State). There were 2,114 county governments with populations less than 50,000.

¹⁷ See U.S. Census Bureau, *2012 Census of Governments, Subcounty General-Purpose Governments by Population-Size Group and State: 2012 - United States - States*, <https://factfinder.census.gov/bkmk/table/1.0/en/COG/2012/ORG07.US01> (last visited June 6, 2018) (2012 Census, Subcounty General-Purpose Governments by Population-Size Group and State). There were 18,811 municipal and 16,207 town and township governments with populations less than 50,000.

¹⁸ See U.S. Census Bureau, *2012 Census of Governments, Elementary and Secondary School Systems by Enrollment-Size Group and State: 2012 - United States-States*, <https://factfinder.census.gov/bkmk/table/1.0/en/COG/2012/ORG11.US01> (last visited June 6, 2018) (2012 Census, Elementary and Secondary School Systems by Enrollment-Size Group and State). There were 12,184 independent school districts with enrollment populations less than 50,000.

¹⁹ See U.S. Census Bureau, *2012 Census of Governments, Special District Governments by Function and State: 2012 - United States-States*, <https://factfinder.census.gov/bkmk/table/1.0/en/COG/2012/ORG09.US01> (last visited June 6, 2018). The U.S. Census Bureau data did not provide a population breakout for special district governments.

²⁰ See 2012 Census, County Governments by Population-Size Group and State; 2012 Census, Subcounty General-Purpose Governments by Population-Size Group and State; 2012 Census, Elementary and Secondary School Systems by Enrollment-Size Group and State. While U.S. Census Bureau data did not provide a population breakout for special district governments, if the population of less than 50,000 for this category of local government is consistent with the other types of local governments the majority of the 38, 266 special district governments have populations of less than 50,000.

²¹ See 2012 Census, Subcounty General-Purpose Governments by Population-Size Group and State; 2012 Census, Elementary and Secondary School Systems by Enrollment-Size Group and State.

²² 47 CFR §§ 54.601, 54.621.

²³ See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 621111 “Offices of Physicians (except Mental Health Specialists),” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621111&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

²⁴ 13 CFR § 121.201, NAICS Code 621111.

operated throughout the entire year in this industry.²⁵ Of that number, 147,718 had annual receipts of less than \$10 million, while 3,108 firms had annual receipts between \$10 million and \$24,999,999.²⁶ Based on this data, we conclude that a majority of firms operating in this industry are small under the applicable size standard.

11. *Offices of Physicians, Mental Health Specialists.* The 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.²⁷ The SBA has established a size standard for businesses in this industry, which is annual receipts of \$11 million dollars or less.²⁸ The U.S. Economic Census indicates that 8,809 firms operated throughout the entire year in this industry.²⁹ Of that number 8,791 had annual receipts of less than \$10 million, while 13 firms had annual receipts between \$10 million and \$24,999,999.³⁰ Based on this data, we conclude that a majority of firms in this industry are small under the applicable standard.

12. *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.S. (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.³¹ The SBA has established a size standard for that industry of annual receipts of \$7.5 million or less.³² The 2012 U.S. Economic Census indicates that 115,268 firms operated in the dental industry throughout the entire year.³³ Of that number 114,417 had annual receipts of less than \$5 million, while

²⁵ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621111, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics-621111 (last visited June 6, 2018).

²⁶ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$11 million or less.

²⁷ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621112 “Offices of Physicians, Mental Health Specialists,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621112&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

²⁸ 13 CFR § 121.201; NAICS Code 621112.

²⁹ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621112, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics-621112 (last visited June 6, 2018).

³⁰ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$11 million or less.

³¹ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621210 “Offices of Dentists,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621210&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

³² 13 CFR § 121.201; NAICS Code 621210.

³³ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621210, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics-621210 (last visited June 6, 2018).

651 firms had annual receipts between \$5 million and \$9,999,999.³⁴ Based on this data, we conclude that a majority of business in the dental industry are small under the applicable standard.

13. *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.³⁵ The SBA has established a size standard for this industry, which is annual receipts of \$7.5 million or less.³⁶ The 2012 U.S. Economic Census statistics show that in 2012, there were 33,940 firms operated throughout the entire year.³⁷ 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 \$9,999,999.³⁸ Based on that data, we conclude that a majority of chiropractors are small.

14. *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.³⁹ The SBA has established a size standard for businesses operating in this industry, which is annual receipts of \$7.5 million or less.⁴⁰ The 2012 Economic Census indicates that 18,050 firms operated the entire year.⁴¹ Of that number, 17,951 had annual receipts of less than \$5 million, while 70 firms had annual receipts between \$5 million and \$9,999,999.⁴² Based on this data, we conclude that a majority of optometrists in this industry are small.

³⁴ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$7.5 million or less.

³⁵ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621310 “Offices of Chiropractors,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621310&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018). See also NAICS Code 621310; 13 CFR § 121.201.

³⁶ 13 CFR § 121.201; NAICS Code 621310.

³⁷ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621310, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621310 (last visited June 6, 2018).

³⁸ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$7.5 million or less.

³⁹ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621320 “Offices of Optometrists,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621320&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

⁴⁰ 13 CFR § 121.201; NAICS Code 621320.

⁴¹ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621320, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621320 (last visited June 6, 2018).

⁴² *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$7.5 million or less.

15. *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.⁴³ The SBA has created a size standard for this industry, which is annual receipts of \$7.5 million or less.⁴⁴ The 2012 U.S. Economic Census indicates that 16,058 firms operated throughout the entire year.⁴⁵ Of that number, 15,894 firms received annual receipts of less than \$5 million, while 111 firms had annual receipts between \$5 million and \$9,999,999.⁴⁶ Based on this data, we conclude that a majority of mental health practitioners who do not employ physicians are small.

16. *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.⁴⁷ The SBA has established a size standard for this industry, which is annual receipts of \$7.5 million or less.⁴⁸ The 2012 U.S. Economic Census indicates that 20,567 firms in this industry operated throughout the entire year.⁴⁹ Of this number, 20,047 had annual receipts of less than \$5 million, while 270 firms had annual receipts between \$5 million and \$9,999,999.⁵⁰ Based on this data, we conclude that a majority of businesses in this industry are small.

