Proposed Rules

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This section of the FEDERAL REGISTER contains notices to the public of the proposed issuance of rules and regulations. The purpose of these notices is to give interested persons an opportunity to participate in the rule making prior to the adoption of the final rules.

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 54

[WC Docket No. 17–310; FCC 22–15; FR ID 75595]

Promoting Telehealth in Rural America

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: In this document, the Federal Communications Commission (Commission) seeks comment on revisions to the Rural Health Care Telecommunications (Telecom) Program rules to ensure that rural healthcare providers receive funding necessary to access the broadband and telecommunications services necessary to provide vital healthcare services; proposes to modify the applicability of the internal funding cap on upfront costs and multi-year commitments in the Rural Health Care Healthcare Connect Fund Program, proposes to streamline the invoice process in the Telecom Program, and seeks comment on ways to further increase the speed of funding commitments.

DATES: Comments are due on or before April 14, 2022 and reply comments are due on or before May 16, 2022. If you anticipate that you will be submitting comments but find it difficult to do so within the period of time allowed by this document, you should advise the listed contact as soon as possible.

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

- *Electronic Filers:* Comments may be filed electronically using the internet by accessing the ECFS: *https://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 at its headquarters. 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, A 20–304 (March 19, 2020), *https://www.fcc.gov/document/fcc-closes-headquarters-open-window-and-changes-hand-delivery-policy.*

People with Disabilities: To request materials in accessible formats for people with disabilities (Braille, large print, electronic files, audio format), send an email to *fcc504@fcc.gov* or call the Consumer & Governmental Affairs Bureau at (202) 418–0530 (voice), (202) 418–0432 (TTY). For detailed instructions for submitting comments and additional information on the rulemaking process, see the **SUPPLEMENTARY INFORMATION** section of this document.

FOR FURTHER INFORMATION CONTACT: Bryan P. Boyle, Wireline Competition Bureau, 202–418–7400 or by email at *Bryan.Boyle@fcc.gov.* Requests for accommodations should be made as soon as possible in order to allow the agency to satisfy such requests whenever possible. Send an email to *fcc504@fcc.gov* or call the Consumer and Governmental Affairs Bureau at (202) 418–0530.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Further Notice of Proposed Rulemaking (FNPRM) in WC Docket No. 17–310; FCC 22–15, adopted on February 18, 2022 and released on February 22, 2022. Due to the COVID–19 pandemic, the Commission's headquarters will be closed to the general public until further notice. The full text of this document is available at the following internet address: *https://docs.fcc.gov/public/attachments/FCC-22-15A1.pdf.*

I. Introduction

1. In the FNPRM the Commission proposes and seeks comment on several revisions to the Commission's Rural Health Care Program (RHC Program) rules designed to ensure that rural healthcare providers receive funding necessary to access the broadband and telecommunications services necessary to provide vital healthcare services while limiting costly inefficiencies and the potential for waste, fraud, and abuse. The RHC Program provides vital support to assist rural health care providers with the costs of broadband and other communications services. Reliable high speed connectivity is critical for rural health care providers to serve patients in rural areas that often have limited resources, fewer doctors, and higher rates for broadband and telecommunications services than urban areas. Recent years have also seen an explosion in demand for telehealth services, a trend accelerated by the COVID–19 pandemic, that has increased the bandwidth needs of rural health care providers. The Commission seeks comment on proposed revisions to the RHC Program's funding determination mechanisms and administrative processes in an effort to improve the accuracy and fairness of RHC Program support and increase the efficiency of program administration.

II. Discussion

2. In the FNPRM, the Commission seeks comment on options for determining support in the Telecom Program and propose revisions to Telecom Program forms to improve the quality and consistency of Telecom Program data. The Commission also seeks comment on an alternative rate determination mechanism to the Rates Database to improve the accuracy of rates in the Telecom Program. Additionally, it proposes to limit the applicability of the internal funding cap on upfront payments and multi-year commitments to instances in which demand exceeds available funding; to target funding for the current funding year over future years when the internal cap is exceeded; and to simplify the invoicing process in the Telecom Program while strengthening protections against waste, fraud and

abuse. The Commission also seeks comment on ways to expedite and streamline the application and funding commitment process.

3. *Determining Accurate Rate in the Telecom Program, Defining cost factors and service technologies for a rate setting mechanism.* As an initial matter, the Commission examines how to classify the inputs used to determine rates in the Telecom Program. To determine rates that reflect the cost of delivering service to health care providers, the data inputs used to determine rates must capture, consistent with section 254(h)(1)(A) of the Telecommunications Act of 1996 (Act), which health care providers are in ''comparable rural areas,'' as well as which Telecom Program supported services are ''similar.'' The Commission seeks therefore comment on several inputs related to rurality classifications for health care providers and categorization of eligible services.

4. *Rurality classifications for health care providers.* The Commission seeks input on how to evaluate rurality to determine what areas are comparable for purposes of determining rates. First, examining how the Commission defines rurality for the RHC Program, proposing to maintain the current standard for ''rural'' used to determine whether a health care provider may participate in the RHC Program. Then seek comment on what factors to consider to differentiate rural areas.

5. *Defining ''Rural Area'' for the Purposes of Program Participation.* Support under section 254(h)(1)(A) of the Act is limited to services provided to persons who reside in ''rural areas.'' The RHC Program employs a definition of ''rural area'' that relies upon a healthcare provider's location relative to the Census Bureau's Core Based Statistical Area designation. In the 2019 *Promoting Telehealth Report and Order,* 84 FR 54952, October 11, 2019), the Commission declined to adopt a new definition of ''rural area'' for the RHC Program because the existing definition served the needs of the program. The Commission also explained that changes to the definition could cause uncertainty and eligibility issues for program participants. The Commission believes these justifications for maintaining the existing definition of ''rural area'' remain applicable today and therefore propose to maintain the current definition of ''rural area'' for the RHC Program.

6. Despite the Commission's belief that the existing definition of ''rural area'' remains applicable today, the Commission seeks comment on whether the proposal to maintain the current definition of ''rural area'' is appropriate for purposes of RHC Program participation. Does the current definition meet the needs of the RHC Program for purposes of eligibility? Are there any alternative definitions that would be more appropriate? For instance, should the Commission adopt a definition that does not rely (or does not exclusively rely) on a healthcare provider's location in relation to relatively densely settled areas, and would such a definition capture areas that reasonably could be viewed as ''rural'' within the meaning of section 254(h)(1)(A) of the Act? Until 2004, the Commission followed the definition used by the Federal Office of Rural Health Policy (FORHP) located within the Health Resources and Services Administration. Are there any definitions used by other government agencies, such as FORHP, or medical organizations that would be more appropriate at this time for the RHC Program? Are there definitions that take into account the geographic features that are unique to Alaska? Commenters are encouraged to describe the effects on Program participants of any potential modifications to the current definition. After the Commission adopted a new standard for ''rural area'' in 2004, it permitted health care providers that were participating in the RHC Program under the previous definition but did not qualify as rural under the new definition to continue to participate in the RHC Program. If the Commission maintains the current definition, should the Commission continue to allow health care providers that do not fall under the current definition, but who were grandfathered under the old definition, to participate in the RHC Program? In the event the Commission adopts a new definition of ''rural area'' that does not encompass health care providers that fall under the current definition, should the Commission permit those providers to continue participating in the RHC Program?

7. *Identification of Geographic Cost Factors.* The Commission next turns to how to identify methods for further classifying gradients or tiers of rurality and what already-existing tools might be used to differentiate gradients or tiers of rurality for the purpose of setting rural and urban rates in the Telecom Program. Under section 254(h)(1)(A) of the Act, carriers must be reimbursed using rates for similar services provided to other customers in ''comparable rural areas'' in the state. In the *Promoting Telehealth Report and Order,* the Commission amended its definition of ''comparable rural areas'' from just the areas immediately surrounding the health care provider to also include similar rural areas. The Commission proposes to maintain a definition of ''comparable rural areas'' that includes the areas immediately surrounding the health care provider and also similar areas within the state and agree with the Commission's previous determination that such an approach reflects a faithful interpretation of the statutory obligation to reimburse carriers for similar services for other customers in ''comparable rural areas'' in the state. The Commission seeks comment on this approach.

8. The Commission also seeks comment on the factors to consider in determining what are ''comparable rural areas'' when establishing rates for telecommunication services. Under the existing Commission rules, rurality tiers are used to determine the comparable rural areas in a state or territory. In the *Promoting Telehealth Report and Order,* the Commission decided that the determination of what rural areas are ''comparable'' should be based on the factors impacting the cost to provide services, and adopted rurality tiers based on the assumption that the costs to provide telecommunication services increases as the population density of an area decreases. The Commission continues to believe that grouping health care providers by geographic area is the best way to ensure that carriers are compensated based on services provided to health care providers in ''comparable rural areas'' and that it is appropriate to consider comparability of rural areas by looking at the factors impacting cost and seek to identify what those factors might be. In addition to population density, distance to the nearest metropolitan area, topography, and existing infrastructure may impact the cost to provide telecommunications services as well. The Commission seeks comment on the extent to which population density, distance, topography, and existing infrastructure could be factors to consider when determining ''comparable rural areas.'' To what extent may these factors affect rates for telecommunications services? Are there other geographic cost factors the Commission should consider that affect telecommunication service rates? Are there geographic cost factors specific to Alaska that should be considered if elected to establish specific rules for ''comparable rural areas'' in Alaska?

9. The Commission seeks comment on whether establishing specific rurality metrics for each health care provider based on multiple geographic cost factors could more accurately determine

prices available to health care providers in rural areas. Specifically, the Commission seeks comment on whether measuring a combined set of factors such as population density, distance to a nearby urban area, topography, and existing infrastructure would be effective in establishing levels of rurality that more accurately reflect the cost of service. How can the Commission account for variances in health care providers' location and topography? Are there any other specific cost factors to consider based on the existing data that are more closely related to or affected by rurality? Finally, given the unique geography and topography of Alaska, are there specific cost factors that impact rates in Alaska only?

10. *Applying Geographic Cost Factors to Rurality Tiers.* Next, the Commission considers whether there are methods to delineate rurality that are preferable to the rurality tier system based on Core Based Statistical Areas adopted by the *Promoting Telehealth Report and Order.* One of the primary reasons for adopting the rurality tiers in the Rates Database was to ensure that rates increased as the level of rurality increased, to reflect a presumed increase in cost of providing service as rurality increased. However, outputs of the Rates Database revealed examples of lower median rural rates in more rural tiers than in less rural tiers (*i.e.,* higher rates in the Rural and Less Rural tiers than in the Extremely Rural and Frontier tiers), and higher median rural rates in less rural tiers than in more rural tiers (*i.e.,* lower rates in the Extremely Rural and Frontier tiers than the Rural and Less Rural tiers). These anomalies raise questions about whether the rurality tiers based on Core Based Statistical Areas accurately group comparable rural areas for purposes of determining telecommunications rates. The Commission seeks comment on whether the current rurality tiers used to determine ''comparable rural areas'' are appropriate for determining accurate and reasonable rates. Despite the anomalies, did the Rates Database deliver rates that are ''rates for similar services provided to other customers in comparable rural areas in that State'' as required by the Telecommunications Act of 1996? Could the current rurality tiers be improved by subdividing them? If so, how could the Commission do so in an objective and administratively feasible way? Are there other explanations besides the classification of rurality tiers for these anomalies? For example, would these anomalies disappear or dissipate if the Commission had better controls for different services or for different service level agreements?

