effective date of March 23, 2023. This action is not a ''major rule'' as defined by 5 U.S.C. 804(2).

Under section 307(b)(1) of the CAA, petitions for judicial review of this action must be filed in the United States Court of Appeals for the appropriate circuit by May 22, 2023. Filing a petition for reconsideration by the Administrator of this final rule does not affect the finality of this rule for the purposes of judicial review nor does it extend the time within which a petition for judicial review may be filed, and shall not postpone the effectiveness of such rule or action. This action may not be challenged later in proceedings to enforce its requirements. See section 307(b)(2).

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. 2023–05820 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 129969]

Promoting Telehealth in Rural America

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: In this document, the Federal Communications Commission (Commission) seeks to support rural health care providers through the Rural Health Care (RHC) Program, 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: Effective April 24, 2023, except for §§ 54.604 (amendatory instruction 2), 54.605 (amendatory instruction 3), and 54.627 (amendatory instruction 8), which are delayed indefinitely. The Commission will publish a document in the **Federal Register** announcing the effective date for those rule sections.

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 Order on Reconsideration, Second Report and Order, and Order (Order) in WC Docket No. 17–310; FCC No. 23–6, adopted on January 26, 2023 and released on 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 Second Further Notice of Proposed Rulemaking (Second FNPRM) that was adopted concurrently with the Order on Reconsideration, Second Report and Order and Order is to be published elsewhere in this issue of the **Federal Register**.

I. Introduction

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

2. In the Order on Reconsideration section, the Commission addresses petitions for reconsideration of the 2019 *Promoting Telehealth Report and Order,* FCC 19–78 rel. August 20, 2019 (84 FR 54952, October 11, 2019) (*2019 R&O*). The Commission grants petitions challenging the database of urban and rural rates (Rates Database) for the Telecommunications Program (Telecom Program) established in the *2019 R&O,* return the Telecom Program to the rate determination rules in place before the adoption of the Rates Database, and deny petitions for reconsideration of other issues from the *2019 R&O.* In the Second Report and Order section, the Commission adopts proposals from the 2022 *Further Notice of Proposed Rulemaking,* FCC 22–15 rel. February 22, 2022 (87 FR 14421, March 15, 2022) (*2022 FNPRM*) to amend RHC Program invoicing processes and the internal cap application and prioritization rules to promote efficiency, reduce delays in funding commitments, and prioritize support for the current funding year. In the Order section, the Commission dismisses as moot Applications for Review of the Commission's guidance to the Universal Service Administrative Company (the Administrator) regarding the Rates Database.

II. Order on Reconsideration

3. In the Order on Reconsideration, the Commission restores the mechanisms for calculating rural and urban rates that existed before adoption of the *2019 R&O.* The Commission upholds the *2019 R&O*'s rule changes regarding what services are similar to one another. The Commission maintains the rurality tiers adopted in the *2019 R&O,* which, due to the elimination of the Rates Database, now apply only to the prioritization of funding requests. The Commission also keeps the internal cap and funding prioritization systems and invoice certifications requirements from the *2019 R&O.*

4. *Rate Determination.* As an initial matter, the Commission grants in part petitions seeking reconsideration of the rules the Commission adopted in the *2019 R&O* to implement the Rates Database and restore the three methods for calculating rural rates in the Telecom Program. The Commission denies petitions for reconsideration seeking review of clarifications and rules adopted in the *2019 R&O* regarding similar services and site and service substitution rules and dismiss as moot all remaining petitions related to the rules governing the Rates Database.

5. *Urban and Rural Rates Determination Mechanism.* The Commission grants in part petitions seeking reconsideration of the adoption of the Rates Database in the *2019 R&O.* The Commission amends the current §§ 54.504 and 54.505 of its rules to eliminate the use of the Rates Database to determine urban and rural rates and rescind the Commission's direction to the Administrator in the *2019 R&O* to create the Rates Database. Based on the record, the Commission finds that reinstating the Commission's previous rules for calculating urban and rural

rates, effective for RHC Program funding year 2024, is the best option for ensuring sufficient, reasonable rural and urban rates.

6. Section 254(h)(1)(A) of the Communications Act (Act) requires that Telecom Program support must be based on the difference between the urban rate, which must be ''reasonably comparable to the rates charged for similar services in urban areas in that State,'' and ''rates for similar services provided to other customers in comparable rural areas,'' *i.e.,* the rural rate. Because the Rates Database was deficient in its ability to set adequate rates, the Commission finds that restoration of the previous rural rate determination rules, which health care providers have continued to use to determine rural rates in recent funding years under the applicable Rates Database waivers, is the best available option pending further examination in the Second FNPRM published elsewhere in this issue of the **Federal Register**, to ensure that healthcare providers have adequate, predictable support.

7. *Rural rates.* The Commission first finds that the rural rates generated by the Rates Database could result in inadequate or inconsistent Telecom Program support for rural health care providers that undermines the goals of the Telecom Program. The Commission agrees with the Schools, Health and Libraries Broadband Coalition (SHLB) and the State of Alaska's general arguments that the Rates Database would not accurately reflect the costs of delivering telecommunications services and would not provide sufficient funding for most rural health care providers because the Rates Database's geographic rurality tiers were too broad and did not accurately represent the cost of serving dissimilar communities. The Commission created the rurality tiers to prevent median rates for more rural areas of a state from being unfairly reduced due to the inclusion of rates for similar services in less rural areas. The approach to rate determination was based on ''the reasonable assumption that the cost to provide telecommunications services increases as the density of an area decreases, as rates are generally a function of population density.'' However, the Commission finds that in light of the significant anomalies in the Rates Database uncovered by the Wireline Competition Bureau (Bureau), including many situations where support amounts for more rural areas were less than those for less rural areas, the petitioners are correct that the geographic tiers used in the Rates Database do not result in rates that accurately reflect the cost of delivering telecommunications services for many rural health care providers.

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

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

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

11. The Commission declines to adopt other options proposed by stakeholders or the Commission because they could lead to Program waste or pose implementation challenges. Alaska Communications and SHLB's suggestion to rely on competitive bidding alone to determine fair market rural rates could result in inflated rural rates. As the Commission previously explained in the *2019 R&O,* only a small percentage of Telecom Program funding requests receive competing bids from multiple service providers, and in the few instances where carriers do compete, they are most likely to compete on non-price characteristics of service. Therefore, the Commission finds that relying on competitive bidding without any other checks on rural rates would give service providers unfettered discretion to set their rates. Additionally, the Commission finds that the implementation challenges associated with the options raised in the *2022 FNPRM,* such as a regression model or a discount tier mechanism prevent us at this time from adopting these mechanisms.

12. *Rural rates waiver.* The Commission finds that Bureau's temporary measure of permitting the use of previously-approved rural rates and urban rates for funding year 2023 is appropriate given that competitive bidding for funding year 2023 has already started. To further alleviate burdens on RHC Program participants as they prepare for funding years 2024 and 2025, the Commission's rules are waived to permit the use of previously-approved rates for any funding year 2024 or 2025 rural rates that would otherwise require approval under Method 3.

