billion annually, or no more than $1.33 billion annually if certain conditions are met, using an updated version of the A–CAM. By adopting this program, the Commission furthered its long-standing goals by promoting the universal availability of voice and broadband networks, while also taking measures to minimize the burden on the nation's ratepayers. The Commission also adopted requirements for the Enhanced A–CAM program to complement existing Federal, state, and local funding programs, so that broadband funding can be used efficiently to maximize the deployment of high-quality broadband service across the United States.

To ensure that the Enhanced A–CAM program does not deprive rural consumers in high-cost areas of broadband service that is as secure as the service deployed pursuant to other Federal funding initiatives, the Commission required Enhanced A–CAM carriers to implement operational cybersecurity and supply chain risk management plans by January 1, 2024—the start of the Enhanced A–CAM support term. Enhanced A–CAM carriers must submit such plans to the Universal Service Administrative Company (USAC) and certify they have done so, by January 2, 2024, or within 30 days of approval under the Paperwork Reduction Act, whichever is later. Failure to submit the plans and make the certification shall result in 25% of monthly support being withheld until the carrier comes into compliance. If a carrier makes a substantive modification to its cybersecurity or supply chain risk management plan, the Commission requires that the carrier submit its updated plan to USAC within 30 days of making that modification.

The purpose of this information collection is to collect the operational cybersecurity and supply chain risk management plans required of the Enhanced A–CAM carriers by the start of the Enhanced A–CAM support term and address the burdens associated with that requirement.

Federal Communications Commission.

Marlene Dortch,

Secretary, Office of the Secretary.

[FR Doc. 2024–00417 Filed 1–10–24; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 54

[WC Docket No. 17–310; FCC No. 23–110; FR ID 195910]

Promoting Telehealth in Rural America

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: In this document, the Federal Communications Commission (Commission) seeks to provide vital support to assist rural health care providers with the costs of broadband and other eligible services. By offering discounted rates for these services, the Rural Health Care (RHC) Program enables health care providers to better treat patients in rural areas that often have fewer medical resources and higher service rates than in urban areas.

DATES: Effective February 12, 2024, except for §§ 54.601(b) and (c) (amendatory instruction 2) and 54.622(e)(1)(i) through (ii) and (i)(3)(iv) (amendatory instruction 4), 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: Philip A. Bonomo, *Philip.Bonomo@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 (voice), 202–418–0432 (TTY).

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Third Report and (*Third R&O*) in WC Docket No. 17–310; FCC No. 23–110, adopted on December 13, 2023, and released on December 14, 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-23-110A1.pdf.*

I. Introduction

1. In the *Third R&O,* the Commission continues its efforts to improve the effectiveness and efficiency of the Rural Health Care (RHC) Program. The RHC Program offers discounted rates for broadband and other communications services to health care providers who use these increasingly essential services to better treat patients in rural areas that may have limited resources, fewer medical professionals, and higher rates for these services than in urban areas. Broadband-enabled telehealth and telemedicine services in particular have proven to be critical tools for the effective delivery of health care to millions of patients in rural areas, as demonstrated by the heightened dependency on these services during the COVID–19 pandemic. Telemedicine and telehealth make the provision of high-quality health care a reality for patients regardless of location or ability to travel. The measures adopted will enhance the provision of these vital services through the RHC Program.

2. The Commission adopts four revisions to the RHC Program as proposed in the Second Further Notice of Proposed Rulemaking, 88 FR 17495, March 23, 2023 (Second FNPRM) (FCC 23–6), aimed at facilitating participation in and improving the administration of the Program. First, the Commission revises the RHC Program rules to permit conditional approval of eligibility for health care providers that expect to be eligible in the near future to allow them to initiate competitive bidding and request funding. Second, to give participants more flexibility with deadlines, the Commission revises its rules to move back the RHC Program's Service Provider Identification Number (SPIN) change deadline to align with the invoice deadline. Third, the Commission simplifies the rules for determining urban rates by eliminating the seldom-used ''standard urban distance'' component of the urban rate rules. Fourth, in a separate action to provide more flexibility with deadlines, the Commission revises the RHC Program rules to permit health care providers to request changes to the dates of their evergreen contracts following a funding commitment.

3. In addition to these revisions, the Commission also on its own motion makes two programmatic improvements to the administration of the RHC Program and Universal Service Fund. To reduce burdens and promote efficiency, the Commission harmonizes the RHC Program eligibility determination process by shifting to the use of a single universal eligibility form for all program participants. Finally, to free up for other uses unclaimed RHC Program support, the Commission establishes a deadline by which health care providers must submit invoices for any undisbursed funding commitments from funding year 2019 and prior that do not currently have an applicable invoice deadline.

II. Discussion

4. In the *Third R&O,* the Commission continues to improve the RHC Program by facilitating health care provider participation in and improving the administration of the Program. Specifically, the Commission revises the RHC Program rules to permit conditional eligibility for health care providers and eliminate the seldom-used ''standard urban distance'' component of the urban rate rule. The Commission also makes two changes relating to RHC Program administrative deadlines by aligning the SPIN change deadline with the existing invoice deadline and permitting health care providers to request a change to evergreen contract dates. The Commission then amends the rules to shift to the use of the same form when determining Telecom and Healthcare Connect Fund (HCF) Program eligibility. Finally, the Commission establishes a deadline by which invoices must be submitted for undisbursed funding commitments from before funding year 2020.

5. *Conditional Approval of Eligibility for Future Eligible Health Care Providers.* The Commission first adopts amendments to the RHC Program rules to allow conditional approval of eligibility consistent with what the Commission proposed in the Second FNPRM. The amendments enable entities that do not meet all eligibility requirements at the time they seek eligibility determinations to obtain conditional approval of eligibility, conduct competitive bidding, and request funding prior to receiving formal approval of eligibility. With this change, entities granted such conditional approval may conduct competitive bidding and request funding before they receive formal eligibility approval, ensuring that they are able to participate in the RHC Program for the funding year in which they expect to receive a formal eligibility approval. However, entities with conditional approval will not receive funding commitments until they meet all eligibility requirements. The substantive standard used to determine full eligibility remains unchanged. This change ensures that health care providers that are not yet eligible during the application window, but expect to become eligible in the near future, are not locked out of much needed funding. All commenters who addressed this proposal supported it, and no commenters opposed this change. This change will be effective for funding year 2025, the competitive bidding process for which begins in mid-2024.

