EPA-APPROVED MICHIGAN REGULATIONS—Continued

Michigan citation	Title	State effective date	EPA approval date	Comments
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R 336.1625	Emission of volatile organic compound from existing equipment utilized in manufacturing synthesized pharmaceutical products.	3/29/2017	6/29/2018, [Insert **Federal Register** citation].	
R 336.1627	Delivery vessels; vapor collection systems.	3/29/2017	6/29/2018, [Insert **Federal Register** citation].	
R 336.1628	Emission of volatile organic compounds from components of existing process equipment used in manufacturing synthetic organic chemicals and polymers; monitoring program.	3/29/2017	6/29/2018, [Insert **Federal Register** citation].	
R 336.1629	Emission of volatile organic compounds from components of existing process equipment used in processing natural gas; monitoring program.	3/29/2017	6/29/2018, [Insert **Federal Register** citation].	
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R 336.1632	Emission of volatile organic compounds from existing automobile, truck, and business machine plastic part coating lines.	3/29/2017	6/29/2018, [Insert **Federal Register** citation].	
R 336.1651	Standards for degreasers	3/29/2017	6/29/2018, [Insert **Federal Register** citation].	
R 336.1660	Standards for volatile organic compounds emissions from consumer products.	3/29/2017	6/29/2018, [Insert **Federal Register** citation].	
R 336.1661	Definitions for consumer products.	3/29/2017	6/29/2018, [Insert **Federal Register** citation].	
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Part 9: Emission Limitations and Prohibitions—Miscellaneous				
R 336.1902	Adoption of Standards by reference.	12/20/2016	6/29/2018, [Insert **Federal Register** citation].	Only sections (1)(a), (b)(i), (b)(iii), (b)(iv), (b)(vii), (b)(viii), (c), (d), (e), (f), (g), (i), (j), (k), (l), (m), (n), and (s); (2)(b), (e), and (g); (3)(a); (4)(a), (b), (c), (d), (e), (f), (l), (m),(o), and (p); (5); (8); and (9).
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[FR Doc. 2018–13953 Filed 6–28–18; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 86

Control of Emissions From New and In-Use Highway Vehicles and Engines

CFR Correction

■ In Title 40 of the Code of Federal Regulations, Parts 82 to 86, revised as of July 1, 2017, on page 1134, following paragraph (b) of § 86.1917, the section heading of § 86.1920 is inserted to read as follows:

§ 86.1920 What in-use testing information must I report to EPA?

* * * * *

[FR Doc. 2018–14145 Filed 6–28–18; 8:45 am]

BILLING CODE 1301–00–D

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 54

[WC Docket No. 17–310; FCC 18–82]

Promoting Telehealth in Rural America

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: In this document, the Federal Communications Commission (the Commission or FCC) addresses the current funding shortfall in the Rural Health Care (RHC) Program, including by raising the annual Program funding cap and applying it to the current

funding year to fully fund eligible funding requests for funding year (FY) 2017, adjusting the funding cap to reflect inflation, and establishing a process to carry-forward unused funds from past funding years for use in future funding years.

DATES: Effective June 29, 2018.

FOR FURTHER INFORMATION CONTACT: Elizabeth Drogula, *elizabeth.drogula@fcc.gov,* Telecommunications Access Policy Division, Wireline Competition Bureau, (202) 418–1591 or TTY: (202) 418–0484.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Report and Order (R&O) in WC Docket No. 17–310; FCC 18–82, adopted on June 19, 2018, and released on June 25, 2018. The full text of this document is available for public inspection during regular business hours in the FCC Reference Center, Room CY–A257, 445 12th Street SW, Washington, DC 20554, or at the following internet address: *https://docs.fcc.gov/public/attachments/FCC-18-82A1.pdf.*

I. Introduction

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

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

3. Given rural health care providers' urgent need for funding, the Commission takes immediate action in the R&O to address the current funding shortfall in the RHC Program, including by raising the annual Program funding cap to $571 million and applying it to the current funding year to fully fund eligible funding requests for FY 2017. The Commission takes this action consistent with the goals of ensuring that rural health care providers are able to get the funding they need from the RHC Program. At the same time, the Commission is mindful of the need to guard against Program waste, fraud, and abuse to ensure that this funding is being spent appropriately. The Commission remains committed to this goal and for that reason, have proposed and sought comment in this proceeding on measures to ensure compliance and to reduce waste, fraud, and abuse in the RHC Program.

II. Discussion

4. In the R&O, the Commission adopts measures to address the increased demand for funding from the RHC Program and thereby promote health care delivery and telemedicine in rural America. Specifically, the Commission (1) increases the annual RHC Program funding cap to $571 million and apply it to FY 2017; (2) decides to annually adjust the RHC Program funding cap to reflect inflation, beginning with FY 2018; and (3) establishes a process to carry-forward unused funds from past funding years for use in future funding years. These actions will provide rural health care providers with a sufficient and more predictable source of universal service funding to deliver vital telemedicine services to their communities.

A. Raising the RHC Program Funding Cap

5. *Background.* In the *2017 NPRM and Order (FCC 17–164),* the Commission sought comment on whether to increase the RHC Program's $400 million annual funding cap and how to determine the appropriate funding cap level. The Commission explained that one metric would be to consider what the cap would have been if adjusted by inflation since its adoption. It therefore sought comment on whether to establish a new RHC Program funding cap based on the expected level had the Commission initiated an annual inflation adjustment in 1997 using the gross domestic product chain-type price index (GDP–CPI). The Commission also sought comment on whether to apply any increased funding cap to FY 2017.

