CAA and applicable Federal regulations. 42 U.S.C. 7410(k); 40 CFR 52.02(a). Thus, in reviewing SIP submissions, EPA's role is to approve state choices, provided that they meet the criteria of the CAA. Accordingly, this action merely approves state law as meeting Federal requirements and does not impose additional requirements beyond those imposed by state law. For that reason, this action:

- Is not a significant regulatory action subject to review by the Office of Management and Budget under Executive Orders 12866 (58 FR 51735, October 4, 1993) and 13563 (76 FR 3821, January 21, 2011);
- Does not impose an information collection burden under the provisions of the Paperwork Reduction Act (44 U.S.C. 3501 *et seq.*);
- Is certified as not having a significant economic impact on a substantial number of small entities under the Regulatory Flexibility Act (5 U.S.C. 601 *et seq.*);
- Does not contain any unfunded mandate or significantly or uniquely affect small governments, as described in the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4);
- Does not have federalism implications as specified in Executive Order 13132 (64 FR 43255, August 10, 1999);
- Is not an economically significant regulatory action based on health or safety risks subject to Executive Order 13045 (62 FR 19885, April 23, 1997);
- Is not a significant regulatory action subject to Executive Order 13211 (66 FR 28355, May 22, 2001); and
- Is not subject to requirements of Section 12(d) of the National Technology Transfer and Advancement Act of 1995 (15 U.S.C. 272 note) because application of those requirements would be inconsistent with the CAA.

In addition, the SIP is not approved to apply on any Indian reservation land or in any other area where EPA or an Indian tribe has demonstrated that a tribe has jurisdiction. In those areas of Indian country, the rule does not have tribal implications and will not impose substantial direct costs on tribal governments or preempt tribal law as specified by Executive Order 13175 (65 FR 67249, November 9, 2000).

Executive Order 12898 (Federal Actions To Address Environmental Justice in Minority Populations and Low-Income Populations, 59 FR 7629, Feb. 16, 1994) directs Federal agencies to identify and address ''disproportionately high and adverse human health or environmental effects'' of their actions on minority populations and low-income populations to the greatest extent practicable and permitted by law. EPA defines environmental justice (EJ) as ''the fair treatment and meaningful involvement of all people regardless of race, color, national origin, or income with respect to the development, implementation, and enforcement of environmental laws, regulations, and policies.'' EPA further defines the term fair treatment to mean that ''no group of people should bear a disproportionate burden of environmental harms and risks, including those resulting from the negative environmental consequences of industrial, governmental, and commercial operations or programs and policies.''

The air agency did not evaluate environmental justice considerations as part of its SIP submittal; the CAA and applicable implementing regulations neither prohibit nor require such an evaluation. EPA did not perform an EJ analysis and did not consider EJ in this action. Due to the nature of the action being taken here, this action is expected to have a neutral to positive impact on the air quality of the affected area. Consideration of EJ is not required as part of this action, and there is no information in the record inconsistent with the stated goal of E.O. 12898 of achieving environmental justice for people of color, low-income populations, and Indigenous peoples.

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Incorporation by reference, Intergovernmental relations, Reporting and recordkeeping requirements, Sulfur oxides.

Dated: March 16, 2023.

Debra Shore,

Regional Administrator, Region 5.

[FR Doc. 2023–05819 Filed 3–22–23; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 54

[WC Docket No. 17–310; FCC No. 23–6; FR ID 129966]

Promoting Telehealth in Rural America

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: In this document, the Federal Communications Commission (Commission) continues its efforts to improve the Rural Health Care (RHC) Program. The RHC Program seeks to support rural health care providers with the costs of broadband and other communications services for patients in rural areas that may have limited resources, fewer doctors, and higher rates than urban areas.

DATES: Comments are due on or before April 24, 2023, and reply comments are due on or before May 22, 2023. If you anticipate that you will be submitting comments but find it difficult to do so within the period of time allowed by this document, you should advise the contact listed as soon as possible.

ADDRESSES: Pursuant to §§ 1.415 and 1.419 of the Commission's rules, 47 CFR 1.415, 1.419, interested parties may file comments and reply comments. You may submit comments, identified by WC Docket No. 17–310, by any of the following methods:

Electronic Filers: Comments may be filed electronically using the internet by accessing the ECFS: *https://www.fcc.gov/ecfs/.*

Paper Filers: Parties who choose to file by paper must file an original and one copy of each filing. Filings can be sent by commercial overnight courier or by first-class or overnight U.S. Postal Service mail. All filings must be addressed to the Commission's Secretary, Office of the Secretary, Federal Communications Commission.

Commercial overnight mail (other than U.S. Postal Service Express Mail and Priority Mail) must be sent to 9050 Junction Drive, Annapolis Junction, MD 20701.

U.S. Postal Service first-class, Express, and Priority mail must be addressed to 45 L Street NE, Washington, DC 20554.

Effective March 19, 2020, and until further notice, the Commission no longer accepts any hand or messenger delivered filings at its headquarters. This is a temporary measure taken to help protect the health and safety of individuals, and to mitigate the transmission of COVID–19. See FCC Announces Closure of FCC Headquarters Open Window and Change in Hand-Delivery Policy, Public Notice, DA 20–304 (March 19, 2020), *https://www.fcc.gov/document/fcc-closes-headquarters-open-window-and-changes-hand-delivery-policy.*

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

FOR FURTHER INFORMATION CONTACT: Bryan P. Boyle *Bryan.Boyle@fcc.gov,*

Wireline Competition Bureau, 202–418–7400 or TTY: 202–418–0484. Requests for accommodations should be made as soon as possible in order to allow the agency to satisfy such requests whenever possible. Send an email to *fcc504@fcc.gov* or call the Consumer and Governmental Affairs Bureau at (202) 418–0530.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Promoting Telehealth in Rural America; Second Further Notice of Proposed Rulemaking (Second FNPRM) in WC Docket No. 17–310; FCC No. 23–6, adopted January 26, 2023 and released January 27, 2023. The full text of this document is available for public inspection during regular business hours at Commission's headquarters 45 L Street NE, Washington, DC 20554 or at the following internet address: *https://docs.fcc.gov/public/attachments/FCC-23-6A1.pdf.* The Order on Reconsideration, Second Report and Order and Order (Orders) that was adopted concurrently with the Second Further Notice of Proposed Rulemaking is to be published elsewhere in the **Federal Register**.

