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

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

ORDER ON RECONSIDERATION, SECOND REPORT AND ORDER, ORDER, AND SECOND FURTHER NOTICE OF PROPOSED RULEMAKING

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By the Commission: Chairwoman Rosenworcel and Commissioners Carr and Starks issuing separate statements.

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I. INTRODUCTION

1. In this Order on Reconsideration, Second Report and Order, Order, and Second Further Notice of Proposed Rulemaking, we continue the Commission's efforts to improve the Rural Health Care (RHC) Program. The RHC Program supports rural health care providers with the costs of broadband and other communications services so that they can serve patients in rural areas that may have limited resources, fewer doctors, and higher rates for broadband and communications services than urban areas. Telehealth and telemedicine services, which expanded considerably during the COVID-19 pandemic, have also become essential tools for the delivery of health care to millions of rural Americans. These services bridge the vast geographic distances that separate health care facilities, enabling patients to receive high-quality medical care without sometimes lengthy or burdensome travel. The RHC Program promotes telehealth by providing financial support to eligible health care providers for broadband and telecommunications services.

2. In today's Order on Reconsideration, we address petitions for reconsideration of the 2019 *Promoting Telehealth Report and Order*.[1] We grant petitions challenging the database of urban and rural rates (Rates Database) for the Telecommunications Program (Telecom Program) established in the *Promoting Telehealth Report and Order*, return the Telecom Program to the rate determination rules in place before the adoption of the Rates Database, and deny petitions for reconsideration of other issues from the *Promoting Telehealth Report and Order*. In the Report and Order, we adopt proposals from the February 2022 *Further Notice* to amend RHC Program invoicing processes and the internal cap application and prioritization rules to promote efficiency, reduce delays in funding commitments, and prioritize support for the current funding year.[2] In the Order, we dismiss as moot Applications for Review of the Commission's guidance to the Universal Service Administrative Company (the Administrator) regarding the Rates Database. Lastly, in the Second Further Notice of Proposed Rulemaking, we propose revisions to the rate determination rules, seek comment on to reinstating the cap on support for satellite services, propose to make it easier for health care providers to receive RHC Program funding as soon as they become eligible, propose to align the deadline to request a Service Provider Identification Number (SPIN) change with the invoice filling deadline, and seek comment on revisions to data collected in the Telecom Program.

II. BACKGROUND

3. The RHC Program consists of two component programs: (1) the Telecom Program; and (2) the Healthcare Connect Fund (HCF) Program. The Telecom Program was established in 1997 and

[1] *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Report and Order, 34 FCC Rcd 7335 (2019) (*Promoting Telehealth Report and Order*).

[2] *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Further Notice of Proposed Rulemaking, FCC 22-15 (Feb. 18, 2022) (*Further Notice*).

subsidizes the difference between the rates in the health care provider's rural area and rates for comparable services available in urban areas within that state.[3] The HCF Program was created in 2012 to promote the use of broadband services and facilitate the formation of health care provider consortia that include both rural and urban health care providers[4] by providing a flat 65% discount on an array of advanced telecommunications and information services.[5]

4. In August 2019, the Commission adopted the *Promoting Telehealth Report and Order*, which included several reforms to RHC Program rules and procedures with the goals of ensuring transparency and consistency in the Program and simplifying the calculation of urban and rural rates used to determine the amount of support available to health care providers under the Telecom Program. Specifically, the Commission directed the Administrator to create the Rates Database and determined that the urban and rural rates would be the median of all rates for functionally similar services[6] in the relevant state within the health care provider's applicable rural area.[7] Other significant reforms included new rules for prioritizing RHC Program support for rural areas in the event Program demand exceeds available funding,[8] reforms to ensure competitive bidding is fair and open,[9] and adopting Program-wide rules and procedures to simplify application processes and provide clarity regarding procedures.[10] Alaska Communications; the North Carolina Telehealth Network Association and Southern Ohio Health Care Network (collectively, NCTN/SOHCN); the Schools, Health and Libraries Broadband Coalition (SHLB); the State of Alaska Office of the Governor; and USTelecom – The Broadband Association (USTelecom) filed petitions for reconsideration seeking reconsideration of various aspects of the *Promoting Telehealth Report and Order*.[11] GCI Communication Corp. (GCI) and Alaska Communications subsequently filed

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[3] *See* 47 U.S.C. § 254(h)(1)(A); *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776, 9093-161, paras. 608-749 (1997) (*Universal Service First Report and Order*).

[4] *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 27 FCC Rcd 16678, 16680, paras. 1-2 (2012) (*Healthcare Connect Fund Order*).

[5] *See* 47 U.S.C. § 254(h)(2)(A); 47 CFR § 54.611; *Healthcare Connect Fund Order*, 27 FCC Rcd at 16680-81, paras. 1-3.

[6] The Commission instructed the Administrator to determine whether services are functionally similar based on a "technology-agnostic inquiry" from the perspective of the end user experience and specifically noted that rates used to determine the median rate should include rates for private carriage and information services. *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7345, para. 18. Section 54.605 of the Commission's rules directs applicants to use the lower of either the rural rate in the database or the rural rate included in a service agreement between the health care provider and the service provider. 47 CFR § 54.605(a).

[7] *See Promoting Telehealth Report and Order*, 34 FCC Rcd at 7372-73, para. 78; 47 CFR §§ 54.604(a), 54.605(a). Under the Commission's rules, the rurality tiers are defined as Less Rural, Rural, Extremely Rural, and Frontier. Less Rural areas are those that contain an urban area with a population of 25,000 or greater but are within a specific census tract that itself does not contain any part of a Place or Urban Area with a population of greater than 25,000. Rural areas are those that are within a Core Based Statistical Area that does not have an Urban Area with a population of 25,000 or greater. Extremely Rural areas are those that are entirely outside of a Core Based Statistical Area. Frontier areas are located in Alaska only, in areas outside of a Core Based Statistical Area that are inaccessible by road as determined by the Alaska Department of Commerce, Community, and Economic Development, Division of Community and Regional Affairs. *See* 47 CFR § 54.605(a)(1)(i)-(iv).

[8] *See* 47 CFR § 54.621(b); *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7390-7403, paras. 116-43.

[9] *See* 47 CFR §§ 54.622-54.623; *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7406-15, paras. 153-71.

[10] *See* 47 CFR §§ 54.624-627; *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7429-33, paras. 203-12.

[11] *See* Alaska Communications Petition for Reconsideration, WC Docket No. 17-310 (filed Nov. 12, 2019) (Alaska Communications Petition); North Carolina Telehealth Network Association and Southern Ohio Health Care Network Petition for Reconsideration and Clarification, WC Docket No. 17-310 (filed Nov. 12, 2019) (NCTNA/SOHCN Petition); Schools, Health and Libraries Broadband Coalition Petition for Reconsideration and Clarification, WC Docket No. 17-310 (filed Nov. 12, 2019) (SHLB Petition); State of Alaska, Office of the

(continued….)

Applications for Review[12] of a guidance letter the Wireline Competition Bureau (Bureau) sent to the Administrator regarding implementation of the Rates Database.[13]

5. Due to significant anomalies in the initial median urban and rural rate calculations in the Rates Database, the Bureau issued a series of waivers of the rules requiring use of the Rates Database through funding year 2023, initially for Alaska and subsequently for the entire United States.[14] In lieu of the Rates Database, Program participants determined urban and rural rates using the rules that were in effect before the adoption of the *Promoting Telehealth Report and Order.*[15] Participants also had the option to use a rate that had previously been approved under those rules.[16]

6. In the *Further Notice*, we provided an overview of concerns about the Rates Database and sought comment on several issues related to determining support in the Telecom Program, including defining rurality, categorizing service technologies, various approaches to rate determination, and the potential transition period.[17] We also sought comment on proposals to reform the RHC Program's internal cap on multi-year commitments and upfront payments, harmonize invoicing procedures, and sought general comment on additional steps to improve application processing, funding decisions, and appeals.[18]

III. ORDER ON RECONSIDERATION

7. In this Order on Reconsideration, we restore the mechanisms for calculating rural and urban rates that existed before adoption of the *Promoting Telehealth Report and Order*. We uphold the *Promoting Telehealth Report and Order*'s rule changes regarding what services are similar to one another. We maintain the rurality tiers adopted in the *Promoting Telehealth Report and Order*, which, due to the elimination of the Rates Database, now apply only to the prioritization of funding requests. We also keep the internal cap and funding prioritization systems and invoice certifications requirements from the *Promoting Telehealth Report and Order*.

(Continued from previous page)
Governor Petition for Reconsideration, WC Docket No. 17-310 (filed Nov. 12, 2019) (State of Alaska Petition); USTelecom – The Broadband Association Petition for Reconsideration and Clarification, WC Docket No. 17-310 (filed Nov. 12, 2019) (USTelecom Petition). A Public Notice seeking comment on the Petitions for Reconsideration was released on December 5, 2019. Petitions for Reconsideration for Action in Proceeding, WC Docket No. 17-310, Public Notice, Report No. 3136 (rel. Dec. 5, 2019); *see also* Federal Communications Commission, Petitions for Reconsideration of Action in Proceeding, 84 FR 69697 (Dec. 19, 2019).

[12] *See* Application for Review of GCI Communication Corp., WC Docket No. 17-310 (filed July 30, 2020) (GCI Application for Review); Application for Review of Alaska Communications, WC Docket No. 17-310 (filed July 30, 2020) (Alaska Communications Application for Review).

[13] Letter from Kris Anne Monteith, Chief, Wireline Competition Bureau, to Radha Seka, Chief Executive Officer, Universal Service Administrative Company, WC Docket No. 17-310 (June 30, 2020) (*Rates Database Implementation Letter*).

[14] *See Promoting Telehealth in Rural America*, WC Docket No. 17-310, Order, DA 21-83 (WCB 2021) (*Alaska Rates Database Waiver Order*); *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Order, DA 21-394 (WCB 2021) (*Nationwide Rates Database Waiver Order*); *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Order, DA 22-401 (WCB Apr. 12, 2022) (*Alaska Rates Database Waiver Extension Order*); *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Order, DA 22-580 (WCB May 25, 2022) (*Nationwide Rates Database Extension Order*).

[15] *See Nationwide Rates Database Waiver Order.*

[16] *See id.*

[17] *Further Notice* at 8-23, paras. 16-63.

[18] *Id*. at 23-29, paras. 64-78.

A. Rates Determination

8. As an initial matter, we grant in part petitions seeking reconsideration of the rules the Commission adopted in the *Promoting Telehealth Report and Order* to implement the Rates Database and restore the three methods for calculating rural rates in the Telecom Program. We deny petitions for reconsideration seeking review of clarifications and rules adopted in the *Promoting Telehealth Report and Order* regarding similar services and site and service substitution rules and dismiss as moot all remaining petitions related to the rules governing the Rates Database.

1. Urban and Rural Rates Determination Mechanism

9. We grant in part petitions seeking reconsideration of the adoption of the Rates Database in the *Promoting Telehealth Report and Order*. We amend the current sections 54.504 and 54.505 of the Commission's rules to eliminate the use of the Rates Database to determine urban and rural rates and rescind the Commission's direction to the Administrator in the *Promoting Telehealth Report and Order* to create the Rates Database.[19] Based on the record before us, we find that reinstating the Commission's previous rules for calculating urban and rural rates, effective for RHC Program funding year 2024, is the best option for ensuring sufficient, reasonable rural and urban rates.[20]

10. Section 254(h)(1)(A) of the Communications Act requires that Telecom Program support must be based on the difference between the urban rate, which must be "reasonably comparable to the rates charged for similar services in urban areas in that State," and "rates for similar services provided to other customers in comparable rural areas," i.e., the rural rate. Because the Rates Database was deficient in its ability to set adequate rates, we find that restoration of the previous rural rate determination rules, which health care providers have continued to use to determine rural rates in recent funding years under the applicable Rates Database waivers,[21] is the best available option pending further examination in the Second Further Notice, to ensure that healthcare providers have adequate, predictable support.[22]

11. *Rural rates.* We first find that the rural rates generated by the Rates Database could result in inadequate or inconsistent Telecom Program support for rural health care providers that undermines the goals of the Telecom Program. We agree with SHLB and the State of Alaska's general arguments that the Rates Database would not accurately reflect the costs of delivering telecommunications services and would not provide sufficient funding for most rural health care providers because the Rates Database's geographic rurality tiers were too broad and did not accurately represent the cost of serving dissimilar communities.[23] The Commission created the rurality tiers to prevent median rates for more rural areas of a state from being unfairly reduced due to the inclusion of rates for similar services in less rural areas.[24] This approach to rate determination was based on "the reasonable assumption that the cost to provide telecommunications services increases as the density of an

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[19] *See* 47 CFR §§ 54.504, 50.505; *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7372-73, paras. 76-78.

[20] Until 2019, these rules had been codified in section 54.607. Because that section number has since been re-assigned, the new rules for determining rural rates will replace the current section 54.605.

[21] *See Alaska Rates Database Waiver Order*; *Nationwide Rates Database Waiver Order*; *Alaska Rates Database Waiver Extension*; *Nationwide Rates Database Extension Order*.

[22] The Bureau permitted the use of previously-approved rural rates in the waivers of the Rates Database. *Nationwide Rates Database Waiver Order,* at 7-8, para. 17. Because the rules we are restoring today did not allow for the use of previously-approved rural rates, this option will not be available to RHC Program participants.

[23] SHLB Petition at 13-14; State of Alaska Petition at 4-5. Commenters responding to the *Further Notice* also argued that the Rates Database provided inadequate support for health care providers. *See* SHLB Comments at 5; SHLB Reply Comments at 7-8; Windstream Comments at 5-7; Alaska Communications Comments at 27; ANHB Comments at 7; GCI Comments at 5. We address arguments made in petitions for reconsideration that the Rates Database provided inadequate support and therefore do not address these comments.

[24] *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7351, para. 33.

area decreases, as rates are generally a function of population density."[25] However, we find that in light of the significant anomalies in the Rates Database uncovered by the Bureau, including many situations where support amounts for more rural areas were less than those for less rural areas,[26] the petitioners are correct that the geographic tiers used in the Rates Database do not result in rates that accurately reflect the cost of delivering telecommunications services for many rural health care providers.[27]

12. Under the rules we reinstate today, healthcare providers may use one of three methods for calculating the rural rates in the Telecom Program, depending on the circumstances: (1) the average of rates that the carrier actually charges to other non-health care provider commercial customers for the same or similar services provided in the rural area where the health care provider is located (Method 1); (2) if the carrier does not have any commercial customers in the health care provider's rural area, the average of tariffed and other publicly available rates charged by other service providers for the same or similar services provided over the same distance in the rural health care provider's area (Method 2); or (3) if there are no such rates or the carrier reasonably determines that those rates would be unfair, a cost-based rate that is approved by the Commission for interstate services (or the relevant state commission for intrastate services) (Method 3).[28] A carrier seeking approval of a rural rate under Method 3 will be required to provide "a justification of the proposed rural rate that includes an itemization of the costs of providing the requested service."[29]

13. We reiterate the requirements previously associated with this methodology. Methods 1, 2, and 3 must be applied sequentially. Method 1 must be used to determine a rural rate unless the service provider selected is not actually charging non-health care provider customers rates for same or similar services in the rural area where the eligible health care provider is located.[30] In that case, health care providers and service providers must attempt to calculate a rural rate using Method 2.[31] If it is not possible to determine a rural rate because there are no tariffed or publicly available[32] rates charged by other service providers for same or similar services in the rural area where the eligible health care provider is located, or if the service provider reasonably determines that the rural rate calculated using

[25] *Id.; see also Connect America Fund, et al.*, WC Docket No. 10-90, et al., Report and Order and Further Notice of Proposed Rulemaking, 26 FCC Rcd 17663, 17717 n.220 (2011) (noting that the same characteristics, such as lack of density, that make it expensive to provide voice service make it expensive to provide broadband service as well); Federal Communications Commission, *Connecting America: The National Broadband Plan*, at 136 (2010) (observing that "[b]ecause service providers in these areas cannot earn enough revenue to cover the costs of deploying and operating broadband networks, including expected returns on capital, there is no business case to offer broadband services in these areas").

[26] *See Nationwide Rates Database Waiver Order*, para. 13 and *Nationwide Rates Database Extension Order*, para. 8.

[27] *But see* infra Section III.B (retaining rurality tiers for purposes of prioritization of funding in the event demand exceeds available funding).

[28] *See* Appendix A, Final Rules, 47 CFR § 54.605, as adopted herein; *see also* 47 CFR § 54.607 (2019).

[29] *See* Appendix A, Final Rules, 47 CFR § 54.605(b)(1), as adopted herein; *see also* 47 CFR § 54.607(b)(1) (2019).

[30] *See* Appendix A, Final Rules, 47 CFR § 54.605(a), as adopted herein; *see also* 47 CFR § 54.607(a) (2019).

[31] *See* Appendix A, Final Rules, 47 CFR § 54.605(b), as adopted herein; *see also* 47 CFR § 54.607(b) (2019).

[32] Available rates include tariff rates and rates posted on service providers' websites, rate cards, and publicly available contracts such as state master contracts, as well as undiscounted rates charged to E-Rate Program applicants, and prior funding year RHC Program pricing data. This list of possible sources of available rates is not intended to be exhaustive and other sources may be possible. *The Wireline Competition Bureau Provides Guidance Regarding the Commission's Rules for Determining Rural Rates in the Rural Health Care Telecommunications Program*, WC Docket No. 02-60, Public Notice, 34 FCC Rcd 533, 537 (WCB 2019) (*Rural Rates Public Notice*).

Method 2 is unfair, then health care providers and service providers may calculate a rural rate using Method 3.[33]

14. Reinstating these rules promotes administrative efficiency and protects the Fund while we consider long-term solutions. We clarify that a rural rate approval for a service will be required only in the first year of an evergreen contract or another form of a multi-year contract unless the rural rates in the contract increase or other substantive terms of the contract change.[34] The rural rate approval for the initial year of the multi-year contract will constitute approval for all subsequent years of the contract, including voluntary extensions so long as the duration of the contract does not exceed five years. Given that service providers may not be expected to submit additional bids for the selected service within the duration of the multi-year contract, we believe that it is reasonable to eliminate rural rate approvals during that period as well. Therefore, previously approved rates for preexisting multi-year contracts do not need to be resubmitted for approval under the rate setting mechanisms we reinstate today.

15. We decline to adopt other options proposed by stakeholders or the Commission because they could lead to Program waste or pose implementation challenges. Alaska Communications and SHLB's suggestion to rely on competitive bidding alone to determine fair market rural rates could result in inflated rural rates.[35] As the Commission previously explained in the *Promoting Telehealth Report and Order*, only a small percentage of Telecom Program funding requests receive competing bids from multiple service providers, and in the few instances where carriers do compete, they are most likely to compete on non-price characteristics of service.[36] Therefore, we find that relying on competitive bidding without any other checks on rural rates would give service providers unfettered discretion to set their rates. Additionally, we find that the implementation challenges associated with the options raised in the *Further Notice,* such as a regression model[37] or a discount tier mechanism prevent us at this time from adopting these mechanisms.

16. *Rural rates waiver*. We find that Bureau's temporary measure of permitting the use of previously-approved rural rates and urban rates for funding year 2023 is appropriate given that competitive bidding for funding year 2023 has already started.[38] To further alleviate burdens on RHC Program participants as they prepare for funding years 2024 and 2025 we waive the Commission's rules

[33] *See* Appendix A, Final Rules, 47 CFR § 54.605(b), as adopted herein; *see also* 47 CFR § 54.607(b) (2019).

[34] *See* Letter from Richard Cameron, Counsel, Alaska Communications to Marlene Dortch, Secretary, FCC, WC Docket No. 17-310, 3 (filed Jan. 19, 2023) (Alaska Communications *Ex Parte*); Letter from Gina Spade, Counsel, ENA Healthcare to Marlene Dortch, Secretary, FCC, WC Docket No. 17-310, 1 (filed Jan. 18, 2023) (ENA *Ex Parte*); Letter from John Nakahata, Counsel, GCI Communication Corp. to Marlene Dortch, Secretary, FCC, WC Docket No. 17-310, 3 (filed Jan. 17, 2023) (GCI Jan. 17, 2023 *Ex Parte*); Letter from Kristen Corra, Policy Counsel, Schools, Health & Libraries Broadband (SHLB) Coalition to Marlene Dortch, Secretary, FCC, WC Docket No. 17-310, 2 (filed Jan. 19, 2023) (SHLB Jan. 19, 2023 *Ex Parte*).

[35] Alaska Communications Petition at 6-7; Letter from Richard R. Cameron, Counsel, Alaska Communications, to Marlene H. Dortch, Secretary, FCC, WC Docket No. 17-310, 2 (filed Feb. 18, 2020). SHLB Petition at 13.

[36] *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7367, para. 65. Because rural healthcare providers do not pay the rural rate, they have little incentive to select a service provider based solely on its rural rate. *See id.*

[37] *See* GCI Reply Comments at 12.

[38] *See Nationwide Rates Database Extension Order*, para. 14; *Alaska Rates Database Extension Order*, para. 11. The Bureau also granted wavier to permit the use of rural and urban rates for funding years 2021 and 2022. *See Nationwide Rates Database Waiver Order*; *Nationwide Rates Database Waiver Order.*

to permit the use of previously-approved rates for any funding year 2024 or 2025 rural rates that would otherwise require approval under Method 3.[39]

17. Generally, the Commission's rules may be waived or suspended for good cause shown.[40] The Commission may exercise its discretion to waive a rule where the particular facts make strict compliance inconsistent with the public interest.[41] In addition, the Commission may take into account considerations of hardship, equity, or more effective implementation of overall policy on an individual basis.[42] Waiver of the Commission's rules is appropriate only if both (1) special circumstances warrant a deviation from the general rule, and (2) such deviation will serve the public interest.[43] As noted by several commenters,[44] potentially having three different sets of rules for determining cost-based rural rates within three or four funding years could present unnecessary administrative burdens. Continuing to permit the use of previously-approved rural rates for Method 3, the most complex rural rates verification process, would significantly curtail those burdens.[45] Furthermore, according to commenters, market conditions appear to indicate that it is unlikely that pricing for Telecom Program funded services will significantly decrease over funding years 2024 or 2025, so utilizing rural rates approved for funding year 2023 in funding years 2024 and 2025 is unlikely to cause wasteful expenditures.[46]

18. A waiver permitting the use of previously-approved rates for funding years 2024 and 2025 Method 3 cost-based rural rates would also serve the public interest. Although there are significant program integrity benefits to rural rates reviews, we find that two years of such benefits is outweighed for funding years 2024 and 2025 by the administrative burdens on both program applicants and the Commission to prepare and approve cost studies. In addition, we find that it is not in the public interest to require service providers to absorb these burdens for funding years 2024 and 2025 given that the Commission is considering additional changes to its rural rate rules for future funding years in today's Second Further Notice of Proposed Rulemaking.[47]

19. In addition, we find that the public interest would not be served by extending this waiver to Method 1 and 2 rural rate or urban rate approvals because the administrative burden and time required for these justifications are considerably less than for Method 3 justifications.[48] Therefore we find that for Method 1 and 2 and urban rate justifications, the program integrity benefits to requiring rate justifications outweigh any administrative burdens associated with complying with these rules for funding years 2024

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[39] *See* Appendix A, Final Rules, 47 CFR § 54.605(b), as adopted herein. Should the Commission adopt new rules for determining rural rates in advance of funding year 2024 or 2025, the Commission reserves the right to have those rules supersede this waiver.

[40] 47 CFR § 1.3.

[41] *Northeast Cellular Telephone Co. v. FCC*, 897 F.2d 1164, 1166 (D.C. Cir. 1990) (*Northeast Cellular*).

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

[43] *Northeast Cellular*, 897 F.2d at 1166.

[44] *See* Letter from John Nakahata, Counsel, GCI Communication Corp. to Marlene Dortch, Secretary, FCC, WC Docket No. 17-310, 2 (filed Jan. 19, 2023) (GCI Jan. 19, 2023 *Ex Parte*) (requesting that the Commission permit the use of previously-approved rural rates in lieu on Method 3 for funding year 2024). *See also* SHLB Jan. 19, 2023 *Ex Parte* at 2 and Alaska Communications *Ex Parte* at 2 (both requesting that the Commission permit the use of previously-approved rural rates for all methods indefinitely until new rules are implemented).

[45] *See* GCI Jan. 19, 2023 *Ex Parte* at 2 (explaining complexities of Method 3 approvals).

[46] *See* Alaska Communications *Ex Parte* at 2; SHLB Jan. 19, 2023 *Ex Parte* at 4.

[47] *See infra* section VI.B.

[48] *See* GCI Jan. 19, 2023 *Ex Parte* at 2 (describing administrative burdens unique to Method 3). *But see* Alaska Communications *Ex Parte* at 2-3; SHLB Jan. 19, 2023 *Ex Parte* at 2 (both filings requesting that previously-approved rates be permitted for all rural and urban rates).

and 2025. Furthermore, we find that a waiver under Methods 1 or 2 is not necessary because, when a service provider cannot find justifying rates under Methods 1 or 2, as some parties contend is common,[49] the service provider has the option to rely on a previously approved Method 3 rate pursuant to the waiver we issue herein.

20. When this Method 3 waiver applies, a service provider may use a previously-approved rural rate from the most recent funding commitment for the facility/service combination at issue provided that funding commitment was issued in funding years 2021, 2022, or 2023. If there is no approved rate for a particular facility/service combination, the health care provider and its carrier may use a rural rate for the most recent funding commitment for the same or similar services to the facility with the same or similar geographic characteristics provided the funding commitment was issued in funding years 2021, 2022, or 2023. If no such comparable rates are available, this waiver is not applicable and the rural rate must be established using a Method 3 cost study pursuant to section 54.605(b) of our rules.[50]

21. For the reasons stated above, we find that restoring the previous rate methodology rules while we consider long-term solutions would best serve Program participants. Program participants are already familiar with the requirements of these methods, which will ease administrative burdens on the Commission, Administrator, and Program participants.

22. Although the rules that we reinstate today do not rely on a median approach to determine rural rates, as a general matter, we disagree with petitioners' concerns with using a median-based approach to determine rural rates. The Rates Database's use of medians was a reasonable application of section 254(h)(1)(A) to prevent outlier prices from skewing support.[51] Alaska Communications argued that, by basing support on a median rate rather than the actual rate charged, the Rates Database would not fulfill the requirements of section 254(h)(1)(A) of the Communications Act that telecommunications carriers receive the difference between the urban rate paid by the healthcare provider and the rate "similar services provided to other customers in comparable rural areas."[52] Similarly, USTelecom raised several concerns about the sufficiency of the median rate approach.[53] Although we agree with petitioners that the Rates Database and geographic tiers established in the *Promoting Telehealth Report and Order* did not accurately reflect the cost of delivering telecommunications services, we find that a median approach to calculate rural rates can satisfy the requirements of section 254(h)(1)(A) because a median can approximate the rates charged in "comparable rural areas in the state."[54] The fact that section 254(h)(1)(A) describes the services provider's obligation to charge "rates" reasonably comparable to urban rates rather than a more restrictive standard such as "the rate charged to an urban health care provider" suggests the Commission could meet the requirements of section 254(h)(1)(A) as long as the level of support in the aggregate would make up the urban-rural differential.

23. *Urban rates*. We also grant petitions seeking rescission of the rules implementing the Rates Database to determine urban rates. Petitioners seeking reconsideration of the *Promoting Telehealth*

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[49] *See* SHLB Jan. 19, 2023 *Ex Parte* at 3 (describing difficulties with obtaining justifying rates under Methods 1 and 2). We note that GCI, which serves rural health care providers throughout remote parts of Alaska and is the largest recipient of Telecom Program funding, projects that approximately 75% of its funding year 2024 TERRA and satellite funding requests will be submitted pursuant to Methods 1 or 2. GCI Jan. 19, 2023 *Ex Parte* at 2.

[50] *See* Appendix A, Final Rules, 47 CFR § 54.605(b).

[51] *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7366, para. 63.

[52] Alaska Communications Petition at 3 (*citing* 47 U.S.C. §254(h)(1)(A)). *See also* Alaska Communications Petition at 4.

[53] USTelecom Petition at 4-7. USTelecom also argued that the Rates Database could result in carriers being prohibited from charging tariffed rates in violation of state law. *See id.* Because we reconsider the Rates Database on other grounds, we need not reach this argument.

[54] 47 U.S.C. § 254(h)(1)(A).

Report and Order raised concerns about the Administrator's ability to determine urban rates using the Rates Database.[55] Furthermore, after the Rates Database launched, specific concerns about the urban rates it generated arose.[56] In the *Nationwide Rates Database Waiver Order*, the Bureau acknowledged urban rate anomalies in the Rates Database in some states, including instances where urban rates for lower bandwidths exceeded urban rates for higher bandwidths for the same service, and examples of urban rates exceeding rural rates in a state.[57] The Bureau concluded that these examples did not amount to convincing evidence of "pervasive nationwide anomalies with urban rates" but did "merit further inquiry and investigation" and therefore waived use of the Rates Database of determining urban rates.[58] In comments in response to the *Further Notice*, SHLB reiterated that the Rates Database had significant urban rate anomalies, including instances in many states in which the median urban rate for a service exceeded at least one rural rate.[59] ADS encouraged the Commission to reinstate a "safe harbor" approach for urban rates.[60]

24. We conclude that reinstating the previous urban rate determination rules is the best way to ensure consistency and predictability in the rate determination process while we consider alternative options for an urban rates determination mechanism going forward.[61] None of the petitions for reconsideration suggested a mechanism for determining urban rates to be used if we were to eliminate the Rates Database, and none opposed returning to the pre-*Promoting Telehealth Report and Order* method for determining urban rates. As with rural rates, health care providers and service providers are already familiar with the pre-2019 rules for determining urban rates, and introducing a completely new set of rules while we consider additional changes could lead to confusion and cause an undue administrative burden. Therefore, going forward, the urban rate for an eligible service submitted by the healthcare provider on FCC Form 466 should be "no higher than the highest tariffed or publicly-available rate charged to a commercial customer for a functionally similar service in any city with a population of 50,000 or more in [a] state."[62] Healthcare providers must document the urban rate with "tariff pages, contracts, a letter on company letterhead from the urban service provider, rate pricing information printed from the urban service provider's website or similar documentation showing how the urban rate was obtained."[63] We believe reinstatement of the prior urban rate setting methodology is the best available solution as we seek comment on potential revisions to the urban rate determination rules in the Second

[55] *See* SHLB Comments at 20-21; USTelecom Comments at 14-15; Alaska Communications Comments 19-21.

[56] *See* Letter from Gina Spade, Counsel, SHLB, to Marlene H. Dortch, Secretary, FCC, WC Docket No. 17-310, at 3-9 (filed Mar. 27, 2021); Letter from John Windhausen, Jr., Executive Director, SHLB, to Jessica Rosenworcel, Acting Chairwoman, FCC, et al., WC Docket No. 17-310 at 4 (filed Jan. 25, 2021); Letter from Kristi Walker, Senior Project Manager, Community Care of West Virginia, to Jessica Rosenworcel, Acting Chairwoman, FCC, et al., WC Docket No. 17-310, at 2 (filed Feb. 18, 2021); Letter from Carl Baranowski, Vice President and Chief Legal Officer, University of Texas Health Science Center at Tyler, to Jessica Rosenworcel, Acting Chairwoman, FCC, et al., WC Docket No. 17-310, at 1 (filed Jan. 27, 2021).

[57] *Nationwide Rates Database Waiver Order* at 9, para. 21.

[58] *Id*. at 9, paras. 21-22.

[59] SHLB Comments at 4.

[60] ADS Comments at 4. This "safe harbor" refers to the Administrator's practice under the pre-2019 rules of posting to its website examples of urban rates for certain services in various states that health care providers could use instead of obtaining urban rates through other means.

[61] Until 2019, these rules had been codified in section 54.605. The current section 54.604, which governs determinations of urban rates using the Rates Database, will be amended to reflect the new rules.

[62] *See* 47 CFR § 54.604(a), Appendix A, Final Rules, 47 CFR § 54.605(a) (2019), as adopted herein.

[63] *See* FCC Form 466 Instructions at 8 (2019).

Further Notice of Proposed Rulemaking herein. As with rural rates, we also affirm the Bureau's decision to permit the use of previously-approved urban rates for funding year 2023.[64]

25. In adopting the Rates Database, the Commission identified several concerns with the rate-setting rules in place at the time, including potential issues with transparency, administrative efficiency, and program integrity.[65] While the Rates Database proved to be an inadequate solution for provisioning sufficient support to RHC Program participants, we remain cognizant of those concerns, and we therefore continue our work to improve the Telecom Program rate determination methodology as discussed in the Second Further Notice of Proposed Rulemaking herein.

2. Similar Services

26. Though RHC Program applicants and participating service providers will no longer use the Rates Database to calculate rural and urban rates, they will continue to need to identify rates for the same or similar services to support rural and urban rates submitted to the Administrator. We therefore address petitions for reconsideration of the Commission's conclusions regarding similar services in the *Promoting Telehealth Report and Order*.[66] We find that the Commission properly determined that similar services can include non-telecommunications services that deliver the same or similar functionality as the requested service and can include services with advertised speeds 30% above or below the speed of the requested service. We instruct the Administrator to apply these requirements to its review of Method 1 and Method 2 submissions and urban rates going forward.

27. *Non-telecommunications services.* We affirm the Commission's finding that, to calculate the most accurate rates, the pool of rates taken into consideration should include rates for services that deliver the functionality sought by the applicant. We therefore deny USTelecom's request to reverse the decision that non-telecommunications services that are functionally similar to eligible telecommunications services be considered similar services for purposes of calculating rates.[67] We reaffirm the Commission's conclusion in the *Promoting Telehealth Report and Order* that similarity of services is a "technology-agnostic inquiry" that should be viewed from the perspective of the end user experience as opposed to regulatory classification.[68]

28. The Telecom Program provides support in accordance with section 254(h)(1)(A) of the Communications Act based on the difference between the urban rate, which must be "reasonably comparable to the rates charged for *similar services* in urban areas in that State," and "rates for *similar services* provided to other customers in comparable rural areas," i.e., the rural rate.[69] Congress did not define the term "similar services."[70] In 2003, the Commission interpreted similar services to mean services that are functionally similar from the perspective of the end user.[71] This interpretation deviated

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[64] *See Nationwide Rates Database Extension Order*, para. 14 and *Alaska Rates Database Extension Order*, para. 11.

[65] *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7363, para. 53.

[66] *See* USTelecom Petition at 11-15 (seeking reconsideration of the Commission's decision that non-telecommunications services can be similar to telecommunications services for purposes of rates determinations); SHLB Petition at 16-17 (seeking reconsideration of the Commission's decision that services with advertised speeds 30% above or below the speed of the requested service be considered functionally similar to the requested service).