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

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

8. *Discussion.* The Commission concludes that raising the RHC Program funding cap is necessary to address current and future demand for supported services by health care providers. Raising the funding cap to $571 million responds to the significant increase in RHC Program demand resulting from the expansion of eligible services and entities since the Program's creation, as well as the advances in technology that often require higher bandwidth (*e.g.,* higher-speed bandwidth, less latency, and diverse

routing) than was contemplated by the Commission when it established a $400 million cap for the Program in 1997. The Commission also finds that increasing the funding cap to what it would have been if indexed annually for inflation since the inception of the Program, using the GDP–CPI index, ensures that RHC Program funding is sufficient to meet current demand, while also minimizing the increased costs of funding, which are imposed on USF contributors and generally passed on to consumers. In addition, adjusting the funding cap to account for inflation over the past 20 years maintains the purchasing power in today's dollars that health care providers held when the RHC Program was first instituted. On these bases, the Commission raises the RHC Program annual funding cap from $400 million to $571 million.

9. The Commission disagrees with those commenters who advocate doubling the RHC Program funding cap to $800 million at this time. The $171 million increase in the annual funding cap exceeds the current demand of $521 million, and commenters fail to provide reliable data justifying a $400 million increase. Moreover, the Commission believes that adopting such a substantial increase at this time is especially imprudent given the concerns in this proceeding about whether potential waste in the RHC Telecommunications Program has contributed to reaching the cap sooner than anticipated and what steps the Commission should take to reduce such waste.

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

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

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

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

14. By taking this action, the Commission makes significant funding available to issue commitments for the full amount approved for FY 2017 funding requests prior to proration. The Commission directs USAC to collect the additional funds needed to fully fund FY 2017 demand over the next two quarters in accordance with the standard process for calculating and announcing the quarterly contribution factor to reduce the impact on ratepayers. The Commission further directs USAC to take any other steps necessary to reverse the proration of approved FY 2017 funding requests, consistent with this R&O.

B. Instituting an Annual Inflation Adjustment

15. *Background.* In addition to whether and how to raise the RHC Program annual funding cap, in the *2017 NPRM and Order, the Commission* sought comment on whether the cap should be adjusted annually for inflation. The Commission noted that other universal service support mechanisms use the GDP–CPI inflation index to adjust funding caps, and inquired whether the RHC Program cap should also be adjusted annually on the same basis. Commenters that support raising the RHC Program funding cap to the level that it would be had it been indexed for inflation using GDP–CPI since the inception of the Program also support adjusting the cap for inflation in future funding years.

16. *Discussion.* The Commission adopts a rule that, beginning in FY 2018, the RHC Program funding cap will be adjusted annually for inflation using the GDP–CPI inflation index. By itself, raising the cap does not create the flexibility necessary to ensure that rural health care providers have affordable access to telecommunications and broadband services in the event of future price inflation. Accordingly, the Commission must also institute an annual inflation adjustment to ensure that the RHC Program maintains consistent purchasing power without

unreasonably increasing the size of the USF and increasing the USF contribution charges that are ultimately passed through to consumers.

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

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

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

19. *Background.* In the *2017 NPRM and Order,* the Commission sought comment on whether to allow unused funds committed in one funding year to be carried forward to a subsequent funding year. In fact, in the accompanying *Order* (FCC 17–164), the Commission directed that unused funds from prior years be carried forward to reduce the effect of proration for certain health care providers in FY 2017. All those who commented on this issue supported the proposal that unused funds be carried forward for use in subsequent years.

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

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

22. Further, the Commission will make unused funds available annually in the second quarter of each calendar year for use in the next full funding year of the RHC Program. Based on the estimates provided by USAC, the Commission will announce a specific amount of unused funds from prior funding years to be carried forward to increase available funding for future funding years. This unused funding may be used to commit to eligible services in excess of the annual funding cap in the event demand in a given year exceeds the cap, or it may be used to reduce collections for the RHC Program in a year when demand is less than the cap. The Bureau will announce the availability and amount of carryover funds during the second quarter of the calendar year.

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

III. Procedural Matters

A. Paperwork Reduction Act Analysis

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

B. Congressional Review Act

25. The Commission will send a copy of the R&O to Congress and the Government Accountability Office, pursuant to the Congressional Review Act, *see* 5 U.S.C. 801(a)(1)(A).

C. Regulatory Flexibility Act

26. The Regulatory Flexibility Act of 1980 (RFA) requires that an agency prepare a regulatory flexibility analysis for notice and comment rulemakings, unless the agency certifies that ''the rule will not, if promulgated, have a significant economic impact on a substantial number of small entities.'' Accordingly, we have prepared a Final Regulatory Flexibility Analysis (FRFA) concerning the possible impact of the rule changes contained in the R&O on small entities. The Commission will send a copy of the R&O, including the FRFA below, in a report to be sent to Congress and the Government Accountability Office pursuant to the Small Business Regulatory Enforcement Fairness Act of 1996. In addition, the Commission will send a copy of the R&O, including the FRFA, to the Chief Counsel for Advocacy of the Small Business Administration. A copy of the R&O and FRFA (or summaries thereof) will also be published in the **Federal Register**.

D. Final Regulatory Flexibility Analysis

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

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

28. Through the R&O, the Commission seeks to improve the Rural Health Care (RHC) Program's capacity to distribute telecommunications and broadband support to health care providers—especially small, rural

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

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

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

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

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

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

31. 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).

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

33. Next, the type of small entity described as a ''small organization'' is generally ''any not-for-profit enterprise which is independently owned and operated and is not dominant in its field.'' Nationwide, as of August 2016, there were approximately 356,494 small organizations based on registration and tax data filed by nonprofits with the Internal Revenue Service (IRS).

34. Finally, the small entity described as a ''small governmental jurisdiction'' is defined generally as ''governments of cities, counties, towns, townships, villages, school districts, or special districts, with a population of less than fifty thousand.'' U.S. Census Bureau data from the 2012 Census of Governments indicate that there were 90,056 local governmental jurisdictions consisting of general purpose governments and special purpose governments in the United States. Of this number, there were 37,132 General purpose governments (county, municipal and town or township) with populations of less than 50,000 and 12,184 Special purpose governments (independent school districts and special districts) with populations of less than 50,000. The 2012 U.S. Census Bureau data for most types of governments in the local government category show that the majority of these governments have populations of less than 50,000. Based on this data the Commission estimates that at least 49,316 local government jurisdictions fall in the category of ''small governmental jurisdictions.''