Introduction

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

The Second FNPRM proposes revisions to the rate determination rules, seeks comment on to reinstating the cap on support for satellite services, proposes to make it easier for health care providers to receive RHC Program funding as soon as they become eligible, propose to align the deadline to request a Service Provider Identification Number (SPIN) change with the invoice filling deadline, and seeks comment on revisions to data collected in the Telecom Program.

Second Further Notice of Proposed Rulemaking

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

Rural Rates. In the Order on Reconsideration published elsewhere in the **Federal Register**, the Commission grants the petitions seeking reconsideration of the Telecom Program Rates Database and restore Methods 1, 2, and 3 for calculating rural rates in the Telecom Program effective for funding year 2024. Although the Commission believes restoring Methods 1, 2, and 3 is the best of the currently available options to ensure that healthcare providers have adequate, predictable support in the short term, the Commission also recognizes that improvements to these methods may be necessary for the long term given the issues that the Commission has previously cited with respect to these rate calculation methodologies. Therefore, in the following sections, the Commission proposes modifications to the three methods to improve the overall calculation of rural rates, make rate calculations simpler to administer, and reduce waste, fraud, and abuse in the Telecom Program for funding year 2024 and beyond. The Commission proposals are similar to the now-reinstated Methods 1 through 3 in that they contain multiple ways to calculate rural rates that are applied sequentially. While the Commission seeks comment specifically on the proposed modification to the methods, at the outset the Commission seeks comment generally on alternative rural rate calculation methods. In proposing alternative rate methodologies, commenters should be specific, point the Commission to available data sources to support any alternative methodology, and explain how any alternative methodology would be more advantageous in protecting the Fund against waste, fraud, and abuse.

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

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

many years should an approval be effective?

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

Market-Based Calculations. The rules that the Commission reinstate in the Order on Reconsideration published elsewhere in the **Federal Register** require health care and service providers to first calculate the rural rate by averaging rates offered by the service provider for an identical or similar service in the rural area in which the health care provider was located (Method 1), and in the event the service provider does not provide such a service, the average of rates offered by carriers other than the service provider (Method 2). The Commission now proposes alternative sequential methods for determining rural rates, which are called ''Method A'' and ''Method B'' for purposes of the Second FNPRM:

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

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

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

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

As to administration, the availability of rural rates on the Open Data platform on the Administrator's website could simplify the rates determination process if the Administrator were to build a tool that allows the filer of a Request for Funding to select the specific funding requests, *i.e.,* prices from past request that would be used as inputs to Method A. The tool would then determine the rural rate under Method A on behalf of the health care provider before it certifies its Request for Funding. The automated process would not pre-determine which health care provider is in a similar rural area as the health care provider applicant. That would be left to the service provider to determine. During application review, the Administrator would verify that the sites from the inputs are in a similar rural area to the health care provider, just as it has done under the now reinstated Methods 1 and 2.

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

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

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

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

Cost-Based Rates. The Commission proposes that service providers continue to have the option to submit a cost-based rate if they cannot calculate a rural rate using Methods A or B. Under the rate determination rules the Commission reinstates, service providers may request approval of a cost-based rate under Method 3 from the Commission (for interstate services) or a state commission (for intrastate services) if there are no rates for the same or similar services in the rural area in which the health care provider is located, or the service provider reasonably determines that the calculated rural rate would not be compensatory. The Commission's rules require the service provider to submit a justification of its requested rural rate, including an itemization of the costs of providing the service requested by the eligible health care provider. To comply with the requirement, the request for approval of a cost-based rural rate requires service providers to include a cost study that demonstrates how the costs of providing services were allocated to RHC Program customers.

In the Promoting Telehealth Report and Order (2019 R&O) (FCC 19–78 rel. August 20, 2019 (84 FR 54952, October 11, 2019)), the Commission eliminated the cost-based method of determining rates and instead concluded that submitting a cost-based rate should serve only as a safety valve for service providers that have no other means of determining a rural rate. The Commission reasoned that implementation of the Rates Database made it unlikely that service providers would be unable to determine a rural rate with the data provided in the database. The Commission established a waiver process that allowed service providers to use a cost-based rate mechanism in ''extreme cases'' where the provider could show that the applicable rural rate from the Rates Database ''would result in objective, measurable economic injury.'' Now that the Rates Database has been eliminated and the previous rate determination rules have been reinstated, the Commission proposes to modify the cost-based rate-determination method to include specific evidentiary requirements to increase transparency in how service providers calculate cost-based rates when a rural rate cannot be calculated under Methods A or B or the carrier reasonably determines that the rural rate calculated under Methods A or B would not generate a reasonably compensatory rate.

