XI. HEALTH CARE PROVIDERS

A. Overview

608. In this section, we conclude that all public and non-profit health care providers that are located in rural areas and meet the statutory definition set forth in section 254(h)(5)(B) are eligible for support under section 254(h)(1)(A). We conclude that under section 254(h)(1)(A), any telecommunications service of a bandwidth up to and including 1.544 Mbps that is necessary for the provision of health care services is eligible for support. We establish limits on the supported services that a rural health care provider may obtain. We also require telecommunications carriers to charge rural health care providers a rate for a supported service that is no higher than the highest tariffed or publicly available rate charged by a carrier to a commercial customer for a similar service in the state's closest city with a population of at least 50,000, taking distance charges into account. In addition, we conclude that a carrier that provides telecommunications services to eligible health care providers at reduced rates may recover the difference, if any, between the rate for similar services provided to other customers in comparable rural areas of the state and the rate charged to the rural health care provider for such services. Pursuant to section 254(h)(2)(A), we provide limited support for toll-free access to an Internet service provider for all health care providers, regardless of their location. Recognizing that section 254 requires that universal service support mechanisms be specific, predictable, and sufficient, we establish support subject to a $400 million annual cap.

B. Services Eligible for Support

1. Background

609. Section 254(c)(1) gives the Commission and Joint Board responsibility for defining a group of core services eligible for federal universal service support.[1550] Section 254(c)(3) provides the Commission with separate authority to designate, in addition to core telecommunications services, "additional" services as eligible for support for public and non-profit health care providers pursuant to section 254(h).[1551]

610. In the Joint Explanatory Statement, Congress explained that section 254(h) is intended "to ensure that health care providers for rural areas . . . have affordable access to modern telecommunications services that will enable them to provide medical . . . services to all parts of the Nation."[1552] The Joint Explanatory Statement also noted that the definition of

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[1550] For a discussion of section 254(c)(1) and core services, *see supra* section IV.B.

[1551] 47 U.S.C. § 254(c)(3).

[1552] Joint Explanatory Statement at 132.

services to be supported by universal service support mechanisms is an evolving one, and "[t]he Commission is given specific authority to alter the definition from time to time,"[1553] and pursuant to 254(c)(3), to specify a separate definition of universal service that would apply only to public institutional telecommunications users.[1554] The Joint Explanatory Statement indicated that "the conferees expect the Commission and the Joint Board to take into account the particular needs of hospitals" in formulating the latter definition.[1555]

611. After the NPRM was issued, the Commission established the Advisory Committee on Telecommunications and Health Care (Advisory Committee).[1556] In its report, issued prior to the Joint Board's Recommended Decision, the Advisory Committee described what it called its "market basket" of "essential telemedicine[1557] applications."[1558] The Advisory Committee developed the market basket as a guide to the level of telecommunications services "necessary to support rural telemedicine efforts."[1559] The applications in the market basket include: 1) health care provider-to-provider consultation between professionals in rural hospitals and clinics, and professionals in other locations, including the capability to transmit data and

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[1553] Joint Explanatory Statement at 131.

[1554] Joint Explanatory Statement at 133. The term "public institutional telecommunications user" is defined in § 47 U.S.C. § 254(h)(5)(c) to include "a health care provider." The term "health care provider" is defined in section 254(h)(5)(B) to mean: "(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 clinics; (v) not-for-profit hospitals; (vi) rural health clinics; and (vii) consortia of health care providers consisting of one or more entities described in clauses (i) through (vii)."

[1555] Joint Explanatory Statement at 133.

[1556] The Advisory Committee was established on June 12, 1996 to advise the Commission and the Joint Board on telemedicine, and particularly the provisions of the Telecommunications Act of 1996 relating to rural health care providers. The Advisory Committee, composed of 38 individuals with expertise and experience in the fields of health care, telecommunications, and telemedicine, issued its report on October 15, 1996.

[1557] For purposes of this Order, we consider the terms "telemedicine," "telehealth," "telemedicinal applications," and "telemedicine-related services" to be interchangeable. The Joint Working Group on Telemedicine defines "telemedicine" as "the use of telecommunications and information [service] technologies for the provision and support of clinical care to individuals at a distance and the transmission of information needed to provide that care." It defines "telehealth" as including clinical care, but additionally encompassing the related areas of "health professionals' education, consumer health education, public health, research and administration of health services." *See* JOINT WORKING GROUP ON TELEMEDICINE, TELEMEDICINE REPORT TO THE CONGRESS at 90, U.S. Department of Commerce (1997) (Joint Working Group Report).

[1558] FCC ADVISORY COMMITTEE ON TELECOMMUNICATIONS AND HEALTH CARE, FINDINGS AND RECOMMENDATIONS (October 15, 1996)(Advisory Committee Report) at 6-7.

[1559] Advisory Committee Report at 6-7.

medical images such as x-rays; 2) provider-to-patient consultation, including the examination or counseling in a multimedia format of patients in rural hospitals and clinics by professionals in urban hospitals using diagnostic devices such as electronic stethoscopes, ophthalmoscopes, otoscopes, EKGs and others; 3) continuing medical education programs for rural physicians and other health care providers; 4) round-the-clock support (including triage) from physicians and specialists either at urban centers or at a local physician's office; 5) a comprehensive set of specialty services -- such as radiology, dermatology, selected cardiology, pathology, obstetrics (fetal monitoring), pediatric, and mental health/psychiatric services -- the diagnostics, data, and images of which should be able to be transmitted at high speed; and 6) interaction between emergency departments and trauma centers in urban areas and helicopters and ambulances at the scene of emergencies in rural areas.[1560]

612. The Advisory Committee recommended that the Commission limit universal service support to services of bandwidths up to and including 1.544 Mbps or its equivalent.[1561] The Advisory Committee called this "the minimum bandwidth necessary" to allow eligible health care practitioners to "access the basic set of telecommunications applications necessary for health care in rural areas"[1562] and recommended that health care providers be able to choose what services they need and obtain support for any telecommunications services up to that bandwidth.[1563] Although it found that the bandwidth needs of a health care provider vary by the size of a facility and number of patients it serves, the Advisory Committee declined to recommend limiting the telecommunications services available for support based on a facility's size.[1564] The Advisory Committee concluded that because health care providers would still be paying rates comparable to those charged in urban areas, these market prices would provide a strong incentive for health care providers to "self-monitor" and avoid excessive use of supported services.[1565] The Advisory Committee also recommended toll-free access to the Internet -- providing access to services such as electronic mail, the most current health care information, and collaborative applications -- be included in the list of telecommunications services necessary for the provision of health care in a state.[1566] In addition, the Advisory Committee recommended

[1560] Advisory Committee Report at 6-7; *see also* AMSC comments at 5-6 (urging the Commission to support mobile telecommunications services to ambulances and other emergency medical vehicles).

[1561] Advisory Committee Report at 1-2. 1.544 Mbps is a digital rate of data transmission of one million five hundred forty four thousand bits per second.

[1562] Advisory Committee Report at 1-2.

[1563] Advisory Committee Report at 1.

[1564] Advisory Committee Report at 7.

[1565] Advisory Committee Report at 7.

[1566] Advisory Committee Report at 4, 6-7.

that an eligible telecommunications carrier receive universal service support to build, upgrade, or extend its backbone infrastructure so it could offer telecommunications services necessary for the provision of health care to all eligible health care providers in the rural areas it served.[1567] The Advisory Committee recommended, that if backbone facilities that had been extended or upgraded with universal service funds were used by other non-eligible customers of the carrier, there should be mechanisms to recover the supported costs of the infrastructure from the profits obtained from serving such customers.[1568]

613. In the Recommended Decision, the Joint Board concluded that the information on the record was insufficient to support a recommendation on the scope of services to be supported for health care providers.[1569] The Joint Board recommended that the Commission solicit information and expert assessment on the exact scope of services that are "necessary for the provision of health care in a state."[1570] The Joint Board concluded that only telecommunications services should be designated eligible for support[1571] and recommended that the Commission seek information on the telecommunications needs of rural health providers and the most cost-effective ways of providing needed services.[1572] The Joint Board also recommended that the Commission support terminating as well as originating services, when the eligible provider incurs such charges;[1573] that the Commission not designate customer premises equipment as eligible for support;[1574] and that the Commission revisit the list of supported additional services by the year 2001, when the Commission is scheduled to re-convene a Joint Board on Universal Service.[1575]

614. The Joint Board found insufficient information in the record to justify a recommendation of support for Internet access for rural health care providers. The Joint Board recommended that the Commission seek information on both the rate of expansion of local access coverage of Internet service providers in rural areas of the country and the costs likely to

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[1567] Advisory Committee Report at 8.

[1568] Advisory Committee Report at 8.

[1569] Recommended Decision, 12 FCC Rcd at 421.

[1570] Recommended Decision, 12 FCC Rcd at 421.

[1571] Recommended Decision, 12 FCC Rcd at 421.

[1572] Recommended Decision, 12 FCC Rcd at 421.

[1573] Recommended Decision, 12 FCC Rcd at 421.

[1574] Recommended Decision, 12 FCC Rcd at 421.

[1575] Recommended Decision, 12 FCC Rcd at 422.

be incurred in providing toll-free Internet access to health care providers in rural areas.[1576] The Joint Board also found insufficient evidence on the record to justify a recommendation that the Commission authorize support for upgrades to the public switched or backbone networks when such upgrades can be shown to be necessary to deliver services to eligible health care providers.[1577] The Joint Board recommended that the Commission seek additional information on the probable costs, advantages, and disadvantages of supporting such upgrades.[1578]

615. In the Recommended Decision Public Notice, the Common Carrier Bureau sought information about the exact scope of services that should be included in the definition of services "necessary for the provision of health care in a State" and the most cost-effective way to provide such services.[1579] The Bureau also sought comment on the relative costs and benefits of supporting technologies and services that require bandwidth higher than 1.544 Mbps.[1580] Moreover, the Bureau sought comment on the costs of supporting upgrades to the public switched network and inquired to what extent, and on what schedule, ongoing network modernization might make such upgrades unnecessary.[1581] In addition, the Bureau sought comment on the probable costs, advantages, and disadvantages of supporting upgrades to the public switched or backbone networks when such upgrades can be shown to be necessary to deliver eligible services to rural health care providers.[1582]

2. Discussion

616. Medical Applications Eligible for Support. In the Recommended Decision, the Joint Board concluded that the information on the record was insufficient to support a recommendation on the scope of services to be supported for health care providers[1583] and recommended that the Commission solicit information and expert assessment on the exact scope of services that are "necessary for the provision of health care in a state."[1584] Consistent with the

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[1576] Recommended Decision, 12 FCC Rcd at 427.

[1577] Recommended Decision, 12 FCC Rcd at 432.

[1578] Recommended Decision, 12 FCC Rcd at 432.

[1579] Recommended Decision Public Notice at 2.

[1580] Recommended Decision Public Notice at 2.

[1581] Recommended Decision Public Notice at 2.

[1582] Recommended Decision Public Notice at 2.

[1583] Recommended Decision, 12 FCC Rcd at 421.

[1584] Recommended Decision, 12 FCC Rcd at 421.

record developed as a result of the Joint Board recommendation, we agree with those commenters suggesting that health care providers themselves are best able to determine those medical applications that should be provided by means of supported telecommunications services.[1585]

617. Commenters submitted a comprehensive, if not exhaustive, list of medical applications that use telecommunications services, including the "market basket" developed by the Advisory Committee.[1586] We reject the suggestions of some commenters that "health care services"[1587] must or should be defined to include only patient care, diagnosis, and treatment,[1588] or to exclude general administrative lines[1589] or all bedside services.[1590] Because the definition of "health care provider" includes, for example, local health departments or agencies and post-secondary educational institutions,[1591] we conclude that Congress did not intend to limit support solely to telecommunications services used for individual patient care.[1592] We also agree with those commenters suggesting that telecommunications services used by public health agencies to provide health-related services -- including the education of the public and the health care community about matters of importance to public health; the collection and dissemination of public health data to appropriate government entities; the coordination of the public response to disasters; and the prevention and control of disease -- should be eligible for universal service support.[1593] We further agree with commenters that in times of disaster, the ability of these

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[1585] *See* Advisory Committee Report at 7; West Virginia Consumer Advocate comments at 13; Wyoming PSC comments at 12.

[1586] *See* Advisory Committee Report at 6-7. *See e.g.,* AAMC comments at 2-3; AHA comments 5; Alaska PSC comments at 5; Ameritech comments at 25; Kansas Hospital Association comments at 1; Nebraska Hospitals comments at 1-2; Nurse Practitioners comments at 2-3; RTC comments at 45-46; St. Alexius comments at 1.

[1587] *See* 47 U.S.C. § 254(h)(1)(A).

[1588] *See* SBC comments at 10.

[1589] *See* SBC comments at 10.

[1590] *See* AT&T comments at 24 n. 15; PacTel comments at 54; SBC comments at 10.

[1591] *See* 47 U.S.C. § 254(h)(5)(i) and (iii).

[1592] *See* Ameritech comments at 25; PacTel comments at 54; SBC comments at 10.

[1593] 47 U.S.C. § 254(h)(1)(A). *See* APHA comments at 1; ASTHO comments at 2; Ford County Health Department comments at 1; Grant County Health Department comments at 1; Gray County Health Department comments at 1; Livingston County Public Health Department comments at 1; Marquette County Health Department comments at 1; Mitchell County Health Dept. comments at 1; Osage County Health Department comments at 1; Osborne County Health Department comments at 1; Phillips County Health Department comments at 1; Russell County Health Department comments at 1; Stanton County Health Department at 1. *See also* HHS

agencies to have ready access to information from each other and from federal emergency and health-management agencies will prevent disease and save lives, and therefore their ability to communicate electronically is important to the health of local communities, the states, and the nation.[1594] Accordingly, we find that "public health services" are "health care services"[1595] for purposes of section 254(h), and as such, the associated telecommunications services necessary to provide such services may be supported by universal service support mechanisms, consistent with the requirements of section 254(h).[1596] For purposes of section 254, we define "public health services" to mean health-related services, including non-clinical, informational, and educational public health services, that local public health departments or agencies are charged with performing under federal and state laws.[1597]

618. Moreover, we disagree with those commenters that urge an unduly strict interpretation of the phrase "*necessary* for the provision of health care services."[1598] As the

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comments at 2 (describing public health services -- including transmission of preventive health data, reports of epidemiological investigations, guidelines for delivery of preventive services, training materials, and emergency notices; professional tele-consultation with two-way interactive audio and video, access to health data and information via Internet, and multi-point consultation for health emergencies -- as health care services requiring and eligible for supported telecommunications services).

[1594] *See* APHA comments at 1; Ford County Health Department comments at 1; Grant County Health Department comments at 1; Gray County Health Department comments at 1; Livingston County Public Health Department comments at 1; Marquette County Health Department comments at 1; Mitchell County Health Dept. comments at 1; Osage County Health Department comments at 1; Osborne County Health Department comments at 1; Phillips County Health Department comments at 1; Russell County Health Department comments at 1; Stanton County Health Department at 1.

[1595] 47 U.S.C. § 254(h)(1)(A).

[1596] 47 U.S.C. § 254(h). HHS suggests that the Commission adopt the broader term "telehealth" in preference to the term "telemedicine" in referring to health-related telecommunications applications including public health applications in order to avoid possible ambiguity as to whether the support we describe here covers such non-clinical-care services. *See* Letter from Donna E. Shalala, Secretary of HHS, to Reed E. Hundt, Chmn. FCC, dated Dec. 19, 1996 (HHS Dec. 19 *ex parte*), transmittal letter at 1. Because we do not use either of these terms to define the services supported under this section, and because we clearly define non-clinical, public health services as eligible for support, we decline to adopt either term and treat the terms "telemedicine" and "telehealth," when used by commenters or otherwise in this Order, as interchangeable. *See supra,* § XI.B.1.

[1597] *See* HHS Dec. 19 *ex parte*, attachment THE ROLE OF PUBLIC HEALTH IN PREVENTION AND MEDICAL CARE at 1 (stating that, among other things, public health educates people about healthy lifestyles; monitors and controls infectious diseases by tracking disease, controlling outbreaks, and promoting immunizations; researches the cause of disease and injury).

[1598] 47 U.S.C. § 254(h)(1)(A) (emphasis added). *See*, e.g., USTA comments at 39 (distinguishing between those services that are "necessary" and those that are "desirable" and proposing that only necessary services be supported); SBC comments at 10 (advocating that support be limited to services that are "required" and "used

Commission has concluded in other contexts, the meaning of the term "necessary" depends on the purposes of the statutory provision in which it is found.[1599] We find that the phrase "necessary for the provision of health care services . . . including instruction relating to such services" means reasonably related to the provision of health care services or instruction because we find that a broad reading of the phrase is consistent with the purpose of section 254(h) which, as Congress has stated, is, in part, "to ensure that health care providers for rural areas . . . have affordable access to modern telecommunications services that will enable them to provide medical . . . services to all parts of the nation."[1600]

619. We emphasize that the determination of what "additional services"[1601] should be eligible for support is not expressly limited by the considerations listed in section 254(c)(1).[1602] Those considerations are relevant to the establishment of core universal services and are not determinative of which "additional" services should receive support for health care providers under the language of section 254(c)(3).[1603] We note that the certification requirements that we adopt today, in particular the requirement that the health care provider certify that the requested service will 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

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solely" to enhance delivery of patient care or for patient diagnostic activities and treatment).

[1599] *See* New England Public Communications Council Petition for Preemption Pursuant to Section 253, *Memorandum Opinion and Order*, CCBPol Docket No. 96-11, FCC 96-470 (rel. Dec. 10, 1996) at para. 24 (*New England Preemption Order*) (stating that although "[a]s a matter of statutory construction, it is generally accepted that the same language used repeatedly in a statute is presumed to bear the same meaning throughout the statute" this presumption may be "disregarded where it is necessary to assign different meanings to the same word to make the statute consistent" (*citing Atlantic Cleaners and Dyers, Inc. v. United States*, 286 U.S. 427, 433 (1932))). For example, in the *Local Competition Order*, we concluded that although the term "necessary" as used in section 254(c)(6) could be interpreted to mean "indispensable," in that provision it should be construed to mean "used" or "useful." *Local Competition Order*, 11 FCC Rcd at 15794.

[1600] *See* Joint Explanatory Statement at 132.

[1601] *See* 47 U.S.C. § 254(c)(3). This provision states: "[i]n addition to the services included in the definition of universal services under paragraph (1), the Commisssion may designate additional services for such support mechanisms for . . . health care providers for the purposes of subsection (h)."

[1602] 47 U.S.C. § 254(c)(1) (requiring the Joint Board in recommending, and the Commission in establishing, the definition of services that are supported by federal universal service support mechanisms to consider, among other things, "the extent to which such telecommunications services . . . (B) have, through the operation of market choices by customers, been subscribed to by a substantial majority of residential customers; and (C) are being deployed in public telecommunications networks by telecommunications carriers"). *See* BellSouth comments at 41; PacTel comments at 54; SBC comments at 10; USTA comments at 39-40.