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

a. Health Care Providers

36. *Offices of Physicians (except Mental Health Specialists).* This U.S. industry comprises establishments of health practitioners having the degree of M.D. (Doctor of Medicine) or D.O. (Doctor of Osteopathy) primarily engaged in the independent practice of general or specialized medicine (except psychiatry or psychoanalysis) or surgery. These practitioners operate private or group practices in their own offices (*e.g.,* centers, clinics) or in the facilities of others, such as hospitals or health maintenance organization (HMO) medical centers. The SBA has created a size standard for this industry, which is annual receipts of $11 million or less. According to 2012 U.S. Economic Census, 152,468 firms operated throughout the entire year in this industry. Of that number, 147,718 had annual receipts of less than $10 million, while 3,108 firms had annual receipts between $10 million and $24,999,999. Based on this data, the Commission concludes that a majority of firms operating in this industry are small under the applicable size standard.

37. *Offices of Physicians, Mental Health Specialists.* The U.S. industry comprises establishments of health practitioners having the degree of M.D. (Doctor of Medicine) or D.O. (Doctor of Osteopathy) primarily engaged in the independent practice of psychiatry or psychoanalysis. These practitioners operate private or group practices in their own offices (*e.g.,* centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers. The SBA has established a size standard for businesses in this industry, which is annual receipts of $11 million dollars or less. The U.S. Economic Census indicates that 8,809 firms operated throughout the entire year in this industry. Of that number 8,791 had annual receipts of less than $10 million, while 13 firms had annual receipts between $10 million and $24,999,999. Based on this data, the Commission concludes that a majority of firms in this industry are small under the applicable standard.

38. *Offices of Dentists.* This U.S. industry comprises establishments of health practitioners having the degree of D.M.D. (Doctor of Dental Medicine), D.D.S. (Doctor of Dental Surgery), or D.D.S. (Doctor of Dental Science) primarily engaged in the independent practice of general or specialized dentistry or dental surgery. These practitioners operate private or group practices in their own offices (*e.g.,* centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers. They can provide either comprehensive preventive, cosmetic, or emergency care, or specialize in a single field of dentistry. The SBA has established a size standard

for that industry of annual receipts of $7.5 million or less. The 2012 U.S. Economic Census indicates that 115,268 firms operated in the dental industry throughout the entire year. Of that number 114,417 had annual receipts of less than $5 million, while 651 firms had annual receipts between $5 million and $9,999,999. Based on this data, the Commission concludes that a majority of business in the dental industry are small under the applicable standard.

39. *Offices of Chiropractors.* This U.S. industry comprises establishments of health practitioners having the degree of D.C. (Doctor of Chiropractic) primarily engaged in the independent practice of chiropractic. These practitioners provide diagnostic and therapeutic treatment of neuromusculoskeletal and related disorders through the manipulation and adjustment of the spinal column and extremities, and operate private or group practices in their own offices (*e.g.,* centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers. The SBA has established a size standard for this industry, which is annual receipts of $7.5 million or less. The 2012 U.S. Economic Census statistics show that in 2012, there were 33,940 firms operated throughout the entire year. Of that number 33,910 operated with annual receipts of less than $5 million per year, while 26 firms had annual receipts between $5 million and $9,999,999. Based on that data, the Commission concludes that a majority of chiropractors are small.

40. *Offices of Optometrists.* This U.S. industry comprises establishments of health practitioners having the degree of O.D. (Doctor of Optometry) primarily engaged in the independent practice of optometry. These practitioners examine, diagnose, treat, and manage diseases and disorders of the visual system, the eye and associated structures as well as diagnose related systemic conditions. Offices of optometrists prescribe and/or provide eyeglasses, contact lenses, low vision aids, and vision therapy. They operate private or group practices in their own offices *(e.g.,* centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers, and may also provide the same services as opticians, such as selling and fitting prescription eyeglasses and contact lenses. The SBA has established a size standard for businesses operating in this industry, which is annual receipts of $7.5 million or less. The 2012 Economic Census indicates that 18,050 firms operated the entire year. Of that number, 17,951 had annual receipts of less than $5 million, while 70 firms had annual receipts between $5 million and $9,999,999. Based on this data, the Commission concludes that a majority of optometrists in this industry are small.

41. *Offices of Mental Health Practitioners (except Physicians).* This U.S. industry comprises establishments of independent mental health practitioners (except physicians) primarily engaged in (1) the diagnosis and treatment of mental, emotional, and behavioral disorders and/or (2) the diagnosis and treatment of individual or group social dysfunction brought about by such causes as mental illness, alcohol and substance abuse, physical and emotional trauma, or stress. These practitioners operate private or group practices in their own offices (*e.g.,* centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers. The SBA has created a size standard for this industry, which is annual receipts of $7.5 million or less. The 2012 U.S. Economic Census indicates that 16,058 firms operated throughout the entire year. Of that number, 15,894 firms received annual receipts of less than $5 million, while 111 firms had annual receipts between $5 million and $9,999,999. Based on this data, the Commission concludes that a majority of mental health practitioners who do not employ physicians are small.

42. *Offices of Physical, Occupational and Speech Therapists and Audiologists.* This U.S. industry comprises establishments of independent health practitioners primarily engaged in one of the following: (1) Providing physical therapy services to patients who have impairments, functional limitations, disabilities, or changes in physical functions and health status resulting from injury, disease or other causes, or who require prevention, wellness or fitness services; (2) planning and administering educational, recreational, and social activities designed to help patients or individuals with disabilities, regain physical or mental functioning or to adapt to their disabilities; and (3) diagnosing and treating speech, language, or hearing problems. These practitioners operate private or group practices in their own offices (*e.g.,* centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers. The SBA has established a size standard for this industry, which is annual receipts of $7.5 million or less. The 2012 U.S. Economic Census indicates that 20,567 firms in this industry operated throughout the entire year. Of this number, 20,047 had annual receipts of less than $5 million, while 270 firms had annual receipts between $5 million and $9,999,999. Based on this data, the Commission concludes that a majority of businesses in this industry are small.