The Commission proposes a revised cost-based method that will require service providers seeking approval of a cost-based rate to satisfy the same evidentiary requirements that the Commission adopted as required for waiver of the Rates Database rules in the 2019 R&O. When service providers submit a cost-based rate, the Commission proposes to require service providers to include all financial data and other information to verify the service provider's assertions, including, at a minimum, the following information:

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

The Commission understands that stakeholders generally disfavored the evidentiary requirements for the cost-based waiver for determining rural rates because of the burdensome nature of the information requested, the possibility that the cost-based method would not provide sufficient support for those that could not calculate their rates using the Rates Database and the fact that these evidentiary requirements go far beyond the evidentiary requirements for Method 3. However, the Commission adopted the waiver process as a safety valve given how infrequently the cost-based method has been used in the Telecom Program's history and the small likelihood that providers could not determine the rural rate using the Rates Database. The Commission believes that such a comprehensive cost-based process would likely incentivize service providers to make every effort to justify their rates under Methods A or B, which would be much simpler for both the Administrator and service providers. Nonetheless, in addition to the proposal, the Commission seeks comment on alternative evidentiary requirements that can assist the Bureau

and Administrator in evaluating cost-based rates in the event that service providers have no other way of determining rates. Do commenters have any recommendations that would increase transparency and efficiency in submitting and reviewing cost-based rates? How common would it be for service providers to have to use this cost-based rates process? Are there changes that the Commission can make to the proposed cost-based rates submission process that would mitigate administrative burdens on service providers without compromising Program integrity? How should service providers and the Bureau use the cost data to determine a cost-based rate to be charged to an individual customer? Should there be a deadline by which the Bureau must complete its cost-based rate review and issue a rate determination? If so, how would such a deadline operate in the event that a service provider submitted incomplete or inaccurate information that required additional submissions to the Bureau? Would the use of cost studies to determine maximum rural rates decrease incentives for new infrastructure investment in hard to serve areas? Do commenters have any concerns that the proposed cost-based rate would not be suitable for health care providers in Alaska? Commenters are strongly encouraged to share specific recommendations.

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

Standard Urban Distance. The rules that the Commission reinstates published elsewhere in the **Federal Register** provide that, if the service is provided over a distance greater than the standard urban distance, which is the average of the longest diameters of all cities with a population of 50,000 or more within a state, the urban rate is the rate no higher than the highest tariffed or publicly-available rate provided over the standard urban distance. The 2019 R&O eliminated the standard urban distance distinction in adopting the Rates Database. The Commission proposes to eliminate this distinction between services provided over and within the standard urban distance and to base all urban rates calculations on rates provided in a city, rather than over the standard urban distance. The Commission expects that eliminating this distinction will simplify the process for determining an urban rate and will not adversely impact most health care providers because few Telecom Program participants calculate urban rates using the standard urban distance. The Commission seeks comment on the impact that this would have on urban rates and administrative burdens. Before the adoption of the Rates Database, how common was it to base urban rates calculations on services in a city (rather than services over the standard urban distance)? Would urban rates increase unduly if the Commission makes this change? The Commission seeks comment on whether to change the standard for ''urban'' from a city with a population of at least 50,000. Will changes to the standard for ''urban'' in conjunction with the elimination of the standard urban distance cause an increase in urban rates?

Sources of Urban Rates. Under the pre-funding year 2020 urban rate rules that the Commission reinstates in the Order on Reconsideration published elsewhere in the **Federal Register**, documentation may be required to substantiate the applicable urban rate. The urban rate is determined by the health care provider, often with the assistance of a consultant or carrier, and reported on the FCC Form 466. To document the urban rate, health care providers may use ''tariff pages, contracts, a letter on company letterhead from the urban service provider, rate pricing information printed from the urban service provider's website or similar documentation showing how the urban rate was obtained.'' In the alternative, health care providers have historically utilized the urban rates listed on the Administrator's website for certain services in certain states. These urban rates are determined by reviewing tariff information on file with the Commission. One advantage of utilizing the urban rates posted to the Administrator's website is that health care providers did not need to provide additional documentation on their FCC Form 466. With the Commission's decision to eliminate the Rates Database, should the Administrator post urban rates as it did prior to the 2019 R&O or is the posting of urban rates of limited utility and unnecessary? Are there changes or updates the Administrator should make to the urban rates it posts on its website? While the Commission has made the decision to eliminate the Rates Database, the database contains urban rates that were collected as part of the database creation process. If the Administrator resumes posting urban rates, should the urban rates currently found in the Rates Database be included in the posted list, or have too many anomalies been identified that will preclude the use of those rates by participants in the Telecom Program?

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

Threshold for ''Urban.'' The standard for ''urban'' of being ''functionally similar service in any city with a population of 50,000 or more in that state'' that the Commission reinstates published elsewhere in the **Federal Register** was originally adopted in 2003. Should the Commission maintain 50,000 as the population threshold for determining an urban area? Is there another population number that better captures the full spectrum of urban

areas or is there a value collected by a different agency that better captures the picture of an urban area?

Network Function. The Commission seeks comment on two matters related to how networks function. First, the Commission seeks comment on reinstating the cap on support for satellite services that was in place before the adoption of the Rates Database. The Commission then seeks comment on the eligibility in the HCF Program of equipment that supports services funded in the Telecom Program.