17. *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

⁴³ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621330 “Offices of Mental Health Practitioners (except Physicians),” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621330&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

⁴⁴ 13 CFR § 121.201; NAICS Code 621330.

⁴⁵ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621330, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621330 (last visited June 6, 2018).

⁴⁶ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$7.5 million or less.

⁴⁷ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621340 “Offices of Physical, Occupational and Speech Therapists and Audiologists,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621340&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

⁴⁸ 13 CFR § 121.201; NAICS Code 621340.

⁴⁹ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621340, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621340 (last visited June 6, 2018).

⁵⁰ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$7.5 million or less.

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.⁵¹ The SBA has established a size standard for businesses in this industry, which is annual receipts of \$7.5 million or less.⁵² The 2012 U.S. Economic Census indicates that 7,569 podiatry firms operated throughout the entire year.⁵³ Of that number, 7,545 firms had annual receipts of less than \$5 million, while 22 firms had annual receipts between \$5 million and \$9,999,999.⁵⁴ Based on this data, we conclude that a majority of firms in this industry are small.

18. *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.⁵⁵ The SBA has established a size standard for this industry, which is annual receipts of \$7.5 million or less.⁵⁶ The 2012 U.S. Economic Census indicates that 11,460 firms operated throughout the entire year.⁵⁷ Of that number, 11,374 firms had annual receipts of less than \$5 million, while 48 firms had annual receipts between \$5 million and \$9,999,999.⁵⁸ Based on this data, we conclude the majority of firms in this industry are small.

19. *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.⁵⁹ The SBA has established a size standard for this industry, which is annual receipts of \$11 million or less.⁶⁰ The 2012 Economic Census indicates that 1,286 firms in this industry operated throughout the entire year.⁶¹ Of that number 1,237 had annual receipts of less than

⁵¹ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621391 “Offices of Podiatrists,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621391&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

⁵² 13 CFR § 121.201; NAICS Code 621391.

⁵³ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621391, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621391 (last visited June 6, 2018).

⁵⁴ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$7.5 million or less.

⁵⁵ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621399 “Offices of All Other Miscellaneous Health Practitioners,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621399&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

⁵⁶ 13 CFR § 121.201; NAICS Code 621399.

⁵⁷ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621399, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621399 (last visited June 6, 2018).

⁵⁸ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$7.5 million or less.

⁵⁹ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621410 “Family Planning Centers,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621410&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

⁶⁰ 13 CFR § 121.201; NAICS Code 621410.

⁶¹ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*,

\$10 million, while 36 firms had annual receipts between \$10 million and \$24,999,999.⁶² Based on this data, we conclude that the majority of firms in this industry are small.

20. *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.⁶³ The SBA has established a size standard for this industry, which is \$15 million or less in annual receipts.⁶⁴ The 2012 U.S. Economic Census indicates that 4,446 firms operated throughout the entire year.⁶⁵ Of that number, 4,069 had annual receipts of less than \$10 million while 286 firms had annual receipts between \$10 million and \$24,999,999.⁶⁶ Based on this data, we conclude that a majority of firms in this industry are small.

21. *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 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.⁶⁷ The SBA has established a size standard for this industry, which is \$32.5 million or less in annual receipts.⁶⁸ The 2012 U.S. Economic Census indicates that 14 firms in this industry operated throughout the entire year.⁶⁹ Of that number, 5 firms had annual receipts of less than \$25 million, while 1 firm had annual receipts between \$25 million and \$99,999,999.⁷⁰ Based on this data, we conclude that approximately one-third of the firms in this industry are small.

22. *Freestanding Ambulatory Surgical and Emergency Centers.* This U.S. industry comprises establishments with physicians and other medical staff primarily engaged in (1) providing

(Continued from previous page)

NAICS Code 621410, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics-621410 (last visited June 6, 2018).

⁶² *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$11 million or less.

⁶³ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621420 “Outpatient Mental Health and Substance Abuse Centers,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621420&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

⁶⁴ 13 CFR § 121.201; NAICS Code 621420.

⁶⁵ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621420, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics-621420 (last visited June 6, 2018).

⁶⁶ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$15 million or less.

⁶⁷ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621491 “HMO Medical Centers,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621491&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

⁶⁸ 13 CFR § 121.201; NAICS Code 621491.

⁶⁹ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621491, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics-621491 (last visited June 6, 2018).

⁷⁰ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$32.5 million or less.

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.⁷¹ The SBA has established a size standard for this industry, which is annual receipts of \$15 million or less.⁷² The 2012 U.S. Economic Census indicates that 3,595 firms in this industry operated throughout the entire year.⁷³ Of that number, 3,222 firms had annual receipts of less than \$10 million, while 289 firms had annual receipts between \$10 million and \$24,999,999.⁷⁴ Based on this data, we conclude that a majority of firms in this industry are small.

23. *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.⁷⁵ The SBA has established a size standard for this industry, which is annual receipts of \$20.5 million or less.⁷⁶ The 2012 U.S. Economic Census indicates that 4,903 firms operated in this industry throughout the entire year.⁷⁷ Of this number, 4,269 firms had annual receipts of less than \$10 million, while 389 firms had annual receipts between \$10 million and \$24,999,999.⁷⁸ Based on this data, we conclude that a majority of firms in this industry are small.

24. *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.⁷⁹ The SBA has established a size standard for this industry, which is annual receipts of \$32.5

⁷¹ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621493 “Freestanding Ambulatory Surgical and Emergency Centers,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621493&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

⁷² 13 CFR § 121.201; NAICS Code 621493.

⁷³ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621493, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621493 (last visited June 6, 2018).

⁷⁴ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$15 million or less.

⁷⁵ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621498 “All Other Outpatient Care Centers,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621498&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

⁷⁶ 13 CFR § 121.201; NAICS Code 621498.

⁷⁷ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621498, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621498 (last visited June 6, 2018).

⁷⁸ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$20.5 million or less.