43. *Offices of Podiatrists.* This U.S. industry comprises establishments of health practitioners having the degree of D.P.M. (Doctor of Podiatric Medicine) primarily engaged in the independent practice of podiatry. These practitioners diagnose and treat diseases and deformities of the foot and operate private or group practices in their own offices (*e.g.,* centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers. The SBA has established a size standard for businesses in this industry, which is annual receipts of $7.5 million or less. The 2012 U.S. Economic Census indicates that 7,569 podiatry firms operated throughout the entire year. Of that number, 7,545 firms had annual receipts of less than $5 million, while 22 firms had annual receipts between $5 million and $9,999,999. Based on this data, the Commission concludes that a majority of firms in this industry are small.

44. *Offices of All Other Miscellaneous Health Practitioners.* This U.S. industry comprises establishments of independent health practitioners (except physicians; dentists; chiropractors; optometrists; mental health specialists; physical, occupational, and speech therapists; audiologists; and podiatrists). These practitioners operate private or group practices in their own offices (*e.g.,* centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers. The SBA has established a size standard for this industry, which is annual receipts of $7.5 million or less. The 2012 U.S. Economic Census indicates that 11,460 firms operated throughout the entire year. Of that number, 11,374 firms had annual receipts of less than $5 million, while 48 firms had annual receipts between $5 million and $9,999,999. Based on this data, the Commission concludes that the majority of firms in this industry are small.

45. *Family Planning Centers.* This U.S. industry comprises establishments with medical staff primarily engaged in providing a range of family planning services on an outpatient basis, such as contraceptive services, genetic and prenatal counseling, voluntary sterilization, and therapeutic and medically induced termination of pregnancy. The SBA has established a size standard for this industry, which is annual receipts of $11 million or less. The 2012 Economic Census indicates that 1,286 firms in this industry

operated throughout the entire year. Of that number 1,237 had annual receipts of less than $10 million, while 36 firms had annual receipts between $10 million and $24,999,999. Based on this data, the Commission concludes that the majority of firms in this industry are small.

46. *Outpatient Mental Health and Substance Abuse Centers.* This U.S. industry comprises establishments with medical staff primarily engaged in providing outpatient services related to the diagnosis and treatment of mental health disorders and alcohol and other substance abuse. These establishments generally treat patients who do not require inpatient treatment. They may provide a counseling staff and information regarding a wide range of mental health and substance abuse issues and/or refer patients to more extensive treatment programs, if necessary. The SBA has established a size standard for this industry, which is $15 million or less in annual receipts. The 2012 U.S. Economic Census indicates that 4,446 firms operated throughout the entire year. Of that number, 4,069 had annual receipts of less than $10 million while 286 firms had annual receipts between $10 million and $24,999,999. Based on this data, the Commission concludes that a majority of firms in this industry are small.

47. *HMO Medical Centers.* This U.S. industry comprises establishments with physicians and other medical staff primarily engaged in providing a range of outpatient medical services to the HMO subscribers with a focus generally on primary health care. These establishments are owned by the HMO. Included in this industry are HMO establishments that both provide health care services and underwrite health and medical insurance policies. The SBA has established a size standard for this industry, which is $32.5 million or less in annual receipts. The 2012 U.S. Economic Census indicates that 14 firms in this industry operated throughout the entire year. Of that number, 5 firms had annual receipts of less than $25 million, while 1 firm had annual receipts between $25 million and $99,999,999. Based on this data, the Commission concludes that approximately one-third of the firms in this industry are small.

48. *Freestanding Ambulatory Surgical and Emergency Centers.* This U.S. industry comprises establishments with physicians and other medical staff primarily engaged in (1) providing surgical services (*e.g.,* orthoscopic and cataract surgery) on an outpatient basis or (2) providing emergency care services (*e.g.,* setting broken bones, treating lacerations, or tending to patients suffering injuries as a result of accidents, trauma, or medical conditions necessitating immediate medical care) on an outpatient basis. Outpatient surgical establishments have specialized facilities, such as operating and recovery rooms, and specialized equipment, such as anesthetic or X-ray equipment. The SBA has established a size standard for this industry, which is annual receipts of $15 million or less. The 2012 U.S. Economic Census indicates that 3,595 firms in this industry operated throughout the entire year. Of that number, 3,222 firms had annual receipts of less than $10 million, while 289 firms had annual receipts between $10 million and $24,999,999. Based on this data, the Commission concludes that a majority of firms in this industry are small.

49. *All Other Outpatient Care Centers.* This U.S. industry comprises establishments with medical staff primarily engaged in providing general or specialized outpatient care (except family planning centers, outpatient mental health and substance abuse centers, HMO medical centers, kidney dialysis centers, and freestanding ambulatory surgical and emergency centers). Centers or clinics of health practitioners with different degrees from more than one industry practicing within the same establishment (*i.e.,* Doctor of Medicine and Doctor of Dental Medicine) are included in this industry. The SBA has established a size standard for this industry, which is annual receipts of $20.5 million or less. The 2012 U.S. Economic Census indicates that 4,903 firms operated in this industry throughout the entire year. Of this number, 4,269 firms had annual receipts of less than $10 million, while 389 firms had annual receipts between $10 million and $24,999,999. Based on this data, the Commission concludes that a majority of firms in this industry are small.

50. *Blood and Organ Banks.* This U.S. industry comprises establishments primarily engaged in collecting, storing, and distributing blood and blood products and storing and distributing body organs. The SBA has established a size standard for this industry, which is annual receipts of $32.5 million or less. The 2012 U.S. Economic Census indicates that 314 firms operated in this industry throughout the entire year. Of that number, 235 operated with annual receipts of less than $25 million, while 41 firms had annual receipts between $25 million and $49,999,999. Based on this data, the Commission concludes that approximately three-quarters of firms that operate in this industry are small.

