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

In the Matter of	)	
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Rural Health Care	)	WC Docket No. 02-60
Support Mechanism	)	
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NOTICE OF PROPOSED RULEMAKING

Adopted: April 18, 2002 **Released: April 19, 2002**

Comment Date: 45 days from publication in Federal Register.
Reply Comment Date: 75 days from publication in Federal Register.

By the Commission: Paras.

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I. INTRODUCTION

1. In this Notice of Proposed Rulemaking (Notice), we seek comment on proposed modifications to our rules and other changes governing the rural health care universal service support mechanism.[1] The Commission implemented the rural health care mechanism at the direction of Congress as provided in the Telecommunications Act of 1996 (1996 Act).[2] In the first five years of its operation, the rural health care mechanism has provided discounts that have facilitated the ability of health care providers to provide critical access to modern telecommunications and information services for medical and health maintenance purposes to rural America. Participation in the rural health care universal service support mechanism, however, has not met the Commission's initial projections. After five years of experience with

[1] For this proceeding, we have opened a separate docket number, WC Docket No. 02-60, in order to facilitate the receipt of comments. The prior history of this proceeding, however, may be found in *Federal-State Joint Board on Universal Service* and *Federal-State Joint Board on Universal Service*, CC Docket Nos. 96-45 and 97-21.

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

the mechanism and considering recent developments, we find it appropriate to assess whether our rules and policies require modification.

2. In light of changes in technology and market conditions as well as recent national events, we find it appropriate to ask whether various aspects of the rural health care support mechanism can be streamlined and improved, in order to best effectuate the mandate of Congress. We seek comment on certain specific changes to the mechanism based on our past experience with the mechanism, and solicit input regarding other changes to improve efficiency, fairness, and overall operation of the mechanism. We believe certain changes to our rules affecting the rural health care support mechanism could significantly bolster the availability of telemedicine and telehealth, thereby enhancing critical diagnosis and communication support for isolated health centers throughout the rural United States in the event of a national public health emergency.

3. Our goals in undertaking this proceeding, consistent with the statute, are four-fold: (1) to ensure that the benefits of the universal service support mechanism for rural health care providers continue to be distributed in a fair and equitable manner; (2) to examine current rules and, if necessary, implement changes to improve and streamline operation of the rural health care universal service support mechanism; (3) to maintain our effective oversight over operation of the mechanism to ensure the statutory goals of section 254 of the Act are met without waste, fraud, or abuse; and (4) to strengthen the ability of rural health care providers to provide critical health care services, consistent with section 254, and thereby further our national homeland security.

4. In this Notice, we seek comment on several general categories of issues, including whether to: clarify how we should treat eligible entities that also perform functions that are outside the statutory definition of "health care provider"; provide support for Internet access; and change the calculation of discounted services, including the calculation of urban and rural rates. In addition, we seek comment on other administrative changes to the rural health care mechanism, including whether and how to: streamline the application process; allocate funds if demand exceeds the annual cap; modify the current competitive bidding rules; and encourage partnerships with clinics at schools and libraries. We also seek comment on other measures to prevent waste, fraud, and abuse; and any other issues concerning the structure and operation of the rural health care universal service support mechanism.

5. We seek comment on these specific proposals, and how such changes could be implemented. We also seek comment on the effect that any such changes may have on demand for support under the universal service mechanism as well as data to support any comments made. We welcome any alternative proposals that are consistent with the statute and that satisfy the expressed goals of this proceeding. We seek comment from state members of the Federal-State Joint Board on Universal Service on the matters raised in this proceeding.

II. BACKGROUND

6. In the 1996 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]

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

(continued....)

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]

7. The Commission implemented this statutory directive by adopting the rural health care support mechanism in the 1997 *Universal Service Order*.[6] 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 or more people, taking distance charges into account.[7] The Commission also adopted mechanisms to provide support for limited toll-free access to an Internet service provider.[8] The Commission adopted an annual cap of $400 million for universal service support for rural health care providers.[9] The Commission based its conclusions on analysis of the state of the rural health care community and technology at that time.[10]

8. 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.[11] Because only

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[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).

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

[7] *Universal Service Order*, 12 FCC Rcd at 9039, para. 608.

[8] *Id.*

[9] 47 C.F.R. § 54.623; *Universal Service Order,* 12 FCC Rcd at 9141, para. 705 (pursuant to sections 254(h)(1)(A) and 254(h)(2) of the Act). 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).

[10] *See 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*)).

[11] 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.

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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.[12] At that time, the Commission made certain changes: (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 number of participants in the rural health care universal service support mechanism.[13] The Commission also determined that the definition of "health care provider" does not include nursing homes, hospices, or other long-term care facilities, and emergency medical service facilities.[14] The Commission also decided not to further clarify the definition of "health care provider" or to provide additional support for long distance telecommunications service.[15]

9. The rural health care community and participating service providers are now in their fifth year of experience with the rural health care support mechanism. Over this period, the rural health care mechanism has provided support to rural health care providers in 40 states and the U.S. Virgin Islands, to obtain access to modern telecommunications and information services for medical and health maintenance purposes.[16] Such support has facilitated the delivery of medical services to people who would 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 send x-rays to radiologists and photographs of skin lesions and other medical conditions to doctors in real time, rather than waiting for scheduled visits or trying to describe such conditions with a degree of accuracy and completeness sufficient to enable responsible and effective medical treatment. Through telemedicine, doctors in our largest cities have been able to help with the birth of babies and provide other medical care in our most remote communities, while psychiatrists and caseworkers in urban areas have been able to treat serious mental illness in rural areas.

10. Several factors prompt us to review anew the rural health care universal service support mechanism. First, the mechanism is greatly underutilized. Notwithstanding the annual funding cap of $400 million, only 700 rural health care providers out of nearly 8,300 received

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Federal-State Joint Board on Universal Service, CC Docket No. 96-45, Fourteenth Order on Reconsideration, FCC 99-256 (adopted September 21, 1999) (*Fourteenth Order on Reconsideration*).

[12] *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, FCC 99-269 (rel. November 1, 1999) (*Fifteenth Order on Reconsideration*), para. 7 (noting that there were 2,500 initial applications, and only a small fraction made it through the first funding cycle).

[13] *Id.*

[14] *Id.*

[15] *Fifteenth Order on Reconsideration*, FCC 99-269, para. 9.

[16] Universal Service Administrative Company 2001 Annual Report.

support in Funding Year 3.[17] As of February 1, 2002, the Rural Health Care Division (RHCD) of the Universal Service Administrative Company (USAC or the Administrator) had disbursed only $13 million in discounts for the first three years of operation of the universal service support mechanism.[18] 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.

11. 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.[19] This change in network infrastructure calls into question the need for continuing discounts for toll free access to rural health care facilities. More sophisticated medical imaging technology is available today than existed in 1997, which requires high speed access to display images used for diagnostic purposes.[20]

12. Finally, 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."[21] Consistent with section 151's 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 cannot be underestimated. 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

[17] *See id.* (stating 703 providers received support); 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).

[18] Universal Service Administrative Company 2001 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).

[19] *See, e.g.,* NTCA Members Internet/Broadband Survey Report, National Telephone Cooperative Association (November 2000) at 9 (quoting a survey of members of the National Telephone Copperative 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 ("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.")

[20] *See, e.g., What's Next: Skyway to Health,* Telephony, April 1, 2002, at 40.

[21] 47 U.S.C. § 151.

addition to crisis response, telemedicine and telehealth could play a critical role in informing rural health care providers about emerging threats and improving preparedness.[22]

III. DISCUSSION

A. Eligible Health Care Providers

13. Section 254(h)(1)(A) of the Act requires telecommunications carriers to provide discounted telecommunications service "to any public or nonprofit health care provider that serves persons who reside in rural areas in that State."[23] Section 254(h)(2)(A) directs the Commission to enhance access to "advanced telecommunications and information services" for, *inter alia*, "public and non-profit . . . health care providers."[24] The term "health care provider" as used in these sections is defined in section 254(h)(7)(B) as follows:

> For purposes of this subsection: . . . [t]he term 'health care provider' means –
>
> (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).[25]

14. The Commission initially addressed the scope of this statutory definition in the *Universal Service Order*, finding that the seven statutory categories adequately described the entities that Congress intended to qualify as health care providers.[26] It declined to expand the definition of "health care provider" beyond the statutorily-enumerated categories, concluding that, had Congress intended any other entities to qualify, it would have included them in the list explicitly.[27] On reconsideration of the *Universal Service Order*, the Commission rejected arguments that it had too narrowly defined the term "health care provider" and that it should expand the definition to include rural nursing homes, hospices, or other long-term care facilities,

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[22] *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).

[23] 47 U.S.C. § 254(h)(1)(A).

[24] 47 U.S.C. § 254(h)(2)(A).

[25] 47 U.S.C. § 254(h)(7)(B).

[26] *Universal Service Order,* 12 FCC Rcd at 8776, 9118-19, paras. 655-56.

[27] *Universal Service Order*, 12 FCC Rcd at 9118, para. 655.

as well as emergency medical service facilities.[28]

15. The Commission concluded that a nursing home, in particular, would be ineligible even if it was part of an eligible rural health clinic. The Commission reasoned that an ineligible entity's relationship with an eligible entity is an insufficient basis for allowing an entity omitted from the list in the statute to qualify for the benefits of the universal service support mechanism and that there was "no rational basis for distinguishing between a rural nursing home that is part of a not-for-profit . . . rural health clinic and a rural nursing home that is associated with any of the other categories of eligible entities listed in the statute."[29] The Commission also rejected eligibility of nursing homes that were part of a rural health clinic because granting such eligibility "would very likely result in a flood of other types of ineligible entities requesting similar treatment, and thus would render meaningless the limitations imposed by Congress in section 254(h)(7)(B)."[30]

16. In this Notice, we again affirm that eligible health care providers are limited to the seven categories enumerated in the statutory definition of "health care provider." In light of the very low utilization of the discounts provided pursuant to section 254(h)(1)(A), however, we invite comment on whether we should revisit our prior interpretations of the terms "health care provider" and "rural health clinic" to enable rural health care providers to be eligible for discounts even if they or their affiliates also function in capacities that do not fall under the statutory definition in section 254(b)(7)(B). In particular, if an entity allocates some of its resources acting as a "rural health clinic" or in another capacity that would qualify it as a "health care provider" under section 254(b)(7)(B), should that entity be eligible for discounts irrespective of whether it (or an affiliate) also functions in a capacity – even on a primary basis – that would *not* qualify it as a "health care provider" under the Act? Such part-time or multipurpose providers may play a vital role in responding to public health crises affecting communities located in remote regions of our country. In some communities, for example, there are rural health clinics and emergency service facilities that are not currently eligible for support because they are operated by entities that also function as nursing homes, hospices, or other long-term care facilities. We seek comment on whether we can and should interpret the statute to enable such clinics and emergency service providers to receive discounted services supported under the rural health care mechanism. The number and importance of clinics with these or similar arrangements may be becoming – or may have already become -- a critical part of the health care network in rural America.

17. We also seek comment on how the rural health care mechanism would benefit entities that function both as covered health care providers and as entities that do not fall under section 254(b)(7)(B). In particular, we seek comment on whether it would be both practicable and consistent with the statute to prorate discounts. Such proration could ensure that the rural health care universal service support mechanism benefits such entities only to the extent that they operate as covered health care providers. We seek comment on the best way to implement such a proposal and how it would affect administrative costs. We also seek comment on what

[28] *Fifteenth Order on Reconsideration*, FCC 99-269, para. 47.

[29] *Id.*

[30] *Id.*

safeguards, if any, we should consider or adopt to ensure that discounted services provided to such multipurpose facilities are used consistent with the statute and our rules.

B. Eligible Services

1. Internet Access

18. Under section 254(h)(1)(A) of the Act, a telecommunications carrier may receive reimbursement for providing telecommunications services to rural health care providers in a State at rates that are reasonably comparable to rates charged for similar services in urban areas of that State, with the amount of the reimbursement equal to the difference, if any, between the rural and urban rates.[31] Under section 254(h)(2)(A), the Commission is authorized to 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 . . ."[32] Thus, the 1996 Act contemplates both support for telecommunications services provided to rural health care providers and enhancing access for health care providers to advanced telecommunications and information services.

19. In the *Universal Service Order*, the Commission, relying on these provisions, authorized limited support for access to the Internet for health care providers. The Commission declined at that time to adopt any proposals for support of the Internet access provided by an ISP, due to the limited information available and the complexity of the proposals.[33] The Commission did find, however, that rural health care providers incur large telecommunications toll charges and those charges were a major deterrent to full use of the Internet for health-related services.[34] Therefore, acting pursuant to its authority under section of 254(h)(2)(A), the Commission provided support for toll charges incurred by all health care providers that could not obtain toll-free access to an ISP.[35] 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.[36] The Commission determined that the dollar cap per provider was "a specific, sufficient, and predictable mechanism, as required by section 254(b)(5) . . . because it limits the amount of support that each health care provider may receive per month to a reasonable level."[37] The Commission recognized, however, that the proliferation of ISPs and the competitive marketplace "soon should eliminate the need for such support."[38]

20. We now seek comment on whether to alter our current framework for providing support for Internet access for rural health care providers. We note that the support for toll

[31] 47 U.S.C. § 254(h)(1)(A).

[32] 47 U.S.C. § 254(h)(2)(A).

[33] *Universal Service Order*, 12 FCC Rcd at 9161, para. 749.

[34] *Universal Service Order*, 12 FCC Rcd at 9107, para. 631.

[35] *Universal Service Order*, 12 FCC Rcd at 9107-08, para. 631.

[36] *Universal Service Order*, 12 FCC Rcd at 9159, para. 745.

[37] *Universal Service Order*, 12 FCC Rcd at 9159-60, para. 746.

[38] *Universal Service Order*, 12 FCC Rcd at 9161, para. 748.

charges is presently unused by applicants because, as a result of the proliferation of ISPs, virtually all rural health care providers can now reach an ISP without incurring toll charges.[39] We seek comment on whether we should eliminate support for toll charges to ISPs and instead provide support for any form of Internet access provided to rural health care providers.

21. The Commission has previously concluded that we have statutory authority to implement a mechanism of universal service support for non-telecommunications services to enhance access to advanced telecommunications and information services under section 254(h)(2)(A), as long as the mechanism is competitively neutral, technically feasible, and economically reasonable.[40] Indeed, in the *Universal Service Order*, the Commission specifically rejected the notion "that support for non-telecommunications services is . . . barred under . . . section 254(h)(2).[41] Moreover, in the schools and libraries universal service support context, the Fifth Circuit affirmed the Commission's determination that 254(h)(2)(A) authorized direct support for Internet access to non-telecommunications service providers.[42]

22. We continue to believe that we have authority to support the services necessary to access the Internet under sections 254(h)(2)(A) and 154(i), and invite comment on this view.[43] 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 *Universal Service Order* was issued, it is time to reevaluate our previous policy decision not to support Internet access service provided by an ISP. Indeed, the Commission has previously recognized that the most efficient and cost-effective way to provide many telemedicine services may be via

[39] No entities applied for support under this section during the last two years of operation of the rural health care universal service mechanism.

[40] *Universal Service Order*, 12 FCC Rcd at 9109, para. 634.

[41] *Id.*

[42] *See Texas Office of Public Utility Counsel*, 183 F.3d at 443-44 (affirming Commission's authority under section 254(h)(2)(A) to provide support for Internet access and internal connections provided by non-telecommunications carriers). *See also Universal Service Order*, 12 FCC Rcd at 9107, para. 630. In the *Universal Service Order*, the Commission addressed, in the context of the schools and libraries universal service mechanism, whether the language in section 254(h)(2)(A) directing the Commission to enhance "access" to information services meant that we could only provide support to schools and libraries for the telecommunications services component needed to gain "access" to the information service provided by an ISP. *Universal Service Order*, 12 FCC Rcd at 9011-12, para. 441. The Commission rejected this interpretation, finding that support for "access" to information services, although not encompassing support for the separate charges for particular proprietary content available on the Internet, did encompass direct support for those information services provided by an ISP that were necessary to access the Internet in general, such as protocol conversion. *Id.* In the schools and libraries context, the Commission relied on two different statutory grounds for its authority to provide universal service support for Internet access. Specifically, the Commission found that sections 254(c)(3) and 254(h)(1)(B) provided one basis for authority to support Internet access and that sections 254(h)(2)(A) and 154(i) provided a separate basis. *Universal Service Order*, 12 FCC Rcd at 9007, para. 596. Moreover, the Commission relied directly and solely on section 254(h)(2)(A) for authority to provide discounts to schools and libraries for Internet access provided by non-telecommunications carriers. *Universal Service Order*, 12 FCC Rcd at 8794, para. 29. Thus, the Commission established that, under sections 254(h)(2)(A) and 154(i), it had authority to support the information services necessary for schools and libraries to gain access to the Internet.

[43] 47 U.S.C. § 254(h)(2)(A).

the Internet.[44] In addition, health care information shared across the Internet may be an important benefit to enable rural health care providers to diagnose, treat, and contain possible outbreaks of disease or respond to health emergencies. We also wish to reduce isolation in rural communities by providing additional health care services to remote areas. We seek comment on the range of health care services and information that are available via the Internet, on the ability of the Internet to provide to rural communities the type of health care information that is available in urban areas, and, in general, on how health care providers can make use of the Internet to provide better health-related services. In light of these changes, the provision of support for Internet access could be beneficial in achieving the goal of section 254. We therefore seek comment on whether the rural health care support mechanism should now include discounts on Internet access, whether provided on a dial-up or high-speed broadband basis, and whether such support would be economically reasonable and technically feasible.

23. We seek comment on how support to rural health care providers for Internet access could be implemented. In determining an appropriate method of implementation, we seek comment on the appropriate balance among various competing factors. If we were to adopt this proposal, we would want to provide an adequate level of support to enable health care providers to afford such access. We also would want not to deter health care providers from seeking service offerings appropriate to their individual needs. At the same time, we seek to ensure that any implementation of support includes measures to avoid waste and fraud without imposing unnecessary costs on the Administrator, and to ensure that support is used for the purposes that Congress intended. One possible solution could be a percentage discount on Internet access charges, analogous to the operation of the schools and libraries support mechanism. Alternatively, we seek comment on whether support for Internet access provided under section 254(h)(2)(A) should include a rural-urban rate comparison of the sort required under section 254(h)(1)(A). We seek comment on the advantages and disadvantages of each proposal and how such proposals could be efficiently and effectively implemented. Further, we encourage commenters suggesting methods of implementation to address these competing concerns, to be specific as to the level of support that we should offer, and to provide us with the facts that they rely upon in advocating a level of support.

24. If commenters believe that Internet access support should take the form of a percentage discount, we invite them to discuss whether we should adopt a single discount rate broadly applicable to all rural health care providers or apply different rates depending on a factor or factors. If commenters argue that the latter approach is preferential, they should specify the factors that we should rely upon in determining rates and, where possible, how rates will vary depending on variations in the applicable factors. In all cases, commenters should specify the facts on which they rely in proposing a particular rate or schedule of rates.

25. Further, to accurately gauge the effect of such a proposal, we should understand how authorizing support for Internet access would increase the demand for support from rural health care providers. We therefore seek comment on the likely demand for Internet access, and from service providers on the cost of such services. We seek comment on whether demand for Internet access is likely to reach the $400 million cap on the amount of support to be provided by the rural health care mechanism, and how increased demand would affect the operation of the

[44] *See Universal Service Order*, 12 FCC Rcd at 9107, 9158, paras. 630, 744.

rural health care mechanism.

26. We recognize that, in certain circumstances, offering support for Internet access to health care providers in rural areas may not adequately ensure that such providers have access to critical medical and public health resources, particularly in the event of a national security emergency. In particular, we lack an adequate record upon which to evaluate whether the non-rural institutions with such resources have the financial wherewithal or alternate public funding to make those medical resources available on networks used by rural health providers. Thus, we encourage interested parties to identify what, if any, new policies we should establish 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).

27. In general, we seek comment on the positive or negative effects that a decision to support Internet access will have on the rural health care support mechanism, from the perspective of the health care providers, the service providers, and the Administrator. In addition, we seek comment on how such implementation could be effectuated in keeping with the Commission's long standing universal service principles, specifically competitive neutrality and technological neutrality.[45] We encourage parties to discuss any issues relevant to whether we should provide support for Internet access, which parties should be eligible for such support, what level of support to provide, the nature of the support, what restrictions we should place on such support, what administrative problems and concerns may arise if we provide such support, and the impact of such support on the mechanism's ability to support other services. We also seek comment on the effects on competition, if any, resulting from providing universal service support for Internet access under the rural health care mechanism. Specifically, we seek comment on whether such support would have positive or negative effects on facilities-based broadband deployment in rural areas.

2. Services Necessary for the Provision of Health Care

28. Under section 254(h)(1)(A), rural health care providers may receive support only for "telecommunications services which are necessary for the provision of health care services . . . including instruction relating to such services . . . ."[46] In the *Universal Service Order*, the Commission found that the phrase "necessary for the provision of health care services ... including instruction relating to such services" meant reasonably related to the provision of health care services or instruction.[47] The Commission further required that the health care provider certify that the requested service would be used exclusively for purposes reasonably related to the provision of health care services or instruction that the health care provider is legally authorized to provide under applicable state law, to help ensure that only eligible services are funded.[48]

[45] 47 U.S.C. § 254(h)(2); *Universal Service Order*, 12 FCC Rcd at 8801, 8802, paras. 46-48, 49.

[46] 47 U.S.C. § 254(h)(1)(A).

[47] *Universal Service Order*, 12 FCC Rcd at 9100, para. 618.

[48] *Universal Service Order*, 12 FCC Rcd at 9150-51, para. 726.

29. We seek comment on whether we should adopt any additional measures to effectuate the statutory restriction in cases where a health care provider engages in both the provision of health care services and other activities. We could rely solely on the certification that none of the telecommunications services being supported will be used in connection with the non-health care related activities. However, if we decide to support services to entities engaged in a substantial amount of a non-health care related activities, the current certification procedure may not be adequate to avoid waste and fraud. We therefore seek comment on how best to avoid waste and fraud, specifically in situations where entities perform a significant amount of non-health related activities.

C. Calculation of Discounted Services

30. 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."[49] Under our rules, the amount of support for an eligible service provided to a rural health care provider is the difference, if any, between the urban rate and the rural rate charged for the service.[50]

31. For service charges that are not distance-based, qualifying entities receive discounts for the difference in urban and rural rates.[51] 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.[52] 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.[53] Under our rules, qualifying entities receive discounts on

[49] 47 U.S.C. § 254(h)(1)(a).

[50] 47 C.F.R. § 54.609(a). The 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). The urban rate is 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. However, if a rural health care provider is seeking discounts for services provided over a distance that is greater than the SUD for that state, the urban rate for purposes of the calculation is the rate charged for a similar service *provided over the SUD* of the nearest city in the state with a population of at least 50,000. *Id.*

[51] 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 the nearest city of at least 50,000 people 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. *See* RHCD web site, Frequently Asked Questions (March 11, 2002) <<http://www.rhc.universalservice.org/faqs/default.asp>>.

[52] 47 C.F.R. § 54.605(d).

[53] 47 C.F.R. § 54.613.

distance-based charges for services over any distance greater than the SUD but less than the MAD.[54]

32. As discussed below, we seek 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. We also seek comment on whether, for purposes of determining the urban rate, the Administrator should allow comparison of rates in any urban area in the state, not just comparison with the rates in the nearest city with a population of over 50,000. In addition, we seek comment on whether to eliminate the MAD restriction, and seek comment on other alternatives. Furthermore, we seek comment on certain changes relating to the calculation of the urban rate in insular areas.

1. Interpretation of Similar Services

33. As noted above, 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."[55]

34. However, our rules do not specify precisely how urban and rural services are to be compared for purposes of determining what are "similar." It has been our policy to base discounts on the difference in urban and rural rates between the same or similar services, such as comparing the rates for rural T-1 service with those of urban T-1 service.[56] Our current policy of comparing technically similar services may, however, inadvertently create inequities between urban and rural health care providers. Doing so does not take into account the fact that some less expensive urban services are unavailable at any price in rural areas, and health care providers are thus required to seek out more expensive services.

35. We seek comment on changing our policy of comparing urban and rural rates for particular telecommunications services, such that the discounts would be calculated by comparing services based on functionality of the service from the perspective of the end user. In particular, we seek 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. We also seek comment on whether this proposed policy change would better effectuate the statutory goals of section 254.

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[54] 47 C.F.R. § 54.609. For example, if a rural health care provider has a dedicated T1 line from its site to an urban hospital with a circuit distance (CD) 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 CD of 100 miles less the SUD of 10 miles, multiplied by the rate of $10 per mile per month). *See* RHCD web site, Frequently Asked Questions (March 11, 2002) <<http://www.rhc.universalservice.org/faqs/default.asp>>.

[55] 47 U.S.C. § 254(h)(1)(A)(*emphasis added*).

[56] *See* "Form 466" Instructions, OMB 3060-0804 (April 2001) at 6 (line 30).

36. We seek comment on the fairest and most effective way to compare functionality between or among different types of telecommunications services. We seek comment on how a functionality-based approach would affect discounts for all telecommunications services, including fractional T-1 lines, ISDN, Frame Relay services, and ATM services, and any other such telecommunications services for which the rural health care universal service support mechanism may offer discounts.

37. We note that the discussion above presupposes that such functionality comparisons would be made between services provided as telecommunications services.[57] If, however, the Commission rules that broadband Internet access services are information services, any such services would be eligible for support only under section 254(h)(2)(A), and not under section 254(h)(1)(A). As noted in paragraph 23 above, we seek comment on whether any support for information services provided under section 254(h)(2)(A) should include a rural/urban rate comparison of the sort required under section 254(h)(1)(A).[58]

38. We also seek comment on how this possible modification would affect health care providers seeking discounts for satellite services. Providers using satellite services have been particularly disadvantaged under the mechanism's current rules. In some areas throughout the United States and related territories, particularly remote and insular areas, satellite systems may provide the only viable means for a rural health care provider to receive telecommunications services. A rural provider using satellite services typically does not receive a discount under this mechanism because, under our current policies, the cost of rural satellite service would be compared to the cost of urban satellite service, and the price of satellite service does not vary by location. In some cases, satellite-based services can be more costly than traditional wireline services. Therefore, we recognize that widespread use of satellite-based services by rural health care providers that do have reasonably priced land-based alternatives, if fully funded by the rural health care mechanism, may prove costly for the universal service support mechanism and offer an unnecessarily expensive service option for some applicants. We therefore seek comment on how to address this concern, which is similar to our concerns with respect to traditional wireline services.

39. The Commission currently has before it a Petition for Reconsideration filed by Mobile Satellite Ventures Subsidiary (MSV), regarding the 1997 *Universal Service Order*, concerning, *inter alia*, the issue of discounts in the rural health care universal service support mechanism for satellite services.[59] MSV, which offers satellite-based emergency medical communications, argues that because the cost of satellite systems is the same in rural and urban areas, providers of satellite-based services are at a disadvantage compared to terrestrial carriers, whose prices are distance sensitive. MSV proposes that the Commission establish "that the urban services that are 'similar' to MSV's rural [services] are the terrestrial mobile

[57] *See Appropriate Framework for Broadband Access to the Internet over Wireline Facilities, Universal Service Obligations of Broadband Providers, Computer II Further Remand Proceedings*, CC Docket Nos. 02-33, 95-20, and 98-10, Notice of Proposed Rulemaking, FCC 02-42, paras. 17-29 (rel. February 15, 2002).

[58] *See supra* para. 23.

[59] AMSC Petition for Clarification or Reconsideration filed July 17, 1997, at 4-5. AMSC subsequently changed its name to Mobile Satellite Ventures Subsidiary (MSV). MSV Comments filed Dec. 20, 2001 (updating its petition for reconsideration).

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."[60] We seek comment on MSV's proposal as a way to make the functional comparison for mobile satellite services, and seek any other proposals for resolving this issue.

40. We further seek comment on whether, and how, a functionality approach could be implemented consistent with current requirements concerning the Maximum Allowable Distance.[61] If the MAD requirement is altered or eliminated as discussed in paragraphs 45-48 below, we seek comment on how that change may interrelate with any proposed treatment of satellite services.

2. Urban Area

41. 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."[62] Under our rules, as described above, the urban rate is based on the rate for similar services in 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.[63] In the *Universal Service Order*, the Commission chose to base the urban rate on the rate in the nearest city of at least 50,000 in the belief that such cities "are large enough that telecommunications rates based on costs would likely reflect the economies of scale and scope that can reduce such rates in densely populated urban areas."[64] In addition, the Commission stated that because the telecommunications services a rural health care provider would use would likely involve transmission facilities linked to the nearest large city, using that location would provide more accurate and realistic comparable rates than using rates from more distant cities. The Commission also noted that while every state has a city of at least 50,000, not every state has larger cities.[65]

42. Our experience with the rural health care universal service support mechanism leads us to consider reevaluating our previous conclusion. A number of applicants have suggested that the last several years of experience have demonstrated that rates and services available in small cities do not yet fully reflect the economies of scale and scope that are found in the most densely populated areas of the state. There is evidence that suggests the largest cities in

[60] *Id* at 5. MSV explains that its rate plans allow for unlimited dispatch minutes per month for calls within a pre-defined talk-group, but impose per-minute airtime rates for calls outside this group. *Id.* n.2. It is unclear exactly how MSV's proposed approach would function, and its applicability to other providers of satellite-based services.

[61] *See infra* paras. 45-48.

[62] 47 U.S.C. § 254(h)(1)(A).

[63] 47 C.F.R. § 54.605(c).

[64] *Universal Service Order*, 12 FCC Rcd at 9125 para. 670.

[65] *Id.*

a state have significantly lower rates and more service options than the city of at least 50,000 nearest the rural health care provider. In addition, our previous assumption that services used by rural health care providers would likely involve transmission links to the nearest city appears not always to be the case. There is increasing evidence that many rural health care providers choose to link their telemedicine networks to pockets of expertise located in larger cities in the state. We seek comment on whether to alter our rules to allow comparison with rates in any city in a state.

43. We recognize allowing a comparison of urban rates with any city in a state may result in certain rural health care providers receiving lower rates, by virtue of this support mechanism, than those obtained in the nearest city of 50,000 or more. The Commission previously expressed concerns about such an outcome in the context of relying on average urban rates in a state.[66] We also note that this change would obviate the Commission's previous concern that some states may not have cities much larger than 50,000, because the comparison would be based on any city in the state. We seek comment on whether this proposal is the best way to effectuate the statutory mandate. We also seek comment on the potential effect this change may have on demand for support under the rural health care mechanism.

44. We further seek comment on any other changes involving the calculation of the urban and rural rate, in order to fulfill the goals and mandate of section 254.

3. Maximum Allowable Distance

45. We seek comment on eliminating or revising the MAD restriction in our rules, which limits support for rural health care providers to distances less than the "distance between the eligible health care provider's site and the farthest point from that site that is on the jurisdictional boundary of the nearest [city of at least 50,000]."[67] In establishing the MAD, the Commission determined that providing discounts only for distance-based charges for the distance between a rural health care provider and the nearest city of 50,000 or more was sufficient to connect the health care provider to adequate services, and would protect against health care providers requesting telemedicine connections to "far flung areas in search of the real or imagined 'expert' in the field."[68] However, our experience to date suggests that limiting rural heath care providers to discounts for connection to the nearest city of 50,000 or more may not be adequate for purposes of creating a comprehensive telemedicine network. We therefore seek comment on changes that would better effectuate the intent of the statute.

46. Removing the MAD would offer rural health care providers greater flexibility in developing appropriate networks, which should improve the delivery of health care in rural areas. There are several legitimate reasons providers would seek connections to places farther away than the nearest city of 50,000. For example, in the case of large telemedicine networks, the circuit from a rural site may run to another rural site to link all sites in a consortium together. Similarly, a carrier may lay cable in a more complex route, but because the Administrator

[66] *Id.*; *see also Universal Service Order*, 12 FCC Rcd at 9130, para. 678.

[67] 47 C.F.R. § 54.613.

[68] *Universal Service Order*, 12 FCC Rcd at 9130, para. 678.

calculates the MAD on the basis of the shortest distance between points, a rural health care provider may lose discounts if the circuit exceeds the MAD. Rural health care providers may wish to connect with a health care facility with the appropriate expertise or other pockets of expertise located beyond the MAD.[69]

47. Eliminating the MAD should reduce the administrative costs because calculating the MAD requires labor-intensive and time-consuming efforts on the part of the Administrator. The RHCD estimates that for each application seeking support for telecommunications service over a distance that exceeds the MAD, the Administrator must devote an average of three additional hours to the application in order to ascertain the proportion of the service for which the applicant is eligible. This process diverts important resources available for all applicants, which may not be cost-effective administratively. It also adds to the complexity of the rural health care universal health care mechanism for applicants. Eliminating the MAD restriction would therefore simplify the application process while reducing administrative overhead, thereby freeing up funds for discounts for other applicants. However, we recognize that eliminating the MAD may result in substantially increased demand if more entities seek support under the mechanism. We seek comment on whether to eliminate the MAD, including the benefits and impact on demand for support under the mechanism, and whether and how we may need to constrain increased costs resulting from changes to the MAD requirement.

48. We seek comment on alternative proposals to address this issue, including whether, in lieu of eliminating the restriction, we 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 so-called tertiary care.[70] If we elect to provide discounts to the nearest point of tertiary care, what standard would be used to define this point, and should we codify that in our regulations? In the alternative, would the creation of a state-by-state matrix listing the longest diameter in each state as the MAD for such state be feasible? We seek comment on whether all of these proposed approaches are consistent with the statutory scheme. Further, if we were to adopt any of the stated proposals, we seek comment on whether it makes sense to retain our rule that support not be provided on telecommunications service over a distance shorter than the Standard Urban Distance (SUD).[71]

[69] For instance, a rural health care facility may wish to link up with the nearest teaching hospital, such as one affiliated with the state university, which typically offers more sophisticated diagnostic capabilities than a community hospital located in the nearest city of 50,000.

[70] *See Recommended Decision*, 12 FCC Rcd at 486. In 1996, out of concern for the amount of limited resources available for telemedicine needs, the American Telemedicine Association proposed that discounted telecommunications services be made available to both primary health care providers located in rural areas and so-called tertiary care facilities located in other parts of the state that have telecommunications links for the provision of health care with rural health care institutions. As of this Notice, we have been unable to identify the criteria for determining the nearest point of tertiary care.

[71] *See supra* para. 31.

4. Insular Areas

49. Section 254(h)(1)(A) specifies that "telecommunications carriers shall . . . provide telecommunications services which are necessary for the provision of health care services in a State . . . 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*."[72] Consistent with this statutory language, the Commission's rules determine the "urban rate" for purposes of determining the amount of support by looking to the rates charged customers for a similar service in the nearest large city in the State.[73] In the *Universal Service Order*, the Commission noted that using urban rates within a State as the benchmark for reasonable rates may be ill-suited to certain insular areas that are relatively rural all over, including areas of the Pacific Islands and the U.S. Virgin Islands.[74] Following up on this concern, the Commission sought comment in the *Unserved and Underserved Areas Further Notice* on whether the calculation of support should be modified for these areas, and invited commenters to propose specific revisions.[75]

50. In response, certain commenters suggested that the Commission had authority under section 254(h)(2)(A) to designate an out-of-state urban locale as the relevant urban benchmark for insular areas such as Guam and the Northern Mariana Islands.[76] We seek 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 even outside of their "State." We also seek comment on any alternative means for addressing the special problems of insular areas, consistent with section 254.

D. Other Changes to the Rural Health Care Support Mechanism

1. Streamlining the Application Process

51. We seek comment on ways to streamline the application process to make it more accessible to rural health care providers. The Commission has recognized in the past that the application process, and the complicated nature of the forms involved, may sometimes be a barrier to applicants.[77] We understand that this process may still provide unnecessary barriers to applicants. We believe the proposals in this Notice could further simplify the operation of the rural health care universal service support mechanism. We seek comment in general on

[72] 47 U.S.C. § 254(h)(1)(A) (*emphasis added*).

[73] 47 C.F.R. §§ 54.605-609.

[74] *Universal Service Order*, 12 FCC Rcd at 9136, para. 694.

[75] *Federal-State Joint Board on Universal Service; Promoting Deployment and Subscribership in Unserved and Underserved Areas, Including Tribal and Insular Areas,* CC Docket No. 96-45, Further Notice of Proposed Rulemaking, 14 FCC Rcd 21177, 21235-236, para. 143 (1999) (*Unserved and Underserved Areas Further Notice*).

[76] *See, e.g.,* Reply Comments of the Commonwealth of the Northern Mariana Islands, filed January 19, 2000, at 8.

[77] *See, e.g.*, *Fifteenth Order on Reconsideration*, FCC 99-269, para. 33; *see also Universal Service Administrative Company Report to the FCC: Evaluation of the Rural Health Care Program*, CC Docket Nos. 96-45 and 97-21, Public Notice, 14 FCC Rcd 5163 (Com. Car. Bur. 1999).

additional ways that the process of submitting, reviewing, and approving applications may be streamlined or otherwise improved to ensure timely, fair, and efficient decision-making.

52. While we welcome comments on all aspects of the application process, we specifically seek comment on the following areas. We seek comment on any additional ways that the calculation of the urban-rural differential on the forms may be made easier. We further seek comment on ways to eliminate delays and lack of response from eligible telecommunications carriers in supplying the information necessary for rural health care providers to complete the process.

53. We also seek comment on ways to ensure that rural health care providers are apprised of changes in deadlines for application filings and other material changes in the application and appeals process.

2. Pro-Rata Reductions If Annual Cap Exceeded

54. We seek comment on whether to modify our current rules governing the allocation of funds under the rural health care universal service support mechanism if demand exceeds the annual cap. The annual cap on universal service support for health care providers is currently $400 million per funding year.[78] Under our rules, if the total demand for support in a year exceeds the cap, the Administrator shall divide the total annual support available by the total amount requested in that year, then 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.[79]

55. Discounts amounts requested under the rural health care universal service support mechanism, to date, have never exceeded the annual cap. However, it is possible that changes adopted in response to this Notice could increase the level of discounts requested in a year such that discounts requested may, at some point in the future, exceed the cap. We therefore seek comment on whether this pro-rata distribution of funds for requested discounts is the most effective and equitable means of distributing limited funds in accordance with the goals and purposes of the statute, or whether an alternative approach should be adopted.

3. Preventing Waste, Fraud, and Abuse

a. Competitive Bidding

56. We seek comment on the effectiveness of the rural health care universal service support mechanism's competitive bidding rules. Under current rules, applicants are required to participate in a competitive bidding process pursuant to Commission regulations and any additional applicable state, local, or other procurement requirements.[80] Applicants are required to submit to the Administrator an FCC Form 465, in which it solicits bids for services from telecommunications carriers, and makes various certifications relating to eligibility under the

[78] 47 C.F.R. § 54.623.

[79] *Id.*

[80] 47 C.F.R. § 54.603(a).

rural health care universal service support mechanism.[81] The Administrator then posts the form on its website, notifying telecommunications carriers that may wish to bid for an applicant's services about the rural health care provider's request.[82] An applicant's FCC Form 465 must be posted on the Administrator's website for at least 28 days before the applicant may enter into a contract for services with a telecommunications carrier, in order to allow sufficient time for different carriers to bid on the requested services.[83]

57. After selecting a telecommunications carrier, the applicant must certify to the Administrator that it has selected the most cost-effective method of providing the requested services, 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 to choosing a method of providing the required health care services."[84] Applicants must also submit to the Administrator paper copies of the responses or bids received.[85]

58. The purpose of the posting requirement for the FCC Form 465 is to provide a rapid and easy mechanism for notifying all potential bidders for services of rural health care providers' requests, in order to encourage competition among bids and enable applicants to secure the most cost-effective services.[86] However, to the extent that some rural areas may have only one service provider, the requirement may result in needless delays for applicants in securing support. We seek comment on whether the requirement can and should be waived in certain circumstances (*e.g.,* when applications are submitted by small entities), whether such a change is necessary or prudent, and how we may implement it with minimal administrative effort and expense, while fulfilling our obligations to reduce waste, fraud, and abuse and ensuring that universal service support is used "wisely and efficiently."[87]

b. Ensuring the Selection of Cost-Effective Services

59. We seek comment on whether there currently are adequate measures to ensure that rural health care providers buy the most cost-effective services. As described above, current rules require applicants to select the most cost-effective method of providing the requested services.[88] However, there are no restrictions on the type of service offerings a rural health care provider may select. We seek comment on how best to ensure that applicants choose the most

[81] 47 C.F.R. § 54.603(b)(1).

[82] 47 C.F.R. § 54.603(b)(2).

[83] 47 C.F.R. § 54.603(b)(3).

[84] 47 C.F.R. § 54.603(b)(4).

[85] *Id.*

[86] *Universal Service Order*, 12 FCC Rcd at 9134, para. 688.

[87] *Id*.

[88] *See supra* para. 57. 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. § 54.604(b)(4).

cost-effective services under the rural health care universal service support mechanism. We also seek comment on how such a change in our rules, if adopted, could be implemented most effectively and equitably, preventing waste and abuse without imposing undue burdens on rural health care providers. In addition, we seek comment on whether we should implement changes to encourage applicants to use lowest cost technology available, regardless of whether that technology involves wireline, coaxial cable, fiber, terrestrial wireless, satellite, or some other technology. If so, we seek comment on how those changes should be implemented.

c. Encouraging Partnerships with Clinics at Schools and Libraries

60. We seek comment on ways in which the rules or policies of the rural health care universal service support mechanism might be altered to better encourage rural health providers to pool resources with other entities in order to limit costs for themselves and thereby utilize support more efficiently. Some parties have questioned the rural health care universal service support mechanism for denying school-based clinics support on the grounds that such clinics are only eligible for discounts under the schools and libraries universal service support mechanism, while the schools and libraries mechanism denies the clinics support for the reason that the clinics are only eligible under the rural health care universal service support mechanism. We seek comment on the extent to which such clinics are or should be eligible under either mechanism, and on whether our rules and policies may encourage rural health care providers to partner with clinics at schools and libraries in rural locations. We further seek comment on other ways in which the Commission might promote similar cost-sharing in order to maximize the appropriate and beneficial use of universal service funds while minimizing waste and abuse.

d. Other Measures to Prevent Waste, Fraud, and Abuse

61. In keeping with our goal of preventing waste, fraud, and abuse, we seek comment on the effectiveness of our current rules regarding audits, and other procedures to ensure the appropriate use of funds available under the rural health care universal service support mechanism. Rural health care providers that receive support are currently subject to record-keeping and record production requirements, and random audits to ensure compliance.[89] We seek comment on the effectiveness of these measures, and whether additional record-keeping or audit requirements are necessary. We further seek comment on any other rules that would help to combat potential waste, fraud, and abuse with respect to the rural health care universal service support mechanism.

4. Further Comments on Issues of Concern

62. We seek additional comments on whether we should adopt additional rule changes, consistent with the statute, to improve our rules and policies regarding the rural health care universal service support mechanism. We welcome the views of applicants, service providers, and others that have experience with, and insight into, the operation of the rural health care universal service support mechanism. Such views will aid us in continuing to streamline and improve our policies and procedures, in order to ensure that eligible rural health care providers have access to modern services.

[89] 47 C.F.R. § 54.619.

E. Effect on Demand for Support

63. In initiating this inquiry, we seek comments on various alternatives to enhance our existing rural health care universal service support mechanism. We are cognizant that these proposals contain measures that may significantly spur demand for advanced telecommunications and information services as well as implement critical cost savings measures designed to improve the efficiency and effectiveness of the mechanism. Given these numerous proposals, we ask that interested parties, to the extent possible, separately identify in their comments what, if any, potential effect individual proposals may have on demand for rural health care support. We note that any such increase in demand for rural health care support will be constrained by the operation of the $400 million rural health care support cap, and thus we seek input from commenters on any assistance they may provide in identifying which specific proposals will be most beneficial to ensuring access to advanced telecommunications and information services for all eligible rural health care providers.[90]

IV. PROCEDURAL MATTERS

A. Initial Paperwork Reduction Analysis

64. This Notice contains either a proposed or modified information collection. As part of a continuing effort to reduce paperwork burdens, we invite the general public and the Office of Management and Budget (OMB) to take this opportunity to comment on the information collections contained in this Notice, as required by the Paperwork Reduction Act of 1995, Public Law 104-13. Public and agency comments are due at the same time as other comments on this Notice; OMB comments are due 60 days from the date of publication of this Notice in the Federal Register. Comments should address: (a) 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; (b) the accuracy of the Commission's burden estimates; (c) ways to enhance the quality, utility, and clarity of the information collected; and (d) 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.

B. Initial Regulatory Flexibility Analysis

65. As required by the Regulatory Flexibility Act of 1980, as amended (RFA), the Commission has prepared this 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 Notice.[91] 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 Notice provided in section IV(C) below. The Commission will send a copy of the Notice, including this IRFA, to the Chief Counsel for Advocacy of the Small Business

[90] 47 C.F.R. § 54.623(a).

[91] *See* 5 U.S.C. § 603. The RFA, *see* 5 U.S.C. §§ 601 – 612, 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).

Administration (SBA).[92] In addition, the Notice and IRFA (or summaries thereof) will be published in the Federal Register.[93]

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

66. The Commission is required by section 254 of the Act to promulgate rules to implement the universal service provisions of section 254. 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.[94] 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 have occurred affecting the rural health universal service support mechanism. As discussed above, several factors prompt us to review anew the rural health care universal service support mechanism, including the underutilization of the mechanism, changes in telecommunications technology and its use by the medical community, and the need to develop a broader and more fully integrated network of health care providers across the nation.[95]

67. In this Notice, we seek comment on whether to: clarify how we should treat eligible entities that also perform functions that are outside the statutory definition of "health care provider"; provide support for Internet access; and modify the calculation of discounted services, including the calculation of urban and rural rates. We also seek comment on other administrative changes to the rural health care mechanism, including whether and how to streamline the application process; allocate funds if demand exceeds the annual cap; modify the current competitive bidding rules; encourage partnerships with clinics at schools and libraries. We also seek comment on other measures to prevent waste, fraud, and abuse; and any other issues concerning the structure and operation of the rural health care universal service support mechanism on which commenters wish to make recommendations. We seek further comment on these proposals and how such changes could be implemented. We also seek comment on the effect that any such changes may have on demand for support under the universal service mechanism as well as data to support any comments made.

2. Legal Basis

68. The legal basis for this Notice is contained in sections 151 through 154, and 254 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151-154 and 254.

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[92] *See* 5 U.S.C. § 603(a).

[93] *See* 5 U.S.C. § 603(a).

[94] *Universal Service Order*, 12 FCC Rcd 8776, 9118-19, paras. 655-56.

[95] *See supra* paras. 10-11.

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

69. The RFA directs agencies to provide a description of, and where feasible, an estimate of the number of small entities that may be affected by the proposed rules, if adopted.[96] The RFA generally defines the term "small entity" as having the same meaning as the terms "small business," "small organization," and "small governmental jurisdiction."[97] In addition, the term "small business" has the same meaning as the term "small business concern" under the Small Business Act.[98] 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).[99]

70. A small organization is generally "any not-for-profit enterprise which is independently owned and operated and is not dominant in its field."[100] Nationwide, as of 1992, there were approximately 275,801 small organizations.[101] 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."[102] As of 1997, there were approximately 87,453 government jurisdictions in the United States.[103] 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.

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[96] 5 U.S.C. § 603(b)(3).

[97] 5 U.S.C. § 601(6).

[98] 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."

[99] 15 U.S.C. § 632.

[100] 5 U.S.C. § 601(4).

[101] 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).

[102] 5 U.S.C. § 601(5).

[103] 1995 Census of Governments, U.S. Census Bureau, United States Department of Commerce, Statistical Abstract of the United States (2000).

a. Rural Health Care Providers

71. 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.[104] Although SBA has not developed a specific size category for small, rural health care providers, 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."[105] We have no additional data specifying the numbers of these health care providers that are small entities. Consequently, using those numbers, we estimate that there are 8, 297 or fewer small health care providers potentially affected by the actions proposed in this Notice.

72. 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.[106] The broad category of Ambulatory Health Care Services consists of further categories and the following SBA small business size standards.[107] 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

[104] *See* 47 U.S.C. § 254(h)(5)(B).

[105] 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. *See 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.

[106] North American Industry Classification System: United States, 1997 at 629-53.

[107] 13 C.F.R. § 121.201, NAICS Codes 621111, 62112, 621210, 621310, 621320, 621330, 621340621391, 621399, 621410, 621420, 621491, 621492, 621493, 621498, 621511, 621512, 621610, 621910, 621991, 621999.

1997.[108] Of these, 339,911 had receipts for that year of less than $5 million.[109] 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.[110] 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.

73. 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.[111] 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.[112] An additional 45 firms had annual receipts of $25 million to $49.99 million.[113] 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.

74. The broad category of Nursing and Residential Care Facilities consists of the following categories and the following small business size standards.[114] 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 indicate that there is a combined total of 18,011 firms that operated in 1997.[115] Of these, 16,165 or fewer firms had annual receipts of below $5 million.[116] 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.[117] We therefore estimate that a great majority of Nursing and Residential Care Facilities are small, given SBA's size categories. In addition, we

[108] 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*).

[109] *Id.*

[110] *Id.*

[111] 13 C.F.R. § 121.201, NAICS Codes 622110, 622210, 622310.

[112] *1997 Health Care Data*.

[113] *Id.*

[114] 13 C.F.R. § 121.201, NAICS Codes 623110, 623210, 623220, 623311, 623312, 623990.

[115] *1997 Health Care Data*.

[116] *Id.*

[117] *Id.*

have no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

75. 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.[118] For all of these health care providers, census data indicate that there is a combined total of 37,778 firms that operated in 1997.[119] 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.[120] We therefore estimate that there 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

76. 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."[121] 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.[122] 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.

77. *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.[123] 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."[124] For example, a PCS provider that is affiliated with

[118] 13 C.F.R. § 121.201, NAICS Code 624230.

[119] *1997 Health Care Data*.

[120] *Id.*

[121] 15 U.S.C. § 632.

[122] 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).

[123] 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.

[124] 15 U.S.C. § 632(a)(1).

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

78. *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.[125] 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.[126] 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 Notice.

79. *Internet Service Providers.* Under the new NAICS codes, SBA has developed a small business size standard for "On-line Information Services," NAICS Code 514191.[127] According to SBA regulations, a small business under this category is one having annual receipts of $21 million or less.[128] According to SBA's most recent data, there are a total of 2,829 firms with annual receipts of $9,999,999 or less, and an additional 111 firms with annual receipts of $10,000,000 or more.[129] Thus, the number of On-line Information Services firms that are small under the SBA's $21 million size standard is between 2,829 and 2,940. Further, some of these Internet Service Providers (ISPs) might not be independently owned and operated. Consequently, we estimate that there are fewer than 2,940 small entity ISPs that may be affected by the decisions and rules of the present action.

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

[125] 13 C.F.R. § 121.210, North American Industry Classification System (NAICS) Codes 513310, 513330, 513340.

[126] *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 (CLECs).

[127] 13 C.F.R. § 121.201, NAICS Code 514191.

[128] *Id*.

[129] *1997 Economic Census*, at 18.

$12.5 million or less.[130] 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.[131] 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.

81. *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.[132] 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.[133] 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.

82. *Cable Systems*. The Commission has developed, with SBA's approval, its own definition of small cable system operators. Under the Commission's rules, a "small cable company" is one serving fewer than 400,000 subscribers nationwide.[134] Based on our most recent information, we estimate that there were 1,439 cable operators that qualified as small cable companies at the end of 1995.[135] Since then, some of those companies may have grown to serve over 400,000 subscribers, and others may have been involved in transactions that caused them to be combined with other cable operators. Consequently, we estimate that there are fewer than 1,439 small entity cable system operators that may be affected by the proposals.

83. The Act also contains a definition of a small cable system operator, which is "a cable operator that, directly or through an affiliate, serves in the aggregate fewer than 1% of all subscribers in the United States and is not affiliated with any entity or entities whose gross annual revenue in the aggregate exceeds $250,000,000."[136] The Commission has determined

[130] 13 C.F.R. § 121.201, NAICS Code 513340.

[131] *1997 Economic Census*, at 16.

[132] 13 C.F.R. § 121.210, NAICS Code 513322.

[133] *Telephone Trends Report*, Table 5.3.

[134] 47 C.F.R. § 67.901(3). The Commission developed this definition based on its determination that a small cable system operator is one with annual revenues of $100 million or less. *Implementation of Sections of the 1992 Cable Act: Rate Regulation*, Sixth Report and Order and Eleventh Order on Reconsideration, 10 FCC Rcd 6393 (1995).

[135] Paul Kagan Associates, Inc., Cable TV Investor, Feb. 29, 1996 (based on figures for Dec. 30, 1995).

[136] 47 U.S.C. § 543(m)(2).

that there are 67,700,000 subscribers in the United States.[137] Therefore, we found that an operator serving fewer than 677,000 subscribers shall be deemed a small operator, if its annual revenues, when combined with the total annual revenues of all of its affiliates, do not exceed $250 million in the aggregate.[138] Based on available data, we find that the number of cable operators serving 677,000 subscribers or less totals approximately 1,450.[139] Although it seems certain that some of these cable system operators are affiliated with entities whose gross annual revenues exceed $250,000,000, we are unable at this time to estimate with greater precision the number of cable system operators that would qualify as small cable operators under the definition in the Act.

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

84. The Notice seeks comment on changes that could modify the reporting and recordkeeping requirements imposed on entities covered by the universal service support mechanism for rural health care providers. Specifically, the Notice proposes that the application process for universal service support for rural health care providers be streamlined. The Notice, however, does not contain any concrete proposals for streamlining, but rather seeks comment on ways that the process of reviewing, submitting and approving applications can be improved and streamlined. This Notice also asks for general comment on measures that could be taken to reduce fraud, waste, and abuse with respect to the rural health care universal service support mechanism, particularly with regards to competitive bidding, measures for ensuring the selection of cost-effective services, and school-library partnerships, but again there are no specific proposals or compliance requirements.

85. In this Notice, we also seek comment on whether it would be appropriate to prorate services for rural health care providers that provide other services. A change in this reporting requirement potentially could require the use of professional skills, including legal and accounting expertise. Without more data, however, we cannot accurately estimate the cost of compliance by small entities.

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

86. 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

[137] FCC Announces New Subscriber Count for the Definition of Small Cable Operator, Public Notice, DA 01-158 (January 24, 2001).

[138] 47 C.F.R. § 76.901(f).

[139] Paul Kagan Associates, Inc., Cable TV Investor, Feb. 29, 1996 (based on figures for Dec. 30, 1995).

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.[140]

87. In this Notice, we make a number of proposals that could have an economic impact on small entities that participate in the universal service support mechanism for rural health care providers. Specifically, we seek comment on: (1) allowing discounts for Internet access by eligible rural health care providers; (2) expanding the number of entities eligible for discounts by changing the definition of "urban area" and the definition of eligible entities; and (3) other proposals that could change how those discounts are calculated. If adopted, these proposals could change the size of the overall pool of eligible applicants for universal service support for rural health care providers, as well as affect the amount of discounts that eligible entities may receive. In seeking to minimize the burdens imposed on small entities where doing so does not compromise the goals of the universal service mechanism, we have invited comment on how these proposals might be made less burdensome for small entities.[141] We again invite commenters to discuss the benefits of such changes on small entities and whether these benefits are outweighed by resulting costs to rural health care providers that might also be small entities.

88. We have also sought comment on how to address financial support of rural health care providers if demand exceeds the annual cap on universal support. Rural health care providers that received discounts in the past may be unable to obtain such support in the future should the demand increase significantly due to changes in eligibility and how discounts are calculated. As current demand has not exceeded the annual cap, however, we are unable to determine the net economic impact of changes to the current system to small entities as a whole. We therefore request that commenters, in proposing possible alterations to our proposed rules, discuss the economic impact that those changes will have on small entities.

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

89. None.

C. Comment Due Dates and Filing Procedures

90. We invite comment on the issues and questions set forth in the Notice of Proposed Rulemaking, Paperwork Reduction Analysis, and Initial Regulatory Flexibility Analysis contained herein. Pursuant to sections 1.415 and 1.419 of the Commission's rules,[142] interested parties may file comments on or before 45 days after this Notice is published in the Federal Register, and reply comment on or before 75 days after this Notice is published in the Federal Register. Comments may be filed using the Commission's Electronic Comment Filing System (ECFS) or by filing paper copies. *See* Electronic Filing of Documents in Rulemaking Proceedings, 63 Fed. Reg. 24,121 (1998).

[140] *See* 5 U.S.C. § 603(c)(1)-(c)(4).

[141] *See supra* para. 58.

[142] 47 C.F.R. §§ 1.415, 1.419.

91. Comments filed through the ECFS can be sent as an electronic file via the Internet to <http://www.fcc.gov/e-file/ecfs.html>. 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, Postal Service mailing address, and the applicable docket or rulemaking number. Parties may also submit electronic comments by Internet e-mail. To receive 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 <your e-mail address>." A sample form and directions will be sent in reply. Or you may obtain a copy of the ASCII Electronic Transmittal From (FORM-ET) at <www.fcc.gov/e-file/email.html>.

92. Parties who 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, Vistronix, 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.

93. 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 12th Street, SW Washington, DC 20554

94. 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 12st Street, S.W., Room CYB402, Washington, D.C. 20554 (see alternative addresses above for delivery by hand or messenger).

95. 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.

96. Written comments by the public on the proposed and/or modified information collections pursuant to the Paperwork Reduction Act of 1995, Pub. L. No. 104-13, are due on or before 45 days after the date of publication in the Federal Register. Written comments must be submitted by the Office of Management and Budget (OMB) on the proposed and/or modified information collections on or before 60 days after date of publication 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 Boley, Federal Communications Commission, Room 1-C804, 445 12th Street, S.W., Washington, DC 20554 (see alternative addresses above for delivery by hand or messenger), or via the Internet to jboley@fcc.gov and to Jeanette Thornton, OMB Desk Officer, 10236 NEOB, 725 - 17th Street, N.W., Washington, D.C. 20503.

97. 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**.** Alternative formats (computer diskette, large print, audio cassette and Braille) are available to persons with disabilities by contacting Brian Millin at (202) 418-7426, TTY (202) 418-7365, or at bmillin@fcc.gov.

V. ORDERING CLAUSES

98. Accordingly, IT IS ORDERED that, pursuant to the authority contained in sections 151 through 154, and 254 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151-154 and 254, this NOTICE OF PROPOSED RULEMAKING IS ADOPTED, as described herein.

99. IT IS FURTHER ORDERED that the Commission's Consumer Information Bureau, Reference Information Center, SHALL SEND a copy of this Notice of Proposed Rulemaking, including the Initial Regulatory Flexibility Analysis, to the Chief Counsel for Advocacy of the Small Business Administration.

FEDERAL COMMUNICATIONS COMMISSION

Marlene H. Dortch
Secretary