[1603] *See* 47 U.S.C. § 254(c)(3).

applicable state law, will help ensure that only eligible services are funded.[1604]

620. Bandwidth Limitations. We conclude that, within the limitations described below, universal service support mechanisms for health care providers should support commercially available services of bandwidths up to and including 1.544 Mbps, or the equivalent transmission speed, but not higher speeds. The Joint Board indicated that the Advisory Committee and a majority of the NPRM commenters that recommended a specific level of bandwidth capacity concluded that health care professionals should be able to choose among any telecommunications services of bandwidths up to and including 1.544 Mbps.[1605] The Joint Board, however, did not make a specific recommendation endorsing this bandwidth limitation, instead recommending that the Commission seek more information on the telecommunications needs of rural health care providers and the most cost-effective ways of providing the needed services.[1606]

621. The majority of parties filing comments following the Recommended Decision agree that telecommunications services necessary for the provision of health care services use bandwidth capacity up to and including 1.544 Mbps.[1607] Only one commenter suggests that a bandwidth limitation at some level below 1.544 Mbps might be appropriate. U S West, which prefers that the Commission set no limit on supported services, contends that if the Commission decides to mandate a particular service, the Commission should designate Private Line Transport Service at 56/64 Kbps. U S West asserts that this level of bandwidth "will adequately meet the various needs of rural health care providers."[1608] Both PacTel and American Telemedicine,

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[1604] *See infra* section XI.F.2.

[1605] *See* Advisory Committee Report at 1-2; Recommended Decision, 12 FCC Rcd at 420.

[1606] *See* Recommended Decision, 12 FCC Rcd at 421.

[1607] *See, e.g.,* Alaska PUC comments at 5; Ameritech comments at 25 (asserting that overwhelming majority of telemedicine applications can be supported by bandwidths ranging from 384 Kbps to 1.544 Mbps); Apple comments at 4; BellSouth comments at 41; HHS comments at 2-4 (contending that the Commission should allow providers to choose any service up to 1.544 Mbps); LCI comments at 13; MCI comments at 19 (stating that "support should be limited to advanced services such as T-1 service"); SBC comments at 10; University of Nevada School of Medicine comments at 1 (urging that "support should be provided to rural communities for services of at least the equivalent of T-1 capacity"); USTA comments at 39-40 ("necessary communications services should be limited to those supporting a capacity of up to and including 1.544 Mbps speed or its equivalent"); U S West comments at 51.

[1608] U S West comments at 51. *But compare* Association for Computing Machinery comments at 1 (stating that "[t]he telecommunications bandwidth required to support real-time access and/or high resolution medical imagery is among the highest required for any computing application so the issue is more than simply universal service, high bandwidth is also needed").

which previously suggested that limiting support to ISDN levels would be sufficient,[1609] now acknowledge that some carriers might find it more cost-effective to provide services up to T-1 speeds[1610] and that 1.544 Mbps is necessary for some real-time interactive emergency and diagnostic-quality video applications.[1611] In particular, commenters indicate that in certain situations involving transmission of video images for diagnostic purposes, limiting support to lesser bandwidths could result in receipt of inconsistent, unstable, or discontinuous images that could increase the risk of inaccurate diagnosis or incorrect treatment.[1612] Moreover, commenters report that services with lesser transmission capacity add significant delay to the transmission of possibly time-critical medical images. For example, the transmission of a single study of chest X-rays containing four film images would take 3.5 hours to transmit over a 28.8 modem, 40 minutes over an ISDN line, and only 4 minutes over a T-1 line at 1.544 Mbps.[1613] We find that this evidence is persuasive and supports the conclusion that bandwidths up to and including 1.544 Mbps are necessary for the provision of health care services.

622. Only one commenter, iSCAN L.P., seeks support for services using bandwidths higher than 1.544 Mbps.[1614] Several other commenters, including the Advisory Committee, contend that the high costs of supporting such telecommunications services would outweigh the benefits and assert that such services are not necessary for the provision of health care services at the present time.[1615] Accordingly, we find that the weight of the record evidence demonstrates that these higher bandwidth services are not presently necessary for the "provision of health care services in a State."[1616] We also find that the record indicates vastly higher costs implicated in supporting services that employ bandwidths higher than 1.544 Mbps.[1617] Like the Joint Board,

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[1609] *See* PacTel NPRM comments at 9; PacTel comments at 54.

[1610] PacTel reply comments at 29.

[1611] American Telemedicine comments at 3.

[1612] *See* St. Alexius comments at 1.

[1613] ORHP/HHS NPRM comments at 9.

[1614] iSCAN L.P. comments at 3-5.

[1615] *See, e,g,*. AAMC comments at 1-2; Ameritech comments at 25; BellSouth comments at 13; Kansas Hospital Association comments at 2; Nebraska Hospitals comments at 2; MCI comments at 19; SBC comments at 4; USTA comments at 39; Wyoming PSC comments at 13.

[1616] *See, e,g.,* Ameritech comments at 25; Advisory Committee Report at 8; BellSouth comments at 13; AAMC comments at 1-2; Kansas Hospital Association comments at 2; MCI comments at 19; Nebraska Hospitals comments at 2; SBC comments at 4; USTA comments at 39; Wyoming PSC comments at 13.

[1617] *See, e.g.*, iSCAN L.P. comments at 3 (stating that cost of 1.544 Mbps telecommunications link between Columbia, S.C. and Charleston, S.C. is approximately $1,968 per month compared to approximately $4,340 per

we are mindful of the need to balance the needs of persons residing in rural areas of the state for telecommunications services necessary for the provision of health care with the costs of such services.[1618] This need for balance, coupled with most commenters' assertions that services with bandwidth greater than 1.544 Mbps are presently unnecessary for the provision of health care leads us to conclude that the cost of supporting such higher bandwidth services greatly exceeds the potential benefits of supporting such services at this time.

623. Because we agree that transmission speeds above 1.544 Mbps are not necessary for the provision of health care services at the present time,[1619] and their cost outweighs the additional benefits they offer,[1620] we reject the suggestions of those commenters that urge us not to limit eligible services.[1621] Moreover, given the strength of record support for these rulings, we decline to require states to establish committees to deliberate on these questions as one commenter proposes, instead establishing a guideline making state-by-state determinations unnecessary.[1622] We also conclude that telecommunications carriers should not determine what telecommunications services health care providers should use or which should be eligible for support,[1623] because we believe that health care providers are best able to determine what telecommunications services best meet their needs and are within their budgets.

624. Consistent with the Joint Board recommendation, we clarify that the support mechanisms discussed in this section support telecommunications services, not the particular facilities over which such services are provided.[1624] Therefore, services operating within the bandwidth limitation may be carried over facilities capable of carrying services at higher bandwidths, so long as the provisions for calculating support set forth herein are followed.[1625]

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month for 8 Mbps link).

[1618] *See* Recommended Decision, 12 FCC Rcd at 431.

[1619] *See, e.g.*, Ameritech comments at 24-25; Nebraska Hospitals comments at 1-2; BellSouth reply comments at 13.

[1620] *See, e.g.*, Kansas Hospital Association comments at 2.

[1621] *See, e.g.*, United Health Services comments at 2; West Virginia Consumer Advocate comments at 13; Wyoming PSC comments at 12 (stating that supported services should be determined by health care providers with little restriction from regulators).

[1622] *See* University of Nevada School of Medicine comments at 1-2.

[1623] *See* PacTel comments at 29; SBC comments at 25; Sprint comments at 4.

[1624] *See* Recommended Decision, 12 FCC Rcd at 421.

[1625] *See infra* section XI.D.2.c.

Accordingly, using for purposes of example some of the services described by commenters, Frame Relay Service,[1626] Private Line Transport Service,[1627] ISDN,[1628] satellite communications,[1629] unlicensed spread spectrum,[1630] non-consumer, point-to-point services,[1631] and similar services, when provided by a telecommunications carrier at speeds not exceeding 1.544 Mbps, and requested and certified as necessary by an eligible health care provider, will be eligible for support.

625. Bifurcated Support. We agree with the Advisory Committee[1632] and decline to adopt the suggestion of several commenters that we create two tiers of support for eligible health care providers.[1633] Some of these commenters propose that large hospitals receive support for telecommunications services with a bandwidth capacity up to and including 1.544 Mbps while small clinics receive support only for services with less bandwidth capacity.[1634] Although they could reduce the costs of health care support,[1635] such proposals do not acknowledge that, if bandwidth capacity of 1.544 Mbps is needed for diagnostic quality, real-time, full-motion, interactive video conferencing to evaluate or treat patients,[1636] then this need is shared by both large hospitals and small rural clinics. For this reason, we do not foreclose the availability of support for such services to any eligible health care provider. We find, however, that the high urban prices of telecommunications services, as well as associated equipment and training, will deter rural health care providers from purchasing any service using greater bandwidth capacity than is necessary to provide health care services or health care instruction.

[1626] *See* U S West comments at 51-52.

[1627] *See* U S West comments at 51-52.

[1628] *See* U S West comments at 51-52.

[1629] *See* Alaska PSC comments at 5.

[1630] *See* Cylink comments at 1-3.

[1631] *See* Cylink comments at 1-3.

[1632] Advisory Committee Report at 7.

[1633] *See* Alaska PSC comments at 5; American Telemedicine comments at 3; AT&T comments at 23; Nebraska Hospitals comments at 2; and ORHP/HHS NPRM comments at 8-9.

[1634] *See* AT&T comments at 23; ORHP/HHS NPRM comments at 8-9; *see also* Recommended Decision, 12 FCC Rcd at 415.

[1635] *See* AT&T comments at 23.

[1636] *See, e.g.,* Alaska PSC comments at 5; American Telemedicine comments at 2; HHS comments at 2-4; Nebraska Hospitals comments at 1; St. Alexius comments at 1.

626. Scope of Services Eligible for Support. For the reasons set forth in the Recommended Decision, we agree with and adopt the recommendation of the Joint Board, unchallenged by any commenter, that terminating services should be supported when they are billed to the eligible health care provider, as in the case of wireless telephone air time charges, and should not be supported otherwise.[1637] We adopt the recommendation of the Joint Board,[1638] supported by several commenters[1639] and otherwise unopposed, that we not support health care providers' acquisition of customer premises equipment such as computers and modems.

627. Like the Joint Board, we conclude that only telecommunications services should be designated for support under 254(h)(1)(A).[1640] Section 254(e) states that only an "eligible telecommunications carrier" under section 214(e) may receive universal service support.[1641] Unlike section 254(h)(1)(B), section 254(h)(1)(A) does not contain an exception to the eligibility requirements of section 254(e). Therefore, we conclude that only eligible telecommunications carriers, as defined in section 254(e), shall be eligible to receive support for providing eligible services to health care providers under section 254(h)(1)(A).

628. We conclude that both eligible telecommunications carriers and telecommunications carriers that do not qualify as eligible telecommunications carriers under section 254(e) may receive support for services provided to eligible health care providers under section 254(h)(2). We find that there is no need to extend eligiblity beyond telecommunications carriers because we are supporting only telecommunications services.[1642]

629. Internet Access. The Joint Board concluded that the record contained insufficient information about the costs of providing Internet access to health care providers to justify a recommendation that such access be supported.[1643] Consistent with the Joint Board recommendation, the Common Carrier Bureau sought comment on the need for supporting

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[1637] *See* Recommended Decision, 12 FCC Rcd at 421.

[1638] *See* Recommended Decision, 12 FCC Rcd at 421.

[1639] *See, e.g.*, SBC comments at 10.

[1640] *See* Recommended Decision, 12 FCC Rcd at 421.

[1641] *See* 47 U.S.C. § 254(e).

[1642] *See* KENNETH MCCLURE ET AL., STATE MEMBERS' REPORT ON THE UNIVERSAL SERVICE SUPPORT FOR RURAL HEALTH CARE PROVIDERS (April 10, 1997) (State Health Care Report) at 4. *Compare* State Health Care Report, Separate Statement of Commissioner Laska Schoenfelder at 7-8 (dissenting from majority position on eligibility).

[1643] Recommended Decision, 12 FCC Rcd at 428.

Internet access for rural health care providers.[1644] The Joint Board recommended that the Commission seek information on both the rate of expansion of local access coverage of Internet service providers in rural areas of the country and the costs likely to be incurred in providing toll-free Internet access to health care providers in rural areas.[1645]

630. As discussed in the schools and libraries section, sections 254(c)(3) and 254(h)(1)(B) of the Act authorize us to permit schools and libraries to receive the telecommunications and information services needed to use the Internet at discounted rates.[1646] In contrast, section 254(h)(1)(A) explicitly limits supported services for health care providers to telecommunications services.[1647] Accordingly, as some commenters suggest,[1648] data links and associated services that meet the statutory definition of information services, because of their inclusion of protocol conversion and information storage, are not eligible for support under section 254(h)(1)(A), as they are under section 254(h)(2)(A). As several commenters maintain, however, the telecommunications component of access to an Internet service provider, provided by an eligible telecommunications carrier, is a telecommunications service eligible for universal service support for health care providers under section 254(h)(1)(A).[1649] That is, any telecommunications service within the prescribed bandwidth limitations used to obtain access to an Internet service provider is eligible for support under section 254(h)(1)(A). The record suggests that the most efficient and cost-effective way to provide many telemedicine services, including many of the health care services described in the Advisory Committee's list of

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[1644] *See* Recommended Decision Public Notice at 2; Recommended Decision, 12 FCC Rcd at 427.

[1645] Recommended Decision, 12 FCC Rcd at 427.

[1646] *See supra* section X.B.1.2.b. (discussing the information services supported under §§ 254(c)(3) and 254(h)(1)(B)).

[1647] 47 U.S.C. §§ 254(c)(3), 254(h)(1)(A), and 254(h)(1)(B). *See supra* section X.B.2.b.

[1648] *See*, e.g., AT&T reply comments at 30; MTS comments at 30; PacTel comments at 5.

[1649] *See, e.g.*, AAMC comments at 1, 2; AHA comments at 1 (urging the Commission to adopt recommendations of Advisory Committee, including Internet access); American Telemedicine comments at 4; APHA comments at 1, 3-5 (stating that telecommunications access, including Internet applications, is important to public health); HHS comments at 2; Nebraska Hospitals comments at 1 (stating that access to the Internet is necessary to provide access to numerous sources of medical information and to distribute health-care-related information); Alaska Telemedicine Project reply comments at 7; NTIA reply comments at 29; Scott & White reply comments at 1; *see also* Letter from Senators Olympia J. Snowe, J. Robert Kerrey, and John D. Rockefeller IV, primary sponsors of the Snowe-Rockefeller-Exon-Kerrey provision of the 1996 Act, to Chmn. Reed E. Hundt, FCC, dated January 9, 1997, at 1 (Senate January 9 *ex parte*) at 2 (supporting local toll rates for Internet access); Letter from Senator Kent Conrad et al., Congress of the United States, to Chmn. Reed E. Hundt, FCC dated January 10, 1997 (Congressional January 10 *ex parte*) at 2 (asserting that the intent of § 254(h)(1)(A) is that "providers receive access to the Internet as quickly as possible, and that they not wait for the marketplace which may not respond to the communications needs of rural communities")..

necessary telemedicine services, is via the Internet.[1650] For example, via the Internet, health care providers may gain access to expert information and databases,[1651] communicate through e-mail and on-line support groups,[1652] and access services sponsored by the National Institute of Health and the National Library of Medicine.[1653]

631. The record developed in response to the Recommended Decision also indicates that rural health care providers often incur large telecommunications toll charges and that these charges are a major deterrent to full use of the Internet for health-related telecommunications services.[1654] Therefore, as discussed below, under section 254(h)(2)(A), we support limited toll charges incurred by health care providers that cannot obtain toll-free access to an Internet service provider.[1655]

632. Infrastructure Development and Upgrade. The Joint Board observed that the issue of what services to support necessarily raises the issue of how to treat a request for a service that is not offered in the health care provider's local area or that could not be supported by the infrastructure or facilities currently in place.[1656] The Joint Board also found insufficient evidence on the record to justify a recommendation that the Commission authorize support for upgrades to the public switched or backbone networks when such upgrades can be shown to be necessary to deliver services to eligible health care providers.[1657] The Joint Board recommended that the Commission seek additional information on the probable costs, advantages, and disadvantages of supporting such upgrades.[1658] Despite requests for further information in the Recommended Decision and the Public Notice, few parties commented on this issue.[1659]

633. As a preliminary matter, we note that several commenters characterize

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[1650] *See* AAMC comments at 2; Advisory Committee Report at 6-7; Nebraska Hospitals comments at 1.

[1651] *See* HHS comments at 5.

[1652] *See* AAMC comments at 2.

[1653] *See* AAMC comments at 2.

[1654] *See* American Telemedicine comments at 4; Advisory Committee Report at 3.

[1655] *See infra* section XI.G.

[1656] *See* Recommended Decision, 12 FCC Rcd at 432.

[1657] Recommended Decision, 12 FCC Rcd at 432.

[1658] Recommended Decision, 12 FCC Rcd at 432.

[1659] *See, e.g.,* PacTel comments at 54; U S West comments at 49-50.

infrastructure development as "network buildout."[1660] As other commenters note, however, providing additional support for network buildout or other infrastructure building technologies may not comport with the principle of competitive neutrality.[1661] We recognize that non-wireline technologies may provide the most cost-effective manner of providing services to areas currently underserved by, or receiving unsatisfactory service from the use of, wireline technologies.[1662] For this reason we will use the term "infrastructure development" instead of "network buildout" and will explore the use of non-wireline technologies as part of the program described below.

634. We agree with MCI that infrastructure development is not a “telecommunications service” within the scope of section 254(h)(1)(A).[1663] We reject the position of AT&T,[1664] however, that support for non-telecommunications services is likewise barred under the companion provisions of section 254(h)(2). We conclude that we have the authority to establish rules to implement a program of universal service support for infrastructure development as a method to enhance access to advanced telecommunications and information services under section 254(h)(2)(A), as long as such a program is competitively neutral, technically feasible, and economically reasonable.[1665] Section 254(h)(2)(A) directs the Commission to establish competitively neutral rules “to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for all . . . health care providers."[1666] Extending or upgrading existing telecommunications infrastructure enhances access to the advanced services that may be offered over that infrastructure.

635. The record contains anecdotal evidence regarding the need for support for

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[1660] *See, e.g.*, BellSouth comments at 44; PacTel comments at 58.

[1661] Several commenters contended that infrastructure development would not be competitively neutral as required by the provisions of section 254(h)(2)(A). *See* Ameritech comments at 27*;* AT&T comments at 26; BellSouth comments at 45-46; NCTA comments at 23-24; PacTel comments at 58; Ameritech reply comments at 9; State Health Care Report at 3.

