

Before the
Federal Communications Commission
Washington, D.C. 20554

In the Matter of
Rural Health Care Support Mechanism
WC Docket No. 02-60

REPORT AND ORDER, ORDER ON RECONSIDERATION,
AND FURTHER NOTICE OF PROPOSED RULEMAKING

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By the Commission: Chairman Powell and Commissioners Abernathy, Copps, and Adelstein
issuing separate statements.

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I. INTRODUCTION

1. In this *Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking*, we modify our rules to improve the effectiveness of the rural health care support mechanism, which provides discounts to rural health care providers to access modern telecommunications for medical and health maintenance purposes. Because participation in the rural health care support mechanism has not met the Commission’s initial projections, we amend our rules to improve the program, increase participation by rural health care providers, and ensure that the benefits of the program continue to be distributed in a fair and equitable manner. Specifically, we expand the scope of entities eligible to receive discounts, provide support for Internet access, and modify the way in which we calculate discounts to offer rural health care providers more flexibility. In addition, in the *Order on Reconsideration*, we deny Mobile Satellite Ventures Subsidiary’s petition for reconsideration of the *1997 Universal*

Service Order.¹ Lastly, in the *Further Notice of Proposed Rulemaking*, we seek comment on modifications to the definition of “rural area” for the rural health care support mechanism, whether additional modifications to our rules are appropriate to facilitate the provision of support to mobile rural health clinics for satellite services, and additional outreach efforts and measures to streamline further the application process. The actions we take today encourage the development of public/private partnerships and other creative solutions to meet the needs of rural communities and increase participation in the rural health care mechanism.

2. The actions we take today will also strengthen telemedicine and telehealth networks across the nation, help improve the quality of health care services available in rural America, and better enable rural communities to rapidly diagnose, treat, and contain possible outbreaks of disease. Moreover, enhancing access to an integrated nation-wide telecommunications network for rural health care providers will further the Commission’s core responsibility to make available a rapid nation-wide network for the purpose of the national defense, particularly with the increased awareness of the possibility of biological or chemical terrorist attacks. Finally, these changes will further the Commission’s efforts to improve its oversight of the operation of the program to ensure that the statutory goals of section 254 of the Telecommunications Act of 1996 are met without waste, fraud, or abuse.²

II. BACKGROUND

3. In section 254 of the Act, Congress sought to provide rural health care providers “an affordable rate for the services necessary for the purposes of telemedicine and instruction relating to such services.”³ Specifically, Congress directed telecommunications carriers “[to] provide telecommunications services which are necessary for the provision of health care services in a State, including instruction relating to such services, to any public or nonprofit health care provider that serves persons who reside in rural areas in that State, at rates that are reasonably comparable to rates charged for similar services in urban areas in that State.”⁴ Congress also directed the Commission to enhance access to advanced telecommunications and information services for health care providers.⁵

4. The Commission implemented this statutory directive by adopting the rural health care support mechanism in the *1997 Universal Service Order*. Specifically, the Commission concluded that telecommunications carriers must charge eligible rural health care providers a rate for each supported service that is no higher than the highest tariffed or publicly available commercial rate for a similar service in the closest city in the state with a population of 50,000

¹ *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776 (1997) (*1997 Universal Service Order*) (*subsequent history omitted*).

² Pub. L. No. 104-104, 110 Stat. 56. The 1996 Act amended the Communications Act of 1934 (the Act). See 47 U.S.C. §§ 151 *et seq.*

³ H.R. Conf. Rep. No. 458, 104th Cong. 2nd Sess. 133 (1996). See also Pub. L. No. 104-104, 110 Stat. 56.

⁴ See 47 U.S.C. §§ 151 *et seq.* (adding 47 U.S.C. § 254(h)(1)(A) to the Act).

⁵ 47 U.S.C. § 254(h)(2)(A).

or more people, taking distance charges into account.⁶ The Commission also adopted mechanisms to provide support for limited toll-free access to an Internet service provider.⁷ The Commission adopted an annual cap of \$400 million for universal service support for rural health care providers.⁸ The Commission based its conclusions on analysis of the condition of the rural health care community and technology at that time.⁹

5. Since then, the Commission has made some changes to the rural health care support mechanism to make it more viable and to reflect technological changes.¹⁰ Because only a small number of rural health care providers qualified for discounts in the original funding cycle, which covered the period from January 1, 1998 through June 30, 1999, the Commission reevaluated the structure of the rural health care universal service support mechanism in the fall of 1999.¹¹ At that time, the Commission: (1) simplified the urban/rural rate calculation; (2) eliminated the per-location discount limit; (3) encouraged participation in consortia; and (4) re-allocated billing and collection expenses by the number of participants in the rural health care universal service support mechanism.¹² The Commission also determined that the definition of “health care provider” does not include nursing homes, hospices, other long-term care facilities, or emergency medical service facilities.¹³ The Commission also decided not to further clarify the definition of “health care provider” or to provide additional support for long distance

⁶ *1997 Universal Service Order*, 12 FCC Rcd at 9093, para. 608.

⁷ *Id.*

⁸ 47 C.F.R. § 54.623; *1997 Universal Service Order*, 12 FCC Rcd at 9141, para. 705. The Commission subsequently limited support for the first funding cycle to \$100 million. See *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Fifth Order on Reconsideration and Fourth Report and Order in CC Docket No. 96-45, 13 FCC Rcd 14915, 14928-33 (1998).

⁹ See *1997 Universal Service Order*, 12 FCC Rcd at 9094 n.1556 (based upon material supplied by the Advisory Committee on Telecommunications and Health Care (comprised of experts in the fields of health care, telecommunications, and telemedicine) and the Federal-State Joint Board on Universal Service (referring to FCC Advisory Committee on Telecommunications and Health Care, Findings and Recommendations, October 15, 1996, and *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Recommended Decision, 12 FCC Rcd 87 (1996) (*Recommended Decision*)).

¹⁰ In September 1999, the Commission adopted the *Fourteenth Order on Reconsideration*, in which the Commission determined that all telecommunications carriers that provide supported services to eligible health care providers under section 254(h)(1)(A) are entitled to have a credit against their universal service contribution obligation equal to the difference between the lower, urban rate they offer eligible health care providers for supported telecommunications services and the higher, rural rates that would normally be charged to these customers. *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Fourteenth Order on Reconsideration, 14 FCC Rcd 20106 (1999) (*Fourteenth Order on Reconsideration*).

¹¹ *Changes to the Board of Directors of the National Exchange Carrier Association, Inc.*, *Federal-State Joint Board on Universal Service*, CC Docket Nos. 97-21 and 96-45, Sixth Order on Reconsideration in CC Docket No. 97-21 and Fifteenth Order on Reconsideration in CC Docket No. 96-45, 14 FCC Rcd 18756, 18760-61, para. 7 (1999) (*Fifteenth Order on Reconsideration*) (noting that there were 2,500 initial applications, and only a small fraction made it through the first funding cycle).

¹² *Fifteenth Order on Reconsideration*, 14 FCC Rcd at 18762, para. 9.

¹³ *Id.* at 18786, para. 48.

telecommunications service.¹⁴

6. The rural health care community and participating service providers now have six years of experience with the rural health care support mechanism.¹⁵ Over this period, the rural health care mechanism has provided support to rural health care providers in 45 states and the U.S. Virgin Islands, to enable them to obtain access to modern telecommunications services for medical and health maintenance purposes.¹⁶ Such support has facilitated the delivery of medical services to people who would otherwise have to wait for care, go without it, or take long and expensive journeys across difficult terrain to find help. Telemedicine allows rural health care providers in isolated areas to consult with specialists in an effective manner and treat patients locally, rather than waiting for scheduled visits or trying to describe patient conditions orally to specialists with the requisite degree of accuracy and completeness.

7. In some instances, telemedicine can save lives. For example, a video teleconference link allowed a surgeon in Anchorage to provide real-time guidance to a doctor in an isolated village in Alaska while he performed life-saving emergency surgery to stem bleeding for a patient diagnosed with an ectopic pregnancy.¹⁷ The emergency surgery was necessary, because the patient could not be airlifted to Anchorage due to fog. In Virginia, telemedicine links, which transported high-quality ultrasound pictures, allowed a neonatal cardiologist to remotely diagnose an infant located in a rural hospital with a descending aorta.¹⁸ The doctor was able to prescribe medication, which provided additional time to transport the infant to a specialty hospital for open heart surgery.

8. In 2002, the Commission issued a *Notice of Proposed Rulemaking (NPRM)* to review the rural health care universal service support mechanism.¹⁹ The Commission was prompted to act by a number of factors. First, the mechanism is greatly underutilized. Only 1,194 rural health care providers out of nearly 8,300 potential applicants received support in Funding Year 2001.²⁰ Indeed, notwithstanding the annual funding cap of \$400 million, the

¹⁴ *Id.* at 18762, para. 9.

¹⁵ Funding Year 2003 is the sixth year of the program.

¹⁶ Second Annual Telehealth Leadership Conference, Washington, DC, June 2, 2003, Session III “Universal Service Fund Update,” available at <http://www.americantelemed.org/conf/annualmeet.htm> (retrieved November 13, 2003) (The following States are not currently receiving support: CT, DE, MD, RI. Two states that do not have rural areas, DC and NJ, are also not currently receiving support.).

¹⁷ Nichole Tsong, *Live Video Gives Kotzebue Doctor a Surgeon’s Eye*, Anchorage Daily News, September 4, 2003, at A1.

¹⁸ Steve Thompson, *No Mountain Too High*, Rural Cooperatives May/June 2003, at 22.

¹⁹ *Rural Health Care Support Mechanism*, Notice of Proposed Rulemaking, WC Docket No. 02-60, 17 FCC Rcd 7806 (2002) (*NPRM*). We received seventy-five comments, fourteen reply comments, and six *ex partes* in response to the *NPRM*. Appendix B provides the full and abbreviated names of the parties. See Appendix B.

²⁰ See USAC Rural Health Care Division All Stats-6-30-03 (FY 2001) (Note that results for Funding Year 2002 that closes on October 8, 2003, are not yet available); Universal Service Administrative Company Report of Health Care Providers Eligible for Support Under the Rural Health Care Universal Service Support Mechanism, at 4 (April 5, 2001) (USAC Research Results Report) (stating there were approximately 8,297 health care providers in the United States as of September 2000).

Rural Health Care Division (RHCD) of the Universal Service Administrative Company (USAC or the Administrator) disbursed only \$30.25 million in total discounts for the first five years of operation of the universal service support mechanism.²¹ Reexamining certain aspects of our rules and instituting other streamlining changes should greatly increase the number of rural health care providers that could benefit from the mechanism, without modifying the existing funding cap.

9. Second, changes in telecommunications technology and its use by the medical community warrant a re-evaluation of some aspects of the mechanism. For instance, Internet points of presence now exist throughout the country's telecommunications network.²² More sophisticated medical imaging technology is available today than existed in 1997, which requires high speed access to display images used for diagnostic purposes.²³

10. Finally, in addition to section 254, our core statutory mandate, as set out in 47 U.S.C. § 151, states in relevant part, that we should make "available, so far as possible, to all the people of the United States ... a rapid, efficient, Nation-wide ... wire and radio communications service with adequate facilities at reasonable charges, for the purpose of the national defense, [and] for the purpose of promoting safety of life and property through the use of wire and radio communication."²⁴ Consistent with the statutory mandate, further utilization of the rural health care universal service support mechanism may benefit the development of a broader and more fully integrated network of health care providers across our nation. In the aftermath of recent national events, the importance of such a network to national security and public safety is significant. Improvements to the rural health care support mechanism also should better enable rural communities to rapidly diagnose, treat, and contain possible outbreaks of disease, while helping to provide better health care generally in rural areas by facilitating broader and faster transfer of critical information. In addition to crisis response, telemedicine and telehealth could play a critical role in informing rural health care providers about emerging

²¹ See Universal Service Administrative Company 2002 Annual Report. The RHCD administers the rural health care support mechanism under the direction of the Federal Communications Commission. See *Changes to the Board of Directors of the National Exchange Carrier Association, Inc., Federal-State Joint Board on Universal Service*, CC Docket Nos. 97-21 and 96-45, Third Report and Order in CC Docket No. 97-21 and Fourth Order on Reconsideration in CC Docket No. 97-21 and Eighth Order on Reconsideration in CC Docket No. 96-45, 13 FCC Rcd 25058 (1998).

²² See, e.g., NTCA Members Internet/Broadband Survey Report, National Telephone Cooperative Association, at 17 (November 2000), available at http://ntca.netstrategies.com/content_documents/broadbandstudy.pdf (retrieved November 13, 2003) (referencing a survey of members of the National Telephone Cooperative Association indicating that about 97% of respondents reported local dial-up telephone access within their service areas). See also Ronald A. Wirtz, *The Need For Speed*, Fedgazetts, November 1, 2001, available at <http://minneapolisfed.org/pubs/fedgaz/01-11/speed.cfm> (retrieved November 13, 2003) ("Early on, access to the Internet often meant a long-distance call to an ISP, which had limited points-of-presence...a variety of sources suggest that [the ISP industry] has grown from several hundred five or six years ago to some 3,500 by 1998, to about 7,000 today, each of which brings with it at least one additional POP to the system, and usually many more.").

²³ See, e.g., David Charles, M.D., *What's Next: Skyway to Health*, Telephony, April 1, 2002, at 40.

²⁴ 47 U.S.C. § 151.

threats and improving preparedness.²⁵

III. REPORT AND ORDER

A. Eligible Health Care Provider

11. *Background.* Section 254(h)(1)(A) requires telecommunications carriers to provide discounted telecommunications services to *any public or non-profit health care provider* that serves rural areas in a State.²⁶ Section 254(h)(7)(B) defines the term “health care provider” as:

- (i) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools;
- (ii) community health centers or health centers providing health care to migrants;
- (iii) local health departments or agencies;
- (iv) community mental health centers;
- (v) not-for-profit hospitals;
- (vi) rural health clinics; and
- (vii) consortia of health care providers consisting of one or more entities described in clause (i) through (vi).²⁷

In the *1997 Universal Service Order*, the Commission declined to expand the definition of “health care provider” beyond these seven statutory categories.²⁸ The Commission concluded that if Congress had intended other entities to qualify as health care providers, it would have explicitly included them within the statute.²⁹ Accordingly, on reconsideration, the Commission rejected arguments to expand the definition of “health care provider” to include long-term care facilities, such as nursing homes and hospices, and emergency medical service facilities.³⁰ The Commission did not address what would constitute a “public” health care provider.

12. Subsequently, in the *NPRM*, the Commission sought comment on whether it should revisit its prior interpretations of the terms “health care provider” and “rural health clinic” to expand the number of entities eligible to receive discounted telecommunications services.³¹ Specifically, the Commission invited comment on whether to expand the definition to include rural health care providers that provide ineligible services, even on a primary basis, but also

²⁵ See, e.g., *HHS Bioterrorism Preparedness: CDC’s Role in Public Health Protection*, Statement by Tommy G. Thompson before the Commission on Energy and Commerce, U.S. House of Representatives (November 15, 2001) (emphasizing the importance of public health communications infrastructure to facilitate information sharing concerning potential bioterrorism agents); 147 Cong. Rec. H10440 (December 19, 2001) (statement of Rep. Bereuter) (noting importance of telemedicine in combating bioterrorism).

²⁶ 47 U.S.C. § 254(h)(1)(A) (emphasis added).

²⁷ 47 U.S.C. § 254(h)(7)(B).

²⁸ *1997 Universal Service Order*, 12 FCC Rcd at 9118-19, paras. 655-56.

²⁹ *Id.*

³⁰ *Fifteenth Order on Reconsideration*, 14 FCC Rcd at 18786, para. 48.

³¹ *NPRM*, 17 FCC Rcd at 7813, para. 16.

serve as a rural health clinic or in another capacity that would qualify it as an eligible “health care provider” under the statute.³² The Commission explained that such multipurpose providers might play a vital role in responding to public health crises affecting communities located in remote regions of our country.³³ The Commission also sought comment on whether it would be practical to prorate discounts to the extent these entities operate as eligible health care providers.³⁴

13. *Discussion.* We now further define the statutory term “public health care provider.” We conclude that dedicated emergency departments of rural for-profit hospitals that participate in Medicare should be deemed “public” health care providers eligible to receive prorated rural health care support.³⁵ We agree with commenters that this clarification is consistent with congressional intent and is necessary to give meaning to the term “public” health care provider under the rural health care program.³⁶ Dedicated emergency departments in for-profit hospitals, including the emergency departments of critical access hospitals,³⁷ are required, pursuant to the

³² *Id.*

³³ *Id.*

³⁴ *Id.* at para. 17.

³⁵ 47 C.F.R. § 54.601(a)(1) as adopted herein. Previously, these providers were ineligible for support because they are associated with for-profit hospitals. *See* 47 U.S.C. § 254(h)(7)(B). Dedicated emergency departments are defined under health care regulations as any department or facility of the hospital, regardless of whether it is located on or off the main hospital campus, that meets at least one of the following requirements:

- (1) It is licensed by the State in which it is located under applicable State law as an emergency room or emergency department;
- (2) It is held out to the public (by name, posted signs, advertising, or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment; or
- (3) During the calendar year immediately preceding the calendar year in which a determination under this section is being made, based on a representative sample of patient visits that occurred during the calendar year, it provides at least one-third of all of its outpatient visits for the treatment of emergency medical conditions on an urgent basis without requiring a previously scheduled appointment.

42 C.F.R. § 489.24.

³⁶ *See, e.g.*, Letter to Marlene Dortch, Secretary, Federal Communications Commission, from Karen S. Rheuban, MD, Medical Director, and Eugene Sullivan, MS, Director, filed on behalf of the Office of Telemedicine, University of Virginia Health System, dated August 15, 2003 (“UVA *Ex Parte*”); Kansas DHE Comments at 1; Kansas Hosp. Assoc. Comments at 1; Kingston eHealth Comments at 4; Minn. Ambulance Assoc. Comments at 1; NRHA Comments 1; Nebraska Office of Rural Health Comments 1.

³⁷ Critical access hospitals were created under the Medicare Rural Hospital Flexibility Program, authorized by Congress under section 4201 of the Balanced Budget Act of 1997. Balanced Budget Act of 1997, Pub. L. 105-33, § 4201, 111 Stat. 251, 712-31, 756-59 (1997). In essence, critical access hospitals are limited-service rural non- or for-profit hospitals that provide outpatient and short-term inpatient hospital care on an urgent or emergency basis, then release patients or transfer them to a full-service hospital. To date, over 100 critical access hospitals have been designated by the state as necessary providers of medical services. *See* National Conference of State Legislatures Rural Health Brief—Ensuring the Survival of Critical Access Hospitals: The New Medicare Rural Hospital Flexibility Program and the Important Role for States (2000), available at <http://www.ruralhealth.hrsa.gov/pub/IssueBrief1.htm> (retrieved September 4, 2003).

(continued...)

Emergency Medical Treatment and Labor Act (EMTALA),³⁸ to provide medical screening examinations to all patients who present themselves and to stabilize or arrange for appropriate transfer of those patients with emergency conditions.³⁹ Thus, such providers are “public” in nature by virtue of the persons they are required, pursuant to EMTALA, to examine and/or treat for emergency medical conditions.

14. Moreover, we now determine that dedicated emergency departments in for-profit rural hospitals constitute “rural health clinics.”⁴⁰ As UVA notes, in most communities, emergency departments are the only ambulatory care entities that serve the public on a 24-hour a day, 7-day a week basis.⁴¹ In many instances, emergency departments of rural for-profit hospitals and critical access hospitals are the only health care providers in rural areas serving the medical needs of the community. Dedicated emergency departments typically provide the types of medical services often provided in traditional health clinics. Therefore, we find that dedicated emergency departments in rural for-profit hospitals should be eligible to receive prorated discounts as “public” “health providers,” and more specifically as “public” “rural health clinics.” It is necessary to clarify the definition of “rural health clinic” in this way to promote timely access to acute specialty healthcare services, chronic disease management programs and other preventive services essential to public health and safety. These entities are generally the initial point of entry into the healthcare system for any person suffering the consequences of a severe catastrophe or accident and constitute a vital segment of the health care community, particularly in the event of a national public health emergency.

15. Additionally, as suggested by several commenters,⁴² given the realities of rural health care providers in offering quality health care services in rural areas, we clarify the entities listed in section 254(h)(7)(B) that qualify as rural “health care providers.” We conclude that entities listed in section 254(h)(7)(B) include non-profit entities that function as one of the listed entities on a part-time basis.⁴³ Pursuant to this modification, non-profit entities that provide ineligible services, even on a primary basis, would be able to receive prorated support

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³⁸ EMTALA was passed as part of the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), which was signed into law in 1986. See Consolidated Omnibus Budget Reconciliation Act of 1985, Pub.L. 99-272, § 9121, 100 Stat. 82 (1986).

³⁹ See 42 U.S.C. § 1395dd. Specifically, section (c)(1) of the Emergency Medical Treatment and Labor Act (EMTALA) states that “if an individual at a hospital has an emergency medical condition which has not been stabilized...the hospital may not transfer the individual unless--(A)(ii) a physician has signed a certification that, based upon the information available at the time of transfer, the medical benefits reasonably expected from the provision of appropriate medical treatment at another medical facility outweigh the increased risks to the individual.” 42 U.S.C. § 1395dd(c)(1). These provisions are applicable to both non-profit and for-profit hospitals. See 42 U.S.C. § 1395dd.