⁷⁹ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621991 “Blood and Organ Banks,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621991&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

million or less.⁸⁰ The 2012 U.S. Economic Census indicates that 314 firms operated in this industry throughout the entire year.⁸¹ Of that number, 235 operated with annual receipts of less than \$25 million, while 41 firms had annual receipts between \$25 million and \$49,999,999.⁸² Based on this data, we conclude that approximately three-quarters of firms that operate in this industry are small.

25. *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).⁸³ The SBA has established a size standard for this industry, which is annual receipts of \$15 million or less.⁸⁴ The 2012 U.S. Economic Census indicates that 2,429 firms operated in this industry throughout the entire year.⁸⁵ Of that number, 2,318 had annual receipts of less than \$10 million, while 56 firms had annual receipts between \$10 million and \$24,999,999.⁸⁶ Based on this data, we conclude that a majority of the firms in this industry are small.

26. *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.⁸⁷ The SBA has established a size standard for this industry, which is annual receipts of \$32.5 million or less.⁸⁸ The 2012 U.S. Economic Census indicates that 2,599 firms operated in this industry throughout the entire year.⁸⁹ Of this number, 2,465 had annual receipts of less than \$25 million, while 60 firms had annual receipts between \$25 million and \$49,999,999.⁹⁰ Based on this data, we conclude that a majority of firms that operate in this industry are small.

⁸⁰ 13 CFR § 121.201; NAICS Code 621991.

⁸¹ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621991, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics-621991 (last visited June 6, 2018).

⁸² *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$32.5 million or less.

⁸³ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621999 “All Other Miscellaneous Ambulatory Health Care Services,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621999&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

⁸⁴ 13 CFR § 121.201; NAICS Code 621999.

⁸⁵ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621999, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics-621999 (last visited June 6, 2018).

⁸⁶ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$15 million or less.

⁸⁷ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621511 “Medical Laboratories,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621511&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

⁸⁸ 13 CFR § 121.201; NAICS Code 621511.

⁸⁹ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621511, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics-621511 (last visited June 6, 2018).

⁹⁰ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$32.5 million or less.

27. *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.⁹¹ The SBA has established size standard for this industry, which is annual receipts of \$15 million or less.⁹² The 2012 U.S. Economic Census indicates that 4,209 firms operated in this industry throughout the entire year.⁹³ Of that number, 3,876 firms had annual receipts of less than \$10 million, while 228 firms had annual receipts between \$10 million and \$24,999,999.⁹⁴ Based on this data, we conclude that a majority of firms that operate in this industry are small.

28. *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.⁹⁵ The SBA has established a size standard for this industry, which is annual receipts of \$15 million or less.⁹⁶ The 2012 U.S. Economic Census indicates that 17,770 firms operated in this industry throughout the entire year.⁹⁷ Of that number, 16,822 had annual receipts of less than \$10 million, while 590 firms had annual receipts between \$10 million and \$24,999,999.⁹⁸ Based on this data, we conclude that a majority of firms that operate in this industry are small.

29. *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.⁹⁹ The SBA has established a size standard for this industry, which is annual receipts of \$15 million or less.¹⁰⁰ The 2012 U.S. Economic

⁹¹ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621512 “Diagnostic Imaging Centers,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621512&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

⁹² 13 CFR § 121.201; NAICS Code 621512.

⁹³ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621512, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621512 (last visited June 6, 2018).

⁹⁴ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$15 million or less.

⁹⁵ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621610 “Home Health Care Services,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621610&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

⁹⁶ 13 CFR § 121.201; NAICS Code 621610.

⁹⁷ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621610, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-621610 (last visited June 6, 2018).

⁹⁸ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$15 million or less.

⁹⁹ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621910 “Ambulance Services,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621910&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

¹⁰⁰ 13 CFR § 121.201; NAICS Code 621910.

Census indicates that 2,984 firms operated in this industry throughout the entire year.¹⁰¹ Of that number, 2,926 had annual receipts of less than \$15 million, while 133 firms had annual receipts between \$10 million and \$24,999,999.¹⁰² Based on this data, we conclude that a majority of firms in this industry are small.

30. *Kidney Dialysis Centers.* This U.S. industry comprises establishments with medical staff primarily engaged in providing outpatient kidney or renal dialysis services.¹⁰³ The SBA has established a size standard for this industry, which is annual receipts of \$38.5 million or less.¹⁰⁴ The 2012 U.S. Economic Census indicates that 396 firms operated in this industry throughout the entire year.¹⁰⁵ Of that number, 379 had annual receipts of less than \$25 million, while 7 firms had annual receipts between \$25 million and \$49,999,999.¹⁰⁶ Based on this data, we conclude that a majority of firms in this industry are small.

31. *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.¹⁰⁷ The SBA has established a size standard for this industry, which is annual receipts of \$38.5 million or less.¹⁰⁸ The 2012 U.S. Economic Census indicates that 2,800 firms operated in this industry throughout the entire year.¹⁰⁹ Of that number, 877 has annual receipts of less than \$25 million, while 400 firms had annual receipts

¹⁰¹ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621910, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics-621910 (last visited June 6, 2018).

¹⁰² *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$15 million or less.

¹⁰³ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621492 “Kidney Dialysis Centers,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621492&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

¹⁰⁴ 13 CFR § 121.201; NAICS Code 621492.

¹⁰⁵ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621492, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics-621492 (last visited June 6, 2018).

¹⁰⁶ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$38.5 million or less.

¹⁰⁷ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 622110 “General Medical and Surgical Hospitals,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=622110&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

¹⁰⁸ 13 CFR § 121.201; NAICS Code 622110.

¹⁰⁹ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 622110, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics-622110 (last visited June 6, 2018).

between \$25 million and \$49,999,999.¹¹⁰ Based on this data, we conclude that approximately one-quarter of firms in this industry are small.

32. *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.¹¹¹ The SBA has established a size standard for this industry, which is annual receipts of \$38.5 million or less.¹¹² The 2012 U.S. Economic Census indicates that 404 firms operated in this industry throughout the entire year.¹¹³ Of that number, 185 had annual receipts of less than \$25 million, while 107 firms had annual receipts between \$25 million and \$49,999,999.¹¹⁴ Based on this data, we conclude that more than one-half of the firms in this industry are small.