11. With respect to anomalies in Alaska, rates for the Rural tier are consistently higher than rates in the Extremely Rural tier due primarily to the state's Census Bureau categorizations. Most of Alaska is not part of a Core Based Statistical Area (CBSA) and therefore Extremely Rural. Juneau and Ketchikan are located in a CBSA and are defined as Rural under Telecom Program rules because they do not contain any Urban Area with a population of 25,000 or greater. However, these areas are isolated in the southeast portion of Alaska, are not necessarily connected by roads despite being located in a CBSA, and are therefore relatively expensive to serve. Would adjusting rurality tiers so that health care providers located in the Juneau and Ketchikan CBSAs fall into the Extremely Rural tier resolve some anomalies? Are there other adjustments that can be made to address this issue?

12. The Commission also seeks comment on replacing the current rurality tiers with alternative methods of determining degrees of rurality, such as the Index of Relative Rurality (IRR). The IRR is a ''continuous, threshold-free, and unit-free measure of rurality.'' IRR addresses degrees of rurality instead of simply designating an area as urban or rural. The IRR focuses on four dimensions of rurality, which include size, density, remoteness, and built-up area, and has three major advantages over typology-based rurality measures. First, it is ''spatially flexible'' in that it is not confined to a particular spatial scale such as counties but can be designed for any spatial units such as townships or census tracts; second, it is a relative and continuous measure and thus treats rurality as a concept rather than a traditional classification; and lastly it is easier to analyze than threshold-based typologies. The Commission seeks comment on using the IRR to replace the current rurality tier system. What would be the advantages and disadvantages of using the IRR to evaluate rurality? What groupings of IRR scores would be appropriate for evaluating rurality tiers? Is the IRR spatially flexible enough to account for Alaska's unique geography? If not, do commenters have specific ideas on how the Commission might build off the IRR to accommodate Alaska?

13. Alternatively, would the Rural Urban Commuting Area (RUCA) codes be preferable to determine rurality tiers? The RUCA codes are a census tract-based classification scheme that uses measures of population density and urbanization in combination with commuting information to characterize all of the nation's census tracts regarding their rural and urban status and relationships to one another. One of the reasons the Commission stopped using FORHP's definition of ''rural area'' in 2004 was because part of FORHP's methodology changed to incorporate the RUCA methodology which at the time failed to incorporate the most recent census data. Since their creation, the RUCA codes have been updated several times with new Census data. The most recent RUCA codes were created by the FORHP, the University of North Dakota Center for Rural Health, and the United States Department of Agriculture (USDA) Economic Research Service and are based on data from the 2010 decennial census and the 2006–10 American Community Survey. The Commission seeks comment on using the RUCA codes to replace the current rurality tiers. What would be the advantages and disadvantages of using the RUCA codes to evaluate rurality? Are the RUCA codes granular enough for Alaska given its unique geography and topography?

14. The Commission seeks comment on other known methods that could more accurately determine degrees of rurality. Are there any other objective and administratively feasible methodologies that should be considered? If so, are these methods appropriate for all states, including Alaska? If the Commission maintains the current definition of ''rural'' for eligibility purposes, how will these new methods interact with the current definition? For example, are there any scenarios in which a particular area is rural under the current definition but would not be sufficiently rural under one of these other methodologies to receive funding? The Commission asks that commenters describe alternate ways to evaluate rurality and, when possible, provide data showing whether these alternatives accurately reflect geographic cost factors in telecommunications rates.

15. The Commission also seeks comment on whether to eliminate rurality tiers altogether and establish rates based on an applicant's census tract information. Examples of such information could include population and business density, measures of terrain and topography such as elevation and slope, measures of distance from urban areas, percentage of built-up areas, etc. Such an approach would be similar to the IRR approach, but instead of producing an index, would directly estimate the impact of various dimensions of rurality on

service prices in a given location. The Commission seeks comment on the feasibility of using specific census tract information to evaluate rurality and determine rates. What are the benefits of using census tract information to determine rates? Do commenters believe that moving away from rurality tiers and relying on census-tract information would more accurately determine reasonable rates? If so, should such an approach be incorporated into the nationwide pricing model that seeks comments.? The Commission also seeks comment on how to use specific census tract information to determine rates if the Commission adopts such an approach. Should the Commission average rates among all ''rural'' census tracts within a state to determine rates? Should the Commission group census tracts that have similar data to evaluate rurality without using specific tiers? How should the Commission group the data? The Commission encourages commenters to suggest creative ways to evaluate rurality and establish rates based on an applicant's census tract information.

16. *Alaska-only Rurality Tiers.* In light of Alaska's unique topography, the Commission seeks comment on whether establishing distinct tiers for Alaska is appropriate for purposes of the Telecom Program. If the Commission adopts one of the alternate methods, will it be appropriate for Alaska, even if it is functional for other states? Should an entirely different method be implemented for evaluating rurality for Alaska than for other states? What specific dimensions of geography and rurality are unique to Alaska that would need to be accounted for in any Alaska-specific methodology? In the 2019 *Promoting Telehealth Report and Order,* the Commission created a Frontier tier unique to Alaska, comprised of off-road areas in the state. The Commission declined, however, to further sub-divide off-road communities in Alaska for determining comparable rural areas. The Commission recognizes that, even in Alaskan off-road communities, different levels of communications infrastructure may exist resulting in different costs for providing and obtaining services. If the Commission maintains the current rurality tiers, should the Commission further sub-divide Alaskan off-road areas to capture these variances in service deployment? If so, what methodology could be used that is objective, administratively feasible, and transparent?

17. *Funding Prioritization.* In the event the Commission adopts a new rurality tier system or an alternative to rurality tiers altogether, the Commission seeks comment on whether the new system should also be used for prioritization. When program demand exceeds available funding, the Commission's current prioritization system prioritizes health care providers in Medically Underserved Areas and health care providers in more rural rurality tiers using the Commission's current methodology for evaluating rurality. If the Commission changes the current methodology for evaluating rurality, should that new methodology replace the current rurality tiers in the prioritization system? Commenters that oppose using the same methodology for evaluating rurality and prioritization should provide viable alternative ways to prioritize funding.

18. *Categorizing service technologies purchased by health care providers.* The Commission examines the categorization of services supported by the Telecom Program. The Commission first seeks comment on approaches to analyzing existing data that would result in more accurate urban and rural rates. The Commission then seeks comment on potential changes to the Telecom Program's categorization of service technologies that could further improve the accuracy of urban and rural rates in future funding years.

19. 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. Correct categorization of ''similar services'' is therefore critical to ensuring that the rates charged to rural health care providers and supported by Telecom Program funds align with the cost of delivering those services and that health care providers receive equitable, consistent funding. Accurate categorization also helps to eliminate the potential for waste and gamesmanship in the Program by, for example, removing incentives for service providers to mischaracterize lower cost services as similar to higher cost services in order to increase Telecom Program funding.

20. The Commission currently analyzes the similarity of services based on whether the services are ''functionally similar as viewed from the perspective of the end user,'' rather than assessing similarity based on technical similarities of the technologies used to deliver service. If a rural health care provider purchases a service that provides a similar user experience to another service, then regardless of underlying media, protocol(s), implementation, or commercial sales/product name, the Commission considers the two services to be functionally similar. For example, if a rural health care provider purchases a satellite service, that service is functionally similar to a DS3 service or Ethernet service from the health care provider's perspective because the services offer features and functions that provide a similar user experience. The Commission proposes to maintain this approach of viewing functional similarity from the perspective of the end user for the purpose of determining urban and rural rates, while also seeking comment about improving the service details incorporated into the rate determination consideration, and the Commission seeks comment on this proposal.

21. In the *Promoting Telehealth Report and Order* the Commission decided to consider services to be ''similar'' if the advertised speed is 30 percent above or below the speed of the service requested by the health care provider. The Commission explained that a 30 percent range would ''provide a sufficiently large range of functionally similar services to enable reasonable rate comparisons.'' The Commission also recognized that factors other than bandwidth such as reliability and security are important to accurately characterizing the functional similarity of services and that these enhanced functions may not be part of a best efforts service. The Commission therefore instructed Universal Service Administrative Company (USAC) to take into account whether a health care provider requests dedicated service or other service level guarantees when grouping similar services for the purpose of rate determination. The Commission further instructed USAC to expand the scope of its inquiry into similar services beyond telecommunications services to include all services that are functionally similar from an end user perspective regardless of regulatory classification. The Commission proposes to continue this technologically-agnostic approach because it is consistent with determining functional similarity from the end user perspective. The Commission seeks comment on maintaining this general approach, including considering advertised speeds within a 30 percent range to be similar.

22. *Existing service category data.* The Commission seeks comment on how to conduct more effective analysis of Telecom Program data which has been previously reported, or will be reported

using the current FCC Form 466, to calculate more accurate urban and rural rates. In the *Promoting Telehealth Report and Order,* the Commission did not elect to consider FCC Form 466 data beyond bandwidth, whether the service is dedicated or best efforts, and whether upload and download speeds are symmetrical or asymmetrical when grouping services within each rurality tier in a State. Is there other data currently available to USAC, or other data that could be provided to USAC such as contract term or volume discounts, that should be factored into rate determination to improve the accuracy of urban and rural rates? Are there adjustments to how USAC groups similar services or otherwise applies data from FCC Form 466 to rate determinations that would improve the accuracy of urban and rural rates?

23. The Commission also seeks comment on recategorizing or refining categorizations for existing Telecom Program service data so that the data more accurately identifies the services being purchased by rural health care providers. The Commission's initial analysis of FCC Form 466 submissions reveals that services reported as ''Ethernet'' or ''MPLS'' that have similar bandwidths frequently have significantly different monthly rates that likely reflect a wide range of customized bundled services and functionalities that can directly impact total costs. These differences are likely attributable in part to overly broad terminology. Telecom Program forms treat multi-protocol label switching (MPLS) as a service when in fact MPLS is a networking technique for routing packets on the internet. There is no standardized meaning of the commercial term ''MPLS,'' and therefore it is possible for service providers to label very different services as MPLS. Furthermore, service providers use a wide variety of pricing models for ''MPLS'' service that make it complicated to compare offerings. Similarly, ''Ethernet'' services are often generic constructs used to create a broad range of services. As a result, it is likely that some of the significant differences in monthly rates for ''Ethernet'' services with comparable bandwidths are due to significant differences in the actual services purchased. A health care provider that selects MPLS or Ethernet service may choose specific security, network management systems, performance guarantees, or technical support that in sum cost significantly more than the basic transmission component of the telecommunications service. Factors beyond the components of the selected service, such as geography, distance, and local exchange carrier channel termination rates can impact the rate for end-to-end service. These non-bandwidth related components of the delivered service may be a significant source of the irregular behavior of the Rates Database, creating anomalies from an inappropriate grouping of rates within a bandwidth or rurality tier that reflect services that are not functionally similar despite having similar bandwidths. Consequently, the medians calculated using these groupings are likely to be unreliable. The Commission seeks comment on this analysis. To the extent these non-bandwidth components impact rates, how should the Commission reconcile its definition and treatment of end-to-end rates?