6. Eligible health care providers, as defined in section 254(h)(7)(B) of the Communications Act and implemented in the Commission's rules, are limited to the following categories: (1) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (2) community health centers or health centers providing health care to migrants; (3) local health departments or agencies; (4) community mental health centers; (5) not-for-profit hospitals; (6) rural health clinics; (7) skilled nursing facilities; and (8) consortia of health care providers consisting of one or more entities falling into the first seven categories. In addition, eligible health care providers must be non-profit or public. In the Telecom Program, only eligible health care providers located in a ''rural area'' defined in § 54.600(e) of the Commission's rules can receive support. The HCF Program, on the other hand, permits rural eligible health care providers as well as non-rural eligible health care providers participating in a majority-rural consortium to receive support.

7. To allow health care providers to receive RHC Program funding as soon as they become eligible, the Commission amends § 54.601 of its rules to permit entities that expect to meet all eligibility requirements before the end of a given upcoming funding year to request and receive a conditional approval of eligibility. The Commission also amends § 54.622(e)(1) of its rules to allow those entities to make the required certifications when filing a Request for Services to initiate competitive bidding. The amendments adopted will enable entities that receive conditional approval of program eligibility to conduct competitive bidding and submit funding requests *prior* to receiving formal approval of eligibility. However, the substantive standard used to determine eligibility remains unchanged. Entities that receive conditional approval of eligibility will not receive funding commitments until they actually become eligible and receive the formal approval of eligibility under the existing substantive standard. No RHC funding shall be committed or disbursed to an entity for any time period that is prior to the date the entity is formally approved as eligible. The Commission directs the Universal Service Administrative Company (Administrator or USAC), upon approval from the Wireline Competition Bureau (Bureau), to implement the conditional approval of eligibility mechanism.

8. This change is warranted given the change to a fixed application filing window in the RHC Program. Before funding year 2016, after an initial application filing window, the Administrator accepted applications on a rolling basis until the last day of the funding year. Since funding year 2017, no applications have been accepted following the close of the initial application window. Beginning in funding year 2021, the Commission's rules require the Administrator to open an initial filing window period with an end date no later than April 1 prior to the start of the funding year.

9. In 2016, when applications were still accepted on a rolling basis and there were two application windows, the Bureau issued the Hope Community Order, DA 16–855, rel. July 29, 2016 (Hope Order), which held that that if an entity had not demonstrated its eligibility at the time of its eligibility determination form submission for a funding year, it would be ineligible to receive RHC Telecommunications Program support for that funding year. The change the Commission makes eliminates this limitation and allows health care providers to seek conditional eligibility approval so they can participate in the program in the year in which they expect to become fully eligible, even if they receive their full eligibility approval after the initial application window closes. Based on experience administering the program, the Commission finds it appropriate to eliminate the Hope Order's requirement that a site be eligible for RHC Program support, which requires that it qualifies as one of the eligible health care providers defined by section 254(h)(7)(B) of the Communications Act, at the time of its request for eligibility determination. In funding year 2013, the funding year at issue in the Hope Order, the Administrator accepted applications on a rolling basis throughout the funding year, which permitted a health care provider to begin receiving funding for RHC Program supported services within a few months after it became an eligible entity under section 254(h)(7)(B) of the Communications Act. Shortly after meeting eligibility requirements, the health care provider could receive its eligibility determination, engage in competitive bidding, file a Request for Funding during the rolling application window, and start to receive funding.

10. Absent this change with the current use of a fixed filing window, a health care provider might have to wait more than one year after becoming an eligible health care provider to receive RHC Program funding. For example, if a new medical provider is in the process of opening and expects to become eligible under section 254(h)(7)(B) of the

Communications Act on July 1, 2025, which is after the initial application filing window, it may not be able to receive RHC Program support for funding year 2025 because it could not have been approved as eligible until after the provider's July 1, 2025 opening date. Permitting conditional approvals of eligibility will allow health care providers that are not yet eligible but expect to become an eligible health care provider in a given upcoming funding year to complete competitive bidding and file Requests for Funding so they are able to receive RHC Program funding as soon as they are fully designated as an eligible health care provider under the Commission's rules.

11. To protect the integrity and success of the RHC program and ensure that no RHC Program funding is disbursed for entities that are not yet fully approved as eligible, the Commission adopts the following safeguards for conditional approvals of eligibility. First, to request conditional approval of eligibility, an applicant must submit an eligibility determination form and supporting documentation to the Administrator, which will include the estimated date that it expects to meet all eligibility requirements. The documentation must show that the entity is or reasonably expects to qualify as a public or non-profit health care provider defined in § 54.600(b) of the Commission's rules by the estimated eligibility date. Additionally, if applying for the Telecom Program or if applying as an individual applicant in the HCF Program, the entity must be located or reasonably expect to be located in a rural area defined in § 54.600(e) of the Commission's rules by the estimated eligibility date, or, if not located in such a rural area, for purposes of applying for the HCF Program, be or plan to be a member of a majority-rural HCF Program consortium that satisfies the eligible rural health care provider composition requirement set forth in § 54.607(b) of the Commission's rules by the estimated eligibility date.

12. Once the Administrator approves an applicant's conditional eligibility, the applicant can proceed to conduct competitive bidding for the conditionally-approved site(s). In order to provide notice of the applicant's conditional eligibility to potential bidders and service providers, an applicant engaging in competitive bidding with conditional eligibility must provide a written indication with its competitive bidding form indicating (1) that the eligibility is conditional, and (2) when the estimated expected eligibility date is. After conducting competitive bidding and signing a service contract, the applicant can submit a funding request during the application filing window for a given funding year, provided that the applicant's estimated expected eligibility date is no later than the end of that funding year. To ensure that no funding is committed or disbursed for health care providers that are conditionally eligible under section 254(h)(7)(B) of the Communications Act or the RHC Program rules, entities with conditional approval of eligibility will not be able to receive funding commitments or disbursements until they meet all eligibility requirements and are granted a formal approval of eligibility. This restriction is consistent with the Commission rule that RHC Program funding is provided to eligible health care providers for services for health care purposes.