⁴⁰ 47 U.S.C. § 254(h)(7)(B)(vi).

⁴¹ See UVA *Ex Parte* at 3.

⁴² See, e.g., Institute of Rural Health Comments at 5; UVA Comments at 7-10.

⁴³ 47 U.S.C. § 254(h)(7)(B).

commensurate with their provision of eligible rural health care services.⁴⁴ For example, if a doctor operated a rural health clinic on a non-profit basis in a rural community one day per week or during evenings in the local community center, that community center would be able to receive prorated support, because it serves as a “rural health clinic” on a part-time basis.⁴⁵ Similarly, if a non-profit community mental health center also operated as a for-profit pharmacy, that center would also be able to receive prorated support as a part-time “community mental health center.”⁴⁶ Our goal in implementing this proposal is two-fold – to encourage the development of public/private partnerships and other creative solutions to meet the needs of rural communities, and to increase participation in the rural health care support mechanism.

16. We decline to expand the definition of health care provider to include nursing homes, hospices, and other long-term care facilities.⁴⁷ Congress specifically listed seven categories of entities eligible for support under this program in section 254(h)(7)(B).⁴⁸ Given this specific listing, we find that if Congress had intended to include nursing homes, hospices, and other long-term care facilities as health care providers, it would have explicitly done so in the statute.⁴⁹ The Commission is not authorized to amend the statute to add categories to the definition, as suggested by commenters. Thus, we affirm the Commission’s previous decision that nursing homes, hospices, and other long-term care facilities are ineligible for support, whether operated on a for-profit or non-profit basis.⁵⁰ However, because Congress did specifically list seven categories of entities qualifying as health care providers, the Commission may clarify the types of entities that fit within those seven categories. Therefore, consistent with our clarification that entities that serve as a non-profit rural health care clinic on a part-time basis are “health care providers,” part-time non-profit rural health care clinics are eligible for prorated support, even when associated with a nursing home, hospice, or other long-term care facility.⁵¹

17. In addition, at this time, we decline to expand the definition of rural health care provider to include any rural, non-profit health care entity with a certified Medicare and/or Medicare provider number as proposed by commenters.⁵² The record lacks sufficient

⁴⁴ 47 C.F.R. § 54.601(d) as adopted herein.

⁴⁵ 47 U.S.C. § 254(h)(7)(B)(vi); *see infra* paras. 49-51 for discussion on allocating eligible and ineligible use.

⁴⁶ *Id.*

⁴⁷ *See, e.g.*, Avera Comments at 1; Cortland Co. Health Dept. Comments at 1; Univ. of Arizona Health Sciences Comments at 1; Arkansas DIS Reply Comments at 1.

⁴⁸ 47 U.S.C. § 254(h)(7)(B).

⁴⁹ 47 U.S.C. §254(h)(7)(B).

⁵⁰ *Fifteenth Order on Reconsideration*, 14 FCC Rcd at 18786, para. 48.

⁵¹ We thus reverse in part the Commission’s decision that non-profit nursing homes, hospices, and long-term care facilities are 100% ineligible. To the extent such entities function as rural health clinics, even on a part-time basis, they would be eligible for prorated support as described above. *See supra* para. 14.

⁵² *See* ATA Comments at 5; CTTC Comments at 4; Center for Telemedicine Law Comments at 5; Institute of Rural Health Comments at 5; MGHS Reply Comments at 6; Nevada State Office Comments at 4; Northwest (continued....)

information to identify the types of entities that would become eligible under this proposal, as Medicare/Medicaid supports a wide range of services, drugs, and products. We are concerned that by including such entities within the definition of “health care provider” we may exceed our statutory authority. Moreover, with the information in the record we are unable to determine the potential impact on the demand for support.

B. Eligible Services

1. Internet Access

18. *Background.* “Information services” are defined in the Act as “the offering of a capability for generating, acquiring, storing, transforming, processing, retrieving, utilizing, or making available information via telecommunications, and includes electronic publishing, but does not include any use of any such capability for the management, control, or operation of a telecommunications system or the management of a telecommunications service.”⁵³ Internet access is an information service that allows consumers, including rural health care providers, to access the Internet.⁵⁴ More specifically, Internet access allows users to “alter the format of information through computer processing applications such as protocol conversion and interaction with stored data.”⁵⁵

19. Section 254(h)(2)(A) provides that the Commission “shall establish competitively neutral rules to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for all public and non-profit elementary and secondary school classrooms, health care providers, and libraries”⁵⁶ Accordingly, the Act contemplates actions to enhance access to information services, such as Internet access, for rural health care providers.⁵⁷

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Telehealth Comments at 3; Poudre Valley Health Comments at 1; Univ. of Tennessee Health Science Comments at 3.

⁵³ 47 U.S.C. § 153(20).

⁵⁴ Fundamentally, the Internet is a global, packet switched network that enables interconnection between networks using Internet Protocol (IP). The Supreme Court has described the Internet as “an international network of interconnected computers.” *Reno v. ACLU*, 521 U.S. 844, 849-50 (1997). See also Kevin Werbach, *Digital Tornado: The Internet and Telecommunications Policy*, Office of Plans and Policy Working Paper Series 29, 15 (1997).

⁵⁵ *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report to Congress, 13 FCC Rcd 11501, 11516-17, para. 33 (1998) (*Report to Congress*) (citations and internal quotations omitted). See also *Appropriate Framework for Broadband Access to the Internet over Wireline Facilities, Universal Service Obligations of Broadband Providers, Computer III Further Remand Proceedings: Bell Operating Company Provision of Enhanced Services; 1998 Biennial Regulatory Review – Review of Computer III and ONA Safeguards and Requirements*, CC Docket Nos. 02-33, 95-20, 98-10, Notice of Proposed Rulemaking, 17 FCC Rcd 3019 nn.16-17, 27, 38 (2002) (*Wireline Broadband Internet Access NPRM*).

⁵⁶ 47 U.S.C. § 254(h)(2)(A).

⁵⁷ See *Texas Office of Public Utility Counsel*, 183 F.3d at 443-44 (affirming the Commission’s authority under section 254(h)(2)(A) to provide support to non-telecommunications carriers in their provision of Internet access and internal connections). See also *1997 Universal Service Order*, 12 FCC Rcd at 9107, para. 630.

20. In the *1997 Universal Service Order*, the Commission concluded that section 254(h)(2)(A) authorizes a universal service support mechanism to enhance access to information services, as long as the mechanism is competitively neutral, technically feasible, and economically reasonable.⁵⁸ The Commission declined, however, to provide support to rural health care providers for Internet access at that time due to the limited record and the complexity of the proposals.⁵⁹ Pursuant to section 254(h)(2)(A), the Commission did, however, provide limited support for toll charges incurred by all health care providers that could not obtain toll-free access to an ISP.⁶⁰

21. In the *NPRM*, the Commission sought comment on whether to provide support for Internet access provided to rural health care providers.⁶¹ The Commission also sought comment on the range of health care services and information that is available via the Internet, on the ability of the Internet to provide to rural communities the types of health care information that are available in urban areas, and, in general, on how health care providers can make use of the Internet to provide better health-related services.⁶² Finally, the Commission sought comment on whether demand for Internet access would likely increase total program demand above the \$400 million cap and how increased demand would affect the operation of the rural health care mechanism.⁶³

22. *Discussion.* Given the rapid development of the Internet's capacities, the proliferation of applications available on the Internet, and the increase in the number of Internet users since the *1997 Universal Service Order* was issued, we believe that it is now appropriate to provide funding for Internet access to rural health care providers.⁶⁴ In particular, we conclude that support equal to twenty-five percent of the monthly cost for any form of Internet access reasonably related to the health care needs of the facility should be provided to rural health care providers.⁶⁵ The definition for Internet access that we adopt here is intended to provide rural health care providers considerable flexibility to utilize the resources available over the Internet that will assist them in fulfilling their health care needs.

23. We agree with commenters that the Internet can serve as an invaluable resource, by

⁵⁸ *1997 Universal Service Order*, 12 FCC Rcd at 9109, para. 634. Indeed, the Commission specifically rejected the notion "that support for non-telecommunications services is . . . barred under . . . section 254(h)(2)." *Id.* See also 47 U.S.C. § 154(i).

⁵⁹ *1997 Universal Service Order*, 12 FCC Rcd at 9106-07, 9161, paras. 629-30, 749.

⁶⁰ *1997 Universal Service Order*, 12 FCC Rcd at 9107-08, para. 631; 47 U.S.C. § 254(h)(2)(A). The support was limited to the lesser of \$180.00 or 30 hours of usage per month, if a rural health care provider could not reach an ISP without incurring toll charges. *1997 Universal Service Order*, 12 FCC Rcd at 9159, para. 745.

⁶¹ *NPRM*, 17 FCC Rcd at 7815, para. 20.

⁶² *Id.* at 7816, para. 22.

⁶³ *Id.* at 7816, para. 25.

⁶⁴ See generally *1997 Universal Service Order*.

⁶⁵ 47 C.F.R. §§ 54.601(c)(2)(ii), 54.621(a) as adopted herein.

providing on-line courses in health education,⁶⁶ medical research,⁶⁷ follow-up care,⁶⁸ regulatory information such as compliance with the Health Insurance Portability and Accountability Act of 1996,⁶⁹ video conferencing,⁷⁰ web-based electronic benefit claim systems including on-line billing,⁷¹ and other crucial business functions.⁷² The incredible potential of the Internet to provide access to such a breadth of medical information may also help reduce isolation in rural communities.⁷³ In light of the development of medical applications for the Internet since 1997, we conclude that encouraging access to this information service will improve the level of care available in rural areas.

24. Furthermore, health care information shared over the Internet may enable rural health care providers to diagnose, treat, and contain possible outbreaks of disease or respond to health emergencies. We agree with commenters that Internet access provides a vital link to information and instantaneous communications in times of natural disasters and public health emergencies.⁷⁴ National connectivity of telehealth and telemedicine networks could also promote the national defense by serving as vehicles for rapid, secure communications in times of emergency,⁷⁵ due to outbreaks of disease or biological and chemical attacks.⁷⁶

⁶⁶ See Alaska Comments at 2; Alliance Comments at 1; Avera Comments at 2.

⁶⁷ See GCI Comments at 6-7.

⁶⁸ See Healthcare Anywhere Reply Comments at 4-9 (“Health care providers can use the Internet to receive immediate results of screenings for patients that is crucial to follow-up care. Patient compliance with follow-up care is more likely if a patient gets the results during his or her visit, gets advice on what to do next, and gets the opportunity to ask questions about his or her condition. A rural patient may need immediate results more than an urban patient because a rural patient is less likely to have a telephone for receiving results and setting up follow-up appointments.”).

⁶⁹ See Alliance Comments 5-6; David Bolt, Lewis Co. Primary Care Center, email 8/22/03; Kansas DHE Comments at 1; Kansas Hosp. Assoc. Comments at 1; *see also* Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 2021-31.

⁷⁰ See Washington Rural Comments at 1-2.

⁷¹ See Shannon Clark, Ashley County Medical Center, email 8/18/03; Kansas DHE Comments at 1; Kansas Hosp. Assoc. at 1.

⁷² See Kansas DHE Comments at 1; Kansas Hosp. Assoc. Comments at 1. “[A]nyone with access to the Internet may take advantage of a wide variety of communication and information retrieval methods...[such as] electronic mail (e-mail), automatic mailing list services (‘mail exploders,’ sometimes referred to as ‘listservs’), ‘newsgroups,’ ‘chat rooms,’ and the ‘World Wide Web.’ All of these methods can be used to transmit text; most can transmit sound, pictures, and moving video images. Taken together, these tools constitute a unique medium -- known to its users as ‘cyberspace’ -- located in no particular geographical location but available to anyone, anywhere in the world, with access to the Internet.” *Reno v. ACLU*, 521 U.S. at 851.

⁷³ See *NPRM*, 17 FCC Rcd at 7816, para. 22.

⁷⁴ See Adams Co. Health Dept. Comments at 2; Alliance Comments at 1-2; Cortland Co. Health Dept. Comments at 1; Lane Co. Health Dept. Comments at 2; NACCHO Comments at 1; NRHA Comments at 2; WGA Comments at 3.

⁷⁵ See Univ. of Arizona Health Sciences Comments at 2; Illinois Center for Rural Health Comments at 3; Kingston eHealth Comments 2, 4; Madden Comments at 2; NM Health Resources Comments at 3; NOSORH Comments at (continued....)

25. Accordingly, for purposes of the rural health care support mechanism only, we define “eligible Internet access” as “an information service that enables rural health care providers to post their own data, interact with stored data, generate new data, or communicate over the World Wide Web.”⁷⁷ Eligible Internet access provides access to the world-wide information resource of the Internet, and includes all features typically provided by Internet service providers to provide adequate functionality and performance. To qualify as Internet access under the definition we adopt today for the rural health care support mechanism, transmissions must traverse the Internet in some fashion. Internet access may provide transport of digital communications using any Internet-based protocols, including encapsulation of data, video, or voice.

26. We specifically decline to adopt the definition of Internet access currently used in the schools and libraries support mechanism. Under those rules, Internet access includes:

- (2) The transmission of information as part of a gateway to an information service, when that transmission does not involve the generation or alteration of the content of information, but may include data transmission, address translation, protocol conversion, billing management, introductory informational content, and navigational systems that enable users to access information services, and that do not affect the presentation of information to users[.]

47 C.F.R. § 54.5.

This definition thus specifically precludes support for features that provide the capability to generate or alter the content of information.⁷⁸ We believe adopting such a limitation for the rural health care program would significantly undercut the utility of providing support for Internet access to rural health care providers, because the ability to alter and interact with information over the Internet is precisely the feature that could facilitate improved medical care in rural areas. Under the rural health care support mechanism, we will provide support for Internet access, as long as it is reasonably related to the health care needs of the facility, and it is the most cost-effective method of meeting those needs.⁷⁹ We will not provide support, however, for the

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3; Tri-County Memorial Hosp. Comments at 2-3. *See also* The Telemedicine Response to Homeland Safety and Security: Developing a National Network for Rapid and Effective Response for Emergency Medical Care (2001), available at <http://www.americantelemed.org/news/homelandsecurity3.3.htm> (retrieved November 13, 2003) (ATA’s proposal regarding the use of telemedicine in support of homeland security).

⁷⁶ *See* Alliance Comments 5-6; FRC Reply Comments at 13; Kingston eHealth Comments 2, 4; Madden Comments at 2; Minn. Ambulance Assoc. Comments at 2; NRHA Comments at 2; Nevada State Office Comments at 6; NM Health Resources Comments at 3; NOSORH Comments at 3; Tri-County Memorial Hosp. Comments at 3.

⁷⁷ 47 C.F.R. § 54.601(c)(2)(i) as adopted herein.

⁷⁸ To implement this rule in the schools and libraries program, the Administrator utilizes cost allocation to provide partial funding to Internet access service that contains both eligible and ineligible features. If, however, the ineligible functionality is strictly ancillary to the principle use of the Internet access service, the full price of the service is eligible for discount. *See* Cost Allocation for Products and Services that Contain Eligible and Ineligible Components (2002), available at <http://www.sl.universalservice.org/reference/costallocationguide.asp> (retrieved November 13, 2003).

⁷⁹ *See supra* para. 22, *infra* para. 28.

purchase of internal connections, computer equipment or other telecommunications equipment, even when used to access the Internet, because such items are not information services.

27. We conclude that a flat discount percentage of twenty-five percent off the cost of monthly Internet access will assist health care providers seeking to purchase Internet access, while also providing incentives for rural health care providers to make prudent economic decisions concerning their telemedical needs.⁸⁰ We agree with commenters that a flat discount, analogous to the operation of the schools and libraries support mechanism, will lead to greater predictability and fairness among health care providers.⁸¹ A flat discount is consistent with section 254(b)(5), which requires “a specific, sufficient, and predictable mechanism . . . because it limits the amount of support that each health care provider may receive per month to a reasonable level.”⁸² A flat discount is also easy to administer. Although it is difficult to estimate the impact of providing support for Internet access service due to the wide range of costs between and among the various types of Internet access services,⁸³ we agree with commenters’ projections that our actions today regarding Internet access are unlikely to result in program demand in excess of the cap.⁸⁴ We act conservatively by choosing a twenty-five

⁸⁰ Rural health care providers can use this discount towards the cost of monthly charges for information services only. *See supra* para. 18 (defining “information services”). Support for telecommunications services is not included under this discount. The Act defines “telecommunications service” as “the offering of telecommunications for a fee directly to the public, or to such classes of users as to be effectively available directly to the public, regardless of the facilities used.” 47 U.S.C. § 153(46).

⁸¹ *See* Alaska Comments at 3; Avera Comments at 2; Florida PSC Comments at 6; Kingston eHealth Comments at 7.

⁸² *1997 Universal Service Order*, 12 FCC Rcd at 9159-60, para. 746; 47 U.S.C. § 254(b)(5).

⁸³ Commenters state that the monthly cost of Internet access in rural areas ranges from \$21.95 to \$800 for DSL, \$45 to \$400 for cable modem, \$40 to \$300 for wireless, \$30 to \$13,000 for satellite, \$200 to \$1046 for T-1, and \$9.95-\$26.95 for dial-up. *See* Jason Wulf, Avera Health, email 8/18/03 (\$21.95/month for DSL); Andy Adams, Murray Hospital, email 8/19/03 (\$60/month for DSL); Cheri Colliton, Perham Memorial Hospital and Home, Perham, MN, email 8/22/03 (\$200-800/month for DSL); Andy Adams, Murray Hospital, email 8/19/03 (\$45/month for cable modem); Karen Thuli, Upland Hills Health, email 8/19/03 (\$140/month for cable modem); Robert Shwajlyk, Nathan Littauer Hospital, Gloversville, NY, email 8/18/03 (\$399.25/month for cable modem); Stephanie Burnfin, Wright Memorial Hospital, email 8/19/03 (\$40/month for wireless); Jason Wulf, Avera Health, email 8/18/03 (\$44.95/month for wireless); Bill Brennan, Saint Francis Medical Center, Grand Island, NE, email 8/19/03 (\$250-300/month for wireless); Nancy Erickson, Kossuth Regional Health Center, Algona, IA, email 8/18/03 (\$30-44/month for satellite); Larry Pergerson, Scotland Health, email 8/18/03 (\$110/month for satellite); Val Warzewick, Yukon-Kuskokwim Health Corporation, Bethel, Alaska, email 8/19/03 (\$13,000/month for satellite); Karen Thuli, Upland Hills Health, email 8/19/03 (\$200/month for T-1); Lee Benson, Faith Regional Health Services, email 8/18/03 (\$900/month for T-1); Rick Tighe, County Hospital, Atlantic, Iowa, email 8/18/03 (\$1046/month for T-1); Chris Gillespie, Dickinson County, email 8/18/03 (\$9.95/month for dial-up); Rick Tighe, County Hospital, Atlantic, Iowa, email 8/18/03 (\$19.95/month for dial-up); Jerry Clayton, Kodiak, AK, email 8/18/03 (\$26.95/month for dial-up).

⁸⁴ *See* Adams Co. Health Dept. Comments at 2; Alliance Comments at 6; Cortland Co. Health Dept. Comments at 2; Lane Co. Health Dept. Comments at 2; NACCHO Comments at 2; NRHA Comments at 2; UVA Comments at 15; Verizon Comments at 4. For example, some commenters projected that assuming 10,000 rural health care providers took advantage of support for Internet access at a rate of approximately \$100 per month, the annual expenditure for Internet access would be \$12 million. *See* Cortland Co. Health Dept. Comments at 2; Lane Co. Health Dept. Comments at 2; NACCHO Comments at 2; NRHA Comments at 2. Assuming, *arguendo*, that all 8,300 eligible providers were to request funding under this mechanism, on a pro-rata basis, that would be roughly (continued....)

percent flat discount initially because it will provide an incentive for rural health care providers to choose a level of service appropriate to their needs, will provide more certainty that demand for Internet access support will not exceed the annual funding cap, and will deter wasteful expenditures. Furthermore, we find that a twenty-five percent discount is reasonable because provision of support to health care providers under the rural health care support mechanism is not contingent on economic need, similar to the twenty-five percent discount provided to the least disadvantaged rural schools and libraries.⁸⁵ As we gain more experience with this aspect of the support mechanism, we will determine whether an increase in the discount is necessary or advisable. Finally, we disagree with WorldCom that support for Internet access must be based on the difference between urban and rural rates, because section 254(h)(2)(A) of the Act, the statutory provision dealing with information services, makes no reference to an urban-rural comparison, unlike section 254(h)(1)(A).⁸⁶ The urban-rural comparison for telecommunications services that Worldcom cites to in section 254(h)(1)(A) does not apply to information services such as Internet access.⁸⁷ Provision of Internet access and other information services is governed by section 254(h)(2)(A).⁸⁸

28. Consistent with the Commission's long-standing principles of competitive neutrality, rural health care providers may receive discounts for the most cost-effective form of Internet access, regardless of the platform.⁸⁹ Thus, a provider could opt for dial-up Internet access or broadband Internet access over wireline, cable, wireless, or satellite platforms.⁹⁰ Health care providers must certify, however, that the particular Internet access service selected is the most cost-effective way of meeting the facility's health care needs.⁹¹ We believe this policy will provide flexibility to rural health care providers to purchase the most appropriate offerings for their health care needs and may also facilitate the deployment of facilities-based broadband

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\$48,000 per provider (\$400 million/8,300). It is unlikely that most entities would receive yearly Internet access discounts anywhere close to this amount. An entity would need to be spending almost \$200,000 per year, or \$16,666 per month, to obtain discounts equivalent to roughly \$48,000, given the twenty-five percent discount we adopt today.