33. *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 adjustable 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.¹¹⁵ The SBA has established a size standard for this industry, which is annual receipts of \$38.5 million or less.¹¹⁶ The 2012 U.S. Economic Census indicates that 346 firms operated in this industry throughout the entire year.¹¹⁷ Of that number, 146 firms had annual receipts of less than \$25 million,

¹¹⁰ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$38.5 million or less.

¹¹¹ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 622210 “Psychiatric and Substance Abuse Hospitals,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=622210&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

¹¹² 13 CFR § 121.201; NAICS Code 622210.

¹¹³ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 622210, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4/naics-622210 (last visited June 6, 2018).

¹¹⁴ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$38.5 million or less.

¹¹⁵ See U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 622310 “Specialty (Except Psychiatric and Substance Abuse) Hospitals,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=622310&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

¹¹⁶ 13 CFR § 121.201; NAICS Code 622310.

¹¹⁷ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*,

while 79 firms had annual receipts between \$25 million and \$49,999,999.¹¹⁸ Based on this data, we conclude that more than one-half of the firms in this industry are small.

34. *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).¹¹⁹ The SBA has established a size standard for this industry, which is annual receipts of \$32.5 million or less.¹²⁰ The 2012 U.S. Economic Census indicates that 541 firms operated in this industry throughout the entire year.¹²¹ Of that number, 509 had annual receipts of less than \$25 million, while 7 firms had annual receipts between \$25 million and \$49,999,999.¹²² Based on this data, we conclude that a majority of firms in this industry are small

2. Providers of Telecommunications and Other Services

a. Telecommunications Service Providers

35. *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.¹²³ U.S. Census Bureau data for 2012 indicate that 3,117 firms operated during that year. Of this total, 3,083 operated with fewer than 1,000 employees.¹²⁴ Consequently, the Commission estimates that most providers of incumbent local exchange service are small businesses that may be affected by our actions. According to Commission data, one thousand three hundred and seven (1,307) Incumbent Local Exchange Carriers reported that they were incumbent local exchange service providers.¹²⁵ Of this total, an estimated 1,006 have 1,500 or fewer employees.¹²⁶ Thus, using the SBA's size standard the majority of Incumbent LECs can be considered small entities.

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NAICS Code 622310, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~622310 (last visited June 6, 2018).

¹¹⁸ *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$38.5 million or less.

¹¹⁹ See U.S. Census Bureau, 2012 NAICS Definitions, NAICS Code 624230 “Emergency and Other Relief Services”, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=624230&search=2012+NAICS+Search&search=2012> (last visited June 6, 2018).

¹²⁰ 13 CFR § 121.201; NAICS Code 624230.

¹²¹ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 624230, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~624230 (last visited June 6, 2018).

¹²² *Id.* The available U.S. Census data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of \$32.5 million or less.

¹²³ See 13 CFR § 121.201. The Wired Telecommunications Carrier category formerly used the NAICS Code of 517110. As of 2017, the U.S. Census Bureau definition shows the NAICS Code as 517311 for Wired Telecommunications Carriers. See U.S. Census Bureau, *2017 NAICS Definition*, 517311 Wired Telecommunications Carriers, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517311&search=2017> (last visited June 6, 2018).

¹²⁴ U.S. Census Bureau, *2012 Economic Census of the United States*, Table No. EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms: 2012* (517110 Wired Telecommunications Carriers), https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5//naics~517110 (last visited June 6, 2018).

¹²⁵ See Federal Communications Commission, *Trends in Telephone Service* at Table 5.3 (*Trends in Telephone Service*), <https://www.fcc.gov/general/trends-telephone-service> (last visited June 6, 2018).

¹²⁶ *Id.*

36. *Interexchange Carriers (IXCs)*. Neither the Commission nor the SBA has developed a definition of small entities specifically applicable to providers of 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.¹²⁷ U.S. Census Bureau data for 2012 indicate that 3,117 firms operated during that year.¹²⁸ Of that number, 3,083 operated with fewer than 1,000 employees.¹²⁹ According to internally developed Commission data, 359 companies reported that their primary telecommunications service activity was the provision of interexchange services.¹³⁰ Of this total, an estimated 317 have 1,500 or fewer employees.¹³¹ Consequently, the Commission estimates that the majority of interexchange service providers that may be affected are small entities.

37. *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.¹³² U.S. Census Bureau data for 2012 indicate that 3,117 firms operated during that year.¹³³ Of that number, 3,083 operated with fewer than 1,000 employees.¹³⁴ Consequently, the Commission estimates that most competitive access providers are small businesses that may be affected by our actions. According to Commission data the *2010 Trends in Telephone Report*, 1,442 CAPs and competitive local exchange carriers (competitive LECs) reported that they were engaged in the provision of competitive local exchange services.¹³⁵ 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.¹³⁶ Consequently, the Commission estimates that most providers of competitive exchange services are small businesses.

38. *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

¹²⁷ See 13 CFR § 121.201. The Wired Telecommunications Carrier category formerly used the NAICS Code of 517110. As of 2017 the U.S. Census Bureau definition shows the NAICS Code as 517311 for Wired Telecommunications Carriers. See U.S. Census Bureau, *2017 NAICS Definition*, 517311 Wired Telecommunications Carriers, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517311&search=2017> (last visited June 6, 2018).

¹²⁸ See U.S. Census Bureau, *2012 Economic Census of the United States*, Table No. EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms: 2012* (517110 Wired Telecommunications Carriers). https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5/naics~517110 (last visited June 6, 2018).

¹²⁹ *Id.*

¹³⁰ See *Trends in Telephone Service*, at Table 5.3.

¹³¹ *Id.*

¹³² See 13 CFR § 121.201. The Wired Telecommunications Carrier category formerly used the NAICS Code of 517110. As of 2017 the U.S. Census Bureau definition shows the NAICS Code as 517311 for Wired Telecommunications Carriers. See U.S. Census Bureau, *2017 NAICS Definition*, 517311 Wired Telecommunications Carriers, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517311&search=2017> (last visited June 6, 2018).

