Before the

Federal Communications Commission

Washington, D.C. 20554

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

**Comments of National Association of Community Health Centers**

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| February 2, 2018 |  |

**Executive Summary**

Community Health Centers are a backbone of the rural “health care safety net”, and Congress explicitly indicated that they are intended to benefit from the Rural Health Care Program. However, in recent years, the RHCP has become an increasingly burdensome and unpredictable program for CHCs. For this reasons, NACHC is pleased that the FCC is reexamining the program’s structure, and offers the following comments:

Funding cap:

* The FCC should raise the $400 million cap for FY16-17 and FY17-18, to reflect recent expansions of the program, and to avoid penalizing providers whom Congress explicitly intended to support.
* Whenever possible, the operational aspects of the RHCP should be aligned with the E-Rate program, including by using GDP-CPI to update the funding cap annually.
* In future years, the funding cap should be to reflect inflation, eligibility expansions, and changes in costs resulting from advances in technology.
* All unused RHCP funding from previous funding years should be made available in subsequent funding years until fully disbursed.

Prioritization of funding requests:

* The current proration approach is inappropriate as it implies that all providers and expenses are of equal merit, despite that fact that some providers are of questionable eligibility and seek a disproportionate share of total RHCP funding.
* The most appropriate prioritization approach is to fully fund requests from individual providers who are clearly eligible under a plain reading of the statute – namely, “public or non-profit” providers who actually “serve(s) persons who reside in rural areas”.
* If a second-tier prioritization approach is needed, the FCC should use scores for rural Health Professional Shortage Areas (HPSA), as calculated by the Federal Department of Health and Human Services.
* The definition of “rural” currently used in E-Rate should be applied to the RHCP.
* Medicaid eligibility is not an appropriate measure of either economic need or the need for health services.

Urban-Rural Consortia:

* Well-intentioned efforts to encourage rural-urban consortia have often not achieved the intended benefits.
* At the same time, they have resulted in increased administrative burdens, and diverted RHCP funds from CHCs (and other eligible providers) to providers whose eligibility is inconsistent with a plain reading of the statute.
* NACHC strongly supports efforts to ensure that the vast majority of RHCP funds are directed to provider organizations who actually treat patients who reside in rural areas. This will require significantly tightening the rules on urban-rural consortia.

Administrative Burden:

* The administrative burden of applying for and participating in the RHCP is becoming unsustainable for many small, rural CHCs.
* NACHC strongly supports efforts to simplify the application and funding process so that it no longer disadvantages and discourages small providers from participating.

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**Comments of the National Association of Community Health Centers**

The National Association of Community Health Centers (NACHC) hereby comments on the Commission’s proposals for reform of the Rural Health Care universal service Program (“RHCP”).[[1]](#footnote-1)

NACHC is the national membership organization for America’s Community Health Centers (also called CHCs or Federally Qualified Health Centers.) As discussed below, CHCs are a critical part of the rural “health care safety net”, assuring access to affordable primary care for over 10 million medically underserved rural patients, most of whom are low-income. In the 1996 Telecommunications Act, Congress explicitly named rural CHCs as one of the seven types of health care providers whom the USAC program was designed to support[[2]](#footnote-2).

In recent years, CHCs have become increasingly concerned that the RHCP has expanded beyond its original intent, to include providers who should not be eligible under a “plain reading” of the statute. As a result, CHCs have been subject to across-the-board funding reductions, and significant administrative complexities that have made it difficult for them to participate in the program that was designed for them. For this reason, we are very pleased that the FCC staff are reexamining the structure and functioning of the RHCP, and welcome the opportunity to comments on how to better align the program with the needs of those providers and patients whom Congress originally intended to support.

To provide context for our specific comments below, we begin by making three critical points.

* Community Health Centers are the backbone of the “rural health care safety net”
* Congress clearly intended rural CHCs to benefit from the RHCP.
* Some provider types who have recently been added to the RHCP do not meet eligibility requirements under a “plain reading” of the statute, and their eligibility is harming CHCs’ ability to benefit from the program.