Satellite Services. The Commission seeks comment on reinstating the cap on support for satellite services in the Telecom Program at the amount of support the health care provider would have received for similar terrestrial-based services. When the Commission established the RHC Program, satellite service was the only available telecommunications service available in some rural areas. However, rural health care providers in those areas generally did not receive Telecom Program discounts because satellite service rates typically did not vary between urban and rural areas. In 2003, the Commission revised its rules to allow eligible rural health care providers to base Telecom Program support for satellite services on urban rates for functionally similar wireline services. However, because satellite services were often significantly more expensive than terrestrial-based services, in rural areas where a functionally similar terrestrial-based service was available the Commission capped support for satellite service at the amount that the health care provider would receive had it chosen the terrestrial-based service. If an eligible rural health care provider chose a satellite-based service that was more expensive than the available equivalent terrestrial-base service, the health care provider was responsible for the additional cost. In the 2019 R&O, the Commission eliminated the cap, effective for funding year 2020, explaining that the limitation on support for satellite services was no longer necessary because rural rates would be determined by the Rates Database and costs for satellite services were decreasing, while also acknowledging that eliminating the cap furthered technological neutrality and that improvements to competitive bidding rules would reduce the need for the cap.

The Commission seeks comment on reinstating the cap on satellite services at the lower of the satellite service rate or the terrestrial service rate and allow rural health care providers to receive discounts for satellite service up to the amount providers would have received if they purchased functionally similar terrestrial-based alternatives, even where terrestrial-based services are available. It appears that the constraints on the price of satellite services that the Commission predicted when it eliminated the cap on satellite services did not come into fruition. Since the elimination of the cap and the waiver of the rates database, Telecom Program support for satellite services has increased significantly. The Commitments for Satellite Services dipped slightly in funding year 2020 but increased significantly after that. Funding Year Amounts: 2019—$28,726,457; 2020—$26,583,278; 2021—$39,487,136; and 2022—$60,098,460.

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

HCF Program Eligible Equipment. The Commission also seeks comment on whether to amend HCF Program rules to make eligible network equipment necessary to make functional an eligible service supported under the Telecom Program. Current HCF Program rules restrict the eligibility of network equipment for individual applicants to equipment necessary to make functional an eligible service supported under the HCF Program. There is no analogous rule in the Telecom Program that provides support for network equipment. Should the Commission consider allowing HCF-eligible equipment to support both HCF and Telecom Program services? Would such a change improve the reliability of Telecom Program supported services? If the Commission were to make network equipment for Telecom Program supported services eligible, what would the financial impact be on the RHC Program? Would HCF Program funding for equipment supporting Telecom Program services reduce Telecom Program expenditures? Expanding the universe of supported equipment would make it more likely that the internal cap would be exceeded. Given the significantly higher discount rates already offered in the Telecom Program, would it be sensible to increase the likelihood of exceeding the internal cap to provide HCF Program funding to support networks that traditionally have been supported in the Telecom Program only? If the Commission implements the change, are there additional safeguards to consider?

Conditional Approval of Eligibility for Future Eligible Health Care Providers. The Commission proposes to amend RHC Program rules for determining eligibility to allow entities that are not yet but will become eligible health care providers in the near future to begin receiving RHC Program funding shortly after they become eligible. Under the Bureau-level Hope Community Order (DA 16–855 rel. July 28, 2016), entities that are not yet eligible health care providers cannot receive an eligibility approval, which is a prerequisite to initiating competitive bidding and filing a Request for Funding, until they are eligible health care providers. As a result of the restriction, if a health care provider does not receive an eligibility approval in time to complete competitive bidding and file a Request for Funding by the close of the application filing window on April 1, the health care provider would have to

wait until a subsequent funding year to receive RHC Program funding, which could result in a delay of a full calendar year.

In order to address the delay in funding, the Commission proposes to amend §§ 54.601 and 54.622 of its rules to allow entities that will soon be eligible health care providers to request and receive a ''conditional approval of eligibility.'' Once the Administrator approves an applicant's conditional eligibility, the applicant could proceed to conduct competitive bidding and submit a Request for Funding during the application filing window. To ensure that no funding is disbursed for entities that are not yet eligible, the Administrator would not issue a funding decision for the funding request until the entity updates its eligibility request by providing documentation showing that it is an eligible health care provider and the Administrator issues a final eligibility approval. The conditional approval of eligibility process would use the same forms used to request eligibility approvals, which are the FCC Form 460 (Eligibility and Registration Form) in the HCF Program and the FCC Form 465 (Description of Services Requested and Certification Form) in the Telecom Program.

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

Administrative Deadlines. The Commission addresses two matters involving RHC Program deadlines. The Commission proposes to push back the deadline for requesting Service Provider Identification Number (SPIN) changes to align with the invoice deadline. The Commission also seeks comment on whether a mechanism to allow post-commitment changes to evergreen contract dates is necessary.

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

The Schools, Health and Libraries Broadband Coalition (SHLB) request that the Commission change the current deadline to make a corrective SPIN change from the service delivery deadline to the invoice filing deadline, which typically falls on October 28. SHLB maintains that the nature of corrective SPIN changes creates a ''recurring hardship for applicants'' unable to meet the deadline which, in turn, results in deadline waiver requests filed with the Commission. According to SHLB, two commonly recurring situations support a change to the corrective SPIN change deadline: (1) mergers and acquisitions that can occur at any time during the funding year and (2) a service provider that assigns one of its multiple SPINs to a funding request without advising the healthcare provider as to the correct SPIN before invoicing begins, a situation that, in many instances, occurs after the service delivery deadline has passed. SHLB maintains that changing the deadline to request a corrective SPIN change to October 28 will provide the Administrator with sufficient time to process the change request without the need for applicants to request deadline waivers from the Commission.