¹³³ See U.S. Census Bureau, *2012 Economic Census of the United States*, Table No. EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms: 2012* (517110 Wired Telecommunications Carriers). https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5/naics~517110 (last visited June 6, 2018).

¹³⁴ *Id.*

¹³⁵ See *Trends in Telephone Service*, at Table 5.3, page 5.5.

¹³⁶ *Id.*

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.”¹³⁷ 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.¹³⁸ U.S. Census data for 2012 show that there were 3,117 firms that operated that year.¹³⁹ Of this total, 3,083 operated with fewer than 1,000 employees.¹⁴⁰ Thus, under this size standard, the majority of firms in this industry can be considered small.

39. *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.¹⁴¹ The appropriate size standard under SBA rules is that such a business is small if it has 1,500 or fewer employees.¹⁴² For this industry, U.S. Census Bureau data for 2012 shows that there were 967 firms that operated for the entire year.¹⁴³ Of this total, 955 firms had employment of 999 or fewer employees and 12 had employment of 1000 employees or more.¹⁴⁴ Thus, under this category and the associated size standard, the Commission estimates that the majority of wireless telecommunications carriers (except satellite) are small entities.

40. The Commission’s own data—available in its Universal Licensing System—indicate that, as of October 25, 2016, there are 280 Cellular licensees that will be affected by our actions today.¹⁴⁵ 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

¹³⁷ See 13 CFR § 120.201. The Wired Telecommunications Carrier category formerly used the NAICS Code of 517110. As of 2017 the U.S. Census Bureau definition shows the NAICS Code as 517311 for Wired Telecommunications Carriers. See U.S. Census Bureau, *2017 NAICS Definition*, 517311 Wired Telecommunications Carriers, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517311&search=2017> (last visited June 6, 2018).

¹³⁸ See U.S. Census Bureau, *2017 NAICS Definition*, 517311 Wired Telecommunications Carriers, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517311&search=2017> (last visited June 6, 2018).

¹³⁹ See U.S. Census Bureau, *2012 Economic Census of the United States*, Table No. EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms: 2012* (517110 Wired Telecommunications Carriers), https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5//naics~517110 (last visited June 6, 2018).

¹⁴⁰ *Id.*

¹⁴¹ NAICS Code 517210. See U.S. Census Bureau, *Program, Survey, Data Set, Dimension, Industry Code, Wireless telecommunications carriers (except satellite)*, <https://factfinder.census.gov/faces/affhelp/jsf/pages/metadata.xhtml?lang=en&type=ib&id=ib.en/ECN.NAICS2012.517210> (last visited June 6, 2018).

¹⁴² 13 CFR § 121.201; NAICS Code 517210.

¹⁴³ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1251SSSZ5, *Information: Subject Series: Estab and Firm Size: Employment Size of Firms for the U.S.: 2012* NAICS Code 517210, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5//naics~517210 (last visited June 6, 2018).

¹⁴⁴ *Id.* Available census data does not provide a more precise estimate of the number of firms that have employment of 1,500 or fewer employees; the largest category provided is for firms with “1000 employees or more.”

¹⁴⁵ See Federal Communications Commission, *Universal Licensing System*, <http://wireless.fcc.gov/uls/index.htm?job=home> (last visited June 6, 2018). For the purposes of this FRFA, consistent with Commission practice for wireless services, the Commission estimates the number of licensees based on the number of unique FCC Registration Numbers.

cellular service, Personal Communications Service (PCS), and Specialized Mobile Radio (SMR) Telephony services.¹⁴⁶ Of this total, an estimated 261 have 1,500 or fewer employees, and 152 have more than 1,500 employees.¹⁴⁷ Thus, using available data, we estimate that the majority of wireless firms can be considered small.

41. *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)¹⁴⁸ 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.¹⁴⁹ For this industry, U.S. Census Bureau data for 2012 show that there were 967 firms that operated for the entire year.¹⁵⁰ Of this total, 955 firms had fewer than 1,000 employees and 12 firms has 1000 employees or more.¹⁵¹ 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.¹⁵² Of these, an estimated 261 have 1,500 or fewer employees and 152 have more than 1,500 employees.¹⁵³ Therefore, more than half of these entities can be considered small.

42. *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.”¹⁵⁴ 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.¹⁵⁵ 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.¹⁵⁶ Of this total, 299 firms had annual receipts of less than \$25 million.¹⁵⁷ Consequently, we estimate that the majority of satellite telecommunications providers are small entities.

43. *All Other Telecommunications.* The “All Other Telecommunications” category is comprised of establishments that are primarily engaged in providing specialized telecommunications

¹⁴⁶ See *Trends in Telephone Service* at Table 5.3.

¹⁴⁷ See *id.*

¹⁴⁸ 13 CFR § 121.201; NAICS Code 517210.

¹⁴⁹ 13 CFR § 121.201; NAICS Code 517210.

¹⁵⁰ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1251SSSZ5, *Information: Subject Series: Estab and Firm Size: Employment Size of Firms for the U.S.:* 2012 NAICS Code 517210, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5//naics~517210 (last visited June 6, 2018).

¹⁵¹ *Id.* Available census data do not provide a more precise estimate of the number of firms that have employment of 1,500 or fewer employees; the largest category provided is for firms with “1000 employees or more.”

¹⁵² See *Trends in Telephone Service* at Table 5.3.

¹⁵³ *Id.*

¹⁵⁴ U.S. Census Bureau, *2017 NAICS Definitions*, “517410 Satellite Telecommunications”; <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=517410&search=2017+NAICS+Search&search=2017> (last visited June 6, 2018).

¹⁵⁵ 13 CFR § 121.201; NAICS Code 517410.

¹⁵⁶ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1251SSSZ4, *Information: Subject Series - Estab and Firm Size: Receipts Size of Firms for the United States:* 2012, NAICS Code 517410, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ4//naics~517410 (last visited June 6, 2018).