# Background

## Community Health Centers are a backbone of the rural “health care safety net”

A Community Health Center (CHCs) is a health care provider that is authorized under Section 330 of the Public Health Service Act[[3]](#footnote-3). As a backbone of the “health care safety net”, all CHCs are required by law to:

* provide a wide range of medical services. These always include primary and preventive care, and generally include pharmacy, dental, mental health, and addiction treatment.
* care for all individuals who present for treatment, regardless of whether they have insurance or are able to pay.
* specifically target geographic areas and populations that the Federal government has determined to be “medically underserved.”
* be non-profit or public, and be governed by a Board, a majority of whose members are CHC patients.

Thus, CHCs are a reliable, affordable source of health care for people who:

* have no health insurance;
* have health insurance but can’t afford the deductibles or copays (called “underinsured” persons);
* have health insurance that few providers will accept (e.g., Medicaid); and/or
* live in areas with few or no medical providers (e.g., rural, highly rural, and frontier areas.)

Nationally, there are over 9,800 CHC sites providing care to over 25 million medically‐underserved individuals – including at least 10 million patients who reside in rural or frontier areas. Over 70% of CHC patients have incomes below the Federal Poverty Level (FPL); if uninsured or underinsured, these individuals pay no more than a nominal fee for their care. Another 20% of CHC patients have incomes between 101% and 200% FPL; if uninsured or underinsured, they are charged based on a sliding fee scale. Because of their focus on ensuring health care access for at-risk populations, CHCs generally run on margins of less than 1%.

Thus, CHCs are a critical part of the “rural health care safety net”, assuring access to affordable medical care for over 10 million medically underserved rural patients, most of whom are low-income. For this reason, it is not surprising that when Congress wrote the 1996 Telecommunication Act, it explicitly identified CHCs as eligible for the RHCP.

## Congress clearly intended rural CHCs to benefit from the RHCP

In drafting Section 254(h) of the Telecommunications Act, Congress was very specific about what providers are eligible for RHCP funding. First, subsection (1)(A) states that in order to be eligible, a health care provider must be:

* either public or nonprofit, AND
* ***serve*** persons who reside in rural area. (In contrast, eligible “educational providers and libraries” are *not* limited to those located in, or serving, specific geographic areas.)

Congress further restricts eligibility by limiting eligible “health care provider(s)” to eight types of providers (at least one of which – skilled nursing facilities --- was added in recent years.) This list includes:

* community and migrant health centers
* not-for-profit hospitals
* rural health clinics
* consortia of providers consisting of one or more entities listed earlier in the statute.

Thus, when it wrote the 1996 Telecommunications Act, Congress was clear that CHCs that serve rural patients are intended to benefit from the RHCP.

## General concerns re: Urban Rural Consortia: Well-intentioned efforts to encourage rural-urban consortia have often not achieved the intended benefits. At the same time, they have resulted in increased administrative burdens, and diverted RHCP funds from CHCs (and other eligible providers) to providers whose eligibility is inconsistent with a plain reading of the statute.

NACHC recognizes that the RHCP’s recent efforts to encourage urban-rural consortia were well-intentioned, as they were expected to “confer benefits upon affiliated rural healthcare providers, including lower broadband costs, access to medical specialists, administrative support, and technical expertise.”

In reality, however, many consortia have often failed to produce the intended benefits. Instead, their impact has often been the opposite of what was intended – namely, increased administrative hassles and reduced financial support for CHCs and other nonprofit providers who actually serve rural residents.

Specifically, NACHC is concerned about recent decisions to expand RHCP eligibility to the following types of providers, via the “consortia” approach:

* ***Providers who exclusively serve patients living in urban areas:*** While the statute explicitly restricts eligibility to providers who “serve persons in rural areas”, the FCC has allowed urban providers to receive RHCP funding as long as they are in a consortia with rural providers – even if those urban providers serve only urban patients. Not only is this inconsistent with the statutory intent, but also:
  + depending on the relative size and of the various consortia members, exclusively-urban members of a consortia can funding that is far larger than the amounts received by their rural partners.
  + there is no limit on the amount of funding that urban hospitals (in eligible consortia) with fewer than 400 beds can receive from the program.
* ***For-profit providers:***  The FCC has permitted emergency departments of for-profit hospitals to be eligible for RHCP funding -- despite statutory language restricting eligibility to “public and non-profit” health care providers.