51. *All Other Miscellaneous Ambulatory Health Care Services.* This U.S. industry comprises establishments primarily engaged in providing ambulatory health care services (except offices of physicians, dentists, and other health practitioners; outpatient care centers; medical and diagnostic laboratories; home health care providers; ambulances; and blood and organ banks). The SBA has established a size standard for this industry, which is annual receipts of $15 million or less. The 2012 U.S. Economic Census indicates that 2,429 firms operated in this industry throughout the entire year. Of that number, 2,318 had annual receipts of less than $10 million, while 56 firms had annual receipts between $10 million and $24,999,999. Based on this data, the Commission concludes that a majority of the firms in this industry are small.

52. *Medical Laboratories.* This U.S. industry comprises establishments known as medical laboratories primarily engaged in providing analytic or diagnostic services, including body fluid analysis, generally to the medical profession or to the patient on referral from a health practitioner. The SBA has established a size standard for this industry, which is annual receipts of $32.5 million or less. The 2012 U.S. Economic Census indicates that 2,599 firms operated in this industry throughout the entire year. Of this number, 2,465 had annual receipts of less than $25 million, while 60 firms had annual receipts between $25 million and $49,999,999. Based on this data, the Commission concludes that a majority of firms that operate in this industry are small.

53. *Diagnostic Imaging Centers.* This U.S. industry comprises establishments known as diagnostic imaging centers primarily engaged in producing images of the patient generally on referral from a health practitioner. The SBA has established size standard for this industry, which is annual receipts of $15 million or less. The 2012 U.S. Economic Census indicates that 4,209 firms operated in this industry throughout the entire year. Of that number, 3,876 firms had annual receipts of less than $10 million, while 228 firms had annual receipts between $10 million and $24,999,999. Based on this data, the Commission concludes that a majority of firms that operate in this industry are small.

54. *Home Health Care Services.* This U.S. industry comprises establishments primarily engaged in providing skilled nursing services in the home, along with

a range of the following: Personal care services; homemaker and companion services; physical therapy; medical social services; medications; medical equipment and supplies; counseling; 24-hour home care; occupation and vocational therapy; dietary and nutritional services; speech therapy; audiology; and high-tech care, such as intravenous therapy. The SBA has established a size standard for this industry, which is annual receipts of $15 million or less. The 2012 U.S. Economic Census indicates that 17,770 firms operated in this industry throughout the entire year. Of that number, 16,822 had annual receipts of less than $10 million, while 590 firms had annual receipts between $10 million and $24,999,999. Based on this data, the Commission concludes that a majority of firms that operate in this industry are small.

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

56. *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 assize standard for this industry, which is annual receipts of $38.5 million or less. The 2012 U.S. Economic Census indicates that 396 firms operated in this industry throughout the entire year. Of that number, 379 had annual receipts of less than $25 million, while 7 firms had annual receipts between $25 million and $49,999,999. Based on this data, the Commission concludes that a majority of firms in this industry are small.

57. *General Medical and Surgical Hospitals.* This U.S. industry comprises establishments known and licensed as general medical and surgical hospitals primarily engaged in providing diagnostic and medical treatment (both surgical and nonsurgical) to inpatients with any of a wide variety of medical conditions. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements. These hospitals have an organized staff of physicians and other medical staff to provide patient care services. These establishments usually provide other services, such as outpatient services, anatomical pathology services, diagnostic X-ray services, clinical laboratory services, operating room services for a variety of procedures, and pharmacy services. The SBA has established a size standard for this industry, which is annual receipts of $38.5 million or less. The 2012 U.S. Economic Census indicates that 2,800 firms operated in this industry throughout the entire year. Of that number, 877 has annual receipts of less than $25 million, while 400 firms had annual receipts between $25 million and $49,999,999. Based on this data, the Commission concludes that approximately one-quarter of firms in this industry are small.

58. *Psychiatric and Substance Abuse Hospitals.* This U.S. industry comprises establishments known and licensed as psychiatric and substance abuse hospitals primarily engaged in providing diagnostic, medical treatment, and monitoring services for inpatients who suffer from mental illness or substance abuse disorders. The treatment often requires an extended stay in the hospital. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements. They have an organized staff of physicians and other medical staff to provide patient care services. Psychiatric, psychological, and social work services are available at the facility. These hospitals usually provide other services, such as outpatient services, clinical laboratory services, diagnostic X-ray services, and electroencephalograph services. The SBA has established a size standard for this industry, which is annual receipts of $38.5 million or less. The 2012 U.S. Economic Census indicates that 404 firms operated in this industry throughout the entire year. Of that number, 185 had annual receipts of less than $25 million, while 107 firms had annual receipts between $25 million and $49,999,999. Based on this data, the Commission concludes that more than one-half of the firms in this industry are small.

59. *Specialty (Except Psychiatric and Substance Abuse) Hospitals.* This U.S. industry consists of establishments known and licensed as specialty hospitals primarily engaged in providing diagnostic, and medical treatment to inpatients with a specific type of disease or medical condition (except psychiatric or substance abuse). Hospitals providing long-term care for the chronically ill and hospitals providing rehabilitation, restorative, and adjustive services to physically challenged or disabled people are included in this industry. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements. They have an organized staff of physicians and other medical staff to provide patient care services. These hospitals may provide other services, such as outpatient services, diagnostic X-ray services, clinical laboratory services, operating room services, physical therapy services, educational and vocational services, and psychological and social work services. The SBA has established a size standard for this industry, which is annual receipts of $38.5 million or less. The 2012 U.S. Economic Census indicates that 346 firms operated in this industry throughout the entire year. Of that number, 146 firms had annual receipts of less than $25 million, while 79 firms had annual receipts between $25 million and $49,999,999. Based on this data, the Commission conclude that more than one-half of the firms in this industry are small.