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

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

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

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

In the Promoting Telehealth in Rural America FNPRM (2022 FNPRM) (FCC 22–15 rel. February 22, 2022 (87 FR 14421, March 15, 2022)), the Commission sought general comment on both existing Telecom Program data collected through current program forms as well as potential changes to the categorization and details of Telecom Program services and data reported on the FCC Form 466. Certain data currently collected appears to be too vague and fails to capture details of the purchased services, resulting in significantly different monthly rates for services broadly categorized that report comparable bandwidths but likely vary significantly. The Commission requested feedback on updating the Telecom Program's categorization of services to more accurately reflect the functionality and cost of services purchased by incorporating data points such as details of service level agreements (SLAs). The Commission also sought comment on collecting data that would classify services based upon functionality, regardless of the commercial name used by the service provider to describe the service. The Commission then sought general comment on revisions to the FCC Form 466 and other Telecom Program forms and corresponding USAC online portals that would improve the accuracy of urban and rural rate determinations and ensure program integrity.

Commenters agreed that collecting more detailed data would result in more accurate categorization of services purchased by health care providers and improve program transparency. Alaska Communications agreed that service categorizations should be more granular and explained that services broadly categorized as ''dedicated'' include a range of services and features, particularly security and reliability, that significantly impact rates. Alaska Communications also noted that the factors identified in the 2022 FNPRM ''can have a profound effect on the functionality of the service from the perspective of the end user.'' GCI suggested that the Commission could collect data on network type, prioritization, and term and volume discounts. GCI also argued that the Commission should collect data on services purchased rather than requiring healthcare providers to submit highly detailed forms when requesting service.

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

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

Contract Type. In many instances services reimbursed under the RHC Program are often part of a contract that bundles many services together. The Commission proposes adding a field that would indicate if the underlying contract includes a bundle and what services the bundle covers. Data collected would include the total number of end points serviced, an indicator of the geographic region of coverage, the contract's duration, discounts and service level agreements that apply to the contract, and the contract's total price including RHC supported services.

Service Details—Connection Endpoint Information. There would be one entry for each endpoint.

Location of Endpoint—Geographically identifiable latitude and longitude.

Distance (If Applicable)—The distance would be in line miles from this endpoint to the far termination endpoint of the link or the central server node. This would be reported if the service provider uses it in the price calculation for this item. This field would be reported in line miles and not straight-line or ''crow fly'' miles.

Connectivity—Point-to-Point, Point-to-Multipoint, Multipoint-to-Multipoint

Application—Voice, Data, or Both

Service or Product—This is the service at the Endpoint. The user would select from the following options: Link (a point-to-point transmission), Device (at an endpoint for a link, such as a router or switch other network-supporting equipment), or Service (provided capabilities using the Links and Devices).

Equipment Vendor/Model—If a device or other equipment is used to extend the eligible service to the endpoint, the user would list it here. All devices would be required to be listed.

Technology—The user would report the technology at the endpoint selecting from items such as: DSL (Digital Subscriber Line), DOCSIS (Data Over Cable Service Interface Specifications), PON (Passive Optimal Network), GPON (Gigabit Passive Optical Network and its variants), and similar, as well as Other (Describe) and N/A.

Bandwidth (Down/Up)—This would be expressed in Mbps.

SLA Coverage—The user would select ''Yes'' or ''No'' to indicate if this endpoint is covered.

Access Media—The user would describe the transmission media that is present at the termination of the

endpoint at each individual facility. This can often, but not always, be considered the last mile. The user would select from: copper, cable, microwave, fiber, high Earth orbit satellite, LEO satellite, power line, other, and N/A.

Monthly Price—This field contains the monthly price in dollars and cents. This price would not include any uplift for SLA coverage, which will be collected elsewhere in the form. If the overall contract price is for a service such as MPLS, the price for each endpoint would be a pro-rated amount associated with each endpoint. Any service portion that cannot be associated with an endpoint, such as MPLS management, would be separately reported as an individual line item(s) in the ''Additional Services and Differentiators'' section. MPLS and similar multi-point solutions would not be reported as a single item. These services would be pro-rated to individual endpoints.

Additional Services and Differentiators—This question would only be used if the service cannot be described in the ''Service Details'' question.

Service Name—This would be a free text descriptor for the provider's name of this item.

Class—This would be a product, service, or differentiator not listed in the ''Service Details'' section because it is not associated with a single endpoint.

Coverage Scope—This field would refer to the scope of the network and contract that this item covers.

Period—This field would indicate the period length in months over which this item will occur. For example, if an ''Installation'' service is provided for the first year and one-half is part of the contract, ''18'' months would be shown.

SLA Coverage—The user would provide a ''Yes'' or ''No'' answer to indicate if this service/differentiator is covered under an SLA.

Monthly Price—This would be expressed in dollars and cents. The provider would pro-rate the monthly average cost for each item if the overall contract price is a single number.

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

Target Measurement—The user would report the item or class of items to be measured such as Availability (Network Level Outage), Availability (Link or Endpoint Level Outage), Repair/Restore Times (MTTR—Mean Time To Repair), or On Site Spares (Response Time for Equipment Under Contract).

SLA Level—High, Medium, or Low that may correspond to individual provider schemes, such as Bronze, Silver, Gold.

Basic, Standard, Premium.

As classified by any system the service provider may use.

What functions are covered?

The user selects between Operations, Performance, Maintenance, Install, Administration, and Compliance.

Period—The user would indicate the period length in months over which this item will occur. For example, if an ''Installation'' service is provided for 18 months, then ''18 months'' would be shown.

Penalties For Non-Performance? (Yes/No)—The user would indicate whether there are specific monetary or other penalties for carrier non-performance of specific SLA requirements written in the contract. The user would select from a drop-down menu. General statements of intent would not constitute a penalty.

SLA Scope—The user would report the scope of the contract that this item covers. Examples of options filers would select from include: Performance (what is delivered), Operations (how it is managed), and Maintenance (how it is repaired).

Description of Target SLA Measurement—An optional free text field the provider could use to enter further clarification for the specific SLA item.