13. Generally, the Commission's rules may be waived or suspended for good cause shown. The Commission may exercise its discretion to waive a rule where the particular facts make strict compliance inconsistent with the public

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

14. A waiver permitting the use of previously-approved rates for funding years 2024 and 2025 Method 3 cost-based rural rates would also serve the public interest. Although there are significant program integrity benefits to rural rates reviews, the Commission finds that two years of such benefits is outweighed for funding years 2024 and 2025 by the administrative burdens on both program applicants and the Commission to prepare and approve cost studies. In addition, the Commission finds that it is not in the public interest to require service providers to absorb these burdens for funding years 2024 and 2025 given that the Commission is considering additional changes to its rural rate rules for future funding years in the Second FNPRM published elsewhere in this issue of the **Federal Register**.

15. In addition, the Commission finds that the public interest would not be served by extending this waiver to Method 1 and 2 rural rate or urban rate approvals because the administrative burden and time required for these justifications are considerably less than for Method 3 justifications. Therefore the Commission finds that for Method 1 and 2 and urban rate justifications, the program integrity benefits to requiring rate justifications outweigh any administrative burdens associated with complying with these rules for funding years 2024 and 2025. Furthermore, the Commission finds that a waiver under Methods 1 or 2 is not necessary because, when a service provider cannot find justifying rates under Methods 1 or 2, as some parties contend is common, the service provider has the option to rely on a previously approved Method 3 rate pursuant to the waiver the Commission issues herein.

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

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

18. Although the rules that the Commission reinstates do not rely on a median approach to determine rural rates, as a general matter, the Commission disagrees with petitioners' concerns with using a median-based approach to determine rural rates. The Rates Database's use of medians was a reasonable application of section 254(h)(1)(A) of the Act to prevent outlier prices from skewing support. Alaska Communications argued that, by basing support on a median rate rather than the actual rate charged, the Rates Database would not fulfill the requirements of section 254(h)(1)(A) of the Act that telecommunications carriers receive the difference between the urban rate paid by the healthcare provider and the rate ''similar services provided to other customers in comparable rural areas.'' Similarly, USTelecom raised several concerns about the sufficiency of the median rate approach. Although the Commission agrees with petitioners that the Rates Database and geographic tiers established in the *2019 R&O* did not accurately reflect the cost of delivering telecommunications services, the Commission finds that a median approach to calculate rural rates can satisfy the requirements of section 254(h)(1)(A) of the Act because a median can approximate the rates charged in ''comparable rural areas in the state.'' The fact that section 254(h)(1)(A) of the Act describes the services provider's obligation to charge ''rates'' reasonably comparable to urban rates rather than a more restrictive standard such as ''the rate charged to an urban health care provider'' suggests the Commission could meet the requirements of section 254(h)(1)(A) of the Act as long as the level of support in the aggregate would make up the urban-rural differential.

19. *Urban rates.* The Commission also grants petitions seeking rescission of the rules implementing the Rates Database to determine urban rates. Petitioners seeking reconsideration of the *2019 R&O* raised concerns about the Administrator's ability to determine urban rates using the Rates Database. Furthermore, after the Rates Database launched, specific concerns about the urban rates it generated arose. In the *Nationwide Rates Database Waiver Order,* DA 21–394 rel. April 8, 2021, the Bureau acknowledged urban rate anomalies in the Rates Database in some states, including instances where urban rates for lower bandwidths exceeded urban rates for higher bandwidths for the same service, and examples of urban rates exceeding rural rates in a state. The Bureau concluded that these examples did not amount to convincing evidence of ''pervasive nationwide anomalies with urban rates'' but did ''merit further inquiry and investigation'' and therefore waived use of the Rates Database of determining urban rates. In comments in response to the *2022 FNPRM,* SHLB reiterated that the Rates Database had significant urban rate anomalies, including instances in many states in which the median urban rate for a service exceeded at least one rural rate. ADS encouraged the Commission to reinstate a ''safe harbor'' approach for urban rates.

20. The Commission concludes that reinstating the previous urban rate determination rules is the best way to ensure consistency and predictability in the rate determination process while considering alternative options for an urban rates determination mechanism going forward. None of the petitions for reconsideration suggested a mechanism for determining urban rates to be used if the Commission was to eliminate the Rates Database, and none opposed returning to the pre-*2019 R&O* method for determining urban rates. As with rural rates, health care providers and service providers are already familiar with the pre-*2019 R&O* rules for

determining urban rates, and introducing a completely new set of rules while the Commission considers additional changes could lead to confusion and cause an undue administrative burden. Therefore, going forward, the urban rate for an eligible service submitted by the healthcare provider on FCC Form 466 should be ''no higher than the highest tariffed or publicly-available rate charged to a commercial customer for a functionally similar service in any city with a population of 50,000 or more in [a] state.'' Healthcare providers must document the urban rate with ''tariff pages, contracts, a letter on company letterhead from the urban service provider, rate pricing information printed from the urban service provider's website or similar documentation showing how the urban rate was obtained.'' The Commission believes reinstatement of the prior urban rate setting methodology is the best available solution while seeking comment on potential revisions to the urban rate determination rules in the Second FNPRM published elsewhere in this issue of the **Federal Register**. As with rural rates, the Commission also affirms the Bureau's decision to permit the use of previously-approved urban rates for funding year 2023.

21. In adopting the Rates Database, the Commission identified several concerns with the rate-setting rules in place at the time, including potential issues with transparency, administrative efficiency, and program integrity. While the Rates Database proved to be an inadequate solution for provisioning sufficient support to RHC Program participants, the Commission remains cognizant of those concerns, and therefore continues the work to improve the Telecom Program rate determination methodology as discussed in the Second FNPRM published elsewhere in this issue of the **Federal Register**.

22. *Similar Services.* Though RHC Program applicants and participating service providers will no longer use the Rates Database to calculate rural and urban rates, they will continue to need to identify rates for the same or similar services to support rural and urban rates submitted to the Administrator. The Commission therefore addresses petitions for reconsideration of its conclusions regarding similar services in the *2019 R&O.* The Commission properly determined that similar services can include non-telecommunications services that deliver the same or similar functionality as the requested service and can include services with advertised speeds 30% above or below the speed of the requested service. The Commission instructs the Administrator to apply these requirements to its review of Method 1 and Method 2 submissions and urban rates going forward.

23. *Non-telecommunications services.* The Commission affirms the its finding, to calculate the most accurate rates, the pool of rates taken into consideration should include rates for services that deliver the functionality sought by the applicant. The Commission therefore denies USTelecom's request to reverse the decision that non-telecommunications services that are functionally similar to eligible telecommunications services be considered similar services for purposes of calculating rates. The Commission reaffirms the Commission's conclusion in the *2019 R&O* that similarity of services is a ''technology-agnostic inquiry'' that should be viewed from the perspective of the end user experience as opposed to regulatory classification.

24. The Telecom Program provides support in accordance with section 254(h)(1)(A) of the Act based on the difference between the urban rate, which must be ''reasonably comparable to the rates charged for *similar services* in urban areas in that State,'' and ''rates for *similar services* provided to other customers in comparable rural areas,'' *i.e.,* the rural rate. Congress did not define the term ''similar services.'' In 2003, the Commission interpreted similar services to mean services that are functionally similar from the perspective of the end user. This interpretation deviated from the Commission's previous policy of calculating support based on the difference between the urban and rural rates for ''technically'' similar services. Without any discussion as to why non-telecommunications services were not considered ''functionally similar,'' the Commission stated that ''[e]ligible health care providers must purchase telecommunications services and compare their service to a functionally equivalent telecommunications service in order to receive this discount'' and created a voluntary ''safe harbor'' for categories of services based on transmission speed that would be considered by the Commission functionally similar for purposes of calculating urban and rural rates.

25. In the *2017 Notice of Proposed Rulemaking,* FCC 17–164 rel. December 18, 2017 (83 FR 303, January 3, 2018) (*2017 NPRM*), the Commission sought comment on changes to the interpretation of similar services. The Commission specifically proposed to ''retain the concept of '*functionally* similar as viewed from the perspective of the end user' '' and additionally proposed to ''require healthcare providers to analyze similarity under specific criteria.'' In the *2019 R&O,* the Commission ultimately retained the ''functionally similar'' standard for defining similar services and, after acknowledging the prior interpretation in 2003, made clear that because the functionally similar standard is technology agnostic and does not turn on regulatory classification, both telecommunications and non-telecommunications services must be considered when identifying similar services for calculating urban and rural rates.

26. USTelecom argues that the Commission did not provide an opportunity for notice and comment, as required by the Administrative Procedure Act (APA), before expanding the inquiry of functionally similar services to include non-telecommunications services. On the contrary, the Commission did provide notice in the *2017 NPRM* of its intent to consider changes to the statutory interpretation of similar services. And as explained in the *2019 R&O,* revisiting the decision would inevitably involve a consideration of the types of services that would fall within the scope of this statutory term. The Commission therefore disagrees with USTelecom that the Commission violated the APA when it clarified the scope of similar services to include not only telecommunications but also non-telecommunications services.

27. The Commission's decision to expand the inquiry of functionally similar services in urban and rural rate determinations was not arbitrary and capricious, as USTelecom separately contends. The Commission also disagrees with USTelecom that the fact that the Telecom Program does not fund information and private carriage services precludes consideration of rates for those services in the rate determination process. As to both arguments, the Commission fully considered these issues in the *2019 R&O* and explained that the end-user experience, not regulatory classification, guides the analysis of whether services are functionally equivalent. The Commission further explained that including information services, which may be less expensive, with functionally similar telecommunications services is consistent with the statutory requirement that the Commission ensure access to telecommunications services for health care providers at rates that are ''reasonably comparable'' to those charged for ''similar services in

urban areas'' because including rates for such functionally similar information services would more accurately reflect the prices available in urban areas for services that deliver the same functionality to end users regardless of classification, and place rural health care providers on equal footing with their urban counterparts.

28. *30 percent threshold.* The Commission also denies SHLB's request that the Commission reconsiders the Commission's determination that services with advertised speeds 30% above or below the speed of the requested service be considered functionally similar to the requested service. SHLB argues that the approach is overbroad and will include services that are dissimilar in function and cost. SHLB, however, does not offer any examples. Comments filed after the Rates Database launched addressing the 30% threshold in response to the *2022 FNPRM* were mixed. Alaska Communications described the 30% bandwidth range as ''not unreasonable,'' but cautioned that there is too little rural rate data in Alaska to ''make this the basis for a complete rural rate methodology.'' NTCA—The Rural Broadband Association (NTCA) argues that the 30% threshold is too broad and urges the Commission to implement a smaller margin based on health care provider use cases, but also does not offer examples of overly broad results.

29. Taking these arguments into account, the Commission decides not to deviate from the Commission's prior conclusion in the *2019 R&O* that the 30% range allows for rate predictability while accounting for the rising demand for faster connectivity. Having a standard for determining similar services based on a range is preferable to having speed tiers, which would need to be frequently refreshed so they would not become out of date, as was the case with the speed tiers that existed before the *2019 R&O.* Moreover, based on the record previously developed, a range of 30% provides a sufficiently large number of inputs for determining rates under Methods 1 and 2. Reducing the range as NTCA requests would likely mean that few services with even slight variations in bandwidth would be similar to one another. Additionally, maintaining the current threshold for similar services of advertised speeds being 30% above or below the speed of the requested service will ease program administration because health care providers are already familiar with this standard.

30. The Commission also disagrees with SHLB's assertion that the *2019 R&O* fails to account for price variations based on contract term or volume discounts, which SHLB maintains will distort rural rate determinations. The *2019 R&O* did account for these price variations when explaining that section 254(h)(1)(A) of the Act requires service providers to provide telecommunications services to eligible providers at ''rates that are reasonably comparable to *rates charged* for similar services in urban areas.''

31. Finally, as requested by General Communication, Inc. (GCI), the Commission clarifies that, in the event there is no comparable rural rate within 30% of the speed of the requested service, the Commission will allow service providers to justify the requested rural rate using the rate for a service that is otherwise similar to the requested service if the requested service has a higher bandwidth than that service. Similarly, as requested by SHLB, the Commission clarifies that if there is no comparable urban rate within the 30% range available, the Commission will allow service providers to use the rate for a higher bandwidth service that falls outside the 30% range but is otherwise similar to the requested service. The Commission finds that providing this flexibility will ease administrative burdens without additional cost to the Universal Service Fund.

32. *Site and Service Substitution.* The Commission denies Alaska Communications' petition for reconsideration to the extent it seeks clarification that ''the Commission intended to include service delivery dates'' in the adopted site and service substitution rule. Alaska Communications explains that service date or evergreen contract date changes are some of the most common changes requested in the RHC Program. Alaska Communications further explains that applicants are required to submit a funding request and include anticipated service dates at the time the request is submitted to the Administrator, but there may be delays for a planned transition or deployment of upgraded services and the anticipated service start or termination dates may change. In response, the Commission clarifies that under § 54.624(a) of the Commission's rules, RHC Program applicants may be able to substitute the requested service when there is a delay in the deployment of the original service and that the funding request could be modified to reflect the substituted service when such a delay may occur. Section 54.624(a) of the Commission's rules is intended to allow applicants flexibility to substitute requested services and to receive RHC Program support for substituted services when the requirements are met.

33. However, the Commission denies Alaska Communications' request to clarify that § 54.624(a) of the Commission's rules allows changes to service dates and evergreen contract dates as ''service substitution'' changes because § 54.624(a) of the Commission's rules does not address service dates or evergreen contract dates. With respect to service date changes, Program participants are already permitted to change the dates for which services are provided. RHC Program participants are required to provide dates of service and contract dates on the Request for Funding (FCC Form 466 or FCC Form 462) for the requested services. If there are changes to the dates for which services were provided or evergreen contract dates, RHC Program participants already modify service dates through other means unrelated to the service substitution process. Therefore, there is already a mechanism for all RHC Program participants to substitute a service if there is a delay in implementing the new service and modify the service dates for the substituted service. Contrary to Alaska Communications' assertion that the process creates additional administrative burdens due to the potential for an appeal, the process is no more administratively burdensome than the service substitution request process. Under both processes, if the Administrator denies a request, the health care provider could file an appeal. With respect to evergreen contract dates, although § 54.624 of the Commission's rules cannot reasonably be interpreted as addressing modifications to evergreen contract dates, the Commission seeks comment in the Second FNPRM published elsewhere in this issue of the **Federal Register** about whether a mechanism to modify evergreen contract dates is appropriate and what such a mechanism might be. Accordingly, the Commission denies the request to modify § 54.624 of the Commission's rules to add modification of service dates and evergreen contract dates as an allowable service substitution.

34. Alaska Communications further requests that when the Administrator contacts a health care provider with questions or requests for additional information regarding urban or rural rates or the terms of the service, the Administrator also be required to communicate the question or information request with the relevant service provider. Health care providers are encouraged to work with their service providers to respond to

information requests from the Administrator regarding, for example, additional information on urban and rural rates and terms of service. Thus, service providers are allowed to provide the requested information needed during the funding application review process. The Commission declines, however, to require the Administrator to issue information requests to the relevant service providers. The Commission concludes that it would be administratively burdensome and a poor use of limited administrative resources to require the Administrator to send these requests to service providers. Applicants that would like assistance from service providers should reach out to providers to pose questions related to the Administrator's review of health care providers' funding applications.

35. *Remaining Requests for Reconsideration of the Rates Database.* The Commission dismisses as moot all other challenges to the Rates Database raised in the petitions for reconsideration that are not applicable to rural rate determinations under Method 1, Method 2, or Method 3 or urban rate determinations. The Commission's decision to eliminate the use of the Rates Database to calculate urban and rural rates renders these challenges moot.

36. *Rurality.* Next, the Commission denies requests to reconsider aspects of the geographically-based rurality tiers adopted in the *2019 R&O.* Though the termination of the Rates Database moots the use of rurality tiers for purposes of rates determination, rurality tiers are also used to prioritize support in the event that demand exceeds available support, a mechanism that is unchanged.

37. In the *2019 R&O,* the Commission established three tiers of rurality to determine comparable rural areas in a state or territory for purposes of the Rates Database: (1) Extremely Rural (areas entirely outside of a Core Based Statistical Area); (2) Rural (areas within a Core Based Statistical Area that does not have an Urban Area with a population of 25,000 or greater); and (3) Less Rural (areas in a Core Based Statistical Area that contains an Urban Area with a population of 25,000 or greater, but are within a specific census tract that itself does not contain any part of a Place or Urban Area with a population of greater than 25,000). For health care providers in Alaska, the Commission bifurcated the Extremely Rural tier to include a Frontier tier for areas not accessible by road.

38. Arguments against the rurality tiers adopted by the Commission in the *2019 R&O* focused on their impact on rates determinations in the Rates Database. With the elimination of the Rates Database, the only remaining relevance of rurality tiers is for purposes of prioritizing support in the event that demand ever exceeds available funding. The Commission finds that the rurality tiers as adopted in the *2019 R&O* are appropriate for purposes of prioritization of support and deny petitions for reconsideration to the extent they request that the Commission eliminate rurality tiers from the rules for all purposes. The rurality tiers will properly target RHC Program funding to less populous areas in the event that prioritization of funds is needed, and the record contains no alternative mechanism for better parsing rurality for this limited purpose.

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

40. Given the Commission's decision on reconsideration to eliminate the rules establishing the Rates Database, the Commission makes two ministerial changes to the rules to reflect the limited use of rurality tiers for prioritization purposes. First, the Commission eliminates the concept of Frontier Areas from the rules because it does not apply to prioritizing support. A ''Frontier Area'' is an area in Alaska outside of a Core Based Statistical Area that is inaccessible by road. The Commission adopted the concept for purposes of the Rates Database only. Second, the Commission amends the codified rules so that rurality tiers are addressed only in rules related to prioritization. The rurality tiers currently appear in two separate sections of the Commission's rules: § 54.605(a), which addresses rural rates, and § 54.621(b), which addresses prioritization of support. The Commission deletes references to the rurality tiers from § 54.605(a) but retain them in § 54.621(b). The Commission also makes minor changes to the text of § 54.621(b) so that it more closely reflects the text of § 54.605(a).

41. *Funding Prioritization—Internal Cap on Multi-Year Commitments and Upfront Payments.* The Commission denies NCTNA/SOHCN's petition for reconsideration requesting an increase to the internal cap on funding available to Healthcare Connect Fund (HCF) applicants seeking support for upfront payments and multi-year commitments. This internal cap limits funding for multi-year commitments and upfront payment to an amount adjusted annually for inflation, which is calculated at $161 million for funding year 2022. The Commission retained the internal cap in the *2019 R&O* after determining that the cap protected against possible underfunding of single-year funding requests and that an increase in the dollar amount of the internal cap may adversely affect single-year requests. The Commission did, however, adopt a rule adjusting the cap annually for inflation as a hedge against loss of purchasing power in the event of price inflation. NCTNA/SOHCN maintain that the decision to not further increase the internal cap is ''based on an incorrect reading of the purpose of [the] cap''—namely, that the principal purpose of establishing the cap was to guard against fluctuations in demands from potentially large upfront infrastructure projects. NCTNA/SOHCN also argue that the Commission should reconsider the cap ''in light of its original purpose and data accumulated since 2013 when it was first implemented'' and therefore should remove multi-year funding commitments from being subject to the cap.

42. The Commission denies NCTNA/SOHCN's request. The internal cap on multi-year commitments and upfront payments in its current form is serving its stated purpose: to limit major fluctuations in demand so as to protect single-year funding requests. In the *2019 R&O,* the Commission noted that the internal cap was first exceeded in funding year 2018 and, but for the cap, all funding requests for that year would have been prorated to bring the total demand for RHC Program support below the Program's overall funding cap. The Commission also finds that the record

does not support removing multi-year commitments from the internal cap. NCTNA/SOHCN point to efficiencies that are inherent to some multi-year funding commitments. However, Universal Service Administrative Company (USAC) data indicates that demand for multi-year commitments accounted for a significant portion of the total demand for multi-year commitments and upfront payments from funding year 2016 to funding year 2021. As demonstrated by demand in recent funding years, removing multi-year commitments from being subject to the internal cap could result in costly multi-year commitment requests usurping funding from single-year requests. The Commission affirms the earlier decision to retain the internal cap on multi-year commitments and upfront payments and, accordingly, deny that portion of the NCTNA/SOHCN petition. In the Second Report and Order section, the Commission amends the rules so that the internal cap applies only when demand exceeds available funding, and when the internal cap does apply, upfront costs and the first year of a multi-year commitment request are prioritized over the second and third year of a multi-year commitment request.

43. *Prioritization System*. Next, the Commission denies SHLB's request that the Commission reconsider the prioritization system adopted by the Commission in the *2019 R&O.* RHC Program prioritization rules require that, in funding years when demand exceeds the funding cap, funding be prioritized based on rurality tiers and whether the area is a Medically Underserved Area/Population. SHLB first argues that the prioritization rules will result in HCF consortia, which include non-rural health care providers that are prioritized last when demand exceeds available funding, bearing the entire burden of RHC Program funding shortfalls initially. SHLB further argues that this impact will erode the consortia model and reduce the benefits of consortia for rural health care providers. The Commission disagrees and finds that, to further the goals of section 254(h) of the Act, it should prioritize funding based on the rurality of the health care provider's location, as well as on the level of medical care need in that location. This prioritization scheme targets support to rural areas that are less likely to have access to telecommunications and advanced services while still providing support for health care consortia that include non-rural health care providers. Thus, while SHLB is correct in noting the benefits that rural health care providers receive as members of consortia, the Commission is not persuaded that these consortia warrant higher funding priority over the most rural and medically underserved health care providers. When the Commission adopted the rules permitting HCF consortia, it limited program participation in a ''fiscally responsible'' manner so as not to jeopardize funding for rural healthcare providers. The prioritization system adopted in the *2019 R&O* aligns with this fiscally responsible approach and the Commission declines to reconsider it here.

44. *Medically Underserved Area and Populations.* The Commission declines to revise our use of the Medically Underserved Areas and Populations (MUA/P) designation to determine funding prioritization based on medical need. The U.S. Department of Health and Human Services Health Resources and Services Administration (HRSA) designates an area as MUA/P when the area lacks sufficient primary care services. SHLB requests that the Commission revises HRSA's data by clarifying that all areas in counties with a population density below twenty persons per square mile will be considered to be MUA/P, arguing that many such sparsely populated areas have never sought MUA/P designation but are nonetheless underserved. The Commission declines to adopt SHLB's requested modification. As the Commission explained in the *2019 R&O,* the MUA/P designation is well-suited for determining prioritization in the Telecom Program because it is objective data from another Federal agency that shows the areas that currently lack health care services and therefore would most benefit from the availability of telehealth services. In addition, relying on HRSA's determination is straight-forward and easy to administer. SHLB did not provide any data that would enable the Commission to verify its claim that many sparsely populated areas have declined to seek a MUA/P designation from HRSA. Furthermore, the Commission declines to add administrative complexity to this paradigm by adding population density into the determination.

45. Certifications. The Commission denies USTelecom's request to reconsider the requirement adopted in the *2019 R&O* that service providers certify on invoices submitted to the Administrator that consultants or third parties hired by a service provider do not have an ownership interest, sales commission arrangement, or other financial stake in the service provider or, in the alternative, that the Commission clarifies that the certification applies only on a forward-looking basis. In response to the request, the Bureau clarified that the prohibition on third party commission arrangements does not apply to competitive bidding processes completed before funding year 2020.

46. The Commission declines, however, to eliminate the certification and now address the arguments that USTelecom raised in its petition for reconsideration. The Commission disagrees with USTelecom's argument that the Commission did not provide adequate notice for the new requirement. The Commission sought comment in the *2017 NPRM* on ''whether to require healthcare providers and service providers to certify that the consultants and outside experts they hire do not have an ownership interest, sales commission arrangement, or other financial stake in the vendor chosen to provide the requested service.'' USTelecom's argument ignores that the certification language adopted in the *2019 R&O* stems directly from the language used in the *2017 NPRM.*

47. Second, while USTelecom acknowledges that the use of consultants that have financial relationships with vendors raises conflict of interest concerns for RHC Program applicants, the Commission disagrees with USTelecom that there are no such concerns for commissioned consultants working for service providers. Similar concerns are applicable to service providers who have commissioned sales agreements with other third parties based on contracts awarded through the Program. For example, there have been previous instances where a service provider's sales agent apparently shared other carriers' confidential pricing information to provide an unfair competitive advantage to that service provider when it responded to a health care provider's request for services. In addition, commissioned consultants or sales agents who simultaneously represent multiple service providers could direct business toward the service provider that pays the highest commission or has the highest bid to maximize their earnings. Such conflicts of interest and anti-competitive conduct violate the Program's longstanding fair and open competitive bidding requirement, which the Commission codified in the *2019 R&O.* The Commission therefore clarifies that agents compensated solely by commission, and not just those that are

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

48. Additionally, the Commission denies USTelecom's request to clarify that a service provider certification addressing ''eligible services'' does not include an attestation that the services for which the disbursement is sought are eligible for Program support. In the *2019 R&O,* the Commission adopted a requirement that service providers certify they have ''charged the health care provider for only eligible services prior to submitting the invoice form and accompanying documentation.'' USTelecom argues that the certification should be interpreted not to apply to the eligibility of the services, arguing that service providers are not responsible for determining the eligibility of services, and that requiring service providers to make such a certification will preclude them from including both eligible services and services not supported by the Program on the same bill submitted to the applicant. On the contrary, the new certification, one of several added to invoicing forms to improve the invoicing process and ensure compliance with Commission rules, does not create a new burden because service providers are already required to abide by Program service eligibility rules. While service providers may include ineligible services and eligible services on the invoices they submit to health care providers, it is critical that service providers engage in due diligence to ensure that they seek reimbursement from the Administrator for eligible services only. Service providers are in the best position to evaluate whether the services they provide are eligible for RHC Program support because they understand the technical details of the services they provide. The Commission therefore confirms that service providers are certifying to the eligibility of the services provided when they certify that they ''charged the health care provider for only eligible services prior to submitting the invoice form and accompanying documentation.'' The Commission clarifies that with respect to billing, service providers may include both eligible and ineligible services on a single bill to the health care provider but RHC Program reimbursement may only be sought for eligible services.

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

III. Second Report and Order

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

51. *Invoicing.* To closer harmonize the invoicing process across the Telecom Program and the HCF Program, the Commission eliminates the use of Health Care Provider Support Schedules (HSSs) in the Telecom Program and requires the participating service provider and health care provider to submit an invoice for service to the Administrator after services are provided consistent with the HCF Program effective for funding year 2024. In the *2022 FNPRM,* the Commission proposed to fully harmonize the invoicing process between the Telecom Program and the HCF Program by having participants in both programs invoice the Administrator for services actually provided using the FCC Form 463 (Invoice and Request for Disbursement Form). Additionally, the Commission proposed to retire the FCC Form 467 (Connection Certification), which is currently used for invoicing in the Telecom Program.

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

53. Creating a new Telecom Program invoicing form, which is distinct from, but functionally similar to, the FCC Form 463 will ensure that invoicing in the Telecom Program occurs after services have actually started, that service providers are reimbursed for actual costs rather than predetermined amounts established by the HSS, and that participants need not take action to change an HSS if the services are terminated or never begin. Having distinct forms for each program will account for the fact that there are consortium applications in the HCF Program but not in the Telecom Program. Additionally, the Commission finds that adopting the process for invoicing in the Telecom Program will further alleviate inefficiencies and protect against waste, fraud, and abuse in the RHC Program. The new process

for invoicing will eliminate the need for health care providers to file, and subsequently amend, an FCC Form 467. It will also reduce the likelihood of improper disbursements because disbursements will be based on charges for services that were actually provided rather than expected charges for services *anticipated* to be provided.

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

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

56. *Internal Cap Application and Prioritization.* The Commission adopts the changes to the RHC Program internal cap application and prioritization proposed in the *2022 FNPRM* effective funding year 2023. The Commission amends RHC Program rules to limit the application of the internal cap on multi-year commitments and upfront payments to funding years for which the total demand exceeds the remaining support available. The Commission also prioritizes upfront payments and the first year of multi-year commitments, and then funds the second and third years of multi-year commitments with any remaining funding in a given funding year. Although demand has been fully satisfied in every funding year since the adoption of the *2019 R&O,* these changes will ensure a smoother, fairer process in the event that prioritization is ever necessary.

57. First, the Commission amends the funding cap rules to limit the application of the internal cap to those application filing window periods during which total demand exceeds total remaining support available for the funding year. All commenters who discussed the proposal supported it. If total demand during a filing window period does not exceed total remaining support available for the funding year, the internal cap will not apply. The total remaining support available for the first filing window period of a funding year is the sum of the inflation-adjusted RHC Program aggregate cap in § 54.619(a) of the Commission's rules and the proportion of unused funding determined for use in the RHC Program pursuant to § 54.619(a)(5) of the Commission's rules.

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

59. Second, the Commission amends the rules to prioritize support for current-year funding requests over future-year funding requests when the internal cap is exceeded. Specifically, the Commission amends § 54.621 of the rules to fund eligible upfront payment requests and the first-year of all multi-year requests before funding the second or third year of any multi-year requests when the internal cap applies and is exceeded. Additionally, the Commission amends the rules to allow the underlying contracts associated with those multi-year commitment requests that are not fully funded to be designated as ''evergreen.''

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

61. To mitigate any potential adverse impact to health care providers whose multi-year commitment requests are affected, the Commission also amends the rules to allow the underlying contracts associated with those multi-year commitment requests that are not fully funded to be designated as

''evergreen,'' provided that the contracts satisfy the criteria set forth in § 54.622(i)(3)(ii) of the Commission's rules. The evergreen designation will exempt applicants from having to complete the competitive bidding process for multi-year contracts that are not initially fully funded due to the new internal cap rules when the applicant subsequently files requests for support pursuant to these contracts. As a result, applicants can request single or multi-year commitments pursuant to these contracts in the next funding year without going through the competitive bidding process.

62. The Commission agrees with Alaska Communications, GCI, and Western New York (WNY) that the internal cap prevents multi-year commitment requests from usurping funding available for single-year requests, and rejects requests by some commenters to eliminate the internal cap or to remove multi-year commitments from the internal cap. This latter group of commenters claims that eliminating the internal cap or removing multi-year commitments from the internal cap would encourage more multi-year commitments, which these commenters claim are more efficient for both the RHC program and individual HCPs. The Commission finds that retaining the current internal cap with the limitations instituted is more fiscally responsible than eliminating the internal cap or removing multi-year commitments from the internal cap. Eliminating the cap or removing multi-year commitments from the internal cap will result in less funding being made available for single year commitments. Multi-year requests tend to be more expensive and without any constraints, those requests will make it more likely that the overall cap is exceeded. In any event, the changes the Commission adopts for the internal cap will likely result in making more funding available for multi-year commitments because, going forward, the internal cap will only apply when total demand exceeds total support available and thus will not apply at all in funding years when total support available can satisfy total demand, leaving open the possibility for additional funding for multi-year commitments beyond the internal cap.

63. The Commission also rejects some commenters' requests to suspend the funding prioritization system until the Commission addresses the allocation of shared network costs for consortia program participants. As an initial matter, the Commission did not seek comment in the *2022 FNPRM* on suspending the funding prioritization scheme. The Commission finds, however, that a rule change is not necessary for the Commission to ensure that consortium members can allocate shared network costs when some members do not receive funding due to prioritization. In any event, as discussed in the Order on Reconsideration section, the Commission's funding prioritization approach remains necessary as it will target support where it is most needed (*i.e.,* those more rural areas with greater medical shortages) in cases where available program funding is exceeded in a given funding year. The Commission therefore rejects the requests to suspend the funding prioritization system.

64. Some commenters argued that an increase to the overall RHC Program cap is appropriate. The Commission finds that the current annually inflation-adjusted overall cap combined with the process to carry-forward unused funding strikes the necessary balance between providing sufficient funding to health care providers and minimizing increased burden on Universal Service Fund (USF) contributors. With the availability of carryover funding, demand has been fully satisfied since funding year 2019. While continuing to monitor overall Program demand, the Commission declines to increase the overall RHC Program cap at this time.

65. *Technical Changes to Previously Codified RHC Rules.* The Commission also takes this opportunity to make two minor corrections to the text of the RHC Program rules. First, the Commission amends the text of § 54.622(e)(1)(i) of the rules to reflect the correct number of health care provider types that are eligible. The Rural Healthcare Connectivity Act of 2016 amended the Communications Act of 1934 to add skilled nursing facilities to the list of health care provider types eligible to receive RHC Program support. In response to the new law, in 2017, the Commission amended § 54.600(a) of the rules to reflect that skilled nursing facilities are eligible for RHC support, which increased the number of eligible health care provider types from seven to eight. In enacting the change, the Commission did not amend a different rule addressing certifications on a Request for Services that refers to ''one of the *seven* categories set forth in the definition of health care provider.'' The Commission now corrects that omission by striking the word ''seven'' from § 54.622(e)(1)(i) of the rules. Striking the word ''seven'' rather than replacing it with ''eight'' is appropriate because quantifying the number of eligible health care provider types in § 54.622(e)(1)(i) of the Commission's rules adds no substantive benefit to RHC Program participants but could potentially lead to confusion if there are future amendments to the health care provider types eligible for the RHC Program. Second, the Commission corrects the cross-reference in § 54.622(a) rules so that it properly references § 54.622(i). The Commission finds that there is good cause to make these changes without notice and comment because seeking comment on these technical amendments, which only serve to conform these references to the current requirements of the rules would be unnecessary.

IV. Order

66. By the Order, the Commission dismisses the Applications for Review of the Bureau's guidance to the Administrator on implementation of the Rates Database submitted by Alaska Communications and GCI. The Commission's decision to eliminate the use of the Rates Database to calculate urban and rural rates renders these Applications for Review moot.

V. Procedural Matters

A. Paperwork Reduction Act

67. This document contains modified information collection requirements subject to the Paperwork Reduction Act of 1995 (PRA), Public Law 104–13. It will be submitted to the Office of Management and Budget (OMB) for review under Section 3507(d) of the PRA. OMB, the general public, and other Federal agencies will be invited to comment on the modified information collection requirements contained in this proceeding. In addition, it is noted that pursuant to the Small Business Paperwork Relief Act of 2002, Public Law 107–198, *see* 44 U.S.C. 3506(c)(4), the Commission previously sought specific comment on how might to further reduce the information collection burden for small business concerns with fewer than 25 employees.

68. In this present document, the Commission has assessed the effects of restoring the use of Methods 1 through 3 for rural rates calculations, eliminating the use of the HSS, and reducing the instances in which the internal cap applies. The Commission finds that restoring the use of Methods 1 through 3 for rural rates calculations might impose information collection burdens on small business, but that this rule change is necessary to protect the integrity of the Universal Service Fund, eliminating the use of the HSS will reduce information collection burdens and reducing the instance in which the internal cap applies will not impact information collection burdens.

B. Congressional Review Act

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

VI. Final Regulatory Flexibility Act

70. The Regulatory Flexibility Act of 1980, as amended (RFA), requires that an agency prepare a regulatory flexibility analysis for notice-and-comment rulemaking proceedings, unless the agency certifies that ''the rule will not, if promulgated, have a significant economic impact on a substantial number of small entities.'' Accordingly, the Commission has prepared a Final Regulatory Flexibility Analysis (FRFA) concerning rule and policy changes in the Order on Reconsideration and Second Report and Order. In the *2022 FNPRM,* the Commission included an Initial Regulatory Flexibility Analysis (IRFA) of the possible significant economic impact on a substantial number of small entities by the policies and rules proposed in the *2022 FNPRM.* The Commission sought written public comment on the proposals in the *2022 FNPRM* including comment on the IRFA. The Commission did not receive any relevant comments in response to the IRFA. This FRFA conforms to the RFA.

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

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

72. In the Second Report and Order section, the Commission adopts proposals from the *2022 FNPRM* to amend RHC Program administrative processes and internal cap application and prioritization rules to promote efficiency, reduce delays in funding commitments, and prioritize support for the current funding year as well as make a minor technical change to the text of the Commission's rules.

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

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

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

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

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

75. 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).

76. *Small Businesses, Small Organizations, Small Governmental Jurisdictions.* The Commission's actions, over time, may affect small entities that are not easily categorized at present. The Commission therefore describes here, at the outset, three broad groups of small entities that could be directly affected herein. First, while there are industry specific size standards for small businesses that are used in the 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.

77. 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.

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

79. Small entities potentially affected by the action 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.

1. Healthcare Providers

80. *Offices of Physicians (except Mental Health Specialists).* This U.S. industry comprises establishments of

health practitioners having the degree of M.D. (Doctor of Medicine) or D.O. (Doctor of Osteopathy) primarily engaged in the independent practice of general or specialized medicine (except psychiatry or psychoanalysis) or surgery. These practitioners operate private or group practices in their own offices (*e.g.,* centers, clinics) or in the facilities of others, such as hospitals or health maintenance organization (HMO) medical centers. The SBA has created a size standard for this industry, which is annual receipts of $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.

81. *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.

82. *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.

83. *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.

84. *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.

85. *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.

86. *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.

87. *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.

88. *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.

89. *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.

90. *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.

91. *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.

92. *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.

93. *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.

94. *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.

95. *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.

96. *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.

97. *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.

98. *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.

99. *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.

100. *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.

101. *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.

102. *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.

103. *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.

2. Providers of Telecommunications and Other Services

104. *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 North American Industry Classification System (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 our actions. According to Commission data, one thousand three hundred and seven (1,307) Incumbent Local Exchange Carriers reported that they were incumbent local exchange service providers. Of this total, an estimated 1,006 have 1,500 or fewer employees. Thus, using the SBA's size standard the majority of incumbent LECs can be considered small entities.

105. *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.

106. *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 our actions. According to Commission data the *2010 Trends in Telephone Report, rel.* September 2010, 1,442 CAPs and competitive local exchange carriers (competitive LECs) reported that they were engaged in the provision of competitive local exchange services. Of these 1,442 CAPs and competitive LECs, an estimated 1,256 have 1,500 or few employees and 186 have more than 1,500 employees. Consequently, the Commission estimates that most providers of competitive exchange services are small businesses.

107. *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.

108. *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.

109. *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), private branch exchange (PBX) equipment, telephone answering machines, local area network (LAN) modems, multi-user modems, and other data communications equipment, such as bridges, routers, and gateways. The SBA has developed a small business size standard for Telephone Apparatus Manufacturing, which consists of all such companies having 1,250 or fewer employees. U.S. Census Bureau data for 2012 show that there were 266 establishments that operated that year. Of this total, 262 operated with fewer than 1,000 employees. Thus, under this size standard, the majority of firms in this industry can be considered small.

110. *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, global positioning system (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.

111. *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.

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

112. The rules adopted in the Second Report and Order will not result in modified reporting, recordkeeping, or other compliance requirements for small or large entities.

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

113. 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.

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

G. Report to Congress

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

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

VII. Ordering Clauses

117. 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 Order on Reconsideration, Second Report and Order, and Order *is adopted.*

118. *It is further ordered* that, pursuant to § 1.429 of the Commission's rules, 47 CFR 1.429, the Petition for Reconsideration filed by Alaska Communications on November 12, 2019, is *granted in part, denied in part,* and *dismissed in part* to the extent described herein.

119. *It is further ordered* that, pursuant to § 1.429 of the Commission's rules, 47 CFR 1.429, the Petition for Reconsideration and Clarification filed by the Schools, Health & Libraries Broadband Coalition on November 12,

2019, is *granted in part, denied in part,* and *dismissed in part* to the extent described herein.

120. *It is further ordered* that, pursuant to § 1.429 of the Commission's rules, 47 CFR 1.429, the Petition for Reconsideration filed by State of Alaska, Office of the Governor on November 12, 2019, is *granted in part, denied in part* and *dismissed in part* to the extent described herein.

121. *It is further ordered* that, pursuant to § 1.429 of the Commission's rules, 47 CFR 1.429, the Petition for Reconsideration and Clarification filed by North Carolina Telehealth Network Association/Southern Ohio Health Care Network on November 12, 2019, is *denied* to the extent described herein.

122. *It is further ordered* that, pursuant to § 1.429 of the Commission's rules, 47 CFR 1.429, the Petition for Reconsideration and Clarification filed by USTelecom—The Broadband Association on November 12, 2019, is *granted in part, denied in part,* and *dismissed in part* to the extent described herein.

123. *It is further ordered* that pursuant to the authority in sections 1 through 4 and 254 of the Communications Act of 1934, as amended, 47 U.S.C. 151–154 and 254, and pursuant to § 1.3 of the Commission's rules, 47 CFR 1.3, that § 54.605(b) of the Commission's rules as amended herein, 47 CFR 54.605(b) *is waived* to the extent provided herein.

124. *It is further ordered*, that pursuant to § 1.103 of the Commission's rules, the provisions of the Order on Reconsideration, Second Report and Order, and Order *will become effective* April 24, 2023, unless indicated otherwise herein.

125. *It is further ordered,* that pursuant to the authority contained in sections 1 through 4, 201 through 205, 254, 303(r), and 403 of the Communications Act of 1934, as amended, 47 U.S.C. 151–154, 201–205, 254, 303(r), and 403, and section 706 of the Telecommunications Act of 1996, 47 U.S.C. 1302, part 54 of the Commission's rules, 47 CFR part 54, is AMENDED, and such rule amendments in the Order on Reconsideration and Second Report and Order *shall be effective* April 24, 2023, except for §§ 54.604, 54.605, and 54.627, which are subject to the Paperwork Reduction Act. The Commission will publish a document in the **Federal Register** announcing the effective date for those rule sections after approved by the Office of Management and Budget as required by the Paperwork Reduction Act.

126. *It is further ordered* that, pursuant to § 1.115 of the Commission's rules, 47 CFR 1.115, the Application for Review filed by GCI Communications Corp. on July 30, 2020, is DISMISSED as moot.

127. *It is further ordered* that, pursuant to § 1.115 of the Commission's rules, 47 CFR 1.1115, the Application for Review filed by Alaska Communications on July 30, 2020, is *dismissed* as moot.

List of Subjects in 47 CFR Part 54

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

Federal Communications Commission.

Marlene Dortch,

Secretary.

Final Rules

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

PART 54—UNIVERSAL SERVICE

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

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

■ 2. Delayed indefinitely, § 54.604 is revised to read as follows:

§ 54.604 Determining the urban rate.

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

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

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

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

■ 3. Delayed indefinitely, § 54.605 is revised to read as follows:

§ 54.605 Determining the rural rate.

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

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

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

(2) The carrier must provide such information periodically thereafter as required, by the state commission for intrastate rates or the Commission for

interstate rates. In doing so, the carrier much take into account anticipated and actual demand for telecommunications services by all customers who will use the facilities over which services are being provided to eligible health care providers.

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

§ 54.619 Cap.

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

* * * * *

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

§ 54.621 Filing window for requests and prioritization of support.

* * * * *

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

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

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

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

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

TABLE 1 TO PARAGRAPH (b)(2)—PRIORITIZATION SCHEDULE

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

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

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

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

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

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

§ 54.622 Competitive bidding requirements and exemptions.

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

they qualify for an exemption. Applicants who utilize a competitive bidding exemption may proceed directly to filing a funding request as described in § 54.623.

* * * * *

(e) * * *

(1) * * *

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

* * * * *

§ 54.627 [Amended]

■ 7. Amend § 54.627 by:

■ a. Removing paragraphs (c)(1) and (2);

■ b. Redesignating paragraph (c)(3) as paragraph (c)(1); and

■ c. Adding reserved paragraph (c)(2).

■ 8. Delayed indefinitely, further amend § 54.627 by revising newly redesignated paragraph (c)(1)(i)(D) to read as follows:

§ 54.627 Invoicing process and certifications.

* * * * *

(c) * * *

(1) * * *

(i) * * *

(D) It has examined the invoice form and supporting documentation and that to the best of its knowledge, information and belief, all statements of fact contained in the invoice form and supporting documentation are true;

* * * * *

[FR Doc. 2023–04991 Filed 3–22–23; 8:45 am]

BILLING CODE 6712–01–P

DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 648

[Docket No. 230316–0077]

RIN 0648–BL90

Magnuson-Stevens Fishery Conservation and Management Act Provisions; Fisheries of the Northeastern United States; 2023–2025 Atlantic Herring Fishery Specifications

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Interim final rule.

SUMMARY: This interim rule implements 2023–2025 Atlantic herring fishery specifications, subject to public comment. This action also removes possession limits in Herring Management Area 1B and Area 3, adjusts 2023 fishery specifications to account either for Management Area catch limit overages or carryover of unharvested catch from 2021, updates the target rebuilding date for herring, removes the inshore midwater trawl restricted area regulations, corrects typographical errors in several existing regulations, and restores regulatory requirements that were unintentionally removed from the Code of Federal Regulations. This action is necessary to respond to updated scientific information from a 2022 management track assessment and to achieve the goals and objectives of the Atlantic Herring Fishery Management Plan. The approved measures are intended to help prevent overfishing, rebuild the overfished herring stock, achieve optimum yield on a continuing basis, and ensure that management measures are based on the best scientific information available.

DATES: Effective March 23, 2023. Public comments must be received by April 24, 2023.

ADDRESSES: You may submit comments, identified by NOAA–NMFS–2023–0015, by the following method:

• *Electronic Submission:* Submit all electronic public comments via the Federal e-Rulemaking Portal. Go to *https://www.regulations.gov* and enter NOAA–NMFS–2023–0015 in the Search box. Click on the ''Comment'' icon, complete the required fields, and enter or attach your comments.

Instructions: Comments sent by any other method or received after the end of the comment period may not be considered by NMFS. All comments received are a part of the public record and will generally be posted for public viewing on *www.regulations.gov* without change. All personal identifying information (*e.g.,* name, address, etc.), confidential business information, or otherwise sensitive information submitted voluntarily by the sender will be publicly accessible. We will accept anonymous comments (enter ''N/A'' in the required fields if you wish to remain anonymous).

Copies of the 2023–2025 herring specifications action, including the Supplemental Information Report (SIR) and the Regulatory Impact Review (RIR) prepared by the New England Fishery Management Council in support of this action, are available from Thomas A. Nies, Executive Director, New England Fishery Management Council, 50 Water Street, Mill 2, Newburyport, MA 01950. These documents are also accessible via the internet at *https://www.nefmc.org/management-plans/herring* or *http://www.regulations.gov.* Copies of the small entity compliance guide are available from on the internet at: *http://www.greateratlantic.fisheries.noaa.gov.*

FOR FURTHER INFORMATION CONTACT: Maria Fenton, Fishery Management Specialist, (978) 281–9196, *Maria.Fenton@noaa.gov.*

SUPPLEMENTARY INFORMATION:

Table of Contents

1. Background

Regulations implementing the Atlantic Herring Fishery Management Plan (FMP) appear at 50 CFR part 648, subpart K. The regulations at § 648.200 require the New England Fishery Management Council to recommend herring specifications for NMFS' review and publication in the **Federal Register**, including: The overfishing limit (OFL); acceptable biological catch (ABC); annual catch limit (ACL); optimum yield (OY); management uncertainty; domestic annual harvest (DAH); domestic annual processing (DAP); U.S. at-sea processing (USAP); border transfer; the sub-ACL for each management area, including seasonal periods as specified by § 648.201(d) and modifications to sub-ACLs as specified by § 648.201(f); and the amount to be set aside for the research set-aside (RSA) (0–3 percent of the sub-ACL from any management area) for a period of 3 years. These regulations also provide the Council with the discretion to modify accountability measures, possession limits, river herring monitoring/avoidance areas, and river herring and shad catch caps through the specifications process.

Consistent with the opportunity for public comment provided by the regulations, NMFS is implementing these specifications as recommended by the Council, subject to further consideration of additional public comments in response to this rule. Immediate implementation pending consideration of public comment allows herring fishery participants increased fishing opportunities consistent with the higher catch limits in this action. The specifications implemented in this action are consistent with the ABC