60. *Emergency and Other Relief Services.* This industry comprises establishments primarily engaged in providing food, shelter, clothing, medical relief, resettlement, and counseling to victims of domestic or international disasters or conflicts (*e.g.,* wars). The SBA has established a size standard for this industry, which is annual receipts of $32.5 million or less. The 2012 U.S. Economic Census indicates that 541 firms operated in this industry throughout the entire year. Of that number, 509 had annual receipts of less than $25 million, while 7 firms had annual receipts between $25 million and $49,999,999. Based on this data, the Commission concludes that a majority of firms in this industry are small.

b. Providers of Telecommunications and Other Services

i. Telecommunications Service Providers

61. *Incumbent Local Exchange Carriers (LECs).* Neither the Commission nor the SBA has developed a small business size standard specifically for incumbent local exchange services. The closest applicable NAICS Code category

is Wired Telecommunications Carriers and under the SBA size standard, such a business is small if it has 1,500 or fewer employees. U.S. Census Bureau data for 2012 indicate that 3,117 firms operated during that year. Of this total, 3,083 operated with fewer than 1,000 employees. Consequently, the Commission estimates that most providers of incumbent local exchange service are small businesses that may be affected by our actions. According to Commission data, one thousand three hundred and seven (1,307) Incumbent Local Exchange Carriers reported that they were incumbent local exchange service providers. 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.

62. *Interexchange Carriers (IXCs).* Neither the Commission nor the SBA has developed a definition of small entities specifically applicable to providers of IXCs. The closest NAICS Code category is Wired Telecommunications Carriers and the applicable size standard under SBA rules consists of all such companies having 1,500 or fewer employees. U.S. Census Bureau data for 2012 indicate that 3,117 firms operated during that year. Of that number, 3,083 operated with fewer than 1,000 employees. According to internally developed Commission data, 359 companies reported that their primary telecommunications service activity was the provision of interexchange services. Of this total, an estimated 317 have 1,500 or fewer employees. Consequently, the Commission estimates that the majority of interexchange service providers that may be affected are small entities.

63. *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 indicate 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,* dated September 2010, 1,442 CAPs and competitive local exchange carriers (competitive LECs) reported that they were engaged in the provision of competitive local exchange services. Of these 1,442 CAPs and competitive LECs, an estimated 1,256 have 1,500 or few employees and 186 have more than 1,500 employees. Consequently, the Commission estimates that most providers of competitive exchange services are small businesses.

64. *Wired Telecommunications Carriers.* The U.S. Census Bureau defines this industry as ''establishments primarily engaged in operating and/or providing access to transmission facilities and infrastructure that they own and/or lease for the transmission of voice, data, text, sound, and video using wired communications networks. Transmission facilities may be based on a single technology or a combination of technologies. Establishments in this industry use the wired telecommunications network facilities that they operate to provide a variety of services, such as wired telephony services, including VoIP services, wired (cable) audio and video programming distribution, and wired broadband internet services. By exception, establishments providing satellite television distribution services using facilities and infrastructure that they operate are included in this industry.'' The SBA has developed a small business size standard for Wired Telecommunications Carriers, which consists of all such companies having 1,500 or fewer employees. U.S. Census data for 2012 show that there were 3,117 firms that operated that year. Of this total, 3,083 operated with fewer than 1,000 employees. Thus, under this size standard, the majority of firms in this industry can be considered small.

65. *Wireless Telecommunications Carriers (except Satellite).* This industry comprises establishments engaged in operating and maintaining switching and transmission facilities to provide communications via the airwaves. Establishments in this industry have spectrum licenses and provide services using that spectrum, such as cellular services, paging services, wireless internet access, and wireless video services. The appropriate size standard under SBA rules is that such a business is small if it has 1,500 or fewer employees. For this industry, U.S. Census Bureau data for 2012 shows that there were 967 firms that operated for the entire year. Of this total, 955 firms had employment of 999 or fewer employees and 12 had employment of 1,000 employees or more. Thus, under this category and the associated size standard, the Commission estimates that the majority of wireless telecommunications carriers (except satellite) are small entities.

66. The Commission's own data—available in its Universal Licensing System—indicate that, as of October 25, 2016, there are 280 Cellular licensees that will be affected by these actions. The Commission does not know how many of these licensees are small, as the Commission does not collect that information for these types of entities. Similarly, according to internally developed Commission data, 413 carriers reported that they were engaged in the provision of wireless telephony, including cellular service, Personal Communications Service (PCS), and Specialized Mobile Radio (SMR) Telephony services. Of this total, an estimated 261 have 1,500 or fewer employees, and 152 have more than 1,500 employees. Thus, using available data, the Commission estimates that the majority of wireless firms can be considered small.

67. *Wireless Telephony.* Wireless telephony includes cellular, personal communications services, and specialized mobile radio telephony carriers. The closest applicable SBA category is Wireless Telecommunications Carriers (except Satellite) and the appropriate size standard for this category under the SBA rules is that such a business is small if it has 1,500 or fewer employees. For this industry, U.S. Census Bureau data for 2012 show that there were 967 firms that operated for the entire year. Of this total, 955 firms had fewer than 1,000 employees and 12 firms has 1,000 employees or more. Thus, under this category and the associated size standard, the Commission estimates that a majority of these entities can be considered small. According to Commission data, 413 carriers reported that they were engaged in wireless telephony. Of these, an estimated 261 have 1,500 or fewer employees and 152 have more than 1,500 employees. Therefore, more than half of these entities can be considered small.

68. *Satellite Telecommunications.* This category comprises firms ''primarily engaged in providing telecommunications services to other establishments in the telecommunications and broadcasting industries by forwarding and receiving communications signals via a system of satellites or reselling satellite telecommunications.'' Satellite telecommunications service providers include satellite and earth station operators. The category has a small business size standard of $32.5 million or less in average annual receipts, under SBA rules. For this category, U.S.

Census Bureau data for 2012 shows that there were a total of 333 firms that operated for the entire year. Of this total, 299 firms had annual receipts of less than $25 million. Consequently, the Commission estimates that the majority of satellite telecommunications providers are small entities.