Price Uplift—The user would report the increase to the contract service price (usually represented as a percentage) that the SLA impacts. If it is not a separate line item in the contract, then the price would be estimated and/or pro-rated by the provider over the period and scope of SLA coverage.

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

Service Provider Filing. The Commission proposes to require service providers to report the technical service details on the FCC Form 466. In the 2022 FNPRM, the Commission sought comment on whether service providers should report certain technical information about services purchased that rural health care providers either cannot access or lack the technical expertise to report. Commenters expressed concerns about increasing technical reporting burdens on healthcare providers. GCI argued that any new collection process should not burden rural health care providers, who are often ''not well positioned to supply technical and granular details about the services they need,'' and suggested collecting additional data through the FCC Form 466. Alaska Communications acknowledged that reporting technical service data would be complicated for health care providers. The Alaska Native Health Board (ANHB) and the Alaska Native Tribal Health Consortium (ANTHC) both supported increased data collection but cautioned against increasing reporting burdens on Tribal and other health care providers.

The Commission agrees with commenters that proposed increases in the level of detailed technical data required on the FCC Form 466 would likely exceed the technical expertise of most health care providers. The service providers are in the best position to understand the difference between a commercial term and a functional capability as well as the difference between a capability and the underlying technology. The Commission therefore proposes that service providers input service information into the FCC Form 466. The Commission tentatively concludes that shifting the responsibility for providing technical details to the service provider would reduce burdens on healthcare providers and improve data quality and consistency. The Commission proposes that service providers provide the technical connection endpoint data as well as any other technical service data that is recommended by commenters and ultimately adopted by the Commission as part of the proceeding. Additionally, the Commission proposes that the service providers include the actual contract as an attachment to the FCC Form 466. This would be treated confidentially and would document the carrier's answers in an official company document. To ensure the accuracy of the information provided, the Commission

proposes that the service provider certify to the accuracy of service provider-supplied information. The Commission seeks comment on these proposals.

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

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

Procedural Matters

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

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

Initial Regulatory Flexibility Analysis

As required by the Regulatory Flexibility Act of 1980, as amended (RFA), the Commission has prepared the Initial Regulatory Flexibility Analysis (IRFA) of the possible significant economic impact on a substantial number of small entities by the policies and rules proposed in the Second FNPRM. Written public comments are requested on the IRFA. Comments must be identified as responses to the IRFA and must be filed by the deadlines for comments. The Commission will send a copy of the Second FNPRM, including the IRFA, to the Chief Counsel for Advocacy of the Small Business Administration (SBA).

Need for, and Objectives of, the Proposed Rules

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

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

Legal Basis

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

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

The reporting, recordkeeping, and other compliance requirements proposed in the Second FNPRM likely would positively and negatively financially impact both large and small entities, including healthcare providers and service providers, and any resulting financial burdens may disproportionately impact small entities given their typically more limited resources. In weighing the likely financial benefits and burdens of the proposed requirements, however, the Commission has determined that the proposed changes would result in more equitable, effective, efficient, clear, and predictable distribution of RHC support, far outweighing any resultant financial burdens on small entity participants.

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

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

Small Businesses, Small Organizations, Small Governmental Jurisdictions. The Commission actions, over time, may affect small entities that are not easily categorized at present. The Commission therefore describes, 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 regulatory flexibility analysis, according to data from the SBA's Office of Advocacy, in general a small business is an independent business having fewer than 500 employees. These types of small businesses represent 99.9 percent of all businesses in the United States which translates to 31.7 million businesses.

Next, the type of small entity described as a ''small organization'' is generally ''any not-for-profit enterprise which is independently owned and operated and is not dominant in its field.'' The Internal Revenue Service (IRS) uses a revenue benchmark of $50,000 or less to delineate its annual electronic filing requirements for small exempt organizations. Nationwide, for tax year 2018, there were approximately 571,709 small exempt organizations in the U.S. reporting revenues of $50,000 or less according to the registration and tax data for exempt organizations available from the IRS.

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

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

Healthcare Providers

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

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

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

Offices of Optometrists. This U.S. industry comprises establishments of health practitioners having the degree of O.D. (Doctor of Optometry) primarily engaged in the independent practice of

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

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

Offices of Physical, Occupational and Speech Therapists and Audiologists. This U.S. industry comprises establishments of independent health practitioners primarily engaged in one of the following: (1) providing physical therapy services to patients who have impairments, functional limitations, disabilities, or changes in physical functions and health status resulting from injury, disease or other causes, or who require prevention, wellness or fitness services; (2) planning and administering educational, recreational, and social activities designed to help patients or individuals with disabilities, regain physical or mental functioning or to adapt to their disabilities; and (3) diagnosing and treating speech, language, or hearing problems. These practitioners operate private or group practices in their own offices (*e.g.,* centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers. The SBA has established a size standard for this industry, which is annual receipts of $8 million or less. The 2012 U.S. Economic Census indicates that 20,567 firms in this industry operated throughout the entire year. Of this number, 20,047 had annual receipts of less than $5 million, while 270 firms had annual receipts between $5 million and $9,999,999. Based on the data, the Commission concludes that a majority of businesses in this industry are small.

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

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

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

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

HMO Medical Centers. This U.S. industry comprises establishments with physicians and other medical staff primarily engaged in providing a range of outpatient medical services to the health maintenance organization (HMO) subscribers with a focus generally on primary health care. These establishments are owned by the HMO. Included in this industry are HMO

establishments that both provide health care services and underwrite health and medical insurance policies. The SBA has established a size standard for this industry, which is $35 million or less in annual receipts. The 2012 U.S. Economic Census indicates that 14 firms in this industry operated throughout the entire year. Of that number, 5 firms had annual receipts of less than $25 million, while 1 firm had annual receipts between $25 million and $99,999,999. Based on the data, the Commission concludes that approximately one-third of the firms in this industry are small.