13. An applicant with conditional approval of eligibility is expected to notify the Administrator within 30 calendar days of its actual eligibility date and provide documentation confirming that it is actually eligible. If the Administrator determines that the entity meets the requirements for a public or non-profit health care provider defined in § 54.600(b) Commission's rules and the requirements for rural location or majority-rural HCF consortium membership set forth in the Commission's rules, the Administrator shall formally approve the applicant's eligibility and designate the applicant as an eligible health care provider. The Administrator will then review the applicant's funding request and issue a funding commitment or denial in a timely manner. The funding commitment shall cover only a time period that starts no earlier than the applicant's actual approved eligibility date and that is within the funding year for which support was requested. No funding shall be committed to ineligible entities or entities with only conditional approval and any support erroneously disbursed to ineligible entities or entities with only conditional approval must be recovered. The Commission directs the Administrator to implement these requirements in its procedures and delegate authority to the Bureau to issue further direction consistent with the *Third R&O* as necessary.

14. *Alignment of the Service Provider Identification Number Change Deadline with Invoice Deadline.* The Commissions next amends its rules to move back the Service Provider Identification Number (SPIN) change filing deadline to align with the invoice filing deadline, rather than the service delivery deadline. A SPIN is a unique number that the Administrator assigns to an eligible service provider seeking to participate in the universal service support programs. An applicant under the HCF Program or Telecom Program may request either a ''corrective SPIN change'' (in cases not involving a change in the service provider associated with the applicant's funding request number) or an ''operational SPIN change'' (in cases involving a change to the service provider associated with the applicant's funding request number). The current filing deadline to submit a SPIN change request is no later than the service delivery deadline, which, with limited exceptions, is June 30 of the funding year for which program support is sought. The invoice deadline is 120 days after the later of the service delivery deadline or the date of a revised funding commitment letter. In the Second FNPRM, the Commission proposed to align the SPIN change deadline with the invoice deadline and commenters supported this change.

15. The Commission moves back the deadline for requesting SPIN changes effective funding year 2023 in response to program participant requests asserting that the nature of corrective SPIN changes creates a ''recurring hardship for applicants'' unable to meet the deadline, which, in turn, results in deadline waiver requests filed with the Commission. According to these participant comments, two commonly recurring situations support a change to the corrective SPIN change deadline: (1) mergers and acquisitions that can occur at any time during the funding year and (2) a service provider that assigns one of its multiple SPINs to a funding request without advising the healthcare provider as to the correct SPIN before invoicing begins, a situation that, in many instances, occurs after the service delivery deadline has passed. These commenters maintain that changing the deadline to request a corrective SPIN change to match the invoice deadline will provide the Administrator with sufficient time to process the change request without the need for applicants to request deadline waivers from the Commission. The Commission agrees with these commenters that the current deadline for requesting corrective SPIN changes imposes unnecessary burdens and challenges for program participants that a later-in-time deadline will largely eliminate.

16. The Commission moves back the SPIN change deadline to align with the invoice deadline, which, in most cases is 120 days after the close of the funding year, to reduce the need for applicants to seek, and for the Commission to address, waivers of the current

corrective SPIN change deadline. This change facilitates participation in and the administration of the program, while still maintaining an administratively reasonable date by which such change requests must be made. Aligning the SPIN change deadline with the invoice deadline will not cause Program participants to miss the invoice deadline because a SPIN change results in a revised commitment letter, which will create a new invoice deadline 120 days from the issuance of the revised commitment letter.

17. *Simplifying Urban Rate Calculations.* In this section, the Commission simplifies the rules for calculating urban rates for the Telecom Program by eliminating the rarely-invoked ''standard urban distance'' provision from its rules. In the Order on Reconsideration, 88 FR 17379, March 23, 2023 (Order on Recon) (FCC 23–6), the Commission eliminated the Rates Database and reinstated the long-standing rules for calculating urban rates. These rules provide that the urban rate for an eligible 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. If, however, the service is provided over a distance greater than the standard urban distance, which is the average of the longest diameters of all cities with a population of 50,000 or more within a state, the urban rate is the rate no higher than the highest tariffed or publicly-available rate provided over the standard urban distance. In the Second FNPRM, the Commission proposed to simplify program rules by eliminating the distinction between services provided over and within the standard urban distance and proposed to base all urban rates calculations on rates provided in a city, rather than over the standard urban distance. It also sought comment on the extent to which health care providers rely on the standard urban distance distinction to calculate urban rates.

18. Based on the record, the Commission finds that adopting its proposal to eliminate the standard urban distance provision from the urban rate rules will help simplify the calculation of urban rates in the Telecom Program. Eliminating it will make clearer the process for determining urban rates and there is no evidence that it will adversely impact health care providers because few, if any, Telecom Program participants calculate urban rates using this distinction. No commenters opined on the extent to which health care providers rely on the standard urban distance provision to calculate urban rates, which suggests that standard urban distance was not commonly invoked to calculate urban rates. The only commenter that addressed this proposal, the Schools, Health & Libraries Broadband (SHLB) Coalition, supported this change. Therefore, the Commission adopts the proposal to base all urban rates calculations on rates provided in a city rather than over the standard urban distance. This change shall be applicable for funding year 2025.

19. *Change of Evergreen Contract Dates.* The Commission next amends the RHC Program rules to permit health care providers to request a change in the evergreen contract dates following a funding commitment. Upon approving such a change, the Administrator will issue a revised funding commitment letter. This change will provide health care providers with the benefits of evergreen contract designation across the full length of the contract's term while also reducing the need for health care providers to seek relief from the Administrator in cases where a post-commitment evergreen contract date change is necessary. This new rule will become effective for funding year 2024.

20. Evergreen contracts are multi-year agreements under which covered services are exempt from the competitive bidding requirements for the term of the contract, which may be extended by up to an aggregate of five years. When the Administrator issues a funding commitment letter, it sets the period for an evergreen contract based on the estimated service start and end dates provided by the health care provider on the Request for Funding. However, as the Commission explained in the Second FNPRM, services sometimes start after the estimated service start date, which means that the evergreen status of the contract expires before it would have if the evergreen designation period was based on the actual service start date. In the Second FNPRM, the Commission sought comments on whether there should be a process for health care providers to change evergreen contract dates after a funding commitment has been made. The Commission also requested comments on how such a process could be accomplished.

21. SHLB and New England Telehealth Consortium (NETC) support, and no party opposes, allowing health care providers to request changes to their evergreen contract dates in cases when the contract supports those changes. SHLB maintains that such requests should always be deemed timely and not precluded by expiration of the 60-day window for an appeal of the original funding commitment. SHLB also suggests that the Commission clarify that the Administrator should defer to the parties' interpretation of a contract's start and end date unless it is ''obviously inconsistent'' with the language of the contract.