¹⁵⁷ *Id.*

services, such as satellite tracking, communications telemetry, and radar station operation.¹⁵⁸ 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.¹⁵⁹ Establishments providing Internet services or voice over Internet protocol (VoIP) services via client-supplied telecommunications connections are also included in this industry.¹⁶⁰ 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.¹⁶¹ For this category, U.S. Census Bureau data for 2012 show that there were 1,442 firms that operated for the entire year.¹⁶² 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 \$49,999,999.¹⁶³ Thus, the Commission estimates that a majority of “All Other Telecommunications” firms potentially affected by our action can be considered small.

b. Internet Service Providers

44. *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.¹⁶⁴ 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.¹⁶⁵ The SBA size standard for this category classifies a business as small if it has 1,500 or fewer employees.¹⁶⁶ U.S. Census Bureau data for 2012 show that there were 3,117 firms that operated that year. Of this total, 3,083 operated with fewer than 1,000 employees.¹⁶⁷ Consequently, under this size standard, the majority of firms in this industry can be considered small.

45. *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.,

¹⁵⁸ See U.S. Census Bureau, *2017 NAICS Definitions*, NAICS Code “517919 All Other Telecommunications,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=517919&search=2017+NAICS+Search&search=2017> (last visited June 6, 2018).

¹⁵⁹ *Id.*

¹⁶⁰ *Id.*

¹⁶¹ 13 CFR § 121.201; NAICS Code 517919.

¹⁶² U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1251SSSZ4, *Information: Subject Series - Estab and Firm Size: Receipts Size of Firms for the United States: 2012*, NAICS Code 517919, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ4/naics~517919 (last visited June 6, 2018).

¹⁶³ *Id.*

¹⁶⁴ See 13 CFR § 121.201. The Wired Telecommunications Carrier category formerly used the NAICS Code of 517110. As of 2017 the U.S. Census Bureau definition show the NAICS Code as 517311. See U.S. Census Bureau, *2017 NAICS Definition*, 517311 Wired Telecommunications Carriers, <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517311&search=2017> (last visited June 6, 2018) (2017 NAICS Definition, 517311 Wired Telecommunications Carriers).

¹⁶⁵ 2017 NAICS Definition, 517311 Wired Telecommunications Carriers.

¹⁶⁶ *Id.*

¹⁶⁷ See U.S. Census Bureau, *2012 Economic Census of the United States*, Table No. EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms: 2012* NAICS Code 517110, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5/naics~517110 (last visited June 6, 2018).

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.¹⁶⁸ For this category, U.S. Census Bureau data for 2012 show 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.¹⁶⁹ Consequently, under this size standard, a majority of firms in this industry can be considered small.

c. Vendors and Equipment Manufacturers

46. *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 less¹⁷⁰ and “Other Communications Equipment Manufacturing” with a size standard of 750 employees or less.¹⁷¹ U.S. Census Bureau data for 2012 show that for Radio and Television Broadcasting and Wireless Communications Equipment firms 841 establishments operated for the entire year.¹⁷² 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.¹⁷³ For Other Communications Equipment Manufacturing, U.S. Census Bureau data for 2012 show that 383 establishments operated for the year.¹⁷⁴ Of that number, 379 firms operated with fewer than 500 employees and 4 had 500 to 999 employees. Based on this data, we conclude that the majority of Vendors of Infrastructure Development or “Network Buildout” are small.

47. *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.¹⁷⁵ The SBA size standard for

¹⁶⁸ 13 CFR § 121.201; NAICS Code 517919.

¹⁶⁹ U.S. Census Bureau, *2012 Economic Census Table*, Table EC1251SSSZ4, *Information: Subject Series - Estab & Firm Size: Receipts Size of Firms for the U.S.: 2012*, NAIC Code 517919, <https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk> (last visited June 6, 2018).

¹⁷⁰ 13 CFR § 121.201; NAICS Code 334220.

¹⁷¹ 13 CFR § 121.201; NAICS Code 334290.

¹⁷² U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012*, NAICS Code 334220, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2//naics~334220 (last visited June 6, 2018).

¹⁷³ *Id.*

¹⁷⁴ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012*, NAICS Code 334290, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2//naics~334290 (last visited June 6, 2018).

¹⁷⁵ U.S. Census Bureau, *2012 NAICS Definition and Comparability*, “2012 NAICS: 334210 - Telephone apparatus manufacturing,” <https://www.census.gov/econ/isp/sampler.php?naicscode=334210&naicslevel=6#> (last visited June 6, 2018).

Telephone Apparatus Manufacturing is all such firms having 1,250 or fewer employees.¹⁷⁶ 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.¹⁷⁷ Of this total, 262 had employment of under 1,000, and an additional 4 had employment of 1,000 to 2,499.¹⁷⁸ Thus, under this size standard, the majority of firms can be considered small.

48. *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.¹⁷⁹ 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.¹⁸⁰ The SBA has established a small business size standard for this industry of 1,250 employees or less.¹⁸¹ U.S. Census Bureau data for 2012 show that 841 establishments operated in this industry in that year.¹⁸² 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.¹⁸³ Based on this data, we conclude that a majority of manufacturers in this industry are small.

49. *Other Communications Equipment Manufacturing.* This industry comprises establishments primarily engaged in manufacturing communications equipment (except telephone

¹⁷⁶ 13 CFR § 121.201; NAICS Code 334210.

¹⁷⁷ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012*, NAICS Code 334210, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2//naics~334210 (last visited June 6, 2018). The number of “establishments” is a less helpful indicator of small business prevalence in this context than would be the number of “firms” or “companies,” because the latter take into account the concept of common ownership or control. Any single physical location for an entity is an establishment, even though that location may be owned by a different establishment. Thus, the numbers given may reflect inflated numbers of businesses in this category, including the numbers of small businesses. In this category, the Census data for firms or companies only gives the total number of such entities for 2012, which was 250. *See also* U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG1, *Manufacturing: Summary Series: General Summary: Detailed Statistics by Subsectors and Industries: 2012*, NAICS Code 334210 https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG1//naics~334210 (last visited June 6, 2018).