⁸⁵ 47 C.F.R. § 54.505(c).

⁸⁶ See WorldCom Comments at 5-6 (agreeing that the Commission has the authority to subsidize Internet access but only the difference between rates for urban and rural Internet access); 47 U.S.C. §§ 254(h)(1)(A), 254(h)(2)(A). *But see* Intelenet Comments at 5; Kingston eHealth Comments at 7-8; Nevada State Office Comments at 6 (agreeing that no urban-rural comparison is necessary).

⁸⁷ 47 U.S.C. §§ 254(h)(1)(A), 254(h)(2)(A).

⁸⁸ 47 U.S.C. § 254(h)(2)(A).

⁸⁹ See 47 U.S.C. § 254(h)(2); *1997 Universal Service Order*, 12 FCC Rcd at 8801-02, paras. 46-49. We note that health care providers in rural insular areas will be able to receive the twenty-five percent discount off the cost of Internet access even if they are located in the most populous area in the State because no urban-rural comparison is required. See *infra* para. 47.

⁹⁰ The comments we received showed that most health care providers prefer broadband technology to dial-up. See Adams Co. Health Dept. Comments at 2; ATA Comments at 11-12; CTL Comments at 11-12; Evangelical Lutheran Comments at 2; GCI Reply Comments at 3-4; Healthcare Anywhere Reply Comments at 4-5.

⁹¹ See *infra* note 184 (defining "cost-effective method").

deployment in rural areas.⁹²

29. Moreover, we will continue to provide support for toll charges incurred by health care providers that cannot obtain toll-free access to an ISP, limited to the lesser of \$180.00 or 30 hours of usage per month.⁹³ The *1997 Universal Service Order* stated that the proliferation of ISPs and the competitive marketplace “soon should eliminate the need for such support.”⁹⁴ However, we are persuaded by commenters’ showings that the need for such support still exists.⁹⁵ Providing support for limited toll charges will place those providers who cannot reach an ISP without incurring toll charges on the same footing as other health care providers with respect to Internet access.

2. Other Services

30. We decline at this time to provide support for services other than telecommunications services, Internet access, and limited toll charges. In the *NPRM*, the Commission sought comment on whether we should establish new policies to enhance access to advanced telecommunications and information services for health care providers consistent with the scope of our authority under section 254(h)(2)(A).⁹⁶ Commenters suggested that telecommunications equipment, surcharges imposed by statewide or regional networks, internal connections, and health care providers’ travel costs should be eligible for universal service support.⁹⁷ We find that providing support for telecommunications equipment, surcharges, and travel costs exceeds the scope of our statutory authority under section 254(h), because these items are neither telecommunications nor information services.⁹⁸ In addition, we believe there is insufficient information in the record to provide support for internal connections. Moreover, given our experience with the schools and libraries support mechanism, we are concerned that providing support for internal connections may place an undue burden on the rural health care support mechanism.

⁹² *Accord* Cortland Co. Health Dept. Comments at 2; Evangelical Lutheran Comments at 2; GCI Comments at 7; Intelnet Comments at 6; Lane Co. Health Dept. Comments at 2; NRHA Comments at 2.

⁹³ 47 C.F.R. §§ 54.601(c)(2), 54.621.

⁹⁴ *1997 Universal Service Order*, 12 FCC Rcd at 9161, para. 748.

⁹⁵ *See, e.g.*, Alaska Comments at 3; Arkansas DIS Reply Comments at 1; Florida PSC Comments at 4-6; PA Public Utility Reply Comments at 7. *But see* Alliance Comments at 1-2; AHA Comments at 4-5; Avera Comments at 1 (advocating elimination of discounts for toll charges).

⁹⁶ *NPRM*, 17 FCC Rcd at 7817, para. 26.

⁹⁷ *See* Illinois Center for Rural Health Comments at 3; Washington Rural Comments at 2.

⁹⁸ 47 U.S.C. § 254(h). We have previously concluded that the provision of universal service support for telecommunications equipment is outside the scope of our statutory authority. *See Fifteenth Order on Reconsideration*, 14 FCC Rcd at 18780-82, paras. 38-40.

C. Calculation of Discounted Services

1. Interpretation of “Similar Services”

31. *Background.* Section 254(h)(1)(A) of the Act provides that “[a] telecommunications carrier shall, upon receiving a bona fide request, provide telecommunications services which are necessary for the provision of health care services in a State, including instruction relating to such services, to any public or nonprofit health care provider that serves persons who reside in rural areas in that State at rates that are reasonably comparable to rates charged for *similar* services in urban areas in that State.”⁹⁹ Our rules do not define “similar” for purposes of comparing urban and rural services.¹⁰⁰ The Commission’s policy has been to calculate discounts for telecommunications services based on the difference between the urban and rural rates for technically similar services.¹⁰¹

32. In the *NPRM*, the Commission sought comment on whether the “similarity” of urban and rural services should be determined on the basis of functionality from the perspective of the end user, rather than on the basis of whether urban and rural services are technically similar.¹⁰² The Commission recognized that the current policy may create inequities between urban and rural health care providers.¹⁰³ Specifically, the Commission sought comment on whether comparisons should be made between or among different types of high-speed transport offered by telecommunications carriers that may be viewed as functionally equivalent by end users.¹⁰⁴

33. *Discussion.* We alter our current policy to allow rural health care providers to compare the urban and rural rates for *functionally* similar services as viewed from the perspective of the end user. We agree with commenters that our current policy of comparing technically similar services does not take into account that certain telecommunications services offered in urban areas are not always available in rural areas.¹⁰⁵ In particular, new technologies are often first deployed in urban areas, and such services may be less expensive than services in rural areas based on older technologies. This modification to our rules will better effectuate the mandate of Congress to ensure comparable services for rural areas, as provided in section 254 of the Act, by allowing rural health care providers to benefit from obtaining telecommunications services at rates equivalent to those in urban areas.¹⁰⁶ Eligible health care providers must

⁹⁹ 47 U.S.C. § 254(h)(1)(A) (emphasis added).

¹⁰⁰ See 47 C.F.R. §§ 54.605, 54.607, 54.609.

¹⁰¹ See “Form 466” Instructions, OMB 3060-0804 (April 2001) at 6 (line 30); *NPRM*, 17 FCC Rcd at 7819, para. 34.

¹⁰² *NPRM*, 17 FCC Rcd at 7819, para. 35.

¹⁰³ *Id.* at para. 34.

¹⁰⁴ *Id.* at para. 35.

¹⁰⁵ See Illinois Center for Rural Health Comments at 2; Kansas DHE Comments at 2; NM Health Resources Comments at 2; NOSORH Comments at 2; Tri-County Memorial Hosp. Comments at 2; Washington Rural Comments at 3.

¹⁰⁶ 47 U.S.C. § 254.

purchase telecommunications services and compare their service to a functionally equivalent telecommunications service in order to receive this discount.

34. Accordingly, we create “safe harbor” categories of functionally equivalent services based on the advertised speed and nature of the service. For purposes of the rural health care support mechanism only, we establish the following advertised speed categories as functionally equivalent: low – 144-256 kbps; medium – 257-768 kbps; high – 769-1400 kbps (1.4 mbps); T-1 – 1.41-8 mbps;¹⁰⁷ T-3 – 8.1-50 mbps. We will also consider whether a service is symmetrical or asymmetrical when determining functional equivalencies. Telecommunications services will be considered functionally similar when operated at advertised speeds within the same category (low, medium, high, T-1, or T-3) and when the nature of the service is the same (symmetrical or asymmetrical). For example, a symmetrical fractional T-1 service operating at an advertised speed of 144 kbps would be considered functionally similar to a symmetrical DSL transmission service with an advertised speed of 256 kbps.¹⁰⁸ By developing “safe harbor” categories of functionally equivalent speeds, we hope to minimize the disparity in rates of services available in rural and urban areas in an administratively easy fashion. We will update these categories, as needed, to reflect technological developments.

2. Urban Area

35. *Background.* Section 254(h)(1)(A) of the Act directs us to provide support for “rates that are reasonably comparable to rates charged for similar services in urban areas in that State.”¹⁰⁹ Thus, under our current rules, for service charges that are not distance-based, qualifying entities receive discounts for the difference, if any, between the urban rate¹¹⁰ and the rural rate¹¹¹ charged for the service.¹¹² The urban rate is based on the rate for similar services in

¹⁰⁷ For purposes of categorizing functionally similar services, E-1 service is equivalent to US T-1 service.

¹⁰⁸ We specifically refer to rates for a DSL transmission service, and not to rates for a DSL-based Internet access service. The Commission has not determined whether DSL-based Internet access is an information service, or telecommunications service. *See generally Wireline Broadband Internet Access NPRM.* We also decline, at this time, to consider, for purposes of making a comparison of functionally similar services, cable modem services to be a telecommunications service, pending the issuance of a non-appealable final judicial decision concluding that it constitutes a telecommunications service. *See generally Brand X Internet Services v. FCC*, No. 02-70518, FCC No. FCC-Act 2-77, 2003 WL 22283874 (9th Cir. 2003) (*Brand X v. FCC*).

¹⁰⁹ 47 U.S.C. § 254(h)(1)(A).

¹¹⁰ The urban rate is currently defined as a rate no higher than the highest tariffed or publicly-available rate charged to a commercial customer for a similar service provided over the same distance in the nearest city in the state with a population of at least 50,000. 47 C.F.R. § 54.605(a) (2003). However, if a rural health care provider is seeking discounts for services provided over a distance that is greater than the standard urban distance (SUD) (the average of the longest diameters of all cities with a population of 50,000 or more within the state) for that state, the urban rate for purposes of the calculation is the rate charged for a similar service provided over the SUD in the nearest city in the state with a population of at least 50,000. 47 C.F.R. § 54.605(b) (2003).

¹¹¹ The current rural rate is 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. 47 C.F.R. § 54.607(a) (2003).

¹¹² 47 C.F.R. § 54.609(a).

the “nearest large city,” defined as “the city located in the eligible health care provider’s state, with a population of at least 50,000, that is nearest to the healthcare provider’s location, measuring point to point, from the health care provider’s location to the point on that city’s jurisdictional boundary closest to the health care provider’s location.”¹¹³

36. In the *NPRM*, the Commission sought comment on whether to alter our rules to allow comparison of rural rates with rates in any urban area in the state, not only comparison with the rates in the nearest city with a population of over 50,000.¹¹⁴ The Commission noted that evidence suggests that the largest cities in a state have significantly lower rates and more service options than the nearest city of at least 50,000 to the health care provider.¹¹⁵ The Commission also sought comment on whether this proposal is the best way to effectuate the statutory mandate.¹¹⁶ Finally, the Commission also invited comment on the potential effect this change may have on demand for support under the rural health care mechanism.¹¹⁷

37. *Discussion.* We now revise section 54.605 of our rules to allow rural health care providers to compare rural rates to urban rates in any city with a population of at least 50,000 in the state, as opposed to the nearest city with a population of 50,000.¹¹⁸ The Commission originally required comparison to the nearest city with 50,000 people, in part, because they believed health care providers would likely connect to a point in that nearest large city.¹¹⁹ Based on our experience with the program and information in the record, health care providers may not always find the needed expertise in the nearest large city.¹²⁰ Allowing comparison to rates in any city in the state acknowledges that rural health care providers may communicate with experts in other cities in the state. Such action also should allow rural health care providers to benefit from the lowest rates for services in the State, thereby providing additional support to develop better telemedicine links. Verizon asserts that, under this policy, rural health care providers may receive better rates than those available in some urban areas of the state.¹²¹ However, we believe that the public interest in providing more flexibility in utilizing telemedicine services and quality health care facilities outweighs any minimal advantage gained

¹¹³ 47 C.F.R. § 54.605(c).

¹¹⁴ *NPRM*, 17 FCC Rcd at 7821, para. 42.

¹¹⁵ *Id.*

¹¹⁶ *Id.* at para. 43.

¹¹⁷ *Id.*

¹¹⁸ 47 C.F.R. § 54.605 as adopted herein. For example, if a rural health care provider is charged by its telecommunications provider \$250.00 for installation of an ISDN-128 Kbps line, and is charged \$175.00 monthly for the service, but the urban rate in a city in the state is only \$150.00 for installation and \$100.00 per month for service, the telecommunications service provider would give the rural health care provider a one-time installation credit of \$100.00 and give a discount of \$75.00 monthly.

¹¹⁹ *1997 Universal Service Order*, 12 FCC Rcd at 9125, para. 670.

¹²⁰ *See, e.g.*, CA Primary Care Assoc. Comments at 2; NSRHN Comments at 9.

¹²¹ *See* Verizon Comments at 14; *see also* WorldCom Comments at 8.

by rural health care providers over those health care providers located in certain urban areas.¹²² Further, we do not believe the urban rates within states differ so significantly that revising this rule will increase demand to the extent that we may risk exceeding the funding cap of \$400 million.

3. Maximum Allowable Distance

38. *Background.* Pursuant to our rules, the Administrator determines the “standard urban distance,” (SUD) which is the average of the longest diameters of all cities in the state with a population of at least 50,000.¹²³ The Administrator also calculates the Maximum Allowable Distance (MAD), which is the distance between the rural health care provider and the farthest point on the jurisdictional boundary of the nearest large city in the state with a population of at least 50,000.¹²⁴ Under our rules, for distance-based charges, qualifying entities that connect to locations within or outside of the state receive discounts for services over any distance greater than the SUD but less than the MAD.¹²⁵

39. In the *NPRM*, the Commission sought comment on whether to eliminate or revise the MAD restriction in our rules.¹²⁶ The Commission further invited comment on, in lieu of eliminating the restriction, whether it should modify it or adopt another limitation, such as the greatest distance between the location of the rural health care provider and the furthest point on the border of the same state or the distance between the health care provider and the nearest point of tertiary care.¹²⁷

40. *Discussion.* We revise the MAD to equal the distance between the rural health care provider and the farthest point on the jurisdictional boundary of the largest city in that State.¹²⁸

¹²² Numerous commenters support modification of this rule to permit rural health care providers to receive support based on a comparison to the lowest rates available in any urban area in the state. *See* Adams Co. Health Dept. Comments at 3; Alaska Comments at 4; AHA Comments at 7; ASTA Comments at 8-12; ATA Comments at 6; Arkansas DIS Reply Comments at 2; Blue Cross Comments at 6; CA Primary Care Assoc. Comments at 2; CTTC Comments at 6; Illinois Center for Rural Health Comments at 1-2; CTL Comments at 6; Cortland Co. Health Dept. Comments at 2; Healthcare Anywhere, Inc. Comments at 5; Institute of Rural Health Comments at 6; Kansas DHE Comments at 2; Kansas Hosp. Assoc. Comments at 2; Madden Comments at 1; Kingston eHealth Comments at 5; Lane Co. Health Dept. Comments at 2; MGHS Reply Comments at 4-5; Minn. Ambulance Assoc. Comments at 2; MHTA Comments at 3; NACCHO Comments at 2; NRHA Comments at 2; NTCA Comments at 7; Nebraska Office of Rural Health Comments at 1; NM Health Resources Comments at 1; NSRHN Comments at 9; NOSORH Comments at 2; Poudre Valley Health Comments at 1; Tri-County Memorial Hosp. Comments at 1; UVA Comments at 14-15; Washington Rural Comments at 3; WGA Comments at 3.

¹²³ 47 C.F.R. § 54.605(d).

¹²⁴ 47 C.F.R. § 54.613.

¹²⁵ 47 C.F.R. § 54.609. For example, if a rural health care provider has a dedicated T-1 line from its site to an urban hospital with a circuit distance of 100 miles, the MAD is 125 miles, the carrier charges \$10 per mile for the line, and the SUD in the state is 10 miles, it would be eligible for \$900 discount per month (the circuit distance of 100 miles less the SUD of 10 miles, multiplied by the rate of \$10 per mile per month).

¹²⁶ *NPRM*, 17 FCC Rcd at 7822, para. 45.

¹²⁷ *Id.* at 7823, para. 48.

¹²⁸ 47 C.F.R. § 54.625(a) as adopted herein.

Accordingly, for distance-based charges actually incurred, we modify our rules to provide support to rural health care providers to any location that exceeds the SUD and is less than this revised MAD.¹²⁹ As the Commission indicated in the *NPRM*, our experience to date suggests that limiting rural health care providers to discounts for distance-based charges to the nearest city of 50,000 or more may not be adequate for purposes of creating a comprehensive telehealth and telemedicine network.¹³⁰ Further, commenters contend that the current MAD assumes that the rural health care provider will connect with specialists in the nearest urban area, which may not necessarily have the essential complement of specialists to provide telemedicine services.¹³¹ We believe, in most instances, calculating the MAD as described above will provide more support for distance-based charges than our current rules, without creating additional administrative burdens for the Administrator. In addition, this modification should provide rural health care providers access to high levels of care and greater flexibility in developing appropriate telehealth networks.

41. Although commenters generally favor eliminating the MAD,¹³² we decline to do so at this time. We are concerned that eliminating the MAD could result in wasteful expenditures for the program, as providers could connect to more distant locations when a closer one would suffice. Expanding the MAD to the largest city in a state should provide support sufficient to enable rural health care providers to connect with health care facilities with a wide range of medical expertise, without introducing the potential for waste associated with eliminating the MAD or making the MAD equal to the furthest point in the state. Moreover, we decline to expand the MAD to equal the distance between the health care provider and the nearest center of tertiary care.¹³³ Although this proposal may have a more direct relationship to health care services, we agree with commenters that the nearest point of tertiary care may not provide the required specialized expertise.¹³⁴ In addition, this proposal would require the identification and continued monitoring of all tertiary care centers throughout the Nation, which would impose significant administrative burdens upon the Administrator of the program.

¹²⁹ 47 C.F.R. § 54.609(a)(1)(ii) as adopted herein.

¹³⁰ *NPRM*, 17 FCC Rcd at 7822, para. 45; *see* Adams Co. Health Dept. Comments at 2; AFHCAN Comments at 7; AHA Comments at 7; CA Primary Care Assoc. Comments at 2; Cortland Co. Health Dept. Comments at 3; Institute of Rural Health Comments at 7; NACCHO Comments at 2; NRHA at 2.

¹³¹ *See, e.g.*, CA Primary Care Assoc. Comments at 2; NSRHN Comments at 9.

¹³² *See, e.g.*, Adams Co. Health Dept. Comments at 2; AFHCAN Comments at 7; Alaska Comments at 5; Alaska Telehealth Comments at 3; ASTA Comments at 8; Arkansas DIS Reply Comments at 2; Blue Cross Comments at 7; CA Primary Care Assoc. Comments at 2; Tri-County Memorial Hosp. Comments at 1; Washington Rural Comments at 2; WGA Comments at 3.

¹³³ The Commission sought comment on this option in the *NPRM*. *NPRM*, 17 FCC Rcd at 7823, para. 48. Noting that it was unable to identify the criteria for determining the nearest point of tertiary care, the Commission also sought comment on how to define the point of tertiary care. No commenter submitted information on the definition of a point of tertiary care.

¹³⁴ *See* NSRHN Comments at 10 (opposing limiting MAD to nearest point of tertiary care in part because not all tertiary care services are offered in all urban communities); *see also* Kingston eHealth Comments at 5-6 (noting that the Pacific jurisdictions lack tertiary hospitals with specialty care).

4. Satellite Services

42. *Background.* Under the Commission's policies, as indicated above, the cost of rural satellite service is compared to the cost of urban satellite service.¹³⁵ Because the price of satellite service typically does not vary by location, rural health care providers using satellite services generally do not receive discounts under the rural health care program.¹³⁶ However, there is an exception that allows for some support for satellite service. Rural health care providers that are located in areas with no terrestrial-based alternative may compare rural satellite rates to urban wireline rates, which results in support for such providers.¹³⁷

43. In the *NPRM*, the Commission sought comment on whether to modify our rules governing discounts for satellite services.¹³⁸ Specifically, the Commission sought comment on how a modification to our current policy to base discounts on the difference in urban and rural rates between functionally similar services would affect health care providers seeking discounts for satellite services.¹³⁹ The Commission recognized that rural health care providers using satellite services, particularly in remote and insular areas, have been disadvantaged under our current policy because, in many instances, satellite systems provide the only viable means for providers to receive telecommunications services.¹⁴⁰

44. *Discussion.* We revise our policy to allow rural health care providers to receive discounts for satellite services even where alternative terrestrial-based services may be available. As suggested by commenters, however, these discounts will be capped at the amount providers would have received if they purchased functionally similar terrestrial-based alternatives.¹⁴¹ Providers seeking discounts for satellite services will be required to provide to the Administrator documentation of the urban and rural rates for the terrestrial-based alternative services. We believe imposing a cap on support for satellite service is necessary because satellite services are often significantly more expensive than terrestrial-based services. Thus, pursuant to these changes, where rural health care providers opt for more expensive satellite-based services when a cheaper terrestrial-based alternative is available, the provider, and not the support mechanism, will be responsible for the additional cost. For example, if a health care provider pays \$100 per month for satellite service, the rural rate for a comparable wireline service plan is \$60 per month, and the urban rate is \$40 per month, the health care provider would receive \$20 per month towards the satellite service. We conclude this approach furthers

¹³⁵ See *supra* para. 35; 47 C.F.R. §§ 54.605, 54.607, 54.609.

¹³⁶ *NPRM*, 17 FCC Rcd at 7820, para. 38.

¹³⁷ Currently, only rural health care providers in Alaska have received support for satellite services pursuant to this policy.

¹³⁸ *NPRM*, 17 FCC Rcd at 7820, para. 38.

¹³⁹ *Id.*

¹⁴⁰ *Id.*

¹⁴¹ See Kansas DHE Comments at 2; Kansas Hosp. Assoc. Comments at 3; UVA Comments at 14; MSV Reply Comments at 6 (suggesting the Commission compare the rural terrestrial cost of mobile services to the urban terrestrial cost and apply that same discount to satellite).

the principle of competitive neutrality and recognizes the role that satellite services may play in rural areas without unduly increasing the size of the fund. We also seek further comment in the accompanying *Further Notice* on whether additional rule changes should be adopted to facilitate support for mobile rural health care providers.¹⁴²

5. Insular Areas

45. *Background.* Section 254(h)(1)(A) provides that telecommunications carriers must offer telecommunications services to rural health care providers “at rates that are reasonably comparable to rates charged for similar services in urban areas *in that State*.”¹⁴³ Consistent with this statutory language, for purposes of calculating the “urban rate” to determine the amount of universal service support received by rural health providers in insular areas,¹⁴⁴ the Commission looks at the rates charged customers for a similar service in the largest population center in the State.¹⁴⁵ The Commission, however, has recognized that use of this calculation may be ill-suited for insular areas because many rural health care providers are located in the largest population center in the territory, which results in no recognizable urban/rural rate comparison.¹⁴⁶ Accordingly, in the *NPRM*, the Commission sought comment on whether section 254(h)(2)(A) gives us the authority to allow rural health care providers to receive discounts by comparing the rural rate to the nearest large city outside of their “State.”¹⁴⁷ The Commission also sought comment on alternative means for addressing the problems of insular areas, consistent with section 254.¹⁴⁸

46. *Discussion.* Although we continue to recognize that using urban rates within a State as the benchmark for reasonable rates may be ill-suited to certain insular areas, we believe that the proposal of some commenters¹⁴⁹ to permit the comparison of insular rural rates to the

¹⁴² See *infra* paras. 64-67.

¹⁴³ 47 U.S.C. § 254(h)(1)(A) (emphasis added). The Commission determined that the provisions of section 254(h)(1)(A) apply to insular areas because the Act defines “State” to include all “territories and possessions” of the United States. 47 U.S.C. §153(40); see *1997 Universal Service Order*, 12 FCC Rcd at 9135, para. 692.

¹⁴⁴ The term “insular area,” includes but is not limited to, American Samoa, the U.S. Virgin Islands, Commonwealth of the Northern Mariana Islands, Guam and Puerto Rico. *1997 Universal Service Order*, 12 FCC Rcd at 9136, para. 695 n.1820.

¹⁴⁵ 47 C.F.R. §§ 54.605-609 (2003). The Commission designated the largest population center as the urban area for insular areas since many insular areas do not have cities with populations as large as 50,000. *1997 Universal Service Order*, 12 FCC Rcd at 9136-38, paras. 693-69.

¹⁴⁶ *NPRM*, 17 FCC Rcd at 7823-24, para. 49.

¹⁴⁷ *Id.* at 7824, para. 50. The Commission also sought comment in the *Unserved and Underserved Areas Further Notice* on this specific issue. *Federal-State Joint Board on Universal Service; Promoting Deployment and Subscriberhip in Unserved and Underserved Areas, Including Tribal and Insular Areas*, CC Docket No. 96-45, Further Notice of Proposed Rulemaking, 14 FCC Rcd 21177, 21235-36, para. 143 (1999) (*Unserved and Underserved Area Further Notice*).

¹⁴⁸ *NPRM*, 17 FCC Rcd at 7824, para. 50.

¹⁴⁹ See, e.g., Alaska Comments at 5; American Samoa Medical Center Comments at 2; ASTA Comments at 3-6; ATA Comments at 13; CTL Comments at 13; Guam Dept. of PHSS Comments at 1. Specifically, they suggest (continued....)

nearest urban area outside the State is inconsistent with the statutory language set forth in section 254(h)(1)(A).¹⁵⁰ As the Commission indicated in the *Fifteenth Order on Reconsideration*, Congress could have provided discounts for telecommunications services that connect rural health care providers to the nearest major hospital within or outside the State.¹⁵¹ Congress, however, explicitly provided that rates should be compared to the urban rate in that State.¹⁵² We continue to believe section 254(h)(1)(A) precludes us from designating an urban area outside of the State as the benchmark for comparison for remote, insular areas.¹⁵³

47. We also disagree with American Samoa Telecommunications Authority that section 254(h)(2)(A) authorizes the Commission to provide support for telecommunication links between American Samoa to an urban center outside the territory, such as Honolulu, Hawaii, without regard to the urban-rural rate difference.¹⁵⁴ Section 254(h)(2)(A) authorizes the Commission to take action to increase access to advanced telecommunications and information services.¹⁵⁵ Support for telecommunications services, however, is provided subject to section 254(h)(1)(A) and as discussed herein, requires an urban to rural comparison within the State. Although we do not believe we can grant the request of providers in insular areas, we do provide support for Internet access for all eligible rural health care providers, including those in insular areas, which we believe will functionally provide significant support to health care providers in insular areas.¹⁵⁶

D. Other Changes to the Rural Health Care Support Mechanism

1. Allocation Guidelines and Record-Keeping Requirements

48. *Background.* Under the Commission's rules, rural health care providers that receive support under the rural health care universal service support mechanism are subject to record-keeping and record production requirements, and random audits to ensure compliance.¹⁵⁷ In the *NPRM*, we sought comment on the effectiveness of our current rules regarding audits, and other

(Continued from previous page) _____
designating Honolulu, Hawaii, as the urban center for comparison for insular areas. *See, e.g.*, American Samoa Medical Center Comments at 2; FRC Reply Comments at 4; Guam Dept. of PHSS Comments at 1; Guam Memorial Hosp. Comments at 2; HTC Reply Comments at 2; IT & E Comments at 1-2.

¹⁵⁰ 47 U.S.C. § 254(h)(1)(A).

¹⁵¹ *Fifteenth Order on Reconsideration*, 14 FCC Rcd at 18784, para. 44.

¹⁵² 47 U.S.C. § 254(h)(1)(A).

¹⁵³ *Id.*

¹⁵⁴ ASTA Comments at 11.

¹⁵⁵ 47 U.S.C. § 254(h)(2)(A).

¹⁵⁶ For example, if an eligible rural health care provider in American Samoa purchased Internet access via satellite, it would receive a twenty-five percent discount on the price for that service. *See supra* paras. 27-28.

¹⁵⁷ *See generally* 47 C.F.R. § 54.619.

procedures to ensure the appropriate use of funds available under this support mechanism.¹⁵⁸

49. *Discussion.* Because entities that engage in both eligible and ineligible activities or that collocate with an entity that provides ineligible services will now be eligible for prorated support, we adopt rules requiring such providers to allocate their discounts to prevent discounts from flowing to ineligible activities or providers of services.¹⁵⁹ Prorated discounts will be provided commensurate only with entities' eligible activities. The method of cost allocation chosen by an applicant should be based on objective criteria, and reasonably reflect the eligible usage of the facilities.¹⁶⁰ Thus, if telecommunications facilities are used jointly for eligible and ineligible purposes, the allocation should be based on the percentage of time the facility is used for eligible purposes or some other method that reasonably reflects eligible usage. Health care providers must keep documentation explaining their allocation methods for five years and present that information to USAC upon request.¹⁶¹ We also direct USAC to evaluate the allocation methods selected by program participants in the course of its audit activities to ensure program integrity. Additionally, we codify the requirement that health care providers must maintain records for their purchases of supported services for at least five years sufficient to document their compliance with all Commission requirements.¹⁶²

50. To illustrate the general principle of discount allocation, we provide several "safe harbor" examples of allocation methods. First, if a dedicated emergency department in a for-profit rural hospital shares access to a T-3 with the rest of the hospital, and the T-3 is used seventy-five hours per week related to EMTALA-emergency care and the education of health care professionals who work in the dedicated emergency department and fifty hours per week related to other hospital use, the T-3 would be used for eligible purposes sixty percent of the time (seventy-five hours of use by emergency department divided by 125 total hours of use by the entire hospital). Therefore, the eligible dedicated emergency department would receive sixty percent of the difference between the urban and rural rate for the T-3. Second, another dedicated emergency department in a for-profit rural hospital that shares access to a T-3 with the rest of the hospital, might choose to allocate discounts based on employee hours. For example, if the emergency department staff, including on-call physicians, is staffed at 3,360 hours per week (twenty employees covering 168 hours per week), and the rest of the hospital is staffed at 4,000 hours per week (100 employees covering 40 hours per week), the emergency department would receive forty-six percent of the difference between the urban and rural T-3 rate (3,360 emergency staff hours divided by 7,360 total staff hours). Third, if a non-profit rural

¹⁵⁸ *NPRM*, 17 FCC Rcd at 7827, para. 61.

¹⁵⁹ 47 C.F.R. § 54.601(d) as adopted herein; *Accord* Intelenet Comments at 2 (encouraging the Commission to modify its rules so that an otherwise eligible health care provider that is collocated with an ineligible entity may be considered for partial universal service support).

¹⁶⁰ 47 C.F.R. § 54.601(d) as adopted herein.

¹⁶¹ See 47 C.F.R. § 54.619(a)(1) as adopted herein. Participants in the schools and libraries program are also required under USAC procedures to retain documentation for five years. See Universal Service Administrative Company: Records Retention, available at <http://www.sl.universalservice.org/applicants/records.asp> (retrieved November 13, 2003).

¹⁶² 47 C.F.R. § 54.619(a)(1) as adopted herein. See also FCC Form 466 Instructions.

health clinic operates in a local community center for five hours one evening per week and uses the community center's T-1 line, and the community center's normal operating hours are 10 AM – 10 PM, Monday thru Saturday, the T-1 would be used for eligible purposes seven percent of the time (five hours divided by eighty-four open hours in a week). Therefore, the eligible non-profit rural health clinic would receive seven percent of the difference between the urban and rural rate for the T-1. Fourth, if a dedicated emergency department in a for-profit rural hospital shares access to a T-1 with the rest of the hospital, and the dedicated emergency department occupies 250 square feet and the hospital occupies 2,500 square feet, the T-1 would be used for eligible purposes ten percent of the time (250 square feet divided by 2,500 square feet). Therefore, the eligible dedicated emergency department would receive ten percent of the difference between the urban and rural rate for the T-1. If a rural health care provider can document that it adopted an allocation method consistent with one of these four examples, we will consider the method compliant with our requirements. Rural health care providers may choose a different allocation method, but will bear the burden of demonstrating, in the event of an audit or otherwise, that the chosen method was based on objective criteria and reasonably reflects the eligible usage of the facilities.

51. Conversely, when services are used solely by an eligible entity for eligible purposes, no allocation would be necessary. For example, if a T-1 is located solely in the dedicated emergency room and is used only for medical or educational purposes, the dedicated emergency room would be able to receive the full discount based on the difference between the urban and rural rate. Similarly, if there is a phone line in a private room at the community center that is dedicated exclusively to a rural health care clinic, no allocation would be necessary because the personnel staffing the part-time rural health care clinic would be the only ones to use the phone.

2. Streamlining the Application Process

52. *Background.* In the *NPRM*, we sought comment on ways to streamline the application process to make it more accessible and reduce overall administrative costs to rural health care providers.¹⁶³ Commenters suggested USAC streamline the application process by pre-filling forms for repeat applicants,¹⁶⁴ combining or eliminating forms,¹⁶⁵ implementing on-line filing¹⁶⁶ and e-certification capability,¹⁶⁷ simplifying the process for identifying urban

¹⁶³ *NPRM*, 17 FCC Rcd at 7825, para. 51.

¹⁶⁴ See ATA Comments at 7-9; CTL Comments 7-9; Institute of Rural Health Comments at 7; Madden Comments at 1; MGHS Reply Comments at 3; MHTA Comments at 2; NM Health Resources Comments at 2; NSRHN Comments at 10-11; Northwest TeleHealth Comments at 2; NOSORH Comments at 2; Tri-County Memorial Hosp. Comments at 2; Univ. of Arizona Health Sciences Comments at 2; Washington Rural Comments at 3; UVA Comments at 18-19.

¹⁶⁵ See AFHCAN Comments at 7; Alaska Telehealth Comments at 3; Blue Cross Comments at 4; GCI Comments at 9; GCI Reply Comments at 6; Nebraska Office of Rural Health Comments at 1-2; Kansas DHE Comments at 2; Kansas Hosp. Assoc. Comments at 2.

¹⁶⁶ See AHA Comments at 8; Avera Comments at 4.

¹⁶⁷ See Blue Cross Comments at 5; NSRHN Comments at 10-11.

rates,¹⁶⁸ and conducting more outreach efforts.¹⁶⁹ Moreover, some commenters suggested that discount payments should be provided directly to health care providers. They argue the current system, which provides discounts directly to service providers after the required paperwork is processed, who in turn provide discounted services to health care providers, results in health care providers having to “front load” the costs of the discount while USAC develops the payment schedule with the service provider.¹⁷⁰

53. *Discussion.* Since the *NPRM* was released, USAC has streamlined the application process significantly in response to the numerous comments submitted in this proceeding on this issue.¹⁷¹ For example, USAC has implemented electronic filing and e-certification for all forms¹⁷² and has arranged for electronic forms to be filled automatically with the previous year's information for repeat on-line filers.¹⁷³ USAC has also created a database of urban rates on its website.¹⁷⁴ As a result, a health care provider can now bypass the arduous step of having to retrieve this information from its carrier. In addition, USAC has significantly expanded its outreach efforts, such as by sending mailings to carriers and health care providers to alert them

¹⁶⁸ See ATA Comments at 7-9; CTL Comments at 7-9; NTCA Comments at 5; Poudre Valley Health Comments at 1; WorldCom Comments at 9-10.

¹⁶⁹ See generally Alaska Comments at 5, 8; Alliance Comments at 5-6; AHA Comments at 8; Arizona Telemedicine Comments at 2; Arkansas DIS Reply Comments at 1; Illinois Center for Rural Health Comments at 2; Florida PSC Comments at 7-8; Kansas DHE comments at 3; Kansas Hosp. Assoc. Comments at 3; Madden Comments at 1; MGHS Reply Comments at 3; Mayo Comments at 1; Nevada State Office Comments at 9; NM Health Resources Comments at 2; NOSORH Comments at 2; Univ. of Arizona Health Sciences Comments at 2; Washington Rural Comments at 3; Tri-County Memorial Hosp. Comments at 2; WorldCom Comments at 9-10.

¹⁷⁰ See ATA Comments at 7-9; Blue Cross Comments at 5-6; CTTC Comments at 7; CTL at 7-9; Grogg Comments at 2; Institute of Rural Health Comments at 4; MGHS Reply Comments at 3; MHTA Comments at 2; NSRHN Comments at 10-11; Northwest TeleHealth Comments at 4; Univ. of Tennessee Health Science Comments at 2-3.

¹⁷¹ See generally AFHCAN Comments at 6-7; Alaska Comments at 5; Alaska Telehealth Comments at 3; Alliance Comments at 3-4; AHA Comments at 8-9; ATA Comments at 7-9; Arizona Telemedicine Comments at 2; Arkansas DIS Reply Comments at 1; Avera Comments at 4; Blue Cross Comments at 4-5; Illinois Center for Rural Health Comments at 2; CTL Comments 7-9; Clifford Comments at 1; GCI Comments at 9; GCI Reply Comments at 6; Institute of Rural Health Comments at 7; Kansas DHE Comments at 2; Madden Comments at 1; MGHS Reply Comments at 3; Minn. Ambulance Assoc. Comments at 2; Nebraska Office of Rural Health Comments at 1-2; Nevada State Office Comments at 9; NM Health Resources Comments at 2; NSRHN Comments at 10-11; Northwest TeleHealth Comments at 2; NOSORH Comments at 2-3; SBC/BellSouth Joint Reply Comments at 4; Tri-County Memorial Hosp. Comments at 1-2; Univ. of Arizona Health Sciences Comments at 2; Washington Rural Comments at 3, 5; WorldCom Comments at 9-10; UVA Comments at 18-19. See also Universal Service Administrative Company: Funding Year 2003 Process Overview, available at http://www.rhc.universalservice.org/overview/processoverview_2003.asp (retrieved November 13, 2003).

¹⁷² USAC launched e-certification for FCC Form 465 on January 28, 2002. New applicants or applicants that have not enabled e-certification must print, sign, and mail a paper FCC Form 465 to USAC. USAC launched e-certification for FCC Form 466 on June 19, 2003 and for FCC Form 467 on April 29, 2002.

¹⁷³ USAC launched pre-filled FCC Form 465 on January 1, 2002, pre-filled FCC Form 466 on June 19, 2003, and pre-filled FCC Form 467 on April 29, 2002.

¹⁷⁴ See Universal Service Administrative Company: Urban Rates, available at <http://www.universalservice.org/rhcdb/urbanrates/search.asp> (retrieved November 13, 2003).

to changes in the program, holding monthly conference calls for carriers and health care providers to ask questions and raise concerns, and setting up a toll-free access number where carriers and health care providers can call at their convenience.¹⁷⁵ Finally, USAC has eliminated the form submitted by service providers, FCC Form 468, by combining the relevant information into FCC Form 466, which is submitted by applicants.¹⁷⁶ This modification to the reimbursement process has reduced to a great extent the interval between receipt of service and payments to service providers, thereby mitigating commenters' concerns.

54. We believe USAC's efforts to ease the burdens of applying to the program have been exemplary, as further evidenced by the number of completed applications received by USAC in Funding Year 2003 compared to Funding Year 2002. Nevertheless, in the *Further Notice of Proposed Rulemaking*, we seek comment on ways in which USAC could further streamline the application process and expand outreach efforts. In addition, we note that the Commission, through the Consumer & Governmental Affairs Bureau, will endeavor through its educational and outreach efforts, to ensure that those most likely affected are informed about the actions taken in this Order. In addition to making fact sheets and other informational materials available for dissemination through the Commission's website, the Commission will include the dissemination of such information as part of its on-going, grassroots outreach efforts directed at rural America and undertaken in coordination with other federal and state agencies.

3. Pro-Rata Reductions If Annual Cap Exceeded

55. *Background.* The annual cap on universal service support for health care providers is currently \$400 million per funding year.¹⁷⁷ Generally, funds are available to applicants filing requests on a first-come-first-served basis.¹⁷⁸ If the total demand for support in a year exceeds the cap, however, the Administrator shall divide the total annual support available by the total amount requested in that year, and multiply that result, which is the pro-rata factor, by the amount requested by each applicant, in order to determine the amount each applicant shall receive.¹⁷⁹ Only applicants that file within the filing window will receive pro-rata support under these circumstances. The filing window date for each Funding Year is posted on USAC's homepage.¹⁸⁰ To date, discount amounts requested under the rural health care universal service support mechanism have never exceeded the annual cap. In light of potential changes to the

¹⁷⁵ See generally USAC's website found at <http://www.rhc.universalservice.org>.

¹⁷⁶ On June 19, 2003, USAC eliminated Form 468 from Funding Year 2003 onward. See Universal Service Administrative Company: FCC Form 468 Eliminated for Funding Year 2003, available at <http://www.rhc.universalservice.org/whatsnew/062003.asp#2> (retrieved November 13, 2002). See also Kansas DHE Comments at 2 and KHA Comments at 2 (suggesting that Form 468 be eliminated to streamline application process because telecommunication carriers struggle to complete the form in a timely manner).

¹⁷⁷ 47 C.F.R. § 54.623(a).

¹⁷⁸ 47 C.F.R. § 54.623(c)(1).

¹⁷⁹ 47 C.F.R. § 54.623(f).

¹⁸⁰ See USAC's homepage available at <http://www.rhc.universalservice.org/homepage.asp> (retrieved November 13, 2003). For example, the filing window for Funding Year 2003 runs from March 26-June 2, 2003. See also 47 C.F.R. § 54.623(c).

program, we sought comment in the *NPRM* on whether to modify our current rules governing the allocation of funds under the rural health care universal service support mechanism if demand should exceed the annual cap.¹⁸¹

56. *Discussion.* Based on our estimates and the comments we have received, we continue to believe that our current rules requiring pro-rata distribution of funds if requests exceed the cap, are the most effective and equitable means of distributing limited funds in accordance with the goals and purposes of the statute. Therefore, we agree with the majority of commenters that the current rules should be maintained.¹⁸² We note that the rules adopted in this Order could increase the level of discounts requested in a year, so applicants are encouraged to submit applications during the filing window to secure their universal service funding. We disagree with the commenter that suggested we prioritize universal service support for telecommunication services over information services.¹⁸³ We do not think such a measure is necessary at this time because program demand has never approached the cap. Moreover, prioritization would add another level of unnecessary administrative complexity to the support mechanism.

4. Ensuring the Selection of Cost-Effective Services

57. *Background.* Current rules require rural health care applicants to consider all bids received in response to the posting on USAC's webpage of their Description of Services Requested Form (FCC Form 465) and certify that they have selected the most cost-effective method of providing the requested services to meet its' health care telecommunications needs.¹⁸⁴ There are no restrictions, however, on the type of service offerings a rural health care provider may select. In the *NPRM*, we sought comment on whether there currently are adequate measures to ensure that rural health care providers purchase the most cost-effective services.¹⁸⁵ We also sought comment on whether we should implement changes to encourage applicants to use the lowest-cost technology available.¹⁸⁶

58. *Discussion.* We agree with commenters that the current rules are adequate to ensure that health care providers select the most cost-effective services.¹⁸⁷ Our certification requirements, combined with the requirement that health care providers remain responsible for a significant portion of service costs (*i.e.*, the urban rate of telecommunications services and 75%

¹⁸¹ *NPRM*, 17 FCC Rcd at 7825, para. 54.

¹⁸² Alliance Comments at 4; Avera Comments at 4; Intelenet Comments at 7; Kansas DHE Comments at 3; Kansas Hosp. Assoc. Comments at 3; PA Public Utility Reply Comments at 8.

¹⁸³ See GCI Comments at 9; GCI Reply Comments at 6.

¹⁸⁴ The most cost-effective method is defined as "the method that costs the least after consideration of the features, quality of transmission, reliability, and other factors that the health care provider deems relevant . . ." 47 C.F.R. § 54.615(c)(7). See also *supra* para. 28.

¹⁸⁵ *NPRM*, 17 FCC Rcd at 7827, para. 59.

¹⁸⁶ *Id.*

¹⁸⁷ Alliance Comments at 5; MSV Comments at 7.

of Internet access) will ensure that rural health care providers make prudent economic decisions.¹⁸⁸ We also agree with commenters that applicants should not be required to use the lowest-cost technology because factors other than cost, such as reliability and quality, may be relevant to fulfill their telemedical needs.¹⁸⁹

5. Other Non-Substantive Rule Changes

59. In the *NECA Order*, the Commission directed the National Exchange Carrier Association (NECA) to establish the Rural Health Care Corporation to administer the rural health care support mechanism.¹⁹⁰ Subsequently, the Commission directed the Rural Health Care Corporation to be merged into a division of USAC.¹⁹¹ In light of the Commission's prior actions, we hereby amend our rules to replace all references to the "Rural Health Care Corporation" with the "Rural Health Care Division."¹⁹² We also revise section 54.609(a)(1)(i) to conform to the *Fifteenth Order on Reconsideration*.¹⁹³ We also adopt several other non-substantive rule changes to improve the clarity of the rules.¹⁹⁴

6. Implementation

60. Funding Year 2003 for the rural health care program ends June 30, 2003, and Funding Year 2004 begins July 1, 2004. Because we do not wish to introduce changes to the program in the middle of a funding year, the modifications to the program adopted in this Order will be implemented beginning with Funding Year 2004. We direct USAC to take the necessary operational steps to implement the improvements to the program adopted herein for Funding Year 2004.

IV. ORDER ON RECONSIDERATION

61. *Background.* In the *1997 Universal Service Order*, the Commission concluded that

¹⁸⁸ Certification that a rural health care provider selects the most cost-effective method, pursuant to § 54.615(c)(7) of our rules, will be extended to include the provision of support for Internet access. 47 C.F.R. § 54.621(a) as adopted herein. *See also supra* note 184 (defining "cost-effective method").

¹⁸⁹ *Accord* Intelenet Comments at 8 (Intelenet posits that rules requiring applicants to use lowest cost technology available could result in providers being relegated to using obsolete or soon-to-be-retired technology. Sometimes initially higher cost options may prove to be lower in the long-run, by providing useful benefits to telemedicine in terms of scalability, maintenance, and future developments).

¹⁹⁰ *Changes to the Board of Directors of the National Exchange Carrier Association, Federal-State Joint Board on Universal Service*, Report and Order and Second Order on Reconsideration, CC Docket Nos. 97-21, 96-45, 12 FCC Rcd 18400 (1997) (*NECA Order*).

¹⁹¹ *Changes to the Board of Directors of the National Exchange Carrier Association, Inc., Federal-State Joint Board on Universal Service*, Third Report and Order, Fourth Order on Reconsideration, Eighth Order on Reconsideration, CC Docket Nos. 97-21, 96-45, 13 FCC Rcd 25058 (1998).

¹⁹² 47 C.F.R. § 54.603 as amended herein.

¹⁹³ *Fifteenth Order on Reconsideration*, 14 FCC Rcd at 18779 n.122.

¹⁹⁴ *See* 47 C.F.R. § 54.601 as adopted herein.

telecommunications carriers must charge eligible rural health care providers a rate for each supported service that is no higher than the highest tariffed or publicly available commercial rate for a similar service in the closest city in the state with a population of 50,000 or more.¹⁹⁵ Subsequently, the predecessor to Mobile Satellite Ventures Subsidiary (MSV), filed a Petition for Clarification or Reconsideration of this decision requesting the Commission to establish “that the urban services that are ‘similar’ to [MSV]’s rural [services] are the terrestrial mobile communications services typically used by ambulances and other emergency medical vehicles in a state’s urban areas . . . [and that] support for rural health care providers that use [MSV]’s services should be calculated on the basis of actual airtime usage rates that [MSV] charges for calls outside a customer’s predefined talk-group.”¹⁹⁶ MSV noted that under this approach, market forces and the relative cost-effectiveness of these competing technologies can determine which mobile technology is the most successful in rural and remote areas.¹⁹⁷ In the *NPRM*, the Commission sought comment on MSV’s proposal.¹⁹⁸

62. *Discussion.* Consistent with the policy objectives underlying our decision as indicated above,¹⁹⁹ we deny, to the extent indicated herein, MSV’s petition for reconsideration of the *1997 Universal Service Order*.²⁰⁰ We decline to revise our policy, as MSV suggests, to subsidize satellite service at the same price as terrestrial mobile service.²⁰¹ We agree with Verizon that equalizing these rates could undercut competition and competitive neutrality.²⁰² Although we agree that MSV and similar carriers provide valuable services to rural areas, particularly insular areas unserved by wireline carriers, we are concerned that equalizing the rates for satellite and terrestrial mobile service could significantly increase program demand and disadvantage those carriers already providing functionally similar services at more competitive prices. Accordingly, we deny MSV’s petition for reconsideration to the extent indicated herein.²⁰³

¹⁹⁵ *1997 Universal Service Order*, 12 FCC Rcd at 9124-25, paras. 669-70.

¹⁹⁶ AMSC Subsidiary Corporation (AMSC) Petition for Clarification or Reconsideration, filed July 17, 1997, at 8-9 (MSV Petition for Reconsideration). AMSC subsequently changed its name to Mobile Satellite Ventures Subsidiary (MSV); MSV Comments, filed Dec. 20, 2001 (updating its petition for reconsideration).

¹⁹⁷ MSV Petition for Reconsideration at 9.

¹⁹⁸ *NPRM*, 17 FCC Rcd at 7820-21, para. 39.

¹⁹⁹ *See supra* para. 44.

²⁰⁰ MSV Petition for Reconsideration; *see also* MSV Comments, filed July 1, 2002. We will address the additional issues raised by MSV in its petition for reconsideration related to the Commission’s high-cost-area support rules in a subsequent order. *See* MSV Petition for Reconsideration at 5-8.

²⁰¹ MSV Petition for Reconsideration at 9.

²⁰² Verizon Comments at 10.

²⁰³ As discussed above, rural health care providers will be able to apply capped discounts towards satellite service. *See supra* para. 44. In addition, if there is no terrestrial alternative, health care providers may compare the cost of rural satellite service to urban wireline rates. *See supra* para. 42.

V. FURTHER NOTICE OF PROPOSED RULEMAKING

A. Definition of “Rural Area”

63. We seek comment on modifications to the definition of “rural area” for the rural health care universal service support mechanism. Currently, an area qualifies as rural if it is located in a non-metropolitan county as defined by the Office of Management and Budget or is specifically identified in the Goldsmith Modification to 1990 Census data published by the Office of Rural Health Care Policy (ORHP).²⁰⁴ In response to the *NPRM*, several commenters state that ORHP no longer utilizes the definition adopted by the Commission in 1997 and that there will be no Goldsmith Modification to the most recent 2000 Census data.²⁰⁵ Several commenters suggest that the Commission adopt the rural designation system currently utilized by ORHP, the Rural Urban Commuting Area (RUCA) system.²⁰⁶ Others propose to define rural as non-urbanized areas, as specified by the Census Bureau.²⁰⁷ Finally, some commenters assert that if the Commission adopts a new definition of rural, it should grandfather existing areas that currently qualify as rural, if they would no longer qualify under the new definition.²⁰⁸

64. We seek comment on whether we should adopt a new definition of rural area for the rural health care program, and, if so, what that new definition should be. We seek comment on whether there are any definitions for rural areas used by other government agencies or medical organizations that would be appropriate for the rural health care program. In addition to describing any proposed new definitions, we ask commenters to address the specific proposals that have already been raised in the record. Commenters are encouraged to describe the effects of any new definition to the program, *e.g.* how many existing rural areas would become non-rural and vice versa. We also seek comment on whether there are reasons we should or should not use the same definition of “rural” for both the rural health care and schools and libraries support mechanisms.²⁰⁹

²⁰⁴ See 47 C.F.R. § 54.5.

²⁰⁵ See Kansas DHE Comments at 3.

²⁰⁶ See, *e.g.*, Illinois Center for Rural Health Comments at 3; NM Health Resources Comments at 3.

²⁰⁷ See, *e.g.*, ATA Comments at 5; Blue Cross Comments at 4; NSRHN Comments at 7-8. For the 2000 Census, urban territories include urbanized areas (UA) and urban clusters (UC), which consist of core census block groups or blocks that have a population density of at least 1,000 people per square mile and surrounding census blocks that have an overall density of at least 500 people per square mile. Rural territories include areas located outside of UAs and UCs. See The United States 2000 Census: Census 2000 Urban and Rural Classification, available at http://census.gov/geo/www/ua/ua_2k.html (retrieved September 11, 2003).

²⁰⁸ See Midwest Networks Comments at 4.

²⁰⁹ We note that the schools and libraries support mechanism currently uses the same definition of rural area as the rural health care support mechanism. We will seek comment on possible changes to the rural area definition in the context of the schools and libraries program in a separate notice of proposed rulemaking. We further note that we have sought comment on the appropriate definition of a “rural area” in the context of promoting the rapid and efficient deployment of spectrum-based services in rural areas. We specifically sought comment on the following definitions: (1) counties with a population density of 100 persons or fewer per square mile; (2) RSAs; (3) non-nodal counties within an EA; (4) the definition for “rural” used by the RUS for its broadband program; (5) the definition for “rural area” used by the Commission in connection with universal service support for schools, libraries, and rural (continued....)

B. Support for Satellite Services for Mobile Rural Health Clinics

65. We also seek comment on whether additional modifications to our rules are appropriate to facilitate the provision of support to mobile rural health clinics for satellite services. Satellite services may be used by mobile rural health clinics that operate in vans or boats to deliver telemedical services via satellite to residents in rural areas. For example, one non-profit entity is launching the first mobile telemammography van to diagnose breast cancer in women in four rural tribal lands in North and South Dakota early next year.²¹⁰ This van will conduct mammograms and deliver results to rural American Indian women while they wait.²¹¹ The van's clinician will send the mammogram via satellite, which is contained in sixty-four megabytes of data, to doctors at the University of Colorado, who will diagnose any abnormalities and email the van with the patient's results.²¹² The van will serve approximately 12,000 women among the four tribes, at a rate of ten to twelve women a day.²¹³ The van will be stationed at each reservation for approximately two weeks at a time and will travel approximately 200-300 days a year, depending on travel time and maintenance and repairs to the van.²¹⁴ Satellite service for the van will cost approximately \$10,000 a month.²¹⁵

66. In the foregoing *Report and Order*, we conclude that support for satellite services should be capped at the amount a provider would receive if it received functionally-similar terrestrial-based services.²¹⁶ We seek comment on whether it is appropriate to apply this rule to mobile rural health care providers, which by their very nature, are unlikely to be able to utilize terrestrially-based services effectively. In particular, due to the mobile nature of a telemedical unit and the large volume of data it will likely send, would a satellite connection be the most cost-effective method of providing service, even if a terrestrial alternative is available? Should a terrestrial alternative be deemed available and "functionally similar," if by its nature it is tied

(Continued from previous page) _____

health care providers; (6) the definition of "rural" based on census tracts as outlined by the Economic Research Service of the USDA; (7) the Census Bureau definition of "rural" counties; and (8) any census tract that is not within ten miles of any incorporated or census-designated place containing more than 2,500 people, and is not within a county or county equivalent which has an overall population density of more than 500 persons per square mile of land. See *Facilitating the Provision of Spectrum-Based Services to Rural Areas and Promoting Opportunities for Rural Telephone Companies To Provide Spectrum-Based Services; 2000 Biennial Regulatory Review, Spectrum Aggregation Limits for Commercial Mobile Radio Services; Increasing Flexibility To Promote Access to and the Efficient and Intensive Use of Spectrum and the Widespread Deployment of Wireless Services, and To Facilitate Capital Formation*, WT Docket Nos. 02-381, 01-14, 03-202, Notice of Proposed Rulemaking, FCC 03-222, paras. 10-12 (rel. Oct. 6, 2003).

²¹⁰ Letter to Marlene Dortch, Secretary for the Federal Communications Commission, from Anne Linton, Healthcare Anywhere dated October 21, 2003 (Healthcare Anywhere *Ex Parte*).

²¹¹ *Id.*

²¹² *Id.*

²¹³ *Id.*

²¹⁴ *Id.*

²¹⁵ *Id.*

²¹⁶ See *supra* para. 44.

to a fixed location? We seek comment on how mobile health care providers should make a cost-effective determination for satellite services and whether they should consider the installation and disconnection charges that would be incurred if the mobile rural health clinic were to order a wireline connection at each docking location. Commenters should also discuss whether mobile rural health clinics should be required to service a specific number of locations before satellite services are deemed cost-effective.

67. In the event we conclude that the cap on the provision of support for satellite services where terrestrial service is available should not apply in these circumstances, how should support be provided (*i.e.*, how should discounts be calculated) for satellite services? Commenters are encouraged to discuss whether rural satellite services for mobile rural health clinics should be compared to urban terrestrial services and under what circumstances. We note that two other commenters in this proceeding proposed to provide support for satellite services for mobile health care providers.²¹⁷ Commenters should discuss these commenters' proposals. We also ask commenters to estimate the amount of support a mobile rural health clinic would likely receive and the number of mobile units that would likely be eligible. The non-profit entity associated with the telemammography van states that distance-based charges will not apply to satellite services in the continental United States.²¹⁸ We seek comment on whether other similarly situated mobile rural health clinics would be subject to distance-based charges using satellite services and, if so, how the revised MAD would impact support levels.

68. We seek comment on how we should determine whether a mobile health clinic serves rural areas. In particular, should that determination depend on the principal place of business of the provider (such as its mailing address), or should it depend on where the mobile health clinic actually provides service? We also seek comment on whether support for a mobile rural health clinic should be prorated if it also serves non-rural locations.

C. Administrative Matters

69. In addition, we seek comment on ways to streamline further the application process and expand outreach efforts. In the foregoing *Report and Order*, we note that USAC has implemented many steps to streamline the application process and has increased its outreach efforts, since the *NPRM* was released in 2002.²¹⁹ Among other things, USAC has implemented on-line application filing and has arranged for electronic forms to be filled automatically with

²¹⁷ See ATA Comments at 13-14; CTL Comments at 13-14. Specifically, these commenters proposed that the Commission should consider allowing MSV and similar companies, to receive universal service support for mobile satellite services when certain conditions are met: (1) the satellite services are provided only via a mobile unit that will serve a minimum of four rural communities within a State; (2) support would not be provided to a company installing a fixed based unit in an area where terrestrial based services are available, unless they can demonstrate that the rates are equal to the highest tariffed rates of the local exchange carrier; (3) discounts for this service would be calculated the same as discounts for terrestrial based service; (4) the healthcare provider using the mobile service must maintain a detailed log of all network time used, the date it was used and the location from which the mobile service was provided, and submit the logs to USAC within forty-five days of the closing of a funding year. See *id.*

²¹⁸ See *Healthcare Anywhere Ex Parte*.

²¹⁹ See *supra* para. 54.

the previous year's information for repeat on-line filers. Nevertheless, we seek comment on what additional steps USAC could take to ease further the burdens associated with the application process. For example, what would be the advantages and disadvantages of implementing multi-year applications, so that beneficiaries would not need to apply every funding year? We also seek comment on whether there are additional outreach efforts that USAC could take to inform eligible applicants of the benefits of the program. For instance, should USAC conduct focus groups among rural health care providers to develop ideas on how to identify providers that operate only on a part-time basis? Should USAC contact service providers in rural areas to solicit suggestions for potential eligible users in the area?

VI. PROCEDURAL MATTERS

A. Regulatory Flexibility Analysis

70. As required by the Regulatory Flexibility Act, 5 U.S.C. § 604, the Commission has prepared a Final Regulatory Flexibility Analysis (FRFA) for the *Report and Order*, set forth at Appendix C. The Commission has also prepared an Initial Regulatory Flexibility Analysis (IRFA) for the *Further Notice of Proposed Rulemaking (Further Notice)*, set forth at Appendix D. Comments on the FRFA and IRFA should be labeled as IRFA or FRFA Comments, and should be submitted pursuant to the filing dates and procedures set forth in paragraphs 72-79, *infra*.

B. Paperwork Reduction Act Analysis

71. This *Report and Order*, *Order on Reconsideration*, and *Further Notice of Proposed Rulemaking (Report and Order)* contains either a proposed or modified information collection. As part of the continuing effort to reduce paperwork burdens, we invite the general public and the Office of Management and Budget (OMB) to comment on the information collections contained in this *Report and Order*, as required by the Paperwork Reduction Act of 1995, 44 U.S.C. § 3501 *et seq.* Public and agency comments are due at the same time as other comments on this *Report and Order*; OMB comments are due 60 days from the date of publication of this *Report and Order* in the Federal Register. Comments should address: 1) whether the proposed collection of information is necessary for the proper performance of the functions of the Commission, including whether the information shall have practical utility; 2) the accuracy of the Commission's burden estimates; 3) ways to enhance the quality, utility, and clarity of the information collected; and 4) ways to minimize the burden of the collection of information on the respondents, including the use of automated collection techniques or other forms of information technology.

C. Filing Procedures

72. Pursuant to sections 1.415 and 1.419 of the Commission's rules,²²⁰ interested parties may file comments not later than 60 days after publication of the *Report and Order* in the Federal Register and may file reply comments not later than 105 days after publication of the *Report and Order* in the Federal Register. In order to facilitate review of comments and reply

²²⁰ 47 C.F.R. §§ 1.415, 1.419.

comments, parties should include the name of the filing party and the date of the filing on all pleadings. Comments may be filed using the Commission's Electronic Comment Filing System (ECFS) or by filing paper copies.²²¹

73. Comments filed through the ECFS can be sent as an electronic file via the Internet to <<http://www.fcc.gov/cgb/ecfs>>. Generally, only one copy of an electronic submission must be filed. If multiple docket or rulemaking numbers appear in the caption of this proceeding, however, commenters must transmit one electronic copy of the comments to each docket or rulemaking number referenced in the caption. In completing the transmittal screen, commenters should include their full name, U.S. Postal Service mailing address, and the applicable docket or rulemaking number. Parties may also submit an electronic comment by Internet e-mail. To get filing instructions for e-mail comments, commenters should send an e-mail to <ecfs@fcc.gov>, and should include the following words in the body of the message, "get form." A sample form and directions will be sent in reply. Or you may obtain a copy of the ASCII Electronic Transmittal Form (FORM-ET) at <www.fcc.gov/e-file/email.html>.

74. Parties that choose to file by paper must file an original and four copies of each filing. Filings can be sent by hand or messenger delivery, by commercial overnight courier, or by first-class or overnight U.S. Postal Service mail (although we continue to experience delays in receiving U.S. Postal Service mail). The Commission's contractor, Natek, Inc., will receive hand-delivered or messenger-delivered paper filings for the Commission's Secretary at a new location in downtown Washington, DC. The address is 236 Massachusetts Avenue, NE, Suite 110, Washington, DC 20002. The filing hours at this location will be 8:00 a.m. to 7:00 p.m. All hand deliveries must be held together with rubber bands or fasteners. Any envelopes must be disposed of before entering the building.

75. Commercial overnight mail (other than U.S. Postal Service Express Mail and Priority Mail) must be sent to 9300 East Hampton Drive, Capitol Heights, MD 20743. U.S. Postal Service first-class mail, Express Mail, and Priority Mail should be addressed to 445 12th Street, SW, Washington, D.C. 20554. All filings must be addressed to the Commission's Secretary, Office of the Secretary, Federal Communications Commission.

If you are sending this type of document or using this delivery method...	It should be addressed for delivery to...
Hand-delivered or messenger-delivered paper filings for the Commission's Secretary	236 Massachusetts Avenue, NE, Suite 110, Washington, DC 20002 (8:00 to 7:00 p.m.)
Other messenger-delivered documents, including documents sent by overnight mail (other than United States Postal Service Express Mail and Priority Mail)	9300 East Hampton Drive, Capitol Heights, MD 20743 (8:00 a.m. to 5:30 p.m.)
United States Postal Service first-class mail, Express Mail, and Priority Mail	445 12 th Street, SW Washington, DC 20554

²²¹See *Electronic Filing of Documents in Rulemaking Proceedings*, 13 FCC Rcd 11322, 11326 (1998).

76. Parties who choose to file by paper should also submit their comments on diskette. These diskettes, plus one paper copy, should be submitted to: Sheryl Todd, Telecommunications Access Policy Division, Wireline Competition Bureau, Federal Communications, at the filing window at 236 Massachusetts Avenue, N.E., Suite 110, Washington, D.C. 20002. Such a submission should be on a 3.5-inch diskette formatted in an IBM compatible format using Word or compatible software. The diskette should be accompanied by a cover letter and should be submitted in “read only” mode. The diskette should be clearly labeled with the commenter’s name, proceeding (including the docket number, in this case WC Docket No. 02-60, type of pleading (comment or reply comment), date of submission, and the name of the electronic file on the diskette. The label should also include the following phrase “Disk Copy - Not an Original.” Each diskette should contain only one party’s pleadings, preferably in a single electronic file. In addition, commenters must send diskette copies to the Commission’s copy contractor, Qualex International, Portals II, 445 12th Street, S.W., Room CYB402, Washington, D.C. 20554 (see alternative addresses above for delivery by hand or messenger).

77. Regardless of whether parties choose to file electronically or by paper, parties should also file one copy of any documents filed in this docket with the Commission’s copy contractor, Qualex International, Portals II, 445 12th Street S.W., CY-B402, Washington, D.C. 20554 (see alternative addresses above for delivery by hand or messenger) (telephone 202-863-2893; facsimile 202-863-2898) or via e-mail at qualexint@aol.com.

78. Written comments by the public on the proposed and/or modified information collections are due on the same day as comments on the *Report and Order*, i.e., on or before 60 days after publication of the *Report and Order* in the Federal Register. Written comments must be submitted by OMB on the proposed and/or modified information collections on or before 60 days after publication of the *Report and Order* in the Federal Register. In addition to filing comments with the Secretary, a copy of any comments on the information collections contained herein should be submitted to Judith B. Herman, Federal Communications Commission, Room 1-C804, 445 12th Street, S.W., Washington, D.C. 20554, or via the Internet to jbherman@fcc.gov, and to Jeanette Thornton, OMB Desk Officer, Room 10236 NEOB, 725 17th Street, N.W., Washington, D.C. 20503 or via the Internet to JThornto@omb.eop.gov.

79. The full text of this document is available for public inspection and copying during regular business hours at the FCC Reference Information Center, Portals II, 445 12th Street, SW, Room CY-A257, Washington, DC, 20554. This document may also be purchased from the Commission’s duplicating contractor, Qualex International, Portals II, 445 12th Street, SW, Room CY-B402, Washington, DC, 20554, telephone (202) 863-2893, facsimile (202) 863-2898, or via e-mail qualexint@aol.com.

D. Further Information

80. Alternative formats (computer diskette, large print, audio recording, and Braille) are available to persons with disabilities by contacting Brian Millin at (202) 418-7426 voice, (202) 418-7365 TTY, or bmillin@fcc.gov. This *Report and Order* can also be downloaded in Microsoft Word and ASCII formats at <<http://www.fcc.gov/ccb/universalservice/highcost>>.

81. For further information, contact Shannon Lipp at (202) 418-7954 or Regina Brown at (202) 418-0792 in the Telecommunications Access Policy Division, Wireline Competition Bureau.

VII. ORDERING CLAUSES

82. Accordingly, IT IS ORDERED that, pursuant to the authority contained in sections 1, 4(i), 4(j), 201-205, 214, 254, and 403 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151, 154(i), 154(j), 201-205, 214, 254, and 403, this *Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking* IS ADOPTED.

83. IT IS FURTHER ORDERED that, pursuant to the authority contained in section 405, of the Communications Act of 1934, as amended, 47 U.S.C. § 405, and sections 0.291 and 1.429 of the Commission's rules, 47 C.F.R. §§ 0.291 and 1.429, Mobile Satellite Ventures Subsidiary's Petition for Clarification or Reconsideration IS DENIED to the extent indicated herein.

84. IT IS FURTHER ORDERED that Part 54 of the Commission's rules, 47 C.F.R. Part 54, IS AMENDED as set forth in Appendix A attached hereto, effective thirty (30) days after the publication of this *Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking* in the Federal Register.

85. IT IS FURTHER ORDERED that the Commission's Consumer and Governmental Affairs Bureau, Reference Information Center, SHALL SEND a copy of this *Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking*, including the Final Regulatory Flexibility Analysis and Initial Regulatory Flexibility Analysis, to the Chief Counsel for Advocacy of the Small Business Administration.

FEDERAL COMMUNICATIONS COMMISSION

Marlene H. Dortch
Secretary

APPENDIX A**Final Rules**

For the reasons discussed in the preamble, the Federal Communications Commission amends 47 C.F.R. 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. §§ 1, 4(i), 201, 205, 214, and 254 unless otherwise noted.

2. Amend § 54.601 by removing paragraphs (a)(3), (b)(3), and (b)(4), redesignating paragraphs (a)(4) and (a)(5) as (a)(3) and (a)(4), revising paragraphs (a)(1), newly redesignated (a)(3), and (c), and adding paragraph (d) to read as follows:

§ 54.601 Eligibility.

(a) * * *

- (1) Except with regard to those services provided under § 54.621(b), only an entity that is either a public or non-profit rural health care provider, as defined in this section, shall be eligible to receive supported services under this subpart.

* * * * *

- (3) For purposes of this subpart, a rural health care provider is a public or non-profit health care provider located in a rural area, as defined in this subpart.

* * * * *

(c) Services.

- (1) Any telecommunications service that is the subject of a properly completed bona fide request by a rural health care provider shall be eligible for universal service support, subject to the limitations described in this paragraph. The length of a supported telecommunications service

may not exceed the distance between the health care provider and the point farthest from that provider on the jurisdictional boundary of the largest city in a state as defined in § 54.625(a).

(2) Internet Access and Limited Toll-Free Access to Internet.

(i) For purposes of this subpart, eligible Internet access is an information service that enables rural health care providers to post their own data, interact with stored data, generate new data, or communicate over the World Wide Web.

(ii) Internet access shall be eligible for universal service support under § 54.621(a).

(iii) Limited toll-free access to an Internet service provider shall be eligible for universal service support under § 54.621(b).

(d) Allocation of Discounts. An eligible health care provider that engages in eligible and ineligible activities or that collocates with an entity that provides ineligible services shall allocate eligible and ineligible activities in order to receive a prorated discount for eligible activities. Health care providers shall choose a method of cost allocation that is based on objective criteria and reasonably reflects the eligible usage of the facilities.

§ 54.603 [Amended]

3. Amend § 54.603 by replacing the term “Rural Health Care Corporation” in paragraphs (b)(1), (b)(2), (b)(3), (b)(4), and (b)(5) with “Rural Health Care Division.”

4. Amend § 54.605 by removing paragraph (c), redesignating paragraphs (d) and (e) as (c) and (d), and revising paragraphs (a) and (b) to read as follows:

§ 54.605 Determining the urban rate.

(a) If a rural health care provider requests an eligible service 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.

* * * * *

5. Revise § 54.609 to read as follows:

§ 54.609 Calculating support.

(a) Except with regard to services provided under § 54.621 and subject to the limitations set forth in this subpart, the amount of universal service support for an eligible service provided to a public or non-profit rural health care provider shall be the difference, if any, between the urban rate and the rural rate charged for the service, as defined herein. In addition, all reasonable charges that are incurred by taking such services, such as state and federal taxes shall be eligible for universal service support. Charges for termination liability, penalty surcharges, and other charges not included in the cost of taking such service shall not be covered by the universal service support mechanisms. Rural health care providers may choose one of the following two support options.

(1) Distance-Based Support. The Administrator shall consider the base rates for telecommunications services in rural areas to be reasonably comparable to the base rates charged for functionally similar telecommunications service in urban areas in that state, and, therefore,

the Administrator shall not include these charges in calculating the support. The Administrator shall include, in the support calculation, all other charges specified, and all actual distance-based charges as follows:

(i) If the requested service distance is less than or equal to the SUD for the state, the distance-based charges for the rural health care provider are reasonably comparable to those in urban areas, so the health care provider will not receive distance-based support.

(ii) If the requested service distance is greater than the SUD for the state, but less than the maximum allowable distance, the distance-based charge actually incurred for that service can be no higher than the distance-based charges for a functionally similar service in any city in that state with a population of 50,000 or more over the SUD.

(iii) "Distance-based charges" are charges based on a unit of distance, such as mileage-based charges.

(iv) Except with regard to services provided under § 54.621, a telecommunications carrier that provides telecommunications service to a rural health care provider participating in an eligible health care consortium, and the consortium must establish the actual distance-based charges for the health care provider's portion of the shared telecommunications services.

(2) Base Rate Support. If a telecommunications carrier, health care provider, and/or consortium of health care providers reasonably determines that the base rates for telecommunications services in rural areas are not reasonably comparable to the base rates charged for functionally similar telecommunications service in urban areas in that state, the telecommunications carrier, health care provider, and/or consortium of health care providers may request that the Administrator perform a more comprehensive support calculation. The requester shall provide to the Administrator the information to establish both the urban and rural rates consistent with § 54.605 and § 54.607, and submit to the Administrator with Form 466 all of the documentation

necessary to substantiate the request.

(i) Except with regard to services provided under § 54.621, a telecommunications carrier that provides telecommunications service to a rural health care provider participating in an eligible health care consortium, and the consortium must establish the applicable rural base rates for telecommunications service for the health care provider's portion of the shared telecommunications services, as well as the applicable urban base rates for the telecommunications service.

(b) Absent documentation justifying the amount of universal service support requested for health care providers participating in a consortium, the Administrator shall not allow telecommunications carriers to offset, or receive reimbursement for, the amount eligible for universal service support.

(c) The universal service support mechanisms shall provide support for intrastate telecommunications services, as set forth in § 54.101(a), provided to rural health care providers as well as interstate telecommunications services.

(3) Satellite services.

(i) Rural public and non-profit health care providers may receive support for rural satellite services, even when another functionally similar terrestrial-based service is available in that rural area. Discounts for satellite services shall be capped at the amount the rural health care provider would have received if they purchased a functionally similar terrestrial-based alternative.

(ii) Rural health care providers seeking discounts for satellite services shall provide to the Administrator with the Form 466 documentation of the urban and rural rates for the terrestrial-based alternatives.

(iii) Where a rural health care provider seeks a more expensive satellite-based service when a less expensive terrestrial-based alternative is available, the rural health care provider shall be

responsible for the additional cost.

6. Amend § 54.613 by revising paragraph (a) to read as follows:

§ 54.613 Limitations on supported services for rural health care providers.

(a) Upon submitting a bona fide request to a telecommunications carrier, each eligible rural health care provider is entitled to receive the most cost-effective, commercially-available telecommunications service at a rate no higher than the highest urban rate, as defined in § 54.605, at a distance not to exceed the distance between the eligible health care provider's site and the farthest point on the jurisdictional boundary of the city in that state with the largest population.

* * * * *

7. Revise § 54.619 to read as follows:

§ 54.619 Audits and recordkeeping.

(a) Health care providers.

(1) Recordkeeping. Health care providers shall maintain for their purchases of services supported under this subpart documentation for five years from the end of the funding year sufficient to establish compliance with all rules in this subpart. Documentation must include, among other things, records of allocations for consortia and entities that engage in eligible and ineligible activities, if applicable.

(2) Production of records. Health care providers shall produce such records at the request of any auditor appointed by the Administrator or any other state or federal agency with jurisdiction.

(3) Random audits. Health care providers shall be subject to random compliance audits to ensure that requesters are complying with the certification requirements set forth in § 54.615(c) and are otherwise eligible to receive universal service support and that rates charged comply with the statute and regulations.

(4) Annual report. The Administrator shall use the information obtained under paragraphs (a)(1), (a)(2), (b)(1) and (b)(2) of this section to evaluate the effects of the regulations adopted in this subpart and shall report its findings to the Commission on the first business day in May of each year.

8. Revise § 54.621 to read as follows:

§ 54.621 Access to advanced telecommunications and information services.

(a) Twenty-five percent of the monthly cost of eligible Internet access shall be eligible for universal support. Health care providers shall certify that the Internet access selected is the most cost-effective method for their health care needs as defined in § 54.615(c)(7), and that purchase of the Internet access is reasonably related to the health care needs of the rural health care provider.

(b) Each eligible health care provider that cannot obtain toll-free access to an Internet service provider shall be entitled to receive the lesser of the toll charges incurred for 30 hours of access per month to an Internet service provider or \$180 per month in toll charge credits for toll charges imposed for connecting to an Internet service provider.

9. Amend § 54.625 by revising paragraph (a) to read as follows:

§ 54.625 Support for services beyond the maximum supported distance for rural health care providers.

(a) The maximum support distance is the distance from the health care provider to the farthest point on the jurisdictional boundary of the city in that state with the largest population, as calculated by the Administrator.

* * * * *

APPENDIX B**List of Parties Filing Comments in Response to
the Notice of Proposed Rulemaking**Comments

1. Adams County Health Department (Adams Co. Health Dept.)
2. Alaska, State of (Alaska)
3. Alaska Federal Health Care Access Network (AFHCAN)
4. Alaska Telehealth Advisory Council (Alaska Telehealth)
5. Alliance Information Management, Inc. (Alliance)
6. American Hospital Association (AHA)
7. American Samoa Medical Center Authority,
LBJ Tropical Medical Center (American Samoa Medical Center)
8. American Samoa Telecommunications Authority (ASTCA)
9. American Telemedicine Association (ATA)
10. Arizona Telemedicine Program (Arizona Telemedicine)
11. Arkansas Department of Information Systems (Arkansas DIS)
12. Avera Health (Avera)
13. Beacon Telecommunications Advisors, LLC (Beacon)
14. California Primary Care Association (CA Primary Care Assoc.)
15. California Rural Health Policy Council (CA Rural Health Policy)
16. California Telehealth & Telemedicine Center (CTTC)
17. Canter for Rural Health,
Illinois Department of Public Health (Illinois Center for Rural Health)
18. Center for Telemedicine Law (CTL)
19. Coder, Denise (Coder)
20. Children's Hospital of L.A. (L.A. Children's Hospital)
21. Clifford, Larry (Clifford)
22. Cortland County Health Department (Cortland Co. Health Dept.)
23. The Evangelical Lutheran Good Samaritan Society (Evangelical Lutheran)
24. Federal Regional Council (FRC)
25. Florida Public Service Commission (Florida PSC)
26. General Communications, Inc. (GCI)
27. Grogg, Kevin, Shepherd Center (Grogg)
28. Guam Department of Mental Health and Substance Abuse (Guam Dept. of MHSA)
29. Guam Department of Public Health and Social Services (Guam Dept. of PHSS)
30. Guam Memorial Hospital Authority (Guam Memorial Hosp.)
31. Healthcare Anywhere, Inc. (Healthcare)
32. Institute of Rural Health, The (Institute of Rural Health)
33. Intelenet Commission (Intelenet)
34. IT&E Overseas, Inc. (IT&E)
35. Kansas Department of Health & Environment (Kansas DHE)
36. Kansas Hospital Association (Kansas Hosp. Assoc.)

37. Kingston eHealth (Kingston eHealth)
38. Lane Co. Health Department (Lane Co. Health Dept.)
39. Madden, Karen A. (Madden)
40. Marquette General Health System (MGHS)
41. Mayo Foundation (Mayo)
42. Mid-Nebraska Telemedicine Network, Good Samaritan Health Systems and, Kearney Nebraska (Mid-Nebraska Telemedicine)
43. Midwest Networks, LLC (Midwest Networks)
44. Minnesota Ambulance Association (Minn. Ambulance Assoc.)
45. Minnesota Rural Health Association (Minn. Rural Health Assoc.)
46. Mobile Satellite Ventures Subsidiary LLC (MSV)
47. Montana Healthcare Telecommunications Alliance (MHTA)
48. National Association of County and City Health Officials (NACCHO)
49. National Organization of State offices of Rural Health (NOSORH)
50. National Rural Health Association (NRHA)
51. National Telecommunications Cooperative Association (NTCA)
52. Nebraska Office of Rural Health (Nebraska Office of Rural Health)
53. Nevada State Office of Rural (Nevada State Office)
54. New Mexico Health Resources, Inc. (NM Health Resources)
55. Northern Sierra Rural Health Network (NSRHN)
56. Northwest TeleHealth (Northwest TeleHealth)
57. Pan Pacific Education and Communication (Pan Pacific Education and Communication)
58. Experiment by Satellite (PEACESAT)
59. PCI Communications (PCI)
60. Poudre Valley Health System (Poudre Valley Health)
61. Rural Wisconsin Health Cooperative (RWHC)
62. Startec Global Communications Corporation (Startec)
63. Tri-County Memorial Hospital (Tri-County Memorial Hosp.)
64. University of Arizona Health Sciences Center (Univ. of Arizona Health Sciences)
65. University of New Mexico Health and Sciences Center (Univ. of NM Health and Sciences)
66. University of Tennessee Health Science Center (Univ. of Tennessee Health Science)
67. University of Vermont College of Medicine (Univ. of Vermont College of Medicine)
68. University of Virginia Office of Telemedicine Health Systems (UVA)
69. VA Medical and Regional Office Center Honolulu (VAMROC-Honolulu)
70. Verizon (Verizon)
71. Washington Rural Health Association (Washington Rural)
72. Western Governors' Association (WGA)
73. Williams, Rustan (Williams)
74. WorldCom, Inc. (WorldCom)
75. Yurok Tribe (Yurok Tribe)

Reply Comments

1. Arkansas Department of Information Systems (Arkansas DIS)
2. Blue Cross of California (Blue Cross)
3. Center for Telemedicine Law (Center for Telemedicine)

4. Commonwealth of the Northern Mariana Islands, Office of the Governor (Commonwealth of the Northern Mariana Islands)
5. Federal Regional Council (FRC)
6. General Communication, Inc. (General Communication)
7. Healthcare Anywhere, Inc. (Healthcare Anywhere)
8. Hemophilia Treatment Center (HTC)
9. Mobile Satellite Ventures Subsidiary LLC (MSV)
10. Pacific Islands Health Officers Association (Pacific Islands HOA)
11. Pennsylvania Public Utility (PA Public Utility)
12. Qwest Communications International Inc. (Qwest)
13. SBC Communications Inc. and BellSouth Corp. (SBC/BellSouth)
14. Verizon (Verizon)

Ex Partes

1. Rep. Boucher (Boucher)
2. Guam, Officer of the Governor (Guam)
3. Healthcare Anywhere (Healthcare Anywhere)
4. National Telecommunications Cooperative Association (NTCA)
5. University of Virginia Office of Telemedicine Health Systems (UVA)
6. Washington Federal Strategies (Washington Federal)

APPENDIX C

FINAL REGULATORY FLEXIBILITY ANALYSIS

(REPORT AND ORDER)

1. As required by the Regulatory Flexibility Act of 1980, as amended (RFA),¹ an Initial Regulatory Flexibility Analysis (IRFA) was incorporated in the Notice of Proposed Rulemaking.² The Commission sought written public comments on the proposals in the NPRM, including comment on the IRFA. The Commission received seventy-five comments, fourteen reply comments, and six *ex partes* in response to the NPRM. This present Final Regulatory Flexibility Analysis (FRFA) conforms to the RFA.³

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

2. The Commission is required by section 254 of the Act to promulgate rules to implement the universal service provisions of section 254.⁴ On May 8, 1997, the Commission adopted rules that reformed its system of universal service support mechanisms so that universal service is preserved and advanced as markets move toward competition.⁵ Among other things, the Commission adopted a mechanism to provide discounted telecommunications services to public or non-profit health care providers that serve persons in rural areas. Over the last few years, important changes in the rural health community prompt us to review the rural health care universal service support mechanism.⁶ In this *Report and Order*, we adopt several modifications to the Commission's rules to improve the effectiveness of the rural health care universal service support mechanism and increase utilization of this mechanism by rural health care providers.

3. Specifically, in the *Report and Order*, we clarify the scope of entities eligible to receive discounts.⁷ We conclude that dedicated emergency departments of rural for-profit hospitals that participate in Medicare should be deemed "public" health care providers eligible to receive prorated rural health care support.⁸ We believe this clarification is necessary to give

¹ See 5 U.S.C. § 603. The RFA, see 5 U.S.C. §§ 601–12, has been amended by the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA), Pub. L. No. 104-121, Title II, 110 Stat. 857 (1996).

² *Rural Health Care Support Mechanism*, Notice of Proposed Rulemaking, WC Docket No. 02-60, 17 FCC Rcd 7806 (2002) (NPRM).

³ See 5 U.S.C. § 604.

⁴ 47 U.S.C. § 254.

⁵ *1997 Universal Service Order*, 12 FCC Rcd at 9118-19, paras. 655-56.

⁶ See *supra* paras. 8-10.

⁷ See *supra* paras. 13-17.

⁸ See *supra* para. 13.

meaning to the term “public” health care provider under the rural health care program. Moreover, we also determine that dedicated emergency departments in for-profit rural hospitals constitute “rural health clinics.”⁹ These entities are generally the initial point of entry into the healthcare system for any person suffering the consequences of a severe catastrophe or accident and constitute a vital segment of the health care community, particularly in the event of a national public health emergency. Additionally, we conclude that entities listed in section 254(h)(7)(B) include non-profit entities that function as one of the listed entities on a part-time basis.¹⁰ Pursuant to this modification, non-profit entities that provide ineligible services, even on a primary basis, would be able to receive prorated support commensurate with their provision of eligible rural health care services.¹¹ Our goal in implementing this proposal is two-fold – to encourage the development of public/private partnerships and other creative solutions to meet the needs of rural communities, and to increase participation in the rural health care support mechanism. Further, because entities that engage in both eligible and ineligible activities or that collocate with an entity that provides ineligible services will now be eligible for prorated support, we also adopt rules requiring such providers to allocate their discounts to prevent discounts from flowing to ineligible activities or providers of services.¹²

4. We also provide funding for Internet access for rural health care providers.¹³ We conclude that support equal to twenty-five percent of the monthly cost for any form of Internet access reasonably related to the health care needs of the facility should be provided to rural health care providers.¹⁴ We believe that the Internet can serve as an invaluable resource, by providing on-line courses in health education, medical research, follow-up care, regulatory information such as compliance with Health Insurance Portability and Accountability Act of 1996, video conferencing, web-based electronic benefit claim systems including on-line billing, and other crucial business functions.¹⁵ The incredible potential of the Internet to access such a breadth of medical information may also help reduce isolation in rural communities. Furthermore, health care information shared over the Internet may enable rural health care providers to diagnose, treat, and contain possible outbreaks of disease or respond to health emergencies. Thus, in light of the development of medical applications for the Internet since 1997, we conclude that encouraging access to this information service will improve the level of care available in rural areas.¹⁶

5. We also alter our current policy to allow rural health care providers to compare the urban and rural rates for *functionally* similar services as viewed from the perspective of the end

⁹ See *supra* para. 14.

¹⁰ See *supra* para. 15.

¹¹ *Id.*

¹² See *supra* paras. 49-51.

¹³ See *supra* para. 22.

¹⁴ *Id.*

¹⁵ See *supra* para. 23.

¹⁶ *Id.*

user.¹⁷ This modification to our rules will better effectuate the mandate of Congress to ensure comparable services for rural areas, as provided in section 254 of the Act, by allowing rural health care providers to benefit from obtaining telecommunications services at rates equivalent to those in urban areas.

6. We also revise section 54.605 of our rules to allow rural health care providers to compare rural rates to urban rates in any city with a population of at least 50,000 in the state, as opposed to the nearest city with a population of 50,000.¹⁸ Allowing comparison to rates in any city in the state acknowledges that rural health care providers may communicate with experts in other cities in the state. Such action also should allow rural health care providers to benefit from the lowest rates for services in the State, thereby providing additional support to develop better telemedicine links.

7. Additionally, we revise the maximum allowable distance (MAD) to equal the distance between the rural health care provider and the farthest point on the jurisdictional boundary of the largest city in that State.¹⁹ Accordingly, for distance-based charges, we modify our rules to provide support to rural health care providers to any location (within or outside of the state) that exceeds the SUD and is less than this revised MAD.²⁰ We believe, in most instances, calculating the MAD as described above will provide more support for distance-based charges than our current rules, without creating additional administrative burdens for the Administrator. In addition, this modification should provide rural health care providers access to high levels of care and greater flexibility in developing appropriate telehealth networks.

8. Lastly, we revise our policy to allow rural health care providers to receive discounts for satellite services even where alternative terrestrial-based services may be available.²¹ However, these discounts will be capped at the amount providers would have received if they purchased functionally similar terrestrial-based alternatives.²² We conclude this approach furthers the principle of competitive neutrality and recognizes the role that satellite services may play in rural areas without unduly increasing the size of the fund.

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

9. No petitions for reconsideration or comments were filed directly in response to the IRFA or on issues affecting small businesses.

C. Description and Estimate of the Number of Small Entities To Which Rules Will Apply

10. The RFA directs agencies to provide a description of, and where feasible, an

¹⁷ See *supra* para. 33.

¹⁸ See *supra* para. 37.

¹⁹ See *supra* para. 40.

²⁰ *Id.*

²¹ See *supra* para. 44.

²² *Id.*

estimate of the number of small entities that may be affected by the proposed rules, if adopted.²³ The RFA generally defines the term “small entity” as having the same meaning as the terms “small business,” “small organization,” and “small governmental jurisdiction.”²⁴ In addition, the term “small business” has the same meaning as the term “small business concern” under the Small Business Act.²⁵ A “small business concern” is one which: (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).²⁶

11. A small organization is generally “any not-for-profit enterprise which is independently owned and operated and is not dominant in its field.”²⁷ Nationwide, as of 1992, there were approximately 275,801 small organizations.²⁸ The term “small governmental jurisdiction” is defined as “governments of cities, counties, towns, townships, villages, school districts, or special districts, with a population of less than fifty thousand.”²⁹ As of 1997, there were approximately 87,453 government jurisdictions in the United States.³⁰ This number includes 39,044 counties, municipal governments, and townships, of which 27,546 have populations of fewer than 50,000 and 11,498 counties, municipal governments, and townships have populations of 50,000 or more. Thus, we estimate that the number of small government jurisdictions must be 75,955 or fewer. Small entities potentially affected by the proposals herein include small rural health care providers, small local health departments and agencies, and small eligible service providers offering discounted services to rural health care providers, including telecommunications carriers and ISPs.

a. Rural Health Care Providers

12. Section 254(h)(5)(B) of the Act defines the term “health care provider” and sets forth seven categories of health care providers eligible to receive universal service support.³¹ Although SBA has not developed a specific size category for small, rural health care providers,

²³ 5 U.S.C. § 603(b)(3).

²⁴ 5 U.S.C. § 601(6).

²⁵ 5 U.S.C. § 601(3) (incorporating by reference the definition of “small-business concern” in the Small Business Act, 15 U.S.C. § 632). Pursuant to 5 U.S.C. § 601(3), the statutory definition of a small business applies “unless an agency, after consultation with the Office of Advocacy of the Small Business Administration and after opportunity for public comment, establishes one or more definitions of such term which are appropriate to the activities of the agency and publishes such definition(s) in the Federal Register.”

²⁶ 15 U.S.C. § 632.

²⁷ 5 U.S.C. § 601(4).

²⁸ 1992 Economic Census, U.S. Bureau of the Census, Table 6 (special tabulation of data under contract to Office of Advocacy of the U.S. Small Business Administration).

²⁹ 5 U.S.C. § 601(5).

³⁰ 1995 Census of Governments, U.S. Census Bureau, United States Department of Commerce, Statistical Abstract of the United States (2000).

³¹ See 47 U.S.C. § 254(h)(5)(B).

recent data indicate that there are a total of 8,297 health care providers, consisting of: (1) 625 “post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools;” (2) 866 “community health centers or health centers providing health care to migrants;” (3) 1633 “local health departments or agencies;” (4) 950 “community mental health centers;” (5) 1951 “not-for-profit hospitals;” and (6) 2,272 “rural health clinics.”³² We have no additional data specifying the numbers of these health care providers that are small entities. In addition, non-profit entities that act as “health care providers” on a part-time basis will now be eligible to receive prorated support. However, we have no data specifying the number of potential new applicants. Consequently, using the data we do have, we estimate that there are 8,297 or fewer small health care providers potentially affected by the actions proposed in this Notice.

13. As noted earlier, non-profit businesses and small governmental units are considered “small entities” within the RFA. In addition, we note that census categories and associated generic SBA small business size categories provide the following descriptions of small entities.³³ The broad category of Ambulatory Health Care Services consists of further categories and the following SBA small business size standards.³⁴ The categories of providers with annual receipts of \$6 million or less consists of: Offices of Dentists; Offices of Chiropractors; Offices of Optometrists; Offices of Mental Health Practitioners (except Physicians); Offices of Physical, Occupational and Speech Therapists and Audiologists; Offices of Podiatrists; Offices of All Other Miscellaneous Health Practitioners; and Ambulance Services. The category of Ambulatory Health Care Services providers with \$8.5 million or less in annual receipts consists of: Offices of Physicians; Family Planning Centers; Outpatient Mental Health and Substance Abuse Centers; Health Maintenance Organization Medical Centers; Freestanding Ambulatory Surgical and Emergency Centers; All Other Outpatient Care Centers, Blood and Organ Banks; and All Other Miscellaneous Ambulatory Health Care Services. The category of Ambulatory Health Care Services providers with \$11.5 million or less in annual receipts consists of: Medical Laboratories; Diagnostic Imaging Centers; and Home Health Care Services. The category of Ambulatory Health Care Services providers with \$29 million or less in annual receipts consists of Kidney Dialysis Centers. For all of these Ambulatory Health Care Service Providers, census data indicate that there is a combined total of 345,476 firms that operated in 1997.³⁵ Of these, 339,911 had receipts for that year of less

³² In the *1997 Universal Service Order*, we estimated that there were (1) 625 “post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools,” including 403 rural community colleges, 124 medical schools with rural programs, [FN426] and 98 rural teaching hospitals; (2) 1,200 “community health centers or health centers providing health care to migrants;” (3) 3,093 “local health departments or agencies” including 1,271 local health departments and 1,822 local boards of health; (4) 2,000 “community mental health centers;” (5) 2,049 “not-for-profit hospitals;” and (6) 3,329 “rural health clinics.” The total of these numbers was 12,296. *1997 Universal Service Order*, 12 FCC Rcd at 9241-42, para. 924. More recent data, however, indicates that some of these 1997 numbers may have been overstated.

³³ North American Industry Classification System: United States, 1997 at 629-53.

³⁴ 13 C.F.R. § 121.201; NAICS Codes 621111, 621112, 621210, 621310, 621320, 621330, 621340, 621391, 621399, 621410, 621420, 621491, 621492, 621493, 621498, 621511, 621512, 621610, 621910, 621991, 621999.

³⁵ 1997 Economic Census, Establishment of Firm Size, U.S. Census Bureau, U.S. Department of Commerce, Economics and Statistics Administration, Document EC97S62S-SZ (*1997 Health Care Data*).

than \$5 million.³⁶ In addition, an additional 3414 firms had annual receipts of \$5 million to \$9.99 million; and additional 1475 firms had receipts of \$10 million to \$24.99 million; and an additional 401 had receipts of \$25 million to \$49.99 million.³⁷ We therefore estimate that virtually all Ambulatory Health Care Services providers are small, given SBA's size categories. In addition, we have no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

14. The broad category of Hospitals consists of the following categories and the following small business providers with annual receipts of \$29 million or less: General Medical and Surgical Hospitals, Psychiatric and Substance Abuse Hospitals; and Specialty Hospitals.³⁸ For all of these health care providers, census data indicate that there is a combined total of 330 firms that operated in 1997, of which 237 or fewer had revenues of less than \$25 million.³⁹ An additional 45 firms had annual receipts of \$25 million to \$49.99 million.⁴⁰ We therefore estimate that most Hospitals are small, given SBA's size categories. In addition, we have no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

15. The broad category of Nursing and Residential Care Facilities consists of the following categories and the following small business size standards.⁴¹ The category of Nursing and Residential Care Facilities with annual receipts of \$6 million or less consists of: Residential Mental Health and Substance Abuse Facilities; Homes for the Elderly; and Other Residential Care Facilities. The category of Nursing and Residential Care Facilities with annual receipts of \$8.5 million or less consists of Residential Mental Retardation Facilities. The category of Nursing and Residential Care Facilities with annual receipts of less than \$11.5 million consists of Nursing Care Facilities and Continuing Care Retirement Communities. For all of these health care providers, census data indicates that there are a combined total of 18,011 firms that operated in 1997.⁴² Of these, 16,165 or fewer firms had annual receipts of below \$5 million.⁴³ In addition, 1205 firms had annual receipts of \$5 million to \$9.99 million, and 450 firms had receipts of \$10 million to \$24.99 million.⁴⁴ We therefore estimate that a great majority of Nursing and Residential Care Facilities are small, given SBA's size categories. In addition, we have no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

³⁶ *Id.*

³⁷ *Id.*

³⁸ 13 C.F.R. § 121.201; NAICS Codes 622110, 622210, 622310.

³⁹ *1997 Health Care Data.*

⁴⁰ *Id.*

⁴¹ 13 C.F.R. § 121.201; NAICS Codes 623110, 623210, 623220, 623311, 623312, 623990.

⁴² *1997 Health Care Data.*

⁴³ *Id.*

⁴⁴ *Id.*

16. The broad category of Social Assistance consists of the category of Emergency and Other Relief Services and small business size standard of annual receipts of \$6 million or less.⁴⁵ For all of these health care providers, census data indicates that there are a combined total of 37,778 firms that operated in 1997.⁴⁶ Of these, 37,649 or fewer firms had annual receipts of below \$5 million. An additional 73 firms had annual receipts of \$5 million to \$9.99 million.⁴⁷ We therefore estimate that virtually all Social Assistance providers are small, given SBA's size categories. In addition, we have no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

b. Providers of Telecommunications and Other Services

17. We have included small incumbent local exchange carriers in this present RFA analysis. As noted above, a "small business" under the RFA is one that, *inter alia*, meets the pertinent small business size standard (*e.g.*, a telephone communications business having 1,500 or fewer employees), and "is not dominant in its field of operation."⁴⁸ The SBA's Office of Advocacy contends that, for RFA purposes, small incumbent local exchange carriers are not dominant in their field of operation because any such dominance is not "national" in scope.⁴⁹ We have therefore included small incumbent local exchange carriers in this RFA analysis, although we emphasize that this RFA action has no effect on Commission analyses and determinations in other, non-RFA contexts.

18. *Total Number of Telephone Companies Affected.* The United States Bureau of the Census (the "Census Bureau") reports that, at the end of 1997, there were 6,239 firms engaged in providing telephone services, as defined therein.⁵⁰ This number contains a variety of different categories of carriers, including local exchange carriers, interexchange carriers, competitive access providers, cellular carriers, mobile service carriers, operator service providers, pay telephone operators, PCS providers, covered SMR providers, and resellers. It seems certain that some of those 6,239 telephone service firms may not qualify as small entities because they are not "independently owned and operated."⁵¹ For example, a PCS provider that is affiliated with an interexchange carrier having more than 1,500 employees would not meet the definition of a small business. It seems reasonable to conclude, therefore, that 6,239 or fewer telephone

⁴⁵ 13 C.F.R. § 121.201; NAICS Code 624230.

⁴⁶ 1997 Health Care Data.

⁴⁷ *Id.*

⁴⁸ 15 U.S.C. § 632.

⁴⁹ Letter from Jere W. Glover, Chief Counsel for Advocacy, SBA, to William E. Kennard, Chairman, FCC (May 27, 1999). The Small Business Act contains a definition of "small-business concern," which the RFA incorporates into its own definition of "small business." See 15 U.S.C. § 632(a) (Small Business Act); 5 U.S.C. § 601(3) (RFA). SBA regulations interpret "small business concern" to take into account the concept of dominance on a national basis. 13 C.F.R. § 121.102(b).

⁵⁰ 1997 Economic Census, Establishment and Firm Size, U.S. Census Bureau, U.S. Department of Commerce, Economics and Statistics Administration, Document EC97S51S-SZ (1997 Economic Census), at 67.

⁵¹ 15 U.S.C. § 632(a)(1).

service firms are small entity telephone service firms that may be affected by the decisions and rules adopted in this *Report and Order*.

19. *Local Exchange Carriers, Interexchange Carriers, Competitive Access Providers, Operator Service Providers, Payphone Providers, and Resellers.* Neither the Commission nor SBA has developed a definition particular to small local exchange carriers (LECs), interexchange carriers (IXCs), competitive access providers (CAPs), operator service providers (OSPs), payphone providers or resellers. The closest applicable definition for these carrier-types under SBA rules is for telephone communications companies other than radiotelephone (wireless) companies.⁵² The most reliable source of information regarding the number of these carriers nationwide of which we are aware appears to be the data that we collect annually on the Form 499-A. According to our most recent data, there are 1,335 incumbent LECs, 349 CAPs, 204 IXCs, 21 OSPs, 758 payphone providers and 454 resellers.⁵³ Although it seems certain that some of these carriers are not independently owned and operated, or have more than 1,500 employees, we are unable at this time to estimate with greater precision the number of these carriers that would qualify as small business concerns under SBA's definition. Consequently, we estimate that there are fewer than 1,335 incumbent LECs, 349 CAPs, 204 IXCs, 21 OSPs, 758 payphone providers, and 541 resellers that may be affected by the decisions and rules adopted in this *Report and Order*.

20. *Internet Service Providers.* The SBA has developed a small business size standard for "On-Line Information Services," NAICS code 514191.⁵⁴ This category comprises establishments "primarily engaged in providing direct access through telecommunications networks to computer-held information compiled or published by others."⁵⁵ Under this small business size standard, a small business is one having annual receipts of \$18 million or less.⁵⁶ Based on firm size data provided by the Bureau of the Census, 3,123 firms are small under SBA's \$18 million size standard for this category code.⁵⁷ Although some of these Internet Service Providers (ISPs) might not be independently owned and operated, we are unable at this time to estimate with greater precision the number of ISPs that would qualify as small business concerns under SBA's small business size standard. Consequently, we estimate that there are 3,123 or fewer small entity ISPs that may be affected.

21. *Satellite Service Carriers.* The SBA has developed a definition for small businesses

⁵² 13 C.F.R. § 121.210, North American Industry Classification System (NAICS) Codes 513310, 513330, 513340.

⁵³ See FCC, Common Carrier Bureau, Industry Analysis Division, *Trends in Telephone Service*, Table 5.3 (August 2001) (*Telephone Trends Report*). The total for resellers includes both toll resellers and local resellers. The category for CAPs also includes competitive local exchange carriers (LECs).

⁵⁴ See generally North American Industry Classification System – United States (1997), NAICS code 514191.

⁵⁵ See generally North American Industry Classification System – United States (1997), NAICS code 514191.

⁵⁶ 13 CFR § 121.201, NAICS code 514191.

⁵⁷ Office of Advocacy, U.S. Small Business Administration, Firm Size Data by Industry and Location.

within the category of Satellite Telecommunications. According to SBA regulations, a small business under the category of Satellite communications is one having annual receipts of \$12.5 million or less.⁵⁸ According to SBA's most recent data, there are a total of 371 firms with annual receipts of \$9,999,999 or less, and an additional 69 firms with annual receipts of \$10,000,000 or more.⁵⁹ Thus, the number of Satellite Telecommunications firms that are small under the SBA's \$12 million size standard is between 371 and 440. Further, some of these Satellite Service Carriers might not be independently owned and operated. Consequently, we estimate that there are fewer than 440 small entity ISPs that may be affected by the decisions and rules of the present action.

22. Wireless Service Providers. The SBA has developed a definition for small businesses within the two separate categories of Cellular and Other Wireless Telecommunications or Paging. Under that SBA definition, such a business is small if it has 1,500 or fewer employees.⁶⁰ According to the Commission's most recent Telephone Trends Report data, 1,495 companies reported that they were engaged in the provision of wireless service.⁶¹ Of these 1,495 companies, 989 reported that they have 1,500 or fewer employees and 506 reported that, alone or in combination with affiliates, they have more than 1,500 employees. We do not have data specifying the number of these carriers that are not independently owned and operated, and thus are unable at this time to estimate with greater precision the number of wireless service providers that would qualify as small business concerns under the SBA's definition. Consequently, we estimate that there are 989 or fewer small wireless service providers that may be affected by the rules.

23. Cable and Other Subscription Programming or Other Program Distribution and Related Entities. The SBA has developed small business size standards which include all such companies generating \$12.5 million or less in revenue annually. These standards cover two categories of Cable Services: Cable and Other Subscription Programming; and Cable and Other Program Distribution.

*24. Cable and Other Subscription Programming.*⁶² This industry comprises establishments primarily engaged in operating studios and facilities for the broadcasting of programs on a subscription or fee basis. These establishments produce programming in their own facilities or acquire programming from external sources. The programming material is usually delivered to a third party, such as cable systems or direct-to-home satellite systems, for transmission to viewers. According to Census Bureau data for 1997, there were a total of 234 firms in this category, total, that had operated for the entire year. Of this total, 188 firms had

⁵⁸ 13 C.F.R. § 121.201; NAICS Code 513340.

⁵⁹ 1997 *Economic Census* at 16.

⁶⁰ 13 C.F.R. § 121.210; NAICS Code 513322.

⁶¹ *Telephone Trends Report*, Table 5.3.

⁶² 13 CFR § 121.201, North American Industry Classification System (NAICS) code 513210 (changed to 515210 in October 2002).

annual receipts of under \$10 million.⁶³ Consequently, the Commission estimates that the majority of providers in this service category are small businesses that may be affected by the rules and policies adopted herein.

25. *Cable and Other Program Distribution.*⁶⁴ This category includes cable systems operators, closed circuit television services, direct broadcast satellite services, multipoint distribution systems, satellite master antenna systems, and subscription television services. According to Census Bureau data for 1997, there were a total of 1,311 firms in this category, total, that had operated for the entire year.⁶⁵ Of this total, 1,180 firms had annual receipts of under \$10 million and an additional 52 firms had receipts of \$10 million or more but less than \$25 million. Consequently, the Commission estimates that the majority of providers in this service category are small businesses that may be affected by the rules and policies adopted herein.

D. Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements

26. The *Report and Order* adopts several modifications to the Commission's rules to improve the effectiveness of the rural health care universal service support mechanism and increase utilization of this mechanism by rural health care providers. As articulated above, in the *Report and Order*, we clarify the scope of entities eligible to receive discounts.⁶⁶ Specifically, because entities that engage in eligible and ineligible activities or that collocate with an entity that provides ineligible services will now be eligible for prorated support, we adopt rules requiring such providers to allocate their discounts to prevent discounts from flowing to ineligible activities or providers of services.⁶⁷ Health care providers are required to maintain documentation explaining their allocation methods for five years and present that information to USAC upon request.⁶⁸ The method of cost allocation chosen by an applicant should be based on objective criteria and reasonably reflect the eligible usage of the facilities. Additionally, health care providers must maintain for their purchases of supported services procurement records for at least five years sufficient to document their compliance with all Commission requirements.⁶⁹

E. Steps Taken to Minimize Significant Economic Impact on Small Entities, and

⁶³ U.S. Census Bureau, 1997 Economic Census, Subject Series: Information, "Establishment and Firm Size (Including Legal Form of Organization)", Table 4, NAICS code 513210 (issued October 2000).

⁶⁴ 13 CFR § 121.201, North American Industry Classification System (NAICS) code 513220 (changed to 517510 in October 2002).

⁶⁵ U.S. Census Bureau, 1997 Economic Census, Subject Series: Information, "Establishment and Firm Size (Including Legal Form of Organization)", Table 4, NAICS code 513220 (issued October 2000).

⁶⁶ See *supra* paras. 13-17.

⁶⁷ 47 C.F.R. § 54.601(d) as adopted herein.

⁶⁸ See 47 C.F.R. § 54.619(a)(1) as adopted herein.

⁶⁹ 47 C.F.R. § 54.619(a)(1) as adopted herein.

Significant Alternatives Considered

27. The RFA requires an agency to describe any significant alternatives that it has considered in reaching its proposed approach impacting small business, which may include the following four alternatives (among others): (1) the establishment of differing compliance and reporting requirements or timetables that take into account the resources available to small entities; (2) the clarification, consolidation, or simplification of compliance or reporting requirements under the rule for small entities; (3) the use of performance, rather than design, standards; and (4) an exemption from coverage of the rule, or part thereof, for small entities.⁷⁰

28. In this *Report and Order*, we amend our rules to improve the program, increase participation by rural health care providers, and ensure that the benefits of the program continue to be distributed in a fair and equitable manner. Specifically, we expand the scope of entities eligible to receive discounts, provide support for Internet access, and modify the way in which we calculate discounts to offer rural health care providers more flexibility. The actions taken in the *Report and Order* help improve the quality of health care services available in rural America, and better enable rural communities to rapidly diagnose, treat, and contain possible outbreaks of disease. Thus, rural health care providers stand to benefit directly from the modifications to our rules and policies.

F. Report to Congress

29. The Commission will send a copy of the *Report and Order*, *Order on Reconsideration*, and *Further Notice of Proposed Rulemaking*, including this FRFA, in a report to be sent to Congress pursuant to the Congressional Review Act.⁷¹ In addition, the Commission will send a copy of the *Report and Order*, *Order on Reconsideration*, and *Further Notice of Proposed Rulemaking*, including this FRFA, to the Chief Counsel for Advocacy of the Small Business Administration. A copy of the *Report and Order*, *Order on Reconsideration*, and *Further Notice of Proposed Rulemaking* and FRFA (or summaries thereof) will also be published in the Federal Register.⁷²

⁷⁰ See 5 U.S.C. §§ 603(c)(1)-(4).

⁷¹ See 5 U.S.C. § 801(a)(1)(A).

⁷² See 5 U.S.C. § 604(b).

APPENDIX D

INITIAL REGULATORY FLEXIBILITY ANALYSIS

(FURTHER NOTICE OF PROPOSED RULEMAKING)

1. As required by the Regulatory Flexibility Act of 1980, as amended (RFA),¹ the Commission has prepared the present 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 this *Further Notice*. Written public comments are requested on this IRFA. Comments must be identified as responses to the IRFA and must be filed by the deadlines for comments on *the Further Notice* provided below in Section VI(C) above. The Commission will send a copy of the *Further Notice*, including this IRFA, to the Chief Counsel for Advocacy of the Small Business Administration.² In addition, the *Further Notice* and IRFA (or summaries thereof) will be published in the Federal Register.³

A. Need for, and Objectives of, the Proposed Rules

2. The Commission is required by section 254 of the Act to promulgate rules to implement the universal service provisions of section 254.⁴ On May 8, 1997, the Commission adopted rules that reformed its system of universal service support mechanisms so that universal service is preserved and advanced as markets move toward competition.⁵ Among other things, the Commission adopted a mechanism to provide discounted telecommunications services to public or non-profit health care providers that serve persons in rural areas. Over the last few years, important changes in the rural health community prompt us to review the rural health care universal service support mechanism.⁶

3. In this *Further Notice*, we seek comment on whether and how to modify the definition of rural area as utilized in the rural health care support mechanism.⁷ We also seek comment on whether additional modifications to our rules are appropriate to facilitate the provision of support to mobile rural health clinics for satellite services.⁸ Lastly, we seek

¹ See 5 U.S.C. § 603. The IRFA, see 5 U.S.C. §§ 601-12, has been amended by the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA) Pub. L. No. 104-121, Title II, 110 Stat 857 (1996).

² See 5 U.S.C. § 603(a).

³ See *id.*

⁴ 47 U.S.C. § 254.

⁵ *1997 Universal Service Order*, 12 FCC Rcd at 9118-19, paras. 655-56.

⁶ See *supra* paras. 8-10.

⁷ See *supra* paras. 63-64.

⁸ See *supra* paras. 65-68.

comments on ways to streamline further the application process and expand outreach efforts.⁹

B. Legal Basis

4. This *Further Notice* is adopted pursuant to sections 1, 4(i), (4j), 201-205, 251, 252, and 303 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151, 154(i), (j), 201-205, 251, 252, and 303.

C. Description and Estimate of the Number of Small Entities To Which Rules Will Apply

5. 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.¹⁰ The RFA generally defines the term “small entity” as having the same meaning as the terms “small business,” “small organization,” and “small governmental jurisdiction.”¹¹ In addition, the term “small business” has the same meaning as the term “small business concern” under the Small Business Act, unless the Commission has developed one or more definitions that are appropriate to its activities.¹² 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) meets any additional criteria established by the Small Business Administration (SBA).¹³

6. We have described in detail, *supra*, in the FRFA, the categories of entities that may be directly affected by any rules or proposals adopted in our efforts to reform the universal service rural health care support mechanism.¹⁴ For this IRFA, we hereby incorporate those entity descriptions by reference.

D. Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements

7. The *Further Notice* seeks comment on potential changes to the definition of “rural area” for the rural health care support mechanism. This potential change will not impact reporting or recordkeeping requirements, however, it could impact the overall pool of eligible applicants. The *Further Notice* also seeks comment on whether additional support should be provided to mobile rural health clinics that utilize satellite services. If changes are adopted, mobile rural health clinics, including small rural health clinics, could potentially be required to

⁹ See *supra* para. 69.

¹⁰ 5 U.S.C. § 604(a)(3).

¹¹ 5 U.S.C. § 601(6).

¹² 5 U.S.C. § 601(3) (incorporating by reference the definition of “small business concern” in 5 U.S.C. § 632). Pursuant to 5 U.S.C. § 601(3), the statutory definition of a small business applies “unless an agency after consultation with the Office of Advocacy of the Small Business Administration and after opportunity for public comment, establishes one or more definitions of such term which are appropriate to the activities of the agency and publishes such definition in the Federal Register.”

¹³ 15 U.S.C. § 632.

¹⁴ See *supra* Appendix C, paras. 10-24.

submit additional information regarding their mobile services, if they choose to seek discounts. Lastly, the *Further Notice* seeks comment on ways to streamline further the application process. If the application process is streamlined further, this would eliminate some of the paperwork associated with the application process.

E. Steps Taken to Minimize Significant Economic Impact on Small Entities, and Significant Alternatives Considered

8. The RFA requires an agency to describe any significant alternatives that it has considered in reaching its proposed approach impacting small business, which may include the following four alternatives (among others): (1) the establishment of differing compliance and reporting requirements or timetables that take into account the resources available to small entities; (2) the clarification, consolidation, or simplification of compliance or reporting requirements under the rule for small entities; (3) the use of performance, rather than design, standards; and (4) an exemption from coverage of the rule, or part thereof, for small entities.¹⁵

9. In this *Further Notice*, we seek comment on a new definition of rural area. If a new definition is adopted, this could change the size of the overall pool of eligible applicants for universal service support for rural health care providers. We also seek comment on whether to provide additional support to mobile rural health clinics that utilize satellite services. In seeking to minimize the burdens imposed on small entities where doing so does not compromise the goals of the universal service mechanism, we invite comment on definitions and proposals for additional support for mobile rural health clinics that might be made less burdensome for small entities. In addition, we seek comment on ways to streamline further the application process and expand outreach efforts. If the application process is streamlined further, this could ease the burden on small entities associated with the application process. Additionally, outreach efforts would better inform such businesses about the benefits of the rural health care program and potentially increase small business participation in the program.

F. Federal Rules that May Duplicate, Overlap, or Conflict with the Proposed Rules

10. None.

¹⁵ See 5 U.S.C. §§ 603(c)(1)-(4).

**SEPARATE STATEMENT OF
CHAIRMAN MICHAEL K. POWELL**

*Re: Rural Health Care Support Mechanism, Report and Order, Order on
Reconsideration, and Further Notice of Proposed Rulemaking*

Telemedicine creates medical expertise on demand for people living in rural America. The telemedicine support measures we adopt today have the potential to bring millions of Americans from rural and remote parts of the country closer than ever to top-quality doctors and medical specialists. Geographic isolation should no longer be a barrier to timely, quality medical care.

Telemedicine networks are also integral to our homeland security efforts. In times of national crisis, telemedicine networks can bring much-needed healthcare information to first responders. For example, telemedicine capabilities serve as a link between medical professionals and homeland security teams to ensure that experts are available in the event of a biological or chemical attack.

Although the rural health care program has a \$400 million annual maximum, demand for Funding Years 2000 and 2001 averaged approximately \$14 million a year. Today, we adopt rule changes to encourage the development of public/private partnerships and other creative solutions to meet the needs of rural communities and increase participation in the rural health care program. Today's Order clarifies that dedicated emergency departments in for-profit rural hospitals are "public" health care providers eligible for support because these rural hospitals are required by other federal laws to examine and stabilize all patients who walk in the door. The rule changes we adopt today represent important reforms of our eligibility criteria and should ensure scope of services eligible for support under our rural health care program.

Most residents in rural or remote areas of the country do not have the luxury of even one major medical facility near their homes, much less access to the world-renowned team of doctors, clinicians and researchers that major educational institutions and research hospitals can assemble. Innovations in computing and telecommunications technology, however, allow doctors to perform many medical procedures even though hundreds or even thousands of miles separate doctor and patient. Recently, I witnessed the transformative potential of telemedicine when I visited the University of Virginia's Office of Telemedicine. At the University of Virginia, I saw firsthand not only the types of technologies that doctors can use to improve health care, but also the telecommunications services – and service providers – that are making telemedicine a reality in rural areas of America and across the globe. The changes to our rural health care program that we adopt today probably may not bring back housecalls, but they will help promote the admirable goal of helping to extend the expertise of some of the nation's most advanced medical professionals into some of the nation's most rural and remote areas.

I look forward to working with my colleagues to unlock the potential of this program and to expeditiously addressing the issues presented in the Further Notice.

**SEPARATE STATEMENT OF
COMMISSIONER KATHLEEN Q. ABERNATHY**

Re: Rural Health Care Support Mechanism, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking

I am extremely pleased to support this Order and its significant improvements to the rural health care support mechanism. While the universal service programs overall have successfully delivered benefits to consumers living in high-cost areas, to patrons of schools and libraries, and to persons of limited means, there is no question that the rural health care mechanism has been underutilized. I am confident that today's action will more faithfully deliver on Congress's promise to lower telecommunications costs for health care providers serving rural communities.

In turn, our action should make telemedicine available for many consumers for whom visits to specialists otherwise would cause great hardships. We often talk about the benefits of broadband services, but telemedicine may be the most important application of them all. Telemedicine has the potential to make it irrelevant whether a patient lives in a downtown urban area or on a mountaintop. I have seen demonstrations of how telemedicine connects patients in remote areas of Alaska to hospitals and clinics hundreds of miles away, often preventing the ordeal (and immense cost) of air transport. I was also privileged to have the opportunity last week to visit the University of Virginia's exemplary telemedicine program, which serves consumers throughout the Appalachian region of the state. It was truly heartwarming to hear testimonials from patients whose lives have been improved by the availability of high-speed telecommunications links throughout rural Virginia. And it was awe-inspiring to listen to a patient's heartbeat or view a cardiac ultrasound in perfect fidelity and clarity from hundreds of miles away. Dr. Karen Rheuban and her colleagues have done an amazing job at UVA, and I hope other states and institutions follow their example.

I also hope that we will find ways in the further rulemaking to fund mobile clinics, such as the satellite-enabled mammography van that Healthcare Anywhere proposes to use to serve women on tribal lands in North and South Dakota. Such innovative ideas not only would bring critical health care services to underserved communities, but also might lower health care costs by making preventive care more widespread.

Finally, while I fully support taking steps that are likely to drive up the demand for universal service funding, I am confident that our rules will continue to ensure that funding needs are met without waste, fraud, or abuse. For example, although we have expanded the program to provide discounts on Internet access for the first time, we have set the initial discount rate for Internet access at a modest 25 percent to prevent excessive fund growth and to ensure that providers have adequate incentives to avoid overpayment. In time, we may decide that additional funding is warranted, but we must balance the tremendous benefits of telemedicine against the significant burdens that are being placed on consumers to fund our various universal service support mechanisms. At this point, the balance clearly tilts in favor of expanding the program, because it has barely begun to fulfill Congress's mandate to establish an effective rural health care support mechanism.

**SEPARATE STATEMENT OF
COMMISSIONER MICHAEL J. COPPS**

*Re: Rural Health Care Support Mechanism, Report and Order, Order on
Reconsideration, and Further Notice of Proposed Rulemaking*

I am pleased—very pleased—to see this rural health care item on our agenda today. This is a program that we need to put to work. We need to put it to work because rural America lags the rest of the country in access to premium health care, and we need to do it now more than ever because of the heightened threats of bio-terrorism and health catastrophe that follow in the wake of 9/11. Rural America wasn't where it should have been in access to good health services before 9/11, and if terror visited there now, all the reports tell us, rural America is less-equipped to deal with it than we are in the metropolitan areas, and goodness knows we need a lot of improvements here, too.

For those who are interested in seeing how rural health care providers can make use of telecommunications infrastructure to provide needed services, it's there to see. In growing numbers of places, you can see telemedicine and telehealth improving the quality of life in rural communities by providing patients in remote areas with access to services that would otherwise have been unavailable. We are seeing patient diagnostic services, patient follow-up care, educational offerings for rural health care professionals, and the dissemination of all sorts of critical health-related information.

Last week, I had the opportunity to learn about this first-hand when I spent some quality time in the south central Wisconsin town of Beaver Dam, at the Beaver Dam Community Hospital. I had the opportunity there to have a long conversation with the people who run this rural facility and the people responsible for the telecommunications technologies used to provide patient care.

Here at the Commission we now understand that our Rural Health Care Program has not lived up to its potential. We set aside as much as \$400 million annually, but in the first five years of the program, just over \$30 million was disbursed to rural facilities. This is not on the scale of what I suspect the Commission had in mind when the program was first set up, and it is certainly not on the scale of what Congress had in mind when it directed the Commission to ensure that health care providers serving rural communities have access to services on par with those available in urban areas. And, as I said a minute ago, it falls even farther short of what it should be in light of 9/11.

In response, we change our rules today. In particular, we expand our interpretation of eligible health care providers, provide flat support for Internet access and revise our standard for urban area rate comparisons. I support these changes because I believe they will improve the Rural Health Care Program in a manner that is consistent with our statutory mandate.

But other problems—serious problems—remain and they keep this program from being utilized the way it should be utilized. My conversations in Beaver Dam, and my earlier conversations in the remote town of Levelock, Alaska, convince me that basic lack of outreach and a cumbersome application process may be the real culprits here.

The Rural Health Care Program is only as strong as the community that knows about it. And you know what? A lot of communities don't know about this program. So, for openers, we need to work much more closely with the American Hospital Association, state health care organizations, rural government associations and telecommunications carriers serving rural communities to get the word out. Like so many of our universal service programs designed for end-user beneficiaries—without outreach they risk irrelevance, perhaps even extinction.

Then there is the application process. It needs a major overhaul. At Beaver Dam Community Hospital, they spent six months to secure what wound up being only a single month of funding. Figuring out the appropriate discount rate, securing necessary information from telecommunications carriers and completing the mountain of related forms is a time consuming and arduous task. The application calls on health care professionals to master the complexities of such things as total billed miles and the intricacies of all sorts of convoluted tariff rates. These rural hospitals have limited staff, they have urgent priorities, and in a matter like this, where months of work translate into a couple thousand dollars of one-month support, they question if the paper chase is at all worth it. From what I saw, I don't blame them. And I fear Beaver Dam's experience is not unusual. I know that USAC has recently made some improvements, including a new database of urban rates and enhanced electronic filing capabilities and also making the second year application easier, and I congratulate them for that. But we can, we should, and we must do more. We are justifiably concerned with deterring waste and abuse, but we should recognize that the complexity of the process here is deterring worthy applicants—and that is really waste and abuse.

I commend the Chairman and the Wireline Competition Bureau for developing this item today, and I am encouraged that the Chairman and Commissioner Abernathy made a trip last week to visit the University of Virginia Office of Telemedicine. Raising the profile of this program helps. Today's Order helps. And tackling some of these other problems would help. This program involves national security and our national well-being. We can all be zealous advocates for this cause. I look forward to working with my colleagues, the Bureau, rural health care providers and the industry to make this program what it deserves to be.

**SEPARATE STATEMENT OF
COMMISSIONER JONATHAN S. ADELSTEIN**

Re: Rural Health Care Support Mechanism, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking

Today we modify our rules to improve the effectiveness of the rural health care support mechanism. I believe that the modifications that we make will improve the program, increase participation of rural health care providers, and ensure that benefits of the program continue to be distributed in a fair and equitable manner. This program has not yet met the Commission's projections, and has not lived up to Congress' expectations. These changes will help the program fulfill its enormous potential to improve the quality of health care in rural America.

Today's decision is one of those that really makes our jobs as public servants incredibly rewarding. There are only winners in today's decision. And we are all winners as a result of today's decision. A chain is only as strong as its weakest link, and today we further fortify the links in our communications network.

As a result of today's decision, more entities will be eligible for funding. It is critically important that we now permit funding of dedicated emergency facilities in for-profit hospitals as "rural health care clinics". These facilities are often the first line of defense and the portal for the patients' entry into the health care system. This change is particularly important in light of our national security concerns and the need to address any national emergency situation that may present itself. For example, if there is a chemical or biological attack and a patient presents himself to the dedicated care facility, access to rural health care funding may help ensure a quicker, more comprehensive determination of the crisis at hand, potentially saving many lives.

It is critical that we will allow for funding of "part-time" rural health care facilities. This is the reversal of a prior rule that rural health care providers associated with non-profit nursing homes, hospices and long term care facilities are 100% ineligible for funding. It will enhance the availability of health care in rural areas that don't have any other option or entity to serve as a health care facility.

Today we also approve funding for Internet access to rural health care providers. We are directing USAC to provide to rural health care providers twenty-five percent of the monthly cost for any form of Internet access reasonably related to the health care needs of the facility. Internet access has changed the world and our interaction with it. The Internet brings the world to us. In remote rural areas, access to the wealth of information and instruction that the Internet provides can mean the difference between life and death. I believe that a twenty-five percent discount is appropriate at this time, but I am willing to consider a higher discount based on the usage we see.

Under our old rules, we would allow rural health care providers to compare their rural rates to urban rates in the nearest city with a population of 50,000. Now we allow the health care providers to compare their rates to any city in their state with a population of greater than 50,000. We have learned through experience that the rural health care providers don't necessarily always choose to connect to a point in the nearest largest city, but may very well choose to connect elsewhere where their needs are better met. This improvement that we make today will allow for rural health care providers to enjoy lower rates and provide access to the services that are most

useful for their facilities.

I strongly support the revision of our policy to allow rural health care providers to receive discounts for satellite services even where alternative terrestrial based services may be available. Different technologies may be better suited to different health care providers and the services that they wish to offer. We should not limit a health care provider's ability to make that assessment and subsequent choice. I do believe, however, that in order to appropriately oversee this fund, capping the discount at the amount providers would have received if they had purchased functionally similar terrestrial-based alternatives is an important addition to prevent waste, fraud and abuse.

I am also pleased that we are continuing to look at the myriad of ways to improve this program by asking questions about the appropriate definition of a rural area. In addition, we are requesting comment on the provision of support to mobile rural health care clinics for satellite services. These questions are imperative to continuing to improve this program that has already done so much good, but can clearly do more. I eagerly await the ideas that health care and service providers will offer in response to our request for more information.

Finally, I'd like to thank USAC for the fine job it has done to help promote this program and all the other universal service programs it administers. I know that USAC works very closely with our staff and serves as a resource that helps us make better, more knowledgeable decisions. In particular I'd like to thank Cheryl Parrino for her leadership and wish her well as she moves on to her next challenge. She will be missed.

I approve this item and look forward to future advances in the program that result from our actions today.