22. The Commission agrees with SHLB and NETC that health care providers should be permitted to request evergreen contract changes following a funding commitment provided the contract supports a change. Aligning a contract's actual service start date with the start date that determines the duration of the evergreen contract period will exempt health care providers from the competitive bidding process for the full length of the contract, thereby providing certainty to RHC Program participants. This change will not alter rules or processes for multi-year commitments or other competitive bidding exemptions. Accordingly, the Commission amends the RHC Program rules to allow health care providers to request changes to evergreen contract dates, subject to the following two requirements.

23. First, the Commission requires that the terms of the evergreen contract support any requested date change. For example, an evergreen contract that specifies a start date effective upon signature of the contracting parties would not be eligible for a contract date change because the start date is a date established by the contract independent of the service start date. By contrast, an evergreen contract with terms specifying a start date tied to the commencement of services yet to be delivered would be eligible for a date change regardless of the date of signature. The Commission makes clear that any changes to the dates of the evergreen contract must be supported by the contract, and declines to adopt SHLB's suggestion that the Administrator defer to the contracting parties' interpretation on the contract timing. As in the case of ''verification of discounts, offsets, or support amounts'' as a general matter under § 54.707 of the Commission's rules, it will be incumbent upon applicants to ensure that the available evidence sufficiently justifies a given date change.

24. Second, the Commission requires that health care providers request an evergreen contract change within 60 days of the date service commences. This 60-day window should provide health care providers with ample time to request a date change without having to resort to appealing the original funding commitment, which addresses the timing concern raised by SHLB and

NETC. The Commission declines, however, to adopt SHLB's approach that all requests for evergreen contract changes be deemed timely. Such an open-ended option would provide no incentive to health care providers to promptly notify the Administrator of evergreen contract date changes. To memorialize the changed evergreen contract dates, the Commission directs the Administrator to issue a revised funding commitment letter to the health care provider reflecting the changed dates. If the Administrator denies a requested change, the Commission directs it to issue a letter to the health care provider explaining the basis for the denial. Finally, the Commission directs the Administrator to develop procedures subject to prior Bureau approval for accepting changes to evergreen contract dates consistent with the amended Commission's rules § 54.622(i)(3), and to publicize instructions on requesting changes to evergreen contract dates with the stakeholder community.

25. *Single Eligibility Form.* To reduce burdens on Telecom Program applicants and improve the efficiency and operation of the RHC Program, the Commission next harmonizes the RHC Program eligibility determination process by establishing a single eligibility determination form for both the Telecom Program and the HCF Program that is required to be filed only once. Applicants must first be determined eligible under section 254(h)(7)(B) of the Communications Act and RHC Program rules to receive support from the RHC Program. The Telecom Program and the HCF Program currently have different procedures for eligibility determinations. In the Telecom Program, applicants seeking eligibility determinations use the FCC Form 465 (Description of Services Requested and Certification Form), which is the same form used to initiate competitive bidding. Thus, even though most Telecom Program applicants' eligibilities are very unlikely to change from year to year, they are required to provide, and the Administrator is required to review, information regarding their eligibility statuses every time there is a new competitive bidding process, which is generally every year.

26. In contrast, when the HCF Program was established in 2012, the Commission instituted a more efficient process for eligibility determinations by separating the process for eligibility determination from the process for competitive bidding. In the HCF Program, applicants file an FCC Form 460 (Eligibility and Registration Form) to seek a one-time eligibility determination that remains in place unless there is a material change in the entity's eligibility. After receiving this eligibility determination, the applicant may file an FCC Form 461 (Request for Services Form) to initiate competitive bidding. Thus, applicants are able to know whether they are eligible before they spend time and resources planning competitive bidding. Because the FCC Form 460 is filed only once, the eligibility determination process in the HCF Program improves efficiency and reduces costs and time for both health care providers and the Administrator.

27. Therefore, beginning funding year 2025, the FCC Form 460 will be used for eligibility determinations in the Telecom Program and the eligibility determination portion will be eliminated from the FCC Form 465. As a result of this change, starting for funding year 2025, the FCC Form 465 will be used solely for competitive bidding in the Telecom Program while the FCC Form 461 will continue to be used for competitive bidding in the HCF Program. Because there are certain differences in eligibility requirements between the Telecom Program and the HCF Program, applicants who are determined eligible in one program are not necessarily eligible in the other program even though one eligibility determination form is used for both programs. For example, non-rural public or non-profit health care providers who are members of majority-rural consortia are eligible to receive support under the HCF Program, but not under the Telecom Program. Thus, in this example, applicants whose FCC Form 460s are submitted specifically for the HCF Program and approved on that basis are not automatically eligible for support in the Telecom Program and must seek eligibility determinations in the Telecom Program if they subsequently wish to demonstrate their eligibility for that program. The Commission directs the Bureau to amend the FCC Form 460 for eligibility determinations for both the Telecom Program and the HCF Program and direct the Administrator to track whether a health care provider is eligible for the Telecom Program, the HCF Program, or both.

28. As part of adopting the FCC Form 460 for the Telecom Program, the Commission also amends § 54.601(b) of its rules to extend it to the Telecom Program effective for funding year 2025. Section 54.601(b) of the Commission's rules addresses the timing requirements for eligibility determinations in the HCF Program and requires health care providers to notify the Administrator of changes to their name, location, contact information, or eligible entity type. It was adopted when the Commission established the HCF Program in 2012 as a procedural rule for specifying the process for determining health care provider eligibility in the HCF Program. There are no corresponding rules for the eligibility determination process in the Telecom Program where applicants previously had to make a new eligibility showing every year they wished to seek support. Since a single eligibility determination form will be used for both programs, and thus now in the Telecom Program, like the HCF Program, applicants will be required to file separate forms for eligibility determination and request for services, and findings of eligibility will remain in place absent a material change in circumstances, it is reasonable to amend § 54.601(b) of the Commission's rules to make it apply to both programs to provide greater clarity to program participants.