[67] USTelecom Petition at 11-15; Letter from B. Lynn Follansbee, Vice President – Policy & Advocacy, USTelecom, to Marlene H. Dortch, Secretary, FCC, WC Docket No. 17-310, 3 (filed July 25, 2019) (USTelecom *Ex Parte*).

[68] *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7345, para. 18.

[69] 47 U.S.C. § 254(h)(1)(A) (emphasis added); *Universal Service First Report and Order*, 12 FCC Rcd at 9119-9133, paras. 657-685; 47 CFR § 54.602(a).

[70] *See generally* 47 U.S.C. § 254(h)(7).

[71] *See 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, 24563-64, paras. 31-34 (2003) (*2003 Internet*

(continued….)

from the Commission's previous policy of calculating support based on the difference between the urban and rural rates for "technically" similar services.[72] Without any discussion as to why non-telecommunications services were not considered "functionally similar," the Commission stated that "[e]ligible health care providers must purchase telecommunications services and compare their service to a functionally equivalent telecommunications service in order to receive this discount" and created a voluntary "safe harbor" for categories of services based on transmission speed that would be considered by the Commission functionally similar for purposes of calculating urban and rural rates.[73]

29. In the *2017 Notice of Proposed Rulemaking*, the Commission sought comment on changes to the interpretation of similar services.[74] The Commission specifically proposed to "retain the concept of '*functionally* similar as viewed from the perspective of the end user'" and additionally proposed to "require healthcare providers to analyze similarity under specific criteria."[75] In the *Promoting Telehealth Report and Order*, the Commission ultimately retained the "functionally similar" standard for defining similar services and, after acknowledging the prior interpretation in 2003, made clear that because the functionally similar standard is technology agnostic and does not turn on regulatory classification, both telecommunications and non-telecommunications services must be considered when identifying similar services for calculating urban and rural rates.[76]

30. USTelecom argues that the Commission did not provide an opportunity for notice and comment, as required by the Administrative Procedure Act (APA), before expanding the inquiry of functionally similar services to include non-telecommunications services.[77] On the contrary, the Commission did provide notice in the *2017 Notice of Proposed Rulemaking* of its intent to consider changes to the statutory interpretation of similar services.[78] And as explained in the *Promoting Telehealth Report and Order*, revisiting this decision would inevitably involve a consideration of the types of services that would fall within the scope of this statutory term.[79] We therefore disagree with USTelecom

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Access Order) (discussing "Interpretation of 'Similar Services'"). The Commission revised its rules on the determination of urban and rural rates consistent with this interpretation in 2003 to reference functionally similar services instead of similar services. *Id*. at 24586-89 (revising rule sections 54.605 and 54.609).

[72] *Id*. at 24563, para. 31.

[73] *Id*. at 24563-64, para. 33-34; *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Notice of Proposed Rulemaking and Order, 32 FCC Rcd 10631, 10655, para. 73 (2017) ("To implement this [functionally similar] standard, the Commission established a voluntary 'safe harbor' whereby a healthcare provider could claim that two services are similar if they both fall within one of five speed tiers.") (*2017 Notice of Proposed Rulemaking*).

[74] *See 2017 Notice of Proposed Rulemaking*, 32 FCC Rcd at 10655-56, paras. 73-78.

[75] *Id*. at 10655, para. 75 (emphasis in original).

[76] *See Promoting Telehealth Report and Order*, 34 FCC Rcd at 7341-46, paras. 15-20.

[77] 5 U.S.C. § 553; USTelecom Petition at 11-14.

[78] *See 2017 Notice of Proposed Rulemaking*, 32 FCC Rcd at 10655, paras. 73-75 & n.104 ("By functionally similar from the perspective of the end user, we mean these services offer features and functions that provide a similar user experience."); *id.* at 10656, para. 77 ("We seek comment on other criteria we could use to establish 'similar services.'").

[79] *See Promoting Telehealth Report and Order*, 34 FCC Rcd at 7343, para. 18, n.55. The Commission also specifically sought comment on using performance criteria associated with packet-based services that are often provided on a non-common carrier basis in the marketplace, e.g., as private carrier or information services. *See 2017 Notice of Proposed Rulemaking*, 32 FCC Rcd at 10656, para. 77. This would provide an additional indication to the public that the Commission was considering a functionally similar standard that would not turn on the regulatory classification of the service.

that the Commission violated the APA when it clarified the scope of similar services to include not only telecommunications but also non-telecommunications services.[80]

31. The Commission's decision to expand the inquiry of functionally similar services in urban and rural rate determinations was not arbitrary and capricious, as USTelecom separately contends.[81] We also disagree with USTelecom that the fact that the Telecom Program does not fund information and private carriage services precludes consideration of rates for those services in the rate determination process.[82] As to both arguments, the Commission fully considered these issues in the *Promoting Telehealth Report and Order* and explained that the end-user experience, not regulatory classification, guides our analysis of whether services are functionally equivalent.[83] The Commission further explained that including information services, which may be less expensive, with functionally similar telecommunications services is consistent with the statutory requirement that the Commission ensure access to telecommunications services for health care providers at rates that are "reasonably comparable" to those charged for "similar services in urban areas" because including rates for such functionally similar information services would more accurately reflect the prices available in urban areas for services that deliver the same functionality to end users regardless of classification, and place rural health care providers on equal footing with their urban counterparts.[84]

32. *30 percent threshold.* We also deny SHLB's request that we reconsider the Commission's determination that services with advertised speeds 30% above or below the speed of the requested service be considered functionally similar to the requested service.[85] SHLB argues that this approach is overbroad and will include services that are dissimilar in function and cost. SHLB, however, does not offer any examples.[86] Comments filed after the Rates Database launched addressing the 30% threshold in response to the *Further Notice* were mixed. Alaska Communications described the 30% bandwidth range as "not unreasonable," but cautioned that there is too little rural rate data in Alaska to "make this the basis for a complete rural rate methodology."[87] NTCA argues that the 30% threshold is too broad and urges the Commission to implement a smaller margin based on health care provider use cases, but also does not offer examples of overly broad results.[88]

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[80] Assuming, *arguendo*, that there was insufficient notice and comment, the Commission's defining of similar services and functionally similar services as referenced in the Commission's rules, to include telecommunications and non-telecommunications services that are functionally similar from the perspective of the end user could have been adopted as an interpretation not subject to the APA's notice-and-comment requirements. *See* 5 U.S.C. § 553(b)(A) (stating that the notice-and-comment requirement do not apply to "interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice."); *Perez v. Mortg. Bankers Ass'n*, 575 U.S. 92, 97 (2015) ("[T]he critical feature of interpretive rules is that they are "issued by an agency to advise the public of the agency's construction of the statutes and rules which it administers."). The Commission's rules use the term "functionally similar" so the clarification made in the *Promoting Telehealth Report and Order* could be viewed as a revised interpretation of the Commission's rules to include non-telecommunications services. 47 CFR §§ 54.604(a), 54.605(a); *Perez*, 575 U.S. at 100 (holding that an interpretive rule can interpret not only a statute but also a prior agency rule).

[81] USTelecom Petition at 14.

[82] USTelecom Petition at 14; USTelecom *Ex Parte* at 2.

[83] *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7344-45, paras. 18-20.

[84] *Id*. at 7345, para. 19; *see also* 47 U.S.C. § 254(h)(1)(A).

[85] SHLB Petition at 16.

[86] *Id.*

[87] Alaska Communications Comments at 18.

[88] NTCA Comments at 9.

33. Taking these arguments into account, we conclude that we should not deviate from the Commission's prior conclusion in the *Promoting Telehealth Report and Order* that the 30% range allows for rate predictability while accounting for the rising demand for faster connectivity.[89] Having a standard for determining similar services based on a range is preferable to having speed tiers, which would need to be frequently refreshed so they would not become out of date, as was the case with the speed tiers that existed before the *Promoting Telehealth Report and Order*. Moreover, based on the record previously developed, a range of 30% provides a sufficiently large number of inputs for determining rates under Methods 1 and 2.[90] Reducing the range as NTCA requests would likely mean that few services with even slight variations in bandwidth would be similar to one another.[91] Additionally, maintaining the current threshold for similar services of advertised speeds being 30% above or below the speed of the requested service will ease program administration because health care providers are already familiar with this standard.

34. We also disagree with SHLB's assertion that the *Promoting Telehealth Report and Order* fails to account for price variations based on contract term or volume discounts, which SHLB maintains will distort rural rate determinations.[92] The *Promoting Telehealth Report and Order* did account for these price variations when explaining that section 254(h)(1)(A) requires service providers to provide telecommunications services to eligible providers at "rates that are reasonably comparable to *rates charged* for similar services in urban areas."[93]

35. Finally, as requested by GCI, we clarify that, in the event there is no comparable rural rate within 30% of the speed of the requested service, the Commission will allow service providers to justify the rural rate using the rate for a higher bandwidth service that is otherwise similar to the requested service.[94] Similarly, as requested by SHLB,[95] we clarify that if there is no comparable urban rate within the 30% range available, the Commission will allow service providers to use the rate for a higher bandwidth service that falls outside the 30% range but is otherwise similar to the requested service.[96] We find that providing this flexibility will ease administrative burdens without additional cost to the Universal Service Fund.

3. Site and Service Substitution

36. We deny Alaska Communications' petition for reconsideration to the extent it seeks clarification that "the Commission intended to include service delivery dates" in the adopted site and

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[89] *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7343-44, para. 16. SHLB also asserts that determining rates on a per-Mbps basis could be used within the 30% advertising speed range. SHLB Petition at 16. The Commission rejected the per-Mbps approach in the *Promoting Telehealth Report and Order* as contrary to the purpose of the similar services inquiry, which is to identify services that are functionally similar to the end user and not to identify services that are similarly priced. *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7366, n.179.

[90] *See id.* at 7343-44, para. 16.

[91] *See* NTCA Comments at 9.

[92] SHLB Petition at 16-17.

[93] *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7344, n.49 (emphasis added). SHLB is mistaken in claiming that section 254(h)(1)(A) only "describes the urban rate" and not the determination of permissible rural rates. *See* SHLB Petition at 17. The very purpose of section 254(h)(1)(A) is to establish the means of determining rural rates by comparison to urban rates (i.e., "[rural] rates that are reasonably comparable to rates charged for similar services in urban areas in the State."). 47 U.S.C. § 254(h)(1)(A).

[94] *See* GCI Jan. 17, 2023 *Ex Parte* at 3.

[95] *See* SHLB Jan. 19, 2023 *Ex Parte* at 4.

[96] The Commission allowed this flexibility in previous waiver orders. *See, e.g.*, *Nationwide Rates Database Waiver Order*, para. 18.

service substitution rule.[97] Alaska Communications explains that service date or evergreen contract date changes are some of the most common changes requested in the RHC Program.[98] Alaska Communications further explains that applicants are required to submit a funding request and include anticipated service dates at the time the request is submitted to the Administrator, but there may be delays for a planned transition or deployment of upgraded services and the anticipated service start or termination dates may change.[99] In response, we clarify that under section 54.624(a) of our rules, RHC Program applicants may be able to substitute the requested service when there is a delay in the deployment of the original service and that the funding request could be modified to reflect the substituted service when such a delay may occur.[100] Section 54.624(a) is intended to allow applicants flexibility to substitute requested services and to receive RHC Program support for substituted services when the requirements are met.[101]

37. However, we deny Alaska Communications' request to clarify that section 54.624(a) allows changes to service dates and evergreen contract dates as "service substitution" changes because section 54.624(a) does not address service dates or evergreen contract dates.[102] With respect to service date changes, Program participants are already permitted to change the dates for which services are provided. RHC Program participants are required to provide dates of service and contract dates on the Request for Funding (FCC Form 466 or FCC Form 462) for the requested services.[103] If there are changes to the dates for which services were provided or evergreen contract dates, RHC Program participants already modify service dates through other means unrelated to the service substitution process.[104] Therefore, there is already a mechanism for all RHC Program participants to substitute a service if there is

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[97] Alaska Communications Petition at 21. *See also* 47 CFR § 54.624.

[98] *Id*. at 21-24.

[99] *Id.* at 21-25.

[100] *See* 47 CFR § 54.624(a) (providing that health care providers or Consortium Leaders may request a site or service substitution if: (1) The substitution is provided for within the contract, within the change clause, or constitutes a minor modification; (2) The site is an eligible health care provider and the service is an eligible service under the Telecommunications Program or Healthcare Connect Fund Program; (3) The substitution does not violate any contract provision or state, Tribal, or local procurement laws; and (4) The requested change is within the scope of the controlling Request for Services, including any applicable RFP used in the competitive bidding process). In addition, "support is restricted to qualifying site and service substitutions that do not increase the total amount of support under the applicable funding commitment." *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7425, para. 194.

[101] *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7425, para. 195 (explaining that the site and service substitution rule provided RHC Program participants with greater flexibility to substitute services when certain conditions are met).

[102] Alaska Communications Petition at 25. *See also* SHLB Jan. 19, 2023 *Ex Parte* at 4-5 (requesting that the Commission direct USAC to create a mechanism to allow modification of evergreen contract dates).

[103] *See* Health Care Providers Universal Service Funding Request and Certification Form, FCC Form 466, Line 30-31, 32, OMB Control No. 3060-0604 (2019), https://www.usac.org/wp-content/uploads/rural-health-care/documents/FCC-Forms/Form_466_2019.pdf (requesting contract start and end dates and service installation date); Rural Health Care (RHC) Universal Service HCF Funding Request Form, FCC Form 462, Lines 19b-19e, OMB Control No. 3060-0804 (2019), https://www.usac.org/wp-content/uploads/rural-health-care/documents/FCC-Forms/Form_462_2019.pdf (requesting service start date as well as contract start and end dates).

[104] In the HCF Program, participants report updates service start dates on their invoicing forms. FCC Form 463 Guide for Service Providers, at 2, https://www.usac.org/wp-content/uploads/rural-health-care/documents/forms-guides/FCC-Form-463-Guide-Service-Provider.pdf (providing instructions for reporting the service start date/shipping date or last day of work). We expect that the new invoice form for the Telecom Program discussed in the Report and Order below will also allow the reporting of updated service start dates. Participants may also request a service delivery date extension prior to the end of the same funding year by contacting the Administrator.

a delay in implementing the new service and modify the service dates for the substituted service. Contrary to Alaska Communications' assertion that this process creates additional administrative burdens due to the potential for an appeal, this process is no more administratively burdensome than the service substitution request process. Under both processes, if the Administrator denies a request, the health care provider could file an appeal.[105] With respect to evergreen contract dates, although section 54.624 cannot reasonably be interpreted as addressing modifications to evergreen contract dates, we seek comment in the Second Further Notice of Proposed Rulemaking below about whether a mechanism to modify evergreen contract dates is appropriate and what such a mechanism might be.[106] Accordingly, we deny the request to modify section 54.624 to add modification of service dates and evergreen contract dates as an allowable service substitution.

38. Alaska Communications further requests that when the Administrator contacts a health care provider with questions or requests for additional information regarding urban or rural rates or the terms of the service, the Administrator also be required to communicate the question or information request with the relevant service provider.[107] Health care providers are encouraged to work with their service providers to respond to information requests from the Administrator regarding, for example, additional information on urban and rural rates and terms of service.[108] Thus, service providers are allowed to provide the requested information needed during the funding application review process.[109] We decline, however, to require the Administrator to issue information requests to the relevant service providers. We conclude that it would be administratively burdensome and a poor use of limited administrative resources to require the Administrator to send these requests to service providers. Applicants that would like assistance from service providers should reach out to providers to pose questions related to the Administrator's review of health care providers' funding applications.[110]

4. Remaining Requests for Reconsideration of the Rates Database

39. We dismiss as moot all other challenges to the Rates Database raised in the petitions for reconsideration that are not applicable to rural rate determinations under Method 1, Method 2, or Method 3 or urban rate determinations.[111] Our decision above to eliminate the use of the Rates Database to calculate urban and rural rates renders these challenges moot.[112]

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[105] *See* 47 CFR § 54.719.

[106] *See infra.* Section VI.E.2.

[107] Alaska Communications Petition at 23.

[108] *See*, *e.g.*, USAC, Rural Health Care, Telecommunications Program, *Telecom Program: Urban and Rural Rates*, https://www.usac.org/wp-content/uploads/rural-health-care/documents/handouts/TelecomRuralUrbanRateInfo-1.pdf (explaining that health care providers should work with their service providers to respond to questions regarding the rural rates) (last visited Jan. 26, 2023); USAC, Rural Health Care, Telecommunications Program, *Step 4: Submit Funding Requests*, https://www.usac.org/rural-health-care/telecommunications-program/step-4-submit-funding-requests/ (providing that "[y]ou may need to work with your service provider to obtain information and documentation necessary to complete the FCC Form 466") (last visited Jan. 26, 2023).

[109] *See id*.

[110] *See id*.

[111] *See* Alaska Communications Petition at 6-8 (arguing that rural rates should be based on the average, not the median, rate in each rurality tier); *id.* at 6-7 (arguing that the Administrator should approve rates that are derived from competitive bids or published rates without using the Rates Database); *id.* at 8-10 (opposing the decision to rely on rates in a less rural geographic tier when not rates are available in the same tier); *id.* at 10-11 (arguing that Rates Database inputs should be limited to rates from the previous calendar year); SHLB Petition at 20-24, USTelecom Petition at 11-14; Alaska Communications Petition at 12-21 (all arguing that the Rates Database is an impermissible delegation of authority to the Administrator); SHLB Petition at 13-15 (arguing that the Rates Database rurality tiers are arbitrary and too broad and would produce rates not tied to any real estimates of service costs).

B. Rurality

40. We next deny requests to reconsider aspects of the geographically-based rurality tiers adopted in the *Promoting Telehealth Report and Order*.[113] Though the termination of the Rates Database moots the use of rurality tiers for purposes of rates determination, rurality tiers are also used to prioritize support in the event that demand exceeds available support, a mechanism that is unchanged by today's actions.[114]

41. In the *Promoting Telehealth Report and Order*, the Commission established three tiers of rurality to determine comparable rural areas in a state or territory for purposes of the Rates Database: (1) Extremely Rural (areas entirely outside of a Core Based Statistical Area); (2) Rural (areas within a Core Based Statistical Area that does not have an Urban Area with a population of 25,000 or greater); and (3) Less Rural (areas in a Core Based Statistical Area that contains an Urban Area with a population of 25,000 or greater, but are within a specific census tract that itself does not contain any part of a Place or Urban Area with a population of greater than 25,000).[115] For health care providers in Alaska, the Commission bifurcated the Extremely Rural tier to include a Frontier tier for areas not accessible by road.[116]

42. Arguments against the rurality tiers adopted by the Commission in the *Promoting Telehealth Report and Order* focused on their impact on rates determinations in the Rates Database.[117] With the elimination of the Rates Database, the only remaining relevance of rurality tiers is for purposes of prioritizing support in the event that demand ever exceeds available funding.[118] We find that the rurality tiers as adopted in the *Promoting Telehealth Report and Order* are appropriate for purposes of prioritization of support and deny petitions for reconsideration to the extent they request that the Commission eliminate rurality tiers from its rules for all purposes. The rurality tiers will properly target RHC Program funding to less populous areas in the event that prioritization of funds is needed, and the

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[112] Additionally, we dismiss the petition for reconsideration filed by USTelecom to the extent it seeks modification of the FCC Form 465 or clarification of its instructions. *See* USTelecom Petition at 23-25. These requests are outside the scope of the *Promoting Telehealth Report and Order*. *See* 47 CFR § 1.429(l)(5) (allowing dismissal of petitions for reconsideration that relate to matters outside the scope of the order for which reconsideration is sought). Furthermore, the FCC Forms 461 and 465 already capture the range of bandwidths the health care provider seeks bids for. *See* Request for Services Form, FCC Form 461, OMB Control No. 3060-0604; Description of Services Requested and Certification Form, FCC Form 465, OMB Control No. 3060-0604.

[113] *See* State of Alaska Petition at 4-7; NCTNA/SOHCN Petition at 10-13; SHLB Petition at 12-15.

[114] *See* 47 CFR § 54.621(b).

[115] *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7346-47, para. 21.

[116] *Id*. at 7352, para. 34. The Commission defined Frontier areas as those that are outside of a Core Based Statistical Area that are inaccessible by road. To determine which communities are connected by roads, the Commission stated that it would use data provided by the Alaska Department of Commerce Community and Economic Development, Division of Community and Regional Affairs. *Id*. at 7352-53, para. 35.

[117] *See* SHLB Petition at 13-14 (contending that the tiers are overly broad because they group together areas of states with differing topography and infrastructure and are therefore not tied to the actual cost of service); State of Alaska Petition at 4-6 (arguing that Alaska should be differentiated geographically based on fiber availability); NCTNA/SOHCN Petition at 10-13 (requesting that the Commission use United States Census Bureau designation that divides Core-Based Statistical Areas into Metropolitan Statistical Areas and Micropolitan Statistical Areas, arguing that relying on Census-recognized designations would allow applicants and the Administrator to pre-qualify sites and determine funding priority for each site).

[118] See 47 CFR § 54.621(b) (setting tiers for prioritization based on rurality tiers and designation as a Medically Underserved Area or Population).

record contains no alternative mechanism for better parsing rurality for this limited purpose.[119]

43. NCTNA/SOHCN suggests that switching to a method based on metropolitan and micropolitan designations would "allow [the Administrator] to pre-qualify sites and to demonstrate rurality and to determine the funding priority each site will receive" and that switching from designations based on census blocks instead of census tracts would be more precise. However, the Administrator has already created a tool that allows health care providers to determine their priority tier based on the current rurality designations, so a change is not necessary to provide this administrative convenience.[120] While we recognize the benefit of precision in parsing rurality, we find that the potential confusion and administrative burdens to all Program participants that would result from abandoning the use of the current rurality tiers, which are consistent with the Commission's long-held definition of "rural," outweighs the impact this change would have on the limited number of health care providers whose rural status would change.[121]

44. Given our decision on reconsideration to eliminate the rules establishing the Rates Database, we make two ministerial changes to our rules to reflect the limited use of rurality tiers for prioritization purposes.[122] First, we eliminate the concept of Frontier Areas from our rules because it does not apply to prioritizing support. A "Frontier Area" is an area in Alaska outside of a Core Based Statistical Area that is inaccessible by road. The Commission adopted this concept for purposes of the Rates Database only.[123] Second, we amend our codified rules so that rurality tiers are addressed only in rules related to prioritization. The rurality tiers currently appear in two separate sections of our rules: section 54.605(a), which addresses rural rates, and section 54.621(b), which addresses prioritization of support. We delete references to the rurality tiers from section 54.605(a) but retain them in section 54.621(b). We also make minor changes to the text of section 54.621(b) so that it more closely reflects the text of section 54.605(a).[124]

C. Funding Prioritization

1. Internal Cap on Multi-Year Commitments and Upfront Payments

45. We deny NCTNA/SOHCN's petition for reconsideration requesting an increase to the internal cap on funding available to HCF applicants seeking support for upfront payments and multi-year commitments.[125] This internal cap limits funding for multi-year commitments and upfront payment to an

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[119] Because there has been sufficient funding to satisfy demand since the prioritization rules adopted in the *Promoting Telehealth Report and Order*, the prioritization system has never been used.

[120] *See* USAC website, Rurality Tier Search Tool, https://www.usac.org/rural-health-care/resources/tools/rurality-tier-search-tool/ (last visited Jan. 26, 2023).

[121] *See Promoting Telehealth Report and Order*, 34 FCC Rcd at 7350, para. 32.

[122] We find additional notice and comment for these changes is not needed because it would be unnecessary given that they are ministerial reflections of other changes to the rules. *See* 5 U.S.C. § 553(b)(B); *see also* 47 CFR § 1.412(c).

[123] *Compare* 47 CFR §54.605(a)(1)(iv) to 47 CFR §54.621(b). For purposes of prioritization, Frontier Areas were treated as part of the Extremely Rural Tier.

[124] Section 54.605(a) defined the Extremely Rural Tier as "areas" entirely outside of a Core Based Statistical Area whereas section 54.621(a) defined it as "counties" entirely outside of Core Based Statistical Area. We apply the nomenclature that appeared in section 54.605(a) to section 54.621(a).

[125] NCTNA/SOHCN Petition at 7. NCTNA/SOHCN also urge the Commission to "revisit" the overall annual cap under the RHC Program. *See id*. at 3-6; *see also* 47 CFR § 54.619(a) (setting the funding cap at $571 million per funding year and adjusting that figure annually for inflation beginning in funding year 2018). We decline to do so here as the time for reconsideration of our decision to increase the cap on overall funding, which was adopted in 2018, has passed. *See Promoting Telehealth in Rural America*, WC Docket No. 17-310, Report and Order, 33 FCC Rcd 6574 (2018) (*RHC Program Cap Order*).

amount adjusted annually for inflation, which is calculated at $161 million for funding year 2022.[126] The Commission retained the internal cap in the *Promoting Telehealth Report and Order* after determining that the cap protected against possible underfunding of single-year funding requests and that an increase in the dollar amount of the internal cap may adversely affect single-year requests.[127] The Commission did, however, adopt a rule adjusting the cap annually for inflation as a hedge against loss of purchasing power in the event of price inflation.[128] NCTNA/SOHCN maintain that the decision to not further increase the internal cap is "based on an incorrect reading of the purpose of [the] cap" – namely, that the principal purpose of establishing the cap was to guard against fluctuations in demands from potentially large upfront infrastructure projects.[129] NCTNA/SOHCN also argue that the Commission should reconsider the cap "in light of its original purpose and data accumulated since 2013 when it was first implemented"[130] and therefore should remove multi-year funding commitments from being subject to the cap.[131]

46. We deny NCTNA/SOHCN's request.[132] The internal cap on multi-year commitments and upfront payments in its current form is serving its stated purpose: to limit major fluctuations in demand so as to protect single-year funding requests. In the *Promoting Telehealth Report and Order*, the Commission noted that the internal cap was first exceeded in funding year 2018 and, but for the cap, all funding requests for that year would have been prorated to bring the total demand for RHC Program support below the Program's overall funding cap.[133] We also find that the record does not support removing multi-year commitments from the internal cap. NCTNA/SOHCN point to efficiencies that are inherent to some multi-year funding commitments.[134] However, USAC data indicates that demand for multi-year commitments accounted for a significant portion of the total demand for multi-year

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[126] *See* 47 CFR § 54.619(a) (establishing an internal cap of $150 million for funding requests for upfront payment and multi-year commitments); 47 CFR § 54.619(a)(2) (requiring the internal cap to be adjusted annually for inflation). *See also Wireline Competitive Bureau Announces E-Rate and RHC Programs' Inflation-Based Caps for Funding Year 2022*, CC Docket No. 02-6, WC Docket No. 02-60, Public Notice, DA 22-271 (WCB Mar. 14, 2022) (announcing an internal cap of $161 million for funding year 2022).

[127] *See Promoting Telehealth Report and Order*, 34 FCC Rcd at 7401, para. 138.

[128] *See id*. at para. 139. To measure increases in the rate of inflation for purposes of adjusting the internal cap on multi-year commitments and upfront payments, the Commission uses the Gross Domestic Product Chain-type Price Index (GDP-CPI). *See* 47 CFR § 54.619(a)(2).

[129] NCTNA/SOHCN Petition at 7.

[130] *Id*. at 9.

[131] *Id.* at 8.

[132] While we deny NCTNA/SOHCN's request to increase the internal cap, the internal cap application rule we adopt today in the Report and Order below reduces the chance that the internal cap will create a cut in funding for multi-year commitment and upfront payment requests, because as long as the total available funding is greater than the total demand, the internal cap will not apply. *See infra* Part IV.B; Appendix A, Final Rules, 47 CFR § 54.619(a), as adopted herein.

[133] Since then, program demand for multi-year commitments and upfront payments has exceeded the internal cap in funding year 2019 and 2020, though full funding of single-year requests was not inhibited. *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 35 FCC Rcd 2659, 2662, para. 8 (2020) (*Funding Year 2019 Demand Order*) (funding year 2019 funding cap on upfront payment and multi-year commitments exceeded by approximately $60 million); *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 35 FCC Rcd 11696, 11698-99, paras. 7, 11 (WCB 2020) (*Funding Year 2020 Demand Order*) (funding year 2020 funding cap on upfront payments and multi-year commitments exceeded by approximately $43 million); *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7400, para. 138.

[134] *See* NCTNA/SOHCN Petition at 8.

commitments and upfront payments from funding year 2016 to funding year 2021.[135] As demonstrated by demand in recent funding years, removing multi-year commitments from being subject to the internal cap could result in costly multi-year commitment requests usurping funding from single-year requests. We affirm the Commission's earlier decision to retain the internal cap on multi-year commitments and upfront payments and, accordingly, deny that portion of the NCTNA/SOHCN petition.[136] In the Report and Order below, we amend our rules so that the internal cap applies only when demand exceeds available funding, and when the internal cap does apply, upfront costs and the first year of a multi-year commitment request are prioritized over the second and third year of a multi-year commitment request.[137]

2. Prioritization System

47. We next deny SHLB's request that we reconsider the prioritization system adopted by the Commission in the *Promoting Telehealth Report and Order*.[138] RHC Program prioritization rules require that, in funding years when demand exceeds the funding cap, funding be prioritized based on rurality tiers and whether the area is a Medically Underserved Area/Population.[139] SHLB first argues that the prioritization rules will result in HCF consortia, which include non-rural health care providers that are prioritized last when demand exceeds available funding, bearing the entire burden of RHC Program funding shortfalls initially.[140] SHLB further argues that this impact will erode the consortia model and reduce the benefits of consortia for rural health care providers.[141] We disagree and find the Commission reasonably concluded that, to further the goals of section 254(h) of the Act, it should prioritize funding based on the rurality of the health care provider's location, as well as on the level of medical care need in that location.[142] This prioritization scheme targets support to rural areas that are less likely to have access to telecommunications and advanced services while still providing support for health care consortia that

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[135] Letter from Mark Sweeney, Vice President, Rural Health Care Division, USAC, to Jodie Griffin, Chief, Telecommunication Access Policy Division, FCC Wireline Competition Bureau, and Bryan Boyle, Deputy Chief, Telecommunication Access Policy Division, FCC Wireline Competition Bureau, WC Docket 17-310, Table 5 (filed Apr. 1, 2022).

[136] NCTNA/SOHN also request that the Commission consider a "carry-forward process" by which unused funding from upfront payments and multi-year commitments be carried forward specifically for commitments above the internal cap in a given funding year. NCTNA/SOHN Petition at 10. We decline to adopt an HCF-specific carry-forward process because of the funding flexibility already afforded to us with the RHC Program-wide carry-forward provision, which is designed to fund future year requests in accordance with the public interest. *See* 47 CFR § 54.619(a)(4); *see also Funding Year 2019 Demand Order*, 35 FCC Rcd at 2663-64, para. 12 (carrying forward unused funds to cover funding year 2019 demand).

[137] *See infra* Part IV.B.

[138] SHLB Petition at 2-3.

[139] 47 CFR § 54.621(b); *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7390, para. 116.

[140] SHLB Petition at 2-3 ("The Order adopts a new system for prioritizing limited RHC funding that, in effect, imposes 100 percent of the burden of any RHC funding shortfalls initially on HCF consortia.").

[141] *Id*. at 3.

[142] *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7389, para. 115. Congress intended for section 254(h) to assist health care providers in rural areas with affordable access to modern communications services to enable them to provide medical services to all parts of the nation. *See* 47 U.S.C. § 254(h); H.R. Rep. No. 104-458, at 131 (1996) (Conf. Rep.) (explaining that Congress intended section 254(h) "to ensure that health care providers for rural areas . . . have affordable access to modern telecommunications services that will enable them to provide medical . . . services to all parts of the Nation" and that "[t]he ability of . . . rural health care providers to obtain access to advanced telecommunications services is critical to ensuring that these services are available on a universal basis."); *see also Universal Service First Report and Order*, 12 FCC Rcd at 8795, para. 31 (stating the "level of discounts correlated to indicators of poverty and high cost [i.e., rurality] for schools and libraries . . . satisfies section 254(h)(1)(B)'s directive that the discount be an amount that is 'appropriate and necessary to ensure affordable access to and use of' the services eligible for the discount.'").

include non-rural health care providers.[143] Thus, while SHLB is correct in noting the benefits that rural health care providers receive as members of consortia,[144] we are not persuaded that these consortia warrant higher funding priority over the most rural and medically underserved health care providers. When the Commission adopted the rules permitting HCF consortia, it limited program participation in a "fiscally responsible" manner so as not to jeopardize funding for rural healthcare providers.[145] The prioritization system adopted in the *Promoting Telehealth Report and Order* aligns with this fiscally responsible approach and we decline to reconsider it here.[146]

3. Medically Underserved Areas and Populations

48. We decline to revise our use of the Medically Underserved Areas and Populations (MUA/P) designation to determine funding prioritization based on medical need. The U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) designates an area as MUA/P when the area lacks sufficient primary care services.[147] SHLB requests that we revise HRSA's data by clarifying that all areas in counties with a population density below twenty persons per square mile will be considered to be MUA/P, arguing that many such sparsely populated areas have never sought MUA/P designation but are nonetheless underserved.[148] We decline to adopt SHLB's requested modification. As the Commission explained in the *Promoting Telehealth Report and Order*, the MUA/P designation is well-suited for determining prioritization in the Telecom Program because it is objective data from another Federal agency that shows the areas that currently lack health care services and therefore would most benefit from the availability of telehealth services.[149] In addition, relying on HRSA's determination is straight-forward and easy to administer.[150] SHLB did not provide any data that would enable the Commission to verify its claim that many sparsely populated areas have declined to seek a MUA/P designation from HRSA.[151] Furthermore, we decline to add administrative complexity to this paradigm by adding population density into the determination.

D. Certifications

49. We deny USTelecom's request that we reconsider the requirement adopted in the *Promoting Telehealth Report and Order* that service providers certify on invoices submitted to the Administrator that consultants or third parties hired by a service provider do not have an ownership interest, sales commission arrangement, or other financial stake in the service provider or, in the

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[143] *See Promoting Telehealth Report and Order*, 34 FCC Rcd at 7389, para. 115. ("Prioritizing limited funding [to health care providers in more rural areas] fulfills the Commission's statutory mandate to preserve and advance universal service.").

[144] *See* SHLB Petition at 8.

[145] *See Healthcare Connect Fund Order*, 27 FCC Rcd at 16707, para. 61.

[146] SHLB also argues that the Commission "ignor[ed] serious practical challenges USAC [the Administrator] will likely face implementing the new prioritization regime as it applies to consortia." SHLB Petition at 6. We disagree and note that the Administrator has created IT systems to implement the Commission's prioritization rules. While we decline to reconsider the prioritization system, the amendment to our rules we adopt today in the Report and Order to have the internal cap apply only when overall demand exceeds available funding alleviates the impact on non-rural health care providers when funding requests for upfront payments and multi-year commitments must be prioritized. *See infra* Part IV.B; Appendix A, Final Rules, 47 CFR § 54.621(b), as adopted herein.