24. *Revision to service categories.* The Commission seeks comment on updating the Telecom Program's categorization of services to more accurately reflect the functionality and cost of services purchased by rural health care providers by incorporating certain key data points into the similar service determination. For example, one rural health care provider might purchase point-to-point transmission services only, while another's purchase might include, at an additional charge, network management services. Failure to control for such a difference could lead to price anomalies. A more rural low-bandwidth transmission only service could be less expensive than a less rural higher-bandwidth service that includes substantial network management. Similarly, Commission staff's analysis of service and rate data submitted by rural health care providers in recent Telecom Program funding years indicates that many rural health care providers choose to purchase telecommunications services with different service level agreements (SLAs). Distinguishing between basic transmission and enhanced services and between services with different service level agreements should more accurately group similar services from the perspective of the functionality delivered to the end user.

25. One potential approach to service categorization could be to first separate data transmission from more comprehensive service offerings and then collect a limited, defined set of data points about the service purchased to enable similar services to be more accurately grouped together when determining rural rates. Different services would be comparable if they provide a comparable user experience, regardless of each service's underlying transmission media, protocol(s), implementation, or commercial sales/product name. This approach would classify services based upon functionality of the service provided, regardless of its commercial name. For example, rural health care providers completing the FCC Form 466 could identify their service functionality based on three factors: system type, system scope, and additional services. System type covers whether the network is a private network, a managed performance network, or a best effort public network. System scope covers network endpoints, *i.e.,* how many separate facilities are to be connected, and if more than one endpoint, whether there is a hybrid mix of transmission media (fiber, microwave, satellite) or service (MPLS, SD–WAN, Ethernet). For each endpoint the following factors would be considered: Connectivity, *i.e.,* whether it is point-to-point (1:1), point-to-multipoint (1:N), and multipoint-to-multipoint (N:N); facility type, *i.e.,* copper, cable, microwave or other terrestrial wireless, fiber and satellite; bandwidth/speed, separately for download and upload; and billable distance if applicable. Additional services would allow for reporting of premises equipment (managed router service administration); priority maintenance support; security; redundancy/diversity options; availability; failover options; overflow options; data CAP; peak/non-peak options; VoIP; and service level agreements.

26. The Commission seeks comment on questions related to this approach. When considering service level agreements, what should be the focus? For example, is it enough to distinguish from all other contracts, contracts that guarantee a minimum amount of downtime and provide liquidated damages or penalty payments when that guarantee is violated? If so, should the Commission distinguish between different downtime minimums and how? If not, what other service level guarantees should be taken into account? Should the Commission ignore any service level guarantees which do not come with material liquidated damages or penalty payments?

27. The Commission also welcomes recommendations for alternative approaches to service categorization. Proponents of an alternative approach should provide an analysis that seeks to demonstrate why their preferred approach will yield more accurate rural and urban rates than those produced by the Rates Database prior to its waiver. Commenters should also discuss whether their alternative approach would be consistent with viewing the

similarity of services from the end user perspective as proposed.

28. *Improving reporting requirements and data quality.* The Commission seeks comment on proposed revisions to Telecom Program forms and corresponding USAC online portals to improve the quality and consistency of Telecom Program data. The Commission seeks comment on revisions to the FCC Form 466 as well as any other RHC Program forms, including Healthcare Connect Fund Program (HCF Program) forms, that would allow the collection of more detailed service information to allow for more accurate comparisons of rates for similar services consistent with the revised rurality classifications and service categories proposed in the FNPRM. The Commission also seeks general comment on the data collected for the Telecom Program. Is there additional data that could improve the accuracy of urban and rural rate determinations? Is there additional data that would be helpful to ensure program integrity and to minimize waste, fraud, and abuse? Is any data collected on FCC Form 466 unnecessary for evaluating the efficacy of Telecom Program expenditures? How should the Telecom Program balance the importance of data quality with concerns about overburdening health care providers with reporting requirements? The Commission also seeks comment on adding a process for updating, correcting, or removing unreliable or inappropriate rate observations. Should a process exist for validating the rate data that is included in the Rates Database, and if so, what should it entail?

29. The Commission also seeks comment on revisions to current sources of urban and rural rates that are used to populate the rate determination mechanism, be it a database or some alternative. In the *Promoting Telehealth Report and Order,* the Commission established a ''broadly inclusive'' list of sources for urban and rural rates including rates from ''service providers' websites, rate cards, contracts such as state master contracts, undiscounted rates charged to E-Rate Program applicants, prior funding years RHC Program pricing data, and National Exchange Carrier Association (NECA) tariff rates.'' The Commission seeks comment on the benefits and drawbacks of continuing to compile rates from multiple sources as opposed to limiting rate data to rates paid by disbursements from the Telecom Program. Does relying on a large sample of rates actually available in the market increase the accuracy of median rates? Would limiting the relevant rates to those submitted by health care providers on FCC Form 466 result in too narrow a sample that is skewed by the lack of competition in many rural areas? How should the Commission balance the benefits of increasing the pool of sample rates with concerns about whether services purchased by other commercial customers are comparable to those purchased by health care providers participating in the Telecom program? If FCC Form 466 reporting requirements are revised to better identify the service being offered, will it still be feasible to compile rates from other sources that do not have similar reporting requirements? The Commission seeks comment on whether, if continuing to collect data from a large range of sources, statistical tools could be used, such as indicator variables in the proposed nationwide regression model, to control for data sourcing.

30. The Commission also seeks comment on whether there is certain information regarding the technical details or components of telecommunications services that rural health care providers cannot access or lack the technical expertise to report to USAC and should therefore be reported by service providers. How can the Commission ensure that health care providers, who may not have technical expertise over the telecommunications services they receive, accurately report the services they receive in the RHC Program? Should the Commission require service providers to submit service information to USAC? How should the Commission balance the value of detailed service data with the importance of minimizing burdens on health care providers and service providers, and also avoiding redundancies in data submissions?

31. *Selecting a rate determination mechanism.* The Commission seeks comment on the most effective method for determining urban and rural rates in an objective, transparent manner that can be uniformly applied to all Telecom Program applications. The Commission also seeks comment on whether, and if so how, to factor market competition into the rate determination mechanism. Are there areas where rural healthcare providers that receive Telecom Program support have competing service alternatives sufficient to enable the Commission to rely on competition to establish reasonable rural rates? If an area has multiple service providers but only one bidder offers to provide service to the rural healthcare provider, should a rate determination mechanism consider the market to be competitive? How should the rate determination mechanism factor in rates for deregulated commercial services that may be similar to services sought through the Telecom Program but are not publicly available?

32. *Modifications to the current urban and rural rates database.* The Commission first seeks comment on whether to retain the requirement that health care providers and service providers use a modified version of the Rates Database to determine urban and rural rates when the current waiver expires. Pursuant to the *Nationwide Rates Database Waiver Order,* DA 21–394, §§ 54.604(a) and 54.605(a) of the Commission's rules are waived for funding year 2021 and funding year 2022, delaying implementation of the Rates Database. Should the Commission revise the Rates Database to incorporate the modified rurality classifications and service categorizations? Will the revisions to those key data inputs be sufficient to resolve the anomalies that resulted in the waiver?

33. The intent of the rate determination process is to establish transparent, predictable, easy-to-administer rural and urban rates that also fulfill the requirements of section 254 of the Act so that Telecom Program subsidies result in rural health care providers paying rates that are reasonably comparable to rates for functionally similar services in urban areas of the health care provider's state and universal service support to service providers that is based on ''rates for similar services provided to other customers in comparable rural areas.'' The Commission seeks comment on whether modifications could be made to a future iteration of the Rates Database to enhance transparency, predictability, or efficient administration.

34. Wireline Competition Bureau's (Bureau) waiver of the Rates Database was due primarily to significant anomalies in median rural rate outputs, specifically instances where median rural rates were lower in more rural areas of state when compared to less rural areas and several instances where median rates for higher bandwidth services were lower than lower bandwidth services in comparable areas. If more effective collection of rates and service descriptions significantly reduces the anomalies found in the current approach, the Commission seeks comment on whether the resulting Rates Database, or some similar set of rate comparisons, should be used for setting urban and rural rates. The Commission seeks comment on whether the modifications to rurality tiers and service categorizations discussed in the FNPRM, or any further modifications

identified by commenters, will sufficiently address those anomalies.

35. The Commission also seeks more general comment on the Rates Database. What are the overall benefits and drawbacks of the Rates Database? How, if at all, have those benefits and drawbacks changed since the Commission adopted the Rates Database in the *Promoting Telehealth Report and Order*? Is a Rates Database framework the best solution for Alaska? Are there alternative methods for determining rates in Alaska that would be objective, independent, and administratively efficient?

36. In the event that the Rates Database is retained for future funding years, the Commission seeks comment on whether to take further action or rescind the guidance previously issued to USAC by the Bureau regarding administration and implementation of the Rates Database. The Commission seeks comment on further guidance or clarifications that would further the goal of promoting transparency and predictability in the rates determination process. Are there additional changes to the Rates Database that might resolve the anomalies the FNPRM? Would determining rates using the average, rather than the median, of inputs provide sufficient and predictable funding?

37. *Alternative rate determination methods.* The Commission seeks comment on potential alternative rate setting mechanisms to the Rates Database. The Commission seeks comment on the benefits and drawbacks of these alternative approaches.

38. *Pricing model with nationwide rate data.* The Commission seeks comment on creating a nationwide regression model to estimate rural and urban rates and determine Telecom program reimbursement on a state-by-state basis. As with the Rates Database, with a regression model, health care providers would enter information about the services for which they seek support. A regression model would estimate the rural and urban rates for Telecom Program-eligible services as determined by the characteristics that are reasonably expected to affect those rates. While the Commission does not know exactly how providers, including providers of Telecom Program services, set prices, certain characteristics are expected to influence a service's price, known as explanatory variables for the purposes of this analysis. For example, based on data submitted by health care providers on the FCC Form 466, the Commission has an indication of the service type (*e.g.,* Ethernet, MPLS, satellite), bandwidth, the health care provider's location, and whether there are service-level agreements associated with the service contract. Using the same data that is used to construct the Rates Database or any new data that may be collected, a Telecom Program regression model would analyze how these explanatory variables influence price, and it would then estimate the rural and urban rates for the particular service purchased by a health care provider in a particular state. The Regression Model Technical Analysis, provides details on the relationship between explanatory variables and the estimated rates (the outcome variables). The Commission seeks comment on the regression model analysis.