Clearly, these expansions are one of the reasons that the $400 million funding cap was exceeded starting in FY16-17. As you know, the FCC’s response to exceeding the cap was to treat all applications received after a certain date the same way – by imposing an across-the-board reduction. ***This across-the-board proration policy is unfair to CHCs and other health care providers who are eligible for RHCP based on a plain reading of the statute, as it implies that their requests are of equal merit to those received from providers whose eligibility is questionable and who seek a disproportionate share of total RHCP funding.***

Also, the addition of these new providers has significantly complicated the application and other administrative aspects of participating in the RHCP – again, discouraging the small safety-net providers whom Congress clearly intended the program to benefit.

With this background, NACHC offers the following comments on specific paragraphs in the NPRM.

# Section A. Addressing RHC Program Funding Levels

## Paragraph 15: **The FCC should raise the $400 million cap for FY16-17 and FY17-18, to reflect recent expansions of the program, and to avoid penalizing providers whom Congress explicitly intended to support.**

NACHC strongly encourages the FCC to raise the funding cap for both FY16-17 and FY17-18. As you are well aware, the statute requires the FCC to enhance access to the degree to which it is “economically reasonable.” In the two decades since the statute was passed, FCC has yet to raise the RHCP funding cap, despite the fact that appropriate demands for the funding have increased due to the following factors:

* Congress’ addition of Skilled Nursing Facilities to the list of eligible providers starting in 2017
* The FCC’s decision to add construction and capital expenses to the types of services that are eligible for reimbursement
* Increases in the number eligible HCPs (within existing categories of eligible provider types)
* Increased costs per eligible HCPs (e.g., to support the adoption of EHRs.)

In addition, as discussed above, the RHCP has been expanded to include health care providers whose eligibility is questionable under a plain reading of the statute.

It is not “economically reasonable” to expand a program over two decades while simultaneously failing to increase funding for it. This failure led to prorated payments in FY16-17, and a continued uncertainty about the level of payments for FY17-18. For CHCs -- whom Congress explicitly identified as RHCP beneficiaries, and who typically run on margins below 1% -- these reductions and uncertainty have created significant challenges.

## Paragraph 15: **Whenever possible, the operational aspects of the RHCP should be aligned with the E-Rate program, including by using GDP-CPI to update the funding cap annually.**

NACHC recommends aligning the RHCP with the E-Rate program whenever possible, in order to create consistency and predictability across the sister programs. We therefore recommend that the cap amount be increased by the GDP-CPI for the years 1997-2018.

## Paragraph 16: **In future years, the funding cap should be to reflect inflation, eligibility expansions, and changes in costs resulting from advances in technology.**

As in E-Rate (and most other Federal programs), in future years the cap should be increased to reflect inflation. In addition, it should be adjusted to reflect:

* Expansions in eligibility that are consistent with the statute, such as the recent expansion to include Skilled Nursing Facilities
* Changes in costs due to changes in services covered, technological advancements, and the resulting need for bandwidth.

Without such adjustments, the actual benefit that the RHCP will provide to its intended beneficiaries will erode over time.

## Paragraph 17: **All unused RHCP funding from previous funding years should be made available in subsequent funding years until fully disbursed.**

As is done in E-Rate, unused RHCP funds committed in one funding year should be rolled over to subsequent funding years until they are fully disbursed. This should include both funds held in reserve for appeals and funds committed to a specific healthcare provider who did not use them. This approach will be consistent with E-Rate, and ensure that funds allocated for RHCP are used for that purpose.

## Paragraphs 18: **The current proration approach is inappropriate as it implies that all providers and expenses are of equal merit, despite that fact that some providers are of questionable eligibility and seek a disproportionate share of total RHCP funding.**

Under the proration system applied in FY16-17, all funding requests received after a certain date were subject to the identical percentage reduction. This approach implies that all requests were of equal merit, in terms of both eligibility and the appropriateness of how much funding was requested.

As discussed above, NACHC strongly disagrees that all FY16-17 funding requests are of equal merit, and deserved to be prorated equally. Rather, those providers who clearly meet the statutory eligibility criteria (e.g., CHCs) should receive full funding before any other providers receive any funding.

## Paragraphs 19: **The most appropriate prioritization approach is to fully fund requests from individual providers who are clearly eligible under a plain reading of the statute – namely, “public or non-profit” providers who actually “serve(s) persons who reside in rural areas”.**

We appreciate the FCC’s outlining several options for prioritizing future requests (e.g., by degree of rurality, or type of service or program.) However, the FCC has failed to mention what should be the most basic rule for prioritization– namely, ensuring compliance with a plain reading of the statute.