[147] *See* HRSA website, Health Workforce Shortage Areas, https://data.hrsa.gov/topics/health-workforce/shortage-areas?tab=muapHeader (last visited Jan. 26, 2023). HRSA uses the Index of Medical Underservice and recommendations from state governors to make this designation. *See id.*

[148] SHLB Petition at 24-25.

[149] *See Promoting Telehealth Report and Order*, 34 FCC Rcd at 7390, para. 116.

[150] *See id.* at 7394, paras. 122-123.

[151] SHLB Petition at 25 & nn. 68-70.

alternative, that we clarify that this certification applies only on a forward-looking basis.[152] In response to this request, the Bureau clarified that the prohibition on third party commission arrangements does not apply to competitive bidding processes completed before funding year 2020.[153]

50. We decline, however, to eliminate this certification and now address the arguments that USTelecom raised in its petition for reconsideration. We disagree with USTelecom's argument that the Commission did not provide adequate notice for this new requirement.[154] The Commission sought comment in the *2017 Notice of Proposed Rulemaking* on "whether to require healthcare providers and service providers to certify that the consultants and outside experts they hire do not have an ownership interest, sales commission arrangement, or other financial stake in the vendor chosen to provide the requested service."[155] USTelecom's argument ignores that the certification language adopted in the *Promoting Telehealth Report and Order* stems directly from the language used in the *Notice of Proposed Rulemaking*.

51. Second, while USTelecom acknowledges that the use of consultants that have financial relationships with vendors raises conflict of interest concerns for RHC Program applicants, we disagree with USTelecom that there are no such concerns for commissioned consultants working for service providers.[156] Similar concerns are applicable to service providers who have commissioned sales agreements with other third parties based on contracts awarded through the Program. For example, there have been previous instances where a service provider's sales agent apparently shared other carriers' confidential pricing information to provide an unfair competitive advantage to that service provider when it responded to a health care provider's request for services.[157] In addition, commissioned consultants or sales agents who simultaneously represent multiple service providers could direct business toward the service provider that pays the highest commission or has the highest bid to maximize their earnings.[158] Such conflicts of interest and anti-competitive conduct violate the Program's longstanding fair and open competitive bidding requirement, which the Commission codified in the *Promoting Telehealth Report and Order*.[159] We therefore clarify that agents compensated solely by commission, and not just those that

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[152] USTelecom Petition at 15-16, 18; *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7414, para. 170; 47 CFR §§ 54.627I(3)(ii)(I), 54.627(d)(1)(ii)(G).

[153] *See Wireline Competition Bureau Clarifies Rural Health Care Program Certification Requirement*, WC Docket No. 17-310, Public Notice, 35 FCC Rcd 5394 (WCB 2020).

[154] USTelecom Petition at 15-16.

[155] *2017 Notice of Proposed Rulemaking*, 32 FCC Rcd at 10659, para. 88.

[156] USTelecom Petition at 16.

[157] *See*, *e.g.*, *Network Services Solutions, LLC*, File No. EB-IHD-15-0001913, Notice of Apparent Liability for Forfeiture and Order, 31 FCC Rcd 12238, 12255-56, para. 52 (2016) (detailing an example of a service provider's sales agent sharing another telecommunications carrier's confidential pricing with Network Services Solutions LLC (NSS) to provide NSS with an unfair competitive advantage in responding to the health care provider's request for services).

[158] *See*, *e.g.*, *Requests for Review of Decisions of the Universal Service Administrator by Windstream Communications LLC*, WC Docket No. 02-60, Order, 35 FCC Rcd 10312, 10315-16, para. 7 (WCB 2020) (explaining that Windstream's non-exclusive sales agent was entitled to receive 20% of the monthly recurring revenue from the RHC Program contracts awarded to Windstream).

[159] *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7410, para. 161. *See also Requests for Review of Decisions of the Universal Service Administrator by Hospital Networks Management, Inc*., WC Docket No. 02-60, 31 FCC Rcd 5731, 5741-42, para. 20 (WCB 2016) (finding that "the principles underlying the *Mastermind Order* and other orders addressing fair and open competitive bidding not only apply to the E-Rate program (more formally knowns as the schools and libraries universal service program), but also to participants in the rural healthcare program.") (internal citations omitted).

are compensated partly by commission are covered by the rules.[160] Finally, we note that USTelecom argues that because the E-Rate Program does not prohibit the use of commissioned consultants or sales agents by service providers and that the Commission has sought to harmonize the E-Rate and RHC Programs, the RHC Program should not prohibit their use. We disagree. While USTelecom is generally correct that the Commission has sought to harmonize requirements between RHC and E-Rate, the greater likelihood of RHC consultant misconduct justifies a different requirement in the RHC Program at this time.[161] As such, we affirm the certification rule and deny USTelecom's request to strike this requirement, which applies to competitive bidding practices from funding year 2020 forward.

52. Additionally, we deny USTelecom's request to clarify that a service provider certification addressing "eligible services" does not include an attestation that the services for which the disbursement is sought are eligible for Program support.[162] In the *Promoting Telehealth Report and Order*, the Commission adopted a requirement that service providers certify they have "charged the health care provider for only eligible services prior to submitting the invoice form and accompanying documentation."[163] USTelecom argues that this certification should be interpreted not to apply to the eligibility of the services, arguing that service providers are not responsible for determining the eligibility of services, and that requiring service providers to make such a certification will preclude them from including both eligible services and services not supported by the Program on the same bill submitted to the applicant.[164] On the contrary, the new certification, one of several added to invoicing forms to improve the invoicing process and ensure compliance with Commission rules,[165] does not create a new burden because service providers are already required to abide by Program service eligibility rules.[166] While service providers may include ineligible services and eligible services on the invoices they submit to health care providers, it is critical that service providers engage in due diligence to ensure that they seek reimbursement from the Administrator for eligible services only. Service providers are in the best position to evaluate whether the services they provide are eligible for RHC Program support because they understand the technical details of the services they provide. We therefore confirm that service providers are certifying to the eligibility of the services provided when they certify that they "charged the health care provider for only eligible services prior to submitting the invoice form and accompanying

[160] *See* USTelecom Petition at 17, n.4 (suggesting that the prohibition may not apply to agents working solely on commission).

[161] Rural health care consultants sometimes provide bids from multiple service providers for a single health care provider, which raises concerns that the consultant could withhold lower-priced bids from the health care provider to maximize the sales commission. *See* Petition for Expedited Declaratory Ruling Regarding the Application of 47 C.F.R. § 54.627 and 47 C.F.R. § 54.622 of The Rural Health Care Program or in the Alternative a Waiver, WC Docket 17-310 (filed Feb. 9, 2021). We further note that financial relationships between service providers and a consultant that is retained by the applicant violate the E-Rate program's competitive bidding rules and are not allowed given the control a consultant may have over the applicant's competitive bid process. *See Requests for Waiver and Review of Decisions of the Universal Service Administrator by Akisha Networks, Inc., et al.*, Order, 27 FCC Rcd 8294, 8295-96, para. 2 (WCB 2012) ("A consultant, acting on behalf of the applicant, exerts great influence on an applicant's bidding process and thus, should not have a financial relationship with a service provider which it selects (or recommends) on behalf of the applicant.").

[162] *Id*. at 21-22.

[163] *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7424-25, paras. 192-93; 47 CFR §§ 54.627(c)(3)(ii)(G), 54.627(d)(1)(ii)((E).

[164] USTelecom Petition at 21-22.

[165] *See Promoting Telehealth Report and Order*, 34 FCC Rcd at 7424-25, paras. 192-93.

[166] *See*, *e.g.*, 47 CFR § 54.603(b) (providing that only telecommunications services are eligible for support through the Telecom Program); 47 CFR § 54.606(a) (providing that universal support under the Telecom Program will be provided for only *eligible* telecommunications services at the difference between the urban rate and the rural rate charged for the service) (emphasis added).

documentation."[167] We clarify that with respect to billing, service providers may include both eligible and ineligible services on a single bill to the health care provider but RHC Program reimbursement may only be sought for eligible services.[168]

53. Finally, we make one minor change to the Telecom Program certifications and issue an additional clarification as sought by USTelecom. First, in order to eliminate the potential for confusion, we grant USTelecom's request[169] to update Telecom Program certifications to add the word "form" after "invoice" to bring the certification in line with the HCF Program certifications.[170] Second, we clarify, as USTelecom requests, that a service provider need not ensure that a health care provider is current on its payments before certifying that the health care provider has "paid the appropriate urban rate."[171] Having outstanding balances on payments owed to a service provider does not necessarily mean that the health care provider did not pay the appropriate urban rate.

IV. SECOND REPORT AND ORDER

54. In this Second Report and Order, we amend the Telecom Program invoicing process to harmonize the RHC invoicing process across the Telecom Program and the HCF Program. We also amend our funding cap and prioritization rules to limit the application of the internal cap and prioritize health care providers' current year financial need over their future year need when the internal cap is exceeded. Additionally, we make minor changes to the text of the RHC Program rules regarding the number of health care provider types that are eligible in the RHC Program. These actions will promote efficiency, reduce delays in funding commitments, and minimize the possibility that some health care providers may not receive their current year's support in the event of prioritization to upfront payment and multi-year commitment requests, while strengthening protections against waste, fraud, and abuse.

A. Invoicing

55. To closer harmonize the invoicing process across the Telecom Program and the HCF Program, we eliminate the use of Health Care Provider Support Schedules (HSSs) in the Telecom Program and require the participating service provider and health care provider to submit an invoice for service to the Administrator after services are provided consistent with the HCF Program effective for funding year 2024.[172] In the *Further Notice*, we proposed to fully harmonize the invoicing process between the Telecom Program and the HCF Program by having participants in both programs invoice the Administrator for services actually provided using the FCC Form 463 (Invoice and Request for Disbursement Form).[173] Additionally, we proposed to retire the FCC Form 467 (Connection Certification), which is currently used for invoicing in the Telecom Program.[174]

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[167] *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7425, para. 193. 47 CFR §§ 54.627(c)(3)(ii)(G)), 54.627(d)(1)(ii)(E).

[168] Service providers submit the FCC Form 463 (for the HCF Program) or the Telecommunications Program invoice form (Telecom Program) to the Administrator to request reimbursement through the RHC Program. The service provider's customer bill to the health care provider is not submitted to the Administrator for reimbursement. Thus, the customer bill may include both eligible and ineligible services, but the invoice form (i.e., the FCC Form 463 or the Telecom Program invoice form) submitted to the Administrator must seek reimbursement for only eligible services and/or equipment. Any ineligible items on the customer bill may not be included in the invoice form submitted to the Administrator.

[169] USTelecom Petition at 22.

[170] *See* Appendix A, Final Rules, 47 CFR § 54.627(c)(1)(i)(D), as adopted herein.

[171] USTelecom Petition at 23.

[172] *See Further Notice at* paras. 72-76 (proposing to eliminate HHSs in the Telecom Program and harmonizing the invoicing process across both Rural Healthcare Program programs).

[173] *See id*. at para. 76.

56. We adopt our proposal to eliminate HSSs in the Telecom Program and retire the FCC Form 467.[175] Eliminating the use of HSSs in the Telecom Program will stop payments being disbursed automatically with minimal action from the health care provider or service provider.[176] Because the FCC Form 467 is the form filed before a health care provider can receive an HSS, it will no longer be necessary and will be eliminated.[177] However, rather than adopt the FCC Form 463 for the Telecom Program as proposed, we instead direct the Administrator, upon approval from the Bureau, to adopt a new invoice form for the Telecom Program that will be filed after services have been provided, and will allow participants to indicate when services have started, and will more clearly identify what services RHC Program applicants receive during the funding year while maintaining separation between the HCF Program and Telecom Program invoicing processes.

57. Creating a new Telecom Program invoicing form, which is distinct from, but functionally similar to, the FCC Form 463 will ensure that invoicing in the Telecom Program occurs after services have actually started, that service providers are reimbursed for actual costs rather than predetermined amounts established by the HSS, and that participants need not take action to change an HSS if the services are terminated or never begin. Having distinct forms for each program will account for the fact that there are consortium applications in the HCF Program but not in the Telecom Program. Additionally, we find that adopting this process for invoicing in the Telecom Program will further alleviate inefficiencies and protect against waste, fraud, and abuse in the RHC Program. This new process for invoicing will eliminate the need for health care providers to file, and subsequently amend, an FCC Form 467. It will also reduce the likelihood of improper disbursements because disbursements will be based on charges for services that were actually provided rather than expected charges for services *anticipated* to be provided.[178]

58. Service providers will initiate the invoicing process by preparing the new Telecom invoicing form and service providers and health care providers will continue to make the same certifications on the new form that they have previously made on Telecom invoicing forms.[179] As with HCF Program invoices, invoices in the Telecom Program can be submitted any time after services have been provided and the service provider sends an invoice to the health care provider. A service provider can submit an invoice form to the Administrator after each month of service or, if it elects to, may alternatively wait until the end of the funding year to submit a single invoice for all services provided during the funding year. All invoices for services actually incurred must be submitted before the invoice filing deadline, consistent with Commission rules.[180]

59. Some commenters raised concerns that adopting a system in which disbursements are

(Continued from previous page)

[174] *See id*. at para. 76.

[175] *See id*. at paras. 75-76. *See also* Windstream Comment at 8-9 (supporting the elimination of the HSS; CHC Comments at 2 (supporting the streamlining of the Telecom Program invoice process and discussing the elimination of the FCC Form 467). Some commenters opposed this proposal, claiming that harmonizing the two programs' invoicing processes would increase administrative burdens and possibly disrupt funding disbursements. *See* ENA Comments at 8-9, GCI Comments at 18, SLHB Comments at 21. *See also* ADS Reply Comments at 3. For the reasons discussed herein, we find that preventing improper payments outweighs added administrative burdens.

[176] *See id*. at para. 74 (describing the invoicing process in the Telecom Program, which relies on a predetermined schedule rather than invoicing against actual costs incurred).

[177] *See id*. at para. 76 ("If the proposal to eliminate HSSs is adopted, the use of the FCC Form 467 would be unnecessary because health care providers would no longer need to file the form to receive HSSs.").

[178] This invoicing process allows service providers to bill for actual charges even if the actual charges are lower than the anticipated charges that the funding commitment is based on.

[179] *See* 47 CFR § 54.627(c)(3).

[180] *See* 47 CFR § 54.627(b).

made based on invoices filed after services are provided, rather than a predetermined HSS for the Telecom Program, would increase administrative burdens, and these burdens could be exacerbated by the fact that invoices in the Telecom Program can be submitted only on an individual basis, rather than on a consortium basis.[181] Other commenters supported harmonizing the invoicing processes so long as there are mechanisms to reduce increased administrative burdens.[182] We recognize that adopting an invoicing system based upon actual expenses incurred will likely require more invoice-related filings from program participants, but the history of improper disbursements from the use of the HSS justifies any potential added burden.[183] To mitigate any administrative burdens,[184] we direct the Bureau to work with the Administrator to develop a mechanism for filing this new form and to provide service providers the functionality to file invoices for multiple funding requests for multiple health care providers in a single filing.

B. Internal Cap Application And Prioritization

60. We adopt the changes to the RHC Program internal cap application and prioritization proposed in the *Further Notice* effective funding year 2023.[185] We amend RHC Program rules to limit the application of the internal cap on multi-year commitments and upfront payments to funding years for which the total demand exceeds the remaining support available.[186] We also prioritize upfront payments and the first year of multi-year commitments, and then fund the second and third years of multi-year commitments with any remaining funding in a given funding year.[187] Although demand has been fully satisfied in every funding year since the adoption of the *Promoting Telehealth Report and Order*, these changes will ensure a smoother, fairer process in the event that prioritization is ever necessary.

61. First, we amend our funding cap rules to limit the application of the internal cap to those application filing window periods during which total demand exceeds total remaining support available for the funding year.[188] All commenters who discussed this proposal supported it.[189] If total demand during a filing window period does not exceed total remaining support available for the funding year, the internal cap will not apply. The total remaining support available for the first filing window period of a funding year is the sum of the inflation-adjusted RHC Program aggregate cap in section 54.619(a)[190] of

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[181] *See* ENA Healthcare Comments at 8-9. *See also* SHLB Reply Comments at 10; GCI Reply Comments at 18. We also reject SHLB's request to direct USAC to change its systems to bill for actual charges instead of funding commitment amounts in lieu of making a rule change. *See* Letter from Kristen Corra, Policy Counsel, Schools, Health & Libraries Broadband (SHLB) Coalition to Marlene Dortch, Secretary, FCC, WC Docket No. 17-310, 3-4 (filed Jan. 17, 2023). Our comprehensive reform will more effectively streamline the Telecom Program invoicing process and better protect Program integrity than SHLB's proposal.

[182] *See* ANTHC Comments at 2, 5; *see also* Windstream Comments at 8-9 ("Not only do Health Care Provider Support Schedules ('HSSs') 'compromise the ability of USAC to administer the Telecom Program effectively and efficiently,' but they also complicate the invoicing process for participating service providers, particularly those that also participate in the HCF Program, where only FCC Form 463 is used.").

[183] *See, e.g.*, *TeleQuality Communications*, LLC, EB-IHD-19-00028870, Order and Consent Decree, 35 FCC Rcd 503, 515 (EB 2020) (*TeleQuality Consent Decree*) (describing invoicing violations in which TeleQuality Communications, LLC invoiced USAC for services that were disconnected before the end of the funding period or were not actually installed and provided).

[184] *See* ANTHC Comments at 2 (requesting that changes to the invoice process mitigate administrative burdens on Tribal entities).

[185] *Further Notice*, at 24-25, paras. 65-66.

[186] *Id*.

[187] *Further Notice* at 25-26, paras. 67-68.

[188] *See* Appendix A, Final Rules, 47 CFR § 54.619(a), as adopted herein.

[189] *See* PCIA Comments at 2; WNY Comments at 1; SHLB Reply Comments at 5.

our rules and the proportion of unused funding determined for use in the RHC Program pursuant to section 54.619(a)(5).[191]

62. This approach will preserve the internal cap's intended purpose of preventing multi-year and upfront payment requests from encroaching on the funding available for single-year requests,[192] because the internal cap would only apply when the total demand exceeds the total remaining support available. No requests will be reduced, even if the internal cap is exceeded, as long as there is sufficient total funding to meet total demand. This approach will also ensure funding for single-year requests in the next funding year.[193] Allowing upfront payment and multi-year commitment requests to be fully funded if funding is available for all demand in the current funding year will also alleviate demand in the next funding year given that funding multi-year commitment requests in the current funding year eliminates demand for those services under the next funding year's cap.

63. Second, we amend our rules to prioritize support for current-year funding requests over future-year funding requests when the internal cap is exceeded.[194] Specifically, we amend section 54.621 of our rules to fund eligible upfront payment requests and the first-year of all multi-year requests before funding the second or third year of any multi-year requests when the internal cap applies and is exceeded.[195] Additionally, we amend our rules to allow the underlying contracts associated with those multi-year commitment requests that are not fully funded to be designated as "evergreen."[196]

64. The amendment to the prioritization process we adopt today increases the chance that health care providers who requested support for upfront payments and multi-year commitments will have their current year's financial need satisfied in the event that prioritization is necessary. The previous prioritization process would have resulted in some health care providers, likely those in the lower

(Continued from previous page)

[190] 47 CFR § 54.619(a).

[191] 47 CFR § 54.619(a)(5). In the event that a second filing window is opened during a funding year, the total remaining support available for the second filing window is the total remaining support after allocating funding to eligible funding requests during the first filing window. 47 CFR § 54.621(a)(2). The last funding year in which there was a second filing window was funding year 2016, and a second filing window is not currently planned for future funding years given that there has been no available funding for a second filing window in recent funding years. *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, 9591 (WCB 2016) (directing USAC to open a second filing window period for funding year 2016). If the total demand during a second filing window exceeds the total remaining support available for the funding year, funding for upfront payment and multi-year commitment requests submitted during the second filing window will be capped at the remaining support available within the internal cap. For example, if the internal cap for the funding year is $161 million and support for eligible upfront payments and multi-year commitments during the first filing window is $130, the remaining support available within the internal cap is $31 million.

[192] *See Promoting Telehealth Report and Order*, 34 FCC Rcd at 7401, para. 138 ("the $150 million cap did the job the Commission intended when it was established – to prevent multi-year and upfront payment requests from usurping the funding available for single-year requests for recurring services and safeguard against large fluctuations in demand for RHC Program funds."); *Healthcare Connect Fund Order*, 27 FCC Rcd at 16802, para. 298.

[193] *See* Alaska Communications Comments at 34 (stating that any attempt to retain the internal cap must prevent multi-year and upfront payment requests from encroaching on single-year requests).

[194] *See* Appendix A, Final Rules, 47 CFR § 54.621(b), as adopted herein.

[195] *See id*. Commenters support this proposal. *See* PCIA Comments at 2; WNY Comments at 1. Under this approach, the second and third years of a request for a multi-year commitment that fall within the same prioritization tier would be treated equally.

[196] *See* Appendix A, Final Rules, 47 CFR § 54.621(b)(4), as adopted herein. As noted below, such contracts must satisfy the criteria set forth in section 54.622(i)(3)(ii) of the Commission's rules. 47 CFR § 54.622(i)(3)(ii). Commenters also support this proposal. *See* WNY Comments at 2.

prioritization categories, losing all or a portion of their requested support for the current funding year while other health care providers receive commitments for the second and third years of multi-year commitments, even though they could request funding for these services in subsequent funding years. This change mitigates such adverse impact to those health care providers. By prioritizing support for upfront payment requests and the first year of multi-year commitment requests when the internal cap applies and is exceeded, health care providers in the lower prioritization categories will more likely receive the current year's requested support. Additionally, the action we take today will further promote broadband network development led by HCF consortia that include non-rural members by lessening the impact of prioritization to those non-rural health care providers and by giving preference to upfront costs such as network construction. We recognize that this amendment will inconvenience some health care providers in the higher prioritization categories that may have to file applications in future funding years for services that otherwise would fall under the second and third year of a multi-year commitment. We conclude, however, that such concerns are outweighed by the benefit to health care providers who, without this rule change, could have their current year funding requests denied or prorated.

65. To mitigate any potential adverse impact to health care providers whose multi-year commitment requests are affected, we also amend our rules[197] to allow the underlying contracts associated with those multi-year commitment requests that are not fully funded to be designated as "evergreen," provided that the contracts satisfy the criteria set forth in section 54.622(i)(3)(ii) of the Commission's rules.[198] The evergreen designation will exempt applicants from having to complete the competitive bidding process for multi-year contracts that are not initially fully funded due to our new internal cap rules when the applicant subsequently files requests for support pursuant to these contracts.[199] As a result, applicants can request single or multi-year commitments pursuant to these contracts in the next funding year without going through the competitive bidding process.

66. We agree with Alaska Communications, GCI, and WNY that the internal cap prevents multi-year commitment requests from usurping funding available for single-year requests,[200] and we reject requests by some commenters to eliminate the internal cap or to remove multi-year commitments from the internal cap. This latter group of commenters claims that eliminating the internal cap or removing multi-year commitments from the internal cap would encourage more multi-year commitments, which these commenters claim are more efficient for both the RHC program and individual HCPs.[201] We find that retaining the current internal cap with the limitations we institute today is more fiscally responsible than eliminating the internal cap or removing multi-year commitments from the internal cap. Eliminating the cap or removing multi-year commitments from the internal cap will result in less funding being made available for single year commitments. Multi-year requests tend to be more expensive and without any constraints, those requests will make it more likely that the overall cap is exceeded. In any event, the

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[197] *See* Appendix A, Final Rules, 47 CFR § 54.621(b)(4), as adopted herein.

[198] 47 CFR § 54.622(i)(3)(ii); *see also Further Notice* at 26, para. 69. In funding year 2018, when the Commission directed USAC to fully fund only the upfront payments and the first year of the multi-year commitments, it also directed USAC to designate the eligible underlying contracts as "evergreen." *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, 34 FCC Rcd 4136, 4138-39, para. 9 (2019).

[199] 47 CFR § 54.622(i)(3).

[200] Alaska Communications Comments at 34 ("Absent a cap, HCF applicants seeking multi-year commitments could artificially inflate demand, potentially harming other applicants that seek one-year funding commitments"); WNY Comments at 2 ("Based on the proposed rules we believe it would be better to keep the internal cap in place with the newly proposed rules"); GCI Reply Comments at 17 ("the Commission should not remove internal caps on funding for upfront and multi-year commitments.").

[201] SHLB Comments at 14 ("network construction of more advanced, future-proof technologies often leads to lower ongoing costs, thus saving money for both the program and for individual HCPs."); NETC Reply Comments at 4 ("Multi-year funding requests are immensely more efficient for both USAC and applicants.").

changes we adopt for the internal cap today will likely result in making more funding available for multi-year commitments because, going forward, the internal cap will only apply when total demand exceeds total support available and thus will not apply at all in funding years when total support available can satisfy total demand, leaving open the possibility for additional funding for multi-year commitments beyond the internal cap.

67. We also reject some commenters' requests to suspend the funding prioritization system until the Commission addresses the allocation of shared network costs for consortia program participants.[202] As an initial matter, we did not seek comment in the *Further Notice* on suspending the funding prioritization scheme. We find, however, that a rule change is not necessary for the Commission to ensure that consortium members can allocate shared network costs when some members do not receive funding due to prioritization. In any event, as discussed in the Order on Reconsideration above, our funding prioritization approach remains necessary as it will target support where it is most needed (i.e., those more rural areas with greater medical shortages) in cases where available program funding is exceeded in a given funding year.[203] We therefore reject the requests to suspend the funding prioritization system.

68. Some commenters argued that an increase to the overall RHC Program cap is appropriate.[204] We find that the current annually inflation-adjusted overall cap combined with the process to carry-forward unused funding strikes the necessary balance between providing sufficient funding to health care providers and minimizing increased burden on USF contributors.[205] With the availability of carryover funding, demand has been fully satisfied since funding year 2019.[206] While we continue to monitor overall Program demand, we decline to increase the overall RHC Program cap at this time.

C. Technical Changes to Previously Codified RHC Rules

69. We also take this opportunity to make two minor corrections to the text of the RHC Program rules. First, we amend the text of section 54.622(e)(1)(i) to reflect the correct number of health care provider types that are eligible. The Rural Healthcare Connectivity Act of 2016 amended the Communications Act of 1934 to add skilled nursing facilities to the list of health care provider types eligible to receive RHC Program support.[207] In response to this new law, in 2017, the Commission amended section 54.600(a) of its rules to reflect that skilled nursing facilities are eligible for RHC support, which increased the number of eligible health care provider types from seven to eight.[208] In

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[202] NETC Reply Comments at 4-5; SHLB Comments at 13-14. *See also* Jeffrey Mitchell, Counsel, New England Telehealth Consortium (NETC) to Marlene Dortch, Secretary, FCC, WC Docket No. 17-310, 2 (filed January 19, 2023) (NETC *Ex Parte*) at 2.

[203] *See supra* Part III.C.2

[204] *See* SHLB Comments at 17; ADS Comments at 5.

[205] *See RHC Program Cap Order*, 33 FCC Rcd at 6580, para. 13. In 2018, the Commission decided to annually adjust the RHC Program funding cap to reflect inflation and established a process to carry-forward unused RHC Program funds on an annual basis for use in future funding years. *See id*. at 6578, para. 9.

[206] *See Funding Year 2019 Demand Order*, 35 FCC Rcd at 2659, 2662, paras. 3, 9; *Funding Year 2020 Demand Order*, 35 FCC Rcd at 11696, 11699, paras. 3, 9; *Wireline Competition Bureau Announces the Availability of Unused Funds to Fully Satisfy Demand for Rural Health Care Program Funding For Funding Year 2022*, WC Docket No. 02-60, Public Notice, DA 22-792, 2022 WL 2965199, at *1 (WCB July 22, 2022).

[207] *See* Frank R. Lautenberg Chemical Safety for the 21st Century Act, Title II – Rural Healthcare Connectivity, Pub. L. No. 114-182 (2016) (Rural Healthcare Connectivity Act of 2016) (amending the Act to include skilled nursing facilities as a health care provider type) (codified at 47 U.S.C. § 254(h)(7)(B). Section 254 was added to the Act by the Telecommunications Act of 1996, Pub. L. No. 104-104, 110 Stat. 56 (1996) (1996 Act).

[208] *See Rural Health Care Support Mechanism,* WC Docket No. 02-60, Memorandum Opinion and Order, 32 FCC Rcd 5260 (2017). *See also* 47 CFR § 54.600(a) (2018).

enacting this change, the Commission did not amend a different rule addressing certifications on a Request for Services that refers to "one of the *seven* categories set forth in the definition of health care provider."[209] We now correct that omission by striking the word "seven" from section 54.622(e)(1)(i) of our rules. Striking the word "seven" rather than replacing it with "eight" is appropriate because quantifying the number of eligible health care provider types in section 54.622(e)(1)(i) adds no substantive benefit to RHC Program participants but could potentially lead to confusion if there are future amendments to the health care provider types eligible for the RHC Program. Second, we correct the cross-reference in section 54.622(a) so that it properly references section 54.622(i).[210] We find that there is good cause to make these changes without notice and comment because seeking comment on these technical amendments, which only serve to conform these references to the current requirements of the rules would be unnecessary.[211]

V. ORDER

70. By this Order, we dismiss the Applications for Review of the Bureau's guidance to the Administrator on implementation of the Rates Database[212] submitted by Alaska Communications and GCI.[213] Our decision above to eliminate the use of the Rates Database to calculate urban and rural rates renders these Applications for Review moot.[214]

VI. SECOND FURTHER NOTICE OF PROPOSED RULEMAKING

71. In this Second Further Notice of Proposed Rulemaking, we first propose modifications to the three rural rate determination methods in the Telecom Program, including changes to the market-based approach of Methods 1 and 2 and new evidentiary requirements for justifying cost-based rates under Method 3. We also propose to simplify urban rate rules by eliminating the "standard urban distance" distinction and seek specific comment on sources for urban rates as well as general comment on our urban rate rules. Next, we seek comment on reinstating the cap on support for satellite services that the Commission eliminated when it adopted the Rates Database and on amending HCF Program rules to make equipment supporting Telecom Program services eligible. In addition, to make it easier for health care providers to receive RHC Program funding as soon as they become eligible entities, we propose a conditional eligibility process to allow entities that will be eligible health care providers in the future to engage in competitive bidding and file Requests for Funding before they become eligible. We also propose to align the deadline to request a Service Provider Identification Number (SPIN) change with the invoice filing deadline and seek comment on a post-commitment process to amend evergreen contract dates. We conclude by seeking comment on proposed revisions to FCC Form 466 intended to improve the quality of Telecom Program data.

A. Rural Rates

72. In the Order on Reconsideration above, we grant the petitions seeking reconsideration of the Telecom Program Rates Database and restore Methods 1, 2, and 3 for calculating rural rates in the

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[209] *See* 47 CFR § 54.603(b)(1)(i) (2018) (emphasis added). This section has subsequently been re-codified as 47 CFR § 54.622(e)(1)(i). *See Promoting Telehealth Report and Order*, 34 FCC Rcd at 7451, Appx. A.

[210] *See* 47 CFR § 54.622(a) (currently citing to "an exemption listed in paragraph (j) in this section" despite the fact that competitive bidding exemptions are listed in section 54.622(i).

[211] *See* 5 U.S.C. § 553(b)(B); *see also* 47 CFR § 1.412(c).

[212] *See Rates Database Implementation Letter.* Because the Rates Database has been rescinded, this letter no longer has any legal effect.

[213] *See* GCI Application for Review; Alaska Communications Application for Review.

[214] Because we dismiss the Applications for Review as moot, we need not determine whether the Applications for Review, which asked the Commission to review guidance by the Bureau directed to the Administrator, met the procedural requirements of section 1.115 of our rules. *See* 47 CFR § 1.115.

Telecom Program effective for funding year 2024. Although we believe restoring Methods 1, 2, and 3 is the best of our currently available options to ensure that healthcare providers have adequate, predictable support in the short term, we also recognize that improvements to these methods may be necessary for the long term given the issues that the Commission has previously cited with respect to these rate calculation methodologies.[215] Therefore, in the following sections, we propose modifications to the three methods to improve the overall calculation of rural rates, make rate calculations simpler to administer, and reduce waste, fraud, and abuse in the Telecom Program for funding year 2024 and beyond. Our proposals are similar to the now-reinstated Methods 1 through 3 in that they contain multiple ways to calculate rural rates that are applied sequentially. While we seek comment specifically on our proposed modification to the methods, at the outset we seek comment generally on alternative rural rate calculation methods. In proposing alternative rate methodologies, commenters should be specific, point the Commission to available data sources to support any alternative methodology, and explain how any alternative methodology would be more advantageous in protecting the Fund against waste, fraud, and abuse.

73. As an initial matter, we address several matters applicable to rural rates regardless of the method used. For both market-based calculations and cost-based rates, we propose that the rural rate not exceed the monthly rate in the contract or other applicable agreement between the service provider and health care provider.[216] This safeguard exists in the rules related to the Rates Database[217] and ensures that rural rates will drop if market prices drop. We seek comment on this proposal. Are there situations in which it would be appropriate to base support on an amount higher than the monthly rate in the contract or other applicable agreement?

74. Additionally, we propose that service providers with multi-year contracts, including evergreen contracts, continue to be required to justify rural rates only in the first year of the contract. Given that service providers would not be expected to submit additional bids within the duration of the multi-year contract, we believe it would be reasonable to exempt such contracts from requiring additional rural rates justifications during the duration of the contract. We seek comment on this proposal. We also seek comment on whether a rural rate approval for a single year contract for the same health care provider for the same service should be effective for multiple funding years to reduce administrative burdens associated with filing rural rate justifications every year. If so, for how many years should an approval be effective?

75. We seek comment on whether the Commission should offer guidance on which point in the procurement and funding cycle service providers should determine rural rates.[218] The Bureau previously advised that service providers should determine the rural rate before responding to a health care provider's request for bids.[219] If the Commission offers further guidance, should it alter the guidance the Bureau previously offered? We also seek comment on whether additional clarification is needed regarding what constitutes "comparable rural areas" for determining rural rates.[220] Are health care providers and service providers currently able to determine what constitute a "comparable rural area?" If the Commission were to offer a clarification on what constitutes "comparable rural areas," what should the clarification state?

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[215] *See Promoting Telehealth Report and Order*, 34 FCC Rcd at 7363-65, paras. 55-58.

[216] *See* Appendix B, 47 CFR § 54.605(d) as proposed herein.