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

All Other Outpatient Care Centers. This U.S. industry comprises establishments with medical staff primarily engaged in providing general or specialized outpatient care (except family planning centers, outpatient mental health and substance abuse centers, HMO medical centers, kidney dialysis centers, and freestanding ambulatory surgical and emergency centers). Centers or clinics of health practitioners with different degrees from more than one industry practicing within the same establishment (*i.e.,* Doctor of Medicine and Doctor of Dental Medicine) are included in this industry. The SBA has established a size standard for this industry, which is annual receipts of $22 million or less. The 2012 U.S. Economic Census indicates that 4,903 firms operated in this industry throughout the entire year. Of this number, 4,269 firms had annual receipts of less than $10 million, while 389 firms had annual receipts between $10 million and $24,999,999. Based on the data, the Commission concludes that a majority of firms in this industry are small.

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

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

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

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 $16.5 million or less. The 2012 U.S. Economic Census indicates that 4,209 firms operated in this industry throughout the entire year. Of that number, 3,876 firms had annual receipts of less than $10 million, while 228 firms had annual receipts between $10 million and $24,999,999. Based on the data, the Commission concludes that a majority of firms that operate in this industry are small.

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

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

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 $41.5 million or less. The 2012 U.S. Economic Census indicates that 396 firms operated in this industry throughout the entire year. Of that number, 379 had annual receipts of less than $25 million, while 7 firms had annual receipts between $25 million and $49,999,999. Based on the data, the Commission concludes that a majority of firms in this industry are small.

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

Psychiatric and Substance Abuse Hospitals. This U.S. industry comprises establishments known and licensed as psychiatric and substance abuse hospitals primarily engaged in providing diagnostic, medical treatment, and monitoring services for inpatients who suffer from mental illness or substance abuse disorders. The treatment often requires an extended stay in the hospital. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements. They have an organized staff of physicians and other medical staff to provide patient care services. Psychiatric, psychological, and social work services are available at the facility. These hospitals usually provide other services, such as outpatient services, clinical laboratory services, diagnostic X-ray services, and electroencephalograph services. The SBA has established a size standard for this industry, which is annual receipts of $41.5 million or less. The 2012 U.S. Economic Census indicates that 404 firms operated in this industry throughout the entire year. Of that number, 185 had annual receipts of less than $25 million, while 107 firms had annual receipts between $25 million and $49,999,999. Based on the data, the Commission concludes that more than one-half of the firms in this industry are small.

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

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

Providers of Telecommunications and Other Services

Telecommunications Service Providers—Incumbent Local Exchange Carriers (LECs). Neither the Commission nor the SBA has developed a small business size standard specifically for incumbent local exchange services. The closest applicable NAICS Code category is Wired Telecommunications Carriers. Under the applicable SBA size standard, such a business is small if it has 1,500 or fewer employees. U.S. Census Bureau data for 2012 indicate that 3,117 firms operated the entire year. Of this total, 3,083 operated with fewer than 1,000 employees. Consequently, the Commission estimates that most providers of incumbent local exchange service are small businesses that may be affected by the 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.

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

Competitive Access Providers. Neither the Commission nor the SBA

has developed a definition of small entities specifically applicable to competitive access services providers (CAPs). The closest applicable definition under the SBA rules is Wired Telecommunications Carriers and under the size standard, such a business is small if it has 1,500 or fewer employees. U.S. Census Bureau data for 2012 indicates that 3,117 firms operated during that year. Of that number, 3,083 operated with fewer than 1,000 employees. Consequently, the Commission estimates that most competitive access providers are small businesses that may be affected by the actions. According to Commission data the 2010 Trends in Telephone Report (rel. September 30, 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.

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

Vendors and Equipment Manufactures—Vendors of Infrastructure Development or ''Network Buildout.'' The Commission has not developed a small business size standard specifically directed toward manufacturers of network facilities. There are two applicable SBA categories in which manufacturers of network facilities could fall and each have different size standards under the SBA rules. The SBA categories are ''Radio and Television Broadcasting and Wireless Communications Equipment'' with a size standard of 1,250 employees or less and ''Other Communications Equipment Manufacturing'' with a size standard of 750 employees or less.'' U.S. Census Bureau data for 2012 shows that for Radio and Television Broadcasting and Wireless Communications Equipment firms 841 establishments operated for the entire year. Of that number, 828 establishments operated with fewer than 1,000 employees, and 7 establishments operated with between 1,000 and 2,499 employees. For Other Communications Equipment Manufacturing, U.S. Census Bureau data for 2012, show that 383 establishments operated for the year. Of that number 379 operated with fewer than 500 employees and 4 had 500 to 999 employees. Based on the data, the Commission concludes that the majority of Vendors of Infrastructure Development or ''Network Buildout'' are small.

Telephone Apparatus Manufacturing. This industry comprises establishments primarily engaged in manufacturing wire telephone and data communications equipment. These products may be stand-alone or board-level components of a larger system. Examples of products made by these establishments are central office switching equipment, cordless and wire telephones (except cellular), PBX equipment, telephone answering machines, LAN modems, multi-user modems, and other data communications equipment, such as bridges, routers, and gateways. The SBA has developed a small business size standard for Telephone Apparatus Manufacturing, which consists of all such companies having 1,250 or fewer employees. U.S. Census Bureau data for 2012 show that there were 266 establishments that operated that year. Of this total, 262 operated with fewer than 1,000 employees. Thus, under the size standard, the majority of firms in this industry can be considered small.

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

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

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

The RFA requires an agency to describe any significant, specifically small business, alternatives that it has considered in reaching its proposed approach, which may include the following four alternatives (among others): ''(1) the establishment of differing compliance or reporting requirements or timetables that take into account the resources available to small entities; (2) the clarification, consolidation, or simplification of compliance and reporting requirements under the rule for such small entities; (3) the use of performance rather than design standards; and (4) an exemption from coverage of the rule, or any part thereof, for such small entities.'' We expect to consider all of these factors when we have received substantive comment from the public and potentially affected entities.

Largely, the proposals in the Second FNPRM if adopted would have no impact on or would reduce the economic impact of current regulations on small entities. Certain proposals could have a positive economic impact on small entities. In the instances in which a proposed change would increase the financial burden on small entities, the Commission has determined that the net financial and other benefits from such changes would outweigh the increased burdens on small entities.

Determining Accurate Rates in the Telecom Program. The Commission proposes modifications to the three rural rate determination methods in the Telecom Program, including changes to the market-based approach of Methods

1 and 2 and new evidentiary requirements for justifying cost-based rates under Method 3. The Commission also proposes that participants with multi-year contracts and evergreen contracts would only have to justify rural rates in the first year of the contract. The Commission also proposes to simplify the calculation of urban rate rules by eliminating the ''standard urban distance'' requirement and seek specific comment on sources of urban rates as well as general comment on the urban rate rules. The Commission proposes to keep the cap on support for satellite services reinstated and seek comment on potential changes to it. Lastly, the Commission seeks comment on proposed revisions to FCC Form 466 intended to improve the quality of Telecom Program data.

Administrative Deadlines. The Commission also proposes to amend program rules align the deadline for filing a SPIN change with the invoice deadline. If implemented, the proposal would have a positive impact on small health care providers because it would reduce the need for them to seek waivers of the current SPIN change deadline. The Commission also seeks comment on whether a mechanism to allow post-commitment changes to evergreen contract dates is necessary.

Future Eligibility. The Commission also proposes a mechanism whereby entities that are not yet eligible health care providers can engage in competitive bidding and file requests for funding, which would allow them to receive RHC Program funding shortly after they become eligible. If implemented, the proposal would have a positive economic impact on small health care providers because it would allow them to receive RHC Program funding shortly after they become eligible.

Federal Rules That May Duplicate, Overlap, or Conflict With the Proposed Rules

None.

Ordering Clauses

Accordingly, it is ordered, pursuant to the authority contained in sections 1, 4(j), 214, 254, and 405 of the Communications Act of 1934, as amended, 47 U.S.C. 151, 154(j), 214, 254, and 405 and §§ 1.115 and 1.429 of the Commission's rules, 47 CFR 1.115, 1.429, that the Second FNPRM *is adopted*.

It is further ordered that, pursuant to applicable procedures set forth in §§ 1.415 and 1.419 of the Commission's rules, 47 CFR 1.415, 1.419, interested parties may file comments on the Second FNPRM on or before April 24, 2023, and reply comments on or before May 22, 2023.

List of Subjects in 47 CFR Part 54

Communications common carriers, Health facilities, internet, Reporting and recordkeeping requirements, Telecommunications.

Federal Communications Commission.

Marlene Dortch,

Secretary.

Proposed Rules

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

PART 54—UNIVERSAL SERVICE

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

Authority: 47 U.S.C. 151, 154(i), 155, 201, 205, 214, 219, 220, 229, 254, 303(r), 403, 1004, 1302, 1601–1609, and 1752, unless otherwise noted.

■ 2. Amend § 54.601 by adding paragraph (c) to read as follows:

§ 54.601 Health care provider eligibility.

* * * * *

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

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

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

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

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

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

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

■ 3. Revise § 54.604 to read as follows:

§ 54.604 Determining the urban rate.

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

■ 4. Revise § 54.605 to read as follows:

§ 54.605 Determining the rural rate.

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

(1) The rural rate shall be the median of publicly available rates charged by other service providers for the same or functionally similar services over the same distance in the rural area where

the health care provider is located (Method A).

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

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

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

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

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

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

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

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

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

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

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

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

(ii) [Reserved]

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

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

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

■ 5. Amend § 54.622 by revising paragraph (e)(1)(i) to read as follows:

§ 54.622 Competitive bidding requirements and exemptions.

* * * * *

(e) * * *

(1) * * *

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

* * * * *

■ 6. Amend § 54.625 by revising paragraph (c) to read as follows:

§ 54.625 Service Provider Identification Number (SPIN) changes.

* * * * *

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

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DEPARTMENT OF THE INTERIOR

Fish and Wildlife Service

50 CFR Part 20

[Docket No. FWS–HQ–MB–2022–0090; FF09M30000–234–FXMB1231099BPP0]

RIN 1018–BF64

Migratory Bird Hunting; Migratory Game Bird Hunting Regulations on Certain Federal Indian Reservations and Ceded Lands

AGENCY: Fish and Wildlife Service, Interior.

ACTION: Proposed rule.

SUMMARY: As part of the rulemaking process for the 2023–2024 season, the U.S. Fish and Wildlife Service (hereinafter, Service or we) proposes a revised process for establishing special regulations for certain Tribes on Federal Indian reservations, off-reservation trust lands, and ceded lands for migratory bird hunting seasons. We are proposing no longer to require that Tribes annually submit a proposal to the Service for our review and approval and no longer to publish in the **Federal Register** the annual Tribal migratory bird hunting regulations, and instead to adopt as regulations elements of our current guidelines for establishing special