As discussed above, section (h)(1)(A) states that the RHCP’s purpose is to provide access to [telecommunications services](https://www.law.cornell.edu/definitions/uscode.php?width=840&height=800&iframe=true&def_id=47-USC-1773906204-1952898750&term_occur=49&term_src=title:47:chapter:5:subchapter:II:part:II:section:254) to “any ***public or nonprofit*** health care provider that ***serves persons who reside in rural areas***”. Thus, any provider who meets these criteria should receive full funding for all appropriate costs before any other provider receives any funding – regardless of their membership in a rural-urban consortia.

## Paragraph 27:   **The definition of “rural” currently used in E-Rate should be applied to the RHCP.**

Health centers have had long-standing concerns about the definition of “rural” currently used in the RHCP, as it disqualifies areas that are clearly rural if they are in proximity to growing urban areas.  (For example, consider Dungannon in Scott County, VA and Ferrum in Franklin County, VA.)  As you are aware, there is already a system in place in E-Rate to determine which locations qualify as rural, for purposes of eligibility for the rural discount bonus.  NACHC recommends that the FCC use the same system to determine which providers qualify as rural under the RHCP.  This approach will: address the concerns raised by rural communities such as those listed above; be straightforward an inexpensive for the FCC to implement; and further increase alignment between the E-Rate and RHCP Programs.

## Paragraph 30: **Medicaid eligibility is not an appropriate measure of either economic need or the need for health services.**

We appreciate the FCC’s efforts to identify an appropriate measure of economic need and need for health services. However, NACHC strongly discourages using Medicaid eligibility as a measure because:

* Medicaid eligibility rules vary enormously by state. For example, those states who chose to expand Medicaid under the Affordable Care Act offer coverage to all adults with incomes below 138% of the Federal Poverty Level (FPL.) In contrast, in states that did not expand Medicaid, the eligibility cut-off for many adults is significantly lower – sometimes below 20% FPL. Thus, data on Medicaid eligibility is generally more indicative of a state’s policy choices than of need.
* There is no good national data on Medicaid eligibility. While there is national data on Medicaid enrollment (the number of people actually enrolled), this data varies not only due to differences in state eligibility rules, but also based on “uptake rates” (the percentage of eligible persons who actually enroll.)

## Paragraph 31: **If a second-tier prioritization approach is needed, the FCC should use scores for rural Health Professional Shortage Areas (HPSA), as calculated by the Federal Department of Health and Human Services.**

As discussed above, if a funding prioritization approach is necessary, the first rule should be to fully fund all appropriate requests from health care providers who are RHCP-eligible under a plain reading of the statute.

However, if a second-tier prioritization approach is needed, NACCH recommends prioritizing requests from health care providers serving patients in areas with the greatest shortages of health professionals.

Fortunately, the Federal government already has a system in place for quantifying and comparing shortages of health professionals. As discussed in the NPRM, the Federal Health Resources and Services Administration (HRSA) within the Department of Health and Human Services is charged with determining which geographic areas, populations, and facilities have a shortage of health care providers. HRSA currently operates two distinct systems to identify and designate shortages: Health Professional Shortage Areas (HPSAs) and Medically Underserved Areas/ Populations (MUA/Ps.) (The two “shortage designation” systems were created by separate statutes for different programs, and have minor technical differences. However, they both generally seek to measure the same thing, and are overlapping – for example, a town can qualify as both a HPSA and an MUA.)

Given HRSA’s long-standing expertise in this area, NACHC strongly encourages the FCC to use HRSA’s shortage designations as its measure of need for health care services. Specifically, we recommend using HPSAs, because HRSA assigns each HPSA a numerical score (ranging from 0 to 26), indicating its level of need, with 26 being the highest. (There is no scoring system for MUA/Ps.) Thus, HPSA scores provide a straightforward way to rank RHCP applicants according to level of need for health services.

The following factors should be taken into account when using HPSA scores to prioritize RHCP applicants:

* HPSAs exist in both urban and rural areas. Therefore, the FCC should implement a “screen” to restrict eligibility to those HPSAs located in rural areas.
* Some RHCP applicants may qualify for more than one type of HPSA – for example, both a primary care and dental HPSA. In these situations, the applicant should be permitted to use the highest score for which they qualify.