[217] *See* 47 CFR § 54.605(a).

[218] *See* Alaska Communications *Ex Parte* at 4 (requesting that the Commission seek comment on when a rate determination should be performed).

[219] *See Rural Rates Public Notice*, 34 FCC Rcd at 532.

[220] *See* 47 U.S.C. § 254(h)(1)(A). *See also* Alaska Communications *Ex Parte* at 3 (requesting that the Commission seek comment on defining the rural area where a health care provider is located).

1. Market-Based Calculations

76. The rules that we reinstate today require health care and service providers to first calculate the rural rate by averaging rates offered by the service provider for an identical or similar service in the rural area in which the health care provider was located (Method 1), and in the event the service provider does not provide such a service, the average of rates offered by carriers other than the service provider (Method 2).[221] We now propose alternative sequential methods for determining rural rates, which we call "Method A" and "Method B" for purposes of this Second Further Notice:[222]

> Method A: The rural rate shall be the median of publicly available rates charged by other service providers[223] for the same or similar services over the same distance in the rural area where the health care provider is located.
>
> Method B: If there are no publicly available rates charged by other service providers for the same or similar services (that is, rates that can be used under Method A), the rural rate shall be the median of the rates that the carrier actually charges to non-health care provider commercial customers for the same or similar services provided in the rural area where the health care provider is located.

This proposal differs from Methods 1 and 2 in two primary respects. First, our new proposed calculations would be based on the *median* of inputs, rather than their average. Calculating rural rates using the median will mute the effect that a small number of abnormally high or low inputs would have on the calculated rural rate.[224] We seek comment on this methodology. Would calculating rural rates using averages be preferable to using medians? If so, why? Are there other ways that we should consider calculating rural rates?

77. The second major way that our proposal varies from Methods 1 and 2 is that the default calculation in our proposal is based on rates charged by other service providers, meaning that a service provider would only be able to use its own rates to calculate the rural rate if there are no applicable rates from other service providers. This change could improve program integrity and provide administrative benefits. As to program integrity, shifting the default rural rates calculation to rates from other service providers could ensure that rural rates in the Telecom Program better reflect market conditions. A service provider would not enjoy inflated rural rates simply because it charges inflated rates to customers outside of the Telecom Program. We seek stakeholder feedback on program integrity implications of our proposal to use rates charged by other service providers as the default for calculating rural rates. Are there any concerns with service providers using competitor's rates to determine rural rates instead of using their own rates? What are the benefits? Are there benefits to using the service provider's own rates as the default as Method 1 does?

78. As to administration, the availability of rural rates on the Open Data platform on the Administrator's website could simplify the rates determination process if the Administrator were to build a tool that allows the filer of a Request for Funding to select the specific funding requests, i.e., prices from past request that would be used as inputs to Method A. The tool would then determine the rural rate under Method A on behalf of the health care provider before it certifies its Request for Funding. Unlike the Rates Database, which we have eliminated in the Order on Reconsideration above, this automated process would not pre-determine which health care provider is in a similar rural area as the health care provider applicant. That would be left to the service provider to determine. During application review,

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[221] *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7363, para. 54.

[222] *See* Appendix B, 47 CFR § 54.605(a)(1) and (2) as proposed herein.

[223] "Other service providers" are considered any service provider with a different SPIN.

[224] *See Promoting Telehealth Report and Order*, 34 FCC Rcd at 7366, para. 63.

the Administrator would verify that the sites from the inputs are in a similar rural area to the health care provider, just as it has done under the now reinstated Methods 1 and 2.

79. We seek comment on developing an automated process to calculate rural rates, to the extent possible, by having USAC's website auto-generate the rural rate after the health care and/or service provider selects sites that are in the same rural area as the HCP. Would this help alleviate administrative burdens associated with calculating rural rates? Should filers be permitted to add rural rates outside of Open Data to be included in the calculation? Are there any circumstances in which a filer should be permitted to exclude a rate even if the rate is for the same or similar services over the same distance in the rural area where the health care provider is located? Are there any disadvantages to automating the rate calculation process in this way? Would a challenge process outside of the normal appeals process be necessary? If so, how should such a challenge process operate? Do commenters have any alternative methods of administering these proposed rate methodology changes that would increase efficiency and transparency? Commenters are encouraged to provide specific suggestions and feedback on how we can best administer changes to the rates determination process.

80. We seek comment on other iterations of the proposed Methods A and B above. For instance, one alternative to our proposal would be to use the lower of the rural rates calculated under Methods A and B. This alternative would ensure that the Fund reaps the benefits of reductions in pricing from the service provider for the applicable funding request or in the overall market. We seek comment on the advantages and disadvantages of this approach.

81. We also seek comment on the rates that should be used for Methods A and B under our proposal. For Method A, are there other sources of publicly available rate information that we should consider, such as tariffed rates? Should Method A inputs be limited to data available in Open Data? Do commenters agree that the data available in Open Data would be sufficient for Program participants to determine a rural rate under Method A? If not, what additional information would be required in Open Data to make such a rate determination? For the proposed Method B, we seek comment on whether we should include the median of *all* of the service provider's own rates for the same or similar services, including rates for USF-supported services, which are currently excluded from Method 1 calculations either in situations where there are no publicly available rates or tariffed rates outside of the service provider's own rates or in all situations. For Method B, should service providers use additional information available in their own records to make a more granular similarity determination?

82. For both proposed Methods A and B, we seek comment on whether we should include both healthcare provider and non-healthcare provider commercial customers in the rural area in which the healthcare provider is located to calculate the rural rate. Do commenters have any concerns with allowing service providers to rely on all of their own rates, including health care provider rates? How should Methods A and B account for the potential price variations caused by term and volume discounts? Do commenters have any concerns that the proposed Methods would not be suitable for health care providers in Alaska? Commenters are encouraged to be specific with their concerns.

2. Cost-Based Rates

83. We propose that service providers continue to have the option to submit a cost-based rate if they cannot calculate a rural rate using Methods A or B. Under the rate determination rules we reinstate today, service providers may request approval of a cost-based rate under Method 3 from the Commission (for interstate services) or a state commission (for intrastate services) if there are no rates for the same or similar services in the rural area in which the health care provider is located, or the service provider reasonably determines that the calculated rural rate would not be compensatory.[225] The Commission's rules require the service provider to submit a justification of its requested rural rate, including an

[225] *See* Appendix A, Final Rules, 47 CFR § 54.605(b), as adopted herein.

itemization of the costs of providing the service requested by the eligible health care provider.[226] To comply with this requirement, the request for approval of a cost-based rural rate requires service providers to include a cost study that demonstrates how the costs of providing services were allocated to RHC Program customers.[227]

84. In the *Promoting Telehealth Report and Order*, the Commission eliminated the cost-based method of determining rates and instead concluded that submitting a cost-based rate should serve only as a safety valve for service providers that have no other means of determining a rural rate.[228] The Commission reasoned that implementation of the Rates Database made it unlikely that service providers would be unable to determine a rural rate with the data provided in the database.[229] The Commission established a waiver process that allowed service providers to use a cost-based rate mechanism in "extreme cases" where the provider could show that the applicable rural rate from the Rates Database "would result in objective, measurable economic injury."[230] Now that we have eliminated the Rates Database and reinstated the previous rate determination rules, we propose to modify the cost-based rate-determination method to include specific evidentiary requirements to increase transparency in how service providers calculate cost-based rates when a rural rate cannot be calculated under Methods A or B or the carrier reasonably determines that the rural rate calculated under Methods A or B would not generate a reasonably compensatory rate.

85. We propose a revised cost-based method that will require service providers seeking approval of a cost-based rate to satisfy the same evidentiary requirements that the Commission adopted as required for waiver of the Rates Database rules in the *Promoting Telehealth Report and Order*.[231] When service providers submit a cost-based rate, we propose to require service providers to include all financial data and other information to verify the service provider's assertions, including, at a minimum, the following information:

- "Company-wide and rural health care service gross investment, accumulated depreciation, deferred state and federal income taxes, and net investment; capital costs by category expressed as annual figures (e.g., depreciation expense, state and federal income tax expense,

[226] *See* Appendix A, Final Rules, 47 CFR § 54.605(b)(1), as adopted herein ("The carrier must provide, to the state commission, [f]or intrastate rates, or to the Commission, for interstate rates, a justification of the proposed rural rate, including an itemization of the costs of providing the requested service").

[227] In 2019, the Commission released a public notice providing guidance to program applicants on what should be included in the cost study. At a minimum, the cost study required a service provider to submit information on the following: "a) The company's total capital expenditures (CAPEX) and operational expenditures (OPEX), with a breakdown of the total figure's components (e.g., depreciation, taxes, return on investment); b) An explanation of how the total CAPEX/OPEX figure is allocated between customers, together with the resulting allocated figures, as necessary to show how the company has allocated CAPEX/OPEX costs to its RHC Program customers; c) The company's total common costs and a breakdown of that total figure's components; and d) An explanation of how the company's total common costs are allocated between customers, together with the resulting allocated figures, as necessary to show how the company has allocated common costs to RHC facilities and to RHC Program customers." *Rural Rates Public Notice*, 34 FCC Rcd 533. However, these specific evidentiary requirements were not codified.

[228] The Commission eliminated the cost-based support mechanism and concluded that cost-based reviews "should not be an alternative method of determining a rural rate under our rules but instead should be reserved for extreme cases where a carrier can demonstrate that determining Telecom Program support under the new rural rate rules adopted by this Report and Order would result in an objective, measurable economic injury." *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7369, para. 71.

[229] *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7369, para. 70.

[230] *Id*. at 7369, para. 71.

[231] *Id*. at 7369-72, paras. 71-75.

return on net investment); operating expenses by category (e.g., maintenance expense, administrative and other overhead expenses, and tax expense other than income tax expense); the applicable state and federal income tax rates; fixed charges (e.g., interest expense); and any income tax adjustments;

- An explanation and a set of detailed spreadsheets showing the direct assignment of costs to the rural health care service and how company-wide common costs are allocated among the company's services, including the rural health care service, and the result of these direct assignments and allocations as necessary to develop a rate for the rural health care service;
- The company-wide and rural health care service costs for the most recent calendar year for which full-time actual, historical cost data are available;
- Projections of the company-wide and rural health care service costs for the funding year in question and an explanation of these projections;
- Actual monthly demand data for the rural health care service for the most recent three calendar years (if applicable);
- Projections of the monthly demand for the rural health care service for the funding year in question, and the data and details on the methodology used to make that projection;
- The annual revenue requirement (capital costs and operating expenses expressed as an annual number plus a return on net investment) and the rate for the funded service (annual revenue requirement divided by annual demand divided by 12 equals the monthly rate for the service), assuming one rate element for the service, based on the projected rural health care service costs and demands;
- Audited financial statements and notes to the financial statements, if available, and otherwise unaudited financial statements for the most recent three fiscal years, specifically, the cash flow statement, income statement, and balance sheets. Such statements shall include information regarding costs and revenues associated with, or used as a starting point to develop, the rural health care service rate; and
- Density characteristics of the rural area or other relevant geographical areas including square miles, road miles, mountains, bodies of water, lack of roads, remoteness, challenges and costs associated with transporting fuel, satellite and backhaul availability, extreme weather conditions, challenging topography, short construction season, or any other characteristics that contribute to the high cost of servicing the health care providers."[232]

86. We understand that stakeholders generally disfavored the evidentiary requirements for the cost-based waiver for determining rural rates because of the burdensome nature of the information requested, the possibility that the cost-based method would not provide sufficient support for those that could not calculate their rates using the Rates Database and the fact that these evidentiary requirements go far beyond the evidentiary requirements for Method 3.[233] However, the Commission adopted the waiver process as a safety valve given how infrequently the cost-based method has been used in the Telecom Program's history and the small likelihood that providers could not determine the rural rate using the

[232] 34 FCC Rcd at 7371-72, para. 74.

[233] *See* Alaska Communications Application for Review, WC Docket No. 17-310 at 18 (filed July 30, 2020) (Alaska Communications AFR). *See also* Application for Review of GCI Communication Corp. (GCI), WC Docket No. 17-310, at 22 (filed July 30, 2020) (GCI AFR) (arguing that the waiver process is "flawed and untested" and did not provide an adequate remedy for program applicants especially given the pervasiveness of the database's arbitrary results).

Rates Database.[234] We believe that such a comprehensive cost-based process would likely incentivize service providers to make every effort to justify their rates under Methods A or B, which would be much simpler for both the Administrator and service providers. Nonetheless, in addition to our proposal, we seek comment on alternative evidentiary requirements that can assist the Bureau and Administrator in evaluating cost-based rates in the event that service providers have no other way of determining rates. Do commenters have any recommendations that would increase transparency and efficiency in submitting and reviewing cost-based rates? How common would it be for service providers to have to use this cost-based rates process? Are there changes that we can make to the proposed cost-based rates submission process that would mitigate administrative burdens on service providers without compromising Program integrity? How should service providers and the Bureau use the cost data to determine a cost-based rate to be charged to an individual customer? Should there be a deadline by which the Bureau must complete its cost-based rate review and issue a rate determination? If so, how would such a deadline operate in the event that a service provider submitted incomplete or inaccurate information that required additional submissions to the Bureau? Would the use of cost studies to determine maximum rural rates decrease incentives for new infrastructure investment in hard to serve areas? Do commenters have any concerns that the proposed cost-based rate would not be suitable for health care providers in Alaska? Commenters are strongly encouraged to share specific recommendations.

B. Urban Rates

87. We next propose to simplify and seek further comment on future urban rate determination rules for the Telecom Program. The Telecom Program subsidizes the difference between the urban rate for a service in the health care provider's State, which must be "reasonably comparable to the rates charged for similar services in urban areas in that State," and the rural rate, which is "the rate for similar services provided to other customers in comparable rural areas" in the State.[235] The rules that we restore on reconsideration today state that urban rates "shall be a rate no higher than the highest tariffed or publicly-available rate charged to a commercial customer for a functionally similar service in any city with a population of 50,000 or more in that state."[236] Following the decision in today's Order on Reconsideration to eliminate the Rates Database and restore the previous rules for determining urban rates effective funding year 2024, we propose to simplify the urban rate rule by eliminating the "standard urban distance" distinction from it and now seek comment on whether any additional changes to those rules are warranted.

88. *Standard urban distance.* The rules that we reinstate today provide that, if the service is provided over a distance greater than the standard urban distance, which is the average of the longest diameters of all cities with a population of 50,000 or more within a state, the urban rate is the rate no higher than the highest tariffed or publicly-available rate provided *over the standard urban distance*.[237] The *Promoting Telehealth Report and Order* eliminated the standard urban distance distinction in adopting the Rates Database.[238] We propose to eliminate this distinction between services provided over and within the standard urban distance and to base all urban rates calculations on rates provided in a city, rather than over the standard urban distance. We expect that eliminating this distinction will simplify the process for determining an urban rate and will not adversely impact most health care providers because

[234] *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7369, para. 70.

[235] 47 U.S.C. § 254(h)(1)(A).

[236] 47 CFR § 54.605(a) (2018). Appendix A, Final Rules, 47 CFR § 54.604, as adopted herein.

[237] *See* Appendix A, Final Rules, 47 CFR § 54.604(b), (c), as adopted herein. *Compare to* Appendix A, Final Rules, 47 CFR § 54.604(a), as adopted herein (if the distance is less than or equal to the standard urban distance, the "'urban rate' for that service shall be a rate no higher than the highest tariffed or publicly-available rate charged to a commercial customer for a functionally similar service *in any city* with a population of 50,000 or more in that state.") (emphasis added).

[238] *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7362-63, para. 52.

few Telecom Program participants calculate urban rates using the standard urban distance. We seek comment on the impact that this would have on urban rates and administrative burdens. Before the adoption of the Rates Database, how common was it to base urban rates calculations on services in a city (rather than services over the standard urban distance)? Would urban rates increase unduly if we make this change? We seek comment below on whether to change the standard for "urban" from a city with a population of at least 50,000. Will changes to the standard for "urban" in conjunction with the elimination of the standard urban distance cause an increase in urban rates?

89. *Sources of urban rates.* Under the pre-funding year 2020 urban rate rules that we reinstate today, documentation may be required to substantiate the applicable urban rate.[239] The urban rate is determined by the health care provider, often with the assistance of a consultant or carrier, and reported on the FCC Form 466. To document the urban rate, health care providers may use "tariff pages, contracts, a letter on company letterhead from the urban service provider, rate pricing information printed from the urban service provider's website or similar documentation showing how the urban rate was obtained."[240] In the alternative, health care providers have historically utilized the urban rates listed on the Administrator's website for certain services in certain states.[241] These urban rates are determined by reviewing tariff information on file with the Commission.[242] One advantage of utilizing the urban rates posted to the Administrator's website is that health care providers did not need to provide additional documentation on their FCC Form 466. With the Commission's decision to eliminate the Rates Database, should the Administrator post urban rates as it did prior to the *Promoting Telehealth Report and Order* or is the posting of urban rates of limited utility and unnecessary? Are there changes or updates the Administrator should make to the urban rates it posts on its website? While the Commission has made the decision to eliminate the Rates Database, the database contains urban rates that were collected as part of the database creation process. If the Administrator resumes posting urban rates, should the urban rates currently found in the Rates Database be included in the posted list, or have too many anomalies been identified that will preclude the use of those rates by participants in the Telecom Program?

90. On a forward going basis, should there be any changes to the now-reinstated urban rate rules? When exploring additional sources of urban rates, should the Commission allow health care providers to use the median of urban rates in the Rates Database as the urban rate? Parties lodging complaints about the use of the Rates Database to determine rural rates had relatively few complaints about its use to determine urban rates.[243] Should the Commission require the Administrator to maintain a Rates Database for urban rates and require that urban rates be calculated utilizing the Rates Database? Alternatively, should a rate survey be used to determine current urban rates instead of relying on the Administrator to determine and post rates? If so, after the initial compilation of the survey, how often should it be updated? Are there any additional factors that we should take into account for calculating urban rates in the Telecom Program?

91. *Threshold for "urban."* The standard for "urban" of being "functionally similar service in any city with a population of 50,000 or more in that state" that we reinstate today[244] was originally adopted in 2003.[245] Should the Commission maintain 50,000 as the population threshold for determining

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[239] *See* FCC Form 466 Instructions at 8 (2019).

[240] *See Dataconnex, LLC*, Notice of Apparent Liability for Forfeiture and Order, 33 FCC Rcd 1575, 1580, para. 10 (2018); *see also* FCC Form 466 Instructions, at 8 (2019).

[241] These rates were frequently referred to as "safe harbor urban rates." *See Promoting Telehealth Report and Order*, 34 FCC Rcd at 7356, para. 41.

[242] *Id.*

[243] *But see* SHLB Comments at 4-5; USTelecom Comments at 14-15.

[244] 47 CFR § 54.605(a) (2018). Appendix A, Final Rules, 47 CFR § 54.604(a), as adopted herein.

[245] *2003 Internet Access Order*, 18 FCC Rcd at 24566, para. 37.

an urban area? Is there another population number that better captures the full spectrum of urban areas or is there a value collected by a different agency that better captures the picture of an urban area?

C. Network Function

92. We next seek comment on two matters related to how networks function. First, we seek comment on reinstating the cap on support for satellite services that was in place before the adoption of the Rates Database. We then seek comment on the eligibility in the HCF Program of equipment that supports services funded in the Telecom Program.

1. Satellite Services

93. We seek comment on reinstating the cap on support for satellite services in the Telecom Program at the amount of support the health care provider would have received for similar terrestrial-based services.[246] When the Commission established the RHC Program, satellite service was the only available telecommunications service available in some rural areas. However, rural health care providers in those areas generally did not receive Telecom Program discounts because satellite service rates typically did not vary between urban and rural areas.[247] In 2003, the Commission revised its rules to allow eligible rural health care providers to base Telecom Program support for satellite services on urban rates for functionally similar wireline services.[248] However, because satellite services were often significantly more expensive than terrestrial-based services, in rural areas where a functionally similar terrestrial-based service was available the Commission capped support for satellite service at the amount that the health care provider would receive had it chosen the terrestrial-based service.[249] If an eligible rural health care provider chose a satellite-based service that was more expensive than the available equivalent terrestrial-base service, the health care provider was responsible for the additional cost.[250] In the *Promoting Telehealth Report and Order*, the Commission eliminated this cap, effective for funding year 2020, explaining that the limitation on support for satellite services was no longer necessary because rural rates would be determined by the Rates Database and costs for satellite services were decreasing, while also acknowledging that eliminating the cap furthered technological neutrality and that improvements to competitive bidding rules would reduce the need for the cap.[251]

94. We seek comment on reinstating the cap on satellite services at the lower of the satellite service rate or the terrestrial service rate and allow rural health care providers to receive discounts for satellite service up to the amount providers would have received if they purchased functionally similar terrestrial-based alternatives, even where terrestrial-based services are available. It appears that the constraints on the price of satellite services that the Commission predicted when it eliminated the cap on satellite services did not come into fruition. Since the elimination of the cap and the waiver of the rates database, Telecom Program support for satellite services has increased significantly. The table below shows that commitments for satellite services dipped slightly in funding year 2020 but increased significantly after that.[252]

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[246] *See* 47 CFR § 54.609(d) (2018); *see also Promoting Telehealth Report and Order*, 34 FCC Rcd at 7378-79, paras. 92-97; Appendix A, Final Rules, 47 CFR § 54.609(d), as adopted herein.

[247] *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7379, para. 92 (*citing Rural Health Care Support Mechanism*, WC Docket No. 02-60, Notice of Proposed Rulemaking, 17 FCC Rcd 7806, 7820, para. 38 (2002)).

[248] *2003 Internet Access Order*, 18 FCC Rcd at 24568, paras. 43-44; 47 CFR § 54.609 (2018).

[249] *2003 Internet Access Order*, 18 FCC Rcd at 24568, para. 44; 47 CFR § 54.609(d) (2018).

[250] 47 CFR § 47.609(d)(3) (2018).

[251] *Promoting Telehealth Report and Order*, 34 FCC Rcd at 7380-81, para. 97.

[252] Letter from Mark Sweeney, Vice President, Universal Service Administrative Company, to Jodie Griffin, Chief, Telecommunications Access Policy Division, Wireline Competition Bureau and Bryan Boyle, Deputy Chief, Telecommunications Access Policy Division, Wireline Competition Bureau, WC Docket 17-310 (filed Jan. 4, 2023).

Commitments for Satellite Services
Funding Years 2019-22

Funding Year	Commitment Amount
2019	$28,726,457
2020	$26,583,278
2021	$39,487,136
2022	$60,098,460

95. This steady growth in demand for satellite services may demonstrate the need to reinstitute the satellite funding cap. Without the constraints on support for satellite services imposed by the Rates Database, it appears that commitments for satellite services could increase to an unsustainable level. As an initial matter, we seek comment on the significance of the increase in commitments for satellite services. Does this increase reflect that the prices charged for satellite services in the Telecom Program increased after the cap was eliminated or are health care providers selecting satellite services because those services are now more competitive with terrestrial-based services? Are service providers less likely to bid on or upgrade networks for terrestrial services because the cap was lifted? Have rates for satellite services due to the availability of low Earth orbit (LEO) satellites dropped enough to make the cap no longer necessary? If that is the case, why did demand for satellite services increase so significantly in recent years? Are there other factors we should consider in determining whether to retain the cap on support for satellite services? For example, is it appropriate to apply the cap in cases where satellite service provides redundancy in the absence of alternative terrestrial-based route diversity? Could reinstatement of the cap discourage investment in LEO satellites? What impact should the RHC Program's historical preference for technological neutrality and the fact that there previously was a cap on satellite services have on this determination? If we reinstitute this cap, are there other changes we should make to it? Should the Commission not apply the cap to funding requests supported by satellite service contracts that were entered into before reinstatement of the cap? Do commenters in Alaska have any concerns with reinstating the cap, given the importance of satellite service in Alaska?

2. HCF Program Eligible Equipment

96. We also seek comment on whether we should amend HCF Program rules to make eligible network equipment necessary to make functional an eligible service supported under the Telecom Program.[253] Current HCF Program rules restrict the eligibility of network equipment for individual applicants to equipment necessary to make functional an eligible service supported under the *HCF Program*.[254] There is no analogous rule in the Telecom Program that provides support for network equipment. Should we consider allowing HCF-eligible equipment to support both HCF and Telecom Program services? Would such a change improve the reliability of Telecom Program supported services? If we were to make network equipment for Telecom Program supported services eligible, what would the financial impact be on the RHC Program? Would HCF Program funding for equipment supporting Telecom Program services reduce Telecom Program expenditures? Expanding the universe of supported equipment would make it more likely that the internal cap would be exceeded. Given the significantly higher discount rates already offered in the Telecom Program, would it be sensible to increase the likelihood of exceeding the internal cap to provide HCF Program funding to support networks that

[253] *See* Jeffrey Mitchell, Counsel, ADS Advanced Data Services, Inc. (ADS) to Marlene Dortch, Secretary, FCC, WC Docket No. 17-310, 2 (filed January 13, 2023) (ADS *Ex Parte*).

[254] *See* 47 CFR § 54.613(a).

traditionally have been supported in the Telecom Program only? If we implement this change, are there additional safeguards we should consider?

D. Conditional Approval of Eligibility for Future Eligible Heath Care Providers

97. We propose to amend RHC Program rules for determining eligibility to allow entities that are not yet but will become eligible health care providers in the near future to begin receiving RHC Program funding shortly after they become eligible.[255] Under the Bureau-level *Hope Community Order*, entities that are not yet eligible health care providers cannot receive an eligibility approval, which is a prerequisite to initiating competitive bidding and filing a Request for Funding, until they are eligible health care providers.[256] As a result of this restriction, if a health care provider does not receive an eligibility approval in time to complete competitive bidding and file a Request for Funding by the close of the application filing window on April 1,[257] the health care provider would have to wait until a subsequent funding year to receive RHC Program funding, which could result in a delay of a full calendar year.[258]

98. In order to address this delay in funding, we propose to amend sections 54.601 and 54.622 of our rules to allow entities that will soon be eligible health care providers to request and receive a "conditional approval of eligibility."[259] Once the Administrator approves an applicant's conditional eligibility, the applicant could proceed to conduct competitive bidding and submit a Request for Funding during the application filing window. To ensure that no funding is disbursed for entities that are not yet eligible, the Administrator would not issue a funding decision for the funding request until the entity updates its eligibility request by providing documentation showing that it is an eligible health care

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[255] Eligible health care providers, as defined in section 254(h)(7)(B) of the Communications Act and implemented in the Commission's rules, are limited to public or non-profit entities falling into one of the following categories: (1) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (2) community health centers or health centers providing health care to migrants; (3) local health departments or agencies; (4) community mental health centers; (5) not-for-profit hospitals; (6) rural health clinics; (7) skilled nursing facilities; and (8) consortia of health care providers consisting of one or more entities falling into the first seven categories. *See* 47 U.S.C. §§ 254(h)(1)(A), (h)(2)(A), (h)(4), (h)(7)(B); 47 CFR §§ 54.600(b), 54.601(a).

[256] *Hope Community Resources, Inc.– Barrow MH, Rural Health Care Universal Service Support Mechanism*, WC Docket No. 02-60, Order, 31 FCC Rcd 7883, 7887-88, para. 9 (WCB 2016) (*Hope Community Order*) ("while Hope Community asserts the Barrow site provides outpatient mental health services, the prospective language … indicate that outpatient services will be provided at a future time," and "we affirm [the Administrator's] decision and find that Hope Barrow did not demonstrate that it was eligible as a 'community mental health center,' at the time of its FCC Form 465 submission for funding year 2013, and therefore was ineligible to receive RHC Telecommunications Program support.").

[257] 47 CFR § 54.621(a)(1).

[258] *See* Letter from Kristen Corra, Policy Counsel, SHLB, to Marlene H. Dortch, Secretary, FCC, WC Docket No. 17-310, at 4 (filed Dec. 9, 2022); SHLB Reply Comments at 11. Under current rules, if a health care provider becomes an eligible health care provider and receives an eligibility approval on March 5, 2024, for example, there would not be enough time to conduct competitive bidding, which includes a minimum 28-day waiting period for posting an FCC Form 461 or 465 on the Administrator's website, before the April 1, 2024 close of the application filing window for funding year 2024. The health care provider would have to wait until funding year 2025, which begins on July 1, 2025, to receive RHC Program funding. When the *Hope Community Order* was adopted, there was a rolling application deadline, which allowed entities to begin receiving RHC Program funding within months of becoming eligible health care providers. *See Hope Community Order*, 31 FCC Rcd at 7885, para. 4. After receiving an eligibility approval, the health care provider could wait the required 28 days for competitive bidding and then file a Request for Funding any time during the funding year.

[259] *See infra* Appendix B, 47 CFR § 54.601(c). In connection with the proposed amendments to section 54.601 of the Commission's rules, we also propose to amend section 54.622(e)(1)(i) of the Commission's rules to allow applicants seeking conditional approval of eligibility to certify their eligibility when submitting a Request for Services. *See infra* Appendix B, 47 CFR § 54.622(e)(1)(i).

provider and the Administrator issues a final eligibility approval. The conditional approval of eligibility process would use the same forms used to request eligibility approvals, which are the FCC Form 460 (Eligibility and Registration Form) in the HCF Program and the FCC Form 465 (Description of Services Requested and Certification Form) in the Telecom Program.

99. We seek comment on the potential impact of and mechanics of the proposed rule changes. How many entities would be impacted by this change? Are there any potential problems associated with this proposal or any potential negative impact on the overall RHC Program? Are any additional safeguards necessary beyond the restriction against the Administrator issuing funding commitments before an entity receives a final eligibility approval? Are there alternatives to our conditional eligibility proposal that would more effectively allow entities that are not yet eligible health care providers to receive RHC Program funding? Finally, are there any RHC Program rule changes beyond those that we propose that would be needed to implement our conditional eligibility proposal?

E. Administrative Deadlines

100. We next address two matters involving RHC Program deadlines. We propose to push back the deadline for requesting Service Provider Identification Number (SPIN) changes to align with the invoice deadline. We also seek comment on whether a mechanism to allow post-commitment changes to evergreen contract dates is necessary.

1. Service Provider Identification Number Change Deadlines

101. We propose to revise the current deadline for requesting Service Provider Identification Number (SPIN) changes from the service delivery deadline to the invoice filing deadline. A SPIN is a unique number that the Administrator assigns to an eligible service provider seeking to participate in the universal service support programs.[260] An applicant under the HCF Program or Telecom Program may request either a "corrective SPIN change" (in cases not involving a change to the service provider associated with the applicant's funding request number) or "operational SPIN change" (in cases involving a change to the service provider associated with the applicant's funding request number).[261] The current filing deadline to submit a SPIN change request is no later than the service delivery deadline, which, with limited exceptions, is June 30 of the funding year for which program support is sought.[262] The Commission established a SPIN change deadline aligned with the service delivery deadline to ensure consistency with the E-Rate Program and reduce the number of requests for extension of the invoice deadline.[263]

102. SHLB requests that the Commission change the current deadline to make a corrective SPIN change from the service delivery deadline to the invoice filing deadline, which typically falls on October 28.[264] SHLB maintains that the nature of corrective SPIN changes creates a "recurring hardship

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[260] To obtain a SPIN, a service provider must file an FCC Form 498 with the Administrator, which refers to a provider's SPIN as its 498 ID. *See* USAC, *Obtain a 498 ID*, https://www.usac.org/rural-health-care/service-providers/step-1-participating-in-the-rhc-program/ (last visited Jan. 26, 2023).

[261] 47 CFR § 54.625(a), (b). For example, a corrective SPIN change is requested to correct ministerial errors or update a SPIN that resulted from a merger or acquisition of companies, and an operational SPIN change is requested when the applicant has a legitimate reason to change service providers, as in the case of a breach of contract. *Id.* The Commission adopted RHC Program SPIN change rules modeled after those of the E-Rate Program in the *Promoting Telehealth Report and Order*. *See Promoting Telehealth Report and Order*, 34 FCC Rcd at 7426-27, paras. 197-99.

[262] *Id*. § 54.625(c). The service delivery deadline is defined in section 54.626(a) of the Commission's rules. *Id*. § 54.626(a).

[263] *See Promoting Telehealth Report and Order*, 34 FCC Rcd at 7427, paras. 198-99.

[264] SHLB January 17, 2023 *Ex Parte*. The invoice filing deadline is 120 days after the later of: (1) the service delivery deadline, or (2) the date of a revised funding commitment letter issued pursuant to an approved post-

(continued….)

for applicants" unable to meet the deadline which, in turn, results in deadline waiver requests filed with the Commission.[265] According to SHLB, two commonly recurring situations support a change to the corrective SPIN change deadline: (1) mergers and acquisitions that can occur at any time during the funding year and (2) a service provider that assigns one of its multiple SPINs to a funding request without advising the healthcare provider as to the correct SPIN before invoicing begins, a situation that, in many instances, occurs after the service delivery deadline has passed.[266] SHLB maintains that changing the deadline to request a corrective SPIN change to October 28 will provide the Administrator with sufficient time to process the change request without the need for applicants to request deadline waivers from the Commission.[267]

103. We tentatively agree with SHLB that the current deadline for requesting corrective SPIN changes imposes unnecessary burdens that a later-in-time deadline will largely eliminate. Delaying the deadline by 120 days (from June 30 to October 28 in most cases) would reduce the need for applicants to seek, and for the Commission to address, waivers of the current corrective SPIN change deadline that result from the types of situations described by SHLB, while still maintaining an administratively reasonable date by which such change requests must be made. Although SHLB focused its request on corrective SPIN changes only, we conclude that it may be needlessly confusing to establish two different SPIN change request deadlines depending on whether the request is corrective or operational in nature. Accordingly, we propose to change the deadline for requesting both corrective and operational SPIN changes from the current service delivery deadline to the invoicing filing deadline.[268] We seek comment on this proposal. Are there other benefits to this change? We anticipate that one potentially undesirable consequence of this change is that it may cause Program participants to delay in filing SPIN change requests, which could result in Program participants missing the invoice deadline. If the SPIN change deadline is moved to the invoice deadline and the health care provider files a SPIN change request so close to the deadline that the Administrator cannot process the request before the invoice deadline, the health care provider will not be able to submit invoices. Does the flexibility this change would offer to health care providers justify the disadvantage to health care providers who are unable to invoice because they filed a SPIN change request too close to the deadline? Parties often indicate that alignment between RHC Program rules and E-Rate Program rules eliminates confusion. Would bringing these deadlines out of alignment create confusion? Are there other reasons not to adopt the same deadline for both corrective and operational SPIN changes?