¹⁷⁸ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012*, NAICS Code 334210, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2//naics~334210 (last visited June 6, 2018). An additional 4 establishments had employment of 2,500 or more.

¹⁷⁹ The NAICS Code for this service is 334220. 13 CFR § 121.201. *See also* U.S. Census Bureau, 2012 NAICS Definitions, “334220 Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing,” <https://factfinder.census.gov/faces/affhelp/jsf/pages/metadata.xhtml?lang=en&type=ib&id=ib.en./ECN.NAICS2012.334220#> (last visited June 6, 2018).

¹⁸⁰ *See also* U.S. Census Bureau, 2012 NAICS Definitions, “334220 Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing,” <https://factfinder.census.gov/faces/affhelp/jsf/pages/metadata.xhtml?lang=en&type=ib&id=ib.en./ECN.NAICS2012.334220#> (last visited June 6, 2018).

¹⁸¹ 13 CFR § 121.201; NAICS Code 334220.

¹⁸² U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012*, NAICS Code 334220, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2//naics~334220 (last visited June 6, 2018).

¹⁸³ *Id.*

apparatus, and radio and television broadcast, and wireless communications equipment).¹⁸⁴ 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.¹⁸⁵ The SBA has established a size for this industry as all such firms having 750 or fewer employees.¹⁸⁶ U.S. Census Bureau data for 2012 show that 383 establishments operated in that year.¹⁸⁷ Of that number, 379 operated with fewer than 500 employees and 4 had 500 to 999 employees.¹⁸⁸ Based on this data, we conclude that the majority of Other Communications Equipment Manufacturers are small.

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

50. There are no new or different reporting, recordkeeping, or other compliance requirements adopted in this Report and Order that would likely financially impact either large or small entities, including health care providers and service providers.

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

51. 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.”

52. As indicated above, in this Report and Order, we increase available funding for all eligible RHC Program entities including small entities. Specifically, we increase RHC Program support, and thereby increase support available for rural, mostly small, health care providers, by: (1) increasing the RHC Program support cap to \$571 million to apply to FY 2017; (2) prospectively increasing the \$571 million RHC Program support cap *via* inflation using the Gross Domestic Price Chain-type Price Index (GDP-CPI) in FY 2018 and beyond; and (3) “carrying forward” unused funds committed in one funding year into subsequent funding years.

53. As noted above, in this Report and Order, we carefully balanced the significant financial hardship faced by rural health care providers due to the otherwise scarcity of funding and the public health consequences that could result from lack of broadband service with the increase in funding needed to meet the new cap. We considered and rejected arguments to double the cap or to increase it beyond the \$571 million that we adopt here. The increased cap, indexed to inflation, and the carry forward of unused funds will make more funding available to eligible health care providers including small entities, while minimizing the amount of funds that are needed to be collected. No commenters proposed significant small business alternatives.

¹⁸⁴ U.S. Census Bureau, *2017 NAICS Definition*, NAICS Code “334290 Other Communications Equipment Manufacturing,” <https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=334290&search=2017+NAICS+Search&search=2017> (last visited June 6, 2018).

¹⁸⁵ *Id.*

¹⁸⁶ 13 CFR § 121.201, NAICS Code 334290.

¹⁸⁷ U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012*, NAICS Code 334290, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2//naics~334290 (last visited June 6, 2018).

¹⁸⁸ *Id.*

G. Report to Congress

54. The Commission will send a copy of the Report and Order, including this FRFA, in a report to be sent to Congress pursuant to the Congressional Review Act. 39 In addition, the Commission will send a copy of the Report and Order, including this FRFA, to the Chief Counsel for Advocacy of the SBA. A copy of the Report and Order and FRFA (or summaries thereof) will also be published in the Federal Register.¹⁸⁹

¹⁸⁹ See 5 U.S.C. § 604(b).

**STATEMENT OF
CHAIRMAN AJIT PAI**

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

In Scottsville, Kentucky, a broadband connection with Vanderbilt University’s Children’s Hospital enables school nurses to give sick students an immediate diagnosis. In Lecanto, Florida and Boise, Idaho, Department of Veterans Affairs health care facilities are using telemedicine to give those who’ve served in America’s armed forces mental health consultations they might not otherwise get. In Staunton, Virginia, a rural hospital called Augusta Health is using telehealth tools to significantly reduce sepsis. In Cleveland, Ohio, the Cleveland Clinic is using telemedicine to dramatically shorten the time it takes to assess and stabilize stroke patients.

These are not hypothetical or unusual cases. I have seen them with my own eyes in each of those communities. They are real evidence that communications technology can make patients healthier and communities stronger. And even with telemedicine’s widespread appeal, we’re still just scratching the surface of its potential. As former FCC Chairman Newton Minow and I recently put it, “Recent advances in communications technology could enable millions of Americans to live healthier, longer lives.”¹

The FCC has a critical role to play in securing this potential. Our Rural Health Care (RHC) program is designed to help health care providers afford the broadband connectivity they need to deliver vital telemedicine services. But the program has been underfunded. Its annual funding cap of \$400 million was set back in 1997 and hasn’t been increased since. As a result, demand for funding has exceeded this cap for two years in a row, leading to funding cuts—and financial hardship—for participating health care providers.

With this *Report and Order*, the FCC takes swift and long-overdue action to address this critical funding crisis. We ensure that the RHC program better reflects the needs of and advances in digital health care. Specifically, we raise the annual funding cap by 43%, to \$571 million. This new funding level reflects what the cap would be today had it been adjusted for inflation all these years. Importantly, we also apply this increased cap to the current funding year (FY 2017) to give rural health care providers immediate relief from funding cuts. And looking to the future, we give providers more certainty by adjusting the cap annually for inflation and allowing unused funds from previous years to be carried forward.

The end result of these reforms will be profound: Healthier Americans make for a better America. And these reforms come none too soon. As Chairman Minow and I argued, “[i]t’s time we integrated communications technology into our health care system just as fully as we have in other parts of our lives.” Our decision today brings us closer to that goal.