29. To further reduce unnecessary burdens and ease the implementation of this change, the Commission directs the Administrator to deem presumptively eligible for funding year 2025 and beyond any health care provider with an existing eligibility approval in the Telecom Program. Because the eligibility status of health care providers rarely changes, an additional up-front eligibility determination for funding year 2025 is unnecessary. This direction is consistent with the eligibility determination process in the HCF Program. The Commission reminds any health care providers with changes to conditions that might impact their eligibility status of the requirement to update the Administrator within 30 days of the change. As before, health care providers in both the Telecom and HCF Programs are required to certify their eligibility when filing a Request for Services to initiate competitive bidding.

30. The Commission emphasizes that its actions do not change the substantive requirements for determining eligibility in the RHC Program. It is the RHC Program applicants' obligation to submit accurate information and certifications regarding their eligibility, including the obligation to notify the Administrator within 30 days of a material change in their eligibility information. Because health care provider eligibility is limited by the Act, the Commission does not have discretion to waive eligibility requirements, and must recover any support erroneously disbursed to ineligible entities.

31. *De-Obligation of Undisbursed, Un-Invoiced Commitments.* The Commission establishes a deadline of July 1, 2024, for Telecom Program

participants to submit invoices for funding years 2019 and earlier, the period during which there was no invoice deadline in the Telecom Program. After that date, funding commitments from funding year 2019 and earlier that have not yet been invoiced will be de-obligated and will not be able to be invoiced. The Commission established an invoice deadline for the Telecom Program effective funding year 2020 in the *Promoting Telehealth Report and Order,* 84 FR 54952, Oct. 11, 2019. The Commission explained that this deadline of 120 days from the service delivery deadline supported the ''harmonization of the invoice deadline for RHC programs'' and provided ''applicants with sufficient time to submit their invoices and seek reimbursements from the Administrator,'' while being ''necessary for the efficient administration of the RHC program.''

32. There is currently $22.2 million in undisbursed, un-invoiced commitments from funding year 2019 and earlier, when there was no invoice submission deadline. Establishing an invoice submission deadline of July 1, 2024, for Telecom Program funding requests from funding year 2019 and earlier and de-obligating unused funding is appropriate for several reasons. It is highly unlikely, given the significant lapse of time, that a significant portion of this funding will ever be invoiced, and some of these commitments may be for services that were ultimately never used. At this point, the Administrator receives very few invoices for services from prior to funding year 2019. Further, this deadline provides ample time for Program participants to assess whether they have undisbursed commitments requiring invoicing and to complete the invoicing process for those funding requests. Any funding de-obligated as a result of this change can be used for more useful purposes.

33. Therefore, all existing Telecom Program commitments from funding year 2019 and earlier must be invoiced by July 1, 2024. This decision does not affect the invoice deadline for Telecom Program funding requests for funding year 2020 and later, which are subject to the invoice deadlines established in § 54.627 of the Commission's rules. In the event that the Administrator issues a funding commitment in the future for a funding request for funding year 2019 or earlier, invoices for that funding commitment must be submitted within 120 days of the issuance of a commitment letter.

III. Procedural Matters

A. Paperwork Reduction Act Analysis

34. This document contains new and modified information collection requirements subject to the Paperwork Reduction Act of 1995 (PRA), Public Law 104–13. All such requirements 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 any new or modified information collection requirements contained in this proceeding. The Commission will publish a separate document in the **Federal Register** at a later date seeking these comments. In addition, its 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 it might further reduce the information collection burden for small business concerns with fewer than 25 employees.

35. In this present document, the Commission has assessed the effects of allowing conditional approvals of eligibility, allowing changes to evergreen contract dates, and adopting for the entire RHC Program eligibility form filing requirements that previously existed only in the HCF Program and finds that the additional funding and administrative conveniences these changes give health care providers justify these changes.

B. Congressional Review Act

36. The Commission has determined and the Administrator of the Office of Information and Regulatory Affairs, Office of Management and Budget, concurs that the rules are non-major under the Congressional Review Act, 5 U.S.C. 804(2). The Commission will send a copy of the *Third R&O* to Congress and the Government Accountability Office pursuant to Congressional Review Act, *see* 5 U.S.C. 801(a)(1)(A).

37. In addition, the Commission will send a copy of the *Third R&O,* including the Final Regulatory Flexibility Analysis (FRFA), to the Chief Counsel for Advocacy of the Small Business Administration pursuant to the Small Business Regulatory Enforcement Fairness Act of 1996.

C. Final Regulatory Flexibility Analysis

38. 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 an FRFA concerning the potential impact of the rule and policy changes adopted in the *Third R&O.*

39. As required by the RFA, an Initial Regulatory Flexibility Analysis (IRFA) was incorporated into the Second FNPRM, FCC 23–6, rel. January 27, 2023. The Commission sought written public comment on the proposals in the Second FNPRM, including comment on the IRFA. No comments were filed addressing the IRFA. This FRFA conforms to the RFA.

i. Need for, and Objectives of, the Third R&O

40. In the *Third R&O,* 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 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 delivering their services to 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.

41. Additionally, the *Third R&O* adopts proposals from the Second FNPRM that allow conditional approvals of eligibility to allow soon-to-be eligible providers to engage in competitive bidding, align the Service Provider Identification Number (SPIN) change deadline with the invoice deadline, simplify urban rate calculations, and allow health care providers to change evergreen contract dates. The Commission also harmonizes the RHC Program eligibility determination process by establishing a single eligibility determination form for the Telecom Program and RHC program and announce a new deadline for the de-obligation of undisbursed, un-invoiced commitments.

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

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

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

43. 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 rules in this proceeding.

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

44. 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 rules adopted herein. 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 SBA.

45. *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, 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 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% of all businesses in the United States, which translates to 33.2 million businesses.

46. 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 2020, there were approximately 447,689 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.

47. 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 indicate 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 36,931 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 enrollment populations of less than 50,000. Accordingly, based on the 2017 U.S. Census of Governments data, the Commission estimates that at least 48,971 entities fall into the category of ''small governmental jurisdictions.''

a. Healthcare Providers

48. *Offices of Physicians (except Mental Health Specialists).* This 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 small business size standard for this industry classifies a business having annual receipts of $14 million or less as small. The 2017 Economic Census indicates that 137,366 firms operated in this industry for the entire year. Of this number, 126,098 firms had revenue of less than $10 million. Based on this data, the Commission concludes that a majority of firms operating in this industry are small under the SBA size standard.

49. *Offices of Dentists.* This 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 small business size standard for this industry classifies a business having annual receipts of $8 million or less as small. The 2017 Economic Census indicates that 113,795 firms operated in this industry for the entire year. Of that number, 112,332 firms had revenue of less than $5 million. Based on this data, the Commission concludes that a majority of dental businesses are small entities.