2. Evergreen Contract Date Changes

104. We seek comment on whether there should be a process for health care providers to change evergreen contract dates following a funding commitment. Evergreen contracts are multi-year agreements under which covered services are exempt from the competitive bidding requirements for the life of the contract.[269] When the Administrator issues a funding commitment letter, it sets the period for an evergreen contract based on the estimated service start and end dates provided by the health care provider on the FCC Form 462.[270] However, services sometimes start after the estimated service start

(Continued from previous page)
commitment request made by the applicant or service provider or a successful appeal of a previously denied or reduced funding request. 47 CFR § 54.627(a).

[265] SHLB Jan. 17, 2023 *Ex Parte* at 4.

[266] *Id*. at 5.

[267] *Id*.

[268] *See* Appendix B, 47 CFR § 54.625 as proposed herein.

[269] 47 CFR § 54.622(i)(3). To be designated an evergreen contract by the Administrator, a contact must be entered into as a result of competitive bidding, contain certain contractual terms, and meet other requirements. *Id*. § 54.622(i)(3)(ii).

[270] *See* SHLB Jan. 19, 2023 *Ex Parte* at 4-5.

date, which means that the evergreen status of the contract expires before it would have if the evergreen designation period was based on the actual service start date.[271] We seek comment on whether there should be a means for a healthcare provider to change evergreen contract dates. Is such an alternative necessary and, if so, how could it be accomplished? Would an alternative means require a change in our rules or could our current rules be interpreted to allow for evergreen contract date changes? What would be the impact of such a change on the duration of evergreen contracts? Would allowing program participants to change evergreen contract dates make it more difficult for the Administrator to process funding requests submitted pursuant to such contracts?

F. FCC Form 466

105. We next seek comment on proposed revisions to the Funding Request and Certification Form (FCC Form 466), including service-specific details that could both improve the accuracy of similar service categorizations under the existing Method 1 and Method 2, or the alternatives we propose in this Second Further Notice, and also result in more accurate cost-based rates. To ensure the reporting of accurate data, we propose to begin collecting this data from service providers because they are in the best position to furnish it.

106. In the *Further Notice*, we sought general comment on both existing Telecom Program data collected through current program forms as well as potential changes to the categorization and details of Telecom Program services and data reported on the FCC Form 466.[272] Certain data currently collected appears to be too vague and fails to capture details of the purchased services, resulting in significantly different monthly rates for services broadly categorized that report comparable bandwidths but likely vary significantly.[273] We requested feedback on updating the Telecom Program's categorization of services to more accurately reflect the functionality and cost of services purchased by incorporating data points such as details of service level agreements (SLAs).[274] We also sought comment on collecting data that would classify services based upon functionality, regardless of the commercial name used by the service provider to describe the service.[275] We then sought general comment on revisions to the FCC Form 466 and other Telecom Program forms and corresponding USAC online portals that would improve the accuracy of urban and rural rate determinations and ensure program integrity.[276]

107. Commenters agreed that collecting more detailed data would result in more accurate categorization of services purchased by health care providers and improve program transparency.[277] Alaska Communications agreed that service categorizations should be more granular and explained that services broadly categorized as "dedicated" include a range of services and features, particularly security and reliability, that significantly impact rates.[278] Alaska Communications also noted that the factors identified in the *Further Notice* "can have a profound effect on the functionality of the service from the perspective of the end user."[279] GCI suggested that the Commission could collect data on network type, prioritization, and term and volume discounts.[280] GCI also argued that the Commission should collect

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[271] *See id.* at 5.

[272] *Further Notice* at 14-17, paras. 35-43.

[273] *Id*. at 15, para. 36.

[274] *Id*. at 15-16, paras. 37, 39.

[275] *Id*. at 16, para. 38.

[276] *Id*. at 16-17, para 41.

[277] *See* ANHB Comments at 7; ANTHC Comments at 3; GCI Comments at 6, 53.

[278] Alaska Communications Comments at 19-20

[279] *Id.* at 18-19.

[280] GCI Comments at 54.

data on services purchased rather than requiring healthcare providers to submit highly detailed forms when requesting service.[281]

108. We propose revisions to the FCC Form 466 to improve the quality, consistency, and level of detail of RHC Program data. Improved data will also increase the accuracy of rural rates calculated through the current three rate determination methods or through any rate determination process that is established in the future. Through our continued review of data currently collected on the FCC Form 466 we have identified five primary issues impacting the ability to calculate rates: (1) services reported by healthcare providers are not defined by a single factor such as technology or speed; (2) some reported rates are based on distance whereas others are not; (3) value-added services beyond data transmission are not reported; (4) bundled prices offered by service providers make "apples-to-apples" rate comparisons difficult; and (5) the form does not measure the impact of SLAs on the rates offered.

109. To address these issues and collect more detailed, accurate data, we propose to revise the FCC Form 466 to collect more granular information about the services purchased by health care providers. We propose to collect the following service details for each connection endpoint.[282] We seek comment on collecting this data on the FCC Form 466 and welcome comments on additional or alternative service data that could improve the accuracy and fairness of Telecom Program rates. We especially request recommendations for additional individual descriptors for the items listed below. The following items are being considered:

- Contract Type. In many instances services reimbursed under the RHC Program are often part of a contract that bundles many services together. We propose adding a field that would indicate if the underlying contract includes a bundle and what services the bundle covers. Data collected would include the total number of end points serviced, an indicator of the geographic region of coverage, the contract's duration, discounts and service level agreements that apply to the contract, and the contract's total price including RHC supported services.
- Service Details - Connection Endpoint Information. There would be one entry for each endpoint.
    - Location of Endpoint – Geographically identifiable latitude and longitude.
    - Distance (If Applicable) – The distance would be in line miles from this endpoint to the far termination endpoint of the link or the central server node. This would be reported if the service provider uses it in the price calculation for this item. This field would be reported in line miles and not straight-line or "crow fly" miles.
    - Connectivity – Point-to-Point, Point-to-Multipoint, Multipoint-to-Multipoint
    - Application – Voice, Data, or Both
    - Service or Product – This is the service at the Endpoint. The user would select from the following options: Link (a point-to-point transmission), Device (at an endpoint for a link, such as a router or switch other network-supporting equipment), or Service (provided capabilities using the Links and Devices).
    - Equipment Vendor/Model – If a device or other equipment is used to extend the eligible service to the endpoint, the user would list it here. All devices would be required to be listed.

[281] *Id.* at 6, 54.

[282] We define a "connection endpoint" to mean termination points set up as part of the requested communication service. For example, a request for a service based upon an MPLS solution could have 10 termination points for several rural clinics, a central hospital, and a diagnostic center. Under our proposal, each of the ten "connection endpoints" would be reported separately. For a simple point-to-point (1:1) connection, two endpoints would be reported. Additionally, an end point can be a location where a separate device, such as a repeater, modem, router, switch, or other supporting service, such as a server, monitoring device, etc., is located that is part of the contract.

  - Technology – The user would report the technology at the endpoint selecting from items such as: DSL (Digital Subscriber Line), DOCSIS (Data Over Cable Service Interface Specifications), PON (Passive Optimal Network), GPON (Gigabit Passive Optical Network and its variants), and similar, as well as Other (Describe) and N/A.
  - Bandwidth (Down/Up) – This would be expressed in Mbps.
  - SLA Coverage – The user would select "Yes" or "No" to indicate if this endpoint is covered.
  - Access Media – The user would describe the transmission media that is present at the termination of the endpoint at each individual facility. This can often, but not always, be considered the last mile. The user would select from: copper, cable, microwave, fiber, high Earth orbit satellite, LEO satellite, power line, other, and N/A.
  - Monthly Price – This field contains the monthly price in dollars and cents. This price would not include any uplift for SLA coverage, which will be collected elsewhere in the form. If the overall contract price is for a service such as MPLS, the price for each endpoint would be a pro-rated amount associated with each endpoint. Any service portion that cannot be associated with an endpoint, such as MPLS management, would be separately reported as an individual line item(s) in the "Additional Services and Differentiators" section. MPLS and similar multi-point solutions would not be reported as a single item. These services would be pro-rated to individual endpoints.
- Additional Services and Differentiators – This question would only be used if the service cannot be described in the "Service Details" question.
  - Service Name – This would be a free text descriptor for the provider's name of this item.
  - Class – This would be a product, service, or differentiator not listed in the "Service Details" section because it is not associated with a single endpoint.
  - Coverage Scope – This field would refer to the scope of the network and contract that this item covers.
  - Period – This field would indicate the period length in months over which this item will occur. For example, if an "Installation" service is provided for the first year and one-half is part of the contract, "18" months would be shown.
  - SLA Coverage – The user would provide a "Yes" or "No" answer to indicate if this service/differentiator is covered under an SLA.
  - Monthly Price – This would be expressed in dollars and cents. The provider would pro-rate the monthly average cost for each item if the overall contract price is a single number.

110. We also propose to collect SLA details on the FCC Form 466, which currently captures whether there is an SLA, but does not collect specific details about it. The specifics of an SLA appear to significantly impact telecommunications service rates and therefore are likely to be a key factor when determining whether services are similar. SLAs are typically sold at varying levels (sometimes with descriptors such as Gold, Silver, or Bronze) and include availability and reliability metrics, service maintenance and management, delineations of service provider and customer responsibilities, and penalties for non-performance. We seek comment on adding the following fields to the FCC Form 466 and also seek comment on any additional SLA data that could improve the accuracy and fairness of Telecom Program rural rates, with one line for each SLA coverage area or item:

- Target Measurement – The user would report the item or class of items to be measured such as Availability (Network Level Outage), Availability (Link or Endpoint Level Outage), Repair/Restore Times (MTTR – Mean Time To Repair), or On Site Spares (Response Time for Equipment Under Contract).
- SLA Level – High, Medium, or Low that may correspond to individual provider schemes, such as
  - Bronze, Silver, Gold.

  - Basic, Standard, Premium.
  - As classified by any system the service provider may use.
- What Functions are Covered?
  - The user selects between Operations, Performance, Maintenance, Install, Administration, and Compliance.
- Period – The user would indicate the period length in months over which this item will occur. For example, if an "Installation" service is provided for 18 months, then "18 months" would be shown.
- Penalties For Non-Performance? (Yes/No) – The user would indicate whether there are specific monetary or other penalties for carrier non-performance of specific SLA requirements written in the contract. The user would select from a drop-down menu. General statements of intent would not constitute a penalty.
- SLA Scope – The user would report the scope of the contract that this item covers. Examples of options filers would select from include: Performance (what is delivered), Operations (how it is managed), and Maintenance (how it is repaired).
- Description of Target SLA Measurement – An optional free text field the provider could use to enter further clarification for the specific SLA item.
- Price Uplift – The user would report the increase to the contract service price (usually represented as a percentage) that the SLA impacts. If it is not a separate line item in the contract, then the price would be estimated and/or pro-rated by the provider over the period and scope of SLA coverage.

111. We seek comment on whether we should apply the proposed revisions to FCC Form 466 to the HCF Funding Request Form (FCC Form 462) for consistency. What are the benefits and/or drawbacks of revising FCC Form 462 to collect more granular service data?

112. *Service Provider Filing*. We propose to require service providers to report the technical service details described above on the FCC Form 466. In the *Further Notice*, we sought comment on whether service providers should report certain technical information about services purchased that rural health care providers either cannot access or lack the technical expertise to report.[283] Commenters expressed concerns about increasing technical reporting burdens on healthcare providers. GCI argued that any new collection process should not burden rural health care providers, who are often "not well positioned to supply technical and granular details about the services they need," and suggested collecting additional data through the FCC Form 466.[284] Alaska Communications acknowledged that reporting technical service data would be complicated for health care providers.[285] ANHB and ANTHC both supported increased data collection but cautioned against increasing reporting burdens on Tribal and other health care providers.[286]

113. We agree with commenters that proposed increases in the level of detailed technical data required on the FCC Form 466 would likely exceed the technical expertise of most health care providers. The service providers are in the best position to understand the difference between a commercial term and a functional capability as well as the difference between a capability and the underlying technology. We therefore propose that service providers input service information into the FCC Form 466. We tentatively conclude that shifting the responsibility for providing technical details to the service provider would reduce burdens on healthcare providers and improve data quality and consistency. We propose that service providers provide the technical connection endpoint data listed above as well as any other

[283] *Further Notice* at 17, para. 43.

[284] GCI Comments at 54.

[285] Alaska Communications Comments at 19-20.

[286] ANHB Comments at 7; ANTHC Comments at 4.

technical service data that is recommended by commenters and ultimately adopted by the Commission as part of this proceeding. Additionally, we propose that the service providers include the actual contract as an attachment to the FCC Form 466. This would be treated confidentially and would document the carrier's answers in an official company document. To ensure the accuracy of the information provided, we propose that the service provider certify to the accuracy of service provider-supplied information. We seek comment on these proposals.

114. We also seek comment on the logistics of service providers filling out portions of the FCC Form 466. We propose that the FCC Form 466 be transferred to the service provider after the health care provider completes the certifications on its portion of the FCC Form 466. We seek comment on how service providers completing part of the FCC Form 466 would impact program deadlines. Should the filing window close denote the health care provider's deadline for completing its portion of the FCC Form 466? If so, how much time should service providers have to complete their portion of it? Finally, we seek comment on the extent to which there might be a miscommunication between health care and service providers about the requested services. In limited circumstances, service providers may be selected to provide RHC Program supported services without submitting a bid in response to an RFP.[287] If there is no contract, how can we ensure that health care providers and service providers agree as to the specific services that will be provided?

G. Digital Equity and Inclusion

115. The Commission, as part of its continuing effort to advance digital equity for all,[288] including people of color, persons with disabilities, persons who live in rural or Tribal areas, and others who are or have been historically underserved, marginalized, or adversely affected by persistent poverty or inequality, invites comment on any equity-related considerations[289] and benefits (if any) that may be associated with the proposals and issues discussed herein. Specifically, we seek comment on how our proposals may promote or inhibit advances in diversity, equity, inclusion, and accessibility, as well the scope of the Commission's relevant legal authority.

VII. PROCEDURAL MATTERS

116. *Regulatory Flexibility Act.* The Regulatory Flexibility Act of 1980, as amended (RFA),[290] requires that an agency prepare a regulatory flexibility analysis for notice-and-comment rulemaking proceedings, unless the agency certifies that "the rule will not, if promulgated, have a

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[287] For example, if a health care provider does not receive responsive bids to its RFP, it may use a pre-existing contract as a "standing bid." *Request for Review of the Decision of the Universal Service Administrator by Kalamazoo Public Schools, Kalamazoo, Michigan, Federal-State Joint Board on Universal Service, Changes to the Board of Directors of the National Exchange Carrier Association, Inc.*, CC Docket Nos. 96-45 and 97-21, Order on Reconsideration, 17 FCC Rcd 22154 (WCB 2002).

[288] Section 1 of the Communications Act of 1934 as amended provides that the FCC "regulat[es] interstate and foreign commerce in communication by wire and radio so as to make [such service] available, so far as possible, to all the people of the United States, without discrimination on the basis of race, color, religion, national origin, or sex." 47 U.S.C. § 151.

[289] The term "equity" is used here consistent with Executive Order 13985 as the consistent and systematic fair, just, and impartial treatment of all individuals, including individuals who belong to underserved communities that have been denied such treatment, such as Black, Latino, and Indigenous and Native American persons, Asian Americans and Pacific Islanders and other persons of color; members of religious minorities; lesbian, gay, bisexual, transgender, and queer (LGBTQ+) persons; persons with disabilities; persons who live in rural areas; and persons otherwise adversely affected by persistent poverty or inequality. *See* Exec. Order No. 13985, 86 Fed. Reg. 7009, Executive Order on Advancing Racial Equity and Support for Underserved Communities Through the Federal Government (January 20, 2021).

[290] The RFA, *see* 5 U.S.C. §§ 601-612, was amended by the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA), Pub. L. No. 104-121, Title II, 110 Stat. 857 (1996).

significant economic impact on a substantial number of small entities."[291] Accordingly, the Commission has prepared a Final Regulatory Flexibility Analysis (FRFA) concerning rule and policy changes in the Order on Reconsideration and Second Report and Order. The FRFA is set forth in Appendix C. It has also prepared an Initial Regulatory Flexibility Analysis (IRFA) concerning potential rule and policy changes contained in the this Second Further Notice of Proposed Rulemaking. The IRFA is set forth in Appendix D.

117. *Paperwork Reduction Act*. This document contains proposed new or modified information collection requirements. The Commission, as part of its continuing effort to reduce paperwork burdens, invites the general public and the Office of Management and Budget (OMB) to comment on the information collection requirements contained in this document, as required by the Paperwork Reduction Act of 1995, Public Law 104-13. In addition, pursuant to the Small Business Paperwork Relief Act of 2002, Public Law 107-198, *see* 44 U.S.C. 3506(c)(4), we seek specific comment on how we might further reduce the information collection burden for small business concerns with fewer than 25 employees.

118. *Congressional Review Act.* The Commission has determined, and the Administrator of the Office of Information and Regulatory Affairs, Office of Management and Budget, concurs, that this rule is "non-major" under the Congressional Review Act, 5 U.S.C. § 804(2). The Commission will send a copy of this Order on Reconsideration, Second Report and Order, Order, and Second Further Notice of Proposed Rulemaking to Congress and the Government Accountability Office pursuant to 5 U.S.C. § 801(a)(1)(A). The Commission will send a copy of this Order on Reconsideration and Second Report and Order to Congress and the Government Accountability Office pursuant to 5 U.S.C. § 801(a)(1)(A).

119. *Ex Parte Rules – Permit-But-Disclose*. This proceeding shall be treated as a "permit-but-disclose" proceeding in accordance with the Commission's *ex parte* rules.[292] Persons making *ex parte* presentations must file a copy of any written presentation or a memorandum summarizing any oral presentation within two business days after the presentation (unless a different deadline applicable to the Sunshine period applies). Persons making oral *ex parte* presentations are reminded that memoranda summarizing the presentation must (1) list all persons attending or otherwise participating in the meeting at which the *ex parte* presentation was made, and (2) summarize all data presented and arguments made during the presentation. If the presentation consisted in whole or in part of the presentation of data or arguments already reflected in the presenter's written comments, memoranda or other filings in the proceeding, the presenter may provide citations to such data or arguments in his or her prior comments, memoranda, or other filings (specifying the relevant page and/or paragraph numbers where such data or arguments can be found) in lieu of summarizing them in the memorandum. Documents shown or given to Commission staff during *ex parte* meetings are deemed to be written *ex parte* presentations and must be filed consistent with rule 1.1206(b). In proceedings governed by rule 1.49(f) or for which the Commission has made available a method of electronic filing, written *ex parte* presentations and memoranda summarizing oral *ex parte* presentations, and all attachments thereto, must be filed through the electronic comment filing system available for that proceeding, and must be filed in their native format (*e.g.*, .doc, .xml, .ppt, searchable .pdf). Participants in this proceeding should familiarize themselves with the Commission's *ex parte* rules.

120. *Comment Period and Filing Requirements*. Pursuant to sections 1.415 and 1.419 of the Commission's rules, 47 CFR §§ 1.415, 1.419, interested parties may file comments and reply comments on or before the dates indicated on the first page of this document. Comments may be filed using the Commission's Electronic Comment Filing System (ECFS). *See Electronic Filing of Documents in Rulemaking Proceedings*, 63 FR 24121 (1998).

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[291] 5 U.S.C. § 605(b).

[292] 47 CFR § 1.1200 *et seq.*

- Electronic Filers: Comments may be filed electronically using the Internet by accessing the ECFS: http://www.fcc.gov/ecfs/.
- Paper Filers: Parties who choose to file by paper must file an original and one copy of each filing.
- Filings can be sent by commercial overnight courier, or by first-class or overnight U.S. Postal Service mail. All filings must be addressed to the Commission's Secretary, Office of the Secretary, Federal Communications Commission.
- Commercial overnight mail (other than U.S. Postal Service Express Mail and Priority Mail) must be sent to 9050 Junction Drive, Annapolis Junction, MD 20701.
- U.S. Postal Service first-class, Express, and Priority mail must be addressed to 45 L Street NE Washington, DC 20554.
- Effective March 19, 2020, and until further notice, the Commission no longer accepts any hand or messenger delivered filings. This is a temporary measure taken to help protect the health and safety of individuals, and to mitigate the transmission of COVID-19. *See FCC Announces Closure of FCC Headquarters Open Window and Change in Hand-Delivery Policy*, Public Notice, 35 FCC Rcd 2788, 2788-89 (OS 2020), https://www.fcc.gov/document/fcc-closes-headquarters-open-window-and-changes-hand-delivery-policy.

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

122. *Contact Person.* For further information about this proceeding, please contact, Bryan P. Boyle, Deputy Division Chief, Telecommunications Access Policy Division, Wireline Competition Bureau, at Bryan.Boyle@fcc.gov.

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

VIII. ORDERING CLAUSES

124. Accordingly, IT IS ORDERED, pursuant to the authority contained in sections 1, 4(j), 214, 254, and 405 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151, 154(j), 214, 254, and 405 and sections 1.115 and 1.429 of the Commission's rules, 47 CFR §§ 1.115, 1.429, that this Order on Reconsideration, Second Report and Order, Order, and Second Further Notice of Proposed Rulemaking IS ADOPTED.

125. IT IS FURTHER ORDERED that, pursuant to section 1.429 of the Commission's rules, 47 CFR § 1.429, the Petition for Reconsideration filed by Alaska Communications on November 12, 2019 is GRANTED IN PART, DENIED IN PART, and DISMISSED IN PART to the extent described herein.

126. IT IS FURTHER ORDERED that, pursuant to section 1.429 of the Commission's rules, 47 CFR § 1.429, the Petition for Reconsideration and Clarification filed by the Schools, Health & Libraries Broadband Coalition on November 12, 2019 is GRANTED IN PART, DENIED IN PART, and DISMISSED IN PART to the extent described herein.

127. IT IS FURTHER ORDERED that, pursuant to section 1.429 of the Commission's rules, 47 CFR § 1.429, the Petition for Reconsideration filed by State of Alaska, Office of the Governor on November 12, 2019 is GRANTED IN PART, DENIED IN PART and DISMISSED IN PART to the extent described herein.

128. IT IS FURTHER ORDERED that, pursuant to section 1.429 of the Commission's rules, 47 CFR § 1.429, the Petition for Reconsideration and Clarification filed by North Carolina Telehealth Network Association/Southern Ohio Health Care Network on November 12, 2019 is DENIED to the extent described herein.

129. IT IS FURTHER ORDERED that, pursuant to section 1.429 of the Commission's rules, 47 CFR § 1.429, the Petition for Reconsideration and Clarification filed by USTelecom – The Broadband Association on November 12, 2019 is GRANTED IN PART, DENIED IN PART, and DISMISSED IN PART to the extent described herein.

130. IT IS FURTHER ORDERED that pursuant to the authority 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 of the Commission's rules, 47 CFR § 1.3, that sections 54.605(b) of the Commission's rules as amended herein, 47 CFR §§ 54.605(b) IS WAIVED to the extent provided herein.

131. IT IS FURTHER ORDERED, that pursuant to section 1.103 of the Commission's rules, the provisions of this Order on Reconsideration, Second Report and Order, Order and Second Further Notice of Proposed Rulemaking WILL BECOME EFFECTIVE thirty (30) days from the date of publication in the Federal Register unless indicated otherwise herein.

132. IT IS FURTHER ORDERED, that pursuant to the authority contained in sections 1 through 4, 201 through 205, 254, 303(r), and 403 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151-154, 201-205, 254, 303(r), and 403, and section 706 of the Telecommunications Act of 1996, 47 U.S.C. § 1302, Part 54 of the Commission's rules, 47 C.F.R. Part 54, is AMENDED as set forth in Appendix A, and such rule amendments shall be effective (30) days after the publication of the Order and Reconsideration and Second Report and Order in the Federal Register, except for sections 54.604, 54.605, and 54.627, which are subject to the PRA and will become effective upon announcement in the Federal Register of OMB approval of the subject information collection requirements.

133. IT IS FURTHER ORDERED that, pursuant to section 1.115 of the Commission's rules, 47 CFR § 1.115, the Application for Review filed by GCI Communications Corp. on July 30, 2020 is DISMISSED as moot.

134. IT IS FURTHER ORDERED that, pursuant to section 1.115 of the Commission's rules, 47 CFR § 1.1115, the Application for Review filed by Alaska Communications on July 30, 2020 is DISMISSED as moot.

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

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

137. IT IS FURTHER ORDERED that the Office of the Managing Director, Performance Evaluation and Records Management, SHALL SEND a copy of this Order on Reconsideration and Second Report and Order in a report to be sent to Congress and the Government Accountability Office pursuant to the Congressional Review Act, 5 U.S.C. § 801(a)(1)(A).

FEDERAL COMMUNICATIONS COMMISSION

Marlene H. Dortch
Secretary

APPENDIX A

FINAL RULES

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

PART 54 – UNIVERSAL SERVICE

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

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

2. Amend § 54.604 to read as follows:

§ 54.604 Determining the urban rate.

(a) Effective funding year 2024, if a rural health care provider requests support for an eligible service to be funded from the Telecommunications Program that is to be provided over a distance that is less than or equal to the "standard urban distance," as defined in paragraph (c) of this section, for the state in which it is located, the "urban rate" for that service shall be a rate no higher than the highest tariffed or publicly-available rate charged to a commercial customer for a functionally similar service in any city with a population of 50,000 or more in that state, calculated as if it were provided between two points within the city.

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

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

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

3. Amend § 54.605 to read as follows:

§ 54.605 Determining the rural rate.

(a) Effective funding year 2024, the rural rate shall be the average of the rates actually being charged to commercial customers, other than health care providers, for identical or similar services provided by the telecommunications carrier providing the service in the rural area in which the health care provider is located. The rates included in this average shall be for services provided over the same distance as the eligible service. The rates averaged to calculate the rural rate must not include any rates reduced by universal service support mechanisms. The "rural rate" shall be used as described in this subpart to determine the credit or reimbursement due to a telecommunications carrier that provides eligible telecommunications services to eligible health care providers.

(b) If the telecommunications carrier serving the health care provider is not providing any identical or similar services in the rural area, then the rural rate shall be the average of the tariffed and other

publicly available rates, not including any rates reduced by universal service programs, charged for the same or similar services in that rural area over the same distance as the eligible service by other carriers. If there are no tariffed or publicly available rates for such services in that rural area, or if the carrier reasonably determines that this method for calculating the rural rate is unfair, then the carrier shall submit for the state commission's approval, for intrastate rates, or for the Commission's approval, for interstate rates, a cost-based rate for the provision of the service in the most economically efficient, reasonably available manner.

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

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

4. Amend § 54.619 by revising paragraph (a) to read as follows:

§ 54.619 Cap.

(a) *Amount of the annual cap.* The aggregate annual cap on federal universal service support for health care providers shall be $571 million per funding year. When total demand during a filing window period exceeds the total remaining support available for the funding year, an internal cap of $150 million per funding year for upfront payments and multi-year commitments under the Healthcare Connect Fund Program shall apply.

(1) * * *

(2) * * *

(3) * * *

(4) * * *

(5) * * *

5. Amend § 54.621 by revising subsection (b) to read as follows:

§ 54.621 Filing window for requests and prioritization of support.

(a) * * * * *

(b) *Prioritization of support.* The Administrator shall act in accordance with this section when a filing window period for the Telecommunications Program and the Healthcare Connect Fund Program, as described in paragraph (a) of this section, is in effect. When a filing period described in paragraph (a) of this section closes, the Administrator shall calculate the total demand for Telecommunications Program and Healthcare Connect Fund Program support submitted by all applicants during the filing window period.

(1) *Circumstances in which prioritization applies.* If the total demand during the filing window period exceeds the total remaining support available for the funding year, prioritization will apply in the following circumstances:

(i) *Internal cap*. If the internal cap is exceeded, the Administrator shall determine whether demand for upfront payments and the first year of multi-year commitments exceeds the internal cap. If such demand exceeds the internal cap, the Administrator shall not fund the second and third year of multi-year commitment requests and then apply the prioritization schedule in paragraph (b)(2) of this section to all eligible requests for upfront payments and the first-year of multi-year commitments to limit the demand for upfront payments and the first year of multi-year commitments within the internal cap. If demand for upfront payments and the first year of multi-year commitments does not exceed the internal cap, the Administrator shall apply the prioritization schedule in paragraph (b)(2) of this section to the second and third year of all eligible requests for multi-year commitments until the internal cap is reached, to ensure that the internal cap is not exceeded.

(ii) *Overall cap*. If the internal cap is not exceeded or if, after demand for upfront payments and multi-year commitments is limited within the internal cap in paragraph (b)(1)(i) of this section, the total remaining demand still exceeds the total remaining support available for the funding year, the Administrator shall apply the prioritization schedule in paragraph (b)(2) of this section to all remaining eligible funding requests.

(2) *Application of prioritization schedule.* When prioritization is necessary under paragraph (b)(1) of this section, the Administrator shall fully fund all applicable eligible requests falling under the first prioritization category of Table 1 before funding requests in the next lower prioritization category. The Administrator shall continue to process all applicable requests by prioritization category until there are no applicable funds remaining. If there is insufficient funding to fully fund all requests in a particular prioritization category, then the Administrator will pro-rate the applicable remaining funding among all applicable eligible requests in that prioritization category only pursuant to the proration process described in paragraph (b)(3) of this section.

TABLE 1 TO PARAGRAPH (b)—PRIORITIZATION SCHEDULE

Health Care Provider Site is Located in:	**In a Medically Underserved Area/Population (MUA/P)**	**Not in MUA/P**
Extremely Rural Tier (areas entirely outside of a Core Based Statistical Area)	*Priority 1*	*Priority 4*
Rural Tier (areas within a Core Based Statistical Area that does not have an urban area or urban cluster with a population equal to or greater than 25,000)	*Priority 2*	*Priority 5*
Less Rural Tier (areas within a Core Based Statistical Area with an urban area or urban cluster with a population equal to or greater than 25,000, but where the census tract does not contain any part of an urban area or urban cluster with population equal to or greater than 25,000)	*Priority 3*	*Priority 6*
Non-Rural Tier (all other non-rural areas)	*Priority 7*	*Priority 8*

(3) *Pro-rata reductions*. When proration is necessary under paragraph (b)(2) of this section, the Administrator shall take the following steps:

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

(ii) The Administrator shall multiply the pro-rata factor by the dollar amount of each applicable funding request in the prioritization category to obtain prorated support for each funding request.

(4) The Administrator shall designate the underlying contracts associated with any multi-year commitment requests that are not fully funded as a result of the prioritization process in this section as "evergreen" provided that those contracts meet the requirements under § 54.622(i)(3)(ii).

6. Amend § 54.622(a) as follows:

§ 54.622 Competitive Bidding Requirements and Exemptions.

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

(b) * * *

(c) * * *

(d) * * *

(e) * * *

(1) * * *

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

7. Amend § 54.627 to delete subsections (c)(1) and (c)(2), renumber current subsection (c)(3) as subsection (c), and revise the new subsection (c)(1)(D), all to read as follows:

§ 54.627 Invoicing Process and Certifications.

(a) * * *

(1) * * *

(b) * * *

(c) *Telecommunications Program.*

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

(i) The health care provider must certify that:

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

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

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

(D) It has examined the invoice form and supporting documentation and that to the best of its

knowledge, information and belief, all statements of fact contained in the invoice form and supporting documentation are true;

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

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

(ii) The service provider must certify that:

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

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

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

(D) It is authorized to submit the invoice;

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

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

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

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

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

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

(d) * * *

APPENDIX B

PROPOSED RULES

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

PART 54 – UNIVERSAL SERVICE

1. Amend § 54.601 to add a new paragraph (c) to read as follows:

§ 54.601 Health care provider eligibility.

* * *

(c) *Conditional Approval of Eligibility*. (1) An entity that is not a public or non-profit health care provider may request and receive a conditional approval of eligibility from the Administrator if the entity satisfies the following requirements:

(i) The entity is or will be physically located in a rural area defined in §54.600(e) of this subpart by an estimated eligibility date or, for the HCF Program only, is not located in a rural area but is or will be a member of a majority-rural Healthcare Connect Fund Program consortium that satisfies the eligible rural health care provider composition requirement set forth in §54.607(b) of this subpart by the estimated eligibility date;

(ii) The entity must provide documentation showing that it will qualify as a public or non-profit health care provider as defined in §54.600(b) of this subpart by the estimated eligibility date; and

(iii) The estimated eligibility date must be in the same funding year as or in the next funding year of the date that the entity requests the conditional approval of eligibility.

(2) An entity that receives conditional approval of eligibility may conduct competitive bidding for the site. An entity engaging in competitive bidding with conditional approval of eligibility must provide a written notification to potential bidders that the entity's eligibility is conditional and specify the estimated eligibility date.

(3) An entity that receives conditional approval of eligibility may file a request for funding for the site during an application filing window opened for a funding year that ends after the estimated eligibility date. The Administrator shall not issue any funding commitments to applicants that have received conditional approval of eligibility only. Funding commitments may be issued only after such applicants receive formal approval of eligibility as described in paragraph (c)(4) of this section.

(4) An entity that receives conditional approval of eligibility is expected to notify the Administrator, along with supporting documentation for the eligibility, within 30 days of its actual eligibility date. The actual eligibility date is the date that the entity qualifies as a public or non-profit health care provider as defined in §54.600(b) of this subpart and may be a different date from the estimated eligibility date. The Administrator shall formally approve the entity's eligibility if the entity meets the requirements for a public or non-profit health care provider defined in §54.600(b) of this subpart, provided that the entity still satisfies the requirement under paragraph (c)(1)(i) of this section. Upon the entity receiving a formal approval of eligibility, the Administrator may issue funding commitments covering a time period that starts no earlier than the entity's actual eligibility date and that is within the funding year for which support was requested.

2. Amend § 54.604 by replacing paragraphs (a) – (d) to read as follows:

§ 54.604. Determining the urban rate.

(a) If a rural health care provider requests support for an eligible service to be funded from the Telecommunications Program the "urban rate" for that service shall be a rate no higher than the highest tariffed or publicly-available rate charged to a commercial customer for a functionally similar service in any city with a population of 50,000 or more in that state, calculated as if it were provided between two points within the city.

3. Amend § 54.605 by replacing paragraph (a) – (c) to read as follows:

§ 54.605. Determining the rural rate.

* * * * *

(a) The rural rate shall be used as described in this subpart to determine the credit or reimbursement due to a telecommunications carrier that provides eligible telecommunications services to eligible health care providers.

(1) The rural rate shall be the median of publicly available rates charged by other service providers for the same or functionally similar services over the same distance in the rural area where the health care provider is located (Method A).

(2) If there are no publicly available rates charged by other service providers for the same or functionally similar services, the rural rate shall be the median of the rates that the carrier actually charges to non-health care provider commercial customers for the same or functionally similar services provided in the rural area where the health care provider is located (Method B).

(3) *Cost-based rate.* If the telecommunications carrier serving the health care provider is not providing any identical or similar services in the rural area or it reasonably determines that the rural rate calculated under sections (a)(1) or (2) would not generate a reasonably compensatory rate, then the carrier shall submit to a state commission, for intrastate rates, or the Commission, for interstate rates, a cost-based rate for the provision of the service.

(i) The carrier must provide to the state commission, for intrastate rates, or the Commission, for interstate rates, a justification of the proposed rural rate, which must include all financial data and other information to verify the service provider's assertions, including at a minimum, the following information:

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

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

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

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

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

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

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

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

(I) Density characteristics of the rural area or other relevant geographical areas including square miles, road miles, mountains, bodies of water, lack of roads, remoteness, challenges and costs associated with transporting fuel, satellite and backhaul availability, extreme weather conditions, challenging topography, short construction season or any other characteristics that contribute to the high cost of servicing the health care providers.

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

(b) The rural rate shall not exceed the monthly rate in the service agreement that the health care provider enters into with the service provider when requesting funding.

(c) Service providers engaged in multi-year or evergreen contracts are required to justify the rural rate only in the first year of the contract.

4. Amend § 54.622(e)(1)(i) to read as follows:

§ 54.622 Competitive Bidding Requirements and Exemptions.

* * *

(e) * * *

(1) * * *

(i) The entity seeking supported services is a public or nonprofit health care provider that falls within one of the categories set forth in the definition of health care provider listed in § 54.600, or will be such a public or nonprofit health care provider before the end of the funding year for which the supported services are requested provided that the entity is requesting or has received a conditional approval of eligibility pursuant to § 54.601(c) of this subpart;

5. Amend § 54.625 by replacing paragraph (c) to read as follows:

§ 54.625 Service Provider Identification Number (SPIN) changes.

* * * * *

(c) *Filing Deadline*. An applicant must file its request for a corrective or operational SPIN change with the Administrator no later than the invoice filing deadline as defined by section 54.627.

APPENDIX C

Final Regulatory Flexibility Analysis

1. As required by the Regulatory Flexibility Act of 1980, as amended (RFA),[1] the Commission included an Initial Regulatory Flexibility Analysis (IRFA) of the possible significant economic impact on a substantial number of small entities by the policies and rules proposed in the February 2022 Further Notice of Proposed Rulemaking (*Further Notice*).[2] The Commission sought written public comment on the proposals in the *Further Notice* including comment on the IRFA. The Commission did not receive any relevant comments in response to this IRFA. This Final Regulatory Flexibility Analysis (FRFA) conforms to the RFA.[3]

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

2. Through this Second Report and Order, the Commission seeks to further improve the Rural Health Care (RHC) Program's capacity to distribute telecommunications and broadband support to health care providers– especially small, rural healthcare providers (HCPs) – in the most equitable and efficient manner as possible. Over the years, telehealth has become an increasingly vital component of healthcare delivery to rural Americans. Rural healthcare facilities are typically limited by the equipment and supplies they have and the scope of services they can offer which ultimately can have an impact on the availability of high-quality health care. Therefore, the RHC Program plays a critical role in overcoming some of the obstacles healthcare providers face in healthcare delivery in rural communities. Considering the significance of RHC Program support, the Commission implements several measures to most effectively meet HCPs' needs while responsibly distributing the RHC Program's limited funds.

3. In the Second Report and Order, we adopt proposals from the February 2022 *Further Notice* to amend RHC Program administrative processes and internal cap application and prioritization rules to promote efficiency, reduce delays in funding commitments, and prioritize support for the current funding year as well as make a minor technical change to the text of our rules.[4]

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

4. There were no comments filed that specifically address the rules and policies proposed in the IRFA.

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

5. Pursuant to the Small Business Jobs Act of 2010,[5] which amended the RFA, the Commission is required to respond to any comments filed by the Chief Counsel of the Small Business Administration (SBA), and to provide a detailed statement of any change made to the proposed rule(s) as a result of those comments.[6] The Chief Counsel did not file any comments in response to the proposed rule(s) in this proceeding.

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[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] *See Further Notice*, WC Docket No. 17-310, Further Notice of Proposed Rulemaking, FCC 22-15 (2022) (*Further Notice*).

[3] *See* 5 U.S.C. § 604.

[4] *See Further Notice* at paras 64-76.

[5] 5 U.S.C. § 604(a)(3).

[6] *Id*.

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

6. 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.[7] The RFA generally defines the term "small entity" as having the same meaning as the terms "small business," "small organization," and "small governmental jurisdiction."[8] In addition, the term "small business" has the same meaning as the term "small business concern" under the Small Business Act.[9] A "small business concern" is one that: (1) is independently owned and operated; (2) is not dominant in its field of operation; and (3) satisfies any additional criteria established by the Small Business Administration (SBA).[10]

7. *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.[11] First, while there are industry specific size standards for small businesses that are used in the regulatory flexibility analysis, according to data from the SBA's Office of Advocacy, in general a small business is an independent business having fewer than 500 employees.[12] These types of small businesses represent 99.9 percent of all businesses in the United States which translates to 31.7 million businesses.[13]

8. 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."[14] The Internal Revenue Service (IRS) uses a revenue benchmark of $50,000 or less to delineate its annual electronic filing requirements for small exempt organizations.[15] Nationwide, for tax year 2018, there were approximately 571,709 small exempt organizations in the U.S. reporting revenues of $50,000 or less according to the registration and tax data for exempt organizations available from the IRS.[16]

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[7] 5 U.S.C. § 603(b)(3).

[8] 5 U.S.C. § 601(6).

[9] 5 U.S.C. § 601(3) (incorporating by reference the definition of "small business concern" in 15 U.S.C. § 632). Pursuant to the RFA, the statutory definition of a small business applies "unless an agency, after consultation with the Office of Advocacy of the Small Business Administration and after opportunity for public comment, establishes one or more definitions of such term which are appropriate to the activities of the agency and publishes such definition(s) in the Federal Register." 5 U.S.C. § 601(3).

[10] *See* 15 U.S.C. § 632.

[11] *See* 5 U.S.C. § 601(3)-(6).

[12] *See* U.S. Small Business Administration, Office of Advocacy, *What's New With Small Business?* (Oct. 2020), https://cdn.advocacy.sba.gov/wp-content/uploads/2020/10/22094424/Whats-New-With-Small-Business-2020.pdf.

[13] *Id*.

[14] 5 U.S.C. § 601(4).

[15] The IRS benchmark is similar to the population of less than 50,000 benchmark in 5 U.S.C § 601(5) that is used to define a small governmental jurisdiction. Therefore, the IRS benchmark has been used to estimate the number small organizations in this small entity description. S*ee* IRS, *Annual Electronic Filing Requirement for Small Exempt Organizations — Form 990-N (e-Postcard), Who May File Form 990-N to Satisfy Their Annual Reporting Requirement*, https://www.irs.gov/charities-non-profits/annual-electronic-filing-requirement-for-small-exempt-organizations-form-990-n-e-postcard (last visited Jan. 26, 2023). We note that the IRS data does not provide information on whether a small exempt organization is independently owned and operated or dominant in its field.

[16] *See* Exempt Organizations Business Master File Extract (EO BMF), "CSV Files by Region," https://www.irs.gov/charities-non-profits/exempt-organizations-business-master-file-extract-eo-bmf. The IRS Exempt Organization Business Master File (EO BMF) Extract provides information on all registered tax-exempt/non-profit organizations. The data utilized for purposes of this description was extracted from the IRS EO

(continued….)

9. 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."[17] U.S. Census Bureau data from the 2017 Census of Governments[18] indicates that there were 90,075 local governmental jurisdictions consisting of general purpose governments and special purpose governments in the United States.[19] Of this number there were 39, 931 general purpose governments (county[20], municipal and town or township[21]) with populations of less than 50,000 and 12,040 special purpose governments (independent school districts[22]) with populations of less than 50,000.[23] Based on the 2017 U.S. Census Bureau data we estimate that at least 48, 971 entities fall in the category of "small governmental jurisdictions."[24]

10. Small entities potentially affected by the proposals herein include eligible rural non-profit and public health care providers and the eligible service providers offering them services, including telecommunications service providers, Internet Service Providers (ISPs), and vendors of the services and equipment used for dedicated broadband networks.[25]

(Continued from previous page)
BMF data for Region 1-Northeast Area (76,886), Region 2-Mid-Atlantic and Great Lakes Areas (221,121), and Region 3-Gulf Coast and Pacific Coast Areas (273,702) which includes the continental U.S., Alaska, and Hawaii. This data does not include information for Puerto Rico.

[17] 5 U.S.C. § 601(5).

[18] *See* 13 U.S.C. § 161. The Census of Governments survey is conducted every five (5) years compiling data for years ending with "2" and "7." *See also* Census of Governments, https://www.census.gov/programs-surveys/cog/about.html.

[19] *See* U.S. Census Bureau, 2017 Census of Governments – Organization Table 2. Local Governments by Type and State: 2017 [CG1700ORG02], https://www.census.gov/data/tables/2017/econ/gus/2017-governments.html. Local governmental jurisdictions are made up of general purpose governments (county, municipal and town or township) and special purpose governments (special districts and independent school districts). *See also* Table 2. CG1700ORG02 Table Notes Local Governments by Type and State_2017.

[20] *See id.* at Table 5. County Governments by Population-Size Group and State: 2017 [CG1700ORG05], https://www.census.gov/data/tables/2017/econ/gus/2017-governments.html. There were 2,105 county governments with populations less than 50,000. This category does not include subcounty (municipal and township) governments.

[21] *See id.* at Table 6. Subcounty General-Purpose Governments by Population-Size Group and State: 2017 [CG1700ORG06], https://www.census.gov/data/tables/2017/econ/gus/2017-governments.html. There were 18,729 municipal and 16,097 town and township governments with populations less than 50,000.

[22] *See id.* at Table 10. Elementary and Secondary School Systems by Enrollment-Size Group and State: 2017 [CG1700ORG10], https://www.census.gov/data/tables/2017/econ/gus/2017-governments.html. There were 12,040 independent school districts with enrollment populations less than 50,000. *See also* Table 4. Special-Purpose Local Governments by State Census Years 1942 to 2017 [CG1700ORG04], CG1700ORG04 Table Notes Special Purpose Local Governments by State Census Years 1942 to 2017.

[23] This total is derived from the sum of the number of general purpose governments (county, municipal and town or township) with populations of less than 50,000 (36,931) and the number of special purpose governments - independent school districts with enrollment populations of less than 50,000 (12,040), from the 2017 Census of Governments - Organizations Tables 5, 6, and 10. While the special purpose governments category also includes local special district governments, the 2017 Census of Governments data does not provide data aggregated based on population size for the special purpose governments category. Therefore, only data from independent school districts is included in the special purpose governments category.

[24] *Id.*

[25] 47 CFR §§ 54.601, 54.621.

1. Healthcare Providers

11. *Offices of Physicians (except Mental Health Specialists)*. This U.S. industry comprises establishments of health practitioners having the degree of M.D. (Doctor of Medicine) or D.O. (Doctor of Osteopathy) primarily engaged in the independent practice of general or specialized medicine (except psychiatry or psychoanalysis) or surgery. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.[26] The SBA has created a size standard for this industry, which is annual receipts of $12 million or less.[27] According to 2012 U.S. Economic Census, 152,468 firms operated throughout the entire year in this industry.[28] 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.[29] Based on this data, we conclude that a majority of firms operating in this industry are small under the applicable size 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.Sc. (Doctor of Dental Science) primarily engaged in the independent practice of general or specialized dentistry or dental surgery. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers. They can provide either comprehensive preventive, cosmetic, or emergency care, or specialize in a single field of dentistry.[30] The SBA has established a size standard for that industry of annual receipts of $8 million or less.[31] The 2012 U.S. Economic Census indicates that 115,268 firms operated in the dental industry throughout the entire year.[32] Of that number 114,417 had annual receipts of less than $5 million, while 651 firms had annual receipts between $5 million and $9,999,999.[33] 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

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[26] *See* U.S. Census Bureau, *2017 NAICS Definition, "621111 Offices of Physicians (except Mental Health Specialists)"* https://www.census.gov/naics/?input=621111&year=2017&details=621111.

[27] *See* 13 CFR § 121.201, NAICS Code 621111.

[28] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621111, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621111&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[29] *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 $12 million or less.

[30] *See* U.S. Census Bureau, *2017 NAICS Definition, "621210 Offices of Dentists"*, https://www.census.gov/naics/?input=621210&year=2017&details=621210.

[31] *See* 13 CFR § 121.201, NAICS Code 621210.

[32] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621210, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621210&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[33] *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 $8 million or less.

facilities of others, such as hospitals or HMO medical centers.[34] The SBA has established a size standard for this industry, which is annual receipts of $8 million or less.[35] The 2012 U.S. Economic Census statistics show that in 2012, 33,940 firms operated throughout the entire year.[36] 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.[37] Based on this 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.[38] The SBA has established a size standard for businesses operating in this industry, which is annual receipts of $8 million or less.[39] The 2012 Economic Census indicates that 18,050 firms operated the entire year.[40] 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.[41] Based on this data, we conclude that a majority of optometrists in this industry are small.

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.[42] The SBA has created a size standard for this industry, which is annual

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[34] *See* U.S. Census Bureau, 2017 NAICS Definition, "621310 "Offices of Chiropractors", https://www.census.gov/naics/?input=621310&year=2017&details=621310.

[35] *See* 13 CFR § 121.201, NAICS Code 621310.

[36] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S*: *2012*, NAICS Code 621310, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621310&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false&vintage=2012.

[37] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[38] *See* U.S. Census Bureau, *2017 NAICS Definition "621320 Offices of Optometrists",* https://www.census.gov/naics/?input=621320&year=2017&details=621320.

[39] *See* 13 CFR § 121.201, NAICS Code 621320.

[40] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621320, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621320&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[41] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[42] *See* U.S. Census Bureau, *2017 NAICS Definition, "621330 Offices of Mental Health Practitioners (except Physicians)"*, https://www.census.gov/naics/?input=621330&year=2017&details=621330.

receipts of $8 million or less. [43] The 2012 U.S. Economic Census indicates that 16,058 firms operated throughout the entire year.[44] 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.[45] 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.[46] The SBA has established a size standard for this industry, which is annual receipts of $8 million or less.[47] The 2012 U.S. Economic Census indicates that 20,567 firms in this industry operated throughout the entire year.[48] 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.[49] 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 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.[50] The SBA has established a size standard for businesses in this industry, which is annual receipts of $8 million or less.[51] The 2012 U.S. Economic Census indicates that 7,569 podiatry firms operated throughout the entire year.[52] Of that number, 7,545

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[43] *See* 13 CFR § 121.201, NAICS Code 621330.

[44] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621330, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[45] *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.

[46] *See* U.S. Census Bureau, *2017 NAICS Definition, "621340 Offices of Physical, Occupational and Speech Therapists and Audiologists",* https://www.census.gov/naics/?input=621340&year=2017&details=621340.

[47] *See* 13 CFR § 121.201, NAICS Code 621340.

[48] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621340, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[49] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $8 million or less.

[50] *See* U.S. Census Bureau, *2017 NAICS Definition, "621391 Offices of Podiatrists"*, https://www.census.gov/naics/?input=621391&year=2017&details=621391.

[51] *See* 13 CFR § 121.201, NAICS Code 621391.

[52] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621391,

(continued….)

firms had annual receipts of less than $5 million, while 22 firms had annual receipts between $5 million and $9,999,999.[53] 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.[54] The SBA has established a size standard for this industry, which is annual receipts of $8 million or less.[55] The 2012 U.S. Economic Census indicates that 11,460 firms operated throughout the entire year.[56] 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.[57] 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.[58] The SBA has established a size standard for this industry, which is annual receipts of $12 million or less.[59] The 2012 Economic Census indicates that 1,286 firms in this industry operated throughout the entire year.[60] Of that number 1,237 had annual receipts of less than $10 million, while 36 firms had annual receipts between $10 million and $24,999,999.[61] Based on this data, we conclude that the majority of firms in this industry is 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

(Continued from previous page)
https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621391&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false&vintage=2012.

[53] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $8 million or less.

[54] *See* U.S. Census Bureau, *2017 NAICS Definition, "621399 Offices of All Other Miscellaneous Health Practitioners"*, https://www.census.gov/naics/?input=621399&year=2017&details=621399.

[55] *See* 13 CFR § 121.201, NAICS Code 621399.

[56] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621399,
https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621399&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[57] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[58] *See* U.S. Census Bureau, *2017 NAICS Definition, "621410 Family Planning Centers",* https://www.census.gov/naics/?input=621410&year=2017&details=621410.

[59] *See* 13 CFR § 121.201, NAICS Code 621410.

[60] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621410,
https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621410&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[61] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $12 million or less.

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.[62] The SBA has established a size standard for this industry, which is $16.5 million or less in annual receipts.[63] The 2012 U.S. Economic Census indicates that 4,446 firms operated throughout the entire year.[64] 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.[65] 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 health maintenance organization (HMO) subscribers with a focus generally on primary health care. These establishments are owned by the HMO. Included in this industry are HMO establishments that both provide health care services and underwrite health and medical insurance policies.[66] The SBA has established a size standard for this industry, which is $35 million or less in annual receipts.[67] The 2012 U.S. Economic Census indicates that 14 firms in this industry operated throughout the entire year.[68] 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.[69] 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 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.[70] The SBA has

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[62] *See* U.S. Census Bureau, *2017 NAICS Definition, "621420 Outpatient Mental Health and Substance Abuse Centers"*, https://www.census.gov/naics/?input=621420&year=2017&details=621420.

[63] *See* 13 CFR § 121.201, NAICS Code 621420.

[64] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.*: *2012,* NAICS Code 621420, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621420&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[65] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[66] *See* U.S. Census Bureau, *2017 NAICS Definition, "621491 HMO Medical Centers",* https://www.census.gov/naics/?input=621491&year=2017&details=621491.

[67] *See* 13 CFR § 121.201, NAICS Code 621491.

[68] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621491, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621491&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[69] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[70] *See* U.S. Census Bureau, *2017 NAICS Definition, "621493 Freestanding Ambulatory Surgical and Emergency Centers"*, https://www.census.gov/naics/?input=621493&year=2017&details=621493.

established a size standard for this industry, which is annual receipts of $16.5 million or less.[71] The 2012 U.S. Economic Census indicates that 3,595 firms in this industry operated throughout the entire year.[72] 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.[73] 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.[74] The SBA has established a size standard for this industry, which is annual receipts of $22 million or less.[75] The 2012 U.S. Economic Census indicates that 4,903 firms operated in this industry throughout the entire year.[76] 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.[77] 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.[78] The SBA has established a size standard for this industry, which is annual receipts of $35 million or less.[79] The 2012 U.S. Economic Census indicates that 314 firms operated in this industry throughout the entire year.[80] Of that number, 235 operated with annual receipts of less than $25 million,

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[71] *See* 13 CFR § 121.201, NAICS Code 621493.

[72] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621493, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621493&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[73] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[74] *See* U.S. Census Bureau, *2017 NAICS Definition, "621498 All Other Outpatient Care Centers",* https://www.census.gov/naics/?input=621498&year=2017&details=621498.

[75] *See* 13 CFR § 121.201, NAICS Code 621498.

[76] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for* the U.S.: 2012, NAICS Code 621498, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621498&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[77] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[78] *See* U.S. Census Bureau, *2017 NAICS Definition*, *"621991 Blood and Organ Banks",* https://www.census.gov/naics/?input=621991&year=2017&details=621991.

[79] *See* 13 CFR § 121.201, NAICS Code 621991.

[80] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621991, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621991&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

while 41 firms had annual receipts between $25 million and $49,999,999.[81] 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).[82] The SBA has established a size standard for this industry, which is annual receipts of $16.5 million or less.[83] The 2012 U.S. Economic Census indicates that 2,429 firms operated in this industry throughout the entire year.[84] 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.[85] Based on this data, we conclude that a majority of the firms in this industry is 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.[86] The SBA has established a size standard for this industry, which is annual receipts of $35 million or less.[87] The 2012 U.S. Economic Census indicates that 2,599 firms operated in this industry throughout the entire year.[88] 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.[89] Based on this data, we conclude that a majority of firms that operate in this industry are small.

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.[90] The SBA has established size standard for this industry, which is annual receipts of $16.5 million or less.[91] The 2012 U.S. Economic Census indicates that 4,209 firms operated in

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[81] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[82] *See* U.S. Census Bureau, *2017 NAICS Definition, "621999 All Other Miscellaneous Ambulatory Health Care Services",* https://www.census.gov/naics/?input=621999&year=2017&details=621999.

[83] *See* 13 CFR § 121.201, NAICS Code 621999.

[84] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621999, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621999&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[85] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[86] *See* U.S. Census Bureau, *2017 NAICS Definition, "621511 Medical Laboratories",* https://www.census.gov/naics/?input=621511&year=2017&details=621511.

[87] *See* 13 CFR § 121.201, NAICS Code 621511.

[88] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.*: *2012*, NAICS Code 621511, https://www.census.gov/naics/?input=621511&year=2017&details=621511.

[89] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[90] *See* U.S. Census Bureau*, 2017 NAICS Definition, "621512 Diagnostic Imaging Centers",* https://www.census.gov/naics/?input=621512&year=2017&details=621512.

[91] *See* 13 CFR § 121.201, NAICS Code 621512.

this industry throughout the entire year.[92] 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.[93] 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.[94] The SBA has established a size standard for this industry, which is annual receipts of $16.5 million or less.[95] The 2012 U.S. Economic Census indicates that 17,770 firms operated in this industry throughout the entire year.[96] 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.[97] 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.[98] The SBA has established a size standard for this industry, which is annual receipts of $16.5 million or less.[99] The 2012 U.S. Economic Census indicates that 2,984 firms operated in this industry throughout the entire year.[100] 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.[101] Based on this data, we conclude that a majority of firms in this industry is small.

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[92] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for* the U.S.: 2012, NAICS Code 621512, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621512&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[93] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[94] *See* U.S. Census Bureau, *2017 NAICS Definition, "621610 Home Health Care Services",* https://www.census.gov/naics/?input=621610&year=2017&details=621610.

[95] *See* 13 CFR § 121.201, NAICS Code 621610.

[96] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S: 2012,* NAICS Code 621610, https://www.census.gov/naics/?input=621991&year=2017&details=6214991.

[97] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[98] *See* U.S. Census Bureau, *2017 NAICS Definition, "621910 Ambulance Services",* https://www.census.gov/naics/?input=621910&year=2017&details=621910.

[99] *See* 13 CFR § 121.201, NAICS Code 621910.

[100] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of* Firms for the U.S.: 2012, NAICS Code 621910, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621910&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[101] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

30. *Kidney Dialysis Centers*. This U.S. industry comprises establishments with medical staff primarily engaged in providing outpatient kidney or renal dialysis services.[102] The SBA has established assize standard for this industry, which is annual receipts of $41.5 million or less.[103] The 2012 U.S. Economic Census indicates that 396 firms operated in this industry throughout the entire year.[104] 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.[105] 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.[106] The SBA has established a size standard for this industry, which is annual receipts of $41.5 million or less.[107] The 2012 U.S. Economic Census indicates that 2,800 firms operated in this industry throughout the entire year.[108] Of that number, 877 has annual receipts of less than $25 million, while 400 firms had annual receipts between $25 million and $49,999,999.[109] 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,

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[102] *See* U.S. Census Bureau, *2017 NAICS Definition, "621492 Kidney Dialysis Centers"*, https://www.census.gov/naics/?input=621492&year=2017&details=621492.

[103] *See* 13 CFR § 121.201, NAICS Code 621492.

[104] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.*: *2012*, NAICS Code 621492, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621492&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false&vintage=2012.

[105] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[106] *See* U.S. Census Bureau, *2017 NAICS Definition, "622110 General Medical and Surgical Hospitals",* https://www.census.gov/naics/?input=622110&year=2017&details=622110.

[107] *See* 13 CFR § 121.201, NAICS Code 622110.

[108] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 622110, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=622110&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false&vintage=2012.

[109] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $41.5 million or less.

diagnostic X-ray services, and electroencephalograph services.[110] The SBA has established a size standard for this industry, which is annual receipts of $41.5 million or less.[111] The 2012 U.S. Economic Census indicates that 404 firms operated in this industry throughout the entire year.[112] 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.[113] 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 adjustive services to physically challenged or disabled people are included in this industry. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements. They have an organized staff of physicians and other medical staff to provide patient care services. These hospitals may provide other services, such as outpatient services, diagnostic X-ray services, clinical laboratory services, operating room services, physical therapy services, educational and vocational services, and psychological and social work services.[114] The SBA has established a size standard for this industry, which is annual receipts of $41.5 million or less.[115] The 2012 U.S. Economic Census indicates that 346 firms operated in this industry throughout the entire year.[116] Of that number, 146 firms had annual receipts of less than $25 million, while 79 firms had annual receipts between $25 million and $49,999,999.[117] 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). [118] The SBA has established a size standard for

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[110] *See* U.S. Census Bureau, *2017 NAICS Definition, "622210 Psychiatric and Substance Abuse Hospitals"*, https://www.census.gov/naics/?input=622210&year=2017&details=622210.

[111] *See* 13 CFR § 121.201, NAICS Code 622210.

[112] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.*: *2012*, NAICS Code 622210, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=622210&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[113] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[114] *See* U.S. Census Bureau*, 2017 NAICS Definition, "622310 Specialty (Except Psychiatric and Substance Abuse) Hospitals"*, https://www.census.gov/naics/?input=622310&year=2017&details=622310.

[115] *See* 13 CFR § 121.201 NAICS Code 622310.

[116] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 622310, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=622310&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false&vintage=2012.

[117] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[118] *See* U.S. Census Bureau, *2017 NAICS Definition, "624230 Emergency and Other Relief Services",* https://www.census.gov/naics/?input=624230&year=2017&details=624230.

this industry which is annual receipts of $35 million or less.[119] The 2012 U.S. Economic Census indicates that 541 firms operated in this industry throughout the entire year.[120] 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.[121] 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.[122] Under the applicable 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 the entire year.[124] Of this total, 3,083 operated with fewer than 1,000 employees.[125] 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.[126] Of this total, an estimated 1,006 have 1,500 or fewer employees.[127] Thus, using the SBA's size standard the majority of incumbent LECs can be considered small entities.

36. *Interexchange Carriers (IXCs)*. Neither the Commission nor the SBA has developed a small business size standard specifically for Interexchange Carriers. The closest applicable NAICS Code category is Wired Telecommunications Carriers.[128] The applicable size standard under SBA rules is that such a business is small if it has 1,500 or fewer employees.[129] U.S. Census Bureau data for 2012 indicate

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[119] *See* 13 CFR § 121.201, NAICS Code 624230.

[120] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 624230, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=624230&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[121] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[122] *See* U.S. Census Bureau, *2017 NAICS Definition, "517311 Wired Telecommunications Carriers"*, https://www.census.gov/naics/?input=517311&year=2017&details=517311.

[123] *See* 13 CFR § 121.201, NAICS Code 517311 (previously 517110).

[124] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms for the U.S.: 2012,* NAICS Code 517110, https://data.census.gov/cedsci/table?text=EC1251SSSZ5&n=517110&tid=ECNSIZE2012.EC1251SSSZ5&hidePreview=false.

[125] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

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

[127] *Id*.

[128] *See* U.S. Census Bureau, *2017 NAICS Definition, "517311 Wired Telecommunications Carriers",* https://www.census.gov/naics/?input=517311&year=2017&details=517311.

[129] *See* 13 CFR § 121.201, NAICS Code 517311 (previously 517110).

that 3,117 firms operated for the entire year.[130] Of that number, 3,083 operated with fewer than 1,000 employees.[131] According to internally developed Commission data, 359 companies reported that their primary telecommunications service activity was the provision of interexchange services.[132] Of this total, an estimated 317 have 1,500 or fewer employees.[133] Consequently, the Commission estimates that the majority of interexchange service providers 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.[134] U.S. Census Bureau data for 2012 indicates that 3,117 firms operated during that year.[135] Of that number, 3,083 operated with fewer than 1,000 employees.[136] 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.[137] 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.[138] 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 facilities that they operate to provide a variety of services, such as wired telephony services, including voice over Internet protocol (VoIP) services; wired (cable) audio and video programming distribution; and wired broadband internet services. By exception, establishments providing satellite television

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[130] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms for the U.S.: 2012,* NAICS Code 517110, https://data.census.gov/cedsci/table?text=EC1251SSSZ5&n=517110&tid=ECNSIZE2012.EC1251SSSZ5&hidePreview=false.

[131] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

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

[133] *Id*.

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

[135] *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.

[136] *Id*.

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

[138] *Id.*

distribution services using facilities and infrastructure that they operate are included in this industry."[139] 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.[140] U.S. Census data for 2012 show that there were 3,117 firms that operated that year.[141] Of this total, 3,083 operated with fewer than 1,000 employees.[142] 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.[143] The appropriate size standard under SBA rules is that such a business is small if it has 1,500 or fewer employees.[144] For this industry, U.S. Census Bureau data for 2012 show that there were 967 firms that operated for the entire year.[145] Of this total, 955 firms employed fewer than 1,000 employees and 12 firms employed of 1000 employees or more.[146] 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 August 31, 2018, there are 265 Cellular licensees that will be affected by our actions.[147] The Commission does not know how many of these licensees are small, as the Commission does not collect that information for these types of entities. Similarly, according to internally developed Commission data, 413 carriers reported that they were engaged in the provision of wireless telephony, including cellular service, Personal Communications Service (PCS), and Specialized Mobile Radio (SMR) Telephony services.[148] Of this total, an estimated 261 have 1,500 or fewer employees, and 152 have more

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[139] *See* 13 CFR § 120.201. The Wired Telecommunications Carrier category formerly used the NAICS code of 517110. As of 2017 the U.S. Census Bureau definition shows the NAICS code as 517311 for Wired Telecommunications Carriers. *See* https://www.census.gov/naics/?input=517911&year=2017&details=517911.

[140] *See* 13 CFR § 120.201, NAICS Code 517311.

[141] *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://data.census.gov/cedsci/table?text=EC1251SSSZ5&n=517110&tid=ECNSIZE2012.EC1251SSSZ5&hidePreview=false.

[142] *Id.*

[143] *See* U.S. Census Bureau, *2017 NAICS Definition, "517312 Wireless Telecommunications Carriers (except Satellite)",* https://www.census.gov/naics/?input=517312&year=2017&details=517312.

[144] *See* 13 CFR § 121.201, NAICS Code 517312 (previously 517210).

[145] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1251SSSZ5, *Information: Subject Series: Estab and Firm Size: Employment Size of Firms for the U.S.: 2012*, NAICS Code 517210, https://data.census.gov/cedsci/table?text=EC1251SSSZ5&n=517210&tid=ECNSIZE2012.EC1251SSSZ5&hidePreview=false&vintage=2012.

[146] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[147] *See* Federal Communications Commission, *Universal Licensing System*, http://wireless.fcc.gov/uls. 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.

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

than 1,500 employees.[149] 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).[150] Under the SBA small business size standard, a business is small if it has 1,500 or fewer employees.[151] For this industry, U.S. Census Bureau data for 2012 show that there were 967 firms that operated for the entire year.[152] Of this total, 955 firms had fewer than 1,000 employees and 12 firms had 1000 employees or more.[153] 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.[154] Of these, an estimated 261 have 1,500 or fewer employees and 152 have more than 1,500 employees.[155] 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."[156] Satellite telecommunications service providers include satellite and earth station operators. The category has a small business size standard of $35 million or less in average annual receipts, under SBA rules.[157] For this category, U.S. Census Bureau data for 2012 show that there were a total of 333 firms that operated for the entire year.[158] Of this total, 299 firms had annual receipts of less than $25 million.[159] 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 primarily engaged in providing specialized telecommunications services,

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[149] *See id*.

[150] *See* U.S. Census Bureau, *2017 NAICS Definition, "517312 Wireless Telecommunications Carriers (except Satellite)*", https://www.census.gov/naics/?input=517312&year=2017&details=517312.

[151] *See* 13 CFR § 121.201, NAICS Code 517312 (previously 517210).

[152] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1251SSSZ5, *Information: Subject Series: Estab and Firm Size: Employment Size of Firms for the U.S.: 2012*, NAICS Code 517210, https://data.census.gov/cedsci/table?text=EC1251SSSZ5&n=517210&tid=ECNSIZE2012.EC1251SSSZ5&hidePreview=false&vintage=2012.

[153] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

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

[155] *Id*.

[156] *See* U.S. Census Bureau, *2017 NAICS Definition, "517410 Satellite Telecommunications",* https://www.census.gov/naics/?input=517410&year=2017&details=517410.

[157] *See* 13 CFR § 121.201, NAICS Code 517410.

[158] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1251SSSZ4, *Information: Subject Series - Estab and Firm Size: Receipts Size of Firms for the U.S.: 2012*, NAICS Code 517410, https://data.census.gov/cedsci/table?text=EC1251SSSZ4&n=517410&tid=ECNSIZE2012.EC1251SSSZ4&hidePreview=false&vintage=2012.

[159] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

such as satellite tracking, communications telemetry, and radar station operation.[160] 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.[161] Establishments providing Internet services or voice over Internet protocol (VoIP) services via client-supplied telecommunications connections are also included in this industry.[162] The SBA has developed a small business size standard for "All Other Telecommunications," which consists of all such firms with annual receipts of $35 million or less.[163] For this category, U.S. Census Bureau data for 2012 show that there were 1,442 firms that operated for the entire year.[164] Of those firms, a total of 1,400 had annual receipts less than $25 million and 15 firms had annual receipts of $25 million to $49, 999,999.[165] Thus, the Commission estimates that the 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.[166] 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.[167] The SBA size standard for this category classifies a business as small if it has 1,500 or fewer employees.[168] U.S. Census Bureau data for 2012 show that there were 3,117 firms that operated that year.[169] Of this total, 3,083 operated with fewer than 1,000 employees.[170] Consequently, under this size standard the majority of firms in this industry can be considered small.

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[160] *See* U.S. Census Bureau, *2017 NAICS Definition*, "*517919 All Other Telecommunications*", https://www.census.gov/naics/?input=517919&year=2017&details=517919.

[161] *Id.*

[162] *Id*.

[163] *See* 13 CFR § 121.201, NAICS Code 517919.

[164] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1251SSSZ4, *Information: Subject Series - Estab and Firm Size: Receipts Size of Firms for the U.S.: 2012*, NAICS Code 517919, https://data.census.gov/cedsci/table?text=EC1251SSSZ4&n=517919&tid=ECNSIZE2012.EC1251SSSZ4&hidePreview=false.

[165] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

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

[167] *Id.*

[168] *See* 13 CFR § 121.201, NAICS Code 517311 (previously 517110).

[169] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms for the U.S.*: *2012*, NAICS Code 517110, https://data.census.gov/cedsci/table?text=EC1251SSSZ5&n=517110&tid=ECNSIZE2012.EC1251SSSZ5&hidePreview=false.

[170] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

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., dial-up ISPs) fall in the category of All Other Telecommunications.[171] The SBA has developed a small business size standard for All Other Telecommunications which consists of all such firms with gross annual receipts of $35 million or less.[172] For this category, U.S. Census Bureau data for 2012 show that there were 1,442 firms that operated for the entire year.[173] Of these firms, a total of 1,400 had gross annual receipts of less than $25 million.[174] 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 less[175] and "Other Communications Equipment Manufacturing" with a size standard of 750 employees or less."[176] U.S. Census Bureau data for 2012 shows that for Radio and Television Broadcasting and Wireless Communications Equipment firms 841 establishments operated for the entire year.[177] Of that number, 828 establishments operated with fewer than 1,000 employees, and 7 establishments operated with between 1,000 and 2,499 employees.[178] For Other Communications Equipment Manufacturing, U.S. Census Bureau data for 2012, show that 383 establishments operated for

[171] *See* U.S. Census Bureau, *2017 NAICS Definition, "517919 All Other Telecommunications",* https://www.census.gov/naics/?input=517919&year=2017&details=517919.

[172] *See* 13 CFR § 121.201, NAICS Code 517919.

[173] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1251SSSZ4, *Information: Subject Series - Estab and Firm Size: Receipts Size of Firms for the U.S.: 2012*, NAICS Code 517919, https://data.census.gov/cedsci/table?text=EC1251SSSZ4&n=517919&tid=ECNSIZE2012.EC1251SSSZ4&hidePreview=false.

[174] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[175] *See* 13 CFR § 121.201, NAICS Code 334220; *see also* U.S. Census Bureau, *2017 NAICS Definition, "334220 Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing",* https://www.census.gov/naics/?input=334220&year=2017&details=334220.

[176] *See* 13 CFR § 121.201, NAICS Code 334290; *see also* U.S. Census Bureau, *2017 NAICS Definition, "334290 Other Communications Equipment Manufacturing"*, https://www.census.gov/naics/?input=334290&year=2017&details=334290.

[177] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012*, NAICS Code 334220, https://data.census.gov/cedsci/table?tid=ECNSIZE2012.EC1231SG2&y=2012&n=334220&vintage=2012&hidePreview=false.

[178] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of establishments that meet the SBA size standard of employment of 1,250 or fewer employees. 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." An establishment is a single physical location at which business is conducted and/or services are provided. It is not necessarily identical with a single firm, company or enterprise, which may consist of one or more establishments. Thus, the numbers given may reflect inflated numbers of businesses in this category, including the number of small businesses. U.S. Census Bureau data does not provide information on the number of firms for this industry.

the year.[179] Of that number 379 operated with fewer than 500 employees and 4 had 500 to 999 employees.[180] 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.[181] These products may be stand-alone or board-level components of a larger system. Examples of products made by these establishments are central office switching equipment, cordless and wire telephones (except cellular), PBX equipment, telephone answering machines, LAN modems, multi-user modems, and other data communications equipment, such as bridges, routers, and gateways.[182] The SBA has developed a small business size standard for Telephone Apparatus Manufacturing, which consists of all such companies having 1,250 or fewer employees.[183] U.S. Census Bureau data for 2012 show that there were 266 establishments that operated that year.[184] Of this total, 262 operated with fewer than 1,000 employees.[185] Thus, under this size standard, the majority of firms in this industry 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.[186] Examples of products made by these establishments are: transmitting and receiving antennas, cable television equipment, GPS equipment,

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[179] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012*, NAICS Code 334290, https://data.census.gov/cedsci/table?tid=ECNSIZE2012.EC1231SG2&y=2012&n=334290&vintage=2012&hidePreview=false.

[180] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of establishments that meet the SBA size standard of employment of 750 or fewer employees. 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." An establishment is a single physical location at which business is conducted and/or services are provided. It is not necessarily identical with a single firm, company or enterprise, which may consist of one or more establishments. Thus, the numbers given may reflect inflated numbers of businesses in this category, including the number of small businesses. U.S. Census Bureau data does not provide information on the number of firms for this industry.

[181] *See* U.S. Census Bureau, *2017 NAICS Definition, "334210 Telephone Apparatus Manufacturing,"* https://www.census.gov/naics/?input=334210&year=2017&details=334210.

[182] *Id.*

[183] *See* 13 CFR § 121.201, NAICS Code 334210.

[184] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012,* NAICS Code 334210, https://data.census.gov/cedsci/table?n=334210&tid=ECNSIZE2012.EC1231SG2&hidePreview=false&vintage=2012. 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." An establishment is a single physical location at which business is conducted and/or services are provided. It is not necessarily identical with a single firm, company or enterprise, which may consist of one or more establishments. Thus, the numbers given may reflect inflated numbers of businesses in this category, including the number of small businesses. U.S. Census Bureau data does not provide information on the number of firms for this industry.

[185] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of establishments that meet the SBA size standard of employment of 1,250 or fewer employees.

[186] *See* U.S. Census Bureau, *2017 NAICS Definitions, "334220 Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing*", https://www.census.gov/naics/?input=334220&year=2017&details=334220.

pagers, cellular phones, mobile communications equipment, and radio and television studio and broadcasting equipment.[187] The SBA has established a small business size standard for this industry of 1,250 or fewer employees.[188] U.S. Census Bureau data for 2012 show that 841 establishments operated in this industry in that year.[189] 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.[190] 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 apparatus, and radio and television broadcast, and wireless communications equipment).[191] 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.[192] The SBA has established a size standard for this industry as all such firms having 750 or fewer employees.[193] U.S. Census Bureau data for 2012 shows that 383 establishments operated in that year.[194] Of that number, 379 operated with fewer than 500 employees and 4 had 500 to 999 employees.[195] 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. The rules adopted in the Second Report and Order will not result in modified reporting, recordkeeping, or other compliance requirements for small or large entities.

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,

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[187] *Id*.

[188] *See* 13 CFR § 121.201, NAICS Code 334220.

[189] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012*, NAICS Code 334220, https://data.census.gov/cedsci/table?text=EC1231SG2&n=334220&tid=ECNSIZE2012.EC1231SG2&hidePreview=false.

[190] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[191] *See* U.S. Census Bureau, *2017 NAICS Definition, "334290 Other Communications Equipment Manufacturing*", https://www.census.gov/naics/?input=334290&year=2017&details=334290.

[192] *Id.*

[193] *See* 13 CFR 121.201, NAICS Code 334290.

[194] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size*: *2012*, NAICS Code 334290, https://data.census.gov/cedsci/table?text=EC1231SG2&n=334290&tid=ECNSIZE2012.EC1231SG2&hidePreview=false&vintage=2012.

[195] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

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."[196]

52. In this Second Report and Order, we take steps to minimize the economic impact on small entities with the rule changes that we have adopted. We amend our invoicing process to harmonize the process across the Telecom Program and the HCF Program. We minimize the impact of this change on small entities by ensuring that there is a mechanism to allow multiple invoices to be filed in a single submission. We also amend our funding cap and prioritization rules to limit the application of the internal cap and prioritize health care providers' current year financial need over their future year need when the internal cap is exceeded. This change will help small entities by reducing the instances in which the internal cap applies and prioritizing funding for the current funding year when it does. These actions will promote efficiency, reduce delays in funding commitments, and minimize the possibility that some health care providers may not receive their current year's support in the event of prioritization to upfront payment and multi-year commitment requests, while strengthening protections against waste, fraud and abuse.

G. Report to Congress

53. The Commission will send a copy of the Second Report and Order, including this FRFA, in a report to be sent to Congress and the Government Accountability Office pursuant to the Small Business Regulatory Enforcement Fairness Act of 1996.[197] In addition, the Commission will send a copy of the Second Report and Order, including the FRFA, to the Chief Counsel for Advocacy of the Small Business Administration. A copy of the Second Report and Order and FRFA (or summaries thereof) will also be published in the Federal Register.

[196] 5 U.S.C. § 603(c)(1) - (4).

[197] 5 U.S.C. § 801(a)(1)(A).

APPENDIX D

Initial Regulatory Flexibility Analysis

1. As required by the Regulatory Flexibility Act of 1980, as amended (RFA),[1] the Commission has prepared this Initial Regulatory Flexibility Analysis (IRFA) of the possible significant economic impact on a substantial number of small entities by the policies and rules proposed in the Second Further Notice of Proposed Rulemaking (*Second Further Notice*). Written public comments are requested on this IRFA. Comments must be identified as responses to the IRFA and must be filed by the deadlines for comments on the *Second Further Notice* provided on the first page of the item. The Commission will send a copy of the *Second Further Notice*, including this IRFA, to the Chief Counsel for Advocacy of the Small Business Administration (SBA).[2] In addition, the *Second Further Notice* and IRFA (or summaries thereof) will be published in the Federal Register.[3]

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

2. Through this *Second Further Notice*, the Commission seeks to further improve the Rural Health Care (RHC) Program's capacity to distribute telecommunications and broadband support to health care providers– especially small, rural healthcare providers (HCPs) – in the most equitable and efficient manner as possible. Over the years, telehealth has become an increasingly vital component of healthcare delivery to rural Americans. Rural healthcare facilities are typically limited by the equipment and supplies they have and the scope of services they can offer which ultimately can have an impact on the availability of high-quality health care. Therefore, the RHC Program plays a critical role in overcoming some of the obstacles healthcare providers face in healthcare delivery in rural communities. Considering the significance of RHC Program support, the Commission proposes and seeks comment on several measures to most effectively meet HCPs' needs while responsibly distributing the RHC Program's limited funds.

3. In this Second Further Notice of Proposed Rulemaking, we seek comment on proposed revisions to rate determination rules, the cap on support for satellite services, and revisions to data collected in the Telecom Program. We also propose changes to allow health care providers to receive funding shortly after they become eligible, allow participants with multi-year and evergreen contracts to only justify rural rates in the first year of the contract, and propose changes to administrative deadlines such as changes to amend program rules to align the deadline for filing a Service Provider Identification Number (SPIN) change with the invoice deadline.

B. Legal Basis

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

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

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

[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] *See* 5 U.S.C. § 603(a).

[3] *See id.*

[4] 5 U.S.C. § 603(b)(3).

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 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 regulatory flexibility analysis, according to data from the SBA's Office of Advocacy, in general a small business is an independent business having fewer than 500 employees.[9] These types of small businesses represent 99.9 percent of all businesses in the United States which translates to 31.7 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] The Internal Revenue Service (IRS) uses a revenue benchmark of $50,000 or less to delineate its annual electronic filing requirements for small exempt organizations.[12] Nationwide, for tax year 2018, there were approximately 571,709 small exempt organizations in the U.S. reporting revenues of $50,000 or less according to the registration and tax data for exempt organizations available from the IRS.[13]

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

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[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 one or more definitions of such term which are appropriate to the activities of the agency and publishes such definition(s) in the Federal Register." 5 U.S.C. § 601(3).

[7] *See* 15 U.S.C. § 632.

[8] *See* 5 U.S.C. § 601(3)-(6).

[9] *See* U.S. Small Business Administration, Office of Advocacy, *What's New With Small Business?* (Oct. 2020), https://cdn.advocacy.sba.gov/wp-content/uploads/2020/10/22094424/Whats-New-With-Small-Business-2020.pdf.

[10] *Id*.

[11] 5 U.S.C. § 601(4).

[12] The IRS benchmark is similar to the population of less than 50,000 benchmark in 5 U.S.C § 601(5) that is used to define a small governmental jurisdiction. Therefore, the IRS benchmark has been used to estimate the number small organizations in this small entity description. S*ee* IRS, *Annual Electronic Filing Requirement for Small Exempt Organizations — Form 990-N (e-Postcard), Who May File Form 990-N to Satisfy Their Annual Reporting Requirement*, https://www.irs.gov/charities-non-profits/annual-electronic-filing-requirement-for-small-exempt-organizations-form-990-n-e-postcard (last visited Jan. 26, 2023). We note that the IRS data does not provide information on whether a small exempt organization is independently owned and operated or dominant in its field.

[13] *See* Exempt Organizations Business Master File Extract (EO BMF), "CSV Files by Region," https://www.irs.gov/charities-non-profits/exempt-organizations-business-master-file-extract-eo-bmf. The IRS Exempt Organization Business Master File (EO BMF) Extract provides information on all registered tax-exempt/non-profit organizations. The data utilized for purposes of this description was extracted from the IRS EO BMF data for Region 1-Northeast Area (76,886), Region 2-Mid-Atlantic and Great Lakes Areas (221,121), and Region 3-Gulf Coast and Pacific Coast Areas (273,702) which includes the continental U.S., Alaska, and Hawaii. This data does not include information for Puerto Rico.

districts, with a population of less than fifty thousand."[14] U.S. Census Bureau data from the 2017 Census of Governments[15] indicates that there were 90,075 local governmental jurisdictions consisting of general purpose governments and special purpose governments in the United States.[16] Of this number there were 39, 931 general purpose governments (county[17], municipal and town or township[18]) with populations of less than 50,000 and 12,040 special purpose governments (independent school districts[19]) with populations of less than 50,000.[20] Based on the 2017 U.S. Census Bureau data we estimate that at least 48, 971 entities fall in the category of "small governmental jurisdictions."[21]

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

1. Healthcare 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 HMO medical

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[14] 5 U.S.C. § 601(5).

[15] *See* 13 U.S.C. § 161. The Census of Governments survey is conducted every five (5) years compiling data for years ending with "2" and "7." *See also* Census of Governments, https://www.census.gov/programs-surveys/cog/about.html.

[16] *See* U.S. Census Bureau, 2017 Census of Governments – Organization Table 2. Local Governments by Type and State: 2017 [CG1700ORG02], https://www.census.gov/data/tables/2017/econ/gus/2017-governments.html. Local governmental jurisdictions are made up of general purpose governments (county, municipal and town or township) and special purpose governments (special districts and independent school districts). *See also* Table 2. CG1700ORG02 Table Notes Local Governments by Type and State_2017.

[17] *See id.* at Table 5. County Governments by Population-Size Group and State: 2017 [CG1700ORG05], https://www.census.gov/data/tables/2017/econ/gus/2017-governments.html. There were 2,105 county governments with populations less than 50,000. This category does not include subcounty (municipal and township) governments.

[18] *See id.* at Table 6. Subcounty General-Purpose Governments by Population-Size Group and State: 2017 [CG1700ORG06], https://www.census.gov/data/tables/2017/econ/gus/2017-governments.html. There were 18,729 municipal and 16,097 town and township governments with populations less than 50,000.

[19] *See id.* at Table 10. Elementary and Secondary School Systems by Enrollment-Size Group and State: 2017 [CG1700ORG10], https://www.census.gov/data/tables/2017/econ/gus/2017-governments.html. There were 12,040 independent school districts with enrollment populations less than 50,000. *See also* Table 4. Special-Purpose Local Governments by State Census Years 1942 to 2017 [CG1700ORG04], CG1700ORG04 Table Notes Special Purpose Local Governments by State Census Years 1942 to 2017.

[20] This total is derived from the sum of the number of general purpose governments (county, municipal and town or township) with populations of less than 50,000 (36,931) and the number of special purpose governments - independent school districts with enrollment populations of less than 50,000 (12,040), from the 2017 Census of Governments - Organizations Tables 5, 6, and 10. While the special purpose governments category also includes local special district governments, the 2017 Census of Governments data does not provide data aggregated based on population size for the special purpose governments category. Therefore, only data from independent school districts is included in the special purpose governments category.

[21] *Id.*

[22] 47 CFR §§ 54.601, 54.621.

centers.[23] The SBA has created a size standard for this industry, which is annual receipts of $12 million or less.[24] According to 2012 U.S. Economic Census, 152,468 firms 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 Dentists*. This U.S. industry comprises establishments of health practitioners having the degree of D.M.D. (Doctor of Dental Medicine), D.D.S. (Doctor of Dental Surgery), or D.D.Sc. (Doctor of Dental Science) primarily engaged in the independent practice of general or specialized dentistry or dental surgery. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers. They can provide either comprehensive preventive, cosmetic, or emergency care, or specialize in a single field of dentistry.[27] The SBA has established a size standard for that industry of annual receipts of $8 million or less.[28] The 2012 U.S. Economic Census indicates that 115,268 firms operated in the dental industry throughout the entire year.[29] Of that number 114,417 had annual receipts of less than $5 million, while 651 firms had annual receipts between $5 million and $9,999,999.[30] Based on this data, we conclude that a majority of business in the dental industry are small under the applicable standard.

12. *Offices of Chiropractors*. This U.S. industry comprises establishments of health practitioners having the degree of D.C. (Doctor of Chiropractic) primarily engaged in the independent practice of chiropractic. These practitioners provide diagnostic and therapeutic treatment of neuromusculoskeletal and related disorders through the manipulation and adjustment of the spinal column and extremities, and operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.[31] The SBA has established a size standard for this industry, which is annual receipts of $8 million or less.[32] The 2012 U.S. Economic Census

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[23] *See* U.S. Census Bureau, *2017 NAICS Definition, "621111 Offices of Physicians (except Mental Health Specialists)"* https://www.census.gov/naics/?input=621111&year=2017&details=621111.

[24] *See* 13 CFR § 121.201, NAICS Code 621111.

[25] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621111, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621111&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[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 $12 million or less.

[27] *See* U.S. Census Bureau, *2017 NAICS Definition, "621210 Offices of Dentists"*, https://www.census.gov/naics/?input=621210&year=2017&details=621210.

[28] *See* 13 CFR § 121.201, NAICS Code 621210.

[29] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621210, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621210&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[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 $8 million or less.

[31] *See* U.S. Census Bureau, 2017 NAICS Definition, "621310 "Offices of Chiropractors", https://www.census.gov/naics/?input=621310&year=2017&details=621310.

[32] *See* 13 CFR § 121.201, NAICS Code 621310.

statistics show that in 2012, 33,940 firms operated throughout the entire year.[33] 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.[34] Based on this data, we conclude that a majority of chiropractors are small.

13. *Offices of Optometrists*. This U.S. industry comprises establishments of health practitioners having the degree of O.D. (Doctor of Optometry) primarily engaged in the independent practice of optometry. These practitioners examine, diagnose, treat, and manage diseases and disorders of the visual system, the eye and associated structures as well as diagnose related systemic conditions. Offices of optometrists prescribe and/or provide eyeglasses, contact lenses, low vision aids, and vision therapy. They operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers, and may also provide the same services as opticians, such as selling and fitting prescription eyeglasses and contact lenses.[35] The SBA has established a size standard for businesses operating in this industry, which is annual receipts of $8 million or less.[36] The 2012 Economic Census indicates that 18,050 firms operated the entire year.[37] 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.[38] Based on this data, we conclude that a majority of optometrists in this industry are small.

14. *Offices of Mental Health Practitioners (except Physicians)*. This U.S. industry comprises establishments of independent mental health practitioners (except physicians) primarily engaged in (1) the diagnosis and treatment of mental, emotional, and behavioral disorders and/or (2) the diagnosis and treatment of individual or group social dysfunction brought about by such causes as mental illness, alcohol and substance abuse, physical and emotional trauma, or stress. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.[39] The SBA has created a size standard for this industry, which is annual receipts of $8 million or less. [40] The 2012 U.S. Economic Census indicates that 16,058 firms operated throughout the entire year.[41] Of that number, 15,894 firms received annual receipts of less than $5

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[33] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S*: *2012*, NAICS Code 621310, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621310&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false&vintage=2012.

[34] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[35] *See* U.S. Census Bureau, *2017 NAICS Definition "621320 Offices of Optometrists",* https://www.census.gov/naics/?input=621320&year=2017&details=621320.

[36] *See* 13 CFR § 121.201, NAICS Code 621320.

[37] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621320, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621320&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[38] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[39] *See* U.S. Census Bureau, *2017 NAICS Definition, "621330 Offices of Mental Health Practitioners (except Physicians)"*, https://www.census.gov/naics/?input=621330&year=2017&details=621330.

[40] *See* 13 CFR § 121.201, NAICS Code 621330.

[41] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621330, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

million, while 111 firms had annual receipts between $5 million and $9,999,999.[42] Based on this data, we conclude that a majority of mental health practitioners who do not employ physicians are small.

15. *Offices of Physical, Occupational and Speech Therapists and Audiologists*. This U.S. industry comprises establishments of independent health practitioners primarily engaged in one of the following: (1) providing physical therapy services to patients who have impairments, functional limitations, disabilities, or changes in physical functions and health status resulting from injury, disease or other causes, or who require prevention, wellness or fitness services; (2) planning and administering educational, recreational, and social activities designed to help patients or individuals with disabilities, regain physical or mental functioning or to adapt to their disabilities; and (3) diagnosing and treating speech, language, or hearing problems. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.[43] The SBA has established a size standard for this industry, which is annual receipts of $8 million or less.[44] The 2012 U.S. Economic Census indicates that 20,567 firms in this industry operated throughout the entire year.[45] 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.[46] Based on this data, we conclude that a majority of businesses in this industry are small.

16. *Offices of Podiatrists*. This U.S. industry comprises establishments of health practitioners having the degree of D.P.M. (Doctor of Podiatric Medicine) primarily engaged in the independent practice of podiatry. These practitioners diagnose and treat diseases and deformities of the foot and operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.[47] The SBA has established a size standard for businesses in this industry, which is annual receipts of $8 million or less.[48] The 2012 U.S. Economic Census indicates that 7,569 podiatry firms operated throughout the entire year.[49] 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.[50] Based on this data, we conclude that a majority of firms in this industry are small.

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[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.

[43] *See* U.S. Census Bureau, *2017 NAICS Definition, "621340 Offices of Physical, Occupational and Speech Therapists and Audiologists"*, https://www.census.gov/naics/?input=621340&year=2017&details=621340.

[44] *See* 13 CFR § 121.201, NAICS Code 621340.

[45] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.*: *2012*, NAICS Code 621340, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[46] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $8 million or less.

[47] *See* U.S. Census Bureau, *2017 NAICS Definition, "621391 Offices of Podiatrists"*, https://www.census.gov/naics/?input=621391&year=2017&details=621391.

[48] *See* 13 CFR § 121.201, NAICS Code 621391.

[49] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621391, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621391&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false&vintage=2012.

[50] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $8 million or less.

17. *Offices of All Other Miscellaneous Health Practitioners*. This U.S. industry comprises establishments of independent health practitioners (except physicians; dentists; chiropractors; optometrists; mental health specialists; physical, occupational, and speech therapists; audiologists; and podiatrists). These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.[51] The SBA has established a size standard for this industry, which is annual receipts of $8 million or less.[52] The 2012 U.S. Economic Census indicates that 11,460 firms operated throughout the entire year.[53] 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.[54] Based on this data, we conclude the majority of firms in this industry are small.

18. *Family Planning Centers*. This U.S. industry comprises establishments with medical staff primarily engaged in providing a range of family planning services on an outpatient basis, such as contraceptive services, genetic and prenatal counseling, voluntary sterilization, and therapeutic and medically induced termination of pregnancy.[55] The SBA has established a size standard for this industry, which is annual receipts of $12 million or less.[56] The 2012 Economic Census indicates that 1,286 firms in this industry operated throughout the entire year.[57] Of that number 1,237 had annual receipts of less than $10 million, while 36 firms had annual receipts between $10 million and $24,999,999.[58] Based on this data, we conclude that the majority of firms in this industry is small.

19. *Outpatient Mental Health and Substance Abuse Centers*. This U.S. industry comprises establishments with medical staff primarily engaged in providing outpatient services related to the diagnosis and treatment of mental health disorders and alcohol and other substance abuse. These establishments generally treat patients who do not require inpatient treatment. They may provide a counseling staff and information regarding a wide range of mental health and substance abuse issues and/or refer patients to more extensive treatment programs, if necessary.[59] The SBA has established a size standard for this industry, which is $16.5 million or less in annual receipts.[60] The 2012 U.S.

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[51] *See* U.S. Census Bureau, *2017 NAICS Definition, "621399 Offices of All Other Miscellaneous Health Practitioners"*, https://www.census.gov/naics/?input=621399&year=2017&details=621399.

[52] *See* 13 CFR § 121.201, NAICS Code 621399.

[53] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621399, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621399&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[54] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[55] *See* U.S. Census Bureau, *2017 NAICS Definition, "621410 Family Planning Centers",* https://www.census.gov/naics/?input=621410&year=2017&details=621410.

[56] *See* 13 CFR § 121.201, NAICS Code 621410.

[57] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621410, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621410&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[58] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $12 million or less.

[59] *See* U.S. Census Bureau, *2017 NAICS Definition, "621420 Outpatient Mental Health and Substance Abuse Centers"*, https://www.census.gov/naics/?input=621420&year=2017&details=621420.

[60] *See* 13 CFR § 121.201, NAICS Code 621420.

Economic Census indicates that 4,446 firms operated throughout the entire year.[61] 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.[62] Based on this data, we conclude that a majority of firms in this industry are small.

20. *HMO Medical Centers*. This U.S. industry comprises establishments with physicians and other medical staff primarily engaged in providing a range of outpatient medical services to the health maintenance organization (HMO) subscribers with a focus generally on primary health care. These establishments are owned by the HMO. Included in this industry are HMO establishments that both provide health care services and underwrite health and medical insurance policies.[63] The SBA has established a size standard for this industry, which is $35 million or less in annual receipts.[64] The 2012 U.S. Economic Census indicates that 14 firms in this industry operated throughout the entire year.[65] 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.[66] Based on this data, we conclude that approximately one-third of the firms in this industry are small.

21. *Freestanding Ambulatory Surgical and Emergency Centers*. This U.S. industry comprises establishments with physicians and other medical staff primarily engaged in (1) providing surgical services (e.g., orthoscopic and cataract surgery) on an outpatient basis or (2) providing emergency care services (e.g., setting broken bones, treating lacerations, or tending to patients suffering injuries as a result of accidents, trauma, or medical conditions necessitating immediate medical care) on an outpatient basis. Outpatient surgical establishments have specialized facilities, such as operating and recovery rooms, and specialized equipment, such as anesthetic or X-ray equipment.[67] The SBA has established a size standard for this industry, which is annual receipts of $16.5 million or less.[68] The 2012 U.S. Economic Census indicates that 3,595 firms in this industry operated throughout the entire year.[69] Of that number, 3,222 firms had annual receipts of less than $10 million, while 289 firms had annual

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[61] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.*: *2012,* NAICS Code 621420, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621420&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[62] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[63] *See* U.S. Census Bureau, *2017 NAICS Definition, "621491 HMO Medical Centers",* https://www.census.gov/naics/?input=621491&year=2017&details=621491.

[64] *See* 13 CFR § 121.201, NAICS Code 621491.

[65] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621491, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621491&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[66] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[67] *See* U.S. Census Bureau, *2017 NAICS Definition, "621493 Freestanding Ambulatory Surgical and Emergency Centers"*, https://www.census.gov/naics/?input=621493&year=2017&details=621493.

[68] *See* 13 CFR § 121.201, NAICS Code 621493.

[69] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621493, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621493&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

receipts between $10 million and $24,999,999.[70] Based on this data, we conclude that a majority of firms in this industry are small.

22. *All Other Outpatient Care Centers*. This U.S. industry comprises establishments with medical staff primarily engaged in providing general or specialized outpatient care (except family planning centers, outpatient mental health and substance abuse centers, HMO medical centers, kidney dialysis centers, and freestanding ambulatory surgical and emergency centers). Centers or clinics of health practitioners with different degrees from more than one industry practicing within the same establishment (i.e., Doctor of Medicine and Doctor of Dental Medicine) are included in this industry.[71] The SBA has established a size standard for this industry, which is annual receipts of $22 million or less.[72] The 2012 U.S. Economic Census indicates that 4,903 firms operated in this industry throughout the entire year.[73] 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.[74] Based on this data, we conclude that a majority of firms in this industry are small.

23. *Blood and Organ Banks*. This U.S. industry comprises establishments primarily engaged in collecting, storing, and distributing blood and blood products and storing and distributing body organs.[75] The SBA has established a size standard for this industry, which is annual receipts of $35 million or less.[76] The 2012 U.S. Economic Census indicates that 314 firms operated in this industry throughout the entire year.[77] 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.[78] Based on this data, we conclude that approximately three-quarters of firms that operate in this industry are small.

24. *All Other Miscellaneous Ambulatory Health Care Services*. This U.S. industry comprises establishments primarily engaged in providing ambulatory health care services (except offices of physicians, dentists, and other health practitioners; outpatient care centers; medical and diagnostic

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[70] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[71] *See* U.S. Census Bureau, *2017 NAICS Definition, "621498 All Other Outpatient Care Centers",* https://www.census.gov/naics/?input=621498&year=2017&details=621498.

[72] *See* 13 CFR § 121.201, NAICS Code 621498.

[73] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for* the U.S.: 2012, NAICS Code 621498, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621498&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[74] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[75] *See* U.S. Census Bureau, *2017 NAICS Definition*, *"621991 Blood and Organ Banks",* https://www.census.gov/naics/?input=621991&year=2017&details=621991.

[76] *See* 13 CFR § 121.201, NAICS Code 621991.

[77] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621991, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621991&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[78] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

laboratories; home health care providers; ambulances; and blood and organ banks).[79] The SBA has established a size standard for this industry, which is annual receipts of $16.5 million or less.[80] The 2012 U.S. Economic Census indicates that 2,429 firms operated in this industry throughout the entire year.[81] 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.[82] Based on this data, we conclude that a majority of the firms in this industry is small.

25. *Medical Laboratories*. This U.S. industry comprises establishments known as medical laboratories primarily engaged in providing analytic or diagnostic services, including body fluid analysis, generally to the medical profession or to the patient on referral from a health practitioner.[83] The SBA has established a size standard for this industry, which is annual receipts of $35 million or less.[84] The 2012 U.S. Economic Census indicates that 2,599 firms operated in this industry throughout the entire year.[85] 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.[86] Based on this data, we conclude that a majority of firms that operate in this industry are small.

26. *Diagnostic Imaging Centers*. This U.S. industry comprises establishments known as diagnostic imaging centers primarily engaged in producing images of the patient generally on referral from a health practitioner.[87] The SBA has established size standard for this industry, which is annual receipts of $16.5 million or less.[88] The 2012 U.S. Economic Census indicates that 4,209 firms operated in this industry throughout the entire year.[89] Of that number, 3,876 firms had annual receipts of less than $10

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[79] *See* U.S. Census Bureau, *2017 NAICS Definition, "621999 All Other Miscellaneous Ambulatory Health Care Services",* https://www.census.gov/naics/?input=621999&year=2017&details=621999.

[80] *See* 13 CFR § 121.201, NAICS Code 621999.

[81] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 621999, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621999&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[82] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[83] *See* U.S. Census Bureau, *2017 NAICS Definition, "621511 Medical Laboratories",* https://www.census.gov/naics/?input=621511&year=2017&details=621511.

[84] *See* 13 CFR § 121.201, NAICS Code 621511.

[85] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.*: *2012*, NAICS Code 621511, https://www.census.gov/naics/?input=621511&year=2017&details=621511.

[86] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[87] *See* U.S. Census Bureau*, 2017 NAICS Definition, "621512 Diagnostic Imaging Centers",* https://www.census.gov/naics/?input=621512&year=2017&details=621512.

[88] *See* 13 CFR § 121.201, NAICS Code 621512.

[89] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for* the U.S.: 2012, NAICS Code 621512, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621512&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

million, while 228 firms had annual receipts between $10 million and $24,999,999.[90] Based on this data, we conclude that a majority of firms that operate in this industry are small.

27. *Home Health Care Services*. This U.S. industry comprises establishments primarily engaged in providing skilled nursing services in the home, along with a range of the following: personal care services; homemaker and companion services; physical therapy; medical social services; medications; medical equipment and supplies; counseling; 24-hour home care; occupation and vocational therapy; dietary and nutritional services; speech therapy; audiology; and high-tech care, such as intravenous therapy.[91] The SBA has established a size standard for this industry, which is annual receipts of $16.5 million or less.[92] The 2012 U.S. Economic Census indicates that 17,770 firms operated in this industry throughout the entire year.[93] 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.[94] Based on this data, we conclude that a majority of firms that operate in this industry are small.

28. Ambulance *Services*. This U.S. industry comprises establishments primarily engaged in providing transportation of patients by ground or air, along with medical care. These services are often provided during a medical emergency but are not restricted to emergencies. The vehicles are equipped with lifesaving equipment operated by medically trained personnel.[95] The SBA has established a size standard for this industry, which is annual receipts of $16.5 million or less.[96] The 2012 U.S. Economic Census indicates that 2,984 firms operated in this industry throughout the entire year.[97] 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.[98] Based on this data, we conclude that a majority of firms in this industry is small.

29. *Kidney Dialysis Centers*. This U.S. industry comprises establishments with medical staff primarily engaged in providing outpatient kidney or renal dialysis services.[99] The SBA has established

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[90] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[91] *See* U.S. Census Bureau, *2017 NAICS Definition, "621610 Home Health Care Services",* https://www.census.gov/naics/?input=621610&year=2017&details=621610.

[92] *See* 13 CFR § 121.201, NAICS Code 621610.

[93] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S: 2012,* NAICS Code 621610, https://www.census.gov/naics/?input=621991&year=2017&details=6214991.

[94] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[95] *See* U.S. Census Bureau, *2017 NAICS Definition, "621910 Ambulance Services",* https://www.census.gov/naics/?input=621910&year=2017&details=621910.

[96] *See* 13 CFR § 121.201, NAICS Code 621910.

[97] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of* Firms for the U.S.: 2012, NAICS Code 621910, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621910&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[98] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[99] *See* U.S. Census Bureau, *2017 NAICS Definition, "621492 Kidney Dialysis Centers"*, https://www.census.gov/naics/?input=621492&year=2017&details=621492.

assize standard for this industry, which is annual receipts of $41.5 million or less.[100] The 2012 U.S. Economic Census indicates that 396 firms operated in this industry throughout the entire year.[101] 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.[102] Based on this data, we conclude that a majority of firms in this industry are small.

30. *General Medical and Surgical Hospitals*. This U.S. industry comprises establishments known and licensed as general medical and surgical hospitals primarily engaged in providing diagnostic and medical treatment (both surgical and nonsurgical) to inpatients with any of a wide variety of medical conditions. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements. These hospitals have an organized staff of physicians and other medical staff to provide patient care services. These establishments usually provide other services, such as outpatient services, anatomical pathology services, diagnostic X-ray services, clinical laboratory services, operating room services for a variety of procedures, and pharmacy services.[103] The SBA has established a size standard for this industry, which is annual receipts of $41.5 million or less.[104] The 2012 U.S. Economic Census indicates that 2,800 firms operated in this industry throughout the entire year.[105] Of that number, 877 has annual receipts of less than $25 million, while 400 firms had annual receipts between $25 million and $49,999,999.[106] Based on this data, we conclude that approximately one-quarter of firms in this industry are small.

31. *Psychiatric and Substance Abuse Hospitals*. This U.S. industry comprises establishments known and licensed as psychiatric and substance abuse hospitals primarily engaged in providing diagnostic, medical treatment, and monitoring services for inpatients who suffer from mental illness or substance abuse disorders. The treatment often requires an extended stay in the hospital. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements. They have an organized staff of physicians and other medical staff to provide patient care services. Psychiatric, psychological, and social work services are available at the facility. These hospitals usually provide other services, such as outpatient services, clinical laboratory services, diagnostic X-ray services, and electroencephalograph services.[107] The SBA has established a size

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[100] *See* 13 CFR § 121.201, NAICS Code 621492.

[101] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.*: *2012*, NAICS Code 621492, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=621492&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false&vintage=2012.

[102] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[103] *See* U.S. Census Bureau, *2017 NAICS Definition, "622110 General Medical and Surgical Hospitals",* https://www.census.gov/naics/?input=622110&year=2017&details=622110.

[104] *See* 13 CFR § 121.201, NAICS Code 622110.

[105] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 622110, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=622110&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false&vintage=2012.

[106] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $41.5 million or less.

[107] *See* U.S. Census Bureau, *2017 NAICS Definition, "622210 Psychiatric and Substance Abuse Hospitals"*, https://www.census.gov/naics/?input=622210&year=2017&details=622210.

standard for this industry, which is annual receipts of $41.5 million or less.[108] The 2012 U.S. Economic Census indicates that 404 firms operated in this industry throughout the entire year.[109] 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.[110] Based on this data, we conclude that more than one-half of the firms in this industry are small.

32. *Specialty (Except Psychiatric and Substance Abuse) Hospitals*. This U.S. industry consists of establishments known and licensed as specialty hospitals primarily engaged in providing diagnostic, and medical treatment to inpatients with a specific type of disease or medical condition (except psychiatric or substance abuse). Hospitals providing long-term care for the chronically ill and hospitals providing rehabilitation, restorative, and adjustive services to physically challenged or disabled people are included in this industry. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements. They have an organized staff of physicians and other medical staff to provide patient care services. These hospitals may provide other services, such as outpatient services, diagnostic X-ray services, clinical laboratory services, operating room services, physical therapy services, educational and vocational services, and psychological and social work services.[111] The SBA has established a size standard for this industry, which is annual receipts of $41.5 million or less.[112] The 2012 U.S. Economic Census indicates that 346 firms operated in this industry throughout the entire year.[113] Of that number, 146 firms had annual receipts of less than $25 million, while 79 firms had annual receipts between $25 million and $49,999,999.[114] Based on this data, we conclude that more than one-half of the firms in this industry are small.

33. *Emergency and Other Relief Services*. This industry comprises establishments primarily engaged in providing food, shelter, clothing, medical relief, resettlement, and counseling to victims of domestic or international disasters or conflicts (e.g., wars). [115] The SBA has established a size standard for this industry which is annual receipts of $35 million or less.[116] The 2012 U.S. Economic Census indicates

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[108] *See* 13 CFR § 121.201, NAICS Code 622210.

[109] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.*: *2012*, NAICS Code 622210, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=622210&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[110] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[111] *See* U.S. Census Bureau*, 2017 NAICS Definition, "622310 Specialty (Except Psychiatric and Substance Abuse) Hospitals"*, https://www.census.gov/naics/?input=622310&year=2017&details=622310.

[112] *See* 13 CFR § 121.201 NAICS Code 622310.

[113] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 622310, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=622310&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false&vintage=2012.

[114] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[115] *See* U.S. Census Bureau, *2017 NAICS Definition, "624230 Emergency and Other Relief Services",* https://www.census.gov/naics/?input=624230&year=2017&details=624230.

[116] *See* 13 CFR § 121.201, NAICS Code 624230.

that 541 firms operated in this industry throughout the entire year.[117] 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.[118] Based on this data, we conclude that a majority of firms in this industry are small.

2. Providers of Telecommunications and Other Services

a. Telecommunications Service Providers

34. *Incumbent Local Exchange Carriers (LECs)*. Neither the Commission nor the SBA has developed a small business size standard specifically for incumbent local exchange services. The closest applicable NAICS Code category is Wired Telecommunications Carriers.[119] Under the applicable SBA size standard, such a business is small if it has 1,500 or fewer employees.[120] U.S. Census Bureau data for 2012 indicate that 3,117 firms operated the entire year.[121] Of this total, 3,083 operated with fewer than 1,000 employees.[122] 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.[123] Of this total, an estimated 1,006 have 1,500 or fewer employees.[124] Thus, using the SBA's size standard the majority of incumbent LECs can be considered small entities.

35. *Interexchange Carriers (IXCs)*. Neither the Commission nor the SBA has developed a small business size standard specifically for Interexchange Carriers. The closest applicable NAICS Code category is Wired Telecommunications Carriers.[125] The applicable size standard under SBA rules is that such a business is small if it has 1,500 or fewer employees.[126] U.S. Census Bureau data for 2012 indicate that 3,117 firms operated for the entire year.[127] Of that number, 3,083 operated with fewer than 1,000

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[117] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1262SSSZ4*, Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the U.S.: 2012*, NAICS Code 624230, https://data.census.gov/cedsci/table?text=EC1262SSSZ4&n=624230&tid=ECNSIZE2012.EC1262SSSZ4&hidePreview=false.

[118] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[119] *See* U.S. Census Bureau, *2017 NAICS Definition, "517311 Wired Telecommunications Carriers"*, https://www.census.gov/naics/?input=517311&year=2017&details=517311.

[120] *See* 13 CFR § 121.201, NAICS Code 517311 (previously 517110).

[121] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms for the U.S.: 2012,* NAICS Code 517110, https://data.census.gov/cedsci/table?text=EC1251SSSZ5&n=517110&tid=ECNSIZE2012.EC1251SSSZ5&hidePreview=false.

[122] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

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

[124] *Id*.

[125] *See* U.S. Census Bureau, *2017 NAICS Definition, "517311 Wired Telecommunications Carriers",* https://www.census.gov/naics/?input=517311&year=2017&details=517311.

[126] *See* 13 CFR § 121.201, NAICS Code 517311 (previously 517110).

[127] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms for the U.S.: 2012,* NAICS Code 517110,

(continued….)

employees.[128] According to internally developed Commission data, 359 companies reported that their primary telecommunications service activity was the provision of interexchange services.[129] Of this total, an estimated 317 have 1,500 or fewer employees.[130] Consequently, the Commission estimates that the majority of interexchange service providers are small entities.

36. *Competitive Access Providers*. Neither the Commission nor the SBA has developed a definition of small entities specifically applicable to competitive access services providers (CAPs). The closest applicable definition under the SBA rules is Wired Telecommunications Carriers and under the size standard, such a business is small if it has 1,500 or fewer employees.[131] U.S. Census Bureau data for 2012 indicates that 3,117 firms operated during that year.[132] Of that number, 3,083 operated with fewer than 1,000 employees.[133] 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.[134] 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.[135] Consequently, the Commission estimates that most providers of competitive exchange services are small businesses.

37. *Wired Telecommunications Carriers*. The U.S. Census Bureau defines this industry as "establishments primarily engaged in operating and/or providing access to transmission facilities and infrastructure that they own and/or lease for the transmission of voice, data, text, sound, and video using wired communications networks. Transmission facilities may be based on a single technology or a combination of technologies. Establishments in this industry use the wired telecommunications network facilities that they operate to provide a variety of services, such as wired telephony services, including voice over Internet protocol (VoIP) services; wired (cable) audio and video programming distribution; and wired broadband internet services. By exception, establishments providing satellite television

(Continued from previous page)
https://data.census.gov/cedsci/table?text=EC1251SSSZ5&n=517110&tid=ECNSIZE2012.EC1251SSSZ5&hidePreview=false.

[128] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

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

[130] *Id*.

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

[132] *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.

[133] *Id*.

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

[135] *Id.*

distribution services using facilities and infrastructure that they operate are included in this industry."[136] 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.[137] U.S. Census data for 2012 show that there were 3,117 firms that operated that year.[138] Of this total, 3,083 operated with fewer than 1,000 employees.[139] Thus, under this size standard, the majority of firms in this industry can be considered small.

38. *Wireless Telecommunications Carriers (except Satellite).* This industry comprises establishments engaged in operating and maintaining switching and transmission facilities to provide communications via the airwaves. Establishments in this industry have spectrum licenses and provide services using that spectrum, such as cellular services, paging services, wireless internet access, and wireless video services.[140] The appropriate size standard under SBA rules is that such a business is small if it has 1,500 or fewer employees.[141] For this industry, U.S. Census Bureau data for 2012 show that there were 967 firms that operated for the entire year.[142] Of this total, 955 firms employed fewer than 1,000 employees and 12 firms employed of 1000 employees or more.[143] Thus under this category and the associated size standard, the Commission estimates that the majority of Wireless Telecommunications Carriers (except Satellite) are small entities.

39. The Commission's own data—available in its Universal Licensing System—indicate that, as of August 31, 2018, there are 265 Cellular licensees that will be affected by our actions.[144] The Commission does not know how many of these licensees are small, as the Commission does not collect that information for these types of entities. Similarly, according to internally developed Commission data, 413 carriers reported that they were engaged in the provision of wireless telephony, including cellular service, Personal Communications Service (PCS), and Specialized Mobile Radio (SMR) Telephony services.[145] Of this total, an estimated 261 have 1,500 or fewer employees, and 152 have more

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[136] *See* 13 CFR § 120.201. The Wired Telecommunications Carrier category formerly used the NAICS code of 517110. As of 2017 the U.S. Census Bureau definition shows the NAICS code as 517311 for Wired Telecommunications Carriers. *See* https://www.census.gov/naics/?input=517911&year=2017&details=517911.

[137] *See* 13 CFR § 120.201, NAICS Code 517311.

[138] *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://data.census.gov/cedsci/table?text=EC1251SSSZ5&n=517110&tid=ECNSIZE2012.EC1251SSSZ5&hidePreview=false.

[139] *Id.*

[140] *See* U.S. Census Bureau, *2017 NAICS Definition, "517312 Wireless Telecommunications Carriers (except Satellite)",* https://www.census.gov/naics/?input=517312&year=2017&details=517312.

[141] *See* 13 CFR § 121.201, NAICS Code 517312 (previously 517210).

[142] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1251SSSZ5, *Information: Subject Series: Estab and Firm Size: Employment Size of Firms for the U.S.: 2012*, NAICS Code 517210, https://data.census.gov/cedsci/table?text=EC1251SSSZ5&n=517210&tid=ECNSIZE2012.EC1251SSSZ5&hidePreview=false&vintage=2012.

[143] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[144] *See* Federal Communications Commission, *Universal Licensing System*, http://wireless.fcc.gov/uls. 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.

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

than 1,500 employees.[146] Thus, using available data, we estimate that the majority of wireless firms can be considered small.

40. *Wireless Telephony*. Wireless telephony includes cellular, personal communications services, and specialized mobile radio telephony carriers. The closest applicable SBA category is Wireless Telecommunications Carriers (except Satellite).[147] Under the SBA small business size standard, a business is small if it has 1,500 or fewer employees.[148] For this industry, U.S. Census Bureau data for 2012 show that there were 967 firms that operated for the entire year.[149] Of this total, 955 firms had fewer than 1,000 employees and 12 firms had 1000 employees or more.[150] 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.[151] Of these, an estimated 261 have 1,500 or fewer employees and 152 have more than 1,500 employees.[152] Therefore, more than half of these entities can be considered small.

41. *Satellite Telecommunications.* This category comprises firms "primarily engaged in providing telecommunications services to other establishments in the telecommunications and broadcasting industries by forwarding and receiving communications signals via a system of satellites or reselling satellite telecommunications."[153] Satellite telecommunications service providers include satellite and earth station operators. The category has a small business size standard of $35 million or less in average annual receipts, under SBA rules.[154] For this category, U.S. Census Bureau data for 2012 show that there were a total of 333 firms that operated for the entire year.[155] Of this total, 299 firms had annual receipts of less than $25 million.[156] Consequently, we estimate that the majority of satellite telecommunications providers are small entities.

42. *All Other Telecommunications*. The "All Other Telecommunications" category is comprised of establishments primarily engaged in providing specialized telecommunications services,

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[146] *See id*.

[147] *See* U.S. Census Bureau, *2017 NAICS Definition, "517312 Wireless Telecommunications Carriers (except Satellite)*", https://www.census.gov/naics/?input=517312&year=2017&details=517312.

[148] *See* 13 CFR § 121.201, NAICS Code 517312 (previously 517210).

[149] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1251SSSZ5, *Information: Subject Series: Estab and Firm Size: Employment Size of Firms for the U.S.: 2012*, NAICS Code 517210, https://data.census.gov/cedsci/table?text=EC1251SSSZ5&n=517210&tid=ECNSIZE2012.EC1251SSSZ5&hidePreview=false&vintage=2012.

[150] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

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

[152] *Id*.

[153] *See* U.S. Census Bureau, *2017 NAICS Definition, "517410 Satellite Telecommunications",* https://www.census.gov/naics/?input=517410&year=2017&details=517410.

[154] *See* 13 CFR § 121.201, NAICS Code 517410.

[155] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1251SSSZ4, *Information: Subject Series - Estab and Firm Size: Receipts Size of Firms for the U.S.: 2012*, NAICS Code 517410, https://data.census.gov/cedsci/table?text=EC1251SSSZ4&n=517410&tid=ECNSIZE2012.EC1251SSSZ4&hidePreview=false&vintage=2012.

[156] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

such as satellite tracking, communications telemetry, and radar station operation.[157] 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.[158] Establishments providing Internet services or voice over Internet protocol (VoIP) services via client-supplied telecommunications connections are also included in this industry.[159] The SBA has developed a small business size standard for "All Other Telecommunications," which consists of all such firms with annual receipts of $35 million or less.[160] For this category, U.S. Census Bureau data for 2012 show that there were 1,442 firms that operated for the entire year.[161] Of those firms, a total of 1,400 had annual receipts less than $25 million and 15 firms had annual receipts of $25 million to $49, 999,999.[162] Thus, the Commission estimates that the majority of "All Other Telecommunications" firms potentially affected by our action can be considered small.

b. Internet Service Providers

43. *Internet Service Providers (Broadband).* Broadband Internet service providers include wired (e.g., cable, DSL) and VoIP service providers using their own operated wired telecommunications infrastructure fall in the category of Wired Telecommunication Carriers.[163] 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.[164] The SBA size standard for this category classifies a business as small if it has 1,500 or fewer employees.[165] U.S. Census Bureau data for 2012 show that there were 3,117 firms that operated that year.[166] 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.

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[157] *See* U.S. Census Bureau, *2017 NAICS Definition*, "*517919 All Other Telecommunications*", https://www.census.gov/naics/?input=517919&year=2017&details=517919.

[158] *Id.*

[159] *Id*.

[160] *See* 13 CFR § 121.201, NAICS Code 517919.

[161] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1251SSSZ4, *Information: Subject Series - Estab and Firm Size: Receipts Size of Firms for the U.S.: 2012*, NAICS Code 517919, https://data.census.gov/cedsci/table?text=EC1251SSSZ4&n=517919&tid=ECNSIZE2012.EC1251SSSZ4&hidePreview=false.

[162] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

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

[164] *Id.*

[165] *See* 13 CFR § 121.201, NAICS Code 517311 (previously 517110).

[166] *See* U.S. Census Bureau, *2012 Economic Census of the United States,* Table ID: EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms for the U.S.*: *2012*, NAICS Code 517110, https://data.census.gov/cedsci/table?text=EC1251SSSZ5&n=517110&tid=ECNSIZE2012.EC1251SSSZ5&hidePreview=false.

[167] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

44. *Internet Service Providers (Non-Broadband)*. Internet access service providers such as Dial-up Internet service providers, VoIP service providers using client-supplied telecommunications connections and Internet service providers using client-supplied telecommunications connections (e.g., dial-up ISPs) fall in the category of All Other Telecommunications.[168] The SBA has developed a small business size standard for All Other Telecommunications which consists of all such firms with gross annual receipts of $35 million or less.[169] For this category, U.S. Census Bureau data for 2012 show that there were 1,442 firms that operated for the entire year.[170] Of these firms, a total of 1,400 had gross annual receipts of less than $25 million.[171] Consequently, under this size standard a majority of firms in this industry can be considered small.

c. Vendors and Equipment Manufacturers

45. *Vendors of Infrastructure Development or "Network Buildout."* The Commission has not developed a small business size standard specifically directed toward manufacturers of network facilities. There are two applicable SBA categories in which manufacturers of network facilities could fall and each have different size standards under the SBA rules. The SBA categories are "Radio and Television Broadcasting and Wireless Communications Equipment" with a size standard of 1,250 employees or less[172] and "Other Communications Equipment Manufacturing" with a size standard of 750 employees or less."[173] U.S. Census Bureau data for 2012 shows that for Radio and Television Broadcasting and Wireless Communications Equipment firms 841 establishments operated for the entire year.[174] Of that number, 828 establishments operated with fewer than 1,000 employees, and 7 establishments operated with between 1,000 and 2,499 employees.[175] For Other Communications Equipment Manufacturing, U.S. Census Bureau data for 2012, show that 383 establishments operated for

[168] *See* U.S. Census Bureau, *2017 NAICS Definition, "517919 All Other Telecommunications",* https://www.census.gov/naics/?input=517919&year=2017&details=517919.

[169] *See* 13 CFR § 121.201, NAICS Code 517919.

[170] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1251SSSZ4, *Information: Subject Series - Estab and Firm Size: Receipts Size of Firms for the U.S.: 2012*, NAICS Code 517919, https://data.census.gov/cedsci/table?text=EC1251SSSZ4&n=517919&tid=ECNSIZE2012.EC1251SSSZ4&hidePreview=false.

[171] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[172] *See* 13 CFR § 121.201, NAICS Code 334220; *see also* U.S. Census Bureau, *2017 NAICS Definition, "334220 Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing",* https://www.census.gov/naics/?input=334220&year=2017&details=334220.

[173] *See* 13 CFR § 121.201, NAICS Code 334290; *see also* U.S. Census Bureau, *2017 NAICS Definition, "334290 Other Communications Equipment Manufacturing"*, https://www.census.gov/naics/?input=334290&year=2017&details=334290.

[174] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012*, NAICS Code 334220, https://data.census.gov/cedsci/table?tid=ECNSIZE2012.EC1231SG2&y=2012&n=334220&vintage=2012&hidePreview=false.

[175] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of establishments that meet the SBA size standard of employment of 1,250 or fewer employees. 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." An establishment is a single physical location at which business is conducted and/or services are provided. It is not necessarily identical with a single firm, company or enterprise, which may consist of one or more establishments. Thus, the numbers given may reflect inflated numbers of businesses in this category, including the number of small businesses. U.S. Census Bureau data does not provide information on the number of firms for this industry.

the year.[176] Of that number 379 operated with fewer than 500 employees and 4 had 500 to 999 employees.[177] Based on this data, we conclude that the majority of Vendors of Infrastructure Development or "Network Buildout" are small.

46. *Telephone Apparatus Manufacturing*. This industry comprises establishments primarily engaged in manufacturing wire telephone and data communications equipment.[178] These products may be stand-alone or board-level components of a larger system. Examples of products made by these establishments are central office switching equipment, cordless and wire telephones (except cellular), PBX equipment, telephone answering machines, LAN modems, multi-user modems, and other data communications equipment, such as bridges, routers, and gateways.[179] The SBA has developed a small business size standard for Telephone Apparatus Manufacturing, which consists of all such companies having 1,250 or fewer employees.[180] U.S. Census Bureau data for 2012 show that there were 266 establishments that operated that year.[181] Of this total, 262 operated with fewer than 1,000 employees.[182] Thus, under this size standard, the majority of firms in this industry can be considered small.

47. *Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing*. This industry comprises establishments primarily engaged in manufacturing radio and television broadcast and wireless communications equipment.[183] Examples of products made by these establishments are: transmitting and receiving antennas, cable television equipment, GPS equipment,

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[176] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012*, NAICS Code 334290, https://data.census.gov/cedsci/table?tid=ECNSIZE2012.EC1231SG2&y=2012&n=334290&vintage=2012&hidePreview=false.

[177] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of establishments that meet the SBA size standard of employment of 750 or fewer employees. 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." An establishment is a single physical location at which business is conducted and/or services are provided. It is not necessarily identical with a single firm, company or enterprise, which may consist of one or more establishments. Thus, the numbers given may reflect inflated numbers of businesses in this category, including the number of small businesses. U.S. Census Bureau data does not provide information on the number of firms for this industry.

[178] *See* U.S. Census Bureau, *2017 NAICS Definition, "334210 Telephone Apparatus Manufacturing,"* https://www.census.gov/naics/?input=334210&year=2017&details=334210.

[179] *Id.*

[180] *See* 13 CFR § 121.201, NAICS Code 334210.

[181] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012,* NAICS Code 334210, https://data.census.gov/cedsci/table?n=334210&tid=ECNSIZE2012.EC1231SG2&hidePreview=false&vintage=2012. 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." An establishment is a single physical location at which business is conducted and/or services are provided. It is not necessarily identical with a single firm, company or enterprise, which may consist of one or more establishments. Thus, the numbers given may reflect inflated numbers of businesses in this category, including the number of small businesses. U.S. Census Bureau data does not provide information on the number of firms for this industry.

[182] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of establishments that meet the SBA size standard of employment of 1,250 or fewer employees.

[183] *See* U.S. Census Bureau, *2017 NAICS Definitions, "334220 Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing*", https://www.census.gov/naics/?input=334220&year=2017&details=334220.

pagers, cellular phones, mobile communications equipment, and radio and television studio and broadcasting equipment.[184] The SBA has established a small business size standard for this industry of 1,250 or fewer employees.[185] U.S. Census Bureau data for 2012 show that 841 establishments operated in this industry in that year.[186] 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.[187] Based on this data, we conclude that a majority of manufacturers in this industry are small.

48. *Other Communications Equipment Manufacturing*. This industry comprises establishments primarily engaged in manufacturing communications equipment (except telephone apparatus, and radio and television broadcast, and wireless communications equipment).[188] 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.[189] The SBA has established a size standard for this industry as all such firms having 750 or fewer employees.[190] U.S. Census Bureau data for 2012 shows that 383 establishments operated in that year.[191] Of that number, 379 operated with fewer than 500 employees and 4 had 500 to 999 employees.[192] Based on this data, we conclude that the majority of Other Communications Equipment Manufacturers are small.

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

49. 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." We expect to consider all of these factors when we have received substantive comment from the public and potentially affected entities.

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[184] *Id*.

[185] *See* 13 CFR § 121.201, NAICS Code 334220.

[186] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size: 2012*, NAICS Code 334220, https://data.census.gov/cedsci/table?text=EC1231SG2&n=334220&tid=ECNSIZE2012.EC1231SG2&hidePreview=false.

[187] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

[188] *See* U.S. Census Bureau, *2017 NAICS Definition, "334290 Other Communications Equipment Manufacturing*", https://www.census.gov/naics/?input=334290&year=2017&details=334290.

[189] *Id.*

[190] *See* 13 CFR 121.201, NAICS Code 334290.

[191] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table ID: EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size*: *2012*, NAICS Code 334290, https://data.census.gov/cedsci/table?text=EC1231SG2&n=334290&tid=ECNSIZE2012.EC1231SG2&hidePreview=false&vintage=2012.

[192] *Id.* The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard.

50. Largely, the proposals in this *Second Further Notice* if adopted would have no impact on or would reduce the economic impact of current regulations on small entities. Certain proposals could have a positive economic impact on small entities. In the instances in which a proposed change would increase the financial burden on small entities, we have determined that the net financial and other benefits from such changes would outweigh the increased burdens on small entities.

51. *Determining Accurate Rates in the Telecom Program*. We propose modifications to the three rural rate determination methods in the Telecom Program, including changes to the market-based approach of Methods 1 and 2 and new evidentiary requirements for justifying cost-based rates under Method 3. We also propose that participants with multi-year contracts and evergreen contracts would only have to justify rural rates in the first year of the contract. We also propose to simplify the calculation of urban rate rules by eliminating the "standard urban distance" requirement and seek specific comment on sources of urban rates as well as general comment on our urban rate rules. We propose to keep the cap on support for satellite services reinstated and seek comment on potential changes to it. Lastly, we seek comment on proposed revisions to FCC Form 466 intended to improve the quality of Telecom Program data.

52. *Administrative Deadlines*. We also propose to amend program rules align the deadline for filing a SPIN change with the invoice deadline. If implemented, this proposal would have a positive impact on small health care providers because it would reduce the need for them to seek waivers of the current SPIN change deadline. We also seek comment on whether a mechanism to allow post-commitment changes to evergreen contract dates is necessary.

53. *Future Eligibility*. We also propose a mechanism whereby entities that are not yet eligible health care providers can engage in competitive bidding and file requests for funding, which would allow them to receive RHC Program funding shortly after they become eligible. If implemented, this proposal would have a positive economic impact on small health care providers because it would allow them to receive RHC Program funding shortly after they become eligible.

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

54. None.

APPENDIX E

2022 Promoting Telehealth Further Notice of Proposed Rulemaking
Comments and Reply Comments

Comments

Commenter	*Abbreviation*	*Date Filed*
Michigan Health & Hospital Association	MHA	Apr. 14, 2022
NTCA – The Rural Broadband Association	NTCA	Apr. 14, 2022
Southern Ohio Health Care Network	SOHCN	Apr. 14, 2022
Advanced Data Services, Inc.	ADS	Apr. 15, 2022
Alaska Communications Systems Group, Inc.	ACS	Apr. 15, 2022
Alaska Native Health Board	ANHB	Apr. 15, 2022
Alaska Native Tribal Health Consortium	ANTHC	Apr. 15, 2022
Community Hospital Corporation	CHC	Apr. 15, 2022
ENA Healthcare Services, LLC	ENA	Apr. 15, 2022
General Communication, Inc.	GCI	Apr. 15, 2022
National Rural Health Association	NRHA	Apr. 15, 2022
Prostate Cancer Impact Alliance	PCIA	Apr. 15, 2022
The Rural Policy Research Institute	RUPRI	Apr. 15, 2022
Schools, Health & Libraries Broadband (SHLB) Coalition	SHLB	Apr. 15, 2022
Western New York Rural Broadband Healthcare Network	WNY RBHN	Apr. 15, 2022
Windstream Services, LLC	Windstream	Apr. 15, 2022

Reply Comments

Commenter	*Abbreviation*	*Date Filed*
Advanced Data Services, Inc.	ADS	May 17, 2022
Alaska Communications Systems Group, Inc.	ACS	May 17, 2022
General Communication, Inc.	GCI	May 17, 2022
New England Telehealth Consortium	NETC	May 17, 2022
Schools, Health & Libraries Broadband (SHLB) Coalition	SHLB	May 17, 2022

STATEMENT OF
CHAIRWOMAN JESSICA ROSENWORCEL

Re: *Promoting Telehealth in Rural America*, Order on Reconsideration, Second Report and Order, Order, and Second Further Notice of Proposed Rulemaking, WC Docket No. 17-310 (January 26, 2023).

What do we bring with us beyond the pandemic? It is a question we are asking in every sector of the economy, in every corner of this country. Our experience with this virus has transformed so much. It has changed where we live, how we work, and what we value in our lives. It also has deepened our dependence on communications. You see this across the board, but especially in healthcare.

That's because telemedicine has moved into the mainstream. Getting an appointment online, checking in with your provider, and having a practitioner diagnose at a distance are all now more common than ever before—and we have embraced the power of telehealth like never before.

This technology, however, is not all new. For more than a quarter of a century, the Federal Communications Commission has been supporting telemedicine. Our groundbreaking Rural Health Care programs have long been a force for good, bringing affordable care to some of the most remote areas of the country by using communications technology to connect patient and provider.

The oldest part of our Rural Health Care Program is known as the Telecom Program. It offers support to rural healthcare providers for the difference between the rates they are charged for communications and those they would pay for the same facilities in urban areas. This program has been a quiet dynamo, helping some of the furthest-flung places in this country stay connected to first class care. I know, I have seen it in action in some of the most isolated communities in Alaska and Montana. This program is a lifesaver.

But a few years ago, here in Washington, this agency got ahead of itself. It tried to "fix" the Telecom Program by setting up a series of databases designed to tell communities exactly what communications services should cost. But this "fix" was littered with anomalies. For instance, in Alaska the database featured a rate for a dedicated transmission service in the Extremely Rural tier that was lower than the rate for the same service in the Less Rural tier. In California, the database showed that a 50 Mbps connection was cheaper than a 20 Mbps connection. Rural healthcare authorities, the providers serving them, and members of Congress spoke up. They pointed out what should have been obvious: this database had serious flaws. More than that, they noted that using it could lead to real problems sustaining connections essential for healthcare in some of the most remote locations in the United States.

So for the last two years the Commission has waived the use of this database. Today, we fix it for good. In fact, we bid it goodbye and return to the earlier system that worked for providers and helped grow this telemedicine program into what it is today. We also continue to allow participants to use already-approved rates for an additional two funding years, to ensure smooth operation of the program. Finally, we take steps to simplify our invoicing rules and reduce funding delays and we ask questions about how to improve the program going forward.

This is good news. The Rural Health Care Program is one of the great gems of this agency. It was early to demonstrate the power of telemedicine and its value in rural communities. And now those communities are no longer outliers when it comes to telehealth technologies. Because the pandemic has demonstrated just how vital they are for everyone, everywhere.

Thank you to the staff responsible for this effort, including Matt Baker, Phil Bonomo, Bryan Boyle, Cheryl Callahan, Callie Coker, Adam Copeland, Chas Eberle, Jodie Griffin, Trent Harkrader, Avis Mitchell, Kiara Ortiz, Hayley Steffen, and Helen Zhang from the Wireline Competition Bureau; Valerie Hill, Richard Mallen, William Richardson, Derek Yeo, and Chin Yoo from the Office of General Counsel; Stacy Jordan, Eugene Kiselev, Paulo Lopes, Alec MacDonnell, Eric Ralph, Don Stockdale,

Shane Taylor, and Stephen Tolbert from the Office of Economics and Analytics; and Cara Grayer and Joy Ragsdale from the Office of Communications Business Opportunities.

STATEMENT OF
COMMISSIONER BRENDAN CARR

Re: *Promoting Telehealth in Rural America*, Order on Reconsideration, Second Report and Order, Order, and Second Further Notice of Proposed Rulemaking, WC Docket No. 17-310 (January 26, 2023).

Bethel, Alaska sits along the banks of the slow-moving Kuskokwim River—about 40 meandering miles upstream from the Bering Sea and 400 air miles west of Anchorage. The town of about 6,000 people is completely cut off from the road system. You can get there by air, by sea, or in the winter, if you're brave enough, by ice road.

Last summer, both Commissioner Simington and I had the chance to spend time in Bethel on a visit led by Senator Sullivan. That's where we met with the health care providers at the Yukon-Kuskokwim Delta Regional Hospital. It's a 50-bed hospital that provides critical care to individuals in Bethel and other remote communities that are spread across a geographic area the size of Oregon. The hospital houses the only emergency room in the region and, for many, it is the only source of trauma care and surgical services. Much like other facilities in Alaska, the hospital's connections and telehealth services are supported by the FCC's Rural Health Care Program.

With respect to closing the digital divide in Alaska, I don't think the FCC has always gotten it right when it comes to our statutory obligations. We have been working hard to correct course, though. Today's decision is another good step in the right direction. I want to thank my colleagues for working with my office to improve today's item both for the providers in Alaska and for those across the country. There is more work to be done, and I am committed to working with all stakeholders to get this program right over the long term.

In closing, I want to recognize the staff and leadership of the Wireline Competition Bureau for their hard work on this item. You have my thanks, and the item has my support.

STATEMENT OF
COMMISSIONER GEOFFREY STARKS

Re: *Promoting Telehealth in Rural America*, Order on Reconsideration, Second Report and Order, Order, and Second Further Notice of Proposed Rulemaking, WC Docket No. 17-310 (January 26, 2023).

We are currently in the midst of a winter season that has seen many, including children, battling what some public health experts have termed a "tripledemic"—COVID, RSV, and a resurgent flu. I can't think of a better time, then, for the Commission to update, and improve, our Rural Health Care Program. Telehealth continues to save and improve lives for those in rural America relying on broadband for their next doctor's appointment. Growing up in a family of doctors, who serve many patients that live in rural America, I've seen and heard how important it is to ensure that rural health care providers have the same connectivity as their urban counterparts. This Program is doing that hard work.

This item has its roots in an *Order* the Commission adopted in 2019. At that time, I joined then-Commissioner Rosenworcel in dissenting from the majority's plan to adopt a new method to determine support for the Telecommunications Program, often called the "Rates Database."

[1] I was worried that the Rates Database could negatively impact program participants and that further study was needed before we should take action.[2] Unfortunately, almost immediately, my fears were realized and the Commission began issuing waivers due to significant anomalies that arose in the initial median urban and rural rate calculations in the Rates Database.

The item we adopt today will provide Rural Health Care Program participants with much-needed clarity and certainty going forward. We return the Telecom Program to the rate determination rules that existed prior to the 2019 *Order*. We eliminate the need to rely on waivers and make additional changes to improve the Rural Health Care Program rules to increase efficiency and reduce delay.

At the same time, we take this opportunity to improve, in a thoughtful manner, the rate determination rules. Importantly, in proposing to update the rules going forward in today's Further Notice, we propose and seek comment on two new methods to determining rural rates. We propose rational methods that should make the process simpler while also protecting the Universal Service Fund from waste, fraud, and abuse. These proposals should make it easier for eligible health care providers to receive support as soon as they become eligible. But, in proposing these changes in the Further Notice, we give those who serve some of the most remote health care providers an opportunity to weigh in and help inform our rulemaking. I hope they do so.

Last, in 2019, and 2022, I repeatedly called for the Commission to collect and use the best data available to analyze proposals as we consider changes to our rules and programs. I'm glad that in this item we seek comment on how to revise FCC Form 466 to improve the data we collect. As we consider additional changes to the Rural Health Care Program, we must ensure that our efforts mitigate and eliminate unintended consequences. To that end, I'm glad that commenters have already favorably weighed in to support collecting more detailed data. Only through a methodical and deliberative process with roots in accurate data can we ensure that the spirit and goals of the Rural Health Care Program are achieved.

I thank the Chairwoman for her leadership and strongly support this item. My thanks to the dedicated FCC staff for their fantastic work.

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[1] *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Report and Order, 34 FCC Rcd 7335, Statement of Commissioner Geoffrey Starks Approving in Part, Dissenting in Part (2019).

[2] *Id.*