[1662] *See* NCTA comments at 24.

[1663] *See* MCI comments at 19.

[1664] *See* AT&T comments at 25-26; *see also* State Health Care Report at 3 (stating that the statute does not specifically contemplate the subsidization of network construction).

[1665] 47 U.S.C. § 254(h)(2)(A).

[1666] 47 U.S.C. § 254(h)(2)(A).

infrastructure development.[1667] We conclude, however, that the existing record contains insufficient information to determine the level of need for such infrastructure development or to estimate reliably the costs to support such development. Moreover, the record contains few details regarding existing federal and state programs already supporting infrastructure development and the extent to which they are meeting existing needs.[1668] Accordingly, we will issue a Public Notice regarding whether and how to support infrastructure development needed to enhance public and not-for-profit health care providers' access to advanced telecommunications and information services.

636. Periodic Review. We have considered carefully the issue of how soon to review and revise the description of supported services and adopt the Joint Board's recommendation to revisit the list of supported services in 2001. We note that there are several advantages to the Joint Board approach. The Joint Board's recommended review date is also the time we have set to re-convene a new Joint Board on universal service, which the statute contemplates will make recommendations to the Commission on modifications to the definition of supported services.[1669]

637. We note the concern of some commenters that technology, markets, and regulations are changing so rapidly, and in some cases so unpredictably, that we should set a review date earlier than the 2001 date recommended by the Joint Board.[1670] On the other hand, we wish to set a review date that allows sufficient time to evaluate the effect of newly adopted regulations. Therefore, we anticipate that, as the Joint Board recommends, we will revisit the list of supported services in 2001, unless changing circumstances require expedited review. Interested parties may submit requests for expedited review based on such changing circumstances.[1671] In particular, we would be interested in comments from the appropriate

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[1667] *See, e.g.,* Letter from Robert M. Halperin, Counsel to Alaska, to William F. Caton, FCC, dated Mar. 7, 1997 (Alaska March 7 *ex parte),* attachment 1 at 2-3; Kansas Hospital Association comments at 2.

[1668] *See, e.g.,* Ameritech comments at 27-28; BellSouth comments at 45-46; State Health Care Report at 3. Federal programs of which we are aware include Office of Rural Health Policy's Rural Telemedicine Network Grant Program and Rural Health Outreach Grant Program; the Telecommunications and Information Infrastructure Program administered by NTIA; and the Internet Connections Grant Program and the High Performance Computing and Communications Program administered by the National Institutes of Health, Department of Health and Human Services. *See* State Health Care Report at 3 (describing federal programs that provide funding for telecommunications programs). We are also aware that recent federal legislation requires the Rural Utility Service to increase the capabilities of the telecommunications infrastructure installed pursuant to its program, which provides long-term loans to improve rural telecommunications infrastructure. *See* 7 U.S.C. § 935(d)(3)(B)(iv); 7 C.F.R. § 1751.106 *et seq.*

[1669] *See* 47 U.S.C. § 254(c)(2).

[1670] *See* Recommended Decision, 12 FCC Rcd at 422; AHA comments at 5; HHS comments at 4.

[1671] *See* ITC comments at 9.

federal agencies working on telehealth applications, because we intend the support we provide to complement the work of other federal programs. Moreover, we will use the monitoring report of the Administrator described below, in conjunction with input from the Joint Working Group on Telemedicine, to evaluate any developing needs for review or redefinition of supported services earlier than recommended by the Joint Board.[1672] This report will be made public so that others may also use it to assess these developing needs.

C. Eligibility of Health Care Providers

1. Defining Eligibility for Health Care Providers

a. Background

638. Section 254(h)(1)(A) grants the right to receive federal universal service support to "any public or non-profit health care provider that serves persons who reside in rural areas of that state."[1673] The provision does not specify, however, where a health care provider must be physically located in order to be eligible for universal service support.

639. The Joint Explanatory Statement indicates that section 254(h) is intended to ensure that "health care providers for rural areas have affordable access to modern telecommunications services that will enable them to provide medical and educational services to all parts of the nation."[1674] In another paragraph, the Joint Explanatory Statement expresses Congress's intent "that the rural health care provider receive an affordable rate for the services necessary for the purposes of telemedicine and instruction relating to such services."[1675] The Joint Explanatory Statement further states that

> [t]he provisions of subsection (h) will help open new worlds of knowledge, learning and education to all Americans - rich and poor, rural and urban. They are intended, for example, to provide the ability to find new information on the treatment of an illness.[1676]

640. The Joint Board recommended that eligibility for universal service support be

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[1672] *See infra* section XI.F.2. (describing monitoring program to collect information for use in periodic review).

[1673] 47 U.S.C. § 254(h)(1)(A).

[1674] Joint Explanatory Statement at 132.

[1675] Joint Explanatory Statement at 133.

[1676] Joint Explanatory Statement at 132.

limited to health care providers that are located in rural areas.[1677] The Joint Board concluded that administering an eligibility definition that includes providers located in urban areas would be "unworkable," given that the statute contemplates a support mechanism designed to reduce rural rates to a level "reasonably comparable" to urban rates.[1678]

b. Discussion

641. Pursuant to section 254(h)(1)(A), "any public or nonprofit health care provider that serves persons who reside in rural areas in that State" is eligible for universal service support. As the Joint Board acknowledged, because nearly all health care providers serve some rural residents, the statute could be read to include nearly every health care provider in the country.[1679] The intent of Congress to limit eligibility under section 254(h)(1)(A) to health care providers located in rural areas is demonstrated by the statutory directive that calculation of the amount of support due a carrier for providing services to a health care provider is to be based on the difference between the "rates for services provided to health care providers for rural areas and the rates for similar services provided to other customers in comparable rural areas."[1680] It would not be logical to compare the rates paid by health care providers with those paid by other customers in comparable rural areas if the health care provider were not also located in a rural area.[1681] Thus, Congress contemplated that an eligible health care provider would otherwise be paying the rates of any other nonresidential customer located in a rural area. The Joint Board's recommendation that eligibility for universal service support be limited to health care providers that are located in rural areas[1682] and its conclusion that administering an eligibility definition that includes providers located in urban areas would be "unworkable"[1683] are consistent with this interpretation.

642. We agree with the Joint Board that we should adopt "a mechanism that includes the largest reasonably practicable number of health care providers that primarily serve rural residents and that, because of their location, are prevented from obtaining telecommunications

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[1677] Recommended Decision, 12 FCC Rcd at 441.

[1678] Recommended Decision, 12 FCC Rcd at 440.

[1679] Recommended Decision, 12 FCC Rcd at 440.

[1680] Recommended Decision, 12 FCC Rcd at 440; 47 U.S.C. § 254(h)(1)(A).

[1681] Recommended Decision, 12 FCC Rcd at 440.

[1682] Recommended Decision, 12 FCC Rcd at 441.

[1683] Recommended Decision, 12 FCC Rcd at 440.

services at rates available to urban customers."[1684] We also agree, therefore, that eligibility to obtain telecommunications services at urban rates should be limited to health care providers located in rural areas. Accordingly, we conclude that all public and nonprofit health care providers that are located in rural areas, as defined below, are eligible to receive supported services pursuant to the mechanisms established in this section.

643. Such an interpretation is consistent with the legislative history of the statute, which indicates that Congress intended section 254(h) "to ensure that health care providers for rural areas . . . have affordable access to modern telecommunications services that will enable them to provide medical . . . services to all parts of the Nation."[1685] The legislative history also indicates that Congress was particularly concerned that "*rural health care providers* [be able] to obtain access to advanced telecommunications services"[1686] and "that the *rural health care provider* receive an affordable rate for the services necessary for the purposes of telemedicine and instruction relating to such services."[1687] Accordingly, we adopt mechanisms to ensure that public and nonprofit rural health care providers receive supported services.

644. We note commenters' concerns that health care providers located outside of rural areas are a major source of health care services and related instruction to rural areas.[1688] Nonetheless, we are bound by the language of the statute, which contemplates support for only those health care providers who would otherwise pay rural rates for supported services. For similar reasons, we agree with the Joint Board and decline to extend support to carriers that provide services to underserved urban areas.[1689] Such an extension of support would be directly contrary to the plain language of section 254(h)(1)(A).

645. As discussed below, we agree with the Joint Board that all public and non-profit health care providers should benefit from the provisions of section 254(h)(2).[1690] Therefore, as discussed below, we conclude that all public and non-profit health care providers that cannot obtain toll-free access to an Internet service provider will be eligible for support for limited toll-

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[1684] Recommended Decision, 12 FCC Rcd at 441.

[1685] Joint Explanatory Statement at 132.

[1686] Joint Explanatory Statement at 132 (emphasis added).

[1687] Joint Explanatory Statement at 133 (emphasis added).

[1688] *See, e.g.,* Colorado LEHTC comments at 3; Community Colleges comments at 20.

[1689] *See* HHS comments at 5.

[1690] *See* Recommended Decision, 12 FCC Rcd at 457.

free access under section 254(h)(2)(A).[1691]

2. Defining Rural Areas

a. Background

646. Section 254(h)(1)(A) provides, in part, that a telecommunications carrier shall provide telecommunications services "to any public or non-profit health care provider that serves persons who reside in *rural areas* in that State . . . at rates that are reasonably comparable to rates charged in urban areas in that State."[1692] In addition, section 254(h)(1)(A) states that the carrier providing such services is "entitled to have an amount equal to the difference, if any, between the rates for services provided to health care providers for *rural areas* in a State and the rates for similar services provided to other customers in comparable *rural areas* in that State treated as a service obligation as part of its obligation to participate in the mechanisms to preserve and advance universal service."[1693]

647. The Commission recognized that, in order to implement section 254(h)(1)(A), it would be necessary to define "rural areas" both to determine the residency of health care patients served by providers and to establish reasonably comparable rates for telecommunications services.[1694] After considering alternative methodologies that ORHP/HHS[1695] and the United States Department of Agriculture's Economic Research Service[1696] had developed, the Advisory Committee recommended that we use the ORHP/HHS method to identify rural areas.[1697] Consistent with the ORHP/HHS approach, the Advisory Committee recommended that the

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[1691] *See supra* section XI.F (discussing eligibility under section 254(h)(2)(A)).

[1692] 47 U.S.C. § 254(h)(1)(A) (emphasis added).

[1693] 47 U.S.C. § 254(h)(1)(A) (emphasis added).

[1694] NPRM at para. 95

[1695] NPRM at para. 96.

[1696] NPRM at para. 97.

[1697] *See* Advisory Committee Report at 3-4. Commentators have noted that there are no operational definitions of "rural areas" that precisely divide the population of the United States into "rural residents" and "urban residents." The two most commonly used definitional constructs are *rural areas and urban areas,* a Bureau of Census designation based on density, and *metropolitan areas and nonmetropolitan areas,* an OMB designation based on the integration of counties with big cities. *See* Letter from Dr. Patricia Taylor, ORHP/HHS to William F. Caton, FCC, dated October 24, 1996 (ORHP/HHS Oct. 24 *ex parte*) attachment at 2 (including attachment, HAROLD F. GOLDSMITH ET AL., IMPROVING THE OPERATIONAL DEFINITION OF "RURAL AREAS" FOR FEDERAL PROGRAMS, Office of Rural Health Policy, 1993 (*"*IMPROVING THE DEFINITION OF RURAL AREAS*")*.

Commission use the OMB's Metropolitan Statistical Area (MSA) designation of metropolitan and nonmetropolitan counties[1698] (or county equivalents)[1699] along with the "Goldsmith Modification"[1700] to metropolitan counties.[1701] The Advisory Committee recognized that large, nominally metropolitan counties can contain significant rural areas that are isolated and lack easy physical access to the central areas of metropolitan counties for health care services.[1702] For that reason, the Advisory Committee suggested using the Goldsmith Modification to identify such areas for inclusion in the category of nonmetropolitan counties.[1703]

648. The Joint Board recommended that we use the same definition of rural areas both to determine whether a health care provider is located in "rural areas of a state" and to designate the "comparable rural areas" needed to calculate the credit or reimbursement due a carrier providing supported services.[1704] In each case, the Joint Board recommended defining "rural areas" as those nonmetropolitan counties identified by the MSA list, together with the additional rural areas identified in the most recent Goldsmith Modification, as ORHP/HHS and the Advisory Committee recommended.[1705] The Joint Board recommended that the Commission

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[1698] The designation of counties as metropolitan or non-metropolitan in character is made officially by OMB, with technical support from the Bureau of the Census, and is based on the size of the largest urban aggregation in a county and patterns of commuting between counties. Generally, counties socially and economically integrated with an urban cluster of at least 50,000 or more persons have been designated as metropolitan counties and the remainder as nonmetropolitan counties. *See* IMPROVING THE DEFINITION OF RURAL AREAS at 7 n.1, footnote 7, *supra., citing* FEDERAL COMMITTEE ON STANDARD METROPOLITAN STATISTICAL AREAS, 1980, *Statistical Reporter* 80(II):335-384.

[1699] The MSA list includes counties, minor civil divisions (MCDs) (e.g., cities, towns, or townships), places independent of MCDs (treated as pseudo-MCDs by Census Bureau for statistical purposes) in New England, and areas treated by the Bureau of the Census as the equivalents of counties for statistical purposes. References herein to "metropolitan counties" or "nonmetropolitan counties" include these areas.

[1700] The Goldsmith Modification identifies small town and open-country parts of large metropolitan counties by census tract or block-numbered area, as defined by the Bureau of the Census. *See* IMPROVING THE DEFINITION OF RURAL AREAS.

[1701] Advisory Committee Report at 3-4.

[1702] Advisory Committee Report at 3-4.

[1703] Advisory Committee Report at 3-4 (stating that ORHP/HHS has used this operational definition of rural areas for more than five years in its Rural Health Outreach Grant Program); *see also* ORHP/HHS NPRM comments at 5 (describing metropolitan and nonmetropolitan areas and the Goldsmith Modification). The Goldsmith Modification strategy for identifying the rural areas of large metropolitan counties is described in IMPROVING THE DEFINITION OF RURAL AREAS.

[1704] *See* Recommended Decision, 12 FCC Rcd at 437.

[1705] Recommended Decision, 12 FCC Rcd at 437.

improve that definition if possible.[1706] In addition, the Joint Board declined to recommend that the Commission designate and direct more support to frontier areas.[1707]

b. Discussion

649. As the Joint Board recognized, section 254(h)(1)(A) requires us to adopt a definition of "rural area" both to determine the location of health care providers and to determine the "comparable rural areas" needed for use in calculating the credit or reimbursement to a carrier that provides services to those health care providers at reduced rates. For both purposes, we adopt the recommendation of the Joint Board and define "rural area" to mean a nonmetropolitan county or county equivalent, as defined by OMB and identifiable from the most recent MSA list released by OMB, or any census tract or block numbered area, or contiguous group of such tracts or areas, within an MSA-listed metropolitan county identified in the most recent Goldsmith Modification published by ORHP/HHS. We agree that counties are units of identification more easily used and administered than the Bureau of the Census's density-based definition of rural and urban areas.[1708] Although some commenters view this definition as too expansive,[1709] we find that it is consistent with the Joint Board's recommendation and congressional intent to adopt "a mechanism that includes the largest reasonably practicable number of rural health care providers that, because of their location, are prevented from obtaining telecommunications services at rates available to urban customers."[1710] As discussed above, because lists of MSA counties and Goldsmith-identified census tracts and blocks already exist, updated to 1996, such an approach is easily administered.[1711] We direct the Administrator

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[1706] Recommended Decision, 12 FCC Rcd at 437.

[1707] *See* Recommended Decision, 12 FCC Rcd at 438.

[1708] *See* IMPROVING THE DEFINITION OF RURAL AREAS at 2.

[1709] *See* RUPRI Rural Telecommunications Task Force at 12.

[1710] Recommended Decision, 12 FCC Rcd at 441. *See also* Joint Explanatory Statement at 132 (stating that section 254(h) is intended "to ensure that health care providers for rural areas . . . have affordable access to modern telecommunications services that will enable them to provide medical . . . services to all parts of the Nation); Joint Explanatory Statement at 133 (expressing concern "that the rural health care provider receive an affordable rate for the services necessary for the purposes of telemedicine and instruction relating to such services").

[1711] OMB annually revises and augments the list of Metropolitan Statistical Areas. Counties or county equivalents not listed are considered nonmetropolitan. ORHP/HHS periodically revises and publishes a list of rural census tracts or block numbered areas located within larger metropolitan counties identified through application of the Goldsmith Modification criteria. Thus a health care provider, located in a county not listed on the MSA list or located in a county within a census tract or block numbered area that is listed in the Goldsmith Modification is located in a "rural area." Any health care provider in the United States or Puerto Rico can identify the census tract or block numbered area within which that provider's site of operation is located by contacting any

to post on a website the most recent versions of the MSA list, the Goldsmith Modification list, and appropriate instructions for identifying the MSA census tract or block numbered area in which a rural health care provider's site is located. In addition, we direct the Administrator to make that information available in hard copy to interested parties upon request.

650. We agree with the Joint Board and decline to adopt a definition of "rural area" consistent with the service territory or study area of a rural telephone company, as defined in the Act.[1712] Indeed, neither the definition of the term "rural telephone company" nor the service boundaries of such companies are well known and using them for eligibility and rate calculation purposes would be more burdensome on rural health care providers and the Administrator than using counties and cities. Moreover, we find no evidence in the record that the service territories of rural telephone companies are expansive enough to cover all the rural areas in the country that are entitled to supported services. Further, such boundaries are constantly changing as rural telephone companies are acquired by other companies, acquire other companies' territories, or apply for study area waivers or modifications. For these reasons, we find the service territory boundaries of rural telephone companies unsuitable for use in designating "rural areas" for the purposes of section 254.

651. We recognize that our decision to define rural area by using the OMB/MSA listing would appear to exclude certain insular areas that do not have counties and are not included in the OMB list or the Goldsmith Modification.[1713] Accordingly, we make special provisions for insular areas, as described below.[1714]

652. Consistent with the Joint Board's recommendation, we decline to make special provisions in this section for "frontier areas," areas with very low population density, as some commenters suggest.[1715] The rate-setting mechanisms that we adopt here apply to all rural areas, including frontier areas. Recognizing, however, the special problems that some health care providers in frontier areas face because of inadequate telecommunications infrastructure, we

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one of eleven offices of the Bureau of the Census's Regional Information Service around the country. A list of these offices, their phone numbers, and states that they cover is attached as an exhibit to the Goldsmith Modification list. Both the current MSA list and the Goldsmith Modification list will be made available through the Internet at www.fcc.gov/healthnet.

[1712] *See* Recommended Decision, 12 FCC Rcd at 438; LCI comments at 11-13 (*citing* 47 U.S.C. §153(37)).

[1713] *See, e.g.,* CNMI comments at 22-24; Governor of Guam comments at 12-13.