### Paragraphs 33-36: **NACHC strongly supports efforts to ensure that the vast majority of RHCP funds are directed to provider organizations who actually treat patients who reside in rural areas. This will require significantly tightening the rules on urban-rural consortia**, including:

### The “majority rural” threshold should be raised to a “minimum 75% rural” threshold.

### There should be no grace period for coming into compliance with requirements around minimum rural percentage.

### As required under a plain reading of the statute, all consortia members must actually provide clinical services to rural residents to be eligible for RHCP funding.

NACHC strongly supports efforts to ensure that all RHCP funds are directed to provider organizations who are eligible under a “plain reading” of the statute – namely, nonprofit and public providers who actually treat patients who reside in rural areas.

Achieving this goal will require the FCC to significantly revise its rules around urban-rural consortia. At present, many eligible consortia are nothing more than a “purchasing group” – the urban participants provide no clinical or technical support to rural providers or their patients. Yet the existence of these consortia is significantly distorting the RHCP by reducing funding and increasing administrative burden on the providers whom the statute was clearly intended to support.

While NACHC supports the continuation of rural-urban consortia, to ensure consistency with statutory intent, these consortia must be restructured such that:

* The “majority rural” threshold should be raised to a “minimum 75% rural” threshold. Even under this higher threshold, given the relative size of urban versus rural providers, it is likely urban providers will receive more funding that rural providers – which is inconsistent with statutory intent.
* There should be no grace period for coming into compliance with requirements around minimum rural percentage (currently “majority rural”, ideally “at minimum 75% rural.”) The existence of any grace period is simply another means for redirecting support intended to rural health care providers to urban providers.
* *All health care providers who receive RHCP funds must actually provide clinical services to rural residents. This is required under a plain reading of statute.* In addition, it is our view that the failure to enforce this requirement is a major reason for the rapid growth of “consortia” that in practice are nothing more than telecomm purchasing groups. In response to this requirement, we expect that many urban providers will either drop out of the program or start providing clinical support to their rural “partners.” In either situation, rural providers and their patients will benefit, as there will be more RHCP funding and clinical support to meet their needs.

# Section B: Promoting Efficient Operation of the RHC Program to Prevent Waste, Fraud, and Abuse

## NACHC strongly supports efforts to increase the integrity of the RHCP.

This includes efforts to:

* identify and cap outlier costs;
* reduce opportunities for manipulating the rural and urban rates in the Telecom Program more generally, and
* codify and enforce reasonable rules around: the use of consultants; restrictions on gifts; and invoicing deadlines.

# Section C. Improving Oversight of the RHC Program

## Paragraphs 92-94: NACHC strongly supports efforts to simplify the application and funding process so that it no longer disadvantages and discourages small providers from participating.

At present, the application process is so complex and extensive that health care providers often hire consultants to navigate it. This puts smaller providers such as CHCs– who cannot afford consultants – at a disadvantage, and increasingly is forcing them to drop out of the program. It also can lead to providers incurring late fees over which they have no control.

Respectfully submitted,

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1. *Promoting Telehealth in Rural America*, WC Docket No. 17-310, Notice of Proposed Rulemaking and Order, FCC 17-164 (rel. Dec. 18, 2017) (the “*Notice & Order*”). As used herein, the “*Notice*” refers to the substantive portions of this document that comprise the Notice of Proposed Rulemaking, paragraphs 15 through 106, as well as the Introduction and Background sections, paragraphs 1 through 14; and the “*Order*” refers to the portions, in particular paragraphs 107 through 117, that make up the substantive portions of the Order. [↑](#footnote-ref-1)
2. Section 254(h)(7)(B)(ii) [↑](#footnote-ref-2)
3. Section 330 of the PHSA authorizes four types of health centers: Community Health Centers (CHCs), and health centers who target: migrant workers; persons experiencing homelessness; and residents of public housing. As CHCs comprise over 80% of all health centers, and all four types of health centers are subject to the similar rules, the term “Community Health Centers” is commonly used to refer to all four types. The term Federally Qualified Health Center (FQHC), which is found in the Social Security Act, is also sometimes used to refer to Section 330 Health Centers. In this document, we use the terms Community Health Center to refer to all health centers authorized under, and subject to the rules of, Section 330 of the PHSA. [↑](#footnote-ref-3)