39. *Model inputs.* The Commission seeks comment on the appropriate set of explanatory variables for use in such a model. The data used to construct the current Rates Database contain a range of information about both the services that are eligible for Telecom Program support and related services. The Rates Database categorizes services by three sets of characteristics: bandwidth, rurality tier, and the presence or absence of a service level agreement (*i.e.,* whether the service was dedicated or best efforts). A regression model would account for the same or an expanded set of characteristics by analyzing a large number of existing rural and urban rates. The Commission seeks comment on using the same characteristics from the Rates Database as explanatory variables in a regression model. The Commission also seeks comment on whether it is beneficial to identify and include in the regression model a broader set of characteristics that are likely determinative of rates. The Commission anticipates that using an expanded list of characteristics would be superior to a model that only relies on bandwidth, rurality tier, and presence or absence of a service-level agreement, because staff review of the data used to construct the Rates Database suggests that other characteristics could significantly contribute to the variation in rates. Further, it is possible to revise the existing set of explanatory variables to better specify the relevant factors that drive rates. For example, modifications to rurality tiers and service categories on which the Commission seeks comment in the FNPRM could improve the model estimates by improving the quality of those key variables and strengthening their relationship to how services are priced.

40. A regression model could also be applied to a subset of the data used to construct the Rates Database based on the underlying source of data (for example, the FCC Form 466 versus E-Rate forms), or alternatively, it could easily account for new data that are subsequently collected. The Commission seeks comment on the best immediately available data that should be included in a regression model if the Commission were to adopt such an approach. Should the Commission include the universe of rates used to determine medians in the Rates Database? Should records used in the regression model be limited to RHC Program rates from FCC Forms 466? How many years of rate data should the regression analysis include? Regression models can control for relatively simple time trends. For example, including data year as an explanatory variable can capture price movements from one year to another. In such cases, using all the available years of data is to be preferred to excluding some of them. However, ensuring time effects are appropriately modeled becomes increasingly difficult when the effect of other explanatory variables on prices also varies with time. In such instances the use of old data may confound, rather than reveal, more recent relationships. The Commission also seeks comment on the type of data to include in a nationwide regression analysis going forward. Would newly collected data stemming from changes to reporting requirements proposed in the FNPRM improve the regression model results? What other data should the Commission consider that could improve the model's ability to estimate rural and urban rates? Beyond conventional regression analysis, should other data-driven approaches be considered, such as machine learning?

41. *State-specific analysis.* Section 254(h)(1)(A) of the Act requires that urban rates be ''reasonably comparable to rates charged for similar services in urban areas in that State'' and that rural rates be ''rates for similar services provided to other customers in comparable rural areas of the state.'' The Commission seeks comment as to whether it would be consistent with the statute to use nationwide inputs as a part of a regression analysis that determines the urban and rural rates within a state. A nationwide regression model would distinguish the independent effects of a range of explanatory variables that influence rates in a statistically coherent fashion, while taking into account the influence of state-specific factors that are not accounted for by the other explanatory variables. Thus, if rates in a given state are higher than other states, the regression model would account for

these differences. Furthermore, additional local factors that influence rates beyond those used by the Rates Database, such as the terrain of a given location or existing network density, could be included within the regression model to further refine state-by-state results.

42. A regression model considers how any explanatory variable the Commission could measure (service type, bandwidth, rurality, state, etc.) affects rates holding the other variables constant. Such an approach separates out the independent effect of each variable on the rate. Thus, the Commission can account for effects on rates that are constant within a state but vary among states, such as state laws that affect construction, labor or other costs, or unique geographic or demographic conditions, by using the state as an explanatory variable in the regression model.

43. In addition, a regression model gains accuracy with more data. Knowledge about how bandwidth or service type affect rates in one state can assist the model in determining how these same factors affect rates in another. Could the use of nationwide data in a regression framework improve the Commission's capacity to set reasonably comparable rates for similar services in any state? The Commission also seeks comment on how to account for factors that are unique to each state.

44. *Rurality-based discount tiers.* Alternatively, the Commission seeks comment on whether to adopt discount rates based on the rurality of the health care provider for the Telecom Program as a way to satisfy the statutory requirements for establishing rates under section 254(h)(1)(A) of the Act. Under a discount rate system, the amount of support would be a percentage of the price of the service listed in the contract, and the percentage paid by the Universal Service Fund would increase as rurality increases. In the E-Rate program, schools and libraries may receive discounts ranging from 20 to 90 percent of the pre-discount price of eligible services and equipment based on indicators of need. The Commission seeks comment on whether an analogous approach establishing discount tiers based on the health care provider's rurality would be an effective, reasonable, and workable method of determining rates for the Telecom Program.

45. The Commission seeks comment on whether a discount rate approach could meet section 254(h)(1)(A) of the Act's requirement that telecommunications carriers provide services to rural health care providers at ''rates that are reasonably comparable to rates charged for similar services in urban areas in that State.'' Historically, the Commission has implemented this statutory mandate by allowing health care providers to report their *exact* urban rates on their own. Section 254(h)(1)(A) of the Act, however, does not require that the rate charged to the health care provider be equal to the rate charged for similar services in a state. It merely requires that the rate charged to the health care provider be ''reasonably comparable'' to that rate. Section 254(h)(1)(A) of the Act also requires that the level of support be the difference between rates charged in urban areas and ''rates for similar services provided to other customers in comparable rural areas in the state.'' Would the amount that a health care provider pays in a discount rate system satisfy the requirements under section 254(h)(1)(A) of the Act given that the costs incurred by the health care provider under such a system would change depending on the price of the service?

46. The Commission also seeks comment on the advantages and disadvantages of a discount rate system in the Telecom Program. Under current program rules, the health care provider does not receive any financial benefit from a reduction in its rural rate because it pays the same urban rate regardless of what the rural rate is. Would a discount rate system incentivize healthcare providers to search for or negotiate lower priced contracts? Would this mechanism consequently apply competitive pressure on telecommunications carriers to submit more competitive bids during the bidding process?

47. The Commission adopted the E-Rate program percentage discount mechanism as recommended by the Joint Board on Universal Service. The Joint Board's recommendation was based on its finding that percentage discounts would ''establish incentives for efficiency and accountability'' by both requiring schools and libraries to pay a share of the cost and encouraging schools and libraries to seek out the lowest pre-discount cost in order to reduce their post-discount cost. However, the Joint Board recognized the importance of focusing the highest discounts on the most disadvantaged schools and libraries and set discounts for those schools and libraries at 90 percent. The Commission seeks comment on potential discount percentages for the Telecom Program as well as whether discount percentage tiers could be determined strictly by the health care provider's rurality or if other data points should factor into discount tier determination. What level of discount would be necessary to ensure reasonable comparability considering the very high cost of services in remote areas, particularly regions of Alaska currently classified as Frontier, and the limited resources of many rural health care providers? Due to the unique challenges that Tribal health care providers face, should Tribal health care providers receive a higher discount rate than non-Tribal providers in comparable rural areas? Would providing a higher discount rate for Tribal health care providers or considering factors other than rurality in determining discount rates comply with section 254(h)(1)(A) of the Act? Are there any other considerations beyond rurality that should be factored into a discount tier approach?

48. *Cost curves.* The Commission also seeks comment on whether independent, reliable cost curves might be used in a future rates determination process to account for the relationship between bandwidth and rates. Although rates generally increase as bandwidth increases if all other factors are unchanged, cost on a per megabit per second basis generally decreases as bandwidth increases. A pricing curve shows how the relationship between cost and bandwidth changes as bandwidth increases. Using a pricing curve might make it possible to increase the sample size of inputs that are used to calculate the rates used to determine support in the Telecom Program beyond inputs 30 percent above or below the speed of the requested service, thereby improving reliability. The Commission could use the pricing curve to establish a baseline per megabit per second rate for inputs consisting of rates that are actually charged, use those inputs to calculate a per megabit per second rate, and then extrapolate the rate for the requested bandwidth with the pricing curve. This option would not be viable without an independent, pricing curve that accurately reflects the relationship between bandwidth and price and can be verified by interested parties. What, if any, independent cost curves reflect the relationship between bandwidth and price? Do these cost curves accurately reflect the relationship between bandwidth and price across all parts of the country? Would a single cost curve be appropriate for all technologies, or does the relationship between bandwidth and cost vary depending on the technology used to deliver the service? Would a single nationwide cost curve produce accurate rates across all geographies? Would the unique

geographic characteristics of Alaska require a separate cost curve? Would the use of a cost curve allow for support that is ''reasonably comparable to rates charged for similar services'' in urban areas? What other aspects of the use of a cost curve should the Commission consider?

49. *Other potential rate determination methods.* In addition to the alternatives, the Commission seeks comment on any other alternative rate determination methods that would increase rate transparency while ensuring program integrity and promoting program administration. SHLB suggested that the Commission change the ''amount of the subsidy in the Telecom Program from 100 percent of the difference between the urban and rural rate to 95 percent of the difference between the urban and rural rate,'' while requiring health care providers to pay the remaining five percent. SHLB claimed at the time that such an approach ''would ensure that HCPs are price sensitive to the total cost of the services.'' The Commission seeks comment on such an approach. If the Commission adopted such an approach, would five percent be an appropriate portion of the urban/rural rate difference for health care providers to pay, or should another percentage be adopted? Should health care providers always pay the same percentage of the urban/rural rate difference or should the percentage vary depending on the circumstances of the health care provider? If the latter, how should the Commission determine when and how the percentage varies? Should the Commission consider capping the total amount that a health care provider would pay under such a system? Would this approach be workable for health care providers in Alaska given the higher costs of providing service in that state? In the *2019 Promoting Telehealth Report and Order,* the Commission declined to follow this approach, finding that ''it would be inconsistent with the goal of section 254'' of the Act. Are there reasons for the Commission to reconsider that analysis?

50. *Potential transition period.* The Bureau's waiver of the use of the Rates Database expires at the end of funding year 2022 and the current Telecom Program rules and forms will govern the rate determination process and Telecom Program data collection at least through funding year 2022 and potentially further into the future depending on rulemaking and implementation timelines. The Commission acknowledges that competitive bidding for funding year 2023 is approaching and may begin as early as July 1, 2022. The Commission seeks comment on how to manage this transition period. To the extent that the new rules established for determining urban and rural rates are not in effect in time for use in funding year 2023, the Commission seeks comment on how to determine urban and rural rates during any transition period that may occur. Should the current waiver of Commission rules governing the Rates Database be extended to permit time for implementation of new rates determination rules and any associated modifications to RHC Program forms and systems? Are there viable alternatives to extending the waiver? If the Commission implements changes to Telecom Program rules and forms, should the Rates Database waiver also be extended for an additional funding year so that USAC can collect one funding year of data under the new rules to repopulate the Rates Database? If the Commission retains the Rates Database, should the reinstated Rates Database continue to rely on rate data collected under previous Telecom Program rules? Should older rates be phased out gradually?