[1714] *See supra* section XI.D.

[1715] *See* AHA comments at 5; High Plains RHN comments at 2; ORHP/HHS NPRM comments at 5-6.

have addressed the issue of infrastructure buildout above.[1716]

3. Definition of Health Care Provider

a. Background

653. Section 254(h)(1)(A) states 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 . . . , to *any public or nonprofit health care provider* that serves persons who reside in rural areas in that State."[1717] Section 254(h)(4) clarifies that "[n]o entity listed in this subsection shall be entitled to preferential rates or treatment as required by this subsection, if such entity operates as a for-profit business."[1718] The "Definitions" provision of section 254 states that:

> For purposes of this subsection: . . . [t]he term 'health care provider' means --
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> (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).[1719]

654. In response to commenters who raised the issue of the definition of the term "health care provider," the Joint Board recommended that the Commission attempt no further clarification of the term.[1720] It found that section 254(h)(5)(B) adequately describes those entities Congress intended to be eligible for universal service support.[1721]

[1716] *See supra* section XI.B.

[1717] 47 U.S.C. § 254(h)(1)(A) (emphasis added).

[1718] 47 U.S.C. § 254(h)(4).

[1719] 47 U.S.C. § 254(h)(5)(B).

[1720] Recommended Decision, 12 FCC Rcd at 444.

[1721] Recommended Decision, 12 FCC Rcd at 444.

b. Discussion

655. We adopt the Joint Board's recommendation that the Commission attempt no further clarification of the term "health care provider," because section 254(h)(5)(B) adequately describes those entities Congress intended to be eligible for universal service support.[1722] Commenters present no convincing justification for expanding the categories of eligible providers beyond those delineated by Congress, which are unambiguously described in section 254(h)(5)(B).

656. Accordingly, we do not include rural home care providers within the definition of health care providers.[1723] Although such providers often deliver critical services and constitute an important segment of the health care community, Congress did not include them among rural health care providers eligible for universal service support. Given the specific categories of health care providers defined in section 254(h)(5)(B), we find that if Congress had intended to include rural home care providers in the list, it would have done so explicitly.[1724] Likewise, we decline to include "not-for-profit entities devoted to continuing medical education" within the definition of health care providers, to the extent that they are not already among those entities listed in section 254(h)(5)(B).[1725]

D. Implementing Support Mechanisms for Rural Health Care Providers

1. Identifying the Applicable Rural Rate

a. Background

657. The method of determining the amount that a telecommunications carrier providing services to an eligible health care provider is entitled to treat as its universal service obligation is described in section 254(h)(1)(A) as follows:

[1722] Recommended Decision, 12 FCC Rcd at 444.

[1723] *See, e.g.*, Kansas Hospital Association comments at 3-4 (stating that the Commission should include rural home care providers as eligible for universal service support).

[1724] *Chevron, U.S.A., Inc. v. Natural Resources Defense Council*, 467 U.S. 837, 842-43 (1984) (stating that the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress).

[1725] *See* RUPRI Rural Telecommunications Task Force comments at 13 (stating that such entities should be eligible for support). Section 254(h)(5)(B)(i) includes post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools among the list of health care providers eligible for universal service support under section 254(h)(1)(A).

> (A) HEALTH CARE PROVIDERS FOR RURAL AREAS. A telecommunications carrier providing service under this paragraph shall be entitled to have an amount equal to the difference, if any, between the rates for services provided to health care providers for rural areas in a State and the rates for *similar services provided to other customers in comparable rural areas in that State* treated as a service obligation as a part of its obligation to participate in the mechanisms to preserve and advance universal service.[1726]

658. The Joint Board recommended a method for determining the "rates for similar services provided to other customers in comparable rural areas" necessary to calculate the amount of support -- the "rural rate." The Joint Board stated that the rural rate should "be determined to be the average of the rates paid by commercial customers, other than health care providers, for identical or technically similar services provided by the carrier providing the service to commercial customers in the rural county in which the health care provider is located."[1727] The Joint Board further recommended that the term "rural county" be defined as any nonmetropolitan county identified in the OMB/MSA list, and any rural area within a metropolitan county described and identified in the "Goldsmith Modification" of the OMB/MSA list.[1728]

659. Where the carrier provides no identical or technically similar services in that rural county, the Joint Board recommended that the rural rate be the average of the tariffed or publicly available rates other carriers charge for the same or similar services in that rural county.[1729] Where no such services are offered by any other carriers, or where the carrier deems the method, as applied to that carrier, to be unfair for any reason, the Joint Board recommended that the carrier should be permitted to submit for its state commission's approval, a cost-based rate for the provision of the service in the most economically efficient, reasonably available manner.[1730] The Joint Board further recommended that if state commission review is not available, the carrier should be allowed to submit its proposed rate to the Commission for approval.[1731] The Joint Board recommended that the proposed rate be supported, justified, reviewed, and approved, in the initial submission and periodically thereafter, according to procedures and

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[1726] 47 U.S.C. § 254(h)(1)(A) (emphasis added).

[1727] Recommended Decision, 12 FCC Rcd at 431.

[1728] *See supra* section XI.C.2.

[1729] *See* Recommended Decision, 12 FCC Rcd at 431.

[1730] *See* Recommended Decision, 12 FCC Rcd at 431.

[1731] *See* Recommended Decision, 12 FCC Rcd at 431.

requirements similar to those used for establishing tariffed rates for telecommunications services in their state.[1732]

b. Discussion

660. We adopt the recommendation of the Joint Board and conclude that the rural rate shall be the average of the rates actually being charged to commercial customers, other than rates reduced by universal service programs, for identical or technically similar services provided by the carrier providing the service in the rural area in which the health care provider is located.[1733] In making this decision, we agree with the Joint Board's conclusion that the approach is "[m]indful of the Commission's obligation to craft a mechanism that is `specific, predictable and sufficient.'"[1734] As the Joint Board recommended, we define "rural area" to mean a nonmetropolitan county or county equivalent, as defined by OMB and identifiable from the most recent MSA list as released by OMB, or any census tract or block numbered area, or contiguous group of such tracts or areas, within an MSA-listed metropolitan county as identified in the most recent Goldsmith Modification published by ORHP/HHS.[1735] We conclude that including the discounted rates charged rural schools and libraries for similar services among the rates averaged would deny the telecommunications carrier full compensation for its services to a rural health care provider. For this reason, like the Joint Board, we conclude that the rates averaged to calculate the rural rate should exclude any rates reduced by universal service programs.[1736] Excluding such rates should help ensure that the rural rate more accurately reflects the costs of providing similar services to other customers in rural areas, so that the carrier providing services receives "sufficient" support, as contemplated by the Act.[1737]

661. Because we find it to be a reasonable procedure that minimizes administrative burdens on health care providers and carriers, we also adopt the Joint Board's recommendation on how to determine the rural rate when the providing carrier is providing no identical or technically similar services to other commercial customers in the relevant rural area. The rural rate must be determined by taking the average of the tariffed and other publicly available rates, not including any rates reduced by universal service programs, charged for the same or similar services in that rural area by other carriers. As the Joint Board recommended, if there are no

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[1732] *See* Recommended Decision, 12 FCC Rcd at 431.

[1733] *See* Recommended Decision, 12 FCC Rcd at 431.

[1734] Recommended Decision, 12 FCC Rcd at 431.

[1735] *See supra* section XI.C.2.

[1736] *See* Recommended Decision, 12 FCC Rcd at 431.

[1737] *See* 47 U.S.C. § 254(b)(5).

such tariffed or publicly available rates for such services in that rural area, or if the carrier considers the method described here, as applied to the carrier, to be unfair for any reason, the carrier may submit, for the state commission's approval, regarding intrastate rates, or the Commission's approval, regarding interstate rates, a cost-based rate for the provision of the service in the most economically efficient, reasonably available manner. We also agree with the Joint Board recommendation that the rate determined under this procedure should be supported and justified periodically, taking into account anticipated and actual demand for telecommunications services by all customers who will make use of the facilities over which services are being provided to eligible health care providers.[1738] We encourage state commissions to review these proposed rates according to procedures and requirements similar to those used for establishing tariffed rates for telecommunications services in their states, as the Joint Board contemplated.[1739]

662. We agree with the Joint Board that by defining "comparable rural areas" as the rural area in which the health care provider is located, the rates charged to non-health care customers for similar services in that area are a reasonable measure of "the rates charged for similar services provided to other customers in comparable rural areas in the state."[1740] If there are no similar services being provided in the rural area, either by the carrier or by others, and thus no rates to average, or if the carrier concludes that rates derived from this formula are unfair, we agree with the Joint Board's reasoning that the availability of a cost-based rate application procedure, such as we have adopted, becomes an important backstop. By providing the carrier an opportunity to obtain review of any aspect of the rate or credit calculation that it considers unfair, such a procedure should ensure that the rate is fair to the carrier and accordingly that the support mechanisms are "sufficient," consistent with section 254(b).[1741]

663. We disagree with Illinois CC's contention that the Commission should limit its role in the establishment of intrastate programs for universal service support and, in particular, its role in the establishment of support mechanisms for rural health care providers, thus leaving this task entirely to the states to perform.[1742] In sections 254(c)(3) and 254(h)(1)(A), Congress clearly expressed its intent that the Commission establish universal service support mechanisms for telecommunications services necessary for the provision of health care in each state.[1743]

[1738] *See* Recommended Decision, 12 FCC Rcd at 431.

[1739] *See* Recommended Decision, 12 FCC Rcd at 431.

[1740] *See* 47 U.S.C. § 254(h)(1)(A); Recommended Decision, 12 FCC Rcd at 431.

[1741] *See* 47 U.S.C. § 254(b)(5).

[1742] Illinois CC comments at 3.

[1743] *See* 47 U.S.C. §§ 254(c)(3) and (h)(1)(A).

Requiring each of more than 50 states and territories to devise its own mechanisms for the support of telecommunications services to health care providers without a federal plan to set minimum support levels across the country would not provide "sufficient" support mechanisms across the country, as contemplated by section 254(b)(5). In addition, we note that under section 254(f), states are entitled to establish and fund their own universal service support mechanisms, not inconsistent with the Commission's rules, which do not interfere with or burden federal universal service support mechanisms, to preserve and advance universal service.[1744]

2. Identifying the Applicable Urban Rate

a. Background

664. Section 254(h)(1)(A) describes the rate that telecommunications carriers may charge eligible rural health care providers as follows:

> (A) HEALTH CARE PROVIDERS FOR RURAL AREAS. - A telecommunications carrier shall . . . provide telecommunications services . . . to any public or non-profit health care provider . . . at rates that are reasonably comparable to rates charged for similar services in urban areas in that State.[1745]

665. The Joint Explanatory Statement states that subsection 254(h) was "intended to ensure that health care providers for rural areas . . . have affordable access to modern telecommunications services that will enable them to provide medical and educational services to all parts of the nation."[1746] The Joint Explanatory Statement particularly emphasizes affordability of telemedicine as a goal of this subsection, stating: "[i]t is intended that the rural health care provider receive an affordable rate for the services necessary for the purposes of telemedicine and instruction relating to such services."[1747]

666. The Joint Board recommended an approach for purposes of designating "urban areas" in order to calculate the rate "reasonably comparable to rates charged . . . in urban areas."[1748] The Joint Board concluded that the Commission should "designate a different, somewhat more refined boundary" than the county boundaries used to designate rural areas,

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[1744] *See* 47 U.S.C. § 254(f).

[1745] 47 U.S.C. § 254(h)(1)(A).

[1746] Joint Explanatory Statement at 132.

[1747] Joint Explanatory Statement at 131.

[1748] *See* 47 U.S.C. § 254(h)(1)(A).

recommending that the Commission use the jurisdictional boundaries of the nearest "large city."[1749] The Joint Board further recommended that the Commission "designate by regulation the exact city population size to define the term `large city.'"[1750]

667. The Joint Board further recommended that "the Commission designate as the rate `reasonably comparable to rates charged for similar services in urban areas in that State' (the `urban rate'), the highest tariffed or publicly available rate actually being charged to commercial customers within the jurisdictional boundary of the nearest large city in the state (measured by airline miles from the health care provider's location to the closest city boundary point)."[1751] The Joint Board concluded that in this context, "`comparable' is most reasonably defined to mean `no higher than the highest' rate charged in the nearest large city (excluding distance-based charges)."[1752] The Joint Board also rejected using averaged rates, including an average of statewide urban rates, an average statewide rate, or an average nationwide rate.[1753]

668. The Joint Board declined to recommend support for distance-based charges or charges for transmissions crossing LATA boundaries, because it concluded that the record lacked sufficient evidence about the costs of reducing or eliminating such charges to justify such a recommendation.[1754] Instead, the Joint Board recommended that the Commission seek additional information about the probable costs of supporting distance-based and LATA-crossing charges for rural health care providers.[1755]

b. Discussion

669. Definition. We adopt the recommendation of the Joint Board with modifications and designate as the rate "reasonably comparable to rates charged for similar services in urban areas in that State" (the "urban rate"), a rate no higher than the highest tariffed or publicly available rate actually being charged to a commercial customer within the jurisdictional boundary of the nearest large city in the state, calculated as described below. Accordingly, we adopt the Joint Board's recommended definition of "urban areas" to be used to calculate the rate

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[1749] *See* Recommended Decision, 12 FCC Rcd at 438.

[1750] Recommended Decision, 12 FCC Rcd at 438.

[1751] Recommended Decision, 12 FCC Rcd at 426.

[1752] Recommended Decision, 12 FCC Rcd at 428.

[1753] Recommended Decision, 12 FCC Rcd at 428.

[1754] Recommended Decision, 12 FCC Rcd at 428.

[1755] Recommended Decision, 12 FCC Rcd at 428.

"reasonably comparable to rates charged . . . in urban areas."[1756] So that the urban rate would "reflect to the greatest extent possible reductions in rates based on large-volume, high-density factors that affect telecommunications rates,"[1757] the Joint Board recommended that the Commission use the jurisdictional boundaries of the nearest "large city" to define the relevant "urban area."[1758] Consistent with the Joint Board's recommendation that the Commission "designate by regulation the exact city population size to define the term `large city,'"[1759] and for the reasons described in the next paragraph, we define the phrase "nearest large city" to mean the city in the state with a population of at least 50,000, nearest to the rural health care provider's site, measured point-to-point, from the health care provider's location to the closest point on that city's jurisdictional boundary. We agree with the Joint Board's conclusion that in this context, "`comparable' is most reasonably defined to mean `no higher than the highest' rate charged in the nearest large city (excluding distance-based charges)."[1760] Subject to the limitations described below, a telecommunications carrier may not charge a rural health care provider a rate higher than the urban rate, as defined herein, for a requested service.

670. Like the Joint Board, we conclude that telecommunications rates in the nearest large city are a reasonable proxy for the "rates . . . in urban areas in a State."[1761] We believe that cities with populations of at least 50,000 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. We also choose the 50,000 city size because an MSA, as defined by OMB, is based in part on counties with cities having a population of 50,000 or more, and every state has at least one MSA with a city that size.[1762] If we chose a city size larger than 50,000, we would be unable to apply this standard to states with no cities of that size. In addition, because the telecommunications services a rural health care provider uses in connection with its provision of the health care services covered by section 254(h) are likely to involve transmission facilities linking that health care provider's premises to a point in that nearest large city, using that location should provide more accurate and more realistic comparable rates for

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[1756] *See* 47 U.S.C. § 254(h)(1)(A); *supra* section XI.D.2.a.

[1757] *See* Recommended Decision, 12 FCC Rcd at 438.

[1758] *See* Recommended Decision, 12 FCC Rcd at 438.

[1759] Recommended Decision, 12 FCC Rcd at 438.

[1760] Recommended Decision, 12 FCC Rcd at 428.

[1761] *See* Recommended Decision, 12 FCC Rcd at 438; 47 U.S.C. § 254(h)(1)(A).

[1762] *See* IMPROVING THE DEFINITION OF RURAL AREAS at Appendix (MSA list). We use the term "state" as it is commonly understood, to refer to one of the fifty states, rather than as it is defined in the Act. *See* 47 U.S.C. § 153(40). Some territories and possessions do not have cities larger than 50,000. *See infra* section XI.D.4.b.

specific services than using rates, or average rates, from more distant urban areas.[1763] We agree with the Joint Board that using the highest tariffed or publicly available rate actually being charged to customers in the nearest city of 50,000 in the state avoids any unfairness that would arise from using average rates.[1764] The Joint Board stated that use of an average rate "would entitle some rural customers to rates below those paid by some urban customers, creating fairness problems for those urban customers and arguably going farther with this mechanism than Congress intended."[1765] The use of average rates could result in pricing telecommunications services to rural health care providers at rates lower than those paid by many nearby urban customers.

671. In the NPRM, the Commission stated that it sought a methodology for establishing "reasonably comparable" rates that was based on publicly available data, neither under-inclusive nor over-inclusive, and easily administered.[1766] We conclude that this method of defining the urban rate is easy to understand and use and thus advances the Commission's goal of fashioning universal service support mechanisms that minimize administrative burdens on regulators and carriers.[1767] We believe that it should be relatively easy to compare a city's jurisdictional boundaries with a carrier's rate or exchange maps[1768] and thus ascertain precisely the applicable rate. Moreover, like the Joint Board, we conclude that using the jurisdictional boundaries of cities makes this plan specific and predictable.[1769]

672. We reject MCI's suggestion that we require telecommunications carriers "to charge rural health care providers no more than the TELRIC rate of the same or comparable service in the nearest urban area."[1770] We are constrained by the language of section

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[1763] Recommended Decision, 12 FCC Rcd at 427; *see also infra* section XI.C.2. (concerning the calculation of the offset or reimbursement owed the carrier).

[1764] Recommended Decision, 12 FCC Rcd at 428.

[1765] The Joint Board rejected using averaged rates, including an average of statewide rates, an average statewide rate, or an average of nationwide rates. *See* Recommended Decision, 12 FCC Rcd at 428.

[1766] NPRM at paras. 95, 98.

[1767] *See* NPRM at para. 100.

[1768] Most carriers have maps of exchange service areas or areas within which rates are charged. Often, such maps are filed with their rate tariffs.

[1769] *See* Recommended Decision, 12 FCC Rcd at 427; 47 U.S.C. § 254(b)(5).

[1770] *See* MCI comments at 19. "TELRIC" or "Total Element Long Run Incremental Cost" is a cost methodology for determining the forward-looking long run economic costs of telecommunications facilities or unbundled network elements. "TELRIC rates" are rates for unbundled network elements and interconnection

254(h)(1)(A) to adopt mechanisms designed to make telecommunications services available to rural health care providers at rates reasonably comparable to "*rates charged* for similar services in urban areas."[1771] To the extent that any rates in the urban areas may reflect TELRIC-based pricing, then the discounted rate will also reflect TELRIC-based pricing. The health care provisions of the statute do not contemplate TELRIC-based pricing in other instances.

673. Rates and Distance-based Charges. In considering how to set rates for telecommunications services "that are reasonably comparable to rates charged for similar services in urban areas in that State,"[1772] the Joint Board considered whether distance-based charges could be eligible for support pursuant to section 254(h)(1)(A).[1773] The Joint Board concluded that, when such charges exceed those charges incurred by commercial customers in the nearest urban area, section 254 "strongly suggests" that they should be made comparable.[1774] As the Joint Board emphasized, "the whole thrust of section 254(h)(1)(A) is that such disparities in telecommunications rates based on distance should be reduced or eliminated by universal service support."[1775] Concluding that the record lacked sufficient evidence regarding the costs of excluding such charges, however, the Joint Board declined to recommend that the Commission eliminate or reduce distance-based charges.[1776] Instead, the Joint Board recommended, in order to determine whether such services should be eligible for universal service support, that the Commission seek additional information about the probable cost of supporting distance-based charges for rural health care providers, when such charges exceed those paid by customers in the nearest urban area of the state.[1777]

674. Based on the record filed in response to the Joint Board's recommendation, we

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based on TELRIC cost assumptions. TELRIC is a version of TSLRIC or Total Service Long Run Incremental Cost, another cost methodology for determining the forward-looking long run economic costs of telecommunications services. Both methodologies are discussed in the *Local Competition Order*, 11 FCC Rcd at 15845.

[1771] 47 U.S.C. § 254(h)(1)(A) (emphasis added).

[1772] 47 U.S.C. § 254(h)(1)(A).

[1773] *See* Recommended Decision, 12 FCC Rcd at 428; Advisory Committee Report at 2 (recommending that "the comparable urban rate should eliminate differences [between] urban and rural rates created by distance").

[1774] *See* Recommended Decision, 12 FCC Rcd at 428.

[1775] Recommended Decision, 12 FCC Rcd at 428.

[1776] Recommended Decision, 12 FCC Rcd at 428.

[1777] Recommended Decision, 12 FCC Rcd at 428. We note that the state members of the Joint Board did not address this issue in their subsequent report on health care issues. *See* State Health Care Report.

agree with the Advisory Committee that support for some distance-based charges is necessary to ensure that rates charged to rural health care providers are "reasonably comparable" to urban rates.[1778] We define distance-based charges as charges based on a unit of distance, such as mileage-based charges. We note that the term "rate" is not defined in section 254(h)(1)(A) or elsewhere in the 1996 Act. Although several incumbent LECs and USTA contend that the term "rate" refers to the cost of each element or sub-element of a telecommunications service,[1779] we conclude that, as used in section 254(h)(1)(A), the term "rate" refers to the entire cost or charge of a service, end-to-end, to the customer.

675. Such an interpretation is consistent with the language and purpose of section 254(h)(1)(A). As discussed above, section 254(h)(1)(A) refers to "rates for *services* provided to health care providers" and "rates for similar *services* provided to other customers,"[1780] not rates for particular facilities or elements of a service. As the record indicates, many, if not most, base rates for telecommunications services are averaged across a state or study area.[1781] It is often distance-based charges, not differences between base rates for service elements, that create great disparities in the overall cost of telecommunications services between urban and rural areas.[1782] Indeed, distance-based charges are often a serious impediment to rural health care providers' use of telemedicine.[1783] If, as several LECs contend, a rural rate is "reasonably comparable" to an urban rate provided that per-mile charges are the same for rural and urban areas,[1784] section

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[1778] Advisory Committee Report at 2; Many commenters support eliminating distance-based charges. *See, e.g.*, AHA comments at 5; American Telemedicine comments at 5; HHS comments at 2, 4; Illinois DPH comments at 2; Kansas DHE comments at 1; Kansas Hospital Association comments at 2; Nebraska Hospitals comments at 3; St. Alexius comments at 1; University of Nevada School of Medicine comments at 1; Scott & White reply comments at 1; University of Kentucky Center for Rural Health reply comments at 1; Letter from Sec. Daniel L. Glickman, Dept of Agriculture, Sec. William M. Daley, Dept. of Commerce, and Sec. Donna Shalala, HHS to Chmn. Reed E. Hundt, FCC, dated April 29, 1997 (Joint Agency April 28 *ex parte*) at 2 (stating that "distance-sensitive elements [of rural telecommunications rates] should be eliminated in order to meet the `reasonably comparable' standard set forth in Section 254(h)(1)").

[1779] *See, e.g.*, Ameritech comments at 25-27; PacTel comments at 3-56; AirTouch reply comments at 33; Ameritech reply comments at 8; GCI reply comments at 14; PacTel reply comments at 30; SBC reply comments at 24-27.

[1780] 47 U.S.C. § 254(h)(1)(A) (emphasis added).

[1781] *See e.g.*, MCI comments at 18; PacTel comments at 14; USTA comments at 40.

[1782] *See e.g.*, American Telemedicine comments at 5.

[1783] *See* American Telemedicine comments at 5; Nebraska Hospitals comments at 2; NTIA comments at 2.

[1784] *See, e.g.*, Ameritech comments at 25-27; PacTel comments at 3-56; AirTouch reply comments at 33; Ameritech reply comments at 8; GCI reply comments at 14; PacTel reply comments at 30; SBC reply comments at 24-27.

254(h)(1)(A) could do little to reduce the disparity between rural and urban rates. Given that Congress emphasized the importance of making telecommunications services affordable for rural health care providers,[1785] it seems unlikely that Congress intended to adopt such a restrictive definition of "rate."[1786] Accordingly, we will support distance-based charges incurred by rural health care providers, consistent with the limitations described herein.

676. Support Mechanisms. Although many commenters support eliminating distance-based charges for rural health care providers,[1787] few suggest how to do so. Nebraska Hospitals advocates providing each eligible rural health care provider with a T-1 circuit linking that provider to its primary source for medical consultation at a price equal to the charge for a similar telecommunications service paid by the urban health care provider located the farthest distance from the latter's serving central office.[1788] We conclude, however, that such a plan would not be competitively neutral, because it links support to the use of a wireline service of a specified bandwidth. Likewise, it would be difficult to administer, given the difficulty of ascertaining the relevant urban health care provider.

677. While contending that the Commission lacks the authority to subsidize distance charges, several ILECs suggest a "reasonable means" by which the Commission could do so.[1789] The ILECs contend that "the maximum distance for which a rural health care provider should be subsidized would be the distance from the rural provider's facility to the nearest urban area," which they define as the nearest city that has a population of 25,000 or more.[1790] Moreover, they propose that we adopt a threshold distance to take into account the potential distance charges paid by urban providers, that would be established on a state-wide basis. They propose that a rural provider should not receive a subsidy on distance-based charges associated with distances

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[1785] Joint Explanatory Statement at 131-32.

[1786] We note that the Senate sponsors of the Snowe-Rockefeller-Exon-Kerrey Amendment to the 1996 Act assert that the Act prohibits "the use of distance in determining transmission rates." *See* Senate Jan. 9 *ex parte*.

[1787] *See, e.g.,* AHA comments at 5; American Telemedicine comments at 5; HHS comments at 2, 4; Illinois DPH comments at 2; Kansas DHE comments at 1; Kansas Hospital Association comments at 2; Nebraska Hospitals comments at 3; Letter from Larry Irving, NTIA, to Chmn. Reed Hundt, FCC, dated 4/24/97 (NTIA 4/24 *ex parte*); St. Alexius comments at 1; University of Nevada School of Medicine comments at 1; Scott & White reply comments at 1; University of Kentucky Center for Rural Health reply comments at 1.

[1788] *See* Nebraska Hospitals comments at 2-3.

[1789] *See* Letter from Robert A. Shives, Jr., PacTel, Mary L. Henze, BellSouth, Marvin Bailey, Ameritech, and Todd F. Silbergeld, SBC, to Kathleen B. Levitz, FCC, dated Apr. 16, 1997 (Assembled Companies Apr. 16 *ex parte*) at 1.

[1790] Assembled Companies Apr. 16 *ex parte* at 2.

less than that threshold distance.[1791] For the reasons discussed above, we find that the Commission has the authority to subsidize distance-based charges, and we adopt an approach similar to that recommended by these ILECs, as discussed below.

678. We conclude that the universal service support mechanisms shall support eligible telecommunications services for a distance not to exceed the distance between the health care provider and the point on the jurisdictional boundary of the city used to calculate the urban rate that is most distant from the health care provider's location. Because rural health care providers may select any commercially available telecommunications service with bandwidths up to and including 1.544 Mbps, such an approach is competitively neutral. Moreover, this plan should suffice to connect a rural health care provider with a health care provider in the nearest large city in the state or an Internet service provider. We agree with those ILECs that contend that establishing a maximum distance for which a rural health care provider can receive support should "protect against an otherwise natural tendency for a subsidized rural provider to request telemedicine connections to far flung areas in search of the real or imagined 'expert' in the field."[1792] Moreover, we agree with the group of ILECs that limiting support to connections to the nearest large city in the state is consistent with Congress's intent to make rural and urban rates comparable, rather than making rural health care providers better off than their urban counterparts.[1793]

679. We clarify that, at its discretion, an eligible rural health care provider may choose to connect to a point within the state or across state lines that is closer than the nearest city with a population of 50,000 or more within the state, provided that the health care services can be provided consistent with state law. We do not limit support to a connection to the nearest large city, irrespective of state lines, because state physician licensing requirements may preclude a rural health care provider from establishing a telemedicine connection with the nearest large city in another state. We note that choosing to connect to a city closer than the nearest large city in the state could reduce the amount that the health care provider itself must pay. Thus, as the group of ILECs suggest, the eligible health care provider has an incentive to make rational choices about the telecommunications services it needs, as well as the flexibility to make decisions based on criteria other than just cost.[1794]

680. As the group of ILECs indicate, urban health care providers are not exempted

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[1791] Assembled Companies Apr. 16 *ex parte* at 3.

[1792] Assembled Companies Apr. 16 *ex parte* at 2.

[1793] Assembled Companies Apr. 16 *ex parte* at 1.

[1794] Assembled Companies Apr. 16 *ex parte* at 2.

from distance charges in connection with the purchase of telecommunications services.[1795] To the extent that they connect with other health care providers and Internet service providers within that city, however, these urban health care providers would appear to be less likely than their rural counterparts to incur distance-based charges over a distance greater than the longest diameter of the city in which they are located. Accordingly, we agree with the group of ILECs that blanket subsidization of distance-based charges for rural health care providers could result in inequalities between rural and urban health care providers.[1796] Therefore, we adopt the ILECs' proposal to adopt a standard urban distance on a state-wide basis that takes into account the potential distance charges paid by urban health care providers. To calculate that distance, however, we adopt a city size consistent with our definition of "nearest large city." Accordingly, we conclude that the longest diameters of all cities with a population of 50,000 or more within a state should be averaged to arrive at that state's standard urban distance.[1797] We conclude that using a state-wide distance figure should minimize the administrative burden on the Administrator and carriers while establishing a reasonable estimation of the distance charges that an urban health care provider might incur.

681. Consistent with that approach, if a rural health care provider requests a service to be provided over a distance that is less than or equal to the standard urban distance for the state in which it is located, the urban rate for that service shall be 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 large city in the state, calculated as if the service were provided between two points within the city. For purposes of calculating the appropriate amount of universal service support, this urban rate will then be compared with the rural rate for a similar service over the same distance. If a rural health care provider requests a service to be provided over a distance that is greater than the standard urban distance for the state in which it is located, the urban rate shall be no higher than the highest tariffed or publicly available rate charged to a commercial customer for a similar service provided over the standard urban distance in the nearest large city in the state, calculated as if the service were provided between two points within the city. This urban rate will then be compared to the rural rate for the same or similar telecommunciations service provided over a distance not to exceed the distance between the health care provider and the point on the jurisdictional boundary of the city used to calculate the urban rate that is most distant from the health care provider's location.

682. InterLATA Charges. We decline to provide additional mechanisms to support what commenters and the Joint Board referred to as LATA-crossing charges. To the extent that

[1795] Assembled Companies Apr. 16 *ex parte* at 2.

[1796] Assembled Companies Apr. 16 *ex parte* at 2-3.

[1797] Assembled Companies Apr. 16 *ex parte* at 3 (proposing that the longest geographical dimension of each city with a population of 25,000 or more within a state be averaged together to arrive at that state's "standard urban mileage" figure).

this term refers to rates for interexchange services, we note that, under the provisions of section 254(g),[1798] such rates charged to health care providers in rural areas are to be no higher than the rates charged to the IXC's subscribers in urban areas. To the extent that the term LATA-crossing charges refers to access charges for a service provided to a rural customer, the mechanisms that we adopt will support such charges by supporting the difference between the rural rate and the urban rate.

683. We note that, as a result of the 1996 Act, competitive entry into the local exchange market will increase. As those markets are opened, firms presently precluded from entering the interLATA market may be allowed to offer interLATA services with the result that LATA boundaries are likely to have less functional importance.[1799] Under these circumstances, charges related to LATA crossing are likely to become less burdensome. We will re-examine this issue no later than the next review of the services eligible for universal service support in the year 2001.

684. Limiting Supported Services. The Act directs that universal service support mechanisms should be specific, predictable, and sufficient.[1800] In order to establish such mechanisms for a new and untried program, we conclude that we must limit the services that a rural health care provider may receive. As discussed above, we conclude that bandwidth transmission speeds above 1.544 Mbps are not necessary for the provision of health care services at this time. Accordingly, we conclude that, upon submitting a bona fide request to a telecommunications carrier, a rural health care provider is eligible to receive, for each separate site or location, the most cost-effective, commercially-available telecommunications service with a bandwidth capacity of 1.544 Mbps at a rate no higher than the urban rate, as defined herein, provided over a distance not to exceed the distance between the health care provider and the point on the jurisdictional boundary of the city used to calculate the urban rate that is the most distant from the health care provider's location (the allowable distance). The most cost effective service is the service available at the lowest cost after consideration of the features, quality of transmission, reliability, and other factors the health care provider deems necessary for the service adequately to transmit the health care services the provider requires.

685. As discussed above, we conclude that allowing a rural health care provider to purchase a service with a bandwidth capacity of 1.544 Mbps, at distances up to the limit described above, should enable such a provider to establish a connection with a health care provider located in the nearest city or with an Internet service provider. The rural health care provider may request any other service or combination of services with transmission speeds slower than 1.544 Mbps, transmitted over the same or shorter distance, so long as the total

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[1798] 47 U.S.C. § 254(g).

[1799] *See* 47 U.S.C. § 271.

[1800] 47 U.S.C. § 254(b)(5).

annual support amount for all such services to that health care provider combined, calculated as provided herein, does not exceed what the support amount would have been for the most cost-effective service with a bandwidth capacity of 1.544 Mbps at the allowable distance, calculated as discussed above. Use of transmission speeds slower than 1.544 Mbps may be required where no 1.544 Mbps service is commercially available or may be the preference of a rural health care provider that desires more than one supported service. For example, a rural health care provider could request one or more ISDN connections to an urban health care provider in the nearest large city, so long as the total amount of support for all the requested services does not exceed the amount that would have been necessary to support the most cost-effective service with a bandwidth capacity of 1.544 Mbps connecting the rural health care provider to the farthest point on the jurisdictional boundary of the nearest large city. If the eligible health care provider is located in a rural area in which a service with a bandwidth capacity of 1.544 Mbps is not commercially available and the rate for such a service is therefore unavailable, the maximum amount of support available shall be the difference, if any, between the urban rate and the rural rate, as defined herein, for the most cost-effective service available using a bandwidth of 1.544 Mbps in another rural area of the state.

3. Competitive Bidding

686. Consistent with the Joint Board's recommendation for eligible schools and libraries, we conclude that eligible health care providers shall be required to seek competitive bids for all services eligible for support pursuant to section 254(h) by submitting their bona fide requests for services to the Administrator. Such requests shall include a statement, signed by an officer of the health care provider authorized to order telecommunications services, certifying under oath to the bona fide request requirements discussed below.[1801] The Administrator shall post the descriptions of requested services on a website so that potential providers can see and respond to them.[1802] As with schools and libraries, the request may be as formal and detailed as the health care provider desires or as required by any applicable federal or state laws or other requirements. The request shall contain information sufficient to enable the carrier to identify and contact the requester and to know what services are being requested. The posting of a rural health care provider's description of services will satisfy the competitive bidding requirement for purposes of our universal service rules. We emphasize, however, that the submission of a request for posting under our rules is not a substitute for any additional and applicable state, local, or other procurement requirements.

687. After selecting a telecommunications carrier, the rural health care provider shall certify to the Administrator that the service chosen is, to the best of the health care provider's

[1801] *See supra* section XI.F.2. As noted, however, the health care provider shall certify to the cost-effectiveness of the selected service only after selecting a telecommunications carrier.

[1802] *See* State Health Care Report at 4 (advocating this approach).

knowledge, the most cost-effective service available. Moreover, the health care provider shall submit to the Administrator copies of the other responses or bids received in response to its request for services. As with schools and libraries, we are not requiring health care providers to select the lowest bids offered, but rather will permit them to take quality of service into account and to choose the offering or offerings that they find most cost-effective, where this is consistent with other procurement rules under which they are obligated to operate.[1803] After being selected, the carrier shall certify to the Administrator the urban rate, the rural rate, and the difference sought as an offset against the carrier's universal service obligation.

688. We adopt a competitive bidding requirement because we find that this requirement should help minimize the support required by ensuring that rural health care providers are aware of cost-effective alternatives. Like the language of section 254(h)(1) targeting support to public and nonprofit health care providers, this approach "ensures that the universal service fund is used wisely and efficiently."[1804]

689. While the Joint Board did not discuss competitive bidding for rural health care providers generally, it rejected a competitive bidding plan suggested by Florida Cable as more complicated and less easily administered than the plan that the Joint Board recommended.[1805] The state members of the Joint Board have subsequently endorsed the use of a competitive bidding process for health care providers to encourage competitive neutrality and foster competition and cost effectiveness.[1806]

4. Insular Areas and Alaska

a. Background

690. Section 254(b)(3)[1807] provides that consumers in insular areas should have access to telecommunications and information services, including interexchange services, advanced

[1803] *See supra* section X.C.2. As we note in the schools and libraries section, federal procurement regulations (which are inapplicable here) specify that in addition to price, federal contract administrators may take into account such factors as: prior experience, including past performance; personnel qualifications, including technical excellence; management capability, including schedule compliance; and environmental objectives. *See* 48 C.F.R. § 15.605(b). Rural health care providers may choose to take such factors into account when reviewing bids.

[1804] 141 Cong. Rec. S8417 (Senator Snowe) June 15, 1995.

[1805] Recommended Decision, 12 FCC Rcd at 427. *See also* Florida Cable NPRM comments at 17-18.

[1806] State Health Care Report at 4.