50. *Offices of Chiropractors.* This 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 small business size standard for this industry classifies a business having annual receipts of $8 million or less as small. The 2017 Economic Census indicates that 34,414 firms operated in this industry for the entire year. Of that number, 34,366 firms operated with revenue of less than $5 million per year. Based on this data, the Commission concludes that a majority of chiropractors are small.

51. *Offices of Optometrists.* This 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 small business size standard for this industry classifies a business having annual receipts of $8 million or less as small. The 2017 Economic Census indicates that 17,879 firms operated in this industry for the entire year. Of this number, 16,792 firms had revenue of less than $5 million. Based on this data, the Commission concludes that a majority of firms in this industry are small.

52. *Offices of Mental Health Practitioners (except Physicians).* This 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 small business size standard for this industry classifies a business having annual receipts of $8 million or less as small. The 2017 Economic Census indicates that 19,316 firms operated in this industry for the entire year. Of that number, 13,318 firms had revenue of less than $5 million. Based on this data, the Commission concludes that a majority of mental health practitioners who do not employ physicians are small.

53. *Offices of Physical, Occupational and Speech Therapists and Audiologists.* This 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 small business size standard for this industry classifies a business having annual receipts of $11 million or less as small. The 2017 Economic Census indicates that 22,402 firms in this industry operated for the entire year. Of that number, 21,712 firms had revenue of less than $5 million. Based on this data, the Commission concludes that a majority of businesses in this industry are small.

54. *Offices of Podiatrists.* This 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 small business size standard for this industry classifies a business having annual receipts of $8 million or less as small. The 2017 Economic Census indicates that 6,673 firms operated in this industry for the entire year. Of that number, 6,235 firms had revenue of less than $5 million. Based on this data, the Commission concludes that a majority of firms in this industry are small.

55. *Offices of All Other Miscellaneous Health Practitioners.* This 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 small business size standard for this industry classifies firms having annual receipts of $9 million or less as small. The 2017 Economic Census indicates that 14,194 firms in this industry operated the entire year. Of that number, 10,874 firms had revenue of less than $5 million. Based on this data, the Commission concludes the majority of firms in this industry are small.

56. *Family Planning Centers.* This 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 small business size standard for this industry classifies firms having annual receipts of $16.5 million or less as small. The 2017 Economic Census indicates that 1,339 firms in this industry operated for the entire year. Of that number, 1,014 firms had revenue of less than $10 million. Based on this data, the Commission concludes that the majority of firms in this industry is small.

57. *Outpatient Mental Health and Substance Abuse Centers.* This 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 small business size standard for this industry classifies a firm as small if it has $16.5 million or less in annual receipts. The 2017 Economic Census indicates that 5,637 firms operated for the entire year. Of this number, 4,534 firms had of less than $10 million. Based on this data, the Commission concludes that a majority of firms in this industry are small.

58. *HMO Medical Centers.* This industry comprises establishments with physicians and other medical staff primarily engaged in providing a range of outpatient medical services to the HMO subscribers with a focus generally on primary health care. These establishments are owned by the HMO. HMO establishments that both provide health care services and underwrite health and medical insurance policies are also included in this industry. The SBA small business size standard for this industry classifies firms having $39 million or less in annual receipts as small. The 2017 U.S. Economic Census indicates that 17 firms in this industry operated for the entire year. However, the 2017 Economic Census does not provide disaggregated financial information for this industry, therefore the Commission cannot determine how many of the firms in this industry are small under the SBA small business size standard.

59. *Freestanding Ambulatory Surgical and Emergency Centers.* This 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 small business size standard for this industry classifies firms having annual receipts of $16.5 million or less as small. The 2017 U.S. Economic Census indicates that 3,888 firms in this industry operated for the entire year. Of that number, 3,132 firms had revenue of less than $10 million. Based on this data, the Commission concludes that a majority of firms in this industry are small.

60. *All Other Outpatient Care Centers.* This 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 small business size standard for this industry classifies a business with annual receipts of $22.5 million or less as small. The 2017 U.S. Economic Census indicates that 5,524 firms operated in this industry for the entire year. Of this number, 4,584 firms had revenue of less than $10 million. Based on this data, the Commission concludes that a majority of firms in this industry are small.

61. *Blood and Organ Banks.* This industry comprises establishments primarily engaged in collecting, storing, and distributing blood and blood products and storing and distributing body organs. The SBA small business size standard for this industry classifies firms having annual receipts of $35 million or less as small. The 2017 U.S. Census Bureau data indicate that 293 firms operated in this industry for the entire year. Of that number, 219 firms operated with revenue of less than $25 million. Based on this data, the Commission concludes the major of firms that operate in this industry are small.

62. *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 small business size standard for this industry classifies businesses having annual receipts of $18 million or less as small. 2017 U.S. Bureau Census data show that 2,968 firms operated in this industry for the entire year. Of that number, 2,810 firms had revenue of less than $10 million. Based on this data, the Commission concludes that a majority of the firms in this industry are small. This 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 small business size standard for this industry classifies a business as small if it has annual receipts of $36.5 million or less. 2017 U.S. Census Bureau data indicate that 2,799 firms operated in this industry for the entire year. Of this number, 2,640 firms had revenue of less than $25 million. Based on this data, the Commission concludes that a majority of firms that operate in this industry are small.

63. *Medical Laboratories.* This 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 small business size standard for this industry classifies a business as small if it has annual receipts of $36.5 million or less. 2017 U.S. Census Bureau data indicate that 2,799 firms operated in this industry for the entire year. Of this number, 2,640 firms had revenue of less than $25 million. Based on this data, the Commission concludes that a majority of firms that operate in this industry are small.

64. *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 small business size standard for this industry classifies firms having annual receipts of $16.5 million or less as small. The 2017 U.S. Economic Census indicates that 3,556 firms operated in this industry for the entire year. Of that number, 3,233 firms had revenue of less than $10 million. Based on this data, the Commission concludes that a majority of firms that operate in this industry are small.

65. *Home Health Care Services.* This 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 small business size standard for this industry classifies a firm having annual receipts of $16.5 million or less as small. The 2017 Economic Census indicates that 19,414 firms operated in this industry for the entire year. Of that number, 18,291 firms had revenue of less than $10 million. Based on this data, the Commission concludes that a majority of firms that operate in this industry are small.

66. *Ambulance Services.* This 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 small business size standard for this industry classifies businesses having annual receipts of $20 million or less as small. The 2017 U.S. Economic Census indicates that 2,744 firms operated in this industry for the entire year. Of that number, 2,539 firms had revenue of less than $10 million. Based on this data, the Commission concludes that a majority of firms in this industry is small.

67. *Kidney Dialysis Centers.* This industry comprises establishments with medical staff primarily engaged in providing outpatient kidney or renal dialysis services. The SBA small business size standard for this industry classifies firms having annual receipts of $41.5 million or less as small. The 2017 U.S. Economic Census indicates that 378 firms operated in this industry for the entire year. Of that number, 271 firms had revenue of less than $25 million. Based on this data, the Commission concludes that a majority of firms in this industry are small.

68. *General Medical and Surgical Hospitals.* This 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. The

hospitals have an organized staff of physicians and other medical staff to provide patient care services and 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 small business size standard for this industry classifies firms having annual receipts of $41.5 million or less as small. The 2017 U.S. Economic Census indicates that 2,948 firms operated in this industry for the entire year. Of that number, 705 firms had revenue of less than $25 million, while 709 firms had revenue between $25 million and $99,999,999 and 1,072 firms had revenue greater than $100,000,000. Based on this data, the Commission concludes that approximately one-quarter of firms in this industry are small.

69. *Psychiatric and Substance Abuse Hospitals.* This 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 small business size standard for this industry classifies a business having annual receipts of $41.5 million or less as small. 2017 U.S. Census Bureau data indicate that 414 firms operated in this industry for the entire year. Of this number, 174 firms had revenue of less than $25 million. The Commission notes that 195 firms had revenue between $25 million and $99,999,999 but are unable to determine the number of firms in this group that have revenue of $41.5 million or less. Thus, based on the available data, under the SBA size standard slightly more than one-third of the businesses in this industry are small.

70. *Specialty (Except Psychiatric and Substance Abuse) Hospitals.* This 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 small business size standard for this industry classifies businesses having annual receipts of $41.5 million or less as small. 2017 U.S. Census Bureau data indicate that 346 firms operated in this industry for the entire year. Of that number, 119 firms had revenue of less than $25 million, while 169 firms had revenue of $25 million or more. Based on this data, the Commission concludes the less than half of the firms in this industry are small.

71. *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 small business size standard for this industry classifies firms having annual receipts of $36.5 million or less as small. The 2017 U.S. Economic Census indicates that 499 firms operated in this industry for the entire year. Of that number, 413 firms had revenue of less than $25 million. Based on this data, the Commission concludes that a majority of firms in this industry are small.

b. Providers of Telecommunications and Other Services

(i) Telecommunications Service Providers

72. The small entities that may be affected are Wireline Providers, Wireless Carriers and Service Providers, and Internet Service Providers.

(ii) Vendors and Equipment Manufacturers

73. *Vendors of Infrastructure Development or ''Network Buildout.''* The Commission nor the SBA have developed a small business size standard specifically directed toward manufacturers of network facilities. There are two applicable industries in which manufacturers of network facilities could fall and each have different SBA business size standards. The applicable industries are ''Radio and Television Broadcasting and Wireless Communications Equipment'' with a SBA small business size standard of 1,250 employees or less, and ''Other Communications Equipment Manufacturing'' with a SBA small business size standard of 750 employees or less.'' U.S. Census Bureau data for 2017 show that for Radio and Television Broadcasting and Wireless Communications Equipment there were 656 firms in this industry that operated for the entire year. Of this number, 624 firms had fewer than 250 employees. For Other Communications Equipment Manufacturing, U.S. Census Bureau data for 2017 show that there were 321 firms in this industry that operated for the entire year. Of that number, 310 firms operated with fewer than 250 employees. Based on this data, the Commission concludes that the majority of firms in this industry are small.

74. *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 small business size standard for Telephone Apparatus Manufacturing classifies businesses having 1,250 or fewer employees as small. U.S. Census Bureau data for 2017 show that there were 189 firms in this industry that operated for the entire year. Of this number, 177 firms operated with fewer than 250 employees. Thus, under the SBA size standard, the majority of firms in this industry can be considered small.

75. *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 small business size standard for this industry classifies businesses having 1,250 employees or less as small. U.S. Census Bureau data for 2017 show that there were 656 firms in this industry that operated for the entire year. Of this number, 624 firms had fewer than 250 employees. Thus, under the SBA size standard, the majority of firms in this industry can be considered small.

76. *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 small business size standard for this industry classifies firms having 750 or fewer employees as small. U.S. Census Bureau data for 2017 show that 321 firms in this industry operated for the entire year. Of this number, 310 firms operated with fewer than 250 employees. Based on this data, the Commission concludes that the majority of firms in this industry are small.

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

77. The rules adopted in the *Third R&O* will result in modified reporting, recordkeeping, or other compliance requirements for small and other entities. Applicants that request conditional approval for eligibility must submit an eligibility determination and supporting documentation, along with an estimated date to meet all eligibility requirements. They must also be located in a rural area as defined in § 54.600(e) of the Commission's rules by the estimated eligibility date, or plan to be a member of a majority-rural Healthcare Connect Fund (HCF) Program consortium that satisfies the eligible rural health care provider composition requirement set forth in § 54.607(b) of the Commission's rules by the estimated eligibility date. An applicant with conditional eligibility that plans to engage in competitive bidding must indicate that the eligibility is conditional, and state the estimated date of eligibility on its competitive bidding form. Applicants with conditional approval of eligibility must also notify the Universal Service Administrative Company (Administrator) within 30 calendar days of its actual eligibility date and provide documentation confirming eligibility. Beginning funding year 2025, a single eligibility determination form for the RHC Program for both the Telecom Program and the HCF Program, FCC Form 469, will be required to be filed once. Applicants will use the FCC Form 460 for eligibility determinations in the Telecom Program and the eligibility determination portion will be eliminated from the FCC Form 465. The Commission also amends § 54.601(b) of the Commission's rules to require health care providers in both programs to notify the Administrator of changes to their name, location, contact information, or eligible entity type. Telecom Program providers with invoices for funding years 2019 and earlier, must submit invoices by July 1, 2024, after which, any funding commitments for 2019 and earlier will be de-obligated and providers will not be able to invoice for services.

78. The Commission expects the actions taken in the *Third R&O* will achieve the goals of improving the effectiveness and efficiency of the RHC Program without placing significant additional costs and burdens on small entities. At present, there is not sufficient information on the record to quantify the cost of compliance for small entities, however, the Commission anticipates that the compliance obligations for small providers will be outweighed by the benefits of improving the RHC Program's capacity to distribute telecommunications and broadband support to rural health care providers.

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

79. The RFA requires an agency to provide ''a description of the steps the agency has taken to minimize the significant economic impact on small entities . . . including a statement of the factual, policy, and legal reasons for selecting the alternative adopted in the final rule and why each one of the other significant alternatives to the rule considered by the agency which affect the impact on small entities was rejected.''

80. In the *Third R&O,* the Commission takes steps to minimize the economic impact on small entities with the rule changes that are adopted. For example, conditional approval of eligibility for RHC Program funding will allow soon-to-be eligible providers to begin competitive bidding and request funding so that they may receive support as soon as they become eligible. The Commission aligns the SPIN change deadline with the invoice filing deadline to give small entities more time to complete SPIN changes. The Commission simplifies urban rate calculations by eliminating the standard urban distance provision, which will ease administrative burdens on small entities. The Commission changes evergreen contract dates to provide small entities with the benefits of evergreen contract designation across the full length of the contract's term. As a part of the reforms to use the same form for eligibility determinations in the Telecom and HCF Program, the Commission allows small entities to continue using their existing eligibility determinations. Finally, in establishing an invoice deadline for funding year 2019 and earlier, the Commission provides ample time for small providers and other entities to meet that deadline. These actions will promote efficiency and promote the goals of these programs, while strengthening protections against waste, fraud and abuse.

vii. Report to Congress

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

IV. Ordering Clauses

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

83. *It is further ordered,* that pursuant to § 1.103 of the Commission's rules, the provisions of the *Third R&O will become effective* February 12, 2024, unless indicated otherwise herein.

84. *It is further ordered,* that pursuant to the authority contained in sections 1–

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 shall be effective February 12, 2024, except for §§ 54.601(b) and (c) and 54.622(e)(1)(i) through (ii) and (i)(3)(iv), which may contain new or modified information collection requirements, will not become effective until the Office of Management and Budget completes any required review under the Paperwork Reduction Act. The Commission directs the Wireline Competition Bureau to publish a document in the **Federal Register** announcing completion of such reviews and the relevant effective dates.

List of Subjects in 47 CFR Part 54

Communications common carriers, Health facilities, Infants and children, Internet, Puerto Rico, Reporting and recordkeeping requirements, Telecommunications, Telephone, Virgin Islands.

Federal Communications Commission.

Marlene Dortch,

Secretary.

Final Rules

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

PART 54—UNIVERSAL SERVICE

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

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

■ 2. Delayed indefinitely, amend § 54.601 by revising paragraph (b) and adding paragraph (c) to read as follows:

§ 54.601 Health care provider eligibility.

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(b) *Determination of health care provider eligibility for the Rural Health Care Program.* (1) Before funding year 2025, health care providers in the Healthcare Connect Fund Program may certify to the eligibility of particular sites at any time prior to, or concurrently with, filing a request for services to initiate competitive bidding for the site. Applicants who utilize a competitive bidding exemption must provide eligibility information for the site to the Administrator prior to, or concurrently with, filing a request for funding for the site. Health care providers must also notify the Administrator within 30 days of a change in the health care provider's name, site location, contact information, or eligible entity type.

(2) Effective for funding year 2025, applicants in the Rural Health Care Program may certify to the eligibility of particular sites prior to, or concurrently with, filing a request for services to initiate competitive bidding for the site. Applicants who utilize a competitive bidding exemption must provide eligibility information for the site to the Administrator prior to, or concurrently with, filing a Request for Funding for the site. Health care providers must notify the Administrator within 30 days of a change in the health care provider's name, site location, contact information, or eligible entity type.

(c) *Conditional approval of eligibility.* Effective for funding year 2025:

(1) An entity that does not yet meet all eligibility requirements under the Rural Health Care Program may request and receive a conditional approval of eligibility from the Administrator if the entity provides documentation showing that it satisfies the following requirements:

(i) The entity is or reasonably expects to qualify as a public or non-profit health care provider as defined in § 54.600(b) by an estimated eligibility date;

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

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

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

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

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

■ 3. Revise § 54.604 to read as follows:

§ 54.604 Determining the urban rate.

(a) Effective funding year 2024:

(1) 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 (a)(3) 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.

(2) 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 (a)(3) 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.

(3) 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.

(4) 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.

(b) As of funding year 2025, if a rural health care provider requests support for an eligible service to be funded from the Telecommunications Program the ''urban rate'' for that service shall be a rate no higher than the highest tariffed or publicly-available rate charged to a commercial customer for a functionally similar service in any city with a population of 50,000 or more in that state, calculated as if it were provided between two points within the city.

■ 4. Delayed indefinitely, amend § 54.622 by revising paragraphs (e)(1)(i) and (ii) and adding paragraph (i)(3)(iv) to read as follows:

§ 54.622 Competitive bidding requirements and exemptions.

* * * * *

(e) * * *

(1) * * *

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

(ii) The health care provider seeking supported services is physically located in a rural area as defined in § 54.600 or is a member of a Healthcare Connect Fund Program consortium which satisfies the rural health care provider composition requirements set forth in § 54.607(b). If an entity seeks supported services under a conditional approval of eligibility set forth in § 54.601(c), the entity expects to be located in a rural area defined in § 54.600 before the end of the funding year for which the supported services are requested, or plans to be a member of a Healthcare Connect Fund Program consortium which satisfies the rural health care provider composition requirements set forth in § 54.607(b) before the end of the funding year for which the supported services are requested;

* * * * *

(i) * * *

(3) * * *

(iv) As of funding year 2024, if the date that services start under an evergreen contract differs from the date services were estimated to start, participants may request a change of the start date and end date of their evergreen contract within 60 days of the actual service start date provided the terms of the evergreen contract support such a change. Upon approving a requested change, the Administrator will issue a revised funding commitment letter to the health care provider reflecting the changed dates. If the Administrator denies a requested change, it will issue a letter to the health care provider explaining the basis for the denial.

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

§ 54.625 Service Provider Identification Number (SPIN) changes.

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

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