69. *All Other Telecommunications.* The ''All Other Telecommunications'' category is comprised of establishments that are primarily engaged in providing specialized telecommunications services, such as satellite tracking, communications telemetry, and radar station operation. This industry also includes establishments primarily engaged in providing satellite terminal stations and associated facilities connected with one or more terrestrial systems and capable of transmitting telecommunications to, and receiving telecommunications from, satellite systems. Establishments providing internet services or voice over internet protocol (VoIP) services via client-supplied telecommunications connections are also included in this industry. The SBA has developed a small business size standard for ''All Other Telecommunications,'' which consists of all such firms with gross annual receipts of $32.5 million or less. For this category, U.S. Census Bureau data for 2012 show that there were 1,442 firms that operated for the entire year. Of these firms, a total of 1,400 had gross annual receipts of less than $25 million and 42 firms had gross annual receipts of $25 million to $49, 999,999. Thus, the Commission estimates that a majority of ''All Other Telecommunications'' firms potentially affected by our action can be considered small.

ii. Internet Service Providers

70. *Internet Service Providers (Broadband).* Broadband internet service providers include wired (*e.g.,* cable, DSL) and VoIP service providers using their own operated wired telecommunications infrastructure fall in the category of Wired Telecommunication Carriers. Wired Telecommunications Carriers are comprised of establishments primarily engaged in operating and/or providing access to transmission facilities and infrastructure that they own and/or lease for the transmission of voice, data, text, sound, and video using wired telecommunications networks. Transmission facilities may be based on a single technology or a combination of technologies. The SBA size standard for this category classifies a business as small if it has 1,500 or fewer employees. U.S. Census Bureau data for 2012 show that there were 3,117 firms that operated that year. Of this total, 3,083 operated with fewer than 1,000 employees. Consequently, under this size standard, the majority of firms in this industry can be considered small.

71. *Internet Service Providers (Non-Broadband).* Internet access service providers such as Dial-up internet service providers, VoIP service providers using client-supplied telecommunications connections and internet service providers using client-supplied telecommunications connections (*e.g.,* dial-up ISPs) fall in the category of All Other Telecommunications. The SBA has developed a small business size standard for All Other Telecommunications, which consists of all such firms with gross annual receipts of $32.5 million or less. For this category, U.S. Census Bureau data for 2012 show that there were 1,442 firms that operated for the entire year. Of these firms, a total of 1,400 had gross annual receipts of less than $25 million. Consequently, under this size standard, a majority of firms in this industry can be considered small.

iii. Vendors and Equipment Manufacturers

72. *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 show that for Radio and Television Broadcasting and Wireless Communications Equipment firms 841 establishments operated for the entire year. Of that number, 828 establishments operated with fewer than 1,000 employees, 7 establishments operated with between 1,000 and 2,499 employees and 6 establishments operated with 2,500 or more employees. For Other Communications Equipment Manufacturing, U.S. Census Bureau data for 2012 show that 383 establishments operated for the year. Of that number, 379 firms operated with fewer than 500 employees and 4 had 500 to 999 employees. Based on this data, the Commission concludes that the majority of Vendors of Infrastructure Development or ''Network Buildout'' are small.

73. *Telephone Apparatus Manufacturing.* This industry comprises establishments primarily engaged in manufacturing wire telephone and data communications equipment. These products may be standalone or board-level components of a larger system. Examples of products made by these establishments are central office switching equipment, cordless telephones (except cellular), PBX equipment, telephones, telephone answering machines, LAN modems, multi-user modems, and other data communications equipment, such as bridges, routers, and gateways.'' The SBA size standard for Telephone Apparatus Manufacturing is all such firms having 1,250 or fewer employees. According to U.S. Census Bureau data for 2012, there were a total of 266 establishments in this category that operated for the entire year. Of this total, 262 had employment of under 1,000, and an additional 4 had employment of 1,000 to 2,499. Thus, under this size standard, the majority of firms can be considered small.

74. *Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing.* This industry comprises establishments primarily engaged in manufacturing radio and television broadcast and wireless communications equipment. Examples of products made by these establishments are: Transmitting and receiving antennas, cable television equipment, GPS equipment, pagers, cellular phones, mobile communications equipment, and radio and television studio and broadcasting equipment. The SBA has established a small business size standard for this industry of 1,250 employees or less. U.S. Census Bureau data for 2012 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.

75. *Other Communications Equipment Manufacturing.* This industry comprises establishments primarily engaged in manufacturing communications equipment (except telephone apparatus, and radio and television broadcast, and wireless communications equipment). Examples of such manufacturing include fire

detection and alarm systems manufacturing, Intercom systems and equipment manufacturing, and signals (*e.g.,* highway, pedestrian, railway, traffic) manufacturing. The SBA has established a size for this industry as all such firms having 750 or fewer employees. U.S. Census Bureau data for 2012 show 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.

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

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

6. Steps Taken To Minimize the Significant Economic Impact on Small Entities, and Significant Alternatives Considered

77. 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.''

78. In the R&O, the Commission increases available funding for all eligible RHC Program entities including small entities. Specifically, the Commission increases RHC Program support, and thereby increases support available for rural, mostly small, health care providers, by: (1) Increasing the RHC Program support cap to $571 million to apply to FY 2017; (2) prospectively increasing the $571 million RHC Program support cap *via* inflation using the Gross Domestic Price Chain-type Price Index (GDP–CPI) in FY 2018 and beyond; and (3) ''carrying forward'' unused funds committed in one funding year into subsequent funding years.

79. In the R&O, the Commission carefully balanced the significant financial hardship faced by rural health care providers due to the otherwise scarcity of funding and the public health consequences that could result from lack of broadband service with the increase in funding needed to meet the new cap. The Commission considered and rejected arguments to double the cap or to increase it beyond the $571 million adopted in the R&O. The increased cap, indexed to inflation, and the carry forward of unused funds will make more funding available to eligible health care providers including small entities, while minimizing the amount of funds that are needed to be collected. No commenters proposed significant small business alternatives.