51. *Reforming the Internal Cap on Multi-Year Commitments and Upfront Payments.* In 2018, the Commission increased the annual RHC Program funding cap to $571 million, annually adjusted the RHC Program funding cap to reflect inflation using the Gross Domestic Product Chain-type Price Index (GDP–CPI), beginning with funding year 2018, and established a process to carry-forward unused funds from past funding years for use in future funding years. In the 2019 *Promoting Telehealth Report and Order,* it further directed the Bureau to adjust the $150 million funding cap on multi-year commitments and upfront payments in the HCF Program (internal cap) pursuant to the same index established for adjusting the overall RHC Program cap, the GDP–CPI inflation index. Any increases to the internal cap is accounted for *within* the overall RHC Program cap, *i.e.,* an increase in the internal cap on multi-year commitments and upfront payments will not increase the overall RHC Program cap. In each of the funding years 2018, 2019, and 2020, gross demand for multi-year commitments and upfront payments exceeded the $150 million internal cap, and the Commission took actions to avoid proration or prioritization reductions of the support for those funding requests. With this history in mind, the Commission proposes reforming the funding cap rules to more efficiently and effectively handle the internal cap on multi-year commitments and upfront payments in the HCP Program by having the internal cap apply only when overall demand exceeds available funding and, if it does apply, targeting funding for equipment and services needed in the funding year at issue.

52. First, to promote the efficiency of the RHC program and reduce delays of funding commitments, the Commission proposes amending the rules to limit the application of the internal cap to only funding years for which the total demand exceeds the total remaining support available. In other words, when the total support available for the funding year, which is the sum of the inflation-adjusted RHC Program aggregate cap in § 54.619(a) of the Commission's rules and the proportion of unused funding determined for use in the RHC Program pursuant to § 54.619(a)(5) of the Commission's rules, could satisfy the total demand, the internal cap would not apply. Specifically, in an initial filing window, the internal cap would apply only when the total program demand during the filing window exceeds the total support available in the RHC Program for the funding year. In the unlikely event that there is an additional filing window in a given year, and if the total demand during the additional filing window exceeds the total remaining support available for the funding year, funding for upfront payment and multi-year commitment requests submitted during the additional filing window will be capped at the remaining support available within the internal cap.

53. This proposed amendment to Commission rules would 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, because the internal cap would still apply in the same way as before when the total demand exceeds the total remaining support available. The Commission seeks comment on this proposed new rule. In particular, will it have any negative impact on the RHC Program? The Commission recognizes there might be concerns that a very large demand for upfront payments and multi-year commitments could consume a significant amount of the unused funds, and consequently could impact the available funding for single-year requests in the next funding year because there would be less unused funding available to be carried forward to the next funding year. The more likely result of fully funding a large demand for upfront payments and multi-year commitments, however, is that *less* funding would be required for

single-year requests in the next funding year. This would be the case because there likely will be fewer single-year requests in the next funding year given that some of the multi-year commitments may have their second-year requests filed as single-year requests in the next funding year if not fully funded. Thus, the full-funding of a large demand for upfront payments and multi-year commitments would be unlikely to cause single-year request prioritization in the next funding year. Nevertheless, the Commission believes that this proposed new rule will not result in all or most unused funding from prior funding years being exhausted in a single funding year because the Bureau, in consultation with the Office of the Managing Director, controls the proportion of unused funding to be used in the RHC Program. Are these assessments reasonable?

54. Second, when the internal cap applies and is exceeded, the Commission proposes to target funding for upfront costs and the first year of multi-year commitment requests and to fund the second and third year of multi-year commitments with any leftover funding. Currently, when funding requests for upfront payments and multi-year commitments must be prioritized, requests falling in a higher prioritization category will be fully funded before requests in the next lower prioritization category can be funded, provided that there are funds available and the internal cap has not been reached. For example, a three-year multi-year commitment request in a ''Priority 2'' tier may have all three years' services funded while a three-year multi-year commitment request in a ''Priority 6'' tier may not be funded at all, including the first year's service.

55. The current prioritization process will inevitably result in some health care providers, likely those in the lower prioritization categories, losing all or a portion of their requested support when the requests must be prioritized 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 the next two funding years. To mitigate the adverse impact on those health care providers, the Commission proposes amending § 54.621 of the Commission's rules to fund upfront payments and the first year of multi-year commitments for all priority tiers (provided funding is available), and then the second and third years of the multi-year commitments until the internal cap is reached. This way, it is more likely that all health care providers that requested upfront payments and multi-year commitments can at least have their current funding year's financial need satisfied. Applicants can still request the second and third year funding in the next funding year. The Commission seeks comment on the proposed change to § 54.621 of the Commission's rules. Alternatively, should the internal cap apply only to self-construction, in order to reduce its impact on other forms of upfront payments, such as funding for equipment, and on multi-year commitments?

56. The Commission also proposes allowing the underlying contracts associated with those multi-year requests that are not fully funded to be designated as ''evergreen,'' provided that the contracts satisfy the criteria set forth in § 54.622(i)(3)(ii) of the Commission's rules. The evergreen designation will exempt applicants from having to complete the competitive bidding process for the contracts when subsequently filing requests for support pursuant to these contracts. As a result, applicants can request multi-year commitments pursuant to these contracts in the next funding year without going through the competitive bidding process. The Commission seeks comment on this proposal.

57. The proposed method for prioritizing upfront payment and multi-year commitment requests applies when both the total support available and the internal cap are exceeded. Should this method also apply when the total support available is exceeded but the internal cap is not exceeded? Currently, if the total demand exceeds the total support available but the demand for upfront payments and multi-year commitments is within the internal cap, all eligible requests (single-year requests and upfront payment and multi-year commitment requests) submitted during the filing window will be prioritized according to the priority schedule defined in § 54.621(b) of the Commission's rules. In such a case, no separate prioritization of the upfront payment and multi-year commitment requests will be conducted because the internal cap is not exceeded. If the proposed method should also apply when the total support available is exceeded but the internal cap is not exceeded, the Commission proposes funding all single-year requests, upfront payments, and the first-year of multi-year commitment requests in accordance with § 54.621(b) of the Commission's rules *before* funding the second year and third year of multi-year commitment requests.

58. The Commission acknowledges that some health care providers, especially those in the higher prioritization categories, may be inconvenienced under the proposed method because they would 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. The Commission tentatively concludes that this inconvenience to those health care providers is outweighed by the benefit to health care providers who, without this rule change, could have funding requests for upfront costs and services in the first year of a multi-year commitment request denied or prorated. Do program participants agree with this tentative conclusion? Are there any additional disadvantages associated with this method? Are there any other approaches to better handle the prioritization reduction of upfront payments and multi-year commitments? Rather than making these changes, would it be better to simply eliminate the internal cap on upfront costs and multi-year commitments? The Commission also seeks comment on whether the current funding cap is sufficient to satisfy demand now and in the coming years for the RHC Program, including whether the current inflation adjustment mechanism accurately reflects changes in the cost to provide broadband and telecommunications services.

59. *Harmonizing Telecom Program Invoicing With HCP Program Invoicing.* In the 2019 *Promoting Telehealth Report and Order,* the Commission established a number of improvements to the invoicing process for both the HCF Program and Telecom Program. Specifically, the Commission established a uniform invoice filing deadline for the RHC Program, beginning with funding year 2020, established a one-time invoice deadline extension allowing service providers and billed entities to request and automatically receive a single one-time 120-day extension of the invoice deadline, and strengthened the certifications under both the Telecom Program and HCF Program.

60. The Commission proposes to fully harmonize the invoicing process between the Telecom Program and the HCF Program. Currently, there are separate invoicing processes for the two programs. Under the Commission's rules, Telecom Program participants ''must submit documentation to [USAC] confirming the service start date, the service end or disconnect date, or whether the service was never turned on.'' Health care providers send this

information to USAC via the FCC Form 467 (Connection Certification). After that, USAC generates a Health Care Provider Support Schedule (HSS), which the service provider uses to determine how much credit the applicant will receive for the services. When the HSS is generated, the service provider reviews the HSS for accuracy and applies the credit to the health care provider's account. Once the credit is applied to the health care provider's account, the service provider can file invoices through USAC's online filing system, My Portal. After an HSS is issued, it is the responsibility of the health care provider to submit a request for an FCC Form 467 revision if services are delayed or not turned on. Absent requests for an FCC Form 467 revision, the service provider may submit invoices for services for the exact amount listed on the HSS and USAC will continue to disburse funds according to the schedule.

61. The Commission tentatively concludes that HSSs compromise the ability of USAC to administer the Telecom Program effectively and efficiently because once a service provider files an invoice and receives a disbursement, the FCC Form 467 can no longer be revised even when there is a change in service. Due to this limitation, if a service is later disconnected or was never actually installed, the service provider could still submit invoices for the service (but only for the amount established in the HSS) and receive disbursements from USAC. In My Portal, when a service provider submits an invoice, the amount requested for disbursement is pre-populated and must match the amount determined in the HSS even if the actual costs reflected in the bill are for less than the HSS amount. In recent years, the Enforcement Bureau discovered instances where invoices submitted under a valid HSS were inaccurate. Specifically, the invoices were for disconnected or uninstalled services, which resulted in funding disbursements to the service provider that exceeded the amount of Telecom Program support to which it was entitled.

62. The HCF Program uses a simpler invoicing process. To invoice in the HCF Program, the participating service provider and the health care provider must submit an invoice for broadband service using FCC Form 463 (Invoice and Request for Disbursement Form) to USAC after services are provided. Once a health care provider receives a bill from its service provider, it can create an invoice for the services received using the FCC Form 463. The health care provider must certify that the information in the form and attachments is accurate and that it or another eligible source has paid the 35 percent contribution. The health care provider then sends the FCC Form 463 to the service provider for approval through My Portal. The service provider reviews the FCC Form 463 and certifies its accuracy, and then submits the form to USAC. Once USAC receives the FCC Form 463, it processes the form and, if approved, funds are then distributed to the service provider. Thus, funding is only disbursed in the HCF Program when actual costs are reflected in an invoice from the service provider. The process of confirming costs with invoices reduces the possibility of over-invoicing because funding is disbursed only when expenses are actually incurred, which differs from the Telecom Program where a service provider may receive funds when the service was never installed or was disconnected.

63. To alleviate inefficiencies and to further protect against waste, fraud, and abuse in the RHC Program, the Commission proposes to revise the rules to eliminate the use of HSSs in the Telecom Program and align the Telecom Program's invoicing process with the HCF Program's invoicing rules. Specifically, the Commission proposes to have participants in both programs invoice USAC for services actually provided using the FCC Form 463 rather than use HSSs in the Telecom Program. The Commission tentatively concludes that eliminating the use of HSSs in the Telecom Program would increase the efficient and effective distribution of program funds because funds would be distributed according to actual costs rather than according to a predetermined schedule. The Commission seeks comment on this tentative conclusion. 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. The Commission therefore proposes to eliminate the use of the FCC Form 467 and retire the form. The Commission tentatively concludes that removing the burden of reporting changes in service would better protect the Telecom Program from waste, fraud, and abuse because it would reduce the possibility that service providers could over invoice USAC for services not provided. The Commission seeks comment on these proposals and invite commenters to comment on whether there is an alternative method for revising the invoicing rules in the Telecom Program to protect against waste, fraud, and abuse.

64. *Application Processing, Funding Decisions, and Appeals of Decisions.* The Commission seeks comment on any additional measures beyond those already taken by the Commission and USAC that could further enhance the efficiency of application processing and the speed in which funding commitment decisions are made. To ensure distribution of support in accordance with program rules and to make the application process as smooth as possible for health care providers, in the *Promoting Telehealth Report and Order,* the Commission directed USAC to develop procedures for application review and to develop outreach materials to help participants navigate program processes. Additionally, USAC recently began a multi-step overhaul of its application platform that should make the funding review process faster and more efficient. Analysis conducted by Commission staff indicates that USAC's processing for RHC Program applications has improved in recent funding years. The Commission seeks comment on what additional steps, if any, the Commission or USAC can take to further expedite application processing while still protecting the integrity of the Fund. Should the Commission consider requiring USAC to process applications and make funding commitment decisions within a specified period of time after the close of the filing window or after the requisite forms and responses to USAC information requests have been deemed received by USAC after initial cursory review? One stakeholder raised concerns that program rules are unclear regarding the eligibility of equipment, leading to inconsistent funding decisions. If this is the case, in what way are program rules unclear regarding the eligibility of equipment and how can they be made clearer? The Commission also seeks comment on whether there are changes that can be made to the existing appeals process for appeals with USAC and the Commission, including whether the Commission or USAC should be required to act on such appeals within a specified period of time.

65. Finally, The Commission seeks comment on whether there are other reforms the Commission should consider to eliminate common errors with the application review and decision-making process. Stakeholders have previously expressed concern about administrative errors on the part of USAC that lead to lengthy delays. Do these types of errors remain a concern?

Are there steps the Commission can take to reduce the administrative costs and burdens on health care providers while maintaining the integrity of the Fund and protecting against waste, fraud, and abuse?

66. *Digital Equity and Inclusion.* The Commission, as part of its continuing effort to advance digital equity for all, 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 and benefits (if any) that may be associated with the proposals and issues discussed herein. Specifically, the Commissions seek comment on how the proposals may promote or inhibit advances in diversity, equity, inclusion, and accessibility, as well the scope of the Commission's relevant legal authority.

III. Procedural Matters

A. Initial Paperwork Reduction Act Analysis

67. 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), the Commission seeks specific comment on how to further reduce the information collection burden for small business concerns with fewer than 25 employees.

B. Initial Regulatory Flexibility Analysis

68. The Regulatory Flexibility Act of 1980, as amended (RFA), 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 significant economic impact on a substantial number of small entities'' by the policies and rules proposed in the FNPRM. Accordingly, the Commission has prepared an Initial Regulatory Flexibility Analysis (IRFA) concerning potential rule and policy changes contained in the FNPRM. 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 FNPRM. The Commission will send a copy of the FNPRM, including this IRFA, to the Chief Counsel for Advocacy of the Small Business Administration (SBA). In addition, the FNPRM and IRFA (or summaries thereof) will be published in the **Federal Register**.

69. *Need for, and Objective of, the Proposed Rules.* Through the FNPRM, the Commission seeks to improve the Rural Health Care (RHC) Program's capacity to distribute telecommunications and broadband support to health care providers–especially small, rural healthcare providers (HCPs)—in the most equitable 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.

70. In the FNPRM, the Commission seeks comment on several measures to improve the process of determining accurate and reasonable rates in the Telecom Program. Specifically, the Commission seeks comment on various data inputs related to rurality classifications for health care providers and categorization of eligible services to determine rates that reflect the cost of delivering service to health care providers. The Commission also seeks comment on how to improve the current rate determination mechanism to prevent some of the inconsistencies and anomalies in Rates Database. The Commission seeks additional comment on alternatives to the Rates Database, including a regression model.

71. The Commission also proposes and seeks comment on a few procedural matters that would improve the overall effectiveness of the RHC Program. For example, the Commission seeks comment on reforming the RHC Program's internal funding cap. Specifically, the Commission proposes to amend the current rules so that the internal cap for upfront costs and multi-year commitments applies only if available funding for the entire program is exceeded. The Commission seeks comment on a two-tiered system that would prioritize first the funding of upfront costs and the first year of multi-year commitments and then the second and third year of multi-year commitments until the internal cap is reached.

72. To alleviate inefficiencies and to further protect against waste, fraud, and abuse in the RHC Program, the Commission also proposes to revise the rules to eliminate the use of Health Care Provider Support Schedules (HSSs) in the Telecom Program and harmonize the Telecom Program's invoicing process with the HCF Program's invoicing rules.

73. *Legal Basis.* The legal basis for the FNPRM is contained in sections 1 through 4(g)(D)(i)–(j), 201–205, 254, 303(r), and 403 of the Communications Act of 1934, as amended by the Telecommunications Act of 1996, 47 U.S.C. 151 through 154(i), (j), 201 through 205, 254, 303(r), and 403.

74. *Description and Estimate of the Number of Small Entities to Which the Proposed Rules Will Apply.* The RFA directs agencies to provide a description of and, where feasible, an estimate of the number of small entities that may be affected by the proposed rules, if adopted. The RFA generally defines the term ''small entity'' as having the same meaning as the terms ''small business,'' ''small organization,'' and ''small governmental jurisdiction.'' In addition, the term ''small business'' has the same meaning as the term ''small business concern'' under the Small Business Act. A ''small business concern'' is one that: (1) Is independently owned and operated; (2) is not dominant in its field of operation; and (3) satisfies any additional criteria established by the Small Business Administration (SBA).

75. *Small Businesses, Small Organizations, Small Governmental Jurisdictions.* The Commission's actions, over time, may affect small entities that are not easily categorized at present. Therefore, at the outset, there are three broad groups of small entities that could be directly affected herein. First, while there are industry specific size standards for small businesses that are used in the regulatory flexibility analysis, according to data from the SBA's Office of Advocacy, in general a small business is an independent business having fewer than 500 employees. These types of small businesses represent 99.9 percent of all businesses in the United States which translates to 31.7 million businesses.

76. 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.'' 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. 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.

77. Finally, the small entity described as a ''small governmental jurisdiction'' is defined generally as ''governments of cities, counties, towns, townships, villages, school districts, or special districts, with a population of less than fifty thousand.'' U.S. Census Bureau data from the 2017 Census of Governments indicates that there were 90,075 local governmental jurisdictions consisting of general purpose governments and special purpose governments in the United States. Of this number there were 39, 931 general purpose governments (county, municipal and town or township) with populations of less than 50,000 and 12,040 special purpose governments (independent school districts) with populations of less than 50,000. Based on the 2017 U.S. Census Bureau data the Commission estimates that at least 48, 971 entities fall in the category of ''small governmental jurisdictions.''

78. 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.

79. *Healthcare Providers, Offices of Physicians (except Mental Health Specialists).* This U.S. industry comprises establishments of health practitioners having the degree of M.D. (Doctor of Medicine) or D.O. (Doctor of Osteopathy) primarily engaged in the independent practice of general or specialized medicine (except psychiatry or psychoanalysis) or surgery. These practitioners operate private or group practices in their own offices (*e.g.,* centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers. The SBA has created a size standard for this industry, which is annual receipts of $12 million or less. According to 2012 U.S. Economic Census, 152,468 firms operated throughout the entire year in this industry. Of that number, 147,718 had annual receipts of less than $10 million, while 3,108 firms had annual receipts between $10 million and $24,999,999. Based on this data, the Commission concludes that a majority of firms operating in this industry are small under the applicable size standard.

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

81. *Offices of Chiropractors.* This U.S. industry comprises establishments of health practitioners having the degree of D.C. (Doctor of Chiropractic) primarily engaged in the independent practice of chiropractic. These practitioners provide diagnostic and therapeutic treatment of neuromusculoskeletal and related disorders through the manipulation and adjustment of the spinal column and extremities, and operate private or group practices in their own offices (*e.g.,* centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers. The SBA has established a size standard for this industry, which is annual receipts of $8 million or less. The 2012 U.S. Economic Census statistics show that in 2012, 33,940 firms operated throughout the entire year. Of that number 33,910 operated with annual receipts of less than $5 million per year, while 26 firms had annual receipts between $5 million and $9,999,999. Based on this data, the Commission concludes that a majority of chiropractors are small.

82. *Offices of Optometrists.* This U.S. industry comprises establishments of health practitioners having the degree of O.D. (Doctor of Optometry) primarily engaged in the independent practice of optometry. These practitioners examine, diagnose, treat, and manage diseases and disorders of the visual system, the eye and associated structures as well as diagnose related systemic conditions. Offices of optometrists prescribe and/or provide eyeglasses, contact lenses, low vision aids, and vision therapy. They operate private or group practices in their own offices (*e.g.,* centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers, and may also provide the same services as opticians, such as selling and fitting prescription eyeglasses and contact lenses. The SBA has established a size standard for businesses operating in this industry, which is annual receipts of $8 million or less. The 2012 Economic Census indicates that 18,050 firms operated the entire year. Of that number, 17,951 had annual receipts of less than $5 million, while 70 firms had annual receipts between $5 million and $9,999,999. Based on this data, the Commission concludes that a majority of optometrists in this industry are small.

83. *Offices of Mental Health Practitioners (except Physicians).* This U.S. industry comprises establishments of independent mental health practitioners (except physicians) primarily engaged in (1) the diagnosis and treatment of mental, emotional, and behavioral disorders and/or (2) the diagnosis and treatment of individual or group social dysfunction brought about by such causes as mental illness, alcohol and substance abuse, physical and emotional trauma, or stress. These practitioners operate private or group practices in their own offices (*e.g.,* centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers. The SBA has created a size standard for this industry, which is annual receipts of $8 million or less. The 2012 U.S. Economic Census indicates that 16,058 firms operated throughout the entire year. Of that number, 15,894 firms received annual receipts of less than $5 million, while 111 firms had annual receipts between $5 million and $9,999,999. Based on this data, the Commission concludes that a majority of mental health practitioners who do not employ physicians are small.

84. *Offices of Physical, Occupational and Speech Therapists and Audiologists.* This U.S. industry comprises establishments of independent health practitioners primarily engaged in one of the following: (1) Providing physical therapy services to patients who have impairments, functional limitations, disabilities, or changes in physical functions and health status resulting from injury, disease or other causes, or who require prevention, wellness or

fitness services; (2) planning and administering educational, recreational, and social activities designed to help patients or individuals with disabilities, regain physical or mental functioning or to adapt to their disabilities; and (3) diagnosing and treating speech, language, or hearing problems. These practitioners operate private or group practices in their own offices (*e.g.,* centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers. The SBA has established a size standard for this industry, which is annual receipts of $8 million or less. The 2012 U.S. Economic Census indicates that 20,567 firms in this industry operated throughout the entire year. Of this number, 20,047 had annual receipts of less than $5 million, while 270 firms had annual receipts between $5 million and $9,999,999. Based on this data, the Commission concludes that a majority of businesses in this industry are small.

85. *Offices of Podiatrists.* This U.S. industry comprises establishments of health practitioners having the degree of D.P.M. (Doctor of Podiatric Medicine) primarily engaged in the independent practice of podiatry. These practitioners diagnose and treat diseases and deformities of the foot and operate private or group practices in their own offices (*e.g.,* centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers. The SBA has established a size standard for businesses in this industry, which is annual receipts of $8 million or less. The 2012 U.S. Economic Census indicates that 7,569 podiatry firms operated throughout the entire year. Of that number, 7,545 firms had annual receipts of less than $5 million, while 22 firms had annual receipts between $5 million and $9,999,999. Based on this data, the Commission concludes that a majority of firms in this industry are small.

86. *Offices of All Other Miscellaneous Health Practitioners.* This U.S. industry comprises establishments of independent health practitioners (except physicians; dentists; chiropractors; optometrists; mental health specialists; physical, occupational, and speech therapists; audiologists; and podiatrists). These practitioners operate private or group practices in their own offices (*e.g.,* centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers. The SBA has established a size standard for this industry, which is annual receipts of $8 million or less. The 2012 U.S. Economic Census indicates that 11,460 firms operated throughout the entire year. Of that number, 11,374 firms had annual receipts of less than $5 million, while 48 firms had annual receipts between $5 million and $9,999,999. Based on this data, the Commission concludes the majority of firms in this industry are small.

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

88. *Outpatient Mental Health and Substance Abuse Centers.* This U.S. industry comprises establishments with medical staff primarily engaged in providing outpatient services related to the diagnosis and treatment of mental health disorders and alcohol and other substance abuse. These establishments generally treat patients who do not require inpatient treatment. They may provide a counseling staff and information regarding a wide range of mental health and substance abuse issues and/or refer patients to more extensive treatment programs, if necessary. The SBA has established a size standard for this industry, which is $16.5 million or less in annual receipts. The 2012 U.S. Economic Census indicates that 4,446 firms operated throughout the entire year. Of that number, 4,069 had annual receipts of less than $10 million while 286 firms had annual receipts between $10 million and $24,999,999. Based on this data, the Commission concludes that a majority of firms in this industry are small.

89. *HMO Medical Centers.* This U.S. industry comprises establishments with physicians and other medical staff primarily engaged in providing a range of outpatient medical services to the health maintenance organization (HMO) subscribers with a focus generally on primary health care. These establishments are owned by the HMO. Included in this industry are HMO establishments that both provide health care services and underwrite health and medical insurance policies. The SBA has established a size standard for this industry, which is $35 million or less in annual receipts. The 2012 U.S. Economic Census indicates that 14 firms in this industry operated throughout the entire year. Of that number, 5 firms had annual receipts of less than $25 million, while 1 firm had annual receipts between $25 million and $99,999,999. Based on this data, the Commission concludes that approximately one-third of the firms in this industry are small.

90. *Freestanding Ambulatory Surgical and Emergency Centers.* This U.S. industry comprises establishments with physicians and other medical staff primarily engaged in (1) providing surgical services (*e.g.,* orthoscopic and cataract surgery) on an outpatient basis or (2) providing emergency care services (*e.g.,* setting broken bones, treating lacerations, or tending to patients suffering injuries as a result of accidents, trauma, or medical conditions necessitating immediate medical care) on an outpatient basis. Outpatient surgical establishments have specialized facilities, such as operating and recovery rooms, and specialized equipment, such as anesthetic or X-ray equipment. The SBA has established a size standard for this industry, which is annual receipts of $16.5 million or less. The 2012 U.S. Economic Census indicates that 3,595 firms in this industry operated throughout the entire year. Of that number, 3,222 firms had annual receipts of less than $10 million, while 289 firms had annual receipts between $10 million and $24,999,999. Based on this data, the Commission concludes that a majority of firms in this industry are small.

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

million and $24,999,999. Based on this data, the Commission concludes that a majority of firms in this industry are small.

92. *Blood and Organ Banks.* This U.S. industry comprises establishments primarily engaged in collecting, storing, and distributing blood and blood products and storing and distributing body organs. The SBA has established a size standard for this industry, which is annual receipts of $35 million or less. The 2012 U.S. Economic Census indicates that 314 firms operated in this industry throughout the entire year. Of that number, 235 operated with annual receipts of less than $25 million, while 41 firms had annual receipts between $25 million and $49,999,999. Based on this data, the Commission concludes that approximately three-quarters of firms that operate in this industry are small.

93. *All Other Miscellaneous Ambulatory Health Care Services.* This U.S. industry comprises establishments primarily engaged in providing ambulatory health care services (except offices of physicians, dentists, and other health practitioners; outpatient care centers; medical and diagnostic laboratories; home health care providers; ambulances; and blood and organ banks). The SBA has established a size standard for this industry, which is annual receipts of $16.5 million or less. The 2012 U.S. Economic Census indicates that 2,429 firms operated in this industry throughout the entire year. Of that number, 2,318 had annual receipts of less than $10 million, while 56 firms had annual receipts between $10 million and $24,999,999. Based on this data, the Commission concludes that a majority of the firms in this industry is small.

94. *Medical Laboratories.* This U.S. industry comprises establishments known as medical laboratories primarily engaged in providing analytic or diagnostic services, including body fluid analysis, generally to the medical profession or to the patient on referral from a health practitioner. The SBA has established a size standard for this industry, which is annual receipts of $35 million or less. The 2012 U.S. Economic Census indicates that 2,599 firms operated in this industry throughout the entire year. Of this number, 2,465 had annual receipts of less than $25 million, while 60 firms had annual receipts between $25 million and $49,999,999. Based on this data, the Commission concludes that a majority of firms that operate in this industry are small. *Centers.* This U.S. industry comprises establishments known as diagnostic imaging centers primarily engaged in producing images of the patient generally on referral from a health practitioner. The SBA has established size standard for this industry, which is annual receipts of $16.5 million or less. The 2012 U.S. Economic Census indicates that 4,209 firms operated in this industry throughout the entire year. Of that number, 3,876 firms had annual receipts of less than $10 million, while 228 firms had annual receipts between $10 million and $24,999,999. Based on this data, the Commission concludes that a majority of firms that operate in this industry are small.

95. *Home Health Care Services.* This U.S. industry comprises establishments primarily engaged in providing skilled nursing services in the home, along with a range of the following: Personal care services; homemaker and companion services; physical therapy; medical social services; medications; medical equipment and supplies; counseling; 24-hour home care; occupation and vocational therapy; dietary and nutritional services; speech therapy; audiology; and high-tech care, such as intravenous therapy. The SBA has established a size standard for this industry, which is annual receipts of $16.5 million or less. The 2012 U.S. Economic Census indicates that 17,770 firms operated in this industry throughout the entire year. Of that number, 16,822 had annual receipts of less than $10 million, while 590 firms had annual receipts between $10 million and $24,999,999. Based on this data, the Commission concludes that a majority of firms that operate in this industry are small.

96. *Ambulance Services.* This U.S. industry comprises establishments primarily engaged in providing transportation of patients by ground or air, along with medical care. These services are often provided during a medical emergency but are not restricted to emergencies. The vehicles are equipped with lifesaving equipment operated by medically trained personnel. The SBA has established a size standard for this industry, which is annual receipts of $16.5 million or less. The 2012 U.S. Economic Census indicates that 2,984 firms operated in this industry throughout the entire year. Of that number, 2,926 had annual receipts of less than $15 million, while 133 firms had annual receipts between $10 million and $24,999,999. Based on this data, the Commission concludes that a majority of firms in this industry is small.

97. *Kidney Dialysis Centers.* This U.S. industry comprises establishments with medical staff primarily engaged in providing outpatient kidney or renal dialysis services. The SBA has established a size standard for this industry, which is annual receipts of $41.5 million or less. The 2012 U.S. Economic Census indicates that 396 firms operated in this industry throughout the entire year. Of that number, 379 had annual receipts of less than $25 million, while 7 firms had annual receipts between $25 million and $49,999,999. Based on this data, the Commission concludes that a majority of firms in this industry are small.

98. *General Medical and Surgical Hospitals.* This U.S. industry comprises establishments known and licensed as general medical and surgical hospitals primarily engaged in providing diagnostic and medical treatment (both surgical and nonsurgical) to inpatients with any of a wide variety of medical conditions. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements. These hospitals have an organized staff of physicians and other medical staff to provide patient care services. These establishments usually provide other services, such as outpatient services, anatomical pathology services, diagnostic X-ray services, clinical laboratory services, operating room services for a variety of procedures, and pharmacy services. The SBA has established a size standard for this industry, which is annual receipts of $41.5 million or less. The 2012 U.S. Economic Census indicates that 2,800 firms operated in this industry throughout the entire year. Of that number, 877 has annual receipts of less than $25 million, while 400 firms had annual receipts between $25 million and $49,999,999. Based on this data, the Commission concludes that approximately one-quarter of firms in this industry are small.

99. *Psychiatric and Substance Abuse Hospitals.* This U.S. industry comprises establishments known and licensed as psychiatric and substance abuse hospitals primarily engaged in providing diagnostic, medical treatment, and monitoring services for inpatients who suffer from mental illness or substance abuse disorders. The treatment often requires an extended stay in the hospital. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements. They have an organized staff of physicians and other medical staff to provide patient care services. Psychiatric, psychological, and social work services are available at the facility. These hospitals usually provide

other services, such as outpatient services, clinical laboratory services, diagnostic X-ray services, and electroencephalograph services. The SBA has established a size standard for this industry, which is annual receipts of $41.5 million or less. The 2012 U.S. Economic Census indicates that 404 firms operated in this industry throughout the entire year. Of that number, 185 had annual receipts of less than $25 million, while 107 firms had annual receipts between $25 million and $49,999,999. Based on this data, the Commission concludes that more than one-half of the firms in this industry are small.

100. *Specialty (Except Psychiatric and Substance Abuse) Hospitals.* This U.S. industry consists of establishments known and licensed as specialty hospitals primarily engaged in providing diagnostic, and medical treatment to inpatients with a specific type of disease or medical condition (except psychiatric or substance abuse). Hospitals providing long-term care for the chronically ill and hospitals providing rehabilitation, restorative, and adjustive services to physically challenged or disabled people are included in this industry. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements. They have an organized staff of physicians and other medical staff to provide patient care services. These hospitals may provide other services, such as outpatient services, diagnostic X-ray services, clinical laboratory services, operating room services, physical therapy services, educational and vocational services, and psychological and social work services. The SBA has established a size standard for this industry, which is annual receipts of $41.5 million or less. The 2012 U.S. Economic Census indicates that 346 firms operated in this industry throughout the entire year. Of that number, 146 firms had annual receipts of less than $25 million, while 79 firms had annual receipts between $25 million and $49,999,999. Based on this data, the Commission concludes that more than one-half of the firms in this industry are small.

101. *Emergency and Other Relief Services.* This industry comprises establishments primarily engaged in providing food, shelter, clothing, medical relief, resettlement, and counseling to victims of domestic or international disasters or conflicts (*e.g.,* wars). The SBA has established a size standard for this industry which is annual receipts of $35 million or less. The 2012 U.S. Economic Census indicates that 541 firms operated in this industry throughout the entire year. Of that number, 509 had annual receipts of less than $25 million, while 7 firms had annual receipts between $25 million and $49,999,999. Based on this data, the Commission concludes that a majority of firms in this industry are small.

102. *Providers of Telecommunications and Other Services, Telecommunications Service Providers. 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. Under the applicable SBA size standard, such a business is small if it has 1,500 or fewer employees. U.S. Census Bureau data for 2012 indicate that 3,117 firms operated the entire year. Of this total, 3,083 operated with fewer than 1,000 employees. Consequently, the Commission estimates that most providers of incumbent local exchange service are small businesses that may be affected by the Commission's actions. According to Commission data, one thousand three hundred and seven (1,307) Incumbent Local Exchange Carriers reported that they were incumbent local exchange service providers. Of this total, an estimated 1,006 have 1,500 or fewer employees. Thus, using the SBA's size standard the majority of incumbent LECs can be considered small entities.

103. *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. The applicable size standard under SBA rules is that such a business is small if it has 1,500 or fewer employees. U.S. Census Bureau data for 2012 indicate that 3,117 firms operated for the entire year. Of that number, 3,083 operated with fewer than 1,000 employees. According to internally developed Commission data, 359 companies reported that their primary telecommunications service activity was the provision of interexchange services. Of this total, an estimated 317 have 1,500 or fewer employees. Consequently, the Commission estimates that the majority of interexchange service providers are small entities.

104. *Competitive Access Providers.* Neither the Commission nor the SBA has developed a definition of small entities specifically applicable to competitive access services providers (CAPs). The closest applicable definition under the SBA rules is Wired Telecommunications Carriers and under the size standard, such a business is small if it has 1,500 or fewer employees. U.S. Census Bureau data for 2012 indicates that 3,117 firms operated during that year. Of that number, 3,083 operated with fewer than 1,000 employees. Consequently, the Commission estimates that most competitive access providers are small businesses that may be affected by these 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. Of these 1,442 CAPs and competitive LECs, an estimated 1,256 have 1,500 or few employees and 186 have more than 1,500 employees. Consequently, the Commission estimates that most providers of competitive exchange services are small businesses.

105. The small entities that may be affected by the reforms include eligible nonprofit and public health care providers and the eligible service providers offering them services, including telecommunications service providers, Internet Service Providers, and service providers of the services and equipment used for dedicated broadband networks.

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

999 employees. Based on this data, the Commission concludes that the majority of Vendors of Infrastructure Development or ''Network Buildout'' are small.

107. *Telephone Apparatus Manufacturing.* This industry comprises establishments primarily engaged in manufacturing wire telephone and data communications equipment. 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. 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. U.S. Census Bureau data for 2012 show that there were 266 establishments that operated that year. Of this total, 262 operated with fewer than 1,000 employees. Thus, under this size standard, the majority of firms in this industry can be considered small.

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

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

110. *Steps Taken to Minimize the Significant Economic Impact of Small Entities and Significant Alternatives Considered.* 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.'' The Commission expects to consider all of these factors when it has received substantive comment from the public and potentially affected entities.

111. Largely, the proposals in the FNPRM if adopted will have no impact on or will reduce the economic impact of current regulations on small entities. Certain proposals could have a positive economic impact on small entities. In the FNPRM, the Commission seeks comment on changes that would streamline and simplify the application process; maximize efficient and fair distribution of support; and increase support for small entities relative to their larger counterparts, thereby decreasing the net economic burden on small entities. In the instances in which a proposed change would increase the financial burden on small entities, the Commission has determined that the net financial and other benefits from such changes would outweigh the increased burdens on small entities.

112. *Determining Accurate Rates in the Telecom Program.* To minimize potential rate variances and anomalies, the Commission seeks comment on how to determine accurate and reasonable urban and rural rates in the Telecom Program. The Commission specifically seeks input on how to define and evaluate rurality to determine what areas are comparable for purposes of determining rates. The Commission then seeks comment on what factors to consider when differentiating rural areas. The Commission seeks comment on approaches to analyzing existing data that would result in more accurate urban and rural rates such as establishing potential changes to the Telecom Program's categorization of service technologies that could further improve the accuracy of urban and rural rates in future funding years. The Commission also seeks comment on ways to improve and modify the current rate determination mechanism, the Rates Database, based on existing data. The Commission also seeks comment on an alternative model to the Rates Database.

113. *Harmonizing the Invoicing Process in the Telecom and HCF Program.* Currently, there are separate invoicing processes for the two programs. To alleviate inefficiencies and to further protect against waste, fraud, and abuse in the RHC Program, the Commission proposes to revise the rules to eliminate the use of HSSs in the Telecom Program and align the Telecom Program's invoicing process with the HCF Program's invoicing rules, which are simpler than the Telecom Program's current invoicing rules. Specifically, the Commission proposes to have participants in both programs invoice for services actually provided using the FCC Form 463 rather than use HSSs in the Telecom Program.

114. *Reform of Program Funding Cap.* The Commission proposes and seeks comment on reforming the RHC Program's funding cap. Specifically, the Commission proposes to amend the current rules so that the internal cap for upfront costs and multi-year commitments apply only if available funding for the entire program is exceeded. The Commission additionally seeks comment on a two-tiered system that would distribute funding first to upfront costs and the first year of multi-year commitments and then the second and third year of multi-year commitments until the internal cap is reached.

115. *Federal Rules That May Duplicate, Overlap, or Conflict With the Proposed Rules.* None.

116. *Ex Parte Rules—Permit-But-Disclose.* The proceeding the FNPRM is a part of shall be treated as a ''permit-but-disclose'' proceeding in accordance with the Commission's *ex parte* rules. Persons making *ex parte* presentations

must file a copy of any written presentation or a memorandum summarizing any oral presentation within two business days after the presentation (unless a different deadline applicable to the Sunshine period applies). Persons making oral *ex parte* presentations are reminded that memoranda summarizing the presentation must (1) list all persons attending or otherwise participating in the meeting at which the *ex parte* presentation was made, and (2) summarize all data presented and arguments made during the presentation. If the presentation consisted in whole or in part of the presentation of data or arguments already reflected in the presenter's written comments, memoranda or other filings in the proceeding, the presenter may provide citations to such data or arguments in his or her prior comments, memoranda, or other filings (specifying the relevant page and/or paragraph numbers where such data or arguments can be found) in lieu of summarizing them in the memorandum. Documents shown or given to Commission staff during *ex parte* meetings are deemed to be written *ex parte* presentations and must be filed consistent with Commission rule 1.1206(b). In proceedings governed by Commission 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.

117. *Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements for Small Entities.* The reporting, recordkeeping, and other compliance requirements proposed in the FNPRM likely would positively and negatively financially impact both large and small entities, including healthcare providers and service providers, and any resulting financial burdens may disproportionately impact small entities given their typically more limited resources. In weighing the likely financial benefits and burdens of the proposed requirements, however, the Commission has determined that the 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.

118. *Application Documentation.* The Commission seeks comment on proposed revisions to Telecom Program forms and corresponding USAC online portals to improve the quality and consistency of Telecom Program data. The Commission seeks comment on revisions to the FCC Form 466 as well as any other RHC Program forms including HCF Program forms that might allow for the collection of more detailed service information to allow for more accurate comparisons of rates for similar services consistent with the revised rurality classifications and service categories proposed in the FNPRM. The Commission also seeks comment on whether there is certain information regarding the technical details or components of telecommunications services that rural health care providers cannot access or lack the technical expertise to report to USAC and should therefore be reported by service providers.

119. *Invoicing Requirements.* To harmonize the Commission's rules under the Telecom and HCF Programs, and to ensure sufficient program oversight, efficiency, and certainty, the Commission proposes to harmonize the invoicing process between the Telecom Program and the HCF Program.

120. *Improving Data Collection.* As the Commission seeks to better monitor RHC Program effectiveness, the Commission seeks general comment on the data collected for the Telecom Program.

IV. Ordering Clauses

121. Accordingly, *it is ordered* that, pursuant to the authority contained in sections 1 through 4, 201–205, 254, 303(r), and 403 of the Communications Act of 1934, as amended by the Telecommunications Act of 1996, 47 U.S.C. 151 through 154, 201 through 205, 254, 303(r), and 403, the Further Notice of Proposed Rulemaking *is adopted.*

122. *It is further ordered* that, pursuant to applicable procedures set forth in §§ 1.415 and 1.419 of the Commission's rules, 47 CFR 1.415, 1.419, interested parties may file comments on the FNPRM on or before April 14, 2022, and reply comments on or before May 16, 2022.

123. *It is further ordered* that the Commission's Consumer and Governmental Affairs Bureau, Reference Information Center, *shall send* a copy of the Further Notice of Proposed Rulemaking, including the Initial Regulatory Flexibility Analysis, to the Chief Counsel for Advocacy of the Small Business Administration.

List of Subjects in 47 CFR part 54

Communications common carriers, Health facilities, Infants and children, internet, Telecommunications, Telephone.

Federal Communications Commission.

Katura Jackson,

Federal Register Liaison Officer.

Proposed Rules

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

PART 54—UNIVERSAL SERVICE

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

Authority: 47 U.S.C. 151, 154(i), 155, 201, 205, 214, 219, 220, 229, 254, 303(r), 403, 1004, 1302, and 1601–1609 unless otherwise noted.

■ 2. Amend § 54.619 by revising paragraph (b) to read as follows:

§ 54.619 Cap.

* * * * *

(b) *Application of the internal cap on multi-year commitments and upfront payments in the Healthcare Connect Fund Program.* The internal cap on multi-year commitments and upfront payments in the Healthcare Connect Fund Program applies only when the total demand during a filing window period exceeds the total remaining support available for the funding year. The total remaining support available for the funding year is based on the inflation-adjusted aggregate annual cap, the proportion of unused funding for use in the Rural Health Care Program determined in paragraph (a)(5) of this section, and the amount of funding allocated in one or more previous filing window periods, if any, of the funding year.

■ 3. Amend § 54.621 by adding paragraph (b)(3) to read as follows:

§ 54.621 Filing window for requests and prioritization of support.

* * * * *

(b) * * *

(3) *Prioritization of upfront payment and multi-year commitment requests.* When the internal cap on multi-year commitments and upfront payments applies pursuant to § 54.619(b) and the demand for upfront payments and multi-year commitments during a filing window period exceeds the internal cap on multi-year commitments and upfront payments in the Healthcare Connect Fund Program, the Administrator shall

fund upfront payments and the first year of the multi-year commitments in all eligible requests in accordance with paragraph (b) of this section before funding the second year and the third year, if applicable, of the multi-year commitment requests in accordance with paragraph (b) of this section until the internal cap is reached or no available funds remaining. The Administrator shall also designate the underlying contracts associated with the multi-year commitment requests that are not fully funded as ''evergreen'' provided those contracts meet the requirements under § 54.622(i)(3)(ii).

■ 4. Amend § 54.627 by revising paragraph (c) to read as follows:

§ 54.627 Invoicing process and certifications.

* * * * *

(c) *Certifications.*

(1) 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 and supporting documentation and that to the best of its knowledge, information and belief, all statements of fact contained in the invoice 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 determined by the Administrator;

(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.

* * * * *

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