[1807] 47 U.S.C. § 254(b)(3).

telecommunications services, and information services that are: (1) reasonably comparable to those services provided in urban areas; and (2) that are available at rates that are reasonably comparable to rates charged for similar services in urban areas.[1808] Congress stated that the Joint Board and the Commission were to consider consumers of telecommunications services in insular areas, such as the Pacific Island territories, when developing support mechanisms for consumer access to telecommunications and information services.[1809]

691. The Joint Board recommended that the Commission seek further information about the issue of whether insular areas experience a disparity in telecommunications rates between urbanized and non-urbanized parts of their territories.[1810] In particular, the Joint Board recommended that the Commission seek further information regarding the size of cities and other demographic information that might be used to establish urban and rural telecommunications rates in each of the insular areas.[1811] In the Recommended Decision Public Notice, the Common Carrier Bureau inquired if insular areas experience a disparity in telecommunications rates between urbanized and non-urbanized areas.[1812]

b. Discussion

692. Statutory Authority. We note that the provisions of section 254(h)(1)(A) apply to insular areas, because the Act defines "State" to include all United States "Territories and possessions."[1813] We conclude, moreover, that section 254(h)(2)(A) authorizes our adoption of special mechanisms by which to calculate support for these territories. Section 254(h)(2)(A) directs us, in part, to establish competitively neutral rules "to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications . . . services for all public and nonprofit . . . health care providers."[1814]

693. Insular Areas. Although the Common Carrier Bureau sought comment on whether insular areas experience a disparity in telecommunications rates between urbanized and

[1808] 47 U.S.C. § 254(b)(3).

[1809] Joint Explanatory Statement at 131.

[1810] Recommended Decision, 12 FCC Rcd at 429.

[1811] Recommended Decision, 12 FCC Rcd at 429.

[1812] Recommended Decision Public Notice at 2.

[1813] *See* 47 U.S.C. § 153(40).

[1814] *See* 47 U.S.C. § 254(h)(2)(A).

non-urbanized areas,[1815] the record contains little information on this point.[1816] Moreover, commenters have provided little information regarding what programs (in addition to those targeted to rural, insular, or high cost areas) are needed to ensure that insular areas have affordable telecommunications services.[1817] Nor have parties, other than CNMI, provided information from which the costs of such programs might be estimated.[1818]

694. The record does indicate, however, that the unique geographic and demographic circumstances of CNMI and Guam -- including their uniformly rural character, their lack of a city with a population as large as 50,000, or indeed any real urbanized population centers, their lack of counties or county equivalents, and the relatively small size and low density of their populations -- render the mechanisms we adopt under section 254(h)(1)(A) ill-suited to these territories without modifications.[1819]

695. We note that the record contains no information about the status and availability of health care services and telemedicine in American Samoa, the U.S. Virgin Islands, or any other insular areas except for CNMI, Guam, and Puerto Rico. We recognize, however, that American Samoa and the U.S Virgin Islands, like CNMI and Guam, are relatively isolated, have small populations, and have limited medical resources.[1820] American Samoa is a chain of seven Pacific islands with a total land area of 76 square miles. Ninety-five percent of the territory's population of 56,000 lives on the island of Tutuila, where the territory's single hospital is also located.[1821] The U. S. Virgin Islands is a United States territory of three islands located in the Carribean Sea 1,000 miles southeast of Miami. The population in 1995 was 110,000. The U.S. Virgin Islands has a Department of Health; two 250-bed hospitals, one on St. Thomas and one

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[1815] *See* Recommended Decision Public Notice at 2. In the NPRM, the Commission requested comment on all issues affecting insular areas. The Common Carrier Bureau's Further Comments Public Notice asked what programs (in addition to those aimed at high cost areas) are needed to ensure that insular areas have affordable telecommunications services.

[1816] CNMI and Guam filed comments addressing this issue and CNMI has, in addition, filed several *ex parte* letters. *See, e.g.*, Letter from Thomas K. Crowe, counsel to CNMI, to William F. Caton, FCC, dated Feb. 7, 1997, and Letter from Thomas K. Crowe, counsel to CNMI, to William F. Caton, FCC, dated Mar. 28, 1997 (CNMI Mar. 28 *ex parte)*.

[1817] *See* Further Comment Public Notice at Question 6.

[1818] CNMI Mar. 28 *ex parte* at 1.

[1819] *See* CNMI comments at 22-23; Governor of Guam comments at 13.

[1820] *See* U.S. DEPARTMENT OF THE INTERIOR, OFFICE OF INSULAR AFFAIRS, A REPORT ON THE STATE OF THE ISLANDS (1996 Insular Report) at 17-23, 67-77 (Aug. 1996).

[1821] 1996 Insular Report at 17, 27.

on St. Croix; a community mental health center; and clinics on St. Croix and St. John.[1822] Therefore, we conclude that we may need to tailor additional support mechanisms to address the unique circumstances faced by both the health care providers and telecommunications carriers that serve these islands.

696. Given the lack of comprehensive information in the record regarding the telecommunications needs of insular areas and the costs of supporting such services, we will issue a Public Notice regarding these issues. Parties may discuss the proposal of the Governor of Guam to designate telecommunications services between an insular area's medical facilities and a supporting medical center in an urban area outside the insular area as services eligible for support.[1823] They may likewise address CNMI's proposal that universal service mechanisms should support per-minute toll charges for inter-island calls.[1824] We will seek additional proposals for support mechanisms by which we could ensure that health care providers located in these territories will have access to the telecommunications services available in urban areas in the country, at affordable rates, as Congress intended.[1825]

697. In this Order, we designate urban and rural areas in these territories by which to set the "urban rate" and calculate the amount of support under section 254(h)(1)(A) consistent with our general approach to that section. Based on their status as the largest population centers in the territories, we designate the following areas as urban areas for purposes of setting the urban rate: for American Samoa, the island of Tutuila; for CNMI, the island of Saipan;[1826] for Guam, the town of Agana; and for the U.S. Virgin Islands, the town of Charlotte Amalie. For purposes of calculating the "rural rate," all other areas in each of the above-listed territories are designated as rural areas.

698. The "urban rate" shall be no higher than the highest tariffed or publicly available rate charged for the requested service in each territory's designated urban area. The "rural rate," used to calculate the support amount, shall be the average of tariffed and other publicly available rates, not including rates reduced by universal service mechanisms, charged for the same or similar services in the rural areas of the territory. If no such services are available in the rural areas of the territory, or, at the carrier's option, the carrier may submit for the territorial commission's approval, a cost-based rate for the provision of the service in the most economically efficient, reasonably available manner. In addition to the support outlined here,

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[1822] 1996 Insular Report at 65, 73-74.

[1823] *See* Governor of Guam comments at 13.

[1824] *See* CNMI comments at 25-26.

[1825] *See* 47 U.S.C. § 254(b)(3); Joint Explanatory Statement at 131.

[1826] *See* CNMI comments at 25-26.

we will provide additional support for limited toll-free access to an Internet service provider pursuant to section 254(h)(2)(A), as discussed below, which applies equally to health care providers in insular areas.[1827]

699. Puerto Rico. We find it unnecessary to adopt measures beyond those adopted for rural health care providers in other areas to ensure that rural health care providers in Puerto Rico have access to affordable telecommunications services that are necessary to provide health care services. The record shows that Puerto Rico has a population of 3.74 million people and well-defined metropolitan and nonmetropolitan areas, including 28 municipalities listed as MSAs.[1828] Puerto Rico has sixty-seven hospitals, including nineteen in nonmetropolitan areas, and the San Juan Regional Hospital and Main Medical Center is an advanced health care center offering sophisticated and advanced health care technology and services.[1829] No commenters have objected to applying to Puerto Rico the mechanisms described in the Recommended Decision for defining the urban and rural rates for rural health care providers. These facts suggest that the universal service support mechanisms for rural health care providers that we have adopted under section 254(h)(1)(A) can be applied within the territorial limits of Puerto Rico. Accordingly, we find it unnecessary to add any provisions for rural health care providers in this insular area.

700. Alaska. The record developed in response to the Recommended Decision suggests that much of the difficulty of implementing telemedicine programs in the vast frontier areas in Alaska arises from the lack of basic telecommunications network infrastructure necessary to support telemedicine.[1830] Alaska asserts that because of the state's vast size, rugged terrain, harsh weather, and sparse population, "the major obstacle to providing telemedicine services in Alaska is that the public switched network is not currently capable of providing services in rural locations where there is significant need."[1831] The Alaska PUC states that Alaska is "heavily dependent on satellite communications to provide links between the majority of remote, rural health care providers and the few regional hospitals," and affordable satellite

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[1827] *See* CNMI comments at 25 n.70 (requesting support for toll-free Internet access); Governor of Guam comments at 4-6 (requesting support for toll-free Internet access).

[1828] *See* Letter from Joaquin A. Marquez, Puerto Rico Telephone Company (PRTC), to William F. Caton, FCC, dated Mar. 25, 1997 (PRTC March 25 *ex parte*) attachment at 6; Letter from Wilfredo Garcia, PRTC, to John Clark, FCC, dated April 8, 1997 (PRTC Apr. 8 *ex parte*).

[1829] *See* Letter from Maria M. Guevara, PRTC, to John Clark, FCC, dated Apr. 11, 1997 (PRTC Apr. 11 *ex parte*), attachment at 7-11.

[1830] Alaska Mar. 7 *ex parte,* attachment at 2-3.

[1831] Alaska Mar. 7 *ex parte,* attachment at 2-3.

connectivity is often limited to bandwidth of 9.6 kbps.[1832] The need to "hop" satellite signals through multiple earth stations and the use of antiquated analog earth stations reduce transmission speed and reliability even further and often result in the inability to use fax machines or computer modems.[1833]

701. To the extent that rural health care providers in Alaska experience distance-sensitive telecommunications charges greater than those faced in urban areas in that state,[1834] the mechanisms adopted in this section should afford some relief to those health care providers by reducing or eliminating such disparities. As discussed above, however, we decline at this time to adopt support mechanisms for infrastructure development, including infrastructure development in Alaska, but encourage parties interested in obtaining such support for Alaska to present comments in response to our Public Notice on this issue.

E. Capping and Administering the Mechanisms

1. Selecting Between Combined or Separate Support Mechanisms for Health Care Providers and for Schools and Libraries

a. Background

702. In the Further Comment Public Notice, the Common Carrier Bureau asked whether separate funding mechanisms should be established for schools and libraries and for rural health care providers.[1835] The Joint Board recommended the use of a single funding mechanism with separate accounting and allocation systems for the two groups.[1836]

b. Discussion

703. As discussed above, consistent with the Joint Board's recommendation, we will use a unified mechanism for eligible health care providers and schools and libraries with separate accounting and allocation systems for the funds collected for the two groups.[1837] We

[1832] Alaska PUC comments at 5.

[1833] Alaska Mar. 7 *ex parte*, attachment at 3.

[1834] *See* Alaska PUC comments at 7.

[1835] Further Comment Public Notice at Question 22.

[1836] Recommended Decision, 12 FCC Rcd at 434.

[1837] *See supra* section X.E.2.

agree with the Joint Board and the parties contending that separate funding mechanisms would be expensive and unnecessary.[1838] We further agree with the Joint Board and commenters that separate accounting and allocation systems are necessary because the 1996 Act establishes different requirements for calculating disbursements to schools and libraries and to health care providers.[1839] Moreover, we find that establishing two separate systems (within the single fund) will facilitate monitoring for fraud, waste, and abuse and, if necessary, amending the systems governing support to one group without necessarily altering the systems for the other group.[1840]

2. Funding Cap

a. Funding Cap Level

704. Although the Joint Board did not propose a funding cap on the amount of universal service support for health care providers, we agree with those commenters who advocate a total cap to control the size of the support mechanisms.[1841] We note that there is no existing program to help us estimate the cost of funding the support program for health care providers that we adopt under sections 254(h)(1)(A) and 254(h)(2)(A), unlike our programs for high cost and low-income assistance for which we have historical data.[1842] Moreover, it is difficult to estimate costs given that technologies are developing rapidly and demand is inherently difficult to predict. Therefore, to fulfill our statutory obligation to create specific, predictable, and sufficient universal service support mechanisms, we establish an annual cap of $400 million on the amount of funds available to health care providers.[1843] Collection and distribution of the funding will begin in January 1998, consistent with other universal service support mechanisms implemented pursuant to this Order.

705. After substantial deliberations, we conclude that a program that calls for contributions of no more than $400 million annually should ensure sufficient mechanisms,

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[1838] *See* Recommended Decision, 12 FCC Rcd at 434.

[1839] *See* Recommended Decision, 12 FCC Rcd at 434; Bell Atlantic NPRM further comments at 7; BellSouth NPRM further comments at 30; PacTel NPRM further comments at 27; U S West NPRM further comments at 12; USTA NPRM further comments at 17.

[1840] *See* AirTouch NPRM further comments at 19; Bell Atlantic NPRM further comments at 7; BellSouth NPRM further comments at 30; PacTel NPRM further comments at 27; U S West NPRM further comments at 12; USTA NPRM further comments at 17.

[1841] *See* AT&T comments at 25; Georgia PSC reply comments at 30; ICC comments at 6; WorldCom comments at 31.

[1842] *See supra* sections VII (high cost) and VIII (low income).

[1843] *See* 47 U.S.C. § 254(b)(5).

because it is based on the maximum amount of service that we have found necessary and on generous estimates of the number of potentially eligible rural health care providers. No commenter has presented record evidence suggesting a method for determining the amount for a cap, so we have estimated the annual aggregate potential demand for funds based on the record evidence. We estimate that the total cost of the program should not exceed $400 million annually, based on the assumptions discussed below.

706. First, we estimate that there are approximately 12,000 health care providers located in rural areas that are eligible to receive supported services under section 254(h)(1)(A). There is no list of public and non-profit health care providers that fit the definition of "health care provider" in section 254(h)(5)(B) and are located in rural areas, and ORHP/HHS suggests that the number of potentially eligible providers would be difficult to determine before the universal service mechanisms are implemented.[1844] Nonetheless, we have developed an estimate of the number of rural health care providers based on figures supplied by various federal agencies and national associations.[1845]

707. Second, we estimate that the maximum cost of providing services eligible for support under section 254(h)(1)(A) is $366 million, if all eligible health care providers obtain the maximum amount of supported services to which they are entitled. That is, we assume that

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[1844] *See* ORHP/HHS NPRM comments at 6-7.

[1845] While these entities have records regarding the types of health care providers that are supported under the Act, such records are often not current and are generally limited to entities that are either grantees of the agencies' programs or members of the associations. In addition, entities that maintain data on health care providers often do not distinguish between private and public or non-profit health care providers or identify those health care providers that are located in rural areas. While we have attempted to compensate for these factors in our estimates, we recognize that our estimate of the number of potentially eligible health care providers is subject to error. We set forth the individual estimates on which the 12,000 total estimate is based, by statutory category of eligible provider and with reference to supporting sources: category 1) 625 "post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools," including 403 rural community colleges (Letter from Kent A. Phillipe, Am. Ass'n of Community Colleges, to John Clark, FCC, dated Mar. 31, 1997, at 2), 124 medical schools with rural programs (Letter from Donna J. Williams, Ass'n of Am. Medical Colleges, to John Clark, FCC, dated Sept. 9, 1997), and 98 rural teaching hospitals (Letter from Kevin G. Serrin, Ass'n of Am. Medical Colleges, to John Clark, FCC, dated Sept. 5, 1996); category 2) 1,200 "community health centers or health centers providing health care to migrants" (Letter from Richard C. Bohrer, Div. of Community and Migrant Health, HHS, to John Clark, FCC, dated Mar. 31, 1997, at 2); category 3) 3,526 "local health departments or agencies," including 1,704 local health departments (Letter from Nancy Rawding, Nat'l Ass'n of County and City Health Officials, to John Clark, FCC, dated Apr. 2, 1997), and 1,822 local boards of health (Letter from Ned E. Baker, Nat'l Ass'n of Local Bds. of Health, to John Clark, FCC, dated Apr. 2, 1997); category 4) 1,500 "community mental health centers" (Telephone contact with Mike Weakin, Ctr. for Mental Health Services, HHS, May 2, 1997); category 5) 2,049 "not-for-profit hospitals" (Am. Hospital Ass'n Ctr. for Health Care Leadership, *A Profile of Nonmetropolitan Hospitals 1991-95*, at 5 (1997)); category 6) 3,329 "rural health clinics" (Letter from Patricia Taylor, ORHP/HHS, to John Clark, FCC, dated May 2, 1997); and category 7) consortia of health care providers accounted for in the first six categories.

each rural health care provider will request support for a service of 1.544 Mbps. We recognize that service of that bandwidth is not available in all areas and that many rural health care providers may choose not to use the full amount of support represented by that service. Therefore, the actual cost of support should be lower than our estimate. We also assume that rates will be higher in rural areas than in urban areas. As the record suggests, however, rates are frequently averaged,[1846] a factor that should likewise reduce the amount of support required. We further assume that for each rural health care provider, the support mechanisms will fund distance-based charges for 100 miles per provider, a reasonable number of miles based on the record.[1847]

708. We further estimate that the maximum cost of support for toll-free access to an Internet service provider, provided under section 254(h)(2)(A), will be $26 million. That estimate is based on an assumption that the number of nonprofit and public health care providers that cannot obtain toll-free access to an Internet service provider is 12,000, our estimate of the number of eligible rural health care providers. Because the record indicates that many rural health care providers can reach an Internet service provider with a local call,[1848] the actual cost of support may be much lower. Moreover, the estimate is based on the assumption that each rural health care provider will use the maximum dollar amount of support ($180 per month). In fact, some rural health care providers may not take Internet service due to the monthly service charge. Moreover, some health care providers eligible to receive limited toll-free access to an Internet service provider may obtain such access from a service provider that imposes a toll charge of less than $.10 per minute, in which case only the toll charges associated with 30 hours of access would be supported, at less than $180 per month. Therefore, the actual cost of support is expected to be lower than our estimate.

709. We decline to adopt a per-institution dollar cap as some commenters propose,[1849] because we believe that the limits on supported services set forth in section XI.B.2 above should

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[1846] *See, e.g.*, MCI comments at 18; SBC reply comment at 24-27; PacTel comments at 14; USTA comments at 40.

[1847] In its comments submitted in response to the NPRM, ORHP/HHS submitted an attachment containing summary data on its telemedicine grantees as of April 1996. The average distance reported for the telemedicine connections to a "point-of-presence" for these grantees was 99.8 miles. *See* ORHP/HHS NPRM comments, attachment. In addition, included with comments submitted in response to the Recommended Decision were numerous survey forms that had been submitted by health care providers involved in telemedicine projects. The Commission received survey forms that provided data on 66 telemedicine projects involving 925 separate sites. The responses, which were not drawn from a scientifically selected or statistically accurate sample, included a statement of the mileage distance to the "nearest city of population equal to or greater than 50,000 in . . . [the respondent's] state." The average distance reported was 118 miles.

[1848] *See, e.g.*, Georgia PSC reply comments at 30; SBC comments at 10.

[1849] *See* AT&T comments at 25; Georgia PSC reply comments at 30.

suffice to ensure that support is distributed equitably among health care providers and that it is specific, predictable, and sufficient.

b. Operation of Cap

710. Timing of Funding Requests. As discussed above, we adopt an annual cap of $400 million for universal service support for health care providers pursuant to sections 254(h)(1)(A) and 254(h)(2) of the Act. Support will be committed on a first-come-first-served basis. Consistent with other universal service support mechanisms implemented pursuant to this Order, the funding year for health care providers will begin on January 1, with requests for support accepted beginning on the first of July prior to each calendar year. For the first year only, requests for support will be accepted as soon as the health care website is open and the applications are available. Health care providers will be permitted to submit funding requests once they have made agreements for specific eligible services,[1850] and the Administrator will commit funds based on those agreements until the total payments committed during a funding year reach the amount of the cap.

711. The Administrator shall measure commitments against the $400 million limit based on the contractually-specified expenditures for recurring flat-rate charges for telecommunications services that a health care provider has agreed to pay and the commitment of an estimated variable usage charge, based on documentation from the health care provider of the estimated expenditures that it has budgeted to pay for its share of usage charges. Health care providers must file their contracts with the Administrator either electronically or by paper copy. Moreover, health care providers must file new funding requests for each funding year. Such requests will be placed in the funding queue based on the date and time they are received by the Administrator.

712. As with schools and libraries, we conclude that these rules will give health care providers the certainty they need for budgeting. Some uncertainty may remain about whether an institution will receive the same level of support from one year to the next because demand for funds may exceed the funds available despite our efforts to set the cap at a level intended to permit participation by all eligible health care providers and the cap might not be raised immediately. If that does occur, we cannot guarantee support in the subsequent year without placing institutions that have not formulated their telecommunications plans in the previous year at a disadvantage, possibly preventing such entities from receiving any universal service support. We acknowledge that requiring annual refiling for recurring charges places an additional administrative burden on eligible institutions. As with schools and libraries, however, we find that allowing funding for recurring charges to carry forward from one funding year to the next would favor those who are already receiving funds and might deny any funding to those who

[1850] Health care providers may insist that those agreements be made contingent on universal service funding approval.

had never before received funding.

713. Adjustments to Cap. We do not anticipate that the cost of funding eligible services will exceed the cap, given the limits on the services that any one health care provider may request, and we do not want to create incentives for health care providers to file requests for services prematurely to ensure funding. If the amount of support needed for requested services exceeds the funding cap, this will indicate that our estimates were less accurate than we expect and will suggest that we must adjust the cap. We will consider the need to revise the cap in our three-year review proceeding and sooner if we find it necessary to ensure the sufficiency of the fund or to respond to requests from interested parties for expedited review.

714. Advance Payment for Multi-Year Contracts. We conclude that providing funding in advance for multiple years of recurring charges could enable an individual health care provider to guarantee that its full needs over a multi-year period were met, even if other health care providers were unable to obtain support due to insufficient funds. Moreover, we are also concerned that funds would be wasted if a prepaid service provider's business failed before it had provided all of the prepaid services. At the same time, we recognize that health care providers often will be able to negotiate better rates for pre-paid/multi-year contracts, reducing the costs that both they and the universal service support mechanisms incur. Therefore, we conclude that while eligible health care providers should be permitted to enter into pre-paid/multi-year contracts for supported services, the Administrator will only commit funds to cover the portion of a long-term contract that is scheduled to be delivered during the funding year. Eligible health care providers may either structure their contracts so that payment is required on at least a yearly basis or, if they wish to enter into contracts requiring advance payment for multiple years of service, they may use their own funds to pay full price for the portion of the contract exceeding one year (pro rata), and request that the service provider rebate the payments from the support mechanism that it receives in subsequent years to the eligible health care provider.

715. Collections. We lack sufficient historical data to estimate accurately the funding demands for the first year of this program. As discussed above, in the past when the Commission has established similar funding mechanisms, the Commission or the Administrator has had access to information upon which to base an estimate of necessary first-year contribution levels. No unified mechanism exists to provide telecommunications and information services to the nation's health care providers. We agree with NYNEX and Bell Atlantic that funds should be collected for assistance to health care providers on an as-needed basis, to meet anticipated actual expenditures over time.[1851] Therefore, we direct the Administrator to collect $100 million for the first three months of 1998 and to adjust future contribution assessments quarterly based on its evaluation of health care provider demand for funds, within the limits of the spending cap we establish here. We direct the Administrator to report to the Commission, on a quarterly basis, both the total amount of payments made to entities providing services to health care

[1851] Letter from G. R. Evans, NYNEX, to William F. Caton, FCC, dated Apr. 30, 1997.

providers to finance universal service support and its determination regarding contribution assessments for the next quarter.[1852]

716. As with the schools and libraries mechanism, we find that adjustments for any large reserve of remaining funds can be addressed in our review in the year 2001. As part of its review in the year 2001, the Joint Board likewise will review the appropriate level of funding of the health care program.

F. Restrictions and Administration

1. Restrictions on Resale and Aggregated Purchases

a. Background

717. Section 254(h)(3) states that "[t]elecommunications services and network capacity provided to a public institutional telecommunications user under this subsection may not be sold, resold, or otherwise transferred by such user in consideration for money or any other thing of value."[1853] The Joint Explanatory Statement explains that this section "clarifies that telecommunications services and network capacity provided to health care providers . . . may not be resold or transferred for monetary gain."[1854]

718. The Joint Board advocated the strict enforcement of the prohibition in section 254(h)(3) against the resale of supported services, and urged that an audit program be established sufficient to monitor effectively and evaluate the use of supported services in aggregated purchase arrangements.[1855] The Joint Board emphasized, however, that this prohibition should not restrict or inhibit joint purchasing and network-sharing arrangements with both public and private entities and individuals. The Joint Board recommended that health care providers be encouraged to enter into aggregate purchasing and maintenance agreements for telecommunications services with other public and private entities and individuals, but that the entities and individuals not eligible for universal service support pay the full contract rates for their portion of the services. In addition, the Joint Board recommended that the Commission's order make clear that, under such arrangements, the qualified health care provider is eligible for reduced rates, and the telecommunications carrier eligible for support, only on that portion of the services purchased and used by that health care provider. The Joint Board concluded that these

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[1852] Quarterly reports shall be filed with the Commission within 30 days after the end of each quarter.

[1853] 47 U.S.C. § 254(h)(3). *See also supra* section XI.D.3 (explaining that the definition of "health care provider" includes "consortia of health care providers").

[1854] Joint Explanatory Statement at 133.

[1855] Recommended Decision, 12 FCC Rcd at 455.

arrangements should be subject to full disclosure and close scrutiny under the audit program it recommended.[1856]

b. Discussion

719. Consortia. We agree with the Joint Board and those commenters observing that aggregated purchase or network sharing arrangements can substantially reduce costs and in some cases are necessary to sustain a rural telecommunications network.[1857] As the Joint Board stated, and as we did with schools and libraries, we recognize that aggregation into consortia can promote efficient shared use of facilities to which each consortium member might need access, but for which no single user needs more than a small portion of the facilities' full capacity.[1858] We also recognize, however, that allowing health care providers to aggregate with other local customers, such as schools and libraries, may increase the difficulty of enforcing the eligibility and resale limitations. Nevertheless, as we did for schools and libraries, we conclude that the benefits of aggregation outweigh the administrative difficulties discussed below. Therefore, we adopt, with slight modification, the Joint Board's recommendation to encourage health care providers to enter into aggregate purchasing and maintenance agreements for telecommunications services with other entities and individuals, as long as the entities not eligible for universal service support pay full rates for their portion of the services.[1859] Consistent with the schools and libraries directive and reasoning regarding aggregated purchase arrangements, however, eligible health care providers participating in consortia that include private sector members will not be eligible to receive universal service support, with one exception.[1860] Eligible health care providers participating in such a consortium may receive support, if the consortium is receiving tariffed rates or market rates, from those providers who do not file tariffs.[1861] We find that this prohibition will deter ineligible, private entities from entering into aggregated purchase arrangements with rural health care providers to receive below-tariff or below-market rates that they otherwise would not be entitled to receive.[1862]

[1856] Recommended Decision, 12 FCC Rcd at 455.

[1857] *See* Recommended Decision, 12 FCC Rcd at 455; ORHP/HHS NPRM comments at 10-11. *See also* American Telemedicine comments at 3; Nebraska Hospitals comments at 2; Taconic Tel. Corp. NPRM reply comments at 5.

[1858] *See supra* section X.C.2.

[1859] Recommended Decision, 12 FCC Rcd at 455.

[1860] *See supra* sections X.C.2., X.D.2.

[1861] *See supra* section X.C.2.

[1862] We do not believe, however, that such a limitation will inhibit the ability of eligible health care providers to participate in advanced telecommunications services or deny access to community-based telecommunications

720. Consistent with our directives pertaining to support for schools and libraries and the Joint Board's recommendation, we require telecommunications carriers to carefully maintain complete records of how they allocate the costs of shared facilities among consortium participants in order to charge eligible health care providers the appropriate amounts. We emphasize that under such arrangements, the rural health care provider is eligible for reduced rates and the telecommunications carrier is eligible for support only on that portion of the services purchased and used by that eligible health care provider. We adopt the Joint Board's recommendation that these arrangements be subject to full disclosure requirements and closely scrutinized under an audit program.[1863] Carriers shall also be required to keep detailed records of services provided to rural health care providers. These records shall be maintained by carriers and shall be available for public inspection. The carriers must quantify and justify the amount of support for which members of consortia are eligible. Accordingly, a provider of telecommunications services to a health care provider participating in a consortium must establish the applicable rural rate for the health care provider's portion of the shared telecommunications services, as well as the relevant urban rate. Absent supporting documentation that quantifies and justifies the amount of universal service support requested by an eligible telecommunications carrier, the Administrator shall not allow that carrier to offset, or receive reimbursement for, the costs of providing services to rural health care providers participating in consortia.[1864]

721. Health care providers that belong to consortia that share facilities should maintain their own records of use, in addition to the records that service providers keep. Such records may be subject to an audit or examination by the Administrator or other state or federal agency with jurisdiction, as described below.[1865] Such monitoring should reduce the opportunity for fraud or misappropriation of universal service funds.

722. These requirements would not prevent state telecommunications agencies like DOAS-IT or urban based health care providers from aggregating demand and providing services to rural health care providers participating in consortia at volume discounted rates or from providing technical assistance, such as network management or centralized administrative

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facilities. *See* RUPRI Rural Telecommunications Task Force comments at 13 (stating that section 254(h)(3) should not be read to produce such a result).

[1863] Recommended Decision, 12 FCC Rcd at 455.

[1864] For example, carriers can submit an itemized bill to the administrator which indicates what percentage or portion of the services provided to a consortium can be attributed to a particular health care provider eligible to receive supported services, along with the applicable rural and urban rates necessary to calculate the amount of support required.

[1865] *See infra* section XI.F.2.b.

functions.[1866] We conclude that it is unlikely that any of the entities providing services under such an arrangement could be eligible for support under section 254(h)(1)(A), because rural health care providers obtaining services at prices averaged throughout the state are unlikely to be paying more than the urban rate. Therefore, unless telecommunications carriers can demonstrate to the Administrator that the average rate that members of a consortium pay is greater than the applicable urban rate, such carriers will not be able to receive universal service support under this provision. Health care providers participating in consortia that are not eligible to receive services supported under section 254(h)(1)(A) may be eligible to receive limited toll-free access to an Internet service provider, as described below.

723. Use of Multi-purpose Telecommunications Connections. To reduce costs to health care providers, we also encourage the use of shared lines. As Community Colleges explains, a health care provider may use a single line to provide multiple services, not all of which are eligible for support.[1867] An eligible health care provider, however, can be eligible for reduced rates, and the telecommunications carrier can be eligible for support, only on that portion of the telecommunications services purchased and used by the health care provider for an eligible purpose. For example, if a health care provider uses a supported T-1 line to send x-rays to a remote location and to provide adult literacy tutoring, the carrier providing those services could receive universal service support only for the portion of the service used for x-ray analysis, because adult literacy tutoring is not necessary for the provision of health care. We agree with Community Colleges that, in order to ensure that only eligible services receive support, single health care providers that use lines for several purposes must maintain records of use, which may be the subject of an audit by the Administrator or other state or federal agency with jurisdiction, as described below.[1868] Moreover, carriers must retain careful records regarding how they have allocated the costs of shared facilities. We expect the Administrator to work with rural health care providers to keep any record keeping requirements to a minimum consistent with the need to ensure the integrity of the program.

2. Bona Fide Requests

a. Background

724. Section 254(h)(1)(A) states that "[a] telecommunications carrier shall, upon receiving a *bona fide request*, provide telecommunications services which are necessary for the

[1866] *See* Georgia Dept. of Admin. Services comments at 2-4; Georgia Dept. of Admin. Services reply comments at 31-32 (explaining that disaggregating rural from urban hospitals would reduce savings from volume discount).

[1867] *See* Community Colleges comments at 19.

[1868] *See* Community Colleges comments at 19.

provision of health care services in a State."[1869]

725. The Joint Board recommended that every health care provider that makes a request for universal service supported telecommunications services be required to submit to the carrier a written request, signed by an authorized officer of the health care provider, certifying under oath to five specified items of information.[1870] The Joint Board concluded that the certification requirements address the portions of section 254(h) governing eligibility for and limiting use of supported services for health care providers.[1871] The Joint Board found such requirements to be the minimum certification necessary for adequate monitoring of compliance with section 254(h)(1)(A) and recommended that the certification be renewed annually.[1872] In addition, the Joint Board recommended that the Commission require the Administrator to establish and administer a monitoring and evaluation program to oversee the use of universal service supported services by health care providers and the pricing of those services by carriers.[1873] The Joint Board also recommended that the Commission encourage carriers across the country to notify eligible health care providers in their service areas of the availability of lower rates resulting from universal service support so that the goals of providing universal service support to rural health care providers will be more rapidly fulfilled.[1874]

b. Discussion

726. Certification Requirements. We adopt the Joint Board's recommendation, with modifications, to require every health care provider that requests universal service supported telecommunications services to submit to the carrier a written request, signed by an officer of the health care provider authorized to order telecommunications services, certifying under oath to the first five conditions detailed below in order to establish a bona fide request for services.[1875] We clarify, however, that a health care provider requesting services eligible for support under section 254(h)(2)(A) need not establish that it is located in a rural area but rather that it cannot obtain toll-free access to an Internet service provider, as discussed below. We also impose an

[1869] 47 U.S.C. § 254(h)(1)(A) (emphasis added).

[1870] *See* Recommended Decision, 12 FCC Rcd at 451.

[1871] *See* Recommended Decision, 12 FCC Rcd at 451.

[1872] *See* Recommended Decision, 12 FCC Rcd at 451.

[1873] *See* Recommended Decision, 12 FCC Rcd at 452.

[1874] *See* Recommended Decision, 12 FCC Rcd at 452.

[1875] Recommended Decision, 12 FCC Rcd at 451. As discussed above, a health care provider will certify to these same conditions when posting a request with the administrator to comply with the competitive bidding requirements. *See supra* section XI.D.3.

additional condition: that the health care provider requesting telecommunications services certify that it is ordering the most cost-effective method(s) of providing the requested services. This is consistent with our requirement that health care providers seek to minimize the cost to the universal service support mechanisms by using a competitive bidding process to secure the most cost-effective service arrangement. We define the most cost-effective method of providing service as the method available at the lowest cost, after consideration of features, quality of transmission, reliability, and other factors that the health care provider deems relevant to choosing an adequate method of providing the required health care services.[1876] Consistent with the Joint Board's recommendation, we require health care providers to renew their certification annually. Health care providers are required to certify to the following conditions:

1) that the requester is a public or nonprofit entity that falls within one of the seven categories set forth in the definition of health care provider in section 254(h)(5)(B);[1877]
2) unless the requested service is supported under section 254(h)(2)(A), that the requester is physically located in a rural area (OMB defined non-metro county or Goldsmith-defined rural section of an OMB metro county);[1878] or, if the requested service is supported under section 254(h)(2)(A), that the requester cannot obtain toll-free access to an Internet service provider;
3) that the services requested will be used solely for purposes reasonably related to the provision of health care services or instruction that the health care provider is legally authorized to provide under the law of the state in which they are provided;[1879]
4) that the services will not be sold, resold, or transferred in consideration of money or any other thing of value;[1880]
5) if the services are being purchased as part of an aggregated purchase with other entities or individuals, the full details of any such arrangement governing the purchase, including

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[1876] *See supra* section XI.D.3.b.

[1877] 47 U.S.C. § 254(h)(5)(B).

[1878] For a discussion of OMB metro and non-metro areas, Metropolitan Statistical Areas and the Goldsmith Modification, *see supra* section XI.C.1.b.

[1879] 47 U.S.C. § 254(h)(1)(A) (stating 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*") (emphasis added).

[1880] 47 U.S.C. § 254(h)(3).

the identities of all co-purchasers and the portion of the services being purchased by the health care provider;[1881]

6) that it is ordering the most cost-effective method(s) of providing the requested services.

727. Like the Joint Board, we find that these requirements, with the modifications noted, should sufficiently ensure that universal service support only goes to those health care providers Congress intended to support and, therefore, no additional requirements are necessary. While we recognize USTA's concern that some health care providers may not have the necessary internal connections or customer premises equipment to use the services requested,[1882] we are confident that those providers will seek and receive the assistance they need before they order services, so that they do not waste their own resources by paying even the significant urban rates for such services. Although we require schools and libraries to self-certify that they have developed technology plans, we note that, unlike health care providers, schools and libraries may receive discounts of up to 90 percent. Therefore, the need for safeguards against unnecessary purchases is greater for schools and libraries than for health care providers. We also reject BellSouth's suggestion that we impose further requirements, because we conclude that those we adopt, coupled with the fact that the health care provider must still pay urban rates for services covered by support mechanisms, should sufficiently deter frivolous and wasteful requests.[1883] We also decline Bell South's suggestion to require a provider to certify that a requested service is widely used in the state, as long as the service is "necessary for the provision of health care."[1884]

728. Compliance Review. We adopt the Joint Board's recommendation that we require the Administrator to establish and administer a monitoring and evaluation program to oversee the use of supported services by health care providers and the pricing of those services, and we adopt an approach consistent with the requirements for schools and libraries.[1885] Like the Joint Board, we conclude that a compliance program is necessary to ensure that services are being used for the provision of lawful health care, that requesters are complying with certification requirements, that requesters are otherwise eligible to receive universal service support, that

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[1881] 47 U.S.C. § 254(h)(3).

[1882] USTA comments at 40.

[1883] *See* BellSouth comments at 41 (suggesting that the Commission require each request to: include a clear and concise statement of the health care need to be satisfied by the service; demonstrate that the requested service is widely used by health care providers in the state; show a verifiable plan for use of the service pursuant to the requirements of the Act; and demonstrate that the requesting provider has the necessary equipment to use the requested service).

[1884] *See infra* section XI.B.3.

[1885] Recommended Decision, 12 FCC Rcd at 452.

rates charged comply with the statute and regulations, and that the prohibitions against resale or transfer for profit are strictly enforced.

729. Accordingly, we conclude that health care providers, as well as telecommunications carriers, should maintain the same kind of procurement records for purchases under this program as they now keep for other purchases. We conclude that health care providers must be able to produce these records at the request of any auditor appointed by the Administrator or any other state or federal agency with jurisdiction that might, for example, suspect fraud or other illegal conduct, or merely be conducting a routine, random audit. We further conclude that health care providers may be subject to random compliance audits by any auditor appointed by the Administrator or any other state or federal agency with jurisdiction to ensure that services are being used for the provision of state authorized health care, that requesting providers are complying with certification requirements, that requesting providers are otherwise eligible to receive supported services, that rates charged comply with the statute and regulations, and that the prohibitions against resale or transfer for profit are strictly enforced.[1886] The compliance audits will also be used to evaluate what services health care providers are purchasing, the costs of such services, and how such services are being used. Such information will permit the Commission to determine whether universal service support policies require adjustment.

730. The Administrator shall develop a method for obtaining information from health care providers on what services they are purchasing and how such services are being used and shall submit a report to the Commission on the first business day in May of each year. The Commission will use this report, in conjunction with any information provided by the Joint Working Group on Telemedicine, to monitor the progress of health care providers in obtaining access to telecommunications and other information services. From such monitoring activities, the Administrator should gather and report the following data: 1) the number and nature of requests for supported services submitted to the Administrator and posted by the Administrator; 2) the number and kinds of services requested; 3) the number, locations, and descriptions of health care providers requesting services; 4) the number and nature of the requests that are filled, delayed, partially filled, or unfilled, and the reasons therefore; 5) the number, nature, and descriptions of carriers offering to provide or providing supported services; 6) the requested services that are found ineligible for support; 7) the rates, prices, and charges for services, including the submissions of proposed urban and rural rates for each service; and 8) the number and nature of rate submissions to state commissions and the Commission.

731. Carrier Notification. We also adopt the Joint Board's recommendation to encourage carriers across the country to notify all health care providers in their service areas of the availability of lower rates resulting from universal service support so that eligible health care

[1886] *See* Recommended Decision, 12 FCC Rcd at 452.

providers can take full advantage of the supported services.[1887] We expect that carriers will market to health care providers. As with schools and libraries, however, we decline to impose a requirement that carriers notify health care providers about the availability of supported services.[1888] We note that many representatives of health care providers are participating in this proceeding, and we believe that these associations will inform their members of the opportunity to secure services under this program. As with schools and libraries, we encourage these groups to do so through such means as trade publications, websites, and conventions.

3. Selecting Between Offset or Reimbursement for Telecommunications Carriers

a. Background

732. Section 254(h)(1)(A) states that a telecommunications carrier that provides designated services to rural health care providers "shall be entitled to have an amount equal to the difference, if any, between the rates for services provided to health care providers for rural areas in a State and the rates for similar services provided to other customers in comparable rural areas in that State treated as a service obligation as a part of its obligation to participate in the mechanisms to preserve and advance universal service."[1889] This language differs from that of section 254(h)(1)(B), pertaining to schools and libraries, which explicitly permits telecommunications carriers providing designated services to schools and libraries to be reimbursed for services, either through an offset to their obligation to contribute to universal service support, or through reimbursement drawn from universal service support mechanisms.[1890]

733. The Joint Board recommended that the Commission allow telecommunications carriers providing services to health care providers under the provisions of section 254(h)(1)(A) to offset the amount eligible for support against the carrier's universal service support obligation.[1891] The Joint Board recommended that the Commission disallow the option of direct reimbursement, although the Joint Board recognized that this alternative is within the Commission's authority.[1892] Acknowledging that the total of a carrier's rate reductions may exceed its universal service obligation in any one year, the Joint Board recommended that

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[1887] Recommended Decision, 12 FCC Rcd at 453.

[1888] *See supra* section X.D.2.

[1889] 47 U.S.C. § 254(h)(1)(A).

[1890] 47 U.S.C. § 254(h)(1)(B).

[1891] Recommended Decision, 12 FCC Rcd at 446.

[1892] Recommended Decision, 12 FCC Rcd at 446.

carriers be allowed to carry offset balances forward to future years, so that the full amounts eligible to be treated as a credit may be applied to reduce their future universal service obligation.[1893]

b. Discussion

734. Subject to the limitations on services previously described, a telecommunications carrier shall receive support for providing an eligible telecommunications service under section 254(h)(1)(A) equal to the difference, if any, between the rural rate and the urban rate charged for the service, as defined above. A telecommunications carrier shall also receive support for providing services under section 254(h)(2)(A), as set forth below. With modifications, we adopt the Joint Board's recommendation that we require carriers to receive this support through offsets to the amount they would otherwise have to contribute to federal universal service support mechanisms, rather than through direct reimbursement. Although we reject NYNEX's conclusion that the statute precludes a mandatory offset rule,[1894] we conclude that allowing direct compensation under some circumstances is consistent with both the statutory language and sound public policy. We conclude that a telecommunications carrier providing eligible services to rural health care providers at reasonably comparable rates under the provisions of section 254(h)(1)(A) should treat the amount eligible for support as an offset against the carrier's universal service support obligation for the year in which the costs were incurred. To the extent that the amount of universal service support owed a carrier exceeds that carrier's universal service obligation, calculated on an annual basis, the carrier may receive a direct reimbursement in the amount of the difference, as the majority of the state members of the Joint Board recommend.[1895] Any reimbursement due a carrier will be made after the offset is credited against that carrier's universal service obligation, but in any event, no later than the first quarter of the calendar year following the year in which the costs for services were incurred.

735. Such an approach is consistent with the statutory language of section 254, which provides generally that a telecommunications carrier may treat the support to which it is entitled under section 254(h)(1)(A) "as a service obligation as a part of its obligation to participate in the mechanisms to preserve and advance universal service."[1896] The statutory provision does not address the specific mechanism for recovery of support but merely indicates that some method of recovery is warranted. In this regard, the language of section 254(h)(1)(A) is general and

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[1893] Recommended Decision, 12 FCC Rcd at 446.

[1894] We note that NYNEX relies on the language of section 254(h)(1)(B), which, as the heading indicates, governs schools and libraries, not health care providers.

[1895] State Health Care Report at 5. *Compare* State Health Care Report, Separate Statement of Commissioner Laska Schoenfelder (dissenting in part), at 7.

[1896] 47 U.S.C. § 254(h)(1)(A).

does not use specific recovery language such as "reimbursement" or "offset," unlike its counterpart for schools, section 254(h)(1)(B), which specifies the manner of recovery. Specifically, section 254(h)(1)(B) provides that a carrier shall have "an amount equal to the amount of the discount treated as an *offset* to its obligation to contribute to the mechanisms to preserve and advance universal service" or "*receive reimbursement* utilizing the support mechanisms to preserve and advance universal service."[1897] Thus, where Congress intended to specify the manner of recovery, it has shown that it will do so. Had Congress intended to allow only for an offset, it could have used the word "offset" as it did in section 254(h)(1)(B). Accordingly, we agree with the Joint Board's conclusion that the Commission has the authority to allow direct reimbursement.[1898]

736. The approach we adopt also should address the potential problem that the Joint Board recognized arises when the total of a carrier's rate reductions exceeds its universal service obligation in any one year.[1899] Moreover, allowing carriers to receive direct reimbursements should help ensure that they have resources adequate to cover the costs of providing supported services. As Alaska PSC suggests, some small carriers would find it particularly difficult to bear such costs absent prompt reimbursement.[1900] Pursuant to the adopted approach, those small carriers that do not contribute to universal service support mechanisms because they qualify for the *de minimis* exemption may receive direct reimbursement as well. Because such carriers must receive reimbursment no later than the first quarter of the calendar year following the year in which the costs for services were incurred, the carriers will never have to wait more than fifteen months to receive payment, an amount of time that we believe is reasonable given the associated administrative burdens on the Administrator.

737. We agree with the Joint Board that "an offset mechanism is both less vulnerable to manipulation and more easily administered and monitored" than direct reimbursement.[1901] We find, however, that the approach we adopt reasonably balances the concerns of carriers with rate reductions exceeding their contributions in a given year against the need for a reimbursement method that may be easily administered and monitored.

G. Advanced Telecommunications and Information Services

1. Background

[1897] *See* 47 U.S.C. § 254(h)(1)(B) (emphasis added).

[1898] Recommended Decision, 12 FCC Rcd at 446.

[1899] Recommended Decision, 12 FCC Rcd at 446.

[1900] *See* Alaska PSC comments at 3-4.

[1901] Recommended Decision, 12 FCC Rcd at 446.

738. Section 254(h)(2) directs the Commission 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 nonprofit . . . health care providers."[1902] Section 254(h)(2) also directs the Commission to "define the circumstances under which a telecommunications carrier may be required to connect its network to such public institutional telecommunications users."[1903] The statute does not define the term "advanced telecommunications services." "Information services" is defined as "the offering of a capability for generating, acquiring, storing, transforming, processing, retrieving, utilizing, or making available information via telecommunications."[1904]

739. The Joint Explanatory Statement provides the following explanation with respect to "advanced telecommunications services:"

> New subsection (h)(2) requires the Commission to establish rules to enhance the availability of advanced telecommunications and information services to public institutional telecommunications users. For example, the Commission could determine that telecommunications and information services that constitute universal service for classrooms and libraries shall include dedicated data links and the ability to obtain access to educational materials, research information, statistics, information on Government services, reports developed by Federal, State, and local governments, and information services which can be carried over the Internet.[1905]

740. The Joint Board concluded that the Commission's adoption of rules providing universal service support pursuant to section 254(h)(1) will significantly increase the availability and deployment of telecommunications services for rural health care providers. Moreover, the Joint Board concluded that the Commission's additional actions, pursuant to the other provisions of section 254, will be sufficient to ensure the enhancement of access to advanced telecommunications and information services for both rural and other health care providers. Furthermore, the Joint Board noted that the class of users who may benefit from the implementation of section 254(h)(2)(A) includes all public and non-profit health care

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[1902] 47 U.S.C. § 254(h)(2)(A).

[1903] 47 U.S.C. § 254(h)(2)(B).

[1904] 47 U.S.C. § 153(20).

[1905] Joint Explanatory Statement at 133.

providers.[1906]

741. The Joint Board declined to make a recommendation regarding toll-free Internet access but recommended that the Commission seek information on the costs likely to be incurred in providing toll-free access to an Internet service provider for rural health care providers.[1907]

2. Discussion

742. We agree with the Joint Board's conclusion that the rules we establish for the provision of universal service support pursuant to section 254(h)(1)(A) should significantly increase the availability and deployment of telecommunications services for rural health care providers.[1908] Moreover, like the Joint Board, we find that the additional support mechanisms adopted in this proceeding, for example, those adopted for high cost areas, also should enhance access to advanced telecommunications and information services for these and other health care providers.[1909] We agree with the Joint Board that the provision of universal service support will stimulate the demand for telecommunications, so that market forces should encourage telecommunications carriers to deploy the facilities needed to enhance access to advanced services.[1910]

743. Nonetheless, we provide additional support under section 254(h)(2)(A) "to enhance . . . access to advanced telecommunications and information services for all public and nonprofit . . . health care providers."[1911] For the reasons discussed below, we will provide universal service support for a limited amount of toll-free access to an Internet service provider. Although the Joint Board did not explicitly recommend supporting toll charges imposed for connecting with an Internet service provider under section 254(h)(2)(A), it did recommend that the Commission seek comment and further information on the need for and costs of providing advanced telecommunications and information services for rural health care providers.[1912] In providing support for a limited amount of toll-free Internet access under section 254(h)(2)(A), we agree with the Joint Board's conclusion that all public and non-profit health care providers

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[1906] Recommended Decision, 12 FCC Rcd at 457.

[1907] Recommended Decision, 12 FCC Rcd. at 427.

[1908] Recommended Decision, 12 FCC Rcd at 457.

[1909] Recommended Decision, 12 FCC Rcd at 462.

[1910] *See* Recommended Decision, 12 FCC Rcd at 462; USTA comments at 41.

[1911] 47 U.S.C. § 254(h)(2)(A).

[1912] Recommended Decision, 12 FCC Rcd at 427.

shall benefit from the implementation of section 254(h)(2)(A).[1913] This conclusion is consistent with the plain language and purpose of section 254(h)(2).

744. Toll-free Access to an Internet Service Provider. As discussed above, we agree with the Joint Board that securing access to the Internet may be a more cost-effective method of meeting some telemedicine needs than relying on other kinds of telecommunications services.[1914] We also agree with those commenters that suggest that toll-free access to an Internet service provider is important to provide cost-effective access to and use of numerous sources of medical information and to facilitate the flow of health care-related information.[1915]

745. We agree with the majority of the state members of the Joint Board that the major cost for rural health care providers seeking access to an Internet service provider is toll charges incurred by providers who lack local dial-up access.[1916] Accordingly, we conclude that each health care provider that cannot obtain toll-free access to an Internet service provider is entitled to receive a limited amount of toll-free access. Upon submitting a request to a telecommunications carrier,[1917] each such health care provider may receive the lesser of the toll charges incurred for 30 hours of access to an Internet service provider or $180.00 per month in toll charge credits for toll charges imposed for connecting to an Internet service provider.[1918] We clarify that such support will fund toll charges but not distance-sensitive charges for a dedicated connection to an Internet service provider.

[1913] Recommended Decision, 12 FCC Rcd at 457.

[1914] Recommended Decision, 12 FCC Rcd at 427.

[1915] *See, e.g.,* AAMC comments at 1-2; AHA comments at 1; Alaska Telemedicine Project reply comments at 7; American Telemedicine comments at 4; APHA comments at 1, 3-5; HHS comments at 2; Nebraska Hospitals comments at 1; NTIA reply comments at 29; Scott & White reply comments at 1; State Health Care Report at 3 (stating that the major cost difference lies in the toll charges incurred by health care providers who do not have local dial up access to the Internet). *See also* Joint Agency Apr. 28 *ex parte* at 2.

[1916] *See* State Health Care Report at 3; Joint Agency Apr. 28 *ex parte* at 2 (stating that "urban health care providers typically do not have to pay long distance rates or per-minute charges to connect to Internet Service Providers, while rural users frequently do," and stating further that "eligible rural health care providers should be exempted from these long distance and per-minute charges").

[1917] *See supra* section XI.B.2 (stating that non-telecommunications carriers are eligible to provide services under section 254(h)(2)).

[1918] *See* Nebraska Hospitals comments at 2 (suggesting that the lowest cost way to assure toll-free Internet access may be to subsidize the local phone companies for an average of 15 hours access, per hospital, per month, at a rate of $.20 per minute and estimating that the cost of such a subsidy would be approximately $3,240.00 per month).

746. Like the majority of the state members of the Joint Board,[1919] we believe that a dollar cap on support for toll-free Internet access is consistent with the Joint Board's objective to develop a cost-effective program.[1920] We agree with Nebraska Hospitals that approximately $180.00 of support for each eligible health care provider, each month, is a reasonable amount of access to support and should create sufficient mechanisms. While Nebraska Hospitals proposed support for 15 hours of access at $.20 per minute, we adopt a dollar cap based on 30 hours of use at a $.10 per minute toll charge. We find that this dollar cap per provider on support for toll-free access to an Internet service provider is a specific, sufficient, and predictable mechanism, as required by section 254(b)(5) of the Act, because it limits the amount of support that each health care provider may receive per month to a reasonable level. This limit should also cause support for toll-free access to an Internet service provider not to increase the size of the fund significantly.[1921]

747. We conclude that this mechanism is consistent with the recommendation of the majority of the state members of the Joint Board who "only support funding the toll charges for one access line to the Internet for a rural health care provider if all other options for affordable Internet access have been exhausted,"[1922] because such support shall only be available until toll-free access becomes available to the community in which the health care provider is located. Moreover, support shall be provided only if the health care provider uses the most cost-effective service, as defined in this section.[1923]

748. We conclude that these support mechanisms will enhance access to advanced telecommunications and information services for all public and nonprofit health care providers in a competitively neutral, technically feasible, and economically reasonable way, consistent with the language of section 254(h)(2)(A).[1924] We conclude that these support mechanisms are competitively neutral, because, as with schools and libraries, health care providers may request wireline or wireless telecommunications links -- including cellular and satellite -- at local calling rates to obtain access to an Internet service provider.[1925] Moreover, the limits on the number of

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[1919] State Health Care Report at 4; *compare* State Health Care Report, Separate Statement of Commissioner Laska Schoenfelder at 6-7 (dissenting in part to the State Members Report) (stating that toll-free access is not economically reasonable).

[1920] Recommended Decision, 12 FCC Rcd at 427.

[1921] *See* AT&T reply comments at 20.

[1922] *See* State Health Care Report at 3.

[1923] *See* State Health Care Report at 3.

[1924] *See* 47 U.S.C. § 254(h)(2)(A).

[1925] *See* American Telemedicine comments at 4-5.

hours and the dollar cap per provider create economically reasonable mechanisms. As several commenters indicate, Internet service providers are proliferating rapidly, and the competitive marketplace soon should eliminate the need for such support.[1926] Contrary to the suggestion of some commenters, including the state members of the Joint Board, we find that providing such support will neither reduce nor distort Internet service providers' incentives to build their own facilities in rural markets.[1927] Rural health care providers are only a fraction of the rural customers Internet service providers could serve. Therefore, competitors will still have incentives to enter the market to compete for eligible health care providers, as well as the larger group of other rural customers including schools and libraries.[1928]

749. We recognize that some commenters propose facilitating Internet access in other ways, including auctions for the establishment of local Internet "points of presence" throughout the country, the creation of special 800-number Internet access, and the development of special incentives to ILECs that might include exemption from current restrictions on providing interLATA services.[1929] We decline to adopt any of these proposals at this time due to the limited information available and their potential complexity.

[1926] *See* Georgia PSC reply comments at 30; SBC comments at 10.

[1927] *See* BellSouth comments at 44; Georgia PSC reply comments at 30; SBC comments at 10. *See also* State Health Care Report at 4 (stating its concern that this support program not create artificial disincentives for economic network construction to meet demand for local dial-up access to the Internet).

[1928] *See* State Health Care Report at 4 (expressing concerns that supporting toll-free Internet access could discourage aggregation of demand in rural communities).

[1929] *See, e.g.,* American Telemedicine comments at 4-5; Wyoming PSC comments at 13.