This result would not have been possible without the hard work of Commission staff. I’d like to thank Dana Bradford, Regina Brown, Cheryl Callahan, Liz Drogula, Trent Harkrader, Avis Mitchell, Kris Monteith, Ryan Palmer, Carol Pomponio, and Arielle Roth from the Wireline Competition Bureau and Malena Barzilai, Rick Mallen, and Chin Yoo from the Office of General Counsel for their efforts to improve the health care options available to rural Americans.

¹ Newton N. Minow and Ajit Pai, “In rural America, digital divide slows a vital path for telemedicine,” *Boston Globe* (May 21, 2018), available at <https://www.bostonglobe.com/opinion/2018/05/20/rural-america-digital-divide-slows-vital-path-for-telemedicine/t8n4ncsfFcUASdf7XLH38J/story.html>.

**STATEMENT OF
COMMISSIONER MICHAEL O'RIELLY**

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

At its core, this order provides additional funding for the universal service Rural Health Care Program, a laudable program currently facing financial difficulties. I have seen the benefits of telemedicine firsthand and understand its importance, especially to the health and safety of Americans in remote parts of the country, such as Alaska. Given the circumstances, I extend my support to the item.

I view it, however, as a first step in a much-needed process to revamp the program to ensure that it is operated in a predictable, sustainable, and accountable manner. Due to inattentiveness on the part of prior Commissions, the program grew rapidly with no reasonable measures in place to ensure that the funding was well targeted or would be prioritized rationally when demand exceeded available funding – an outcome I predicted years ago and urged the previous Chairman to address. Moreover, insufficient oversight of the program and the Universal Service Administrative Company (USAC) has led to confusion and lengthy funding delays, creating unpredictability for communications providers, healthcare participants, and rural communities that have benefitted from the program. Therefore, while this order may temporarily resolve a current funding shortfall, there is much more to do to put the program on long-term solid footing, including implementing appropriate changes to USAC. I appreciate that Chairman Pai is willing to tackle such fundamental reforms to the program.

Generally, this order highlights the need for an overall cap on the universal service fund (USF). I have heard the argument that, as long as each program is capped, there is no need for an overarching spending limit across the four USF programs. However, as each program has reached its budget, the Commission has historically increased each one, as we do today, without much consideration given to total spending and its impact on the consumers and businesses who pay extra fees on their phone bills to support it. That is not acceptable. Instead, the Commission must set a topline figure that represents the combined amount we are willing to take from hardworking Americans and we must manage all four programs within that dollar amount. Under this framework, the Commission would still have the ability to increase funding for a particular program, if necessary. But, doing so would require the agency to expressly consider the costs and benefits of its actions and find appropriate offsets, if needed, to stay within that overall limit. I thank the Chairman for agreeing to work with me on this important issue.

On a side note, it is past time that the Commission work with other federal government departments and agencies to determine how our rather narrow telemedicine program works within the larger health care system. Currently, telecommunications consumers are paying higher rates than necessary in order to fund our Rural Health Care Program and this has a positive impact on overall health care costs. To put it succinctly, if our program were to end tomorrow, total U.S. health care expenditures would increase by some factor, likely many multiples compared to the program's investment. Unfortunately, we are not credited, nor do consumers experience, any of the benefit enjoyed by other health care agencies. I intend to discuss this point further in the future to ensure greater coordination and cohesion regarding this dynamic.

I vote to approve.

**STATEMENT OF
COMMISSIONER BRENDAN CARR**

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

Too many Americans living in our country's rural communities are at risk of falling behind when it comes to high-quality, affordable healthcare. It often is difficult to find specialists in many rural communities and even basic care can be out of reach, as we see rural hospitals closing by the dozen. The FCC's Rural Health Care Program can help make a difference.

I saw this a few weeks ago when I visited Lennox, South Dakota (pop. 2,111). I had the chance to tour a skilled nursing facility—supported by the FCC's Rural Health Care Program—and see how they are using broadband-enabled technology to improve patient outcomes and eliminate unnecessary costs. One way they do this is through their 'Johnny 5.' It's a connected workstation that allows patients at the Lennox facility to visit virtually with a doctor located in Sioux Falls or elsewhere. This broadband connection has eliminated the need for the long and sometimes arduous ambulance ride into bigger cities and gives patients access to specialists that they might otherwise be unable to see.

But the Rural Health Care Program is running into a funding shortfall, which is creating uncertainty for participating providers and patients alike. So I am glad to support this item, which would address the shortfall and provide longer-term certainty by adjusting the annual funding cap for inflation. This will make sure that health care providers can continue their important work of providing telehealth services to rural communities across the country.

**STATEMENT OF
COMMISSIONER JESSICA ROSENWORCEL**

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

I have witnessed village clinics in rural Alaska use broadband to provide first-class care to patients in some of this country's most remote communities. I have watched as pediatric surgeons in California share their expertise via video with patients many miles away. I have seen rural clinics in Montana that use their connectivity to exchange electronic medical records on both sides of the continental divide. These experiences amaze because they can challenge our traditional notions of health care. They make clear that telemedicine can collapse distance and time and enhance the quality of care while also improving outcomes and lowering costs.

With this order, we take an appropriate step to provide additional funding to relieve health care providers of a shortfall that is harming their participation in the Rural Health Care universal service program. Our action is needed now because in its current formulation, the Rural Health Care program has been stretched to the breaking point. There's an honest reason for that. When this program got its start two decades ago, neither connectivity nor medicine looked much like they do today. Virtual reality, prescription vending machines controlled by doctors at a distance, and electronic health records were the stuff of science fiction. Now they are increasingly commonplace.

While injecting more funding into the program is the right call, we need to acknowledge our actions here are no more than a short-term band-aid. If we want this program to truly thrive, it is going to require more long-term care and attention than we provide today. I look forward to doing so because I believe strengthening the reach and power of telemedicine is a vital part of ensuring that the future of our rural communities can be bright.