7. Report to Congress

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

E. Effective Date of Report and Order

81. The Commission finds good cause to make the rule changes herein effective June 29, 2018, pursuant to section 553(d) of the Administrative Procedure Act. Agencies determining whether there is good cause to make a new rule or rule revision take effect less than 30 days after **Federal Register** publication must balance the necessity for immediate implementation against principles of fundamental fairness that require that all affected persons be afforded a reasonable time to prepare for the effective date of the new rule. Making these rule changes effective June 29, 2018 enables eligible health care providers to benefit from the increased funding cap for FY 2017, thereby avoiding the financial hardship caused by the proration of their funding commitments and the potential public health crises that could result. As noted earlier, the current reduction in funding may impede the ability of rural health care providers to provide essential health care services in their rural communities, or require them to scale back service offerings or quality, and these consequences could be particularly severe for small, rural health care providers with limited budgets.

82. Further, making these rule changes effective upon publication will not burden contributors or RHC Program participants. As a practical matter, contributors pass through their contribution obligations to their end users by a line item on the end user's invoice, which they update quarterly based on the contribution factor. The additional funding required by the R&O to be applied to FY 2017 will be collected over the next two quarters in accordance with our regular course of business for calculating and announcing the quarterly contribution factor, thus requiring no additional or different administrative burden on contributors. No additional time is needed for affected parties to prepare for the rules' effectiveness because USAC and interested parties have already applied for and processed the requests for funding for the current RHC Program year (FY 2017). Additionally, the rule change to increase the funding cap enables eligible health care providers to benefit from increased funding in the current funding year and does not oblige them to take any particular action. The rule changes that index the funding cap to inflation and carry forward unused funds do not impose any additional requirement on RHC Program participants and will be implemented by Commission staff and USAC during FY 2018. Thus, the Commission finds good cause to make these rule changes effective June 29, 2018.

IV. Ordering Clauses

83. Accordingly, *it is ordered* that, pursuant to sections 4(i) through (j), 201(b), and 254 of the Communications Act of 1934, as amended, 47 U.S.C. 154(i) through (j), 201(b), 254, the Report and Order *is adopted*.

84. *It is furthered ordered* that part 54 of the Commission's rules, 47 CFR part 54, is *amended*, and such rules shall become effective June 29, 2018.

85. *It is further ordered* that, pursuant to the authority contained in sections 1 through 4 and 254 of the Communications Act of 1934, as amended, 47 U.S.C. 151 through 154 and 254, and pursuant to § 1.3 and of the Commission's rules, 47 CFR 1.3, that § 54.675 of the Commission's rules, 47 CFR 54.675, *is waived* to the extent provided herein.

86. *It is further ordered* that, pursuant to the authority contained in sections 1 through 4 and 254 of the Communications Act of 1934, as amended, 47 U.S.C. 151 through 154 and 254, the petitions for waiver filed by Schools, Health, and Libraries Broadband Coalition filed on April 3, 2018, Advanced Data Solutions (on behalf of Frontier Community Services, Central Peninsula Hospital, Cordova Community Medical Center, Camai

Community Health Center, IHS/ABQ Alamo Health Center and Kenaitze Indian Tribe) filed on May 15, 2018, Bristol Bay Area Health Corporation filed on April 2, 2018, and Council of Athabascan Tribal Government filed on April 9, 2018 *are dismissed as moot*.

87. *It is further ordered* that, pursuant to 5 U.S.C. 801(a)(1)(A), the Commission *shall send* a copy of the Report and Order to Congress and to the Government Accountability Office pursuant to the Congressional Review Act.

88. *It is further ordered* that the Commission's Consumer and Governmental Affairs Bureau, Reference Information Center, *shall send* a copy of the Report and Order, including the Final Regulatory Flexibility Analysis, to the Chief Counsel for Advocacy of the Small Business Administration.

Federal Communications Commission.

Katura Jackson,

Federal Register Liaison Officer, Office of the Secretary.

List of Subjects in 47 CFR Part 54

Communications common carriers, Health facilities, internet, Telecommunications.

Final Rule

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

PART 54—UNIVERSAL SERVICE

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

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

■ 2. Amend § 54.675 by revising paragraph (a) to read as follows:

§ 54.675 Cap.

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

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

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

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

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

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

* * * * *

[FR Doc. 2018–14073 Filed 6–28–18; 8:45 am]

BILLING CODE 6712–01–P

DEPARTMENT OF DEFENSE

Defense Acquisition Regulations System

48 CFR Parts 215, 217, and 243

[Docket DARS–2016–0026]

RIN 0750–AI99

Defense Federal Acquisition Regulation Supplement: Undefinitized Contract Action Definitization (DFARS Case 2015–D024)

AGENCY: Defense Acquisition Regulations System, Department of Defense (DoD).

ACTION: Final rule.

SUMMARY: DoD is issuing a final rule amending the Defense Federal Acquisition Regulation Supplement (DFARS) to provide a more transparent means of documenting the impact of costs incurred during the undefinitized period of an undefinitized contract action on allowable profit.

DATES: Effective June 29, 2018.

FOR FURTHER INFORMATION CONTACT: Mr. Mark Gomersall, telephone 571–372–6176.

SUPPLEMENTARY INFORMATION:

I. Background

DoD published a proposed rule in the **Federal Register** at 81 FR 73007 on October 21, 2016, to amend the DFARS to provide a more transparent means of documenting the impact of costs incurred during the undefinitized period of an undefinitized contract action (UCA), and to recognize when contractors demonstrate efficient management and internal cost control systems through the submittal of a timely, auditable proposal in furtherance of definitization of a UCA. In some cases, DoD contracting personnel have not documented their consideration of the reduced risk to the contractor of costs incurred during the undefinitized period of a UCA. While such costs generally present very little risk to the contractor, the contracting officer should consider the reasons for any delays in definitization in making their determination of the appropriate assigned value for contract type risk.

II. Discussion and Analysis

Two respondents submitted public comments in response to the proposed rule. DoD reviewed the public comments in the development of this final rule. An analysis of the comments is provided as follows: