

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

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

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

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

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I. INTRODUCTION

1. In this Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking (*Second Report and Order*), we modify our rules to improve the effectiveness of the rural health care universal service support mechanism. The mechanism provides discounts to rural health care providers to access modern telecommunications for medical and health maintenance purposes. Specifically, in this *Second Report and Order*, we change the Commission’s definition of rural for the purposes of the rural health care support mechanism because the definition currently used by the Commission is no longer being updated with new Census Bureau data.¹ We also revise our rules to expand funding for mobile rural health care services by subsidizing the difference between the rate for satellite service and the rate for an urban wireline service with a similar bandwidth.² Furthermore, we improve our administrative process by establishing a fixed deadline for applications for support.³ On reconsideration, we permit rural health care providers in states that are entirely rural to receive support for advanced telecommunications and information services under section 254(h)(2)(A).⁴ Lastly, in the *Further Notice*, we seek comment on whether we should increase the percentage discount that rural health care providers receive for Internet access and whether infrastructure development should be funded.⁵ Additionally, we seek comment on whether to modify our rules specifically to allow mobile rural health care providers to use services other than satellite.⁶

2. The actions we take today will improve significantly the ability of rural health care providers to respond to the medical needs of their communities, provide needed aid to strengthen telemedicine and telehealth networks across the nation, help improve the quality of health care services available in rural America, and better enable rural communities to rapidly diagnose, treat, and contain possible outbreaks of disease. In addition, these changes will equalize access to quality health care between rural and urban areas and will support telemedicine networks if needed for a national emergency. Enhancing access to an integrated nationwide telecommunications network for rural health care providers will further the Commission’s core responsibility to make available a rapid nationwide network for the purpose of the national defense, particularly with the increased awareness of the possibility of terrorist attacks. Finally, these changes will further the Commission’s efforts to improve its oversight of the operation of the program to ensure that the statutory goals of section 254 of the Telecommunications Act of 1996 are met

¹See *infra* paras. 9-23.

²See *infra* paras. 24-32.

³See *infra* paras. 33-34.

⁴47 U.S.C. § 254(h)(2)(A). See *infra* paras. 35-44.

⁵See *infra*. paras. 45-49, 51-53. Infrastructure development would include upgrades to the public switched or backbone networks. *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776, 9107, para. 632 (1997) (*1997 Universal Service Order*) (*subsequent history omitted*).

⁶See *infra* para. 50.

without waste, fraud, or abuse.

II. BACKGROUND

3. In section 254 of the Telecommunications Act of 1996,⁷ Congress sought to provide rural health care providers “an affordable rate for the services necessary for the purposes of telemedicine and instruction relating to such services.”⁸ Specifically, Congress directed telecommunications carriers “[to] provide telecommunications services which are necessary for the provision of health care services in a State, including instruction relating to such services, to any public or nonprofit health care provider that serves persons who reside in rural areas in that State at rates that are reasonably comparable to rates charged for similar services in urban areas in that State.”⁹ Congress also directed the Commission to enhance access to advanced telecommunications and information services for health care providers.¹⁰

4. The Commission implemented this statutory directive by adopting the rural health care support mechanism in the *1997 Universal Service Order*.¹¹ Specifically, the Commission concluded that telecommunications carriers must charge eligible rural health care providers a rate for each supported service that is no higher than the highest tariffed or publicly available commercial rate for a similar service in the closest city in the state with a population of 50,000 or more people, taking distance charges into account.¹² The Commission also adopted mechanisms to provide support for limited toll-free access to an Internet service provider.¹³ Finally, the Commission adopted an annual cap of \$400 million for universal service support for rural health care providers.¹⁴ The Commission based its conclusions on analysis of the condition of the rural health care community and technology at that time.¹⁵

5. Since the *1997 Universal Service Order*, the Commission has made some changes to the rural health care support mechanism to make it more viable and to reflect technological changes.¹⁶ For

⁷Pub. L. No. 104-104, 110 Stat. 56.

⁸H.R. Conf. Rep. No. 458, 104th Cong. 2nd Sess. 133 (1996).

⁹See 47 U.S.C. §§ 151 *et seq.* (adding 47 U.S.C. § 254(h)(1)(A) to the Act). The term “State” includes the District of Columbia and the territories and possessions. 47 U.S.C. § 153(40). *See also infra* n.132.

¹⁰47 U.S.C. § 254(h)(2)(A).

¹¹*1997 Universal Service Order*, 12 FCC Rcd 8776.

¹²*Id.* at 9093, para. 608.

¹³*Id.*

¹⁴47 C.F.R. § 54.623; *1997 Universal Service Order*, 12 FCC Rcd at 9141, para. 705. The Commission subsequently limited support for the first funding cycle to \$100 million. *See Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Fifth Order on Reconsideration and Fourth Report and Order, 13 FCC Rcd 14915, 14928-33, paras. 20-29 (1998).

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

¹⁶In September 1999, the Commission adopted the *Fourteenth Order on Reconsideration*, in which the Commission determined that all telecommunications carriers that provide supported services to eligible health care providers under section 254(h)(1)(A) are entitled to have a credit against their universal service contribution obligation equal to the difference between the lower, urban rate they offer eligible health care providers for supported telecommunications services and the higher, rural rates that would normally be charged to these customers.

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example, in 1999, after determining that only a small number of rural health care providers qualified for discounts in the original funding cycle, which covered the period from January 1, 1998, through June 30, 1999, the Commission reevaluated the structure of the rural health care universal service support mechanism.¹⁷ As a result, the Commission: (1) simplified the urban/rural rate calculation; (2) eliminated the per-location discount limit; (3) encouraged participation in consortia; and (4) re-allocated billing and collection expenses by the number of participants in the rural health care universal service support mechanism.¹⁸ The Commission also determined that the definition of “health care provider” does not include nursing homes, hospices, other long-term care facilities, or emergency medical service facilities.¹⁹ The Commission also decided not to clarify further the definition of “health care provider” or to provide additional support for long distance telecommunications service.²⁰

6. In 2002, the Commission issued a Notice of Proposed Rulemaking (*NPRM*) to review the rural health care universal service support mechanism.²¹ In particular, the Commission sought comment on whether to: clarify how the Commission should treat eligible entities that also perform functions that are outside the statutory definition of “health care provider”; provide support for Internet access; and change the calculation of discounted services, including the calculation of urban and rural rates.²² In addition, the Commission sought comment on whether and how to streamline the application process; allocate funds if demand exceeds the annual cap; modify the current competitive bidding rules; and encourage partnerships with clinics at schools and libraries.²³ The Commission sought further comment on other measures to prevent waste, fraud, and abuse, and on other issues concerning the structure and operation of the rural health care support mechanism.²⁴

7. On November 17, 2003, the Commission released a *Report and Order* that modified the Commission’s rules to improve the effectiveness of the rural health care support mechanism.²⁵ Among other changes, the *Report and Order*: (1) clarified that dedicated emergency departments of rural for-profit hospitals that participate in Medicare are “public” health care providers and are eligible to receive prorated rural health care support; (2) clarified that non-profit entities that function as rural health care providers on a part-time basis are eligible for prorated rural health care support; (3) revised the rules to provide a 25 percent discount off the cost of monthly Internet access for eligible rural health care providers; (4) revised the rules to allow rural health care providers to compare the urban and rural rates

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Federal-State Joint Board on Universal Service, CC Docket No. 96-45, Fourteenth Order on Reconsideration, 14 FCC Rcd 20106 (1999) (*Fourteenth Order on Reconsideration*).

¹⁷*Changes to the Board of Directors of the National Exchange Carrier Association, Inc.*, *Federal-State Joint Board on Universal Service*, CC Docket Nos. 97-21 and 96-45, Sixth Order on Reconsideration in CC Docket No. 97-21 and Fifteenth Order on Reconsideration in CC Docket No. 96-45, 14 FCC Rcd 18756, 18760-61, para. 7 (1999) (Fifteenth Order on Reconsideration) (noting that there were 2,500 initial applications, and only a small fraction made it through the first funding cycle).

¹⁸*Fifteenth Order on Reconsideration*, 14 FCC Rcd at 18762, para. 9.

¹⁹*Id.* at 18786, para. 48.

²⁰*Id.* at 18773, 18786, paras. 26, 48-49.

²¹*Rural Health Care Support Mechanism*, Notice of Proposed Rulemaking, WC Docket No. 02-60, 17 FCC Rcd 7806 (2002) (*NPRM*).

²²*Id.* at 7806, para. 4.

²³*Id.*

²⁴*Id.*

²⁵*See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 18 FCC Rcd 24546 (2003) (*Report and Order*).

for functionally similar services as viewed from the perspective of the end user; (5) revised the rules to allow rural health care providers to compare rural rates to urban rates in any city with a population of at least 50,000 in the state; (6) revised the definition of the Maximum Allowable Distance to equal the distance between the rural health care provider and the farthest point on the jurisdictional boundary of the largest city in that state; and (7) revised the rules to allow rural health care providers to receive discounts for satellite services even where alternative terrestrial-based services may be available, but capped such support at the amount providers would have received if they purchased functionally similar terrestrial-based alternatives.²⁶ These changes were implemented in Funding Year 2004.²⁷

8. In the *Report and Order*, the Commission sought comment on the definition of “rural area” for the rural health care program.²⁸ Since 1997, the Commission has used the definition of “rural” as defined by the Office of Rural Health Care Policy (ORHP).²⁹ ORHP, however, no longer uses that definition. We sought comment on whether we should also use the new definition ORHP has adopted or use a different definition. We also sought comment on whether additional modifications to the Commission’s rules are appropriate to facilitate the provision of support to mobile rural health clinics for satellite services and whether other measures were necessary to further streamline the administrative burdens associated with applying for support.³⁰ In this *Second Report and Order*, we address the comments filed in response to the *Further Notice* released in 2003.³¹

III. REPORT AND ORDER

A. Definition of “Rural Area”

1. Background

9. In the 2003 *Report and Order*, we sought comment on modifications to the definition of “rural area” for the rural health care universal service support mechanism.³² In 1997, the Commission adopted the definition of rural used by the Office of Rural Health Care Policy (ORHP).³³ Under ORHP’s definition, an area is rural if it is not located in a county within a Metropolitan Statistical Area (MSA) as defined by the Office of Management and Budget (OMB) or if it is specifically identified as “rural” in

²⁶*Id.*

²⁷Funding Year 2003 for the rural health care program ended June 30, 2004, and Funding Year 2004 began July 1, 2004. Because the Commission did not wish to introduce changes to the program in the middle of a funding year, the modifications to the program adopted in the *Report and Order* were implemented beginning with Funding Year 2004. *Report and Order*, 18 FCC Rcd at 24577, para. 60.

²⁸*Id.* at 24578, para. 63.

²⁹1997 *Universal Service Order*, 12 FCC Rcd at 9115-9116, para 649.

³⁰*Report and Order*, 18 FCC Rcd at 24579-81, paras. 65-66, 69.

³¹In a letter filed August 11, 2004, the Appalachian Regional Commission asked the Commission (1) to eliminate the urban-rural comparison for purposes of calculating support for telecommunications services so that rural health care providers could instead receive a flat discount off the regular rate for the services; (2) to provide support for telemedicine equipment; and (3) to provide support to for-profit health care providers that otherwise do not qualify as “public or non-profit” health care providers. Letter from Anne B. Pope, Federal Co-Chair, Appalachian Regional Commission, to Marlene H. Dortch, Secretary, Federal Communications Commission, *Rural Health Care Support Mechanism*, Docket No. 02-60, (Aug. 11, 2004). While we believe these three requests would strengthen the rural health care mechanism, we cannot take any action because we believe the statute precludes us from doing so. See 47 U.S.C. § 254(h)(1)(A).

³²*Report and Order*, 18 FCC Rcd at 24578, paras. 63-64.

³³1997 *Universal Service Order*, 12 FCC Rcd at 9115-9116, para. 649.

the Goldsmith Modification to the 1990 Census data.³⁴ ORHP, however, no longer uses the MSA/Goldsmith method and has not developed the Goldsmith Modification to the most recent 2000 Census data.³⁵ Instead, ORHP has adopted the Rural Urban Commuting Area (RUCA) system for rural designation, and currently uses 1990 Census data until it can incorporate the 2000 Census data.³⁶ Furthermore, since the Commission's adoption of the MSA/Goldsmith definition of rural, OMB has restructured its definitions of MSAs and non-MSAs by adding another category – the Micropolitan Statistical Area (MiSA).³⁷ Therefore, because the current definition of “rural area” for the rural health care support mechanism is obsolete and will not be updated, the Commission must modify its definition to ensure that universal service funding is dedicated to improving the quality of health care facilities and services available in rural America.

10. In the 2003 *Report and Order*, the Commission specifically sought comment on whether any definitions for rural areas used by other government agencies or medical organizations would be appropriate for the rural health care program.³⁸ The Commission encouraged commenters to describe the effects of any new definition to the program, *e.g.*, how many existing rural areas would become non-rural and vice versa.³⁹ The Commission also sought comment on whether we should use the same definition of “rural” for both the rural health care and schools and libraries support mechanisms.⁴⁰

³⁴See 47 C.F.R. § 54.5 (“A rural area is a non-metropolitan county or county equivalent, as defined in the Office of Management and Budget’s (OMB) Revised Standards for Defining Metropolitan Areas in the 1990s and identifiable from the most recent Metropolitan Statistical Area (MSA) list released by OMB, or any contiguous non-urban Census Tract or Block Numbered Area within an MSA-listed metropolitan county identified in the most recent Goldsmith Modification published by the Office of Rural Health Policy of the U.S. Department of Health and Human Services.”). The Goldsmith Modification is a procedure for identifying isolated rural neighborhoods within large metropolitan counties. See Harold F. Goldsmith, Dena S. Puskin, and Dianne J. Stiles, *Improving the Operational Definition of “Rural Areas” for Federal Programs*, Federal Office of Rural Health Policy 1993, available at <http://ruralhealth.hrsa.gov/pub/Goldsmith.htm> (retrieved Sept. 17, 2004).

³⁵In order to administer the requirements of the Commission’s rural health care universal support mechanism, USAC continues to use the 1990 Census-based MSA/Goldsmith definition of rural for the rural health care program. This information does not reflect any of the information obtained during the 2000 Census.

³⁶See <http://ruralhealth.hrsa.gov/funding/eligibilitytestv2.asp> (retrieved Sept. 23, 2004).

³⁷A Metropolitan Statistical Area (MSA) is a Core Based Statistical Area (CBSA) associated with at least one urbanized area that has a population of at least 50,000. An MSA comprises the central county or counties containing the core (either an urbanized area or an urban cluster), plus adjacent outlying counties having a high degree of social and economic integration with the central county as measured through commuting. A Micropolitan Statistical Area (MiSA) is a CBSA associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000. The MiSA comprises the central county or counties containing the core, plus adjacent outlying counties having a high degree of social and economic integration with the central county as measured through commuting. *Standards for Defining Metropolitan and Micropolitan Statistical Areas*, Office of Management and Budget, 65 FR 82228, no. 249 (Dec. 27, 2000).

³⁸*Report and Order* 18 FCC Rcd at 24578, para. 64.

³⁹*Id.*

⁴⁰*Id.* We note that the schools and libraries universal support mechanism currently uses the same definition of rural area as the rural health care universal support mechanism. See 47 C.F.R. § 54.5. We sought comment on possible changes to the rural area definition in the context of the schools and libraries program in a separate notice of proposed rulemaking. *Schools and Libraries Universal Service Support Mechanism*, CC Docket No. 02-6, Third Report and Order and Second Further Notice of Proposed Rulemaking, 2003 WL 23009204, FCC 03-323 at para. 67 (rel. Dec. 23, 2003).

2. Discussion

11. We conclude that the record supports the adoption of a new definition of “rural area” for the rural health care program.⁴¹ We received several proposals from commenters for a new definition of rural.⁴² Most of those definitions are currently used by other federal agencies to determine eligibility for other federal programs.⁴³ As we explain in further detail below, we find that those proposals are either over-inclusive or under-inclusive for our purpose. That is, based on an evaluation of the proposals contained in the record, such definitions would allow more areas to be considered rural than is appropriate for the rural health care program or would not include areas that are appropriately rural. It is particularly important that the Commission take its responsibility to reach an accurate definition seriously and avoid over-inclusiveness or under-inclusiveness, given that the statute directs us to provide support to health care providers serving people who reside in rural areas. The Commission should neither dilute the fund by using a methodology that is too broad, nor fail to achieve the goals of the 1996 Act by using a methodology that is not broad enough. As such, the Commission has built on commenters’ proposals to develop a slightly more layered approach that more accurately defines the rural areas eligible for support under the rural health care mechanism.

12. Whether an area is “rural” is determined by applying the following test. If an area is outside of any Core Based Statistical Area (CBSA), it is rural.⁴⁴ Areas within CBSAs can be either rural or non-rural, depending on the characteristics of the CBSA. Small CBSAs – those that do not contain an urban area with populations of 25,000 or more – are rural.⁴⁵ Within large CBSAs – those that contain urban areas with populations of 25,000 or more – census tracts can be either rural or non-rural depending on the characteristics of the particular census tract.⁴⁶ If a census tract in a large CBSA does not contain any

⁴¹See, e.g., Rep. Boucher Comments at 1-6; UVA Comments at 13-14; Verizon Comments at 3; IUB Reply at 1; CalSORH Comments at 2; 47 C.F.R. § 54.5 (definition of “rural area”) as adopted herein.

⁴²See, e.g., ATA Comments at 4; Rep. Boucher Comments at 7; UVA Comments at 14-15; Virginia Comments at 2; CHA Comments at 5; CTEC Comments at 4-5; CalSORH Comments at 1; Mount Valley Comments at 1; NRHC Comments at 1; Placer County Comments at 5; SCCHC Comments at 2; Blue Cross Comments at 3; CPCA Comments at 4; NRHA Comments at 1.

⁴³For example, the United States Department of Agriculture (USDA) Rural Broadband Loan and Loan Guarantee Program, 7 C.F.R. § 1738.2, and Rural Urban Commuting Area (RUCA) codes, used by ORHP, available at <http://ruralhealth.hrsa.gov/funding/eligibilitytestv2.asp>, (retrieved Sept. 17, 2004).

⁴⁴See <http://www.census.gov/population/www/estimates/metrodef.html> for the current (December 2003) list of CBSAs (Metropolitan and Micropolitan Statistical Area and Components). A CBSA is statistical geographic entity consisting of the county or counties associated with at least one core (a densely settled concentration of population, comprising either an urbanized area (of 50,000 or more population) or an urban cluster (of 10,000 to 49,999 population) defined by the Census Bureau) of at least 10,000 people, plus adjacent counties having a high degree of social and economic integration with the core as measured through commuting ties with the counties containing the core. Metropolitan and Micropolitan Statistical Areas are the two categories of CBSAs. See *Standards for Defining Metropolitan and Micropolitan Statistical Areas*, 65 FR 82228.

⁴⁵The urbanized population is the population contained in the urban area (urbanized area or urban cluster) at the core of the CBSA as well as all other urban areas in the CBSA. Urbanized areas and urban clusters are areas of “densely settled territory,” as defined by the Census Bureau. See U.S. Census Bureau, 2000 Census of Population and Housing, Summary File 3: Technical Documentation, 2002, Appendix A. A list of urban areas for the 2000 Census can be found at <http://www.census.gov/geo/www/ua/ctrlplace.html>, (retrieved Sept. 17, 2004).

⁴⁶Census tracts are small, relatively permanent statistical subdivisions of a county or statistically equivalent entity. Tracts in the United States, Puerto Rico and the U.S. Virgin Islands generally have between 1,500 and 8,000 people, with an optimum size of 4,000. See U.S. Census Bureau, 2000 Census of Population and Housing, Summary File 3: Technical Documentation, 2002, Appendix A.

part of a place or urban area with a population greater than 25,000, then that tract is rural.⁴⁷ Alternatively, if a census tract in a large CBSA contains all or part of a place or urban area with a population that exceeds 25,000, then it is not rural.

13. To eliminate any confusion regarding implementation of this definition, the Commission will identify the areas that are rural and post the list on the Universal Service Administrative Company (USAC) web site, as is done now.⁴⁸ The list will include counties that are rural or partially rural. As now, for those counties that are partially rural, eligible census tracts will be listed. Applicants can determine their census tract using the link on the USAC web site or by calling USAC's helpline for assistance.⁴⁹ As such, the process for rural health care providers to determine their eligibility will be the same with the new definition as with the definition currently in use. The new definition will be effective as of Funding Year 2005, which begins July 1, 2005.

14. The new definition of rural area furthers the goals of section 254 for several reasons. Our new definition uses a methodology similar to our current definition. Just like our prior definition, all counties that are not located in a CBSA are defined as rural. For those counties located in a CBSA, as under the current definition, a further analysis is conducted for certain counties that have both urban and rural areas. The Goldsmith methodology, however, only called for such further analysis for counties comprising a larger geographic area, while our new definition expands the review to include counties of all sizes.⁵⁰ As such, we believe our new definition improves upon the method that we previously used to determine which areas are rural by more accurately carving out the rural areas within counties that are located in a CBSA. For example, Dungannon, Virginia, which has a population of 317, is located in the northeastern corner of Scott County, Virginia.⁵¹ Though Scott County is part of the Kingsport-Bristol-Bristol, TN-VA Metropolitan Statistical Area, Dungannon is 28 miles – about an hour drive – from Kingsport, TN, the nearest large urban area.⁵² Under our previous definition, Dungannon was not rural because it was located in a small county that was part of an MSA. Under our new definition, however, we conduct a more granular review of Scott County at the census tract level. The census tract in which Dungannon is located does not contain any part of a place or urban area with greater than a 25,000 population. Therefore, Dungannon is rural, and any health care provider located in Dungannon is eligible for support.

15. We selected 25,000 as the population threshold for the further analysis. While choosing the threshold is not an exact science, we believe urban areas above this size possess a critical mass of population and facilities. Although this standard may mean that some current eligible providers might no longer qualify, as noted below, we permit all health care providers that have received a funding commitment from USAC since 1998 to continue to qualify for funding for the next three years under the old definition. As we noted above, our new definition also allows rural health care providers to determine their eligibility in the same manner as under the old definition. Furthermore, because the definitions are similar, rural health care providers will not have to adjust to a new application process.

⁴⁷Places include census-designated places, consolidated cities and incorporated places. See U.S. Census Bureau, 2000 Census of Population and Housing, Summary File 3: Technical Documentation, 2002, Appendix A.

⁴⁸See www.rhc.universalservice.org/eligibility/applicants.asp (retrieved Sept. 23, 2004).

⁴⁹See <http://www.rhc.universalservice.org/eligibility/ruralareas.asp> (retrieved Nov. 3, 2004) or the Universal Service Administrative Company's (USAC) Customer Service Support Center at 1-800-229-5476.

⁵⁰See Harold F. Goldsmith, Dena S. Puskin, and Dianne J. Stiles, *Improving the Operational Definition of "Rural Areas" for Federal Programs*, Federal Office of Rural Health Policy 1993, available at <http://ruralhealth.hrsa.gov/pub/Goldsmith.htm> (retrieved Sept. 17, 2004).

⁵¹U.S. Census Bureau, 2000 Census of Population and Housing, Summary File 3, State Geography File, 2002.

⁵²See www.mapquest.com; see also Rep. Boucher Comments at 3; UVA Comments at 10.

An approach that simplifies the application process for rural health care providers will help ensure that applicants will not be deterred from applying for support due to administrative burdens.

16. We disagree with those commenters who propose that we use the USDA Rural Broadband Loan and Loan Guarantee program (Rural Broadband Program) definition of “rural community.”⁵³ For the purposes of that program, Congress defined an eligible rural community as any incorporated or unincorporated place that has no more than 20,000 inhabitants.⁵⁴ ATA and other commenters argue that the Rural Broadband Program’s definition allows a much larger area to be considered rural, and a broader definition of rural is imperative in order to align the rural health care program with other federal telemedicine programs.⁵⁵ We find, however, that the Rural Broadband Program definition suffers from the same under-inclusiveness as our prior definition; it would exclude all areas within MSAs, including towns such as Dungannon, Virginia. Moreover, the Rural Broadband Program definition is over-inclusive for our purposes because that definition would define any area just outside of a city or town boundary as rural. In contrast, our definition identifies those areas as non-rural, thus removing areas from eligibility that are truly not rural.

17. Furthermore, the Rural Broadband Program’s other eligibility criteria are more stringent than the rural health care program. Unlike the Commission’s universal service program, under which any applicant that meets the definition of rural will receive funding unless it fails to meet application deadlines, the Rural Broadband Program’s definition identifies those applicants eligible to *apply* for grants and loans.⁵⁶ The Rural Broadband Program has additional steps through which it can screen applicants to ensure they are serving rural communities and is not obligated to fund every applicant. We do not have such discretion in our program.

18. UVA and other commenters propose a modification to the USDA definition that they assert would cure the over-inclusiveness problem.⁵⁷ Specifically, they propose to add a county-based population density requirement (250 people per square mile) to the definition.⁵⁸ As an initial matter, a county often covers too much area to accurately predict whether the entire county is rural. Furthermore, a population density requirement of 250 people per square mile in a county would allow counties that are fairly urban to be considered rural. For example, San Bernardino County in California has a population density of under 100 people per square mile, yet it contains urban areas, such as San Bernardino.⁵⁹ As

⁵³ 7 U.S.C. § 950 bb(b)(2) (“The term “eligible rural community” means any area of the United States that is not contained in an incorporated city or town with a population in excess of 20,000 inhabitants.”). An “eligible rural community,” as defined by USDA regulations, is “any incorporated or unincorporated place in the United States, its territories and insular possessions (including any area within the Federated States of Micronesia, the Republic of the Marshall Islands, and the Republic of Palau) that: (1) Has no more than 20,000 inhabitants based on the most recent available population statistics of the Bureau of the Census and (2) Is not located in an area designated as a standard metropolitan statistical area. For purposes of this part, ‘place’ may include any area located outside the boundaries of any incorporated or unincorporated city, village or borough having a population exceeding 20,000 that is not within an area designated as a standard metropolitan statistical area.” 7 C.F.R. § 1738.2.

⁵⁴ *Id.*

⁵⁵ See ATA Comments at 4; Rep. Boucher Comments at 7; UVA Comments at 14-15; Virginia Comments at 2; CHA Comments at 5; CTEC Comments at 4-5.

⁵⁶ See generally 7 C.F.R. § 1738.

⁵⁷ See UVA Comments at 15; Rep. Boucher Comments at 9; Virginia Comments at 2; CHA Comments at 4.

⁵⁸ *Id.*

⁵⁹ For these reasons, we also choose not to adopt the definition of “rural area” recently established by the Commission to apply as the default definition for Commission wireless radio service rules, policies and analyses. See *Facilitating the Provision of Spectrum-Based Service to Rural Areas and Promoting Opportunities for Rural Telephone Companies to Provide Spectrum-Based Services*, WT Docket No. 02-381, 2000 Biennial Regulatory

(continued....)

noted above, this limitation would not solve the problem of areas just outside of a city or town boundary being defined as rural. We conclude that the census tract level analysis adopted here will lead to more precise results.

19. Similarly, we are not convinced by commenters who recommend that we should incorporate Rural Urban Commuting Area (RUCA) codes in conjunction with the CBSA-based definitions, as a replacement for the Goldsmith Modification.⁶⁰ Dr. Patricia Taylor argues that the Commission's new definition of "rural area" should be as similar to its original definition as is technically feasible.⁶¹ According to Dr. Taylor, RUCA codes are a logical extension of the Goldsmith Modification in that both utilize workforce commuting data to identify the isolated towns and rural areas of metropolitan counties.⁶² The RUCA algorithm is a national measure that is applied to all census tracts in the nation to identify rural areas, unlike the Goldsmith Modification, is applied only to counties of a certain size.⁶³

20. While we agree that the OMB/RUCA definition has several advantages, we are not convinced that this definition is optimal for our purposes. First, as commenters note, the RUCA definition could disadvantage western states. RUCA is based on measures of urbanization, population density and daily commuting.⁶⁴ Several commenters argue that RUCA's reliance on commuting flows is flawed because it does not take into account the fact that commuting distances and times in western states are much farther and longer than in eastern states.⁶⁵ According to commenters, several areas in California (such as Fall River Mill, Round Mountain and Shingletown) would lose their rural status if the RUCA codes were used in lieu of the Goldsmith Modification.⁶⁶ These communities have not grown considerably nor has their population density changed since the 1990 Census. However, these communities are within commuting distance of a larger urban area, and thus, are not considered rural under RUCA.⁶⁷ Additionally, the RUCA analysis is based on the percentage of residents who commute

(...continued from previous page)

Review Spectrum Aggregation Limits For Commercial Mobile Radio Services, WT Docket No. 01-14, *Increasing Flexibility To Promote Access to and the Efficient and Intensive Use of Spectrum and the Widespread Deployment of Wireless Services, and To Facilitate Capital Formation*, WT Docket No. 03-202, Report and Order and Further Notice of Proposed Rulemaking, FCC 04-166, para. 11 (rel. Sept. 27, 2004) (*Rural Spectrum Order*). In the *Rural Spectrum Order*, the Commission defined "rural area" as those counties (or equivalent) with a population density of 100 people per square mile or less, based upon the most recently available Census data. *Id.* The *Rural Spectrum Order* acknowledges, however, that "the application of a single, comprehensive definition for 'rural area' may not be appropriate for all purposes." *Id.* at para. 12. We believe that the *Rural Spectrum Order* definition is not suitable for the rural health care program because, where universal service support is concerned, we do not believe a county-wide density definition, without further layers of analysis below the county level in at least some instances, is appropriate.

⁶⁰ORHP collaborated with USDA's Economic Research Service to develop the RUCA codes. <http://ruralhealth.hrsa.gov/funding/eligibilitytestv2.asp> (retrieved Sept. 17, 2004).

⁶¹Taylor Comments at 2. Dr. Taylor was the director of research at the ORHP and served as its expert on definitions of rural. Taylor Comments at 1.

⁶²*Id.* at 1.

⁶³*Id.* at 2.

⁶⁴See *Measuring Rurality: Rural-Urban Commuting Area Codes*, Economic Research Service, United States Department of Agriculture (USDA), available at <http://www.ers.usda.gov/briefing/Rurality/RuralUrbanCommutingAreas/> (retrieved Sept. 23, 2004).

⁶⁵See Placer County Comments at 7; CPCA Comments at 2; SCCHC Comments at 1-2; Rural Healthcare Center Comments at 4-5; CHA Comments at 3; CalSORH Comments at 1-2; CTEC Comments at 3-4.

⁶⁶See, e.g., CTEC Comments at 3-4; CHA Comments at 3-4; CPCA Comments at 2-3; Shingletown Comments at 2-3; Placer County Comments at 7.

⁶⁷See Rural Healthcare Center Comments at 5; SCCHC Comments at 2; Placer County Comments at 7.

to nearby urban areas.⁶⁸ Those residents could receive at least some medical care near where they work. RUCA, however, does not consider that many residents do not commute and therefore are served by the health care providers in their communities.⁶⁹ RUCA does not consider that in such communities there is often no public transportation service and the health care providers located in the communities are the only medical services available to the individuals in the community who cannot or do not commute out of the area.⁷⁰ Consequently, we are not convinced that using a measure of how many individuals are leaving a community to determine whether it is rural adequately describes the services and resources that are needed to serve the resident population. For that reason, our definition does not rely solely on commuting patterns. Finally, RUCA does not currently incorporate 2000 Census data.⁷¹ While the ORHP intends to revise the system to include more recent data, we do not currently have the data to determine the effect of this definition.

21. Another option suggested by commenters would permit health care providers to establish their eligibility based on any definition of “rural” in any other federal program, or under any state definition if recognized by a federal agency.⁷² Combining the definition and eligibility requirements of all federal definition and federally recognized state definitions would lead to an unworkable definition. Permitting health care providers to shop for the best definition would make administration of the program extremely difficult. The Commission would have no control over the substance of the various definitions and would be at the mercy of other federal agencies, whose goals and eligibility criteria may be very different from our own.⁷³ Additionally, it would be difficult to determine the impact of such a broad definition on the number of eligible entities nationwide, and, subsequently, the impact on the funds available. Finally, the definition would be subject to change every year, as federal and state agencies change their definitions. Thus, we reject this option.

22. Finally, we reject Placer County’s argument that eligibility should be determined by the location of patients, not the location of the facility.⁷⁴ This low standard suggested by Placer County – that two patients that reside in rural areas establish eligibility – would result in virtually every health care facility in the country, including New York City’s Mt. Sinai Hospital and Baltimore’s Johns Hopkins Medical Center, being eligible for discounts under the Commission’s program, in direct contravention to Congress’ specific intent to limit support to rural health care providers.⁷⁵

23. *Transition.* Several commenters recommend that the Commission grandfather current health care providers who lose their “rural” status as a result of our new definition of “rural area.”⁷⁶

⁶⁸See <http://ruralhealth.hrsa.gov/funding/eligibilitytestv2.asp> (retrieved Sept. 23, 2004).

⁶⁹See Rural Healthcare Center Comments at 5; SCCHC Comments at 2.

⁷⁰See SCCHC Comments at 2.

⁷¹See *Geographic Eligibility for Rural Health Grant Programs*, Office of Rural Health Policy, United States Department of Health and Human Services, available at <http://ruralhealth.hrsa.gov/funding/eligibilitytestv2.asp> (retrieved Sept. 27, 2004)

⁷²For instance, several parties suggest that California’s Medical Service Study Area (MSSA) program should be used as a means to establish eligibility under the Commission’s health care support mechanism. See CalSORH Comments at 1; Mount Valley Comments at 1; NRHC Comments at 1; Placer County Comments at 5; SCCHC Comments at 2; Blue Cross Comments at 3; CPCA Comments at 4; NRHA Comments at 1.

⁷³See *supra* para 17.

⁷⁴Placer County Comments at 3-4.

⁷⁵See 47 U.S.C. § 254(h)(1)(A); Verizon Reply at 5.

⁷⁶See, e.g., ANTHC Reply at 2; ATA Comments at 4; Avera Comments at 2; Blue Cross Comments at 4; CPCA Comments at 4; GCI Reply at 4; IUB Comments at 4; MMH Comments at 1; Mountain Valley Comments at 1; NRHC Comments at 1; Rural Healthcare Center Comments at 8-9; MMH at 2; SCCHC Comments at 2-3.

Commenters assert that a change in the definition of rural does not change the rural nature of the communities being served.⁷⁷ They argue that many communities remain isolated from their nearest urban area, still suffer from inadequate access to telecommunications services, and their patients still need the services that telemedicine provides them.⁷⁸ On the other hand, we acknowledge that many formerly eligible areas may lose their eligibility not because of the change in our definition of “rural areas,” but rather because of the growth of metropolitan areas.⁷⁹ Commenters argue that the Commission does not have a legal basis to provide funding for applicants that are not eligible under the new definition.⁸⁰ We find that the arguments of both sets of commenters have merit. It would be difficult to determine which rural health care providers no longer are eligible because they are no longer rural and which are no longer eligible simply because we revised our definition.⁸¹ To ease the transition to the new definition, then, we permit all health care providers that have received a funding commitment from USAC since 1998 to continue to qualify for support under the universal service mechanism for health care providers for funding for the next three years under the old definition.⁸² Thereafter, health care providers must qualify under our new definition to receive funding. We find that this transition period is necessary to allow rural health care providers to plan for the elimination of support. In addition, the transition period will allow the Commission time to review the effect of this definition.

B. Support for Satellite Services for Mobile Rural Health Care Providers

1. Background

24. Telecommunications services may be used by mobile rural health care providers that operate in vans or boats to deliver telemedical services. These providers often travel to remote areas of the country to deliver healthcare services to underserved populations. Health technicians for mobile rural health care providers aboard vans or boats screen patients for particular health conditions that may go unnoticed or untreated due to the lack of quality health care facilities in such areas. For example, Healthcare Anywhere, a non-profit entity, has plans to launch a mobile telemammography service to examine women living on or near rural tribal lands in North and South Dakota for signs of breast cancer.⁸³ Traveling by van, Healthcare Anywhere will conduct mammograms and deliver the results within an hour to rural American Indian women while they wait.⁸⁴ The van’s clinician will send the mammogram via satellite to doctors, who will diagnose any abnormalities and e-mail the van with the

⁷⁷*See id.*

⁷⁸*See* Rural Healthcare Center Comments at 8-9; *see also* Blue Cross Comments at 4; CPCA Comments at 4; SCCHC Comments at 2-3; Avera Comments at 2.

⁷⁹Taylor Comments at 3; Verizon Comments at 6-7.

⁸⁰Verizon Comments at 2, 6-7; Verizon Reply at 9; BellSouth Reply at 3-4; Taylor Comments at 3; IUB Reply at 2.

⁸¹As stated above, ORHP no longer uses the MSA/Goldsmith method and has not developed the Goldsmith Modification to the most recent 2000 Census data. *See supra* para. 9. Therefore, we have no way to compute the old definition to the new definition with updated Census data.

⁸²47 C.F.R. § 54.501(a)(3)(i) as adopted herein.

⁸³*Report and Order*, 18 FCC Rcd at 24579, para. 65 (citing Letter to Marlene Dortch, Secretary, Federal Communications Commission, from Anne Linton, Healthcare Anywhere, Rural Health Care Support Mechanism, WC Docket No. 02,60, (Oct. 21, 2003) (Healthcare Anywhere *Ex Parte*)); Healthcare Anywhere Comments at 7. Additionally, the Institute for International Emergency Medicine and Health (IEMH) is developing a partnership with Native American tribes to provide real-time telemedicine consultations, training, and support to health workers on reservations. *See* IEMH Comments at 2.

⁸⁴*Report and Order*, 18 FCC Rcd at 24579, para. 65 (citing Healthcare Anywhere *Ex Parte*); Healthcare Anywhere Comments at 7.

patient's results.⁸⁵ The mobile rural health care provider's telemedicine link must be able to move the medical images, voice communications, and provide ancillary Internet access allowing staff on the mobile unit and patient to receive interpretative reports by e-mail.⁸⁶ The Healthcare Anywhere van will serve approximately ten tribes and travel to approximately four locations on each reservation twice a year.⁸⁷ The van will be stationed at each location for approximately one week at a time and operate approximately forty weeks out of the year.⁸⁸

25. In the 2003 *Report and Order*, we sought comment on whether additional modifications to our rules are appropriate to facilitate the provision of support to mobile rural health care providers using satellite services.⁸⁹ We specifically sought comment on whether support for satellite services for mobile rural health care providers should be capped at the amount a provider would receive if it received funding for functionally similar wireline services.⁹⁰ We also sought comment on how mobile health care providers should make a cost-effective determination for satellite services and whether they should consider the installation and disconnection charges that would be incurred if the mobile rural health clinic were to order a wireline connection at each docking location.⁹¹ We further sought comment on how we should determine whether a mobile rural health care provider serves rural areas and whether support for a mobile rural health care provider should be prorated if it also serves non-rural locations.⁹²

2. Discussion

26. Pursuant to section 254(h)(1)(A) of the Act, telecommunications carriers must provide telecommunications services to rural health care providers at "rates that are reasonably comparable to rates charged for similar services in urban areas in that State."⁹³ Under the Commission's prior policies, the cost of rural satellite service was compared to the cost of urban satellite service.⁹⁴ For satellite services, however, the price typically does not vary by location. Therefore rural health care providers did not receive discounts on such service under the rural health care program.⁹⁵ In the 2003 *Report and Order*, we revised this policy to allow rural health care providers to receive discounts for satellite service even where wireline services are available, but we capped the discount at the amount providers would have received if they purchased functionally similar wireline alternatives.⁹⁶

27. The situation of the mobile rural health care provider, however, is different. By definition, mobile rural health care providers do not stay in a fixed location.⁹⁷ To receive telecommunications

⁸⁵*Report and Order*, 18 FCC Rcd at 24579, para. 65 (citing Healthcare Anywhere *Ex Parte*).

⁸⁶*Id.*

⁸⁷Healthcare Anywhere Comments at 11.

⁸⁸*Report and Order*, 18 FCC Rcd at 24579, para. 65 (citing Healthcare Anywhere *Ex Parte*).

⁸⁹*Id.* Under the Commission's rules, for service charges that are not distance-based, qualifying entities receive discounts for the difference, if any, between the urban and rural rate charged for the service. 47 C.F.R. § 54.609(a).

⁹⁰*Report and Order*, 18 FCC Rcd at 24579, para. 65.

⁹¹*Id.*

⁹²*Id.* at 24580, para. 68.

⁹³47 U.S.C. § 254(h)(1)(A).

⁹⁴*See Report and Order*, 18 FCC Rcd 24564-65, para. 35; 47 C.F.R. §§ 54.605, 54.607, 54.609.

⁹⁵*NPRM*, 17 FCC Rcd at 7820, para. 38.

⁹⁶47 C.F.R. § 54.609(a)(3); *Report and Order*, 18 FCC Rcd 24568, para. 44.

⁹⁷*See Healthcare Anywhere Comments* at 11-12.

services, they would either have to install a wireline telecommunications service to every location they serve or use a satellite or other mobile service that can function in every location. In some cases, wireline services are not available because the locations are so remote. Even if a wireline service is technically available, the number of locations served results in what otherwise might be a more expensive satellite service becoming more cost-effective and more efficient. In those situations, as commenters note, for practical purposes no wireline service is available, so rural health care providers must use a satellite or other mobile telecommunications service.⁹⁸

28. *Cost benchmark for mobile rural health care provider.* Accordingly, after reviewing the record in this proceeding, we revise our rules to allow mobile rural health care providers to receive discounts for satellite services calculated by comparing the rate for the satellite service to the rate for an urban wireline service with a similar bandwidth.⁹⁹ We will not cap the discount for the satellite service at an amount of a functionally similar wireline alternative for mobile rural health care providers.¹⁰⁰ This approach will provide the support necessary to make mobile telemedicine economical for rural health care providers to provide high-quality health care to rural and remote areas, and further the principle embodied in section 254(h)(1)(A) to make telecommunications rates for public and non-profit rural health care providers comparable to those paid in urban areas.¹⁰¹ We conclude that this revision furthers the principle of competitive neutrality and recognizes the role that telecommunications services play in rural areas without unduly increasing the size of the fund. Further, consistent with section 254, it helps to provide an affordable rate for the services necessary for telemedicine in rural America, strengthens telemedicine and telehealth networks across the nation, helps improve the quality of health care services available in rural America, and better enables rural communities to rapidly diagnose, treat, and contain possible outbreaks of disease.¹⁰²

29. *Criteria for mobile rural health care providers.* Our current rules, combined with the requirement that health care providers remain responsible for a significant portion of service costs (*i.e.*, the urban rate), are adequate to ensure that rural health care providers select the most cost-effective services and will ensure that rural health care providers make prudent economic decisions.¹⁰³ We agree, however, with commenters that suggest that certain parameters or procedures should be established for determining what constitutes a “mobile” rural health care provider so that providers cannot obtain satellite services where such services are not the most cost-effective option.¹⁰⁴ In doing so, we recognize that by requiring the mobile rural health care provider to serve a specific number of sites or requiring the mobile rural health care provider to move a certain number of times during the year to be eligible for

⁹⁸See Healthcare Anywhere Comments at 6-11; GCI Reply at 4-6. In the *Further Notice* below, we seek comment on whether to modify our rules to allow mobile rural health care providers to use services other than satellite. See *infra* para. 50.

⁹⁹47 C.F.R. § 54.609(e)(1) as adopted herein.

¹⁰⁰*Id.* Our current rules allow rural health care providers that are located in areas with no wireline alternatives to compare rural fixed satellite rates to urban wireline rates. See 47 C.F.R. § 54.609(a)(3); *Report and Order*, 18 FCC Rcd 24568, para. 44. However, discounts for satellite services are capped at the amount the rural health care provider would have received if they purchased a functionally similar terrestrial-based alternative. 47 C.F.R. § 54.609(a)(3)(i).

¹⁰¹See 47 U.S.C. § 254(h)(1)(A).

¹⁰²See 47 U.S.C. § 254(b)(1), (3) (“Quality services should be available at just, reasonable, and affordable rates”, “Consumers in all regions of the Nation, . . . should have access to telecommunications and information services, . . . that are reasonably comparable to those services provided in urban areas and that are available at rates that are reasonably comparable to rates charged for similar services in urban areas.”).

¹⁰³See 47 C.F.R. § 54.615(c)(7).

¹⁰⁴See Verizon Comments at 9-10; Avera Comments at 4.

support, we may limit the flexibility that would best support the development of mobile telemedicine. As Healthcare Anywhere asserts, some telemedicine projects may move to a different site each month while other projects may serve 50 sites per year.¹⁰⁵ Other telemedicine projects may serve six sites but spend only a week at a time at each site.¹⁰⁶

30. Because we believe some threshold must be established, however, mobile rural health care providers will be required to submit to USAC the number of sites the mobile rural health care provider will serve during the year.¹⁰⁷ Where a mobile rural health care provider serves eight or more different sites in a year, we will presume that satellite services are most cost-effective. We conclude that where a mobile rural health care provider serves less than eight different sites per year, the mobile health care provider will be required to document and explain why satellite services are necessary to achieve the health care delivery goals of the mobile telemedicine project.¹⁰⁸ This threshold provides mobile rural health care providers with the flexibility needed to support a mobile telemedicine project, while at the same time furthering the Commission's efforts to improve its oversight of the operation of the program to ensure that the statutory goals of section 254 of the Telecommunications Act of 1996 are met without waste, fraud, or abuse.¹⁰⁹ In instances where a mobile rural health care provider serves less than eight different sites per year, USAC will determine on a case-by-case basis whether the telecommunications service selected by the mobile rural health care provider is the most cost-effective option for the telemedicine project in light of the limited number of sites served per year.¹¹⁰ For example, if a T1 connection connecting a rural site costs \$1,500 and the mobile health care provider serves only four rural sites (net cost of \$6,000), then four T1 connections would be more cost-effective than one \$10,000 satellite connection. In this instance, where the cost of a T1 connection is significantly lower than a satellite connection, the satellite service would not be eligible for support.¹¹¹

31. Additionally, mobile rural health care providers seeking discounts for satellite services will be required to certify that they are serving eligible rural areas.¹¹² Providers must keep annual logs indicating: (i) the date and locations of each clinic stop; and (ii) the number of patients served at each such clinic stop. Mobile rural health care providers must maintain their annual logs for a period of five years and make such logs available to the Administrator and the Commission upon request.¹¹³ These measures will provide mobile rural health care providers with the flexibility to make choices made based upon delivery needs rather than the telecommunications service availability, while at the same time encouraging innovation, and further ensuring that mobile rural health care providers make prudent economic decisions.

32. In order to receive the discount, mobile rural health care providers will be required to provide to USAC documentation of the price for bandwidth equivalent wireline services in the urban area in the state to be covered by the project. Where a telemedicine project serves locations in different states, the provider must provide the price for bandwidth equivalent wireline services in the urban area,

¹⁰⁵Healthcare Anywhere Comments at 11.

¹⁰⁶*Id.*

¹⁰⁷47 C.F.R. § (e)(2)(i) as adopted herein.

¹⁰⁸*See* 47 C.F.R. § (e)(2)(ii) as adopted herein.

¹⁰⁹Pub. L. No. 104-104, 110 Stat. 56. The 1996 Act amended the Communications Act of 1934 (the Act). *See* 47 U.S.C. §§ 151 *et seq.*

¹¹⁰47 C.F.R. § (e)(2)(ii) as adopted herein.

¹¹¹*Id.*

¹¹²47 C.F.R. § 54.615(c)(2) as adopted herein.

¹¹³*See* 47 C.F.R. § 54.619(a)(1) as adopted herein.

proportional to the locations served in each state.¹¹⁴ The method of cost allocation chosen by an applicant should be based on objective criteria, and reasonably reflect the eligible usage of the mobile rural health clinic.¹¹⁵ Where mobile rural health care provider is also serving patients in urban areas, prorated discounts will be provided commensurate only with the time the mobile rural health care provider is serving patients in rural areas. For example, if a mobile rural health care provider provides services at an urban location for four out of 52 weeks, the support will be reduced by 8 percent. If it serves an urban location 26 out of 52 weeks, the support will be reduced by 50 percent. In accordance with section 54.619(a), mobile rural health care providers must keep documentation explaining their allocation methods for five years and present that information to USAC upon request.¹¹⁶ We also direct USAC to evaluate the allocation methods selected by program participants in the course of its audit activities to ensure program integrity and to ensure that providers are complying with the program's certification requirements.¹¹⁷ Additionally, pursuant to section 54.619(a) of the Commission's rules, providers providing mobile health services must maintain records for their purchases of supported services for at least five years sufficient to document their compliance with all Commission requirements.¹¹⁸

C. Deadline Established for Filing FCC Form 466

1. Background

33. Currently, the Commission's rules do not provide a final annual deadline for filing FCC Form 466¹¹⁹ for health care providers seeking discounts for a specific funding year under the rural health care universal service support mechanism.¹²⁰ Although the Rural Health Care Division (RHCD) of USAC accepts FCC Form 466 and accompanying documentation at any time during the funding year, RHCD encourages health care providers to submit their FCC Form 466 during the "Form Filing

¹¹⁴See 47 C.F.R. § 54.609(a).

¹¹⁵47 C.F.R. § 54.601(d). Because mobile health care clinics by their nature will not be tied to a fixed location, under the Commission's rules, such providers of mobile health services shall receive discounts based on the percentage of time they are providing services in rural areas. 47 C.F.R. § 54.601(d); *Report and Order*, 18 FCC Rcd at 24554-55, para. 15 (allowing "non-profit entities that provide ineligible services, even on a primary basis, [to] receive prorated support commensurate with their provision of eligible rural health care services.").

¹¹⁶47 C.F.R. § 54.619(a)(1), (2).

¹¹⁷See 47 C.F.R. § 54.619(a)(3). The certification requirements for rural health care providers are set forth at 47 C.F.R. § 54.615(c).

¹¹⁸47 C.F.R. § 54.619(a)(1). See FCC Form 466 Instructions.

¹¹⁹Form 466 is the means by which an applicant identifies the telecommunications service, rates, carrier(s), and the date(s) of carrier selection. The applicant must submit one Form 466 for each service (*i.e.*, circuit) for which the HCP is seeking a reduced rate. The Rural Health Care Division (RHCD) of the Universal Service Administrative Company (USAC) cannot commit universal service funds for the benefit of the HCP until RHCD receives Form 466. See Form 466 Instructions, available at <http://www.rhc.universalservice.org/Download/2004/doc/466i.DOC> (retrieved Nov. 3, 2004).

¹²⁰FCC Form 466 informs the RHCD that the health care provider has entered into an agreement with a telecommunications carrier for a service eligible for universal service support. The applicant identifies the telecommunications service, rates, carrier(s), and the date(s) of carrier selection on FCC Form 466. The applicant must submit one FCC Form 466 for each service (*i.e.*, circuit) for which the health care provider is seeking a reduced rate. The RHCD can not commit universal service funds for the benefit of the rural health care provider until RHCD receives FCC Form 466. Form 466 Instructions, available at http://www.rhc.universalservice.org/forms/466inst_y4_5.asp (retrieved Sept. 8, 2004).

Window.”¹²¹ The opening and closing dates of the Form Filing Window are announced each year on the RHCD web site.¹²² FCC Form 466s received after the close of the Form Filing Window are processed and prioritized according to the date of receipt by RHCD.¹²³ RHCD, however, continues to accept and process FCC Form 466s throughout the funding year until RHCD reaches the annual funding cap established by the Commission,¹²⁴ or until the Commission releases a *Public Notice* establishing a final deadline for filing FCC Form 466.¹²⁵

2. Discussion

34. In the 2002 *NPRM* and 2003 *Report and Order*, we sought comment on ways to streamline the application process.¹²⁶ We establish June 30 as the final deadline for filing FCC Forms 466 and 466-A¹²⁷ for health care providers seeking discounts for a specific funding year under the rural health care universal service support mechanism.¹²⁸ We conclude that providing an established deadline will provide specificity and finality to rural health care providers and will not require them to continue to check for Commission public notices.¹²⁹ This deadline is also consistent with the RHCD’s efforts to provide specific guidance to health care providers when submitting applications for universal service support. Applicants have more than a year to submit the necessary documentation for their application for support. In addition, a deadline of June 30 for filing FCC Forms 466 and 466-A coincides with the end of the funding year.¹³⁰ Under section 54.623 of our rules, USAC can still set the dates for the Filing Window for purposes of the annual cap.¹³¹

¹²¹The “Form Filing Window” is a period during which all FCC Forms 466 received by the RHCD will be treated as if they had arrived on the first day for purposes of funding priority. See Form 466 Instructions, available at http://www.rhc.universalservice.org/forms/466inst_y4_5.asp (retrieved Sept. 8, 2004).

¹²²*Id.*

¹²³*Id.*

¹²⁴The Commission has established an annual cap on federal universal service support for health care providers at \$400 million per funding year. 47 C.F.R. § 54.623(a).

¹²⁵*Id.*; see Deadline Established for Completing Funding Year 2003 Application Process for Rural Health Care Universal Service Support Mechanism, WC Docket No. 02-60, *Public Notice*, DA 04-2347 (rel. July 28, 2004) (announced a final deadline of Sept. 20, 2004 for filing FCC Form 466); Universal Service Deadline for Completing Funding Year 2002 Rural Healthcare Application Process Announced, WC Docket No. 02-60, *Public Notice*, DA 03-2633 (rel. Aug. 13, 2003) (announced a final deadline of Oct. 8, 2003 for filing FCC Form 466); New Universal Service Deadline for Completing Funding Year 2001 Rural Healthcare Application Process, WC Docket No. 02-60, *Public Notice*, DA 02-2551 (rel. Oct. 4, 2002) (announced a final deadline of Oct. 11, 2002 for filing FCC Form 466).

¹²⁶See *Report and Order*, 18 FCC Rcd at 24580-81, para. 69; *NPRM*, 17 FCC at 7825, para. 53 (“We also seek comments on ways to ensure that rural health care providers are apprised of changes in deadlines for application filings and other material changes in the application and appeals process.”).

¹²⁷Form 466-A is used by health care providers and their authorized representatives to request from the RHCD the benefit of reduced rates for Internet service. The applicant must submit one Form 466-A for each Internet Service Provider. See Form 466-A Instructions, available at <http://www.rhc.universalservice.org/Download/2004/doc/466ai.doc> (retrieved Nov. 3, 2004).

¹²⁸47 C.F.R. § 54.623(c)(3) as adopted herein.

¹²⁹See 47 U.S.C. § 254(b)(5) (“There should be specific, predictable and sufficient Federal and State mechanisms to preserve and advance universal service.”)

¹³⁰See 47 C.F.R. § 54.623(b).

¹³¹See 47 C.F.R. § 54.623.

IV. ORDER ON RECONSIDERATION

1. Background

35. Under section 254(h)(1)(A), telecommunications carriers are required to offer telecommunications services to rural health care providers at rates that are reasonably comparable to rates charged for similar services in urban areas in that state.¹³² To determine the amount of universal service support rural health care providers receive in insular areas, the Commission looks at the rates charged for similar services in the largest population center in the state.¹³³

36. The American Samoa Telecommunications Authority (ASTCA) has filed a Petition for Reconsideration of the Commission's decision in the 2003 *Report and Order* that the Commission is not authorized to provide universal service support for telecommunications services for health care providers located in insular areas.¹³⁴ Specifically, the Commission found that section 254(h)(1)(A) precluded it from designating an urban area outside of a state as the benchmark for the urban-rural comparison for insular areas.¹³⁵ The Commission concluded that such a comparison is inconsistent with the statutory language set forth in section 254(h)(1)(A), which, as noted above, explicitly requires an urban-rural rate comparison within the state.¹³⁶ The Commission further determined that funding for advanced telecommunications and information services under section 254(h)(2)(A) must be based on the urban-rural rate comparison set forth in section 254(h)(1)(A).¹³⁷ In the *1997 Universal Service Order*, the Commission designated certain areas within insular areas, including the island of Tutuila in American Samoa, as "urban areas" for purposes of setting the urban rate for those areas, based on their status as the largest population centers in the territories.¹³⁸

37. In its Petition, ASTCA states that it provides advanced broadband telecommunications service (*i.e.*, 384 kbps links) connecting the LBJ Tropical Medical Center and the American Samoa Department of Health, both of which are located in Tutuila, with the University of Hawaii in

¹³²47 U.S.C. § 254(h)(1)(A). The term "State" includes the District of Columbia and the territories and possessions. 47 U.S.C. § 153(40). United States territories and possessions are Puerto Rico, the U.S. Virgin Islands, Guam, the Northern Marianas, American Samoa, Baker Island, Howland Island, Jarvis Island, Johnston Atoll, Kingman Reef, the Midway Atoll, Navassa Island, the Palmyra Atoll, and Wake Island. Starting in 1947, the United States administered the United Nations Trust Territories of the Pacific Islands, consisting of the Republic of Palau, the Federated States of Micronesia, the Republic of the Marshall Islands, and the Northern Marianas. In negotiations over the last decade concerning the future status of these political entities, the Northern Marianas elected commonwealth status as a territory of the United States. The Marshall Islands, Micronesia, and Palau became independent, sovereign nations on Oct. 21, 1986, Nov. 3, 1986, and Oct. 1, 1994, respectively, electing to enter into a Compact of Free Association with the United States. *See* 48 U.S.C.A. Ch. 14, refs. & annos.; *Temengil v. Trust Territory of the Pacific Islands*, 881 F.2d 647, 650-51 (9th Cir. 1989). Thus, Palau, the Federated States of Micronesia, and the Marshall Islands are not "states" within the meaning of that term in the Communications Act of 1934. *See Policy and Rules Concerning the Interstate, Interexchange Marketplace*, CC Docket No. 96-61, Report and Order, 11 FCC Rcd. 9564, 9589, n.118 (1996).

¹³³47 C.F.R. §§ 54.605-609.

¹³⁴American Samoa Telecommunications Authority Petition for Reconsideration, *Rural Health Care Support Mechanism*, WC Docket No. 02-60 (Jan. 23, 2004) (ASTCA Petition for Reconsideration).

¹³⁵*Report and Order*, 18 FCC Rcd at 24570, para. 47; 47 U.S.C. § 254(h)(1)(A).

¹³⁶47 U.S.C. § 254(h)(1)(A).

¹³⁷*See Report and Order*, 18 FCC Rcd at 24570, para. 47.

¹³⁸*1997 Universal Service Order*, 12 FCC Rcd at 9137, para. 697. Tutuila is the largest population center in American Samoa. *See* ASTCA Petition for Reconsideration at 3; ASTCA Reply to Opposition at 5. All other areas in the territories were designated as "rural areas" for purposes of calculating the rural rate. *Id.*

Honolulu.¹³⁹ ASTCA maintains that providing these links is an extraordinarily expensive undertaking, but is critical for patient well-being, given the current lack of qualified physicians in the territory.¹⁴⁰ ASTCA does not charge LBJ Tropical Medical Center or the American Samoa Department of Health for this telecommunications service and does not receive support from either the American Samoa government or any U.S. federal program.¹⁴¹ ASTCA urges the Commission to reconsider its conclusion that the Commission is not authorized under section 254(h)(2)(A) to provide universal service support for advanced telecommunications services for health care providers located in insular areas.¹⁴²

2. Discussion

38. We grant, to the extent indicated herein, ASTCA's Petition for Reconsideration of the 2003 *Report and Order*. In light of the compelling and unique combination of circumstances facing "entirely rural" states, we believe that it is appropriate to establish a support mechanism under section 254(h)(2)(A) that will provide funding for the provision of advanced telecommunications and information services.¹⁴³ We therefore amend our rules to provide support to health care providers in states that are "entirely rural" equal to 50 percent of the monthly cost of advanced telecommunications and information services reasonably related to the health care needs of the facility.¹⁴⁴

39. We find that the Commission has authority to amend its rules for these specific circumstances under section 254(h)(2)(A).¹⁴⁵ Section 254(h)(2)(A) directs the Commission to establish competitively neutral rules to enhance access to advanced telecommunications and information services for health care providers.¹⁴⁶ Section 254(h)(2)(A) gives the Commission broad authority to fulfill this statutory mandate.¹⁴⁷ Unlike Congress' directive to the Commission in section 254(h)(1)(A), however,

¹³⁹ASTCA Petition for Reconsideration at 2.

¹⁴⁰*Id.*

¹⁴¹*Id.* at 3.

¹⁴²ASTCA Petition for Reconsideration at 7. ASTCA does not challenge the Commission's determination regarding section 254(h)(1)(A). Rather, the focus of ASTCA's argument concerns the Commission's authority to provide support for advanced telecommunications and information services pursuant to section 254(h)(2)(A). 47 U.S.C. § 254(h)(2)(A).

¹⁴³"Entirely rural" states are those states in which every county meets our definition of rural. USAC provides a list of eligible rural areas within the United States. Most states contain some combination of both rural and urban counties. Under our current definition, USAC identifies American Samoa, the U.S. Virgin Islands, the Commonwealth of Northern Mariana Islands, and Guam as entirely rural. *See* <www.rhc.universalservice.org/eligibility/rurallist.asp>.

¹⁴⁴47 C.F.R. § 54.621(c) as adopted herein.

¹⁴⁵47 U.S.C. § 254(h)(2)(A). In *Texas Office of Public Utility Counsel v. FCC*, the court upheld the Commission's authority under section 254(h)(2)(A) to provide universal service support for "advanced services," for non-rural health care providers. *TOPUC v. FCC*, 183 F.3d 393, 446 (5th Cir. 1999), *aff'g in part, rev'g in part, and remanding in part, Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, First Report and Order, 12 FCC Rcd 8776 (1997) (*TOPUC*). Specifically, the court affirmed the Commission's decision to provide support for advanced telecommunications and information services by subsidizing telephone calls to Internet service providers. *Id.*

¹⁴⁶47 U.S.C. § 254(h)(2)(A).

¹⁴⁷*See TOPUC* at 444 ("We are convinced that Congress intended to allow the Commission broad authority to implement this section of the Act."). The Commission has determined that section 254(h)(2)(A), in conjunction with section 4(i), authorizes universal service support for advanced services provided by non-telecommunications carriers to enable schools and libraries to select the most cost-effective provider of Internet access and internal connections. *1997 Universal Service Order*, 12 FCC Rcd at 9084-87, paras. 589-94. The Commission has also concluded that section 254(h)(2)(A) authorizes the establishment of a universal service support mechanism for infrastructure development to enhance access to advanced telecommunications and information services, as long as

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the Commission's authority under section 254(h)(2)(A) is discretionary, not mandatory.¹⁴⁸ We find that there is a special need for the Commission to use its discretion to establish rules that will enhance access to advanced telecommunications and information services for health care providers in entirely rural states.

40. This support is necessary to address the unique circumstances faced by health care providers and telecommunications carriers serving American Samoa and other similarly situated geographic areas. Geographic isolation and the lack of adequate local resources in "entirely rural" states can be mitigated by the availability and use of modern technology. Facilitating access to advanced telecommunications and information services would improve the quality of health care in geographically remote areas. As the Commission has recognized in the past, access to advanced telecommunications services and information services provides the most efficient, cost-effective way to provide many telemedicine services.¹⁴⁹ Telemedicine and other forms of treatment supported by advanced telecommunications services and information services avoid the need for off-island referrals in many cases by allowing local physicians to consult much more easily and frequently with physicians at fully equipped health care facilities. Off-island medical referrals are often necessary for patient well-being but can be extraordinarily expensive.¹⁵⁰

41. Section 254(h)(2)(A) directs the Commission to enhance access to advanced telecommunications and information services to the extent technically feasible and economically reasonable.¹⁵¹ We find that providing universal service support to these specific health care providers is technically feasible and economically reasonable. There is no dispute that access to advanced telecommunications and information services is technically feasible in these areas. In fact, such services are currently being provided.¹⁵² We believe our actions to enhance access are also economically reasonable. We do not believe this discount will significantly increase distributions from the underutilized rural health care fund because the number of eligible entities is so small.¹⁵³ The funding amount also is unlikely to significantly increase in the future because the current list of eligible entirely rural areas is not likely to change.

42. We have long recognized that Congressional goals for this program were unfulfilled in American Samoa and other entirely rural states.¹⁵⁴ In the *1997 Universal Service Order*, the

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the mechanism is competitively neutral, technically feasible, and economically reasonable. *Id.* at 9109. para. 634. In addition, the Commission has determined that it is authorized under section 254(h)(2)(A) to provide support for Internet access for rural health care providers. *See Report and Order*, 18 FCC Rcd at 24457-62, paras. 22-28.

¹⁴⁸*See TOPUC*, at 446 (finding that the Commission is not obligated to act under section 254(h)(2)(A)). *See also 1997 Universal Service Order*, 12 FCC Rcd at 9109. para. 634 (authorizing the Commission to establish competitively neutral rules to enhance access to advanced telecommunications and information services when it is technically feasible and economically reasonable to do so.)

¹⁴⁹*See Report and Order*, 18 FCC Rcd at 24557-58, paras. 22-24.

¹⁵⁰For example, off-island medical referral costs for the LBJ Medical Center in American Samoa totaled more than \$6 million for fiscal year 1997 and almost \$4.5 million for fiscal year 1998. *See ASTCA Petition for Reconsideration at Attachment.*

¹⁵¹47 U.S.C. § 254(h)(2)(A).

¹⁵²*See ASTCA Petition for Reconsideration.*

¹⁵³American Samoa has seven islands covering 76 square miles. According to 2000 Census information, American Samoa's population was estimated to be 57,300. The Commonwealth of the Northern Mariana Islands has fourteen islands covering 183.5 miles and had approximately 69,221 residents in 2000. *See* <<http://www.census.gov>>.

¹⁵⁴*See Report and Order*, 18 FCC Rcd at 24569, para. 47.

Commission attempted to address this problem under section 254(h)(1)(A) by designating larger population centers as “urban,” but those designations failed to result in any support for entirely rural states.¹⁵⁵ Thus, health care providers in these states do not receive universal service funding for the provision of telecommunications services, because, as discussed above, there may be no urban-rural rate difference within the state upon which to base the discount calculation.¹⁵⁶ We conclude that the support mechanism we adopt today furthers Congress’ goals of strengthening the ability of health care providers in remote areas to provide critical health care services and improving health care for rural residents. Congress sought to ensure that all rural health care providers have affordable access to modern telecommunications services that will enable them to provide quality medical and educational services.¹⁵⁷ Congress specifically directed the Commission to consider health care providers in insular areas when developing support mechanisms for access to telecommunications and information services.¹⁵⁸ Congressional intent also supports the adoption of special mechanisms by which to calculate support for insular areas.¹⁵⁹

43. Furthermore, we do not think that section 254(h)(1)(A) prohibits us from establishing this support. In the 2003 *Report and Order*, the Commission determined that section 254(h)(2)(A) was linked to section 254(h)(1)(A), such that funding for advanced telecommunications services must also be based on the urban-rural rate comparison for telecommunications services found in section 254(h)(1)(A).¹⁶⁰ Upon further review, however, we conclude that the two statutory provisions are not inextricably linked.¹⁶¹ The methodology we use to calculate support under section 254(h)(2)(A), therefore, does not have to be based on the urban-rural comparison.

44. Section 254(h)(2)(A), however, does not establish a methodology for calculating universal service support. The Commission provides a flat discount for Internet access for all eligible rural health care providers pursuant to section 254(h)(2)(A).¹⁶² We find that it is reasonable to use a similar

¹⁵⁵See 1997 *Universal Service Order*, 12 FCC Rcd at 9137-38, para. 697.

¹⁵⁶It is often the case that these states’ only medical facilities are situated in those areas designated as “urban.”

¹⁵⁷S. Rep. No. 230, 104th Cong., 2nd Sess., 132 (1996) (Joint Explanatory Statement) (“... any telecommunications carrier shall, upon a bona fide request, provide telecommunications services necessary for the provision of health care services to any health care provider serving persons who reside in rural areas. The rates charged for the service shall be rates that are reasonably comparable to rates charged for similar services in urban areas. It 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.”)

¹⁵⁸H.R. Conf. Rep. No. 458, 104th Cong. 2nd Sess. (1996). All of the areas that have been identified by USAC as “entirely rural” are insular areas. See *supra* n.132.

¹⁵⁹Joint Explanatory Statement at 131 (“...section 254 is intended to ensure that health care providers for rural areas, elementary and secondary school classrooms, and libraries have affordable access to modern telecommunications services that will enable them to provide medical and educational services to all parts of the Nation.”)

¹⁶⁰See *Report and Order*, 18 FCC Rcd at 24570, para. 47. See also Verizon Opposition at 3-4. In the *Report and Order*, the Commission specifically rejected WorldCom’s argument that Internet access funding must be based on the urban-rural comparison found in section 254(h)(1)(A). The Commission found that the provision of Internet access and other information services is governed by section 254(h)(2)(A). *Id.* at para. 27.

¹⁶¹See *TOPUC* at 466 (the Commission has authority to extend support to all health care providers under section 254(h)(2)(A) and did not have to limit support to just rural providers pursuant to section 254(h)(1)(A).

¹⁶²See 47 C.F.R. § 54.621. Pursuant to section 254(h)(2)(A), the Commission adopted a 25 percent discount off the cost of monthly Internet access for all eligible rural health care providers. See *Report and Order*, 18 FCC Rcd at 24457-61, paras. 22-28; 47 U.S.C. § 254(h)(2)(A). This support, however, does not fund telecommunications services or other information services and also does not provide the level of funding necessary to maintain the

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methodology for support for entirely rural areas because we are relying on the same statutory provision. Therefore, we establish a 50 percent discount off the commercial rate for the purchase of advanced telecommunications and information services for states that are “entirely rural.”¹⁶³ We emphasize that the *entire* state must meet the definition of rural, as described above, to be eligible to receive the 50 percent discount.¹⁶⁴ We conclude that this discount will assist health care providers in the purchase of such services as well as subsidize the cost of these services in areas where they are currently being provided. Based on past experience, a flat discount is easy to administer and is consistent with section 254(b)(5), which requires a specific, sufficient, and predictable mechanism.¹⁶⁵ In addition, a flat discount percentage of 50 percent is both technically feasible and economically reasonable, because it provides a limit on the amount of support per provider, it provides incentives for rural health care providers to make prudent economic decisions concerning their telemedical needs, and it will deter wasteful expenditures.¹⁶⁶ Further, we find that a 50 percent discount is slightly less than the average discount rural health care providers currently receive for telecommunications services under section 254(h)(1)(A).¹⁶⁷ Consistent with the Commission’s principles of competitive neutrality, eligible health care providers may receive increased discounts for any advanced telecommunications and information service, regardless of the platform.¹⁶⁸

V. FURTHER NOTICE OF PROPOSED RULEMAKING

A. Internet Access

1. Background

45. Section 254(h)(2)(A) provides that the Commission “shall establish competitively neutral rules to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for all public and non-profit elementary and secondary school classrooms, health care providers, and libraries”¹⁶⁹ Accordingly, the Act contemplates actions to enhance access to information services, such as Internet access, for rural health care providers.¹⁷⁰

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infrastructure designed to support the provision of advanced telecommunications and information services in entirely rural states.

¹⁶³See 47 C.F.R. § 54.621 as amended herein.

¹⁶⁴The Commission will post the list of states and territories that are “entirely rural” on USAC’s website, as is done now. See *supra* para. 13.

¹⁶⁵47 U.S.C. § 254(b)(5). As discussed above, the Commission adopted a flat discount of 25 percent off the cost of monthly Internet access for all eligible rural health care providers. See *Report and Order*, 18 FCC Rcd at 24460-61, para. 27. See also 47 C.F.R. § 54.621.

¹⁶⁶*Report and Order*, 18 FCC Rcd at 24560-61, para. 27. Health care providers in entirely rural areas will have an incentive to choose a level of service appropriate to their needs.

¹⁶⁷47 U.S.C. § 254(h)(1)(A). See http://www.atmeda.org/news/2004_presentations/13 (average support is 66 percent of service cost).

¹⁶⁸See *Report and Order*, 18 FCC Rcd at 24561-62, para. 28.

¹⁶⁹47 U.S.C. § 254(h)(2)(A).

¹⁷⁰See *TOPUC*, 183 F.3d at 443-44 (affirming the Commission’s authority under section 254(h)(2)(A) to provide support to non-telecommunications carriers in their provision of Internet access and internal connections). See also *1997 Universal Service Order*, 12 FCC Rcd at 9107, para. 630.

46. In the 2003 *Report and Order*, the Commission determined that, given the rapid development of the Internet's capacities, the proliferation of applications available on the Internet, and the increase in the number of Internet users, it was appropriate to provide funding for Internet access to rural health care providers.¹⁷¹ The Commission defined eligible Internet access as an information service that enables rural health care providers to post their own data, interact with stored data, generate new data, or communicate over the World Wide Web.¹⁷² In particular, the Commission concluded that support equal to 25 percent of the monthly cost for any form of Internet access reasonably related to the health care needs of the facility should be provided to rural health care providers.¹⁷³ In doing so, the Commission stated that a flat discount percentage of 25 percent off the cost of monthly Internet access would assist rural health care providers seeking to purchase Internet access, while also providing incentives for providers to make prudent economic decisions concerning their telemedical needs.¹⁷⁴ The Commission specifically noted that it was acting conservatively by choosing a 25 percent flat discount initially.¹⁷⁵ The Commission also stated that it will determine whether an increase in the discount is necessary or advisable as it gains more experience with this aspect of the support mechanism.¹⁷⁶

2. Discussion

47. To the extent that we were concerned in the 2003 *Report and Order* that demand for Internet access support would exceed the annual funding cap, to date, those concerns have not come to fruition.¹⁷⁷ This does not mean, however, that we can increase the discount for Internet access. We continue to remain concerned that rural health care providers choose a level of service appropriate to their needs, and we want to deter wasteful expenditures.¹⁷⁸ Because requests for Internet access discounts have remained at low levels, we take this opportunity to seek comment on whether a 25 percent flat discount off the cost of monthly Internet access for eligible rural health care providers is sufficient. We continue to believe that a flat discount will lead to greater predictability and fairness among health care providers.¹⁷⁹ We encourage commenters to be specific as to the level of support that we should offer, and to provide us with the facts that they rely upon in advocating a level of support.

48. Further, to accurately gauge the demand for support under the rural health care mechanism, we seek comment on the effect that an increase in Internet access support would have on the demand for support from rural health care providers. We therefore seek comment from rural health care providers on the demand for Internet access, and from service providers on the cost of such services. We seek comment on whether demand for Internet access is likely to reach the \$400 million cap on the amount of support to be provided by the rural health care mechanism, and how increased demand would affect the

¹⁷¹*Report and Order*, 18 FCC Rcd at 24557, para. 22. The Commission found authority for this funding under section 254(h)(2)(A) of the Telecommunications Act of 1996. 47 U.S.C. § 254(h)(2)(A).

¹⁷²47 C.F.R. § 54.601(c)(2)(i). *See also Report and Order*, 18 FCC Rcd at 24559, para. 25.

¹⁷³*Report and Order*, 18 FCC Rcd at 24557, para. 22; 47 C.F.R. §§ 54.601(c)(2)(ii), 54.621(a).

¹⁷⁴*Report and Order*, 18 FCC Rcd at 24560-61, para. 27. Rural health care providers can use this discount towards the cost of monthly charges for information services only. *Id.* at para. 18 (defining "information services"). Support for telecommunications services is not included under this discount. The Act defines "telecommunications service" as "the offering of telecommunications for a fee directly to the public, or to such classes of users as to be effectively available directly to the public, regardless of the facilities used." 47 U.S.C. § 153(46).

¹⁷⁵*Report and Order*, 18 FCC Rcd at 24560-61, para. 27.

¹⁷⁶*Id.*

¹⁷⁷*Id.*

¹⁷⁸*Id.*

¹⁷⁹*Id.*

operation of the rural health care mechanism.

49. We also seek comment on the positive or negative effects that a decision to increase Internet access support will have on the rural health care support mechanism, from the perspective of the health care providers, the service providers, and USAC. We encourage parties to discuss any issues relevant to whether we should provide increased support for Internet access, what level of support to provide, what restrictions, if any, we should place on such support, what administrative problems and concerns may arise if we provide increased support, and the impact of an increase in support on the mechanism's ability to support other services. Specifically, we seek comment on whether an increase of support would have positive or negative effects on facilities-based broadband deployment in rural areas.

B. Support for Other Telecommunications Services for Mobile Rural Health Care Providers

50. In the foregoing *Report and Order*, we revise our policy to allow mobile rural health care clinics to receive discounts for satellite services calculated by comparing the actual cost of the satellite service to the rate for an urban wireline service with a similar bandwidth.¹⁸⁰ We recognize that not only satellite services but other telecommunications platforms, such as terrestrial wireless, may provide the most cost-effective means of providing the telemedicine link. Because we want to encourage mobile health care providers to consider all available telecommunications services when determining which service best suits the needs of the telemedicine project, we seek comment on whether to modify our rules specifically to allow mobile rural health care providers to use services other than satellite. We seek comment on what other telecommunications services might be available to support mobile rural telemedicine projects. We ask commenters to address how such service may be a more cost-effective method of providing service than a satellite connection. We also request whether services other than satellite services would require different rules, different eligibility criteria or any other changes from the rules we establish today.

C. Support for Infrastructure Development

51. In the *1997 Universal Service Order*, the Commission requested comment on whether and how to support infrastructure development or “network buildout” needed to enhance public and not-for-profit health care providers’ access to advanced telecommunications and information services.¹⁸¹ At the time, the Commission noted that the record contained anecdotal evidence regarding the need for support for infrastructure development. We now seek to refresh the record on this issue.

52. In the *1997 Universal Service Order*, the Commission agreed with MCI that infrastructure development is not a “telecommunications service” within the scope of section 254(h)(1)(A) and concluded that the Commission has the discretionary 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.¹⁸² 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.”¹⁸³ Extending or upgrading existing telecommunications infrastructure could enhance access to the advanced services that may be offered over that infrastructure. Alternatively, in the

¹⁸⁰See *supra* paras. 26-32.

¹⁸¹*1997 Universal Service Order* at 9109-10, para. 635.

¹⁸²*Id.* at para. 634.

¹⁸³47 U.S.C. § 254(h)(2)(A).

schools and libraries context, the Commission has recognized that some carrier infrastructure costs may be passed on as a component of monthly service charges.¹⁸⁴

53. Should the Commission authorize support for upgrades to the public switched or backbone networks? How would the program be structured so that it is competitively neutral, technically feasible and economically reasonable? If so, how should the Commission limit such support so that funds are only provided when such upgrades can be shown to be necessary to deliver services to eligible health care providers? Should certifications or other evidence of necessity attesting to the use of such support be required from the rural health care provider or the service provider? Are other safeguards required to ensure that no waste, fraud or abuse occurs? Should these charges be prorated over a specified number of years? Commenters should provide specific information on the probable costs, advantages, and disadvantages of supporting such upgrades. Commenters should also provide information regarding the effect on the fund's resources.

VI. PROCEDURAL MATTERS

A. Regulatory Flexibility Analysis

54. As required by the Regulatory Flexibility Act, 5 U.S.C. § 604, the Commission has prepared a Final Regulatory Flexibility Analysis (FRFA) for the *Report and Order* and *Order on Reconsideration*, set forth at Appendix C. The Commission has also prepared an Initial Regulatory Flexibility Analysis (IRFA) for the *Further Notice of Proposed Rulemaking (Further Notice)*, set forth at Appendix D. Comments on the IRFA should be labeled as IRFA Comments, and should be submitted pursuant to the filing dates and procedures set forth in paragraphs 58-65, *infra*.

B. Paperwork Reduction Act Analysis

1. Final Regulatory Flexibility Analysis

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

56. In this present document, we have assessed the effects of the measures adopted to protect against waste, fraud and abuse in the administration of the rural health care universal service support mechanism. We find that the modified information and record retention requirements for mobile rural health care providers and the modified certification requirements for health care providers in states that are entirely rural will not be unduly burdensome on small businesses.

¹⁸⁴*Request for Review of the Decision of the Universal Service Administrator by Brooklyn Public Library, Federal-State Joint Board on Universal Service, Changes to the Board of Directors of the National Exchange Carrier Association, Inc.*, Order, File No. SLD-149423, CC Docket Nos. 96-45 and 97-21, 15 FCC Rcd 18598, 19599-600, 18602-3, paras. 4, 9 (2000); *Request for Review by the Department of Education of the State of Tennessee of the Decision of the Universal Service Administrator, Request for Review by Integrated Systems and Internet Solutions, Inc. of the Decision of the Universal Service Administrator, Request for Review by Education Networks of America of the Decision of the Universal Service Administrator, Federal-State Joint Board on Universal Service, Changes to the Board of Directors of the National Exchange Carrier Association, Inc.*, Order, Application No. 18132, CC Docket Nos. 96-45, 97-21, 14 FCC Rcd 13734, 13749, para. 29.

2. Initial Regulatory Flexibility Analysis

57. The *Further Notice* does not contain proposed information collections(s) subject to the Paperwork Reduction Act of 1995, Public Law 104-13. In addition, therefore, it does not contain any new or modified “information collection burden for small businesses with fewer than 25 employees,” pursuant to the Small Business Paperwork Relief Act of 2002, Public Law 107-198, *see* 44 U.S.C. 3506(c)(4).

C. Filing Procedures

58. Pursuant to sections 1.415 and 1.419 of the Commission’s rules,¹⁸⁵ interested parties may file comments not later than 60 days after publication of this *Second Report and Order* in the Federal Register and may file reply comments not later than 90 days after publication of this *Second Report and Order* in the Federal Register. In order to facilitate review of comments and reply comments, parties should include the name of the filing party and the date of the filing on all pleadings. Comments may be filed using the Commission’s Electronic Comment Filing System (ECFS) or by filing paper copies.¹⁸⁶

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

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

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

| If you are sending this type of document or using this delivery method... | It should be addressed for delivery to... |
|--|---|
| Hand-delivered or messenger-delivered paper filings for the Commission’s Secretary | 236 Massachusetts Avenue, NE, Suite 110, Washington, DC 20002 (8:00 to 7:00 p.m.) |
| Other messenger-delivered documents, | 9300 East Hampton Drive, |

¹⁸⁵47 C.F.R. §§ 1.415, 1.419.

¹⁸⁶*See* Electronic Filing of Documents in Rulemaking Proceedings, 13 FCC Rcd 11322, 11326 (1998).

| | |
|---|---|
| including documents sent by overnight mail (other than United States Postal Service Express Mail and Priority Mail) | Capitol Heights, MD 20743 (8:00 a.m. to 5:30 p.m.) |
| United States Postal Service first-class mail, Express Mail, and Priority Mail | 445 12 th Street, SW Washington, DC 20554 |

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

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

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

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

D. Further Information

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

67. For further information, contact Regina Brown at (202) 418-0792 or Dana Bradford at (202)

418-1932 in the Telecommunications Access Policy Division, Wireline Competition Bureau.

VII. ORDERING CLAUSES

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

69. IT IS FURTHER ORDERED that, pursuant to the authority contained in section 405, of the Communications Act of 1934, as amended, 47 U.S.C. § 405, and sections 0.291 and 1.429 of the Commission's rules, 47 C.F.R. §§ 0.291 and 1.429, American Samoa Telecommunications Authority's Petition for Reconsideration IS GRANTED to the extent indicated herein.

70. IT IS FURTHER ORDERED that Part 54 of the Commission's rules, 47 C.F.R. Part 54, except §§ 54.609, 54.619, which will become effective upon Office of Management and Budget approval, IS AMENDED as set forth in Appendix A attached hereto, effective thirty (30) days after the publication of this *Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking* in the Federal Register.

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

FEDERAL COMMUNICATIONS COMMISSION

Marlene H. Dortch
Secretary

APPENDIX A**Final Rules**

For the reasons discussed in the preamble, the Federal Communications Commission amends 47 C.F.R. Part 54 as follows:

PART 54 - UNIVERSAL SERVICE

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

Authority: 47 U.S.C. §§ 1, 4(i), 201, 205, 214, and 254 unless otherwise noted.

2. Amend § 54.5 by revising the definition of “Rural area” to read as follows:

§ 54.5 Terms and definitions.

* * * * *

Rural area. For purposes of the schools and libraries universal support mechanism, a “rural area” is a nonmetropolitan county or county equivalent, as defined in the Office of Management and Budget’s (OMB) Revised Standards for Defining Metropolitan Areas in the 1990s and identifiable from the most recent Metropolitan Statistical Area (MSA) list released by OMB, or any contiguous non-urban Census Tract or Block Numbered Area within an MSA-listed metropolitan county identified in the most recent Goldsmith Modification published by the Office of Rural Health Policy of the U.S. Department of Health and Human Services. For purposes of the rural health care universal service support mechanism, a “rural area” is an area that (a) is entirely outside of a Core Based Statistical Area; (b) is within a Core Based Statistical Area that does not have any Urban Area with a population of 25,000 or greater; or (c) is in a Core Based Statistical Area that contains an Urban Area with a population of 25,000 or greater, but is within a specific census tract that itself does not contain any part of a Place or Urban Area with a population of greater than 25,000. “Core Based Statistical Area” and “Urban Area” are as defined by the Census Bureau and “Place” is as identified by the Census Bureau.

* * * * *

3. Amend § 54.601 by adding paragraphs (a)(3)(i) and (c)(3) to read as follows:

§ 54.601 Eligibility.

(a) * * *

* * * * *

(3) * * *

(i) Any health care provider that was located in a rural area under the definition used by the Commission prior to July 1, 2005, and that had received a funding commitment from USAC since 1998, shall continue to qualify for support under the universal service mechanism for health care providers for a period of three years, beginning July 1, 2005.

* * * * *

(c) * * *

* * * * *

(3) Advanced telecommunications and information services as provided under § 54.621.

* * * * *

4. Amend § 54.609 by adding paragraph (e) to read as follows:

§ 54.609 Calculating support.

* * * * *

(e) Mobile rural health care providers.

(1) Calculation of support. Mobile rural health care providers may receive discounts for satellite services calculated by comparing the rate for the satellite service to the rate for an urban wireline service with a similar bandwidth. Discounts for satellite services shall not be capped at an amount of a functionally similar wireline alternative. Where the mobile rural health care provider provides service in more than one state, the calculation shall be based on the urban areas in each state, proportional to the number of locations served in each state.

(2) Documentation of support.

(i) Mobile rural health care providers shall provide to the Administrator documentation of the price of bandwidth equivalent wireline services in the urban area in the state or states where the service is provided. Mobile rural health care providers shall provide to the Administrator the number of sites the mobile health care provider will serve during the funding year.

(ii) Where a mobile rural health care provider serves less than eight different sites per year, the mobile rural health care provider shall provide to the Administrator documentation of the price of bandwidth equivalent wireline services. In such case, the Administrator shall determine on a case-by-case basis whether the telecommunications service selected by the mobile rural health care provider is the most cost-effective option. Where a mobile rural health care provider seeks a more expensive satellite-based service when a less expensive wireline alternative is most cost-effective, the mobile rural health care provider shall be responsible for the additional cost.

5. Amend § 54.615 by revising paragraph (c)(2) to read as follows:

§ 54.615 Obtaining services.

* * * * *

(c) * * *

(1) * * *

(2) The requester is physically located in a rural area, unless the health care provider is requesting services provided under § 54.621; or, if the requester is a mobile rural health care provider requesting services under § 54.609(e), that the requester has certified that it is serving eligible rural areas.

* * * * *

6. Amend § 54.619 by revising paragraph (a) and adding paragraph (a)(1) to read as follows:

§ 54.619 Audits and recordkeeping.

(a) Health care providers.

(1) Health care providers shall maintain for their purchases of services supported under this subpart documentation for five years from the end of the funding year sufficient to establish compliance with all rules in this subpart. Documentation must include, among other things, records of allocations for consortia and entities that engage in eligible and ineligible activities, if applicable. Mobile rural health care providers shall maintain annual logs indicating: (i) the date and locations of each clinic stop; and (ii) the number of patients served at each such clinic stop. Mobile rural health care providers shall maintain its annual logs for a period of five years. Mobile rural health care providers shall make its logs available to the Administrator and the Commission upon request.

* * * * *

7. Amend § 54.621 by adding paragraph (c) to read as follows:

§ 54.621 Access to advanced telecommunications and information services.

* * * * *

(c) Health care providers located in States that are entirely rural shall be eligible to receive universal service support equal to 50 percent of the monthly cost of advanced telecommunications and information services reasonably related to the health care needs of the facility.

§ 54.623 Cap.

8. Amend § 54.623 by revising paragraphs (a), (b), (c)(2), (c)(3) to read as follows:

(a) Amount of the annual cap. The annual cap on federal universal service support for health care providers shall be \$400 million per funding year, with the following exceptions.

(b) Funding year. A funding year for purposes of the health care providers cap shall be the period July 1 through June 30.

(c) * * *

* * * * *

(2) For each funding year, which will begin on July 1, the Administrator shall implement a filing period that treats all health care providers filing within that period as if they were simultaneously received. The filing period shall begin on the date that the Administrator begins to receive applications for support, and shall conclude on a date to be determined by the Administrator.

(3) The Administrator may implement such additional filing periods as it deems necessary. The deadline for all required forms to be filed with the Administrator is June 30 for the funding year that begins on the previous July 1.

* * * * *

APPENDIX B

**List of Parties Filing Petitions for Reconsideration and Comments
in Response to the Report and Order, Order on Reconsideration,
and Further Notice of Proposed Rulemaking**

I. Report and OrderPetition for Reconsideration

American Samoa Telecommunications Authority (ASTCA)

Opposition to Petition for Reconsideration

Verizon telephone companies (Verizon)

Reply to Opposition to Petition for Reconsideration

American Samoa Telecommunications Authority (ASTCA)

II. Further Notice of Proposed RulemakingComments

1. Alaska, Department of Health and Social Services (Alaska)
2. Alliance Information Management, Inc. (Alliance)
3. American Hospital Association (AHA)
4. American Telemedicine Association (ATA)
5. Avera Health (Avera)
6. Blue Cross of California Telemedicine Program (Blue Cross)
7. Boucher, Rick, Member of Congress (Rep. Boucher)
8. California Healthcare Association (CHA)
9. California Primary Care Association (CPCA)
10. California State Office of Rural Health (CalSORH)
11. California Telemedicine and eHealth Center (CTEC)
12. Commonwealth of Virginia, Office of Attorney General (Commonwealth of VA)
13. Healthcare Anywhere, Inc. (Healthcare Anywhere)
14. Institute for International Emergency Medicine and Health (IEMH)
15. Iowa Utilities Board (IUB)
16. Mayers Memorial Hospital District (MMH)
17. Mountain Valleys Health Centers (Mountain Valleys)
18. National Organization of State Offices of Rural Health (NOSORH)
19. National Rural Health Association (NRHA)
20. Northeastern Rural Health Clinics (NRHC)
21. Northern Sierra Rural Health Network (NSRHN)
22. Office of Rural Community Affairs (Rural Community)
23. Office of Telemedicine of the University of Virginia Medical Center (UVA)
24. Pan-Pacific Education and Communication Experiments by Satellite (PEACESAT)
25. Placer County Health and Human Services Administration (Placer)
26. Rural Healthcare Center, California Healthcare Association (Rural Healthcare Center)
27. Shasta Consortium of Community Health Centers (SCCHC)

28. Shingletown Medical Center (Shingletown)
29. Taylor, Patricia, Ph.D. (Taylor)
30. Verizon telephone companies (Verizon)
31. Virginia Department of Health (Virginia)

Reply Comments

1. Alaska Native Tribal Health Consortium (ANTHC)
2. BellSouth Corporation (BellSouth)
3. General Communication, Inc. (GCI)
4. Healthcare Anywhere, Inc. (Healthcare Anywhere)
5. Iowa Utilities Board (IUB)
6. O'Connor, Michael (O'Connor)
7. Office of Telemedicine of the University of Virginia Medical Center (UVA)
8. Verizon telephone companies (Verizon)

APPENDIX C

FINAL REGULATORY FLEXIBILITY ANALYSIS

(REPORT AND ORDER AND ORDER ON RECONSIDERATION)

1. As required by the Regulatory Flexibility Act of 1980, as amended (RFA),¹ an Initial Regulatory Flexibility Analysis (IRFA) was incorporated in the Further Notice of Proposed Rulemaking.² The Commission sought public comments on the proposals in the Further Notice of Proposed Rulemaking, including comment on the IRFA. This present Final Regulatory Flexibility Analysis (FRFA) conforms to the RFA.³

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

2. The Commission is required by section 254 of the Act to promulgate rules to implement the universal service provisions of section 254.⁴ On May 8, 1997, the Commission adopted rules that reformed its system of universal service support mechanisms so that universal service is preserved and advanced as markets move toward competition.⁵ Among other programs, the Commission adopted a program to provide discounted telecommunications services to public or non-profit health care providers that serve persons in rural areas.⁶ Over the last few years, important changes in the rural health community, such as technological advances and the increasing variety of needs of the rural health care community, have prompted us to review the rural health care universal service support mechanism.⁷ In this *Report and Order* and *Order on Reconsideration*, we adopt several modifications to the Commission's rules to improve the effectiveness of the rural health care universal service support mechanism and increase utilization of this mechanism by rural health care providers.

3. Specifically, in this *Report and Order*, we change the Commission's definition of rural for the purposes of the rural health care support mechanism because the definition currently used by the Commission is no longer being updated with new Census Bureau data by the Office of Rural Health Care Policy, the agency that developed the definition.⁸ Specifically, the new definition improves upon the previous method of determining which areas are rural by more accurately identifying the rural areas within counties.⁹ We also revise our rules to allow mobile rural health care providers to receive discounts for satellite services calculated by comparing the rate for the satellite service to the rate for an urban wireline service with a similar bandwidth.¹⁰ Mobile rural health care providers travel to remote areas of

¹See 5 U.S.C. § 603. The RFA, *see* 5 U.S.C. § 601 – 612, has been amended by the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA), Pub. L. No. 104-121, Title II, 110 Stat. 857 (1996).

²*Rural Health Care Support Mechanism*, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, WC Docket No. 02-60, 18 FCC Rcd 24546 (2002) (*Report and Order*).

³See 5 U.S.C. § 604.

⁴47 U.S.C. § 254.

⁵1997 *Universal Service Order*, 12 FCC Rcd at 9118-19, paras. 655-56.

⁶See *id.*

⁷See *Second Report and Order*, paras. 5-8.

⁸*Id.* at paras. 9-23.

⁹*Id.*

¹⁰*Id.* at paras. 24-32.

the country to deliver health care services to underserved populations for particular health conditions that may go unnoticed or untreated due to the lack of health care facilities in such areas. Thus, this approach will provide the support necessary to make mobile telemedicine economical for rural health care providers to provide high-quality health care to rural and remote areas, and to make telecommunications rates for public and non-profit rural health care providers comparable to those paid in urban areas. Furthermore, to provide specificity and finality to rural health care providers, we improve our administrative process by establishing a fixed deadline for applications for support.¹¹

4. On reconsideration, we permit rural health care providers in states that are entirely rural, such as American Samoa, to receive support for advanced telecommunications and information services under section 254(h)(2)(A).¹² Under the Commission's current policy, health care providers in these areas do not receive universal service funding for the provision of telecommunications services because no urban-rural rate difference exists within the state or territory upon which to base the discount calculation. Telemedicine and other forms of treatment supported by advanced telecommunications services and information services eliminate the need for referrals to other locations by allowing local physicians to consult much more easily and frequently with physicians at fully equipped health care facilities. We expect this rule change will strengthen the ability of health care providers in states and territories that are entirely rural to provide critical health care services and improve health care for rural residents.

5. We believe that such actions will improve significantly the ability of rural health care providers to respond to the medical needs of their communities, provide needed aid to strengthen telemedicine and telehealth networks across the nation, help improve the quality of health care services available in rural America, and better enable rural communities to rapidly diagnose, treat, and contain possible outbreaks of disease.¹³ In addition, these changes will equalize access to quality health care between rural and urban areas and will support telemedicine networks if needed for a national emergency.¹⁴ Enhancing access to an integrated nationwide telecommunications network for rural health care providers will further the Commission's core responsibility to make available a rapid nationwide network for the purpose of the national defense, particularly with the increased awareness of the possibility of terrorist attacks.¹⁵ Finally, these changes will further the Commission's efforts to improve its oversight of the operation of the program to ensure that the statutory goals of section 254 of the Telecommunications Act of 1996 are met without waste, fraud, or abuse.¹⁶

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

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

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

7. The RFA directs agencies to provide a description of, and where feasible, an estimate of the

¹¹*Id.* at paras. 33-34.

¹²*Id.* at paras. 35-44; 47 U.S.C. § 254(h)(2)(A).

¹³*Id.* at para. 2.

¹⁴*Id.*

¹⁵*Id.*

¹⁶*Id.*

number of small entities that may be affected by the rules.¹⁷ The RFA generally defines the term “small entity” as having the same meaning as the terms “small business,” “small organization,” and “small governmental jurisdiction.”¹⁸ In addition, the term “small business” has the same meaning as the term “small business concern” under the Small Business Act.¹⁹ A “small business concern” is one which: (1) is independently owned and operated; (2) is not dominant in its field of operation; and (3) satisfies any additional criteria established by the Small Business Administration (SBA).²⁰

a. Rural Health Care Providers

8. Section 254(h)(5)(B) of the Act defines the term “health care provider” and sets forth seven categories of health care providers eligible to receive universal service support.²¹ Although the SBA has not developed a specific size category for small, rural health care providers, recent data indicate that there are a total of 8,297 health care providers, consisting of: (1) 625 “post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools;” (2) 866 “community health centers or health centers providing health care to migrants;” (3) 1633 “local health departments or agencies;” (4) 950 “community mental health centers;” (5) 1951 “not-for-profit hospitals;” and (6) 2,272 “rural health clinics.”²² We have no additional data specifying the numbers of these health care providers that are small entities nor do we know how many are located in areas we have define as rural. In addition, non-profit entities that act as “health care providers” on a part-time basis are eligible to receive prorated support and we have no ability to quantify how many potential eligible applicants fall into this category. However, we have no data specifying the number of potential new applicants. Consequently, using the data we do have, we estimate that there are 8,297 or fewer small health care providers potentially affected by the actions proposed in this Notice.

9. As noted earlier, non-profit businesses and small governmental units are considered “small entities” within the RFA. In addition, we note that census categories and associated generic SBA small business size categories provide the following descriptions of small entities. The broad category of Ambulatory Health Care Services consists of further categories and the following SBA small business size standards. The categories of small business providers with annual receipts of \$6 million or less consists of: Offices of Dentists; Offices of Chiropractors; Offices of Optometrists; Offices of Mental Health Practitioners (except Physicians); Offices of Physical, Occupational and Speech Therapists and Audiologists; Offices of Podiatrists; Offices of All Other Miscellaneous Health Practitioners; and

¹⁷5 U.S.C. § 603(b)(3).

¹⁸5 U.S.C. § 601(6).

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

²⁰15 U.S.C. § 632.

²¹See 47 U.S.C. § 254(h)(5)(B).

²²In the 1997 *Universal Service Order*, we estimated that there were (1) 625 “post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools,” including 403 rural community colleges, 124 medical schools with rural programs, and 98 rural teaching hospitals; (2) 1,200 “community health centers or health centers providing health care to migrants”; (3) 3,093 “local health departments or agencies” including 1,271 local health departments and 1,822 local boards of health; (4) 2,000 “community mental health centers”; (5) 2,049 “not-for-profit hospitals”; and (6) 3,329 “rural health clinics.” The total of these numbers was 12,296. 1997 *Universal Service Order*, 12 FCC Rcd at 9241-42, para. 924.

Ambulance Services.²³ The category of small business Ambulatory Health Care Services providers with \$8.5 million or less in annual receipts consists of: Offices of Physicians; Family Planning Centers; Outpatient Mental Health and Substance Abuse Centers; Health Maintenance Organization Medical Centers; Freestanding Ambulatory Surgical and Emergency Centers; All Other Outpatient Care Centers, Blood and Organ Banks; and All Other Miscellaneous Ambulatory Health Care Services.²⁴ The category of Ambulatory Health Care Services providers with \$11.5 million or less in annual receipts consists of: Medical Laboratories; Diagnostic Imaging Centers; and Home Health Care Services.²⁵ The category of Ambulatory Health Care Services providers with \$29 million or less in annual receipts consists of Kidney Dialysis Centers.²⁶ For all of these Ambulatory Health Care Service Providers, census data indicate that there is a combined total of 345,476 firms that operated in 1997.²⁷ Of these, 339,911 had receipts for that year of less than \$5 million.²⁸ In addition, an additional 3,414 firms had annual receipts of \$5 million to \$9.99 million; and additional 1,475 firms had receipts of \$10 million to \$24.99 million; and an additional 401 had receipts of \$25 million to \$49.99 million.²⁹ We therefore estimate that virtually all Ambulatory Health Care Services providers are small, given SBA's size categories. We note, however, that our rules affect non-profit and public healthcare providers, and many of the providers noted above would not be considered "public" or "non-profit." In addition, we have no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

10. The broad category of Hospitals consists of the following categories and the following small business providers with annual receipts of \$29 million or less: General Medical and Surgical Hospitals, Psychiatric and Substance Abuse Hospitals; and Specialty (Except Psychiatric and Substance Abuse) Hospitals.³⁰ For all of these health care providers, census data indicate that there is a combined total of 330 firms that operated in 1997, of which 237 or fewer had revenues of less than \$25 million.³¹ An additional 45 firms had annual receipts of \$25 million to \$49.99 million.³² We therefore estimate that most Hospitals are small, given SBA's size categories. In addition, we have no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

11. The broad category of Social Assistance consists of the category of Emergency and Other Relief Services and small business size standard of annual receipts of \$6 million or less.³³ For all of these health care providers, census data indicates that there are a combined total of 37,778 firms that operated in 1997.³⁴ Of these, 37,649 or fewer firms had annual receipts of below \$5 million. An additional 73 firms had annual receipts of \$5 million to \$9.99 million.³⁵ We therefore estimate that

²³13 C.F.R. § 121.201, North American Industry Classification System (NAICS) Codes 621210, 621310, 621320, 621330, 621340, 621391, 621399, 621910.

²⁴13 C.F.R. § 121.201, NAICS Codes 621111, 621112, 621410, 621420, 621491, 621493, 621498, 621991, 621999.

²⁵13 C.F.R. § 121.201, NAICS Codes 621511, 621512, 621610.

²⁶13 C.F.R. § 121.201, NAICS Code 621492.

²⁷1997 Economic Census, Establishment of Firm Size, U.S. Census Bureau, U.S. Department of Commerce, Economics and Statistics Administration, Document EC97S62S-SZ (*1997 Health Care Data*).

²⁸*Id.*

²⁹*Id.*

³⁰13 C.F.R. § 121.201, NAICS Codes 622110, 622210, 622310.

³¹1997 Health Care Data.

³²*Id.*

³³13 C.F.R. § 121.201, NAICS Code 624230.

³⁴1997 Health Care Data.

³⁵*Id.*

virtually all Social Assistance providers are small, given SBA's size categories. In addition, we have no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

b. Providers of Telecommunications and Other Services

12. We have included small incumbent local exchange carriers in this present RFA analysis. As noted above, a "small business" under the RFA is one that, inter alia, meets the pertinent small business size standard (e.g., a telephone communications business having 1,500 or fewer employees), and "is not dominant in its field of operation."³⁶ The SBA's Office of Advocacy contends that, for RFA purposes, small incumbent local exchange carriers are not dominant in their field of operation because any such dominance is not "national" in scope.³⁷ We have therefore included small incumbent local exchange carriers in this RFA analysis, although we emphasize that this RFA action has no effect on Commission analyses and determinations in other, non-RFA contexts.

13. *Total Number of Telephone Companies Affected.* The Wireline Competition Bureau reports that, as of October 22, 2003, there were 4,748 firms engaged in providing telephone services, as defined therein.³⁸ This number contains a variety of different categories of carriers, including local exchange carriers, interexchange carriers, competitive access providers, cellular carriers, mobile service carriers, operator service providers, pay telephone operators, PCS providers, covered SMR providers, and resellers. It seems certain that some of those 4,748 telephone service firms may not qualify as small entities because they are not "independently owned and operated."³⁹ For example, a PCS provider that is affiliated with an interexchange carrier having more than 1,500 employees would not meet the definition of a small business. It seems reasonable to conclude, therefore, that 4,748 or fewer telephone service firms are small entity telephone service firms that may be affected by the decisions and rules adopted in this Report and Order.

14. *Local Exchange Carriers, Interexchange Carriers, Competitive Access Providers, Operator Service Providers, Payphone Providers, and Resellers.* Neither the Commission nor SBA has developed a definition particular to small local exchange carriers (LECs), interexchange carriers (IXCs), competitive access providers (CAPs), operator service providers (OSPs), payphone providers or resellers. The closest applicable definition for these carrier-types under SBA rules is for Wired Telecommunications Carriers having less than 1,500 employees.⁴⁰ The most reliable source of information regarding the number of these carriers nationwide of which we are aware appears to be the data that we collect annually on the Form 499-A. According to our most recent data, there are 1,335 incumbent LECs, 349 CAPs, 204 IXCs, 21 OSPs, 758 payphone providers and 454 resellers.⁴¹ Although it seems certain that some of these carriers are not independently owned and operated, or have more than

³⁶15 U.S.C. § 632.

³⁷Letter from Jere W. Glover, Chief Counsel for Advocacy, SBA, to William E. Kennard, Chairman, FCC (May 27, 1999). The Small Business Act contains a definition of "small-business concern," which the RFA incorporates into its own definition of "small business." See 15 U.S.C. § 632(a) (Small Business Act); 5 U.S.C. § 601(3) (RFA). SBA regulations interpret "small business concern" to take into account the concept of dominance on a national basis. 13 C.F.R. § 121.102(b).

³⁸FCC, Wireline Competition Bureau, Industry Analysis and Technology Division, "Trends in Telephone Service: at Table 5.3, page 5-5 (May 2004). This source uses data that are current as of October 22, 2003.

³⁹15 U.S.C. § 632(a)(1).

⁴⁰13 C.F.R. § 121.201, NAICS Code 517110.

⁴¹See FCC, Common Carrier Bureau, Industry Analysis Division, *Trends in Telephone Service*, Table 5.3 (August 2001) (*Telephone Trends Report*). The total for resellers includes both toll resellers and local resellers. The category for CAPs also includes competitive local exchange carriers (LECs).

1,500 employees, we are unable at this time to estimate with greater precision the number of these carriers that would qualify as small business concerns under SBA's definition. Consequently, we estimate that there are fewer than 1,335 incumbent LECs, 349 CAPs, 204 IXC's, 21 OSPs, 758 payphone providers, and 541 resellers that may be affected by the decisions and rules adopted in this Report and Order.

15. *Internet Service Providers.* The SBA has developed a small business size standard for "On-Line Information Services," NAICS code 518111.⁴² This category comprises establishments "primarily engaged in providing direct access through telecommunications networks to computer-held information compiled or published by others."⁴³ Under this small business size standard, a small business is one having annual receipts of \$21 million or less.⁴⁴ Based on firm size data provided by the Bureau of the Census, 3,123 firms are small under SBA's \$21 million size standard for this category code.⁴⁵ Although some of these Internet Service Providers (ISPs) might not be independently owned and operated, we are unable at this time to estimate with greater precision the number of ISPs that would qualify as small business concerns under SBA's small business size standard. Consequently, we estimate that there are 3,123 or fewer small entity ISPs that may be affected.

16. *Satellite Service Carriers.* The SBA has developed a definition for small businesses within the category of Satellite Telecommunications. According to SBA regulations, a small business under the category of Satellite communications is one having annual receipts of \$12.5 million or less.⁴⁶ According to SBA's most recent data, there are a total of 371 firms with annual receipts of \$9,999,999 or less, and an additional 69 firms with annual receipts of \$10,000,000 or more.⁴⁷ Thus, the number of Satellite Telecommunications firms that are small under the SBA's \$12 million size standard is between 371 and 440. Further, some of these Satellite Service Carriers might not be independently owned and operated. Consequently, we estimate that there are fewer than 440 small entity ISPs that may be affected by the decisions and rules of the present action.

17. *Wireless Service Providers.* The SBA has developed a definition for small businesses within the two separate categories of Cellular and Other Wireless Telecommunications. Under that SBA definition, such a business is small if it has 1,500 or fewer employees.⁴⁸ According to the Commission's most recent Telephone Trends Report data, 1,495 companies reported that they were engaged in the provision of wireless service.⁴⁹ Of these 1,495 companies, 989 reported that they have 1,500 or fewer employees and 506 reported that, alone or in combination with affiliates, they have more than 1,500 employees. We do not have data specifying the number of these carriers that are not independently owned and operated, and thus are unable at this time to estimate with greater precision the number of wireless service providers that would qualify as small business concerns under the SBA's definition. Consequently, we estimate that there are 989 or fewer small wireless service providers that may be affected by the rules.

⁴²13 CFR § 121.201, NAICS code 518111.

⁴³*Id.*

⁴⁴*Id.*

⁴⁵Office of Advocacy, U.S. Small Business Administration, Firm Size Data by Industry and Location.

⁴⁶13 C.F.R. § 121.201, NAICS Code 517410.

⁴⁷1997 Economic Census at 16.

⁴⁸13 C.F.R. § 121.201, NAICS Code 517212.

⁴⁹Telephone Trends Report, Table 5.3.

18. *Vendors of Infrastructure Development or “Network Buildout.”* The Commission has not developed a small business size standard specifically directed toward manufacturers of network facilities. The closest applicable definition of a small entity are the size standards under the SBA rules applicable to manufacturers of “Radio and Television Broadcasting and Communications Equipment” (RTB) and “Other Communications Equipment.”⁵⁰ According to the SBA’s regulations, manufacturers of RTB or other communications equipment must have 750 or fewer employees in order to qualify as a small business.⁵¹ The most recent available Census Bureau data indicates that there are 1,187 establishments with fewer than 1,000 employees in the United States that manufacture radio and television broadcasting and communications equipment, and 271 companies with less than 1,000 employees that manufacture other communications equipment.⁵² Some of these manufacturers might not be independently owned and operated. Consequently, we estimate that the majority of the 1,458 internal connections manufacturers are small.

19. *Cable and Other Program Distribution.*⁵³ The SBA has developed a small business size standard which includes all such companies generating \$12.5 million or less in revenue annually. This standard covers Cable and Other Program Distribution. Only businesses in Cable and Other Program Distribution category can be affected by the rules and policies adopted herein. This category includes cable systems operators, closed circuit television services, direct broadcast satellite services, multipoint distribution systems, satellite master antenna systems, and subscription television services. According to Census Bureau data for 1997, there were a total of 1,311 firms in this category, total, that had operated for the entire year.⁵⁴ Of this total, 1,180 firms had annual receipts of under \$10 million and an additional 52 firms had receipts of \$10 million or more but less than \$25 million. Consequently, the Commission estimates that the majority of providers in this service category are small businesses that may be affected by the rules and policies adopted herein.

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

20. This *Report and Order* and this *Order on Reconsideration* adopts several modifications to the Commission’s rules to improve the effectiveness of the rural health care universal service support mechanism and increase utilization of this mechanism by rural health care providers. As articulated above, in the *Report and Order*, we change the Commission’s definition of rural for the purposes of the rural health care support mechanism.⁵⁵ The new definition will not impact reporting or recordkeeping requirements. It does, however, change the overall pool of eligible applicants. Second, the *Report and Order* expands funding for mobile rural health care services by subsidizing the difference between the actual rate of satellite service for mobile rural health care providers and the rate for an urban wireline service with a similar bandwidth.⁵⁶ Because mobile rural health care providers will now be eligible for support, we adopt rules requiring such providers to submit an estimated number of sites the mobile

⁵⁰13 C.F.R. § 121.201, NAICS Codes 334220, 334290.

⁵¹*Id.*

⁵²1997 Economic Census, Manufacturing, Industry Series, Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing, Document No. E97M-3342B (August 1999), at 9; 1997 Economic Census, Manufacturing, Industry Series, Other Communications Equipment Manufacturing, Document No. EC97M-3342C (September 1999), at 9 (both available at <http://www.census.gov/prod/www/abs/97ecmani.html>).

⁵³13 CFR § 121.201, NAICS code 517510.

⁵⁴*Id.*

⁵⁵See *Second Report and Order* at paras. 9-23.

⁵⁶*Id.* at paras. 24-32.

health care provider will serve during the year.⁵⁷ Additionally, mobile rural health care providers seeking discounts for satellite services will be required to certify that they are serving eligible rural areas.⁵⁸ Providers must keep annual logs indicating: (i) the date and locations of each clinic stop; and (ii) the number of patients served at each such clinic stop. Mobile rural health care providers must maintain their annual logs for a period of five years and make such logs available to the Administrator and the Commission upon request.⁵⁹ Further, in order to receive the discount, mobile rural health care providers will be required to provide to USAC documentation of the price for bandwidth equivalent wireline services in the urban area in the state to be covered by the project.⁶⁰ The *Order on Reconsideration* does not contain any reporting, recordkeeping, or other compliance requirements.

21. These reporting and recordkeeping requirements in the *Report and Order* will minimally impact both small and large entities. However, even though the minimal impact may be more financially burdensome for smaller entities, the minimal impact of such requirements is outweighed by the benefit of providing support necessary to make mobile telemedicine economical for rural health care providers to provide health care to rural and remote areas, and to make telecommunications rates for public and non-profit rural health care providers comparable to those paid in urban areas. Further, these requirements are necessary to ensure that the statutory goals of section 254 of the Telecommunications Act of 1996 are met without waste, fraud, or abuse.

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

22. The RFA requires an agency to describe any significant alternatives that it has considered in reaching its proposed approach impacting small business, which may include the following four alternatives (among others): (1) the establishment of differing compliance and reporting requirements or timetables that take into account the resources available to small entities; (2) the clarification, consolidation, or simplification of compliance or reporting requirements under the rule for small entities; (3) the use of performance, rather than design, standards; and (4) an exemption from coverage of the rule, or part thereof, for small entities.⁶¹

23. In this *Report and Order*, we amend our rules to improve the program, increase participation by rural health care providers, and ensure that the benefits of the program continue to be distributed in a fair and equitable manner. The actions taken in this *Report and Order* help improve the quality of health care services available in rural America, and better enable rural communities to rapidly diagnose, treat, and contain possible outbreaks of disease. Thus, rural health care providers stand to benefit directly from the modifications to our rules and policies.

24. We have taken the following steps to minimize the impact on small entities. First, to ease the transition to the new definition, we permit all health care providers that have received a funding commitment from USAC since 1998 to continue to qualify for funding for the next three years under the old definition. Thereafter, health care providers must qualify under our new definition to receive funding. We find that this transition period is necessary to allow rural health care providers to plan for the elimination of support. The alternative of not providing for a transition period was considered but rejected because we believe a transition period is necessary to allow rural health care providers to plan for the elimination of support, thus minimizing any adverse or unfair impact on smaller entities. In

⁵⁷47 C.F.R. § 54.609(e)(2)(i) as adopted herein.

⁵⁸47 C.F.R. § 54.615(c)(2) as adopted herein.

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

⁶⁰47 C.F.R. § 54.609(e)(2)(i) as adopted herein.

⁶¹See 5 U.S.C. §§ 603(c)(1)-(4).

addition, this transition period will allow us time to review the effect of this definition on smaller entities. Second, our new definition allows rural health care providers to determine their eligibility in the same manner as under the old definition. Because the old and new definitions are similar, rural health care providers will not have to adjust to a new application process. The alternative of not allowing rural health care providers to determine their eligibility in the same manner was also considered but rejected because we wanted to minimize confusion on the part of applicants. An approach that simplifies the application process for rural health care providers will help ensure that applicants, including small entities, will not be deterred from applying for support due to administrative burdens. Lastly, for mobile rural health care services, we have established a presumption that will minimize administrative burdens for all applicants, including smaller entities. Mobile rural health care providers will be required to submit to USAC an estimated number of sites the mobile rural health care provider will serve during the year. Where a mobile rural health care provider serves eight or more sites in a year, we will presume that satellite services are most cost-effective and we will not require a further showing from such providers.

F. Report to Congress

25. The Commission will send a copy of the *Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking*, including this FRFA, in a report to be sent to Congress pursuant to the Congressional Review Act.⁶² In addition, the Commission will send a copy of the *Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking*, including this FRFA, to the Chief Counsel for Advocacy of the Small Business Administration. A copy of the *Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking* and FRFA (or summaries thereof) will also be published in the Federal Register.⁶³

⁶²See 5 U.S.C. § 801(a)(1)(A).

⁶³See 5 U.S.C. § 604(b).

APPENDIX D

INITIAL REGULATORY FLEXIBILITY ANALYSIS

(FURTHER NOTICE OF PROPOSED RULEMAKING)

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

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

2. The Commission is required by section 254 of the Act to promulgate rules to implement the universal service provisions of section 254.⁴ On May 8, 1997, the Commission adopted rules that reformed its system of universal service support mechanisms so that universal service is preserved and advanced as markets move toward competition.⁵ Among other programs, the Commission adopted a program to provide discounted telecommunications services to public or non-profit health care providers that serve persons in rural areas.⁶ Important changes in the rural health community over the past few years, such as technological advances and the variety of needs of the rural health care community, prompt us to review the rural health care universal service support mechanism.⁷

3. In this *Further Notice*, we seek comment on whether we should increase the percentage discount that rural health care providers receive for Internet access.⁸ To the extent that we were concerned, in the 2003 *Report and Order*, that demand for Internet access support would exceed the annual funding cap, to date, those concerns have not come to fruition at this time. Therefore, we take this opportunity to seek comment on whether a 25 percent flat discount off the cost of monthly Internet access for eligible rural health care providers is sufficient. We also seek comment, in this *Further Notice*, on whether infrastructure development should be funded.⁹ In the 1997 *Universal Service Order*,

¹See 5 U.S.C. § 603. The IRFA, *see* 5 U.S.C. § 601 *et seq.*, has been amended by the Contract with America Advancement Act of 1996, Pub. L. No. 104-121, 110 Stat 847 (1996) (CWAAA). Title II of the CWAAA is the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA).

²See 5 U.S.C. § 603(a).

³See *id.*

⁴47 U.S.C. § 254.

⁵1997 *Universal Service Order*, 12 FCC Rcd at 9118-19, paras. 655-56.

⁶See *id.*

⁷See *Second Report and Order*, paras. 5-8.

⁸*Id.* at paras. 45-49.

⁹*Id.* at paras. 51-53.

the Commission requested comment on whether and how to support infrastructure development or “network buildout” needed to enhance public and not-for-profit health care providers’ access to advanced telecommunications and information services.¹⁰ At the time, the Commission noted that the record contained anecdotal evidence regarding the need for support for infrastructure development.¹¹ We now seek to refresh the record on this issue. Additionally, in this *Further Notice*, we seek comment on whether to modify our rules specifically to allow mobile rural health care providers to use services other than satellite.¹² In the foregoing *Report and Order*, we revise our policy to allow mobile rural health care clinics to receive discounts for satellite services calculated by comparing the actual cost of the satellite service to the rate for an urban wireline service with a similar bandwidth.¹³ However, we recognize that not only satellite services but other telecommunications platforms, such as terrestrial wireless, may provide the most cost-effective means of providing the telemedicine link. Therefore, because we want to encourage mobile health care providers to consider all available telecommunications services when determining which service best suits the needs of the telemedicine project, we seek comment on whether to allow mobile rural health care providers to use telecommunications services other than satellite.

B. Legal Basis

4. This *Further Notice* is adopted pursuant to sections 1, 4(i), (4j), 201, 202, 254, and 303 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151, 154(i), (j), 201, 202, 254, and 303.

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

5. The RFA directs agencies to provide a description of and, where feasible, an estimate of the number of small entities that will be affected by the proposed rules, if adopted.¹⁴ The RFA generally defines the term “small entity” as having the same meaning as the terms “small business,” “small organization,” and “small governmental jurisdiction.”¹⁵ In addition, the term “small business” has the same meaning as the term “small business concern” under the Small Business Act.¹⁶ A small business concern is one which: (1) is independently owned and operated; (2) is not dominant in its field of operation; and (3) satisfies any additional criteria established by the Small Business Administration (SBA).¹⁷

6. We have described in detail, *supra*, in the FRFA, the categories of entities that may be directly affected by any rules or proposals adopted in our efforts to reform the universal service rural

¹⁰1997 *Universal Service Order* at 9109-10, para. 635.

¹¹*Id.*

¹²*Id.* at para. 50.

¹³See *Report and Order* at paras. 26-32.

¹⁴5 U.S.C. § 603(b)(3).

¹⁵5 U.S.C. § 601(6).

¹⁶*Id.* § 601(3) (incorporating by reference the definition of “small business concern” in 15 U.S.C. § 632). Pursuant to 5 U.S.C. § 601(3), the statutory definition of a small business applies “unless an agency, after consultation with the Office of Advocacy of the Small Business Administration and after opportunity for public comment, establishes one or more definitions of such terms which are appropriate to the activities of the agency and publishes such definitions(s) in the Federal Register.”

¹⁷15 U.S.C. § 632.

health care support mechanism.¹⁸ For this IRFA, we hereby incorporate those entity descriptions by reference.

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

7. This *Further Notice* seeks comment on whether we should increase the percentage discount that rural health care providers receive for Internet access and whether infrastructure development should be funded.¹⁹ These potential changes will not impact reporting or recordkeeping requirements. They may, however, increase the number of applicants. Additionally, this *Further Notice* seeks comment on whether to modify our policy specifically to allow mobile rural health care providers to use services other than satellite services, such as terrestrial wireless.²⁰ If this proposal is adopted, mobile rural health care providers could potentially be required to submit additional information regarding their mobile services, if they choose to seek discounts. Any reporting and/or recordkeeping requirements adopted as part of this modification would only minimally impact both small and large entities. However, any minimal impact of such requirements would be outweighed by the benefit of providing support necessary to make mobile telemedicine economical for rural health care providers to provide high-quality health care to rural and remote areas, and to make telecommunications rates for public and non-profit rural health care providers comparable to those paid in urban areas. Further, such requirement/s may be necessary to ensure that the statutory goals of section 254 of the Telecommunications Act of 1996 are met without waste, fraud, or abuse.

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

8. The RFA requires an agency to describe any significant, specifically small business, alternatives that it has considered in reaching its proposed approach, which may include the following four alternatives (among others): (1) the establishment of differing compliance or reporting requirements or timetables that take into account the resources available to small entities; (2) the clarification, consolidation, or simplification of compliance or reporting requirements under the rule for small entities; (3) the use of performance, rather than design, standards; and (4) an exemption from coverage of the rule, or any part thereof, for small entities.²¹

9. In this *Further Notice*, we seek comment on whether we should increase the percentage discount that rural health care providers receive for Internet.²² We also seek comment on whether infrastructure development should be funded by the universal service fund.²³ Further, in this *Further Notice*, we seek comment on whether to modify our rules specifically to allow mobile rural health care providers to use services other than satellite, such as terrestrial wireless, to provide support to mobile rural health care providers.²⁴ If these proposals are adopted, we believe the proposed changes will help small businesses by providing additional support under the rural health care mechanism than is currently

¹⁸See FRFA at Appendix C, paras. 5-19.

¹⁹*Second Report and Order* at paras. 45-49, 51-53.

²⁰*Id.* at para. 50.

²¹See 5 U.S.C. § 603(c).

²²*Id.* at paras. 45-49.

²³*Id.* at paras. 51-53.

²⁴*Id.* at para. 50.

available and provide rural health care providers with greater flexibility in choosing the services that best suit their needs. These proposed changes could potentially increase the number of applicants, including small entities, seeking support under the rural health care support mechanism. Affected small businesses could include rural health care providers and small companies serving those rural health care providers. In seeking to minimize any burdens imposed on small entities, where doing so does not compromise the goals of the universal service mechanism, we invite comment on alternative ways to minimize any significant economic impact of our proposals on small entities and on any alternatives to these proposals that may be more beneficial to small entities.

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

10. None

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

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

Telecommunications technology can make a dramatic difference in the lives of patients and healthcare professionals. The transformative potential of telemedicine is happening at places such as the University of Virginia's Office of Telemedicine and University of Tennessee Telehealth Network. In Iraq, telemedicine links are allowing troops in Iraq to communicate with their loved ones in the U.S., face-to-face. With the support of our rural health care mechanism, doctors are using technology to improve health care by making telemedicine a reality in rural areas of America and across the globe.

Today's item furthers the Commission's efforts to improve the rural healthcare support mechanism to ensure that the statutory goals of section 254 of the Telecommunications Act of 1996 are met. The definition of rural has generated a lot of interest from the applicant community and I am pleased to support a decision that updates the definition based on the 2000 census data. With each revision to the program we see the positive results for rural health care providers and the people they serve. I am also pleased to support revisions to our rules to expand funding for mobile rural health care services by subsidizing the difference between the rate for satellite service and the rate for an urban wireline service with a similar bandwidth.

Lastly, in the *Further Notice*, the Commission seeks comment on whether it should increase the percentage discount that rural health care providers receive for Internet access and whether infrastructure development should be funded. Additionally, the Commission seeks comment on whether to modify its rule specifically to allow mobile rural health care providers to receive discounts for facilities other than satellite. I look forward to working with my colleagues to further unlock the potential of this program and to address the issues raised in the *Further Notice*.

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

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

This Order continues the Commission's progress in improving the rural health care support mechanism, which in turn will help deliver the promise of telemedicine to more Americans. The rural health care mechanism has been significantly underutilized for years. Our actions in the First Report and Order and in this item will better fulfill Congress's intent to lower telecommunications costs for health care providers serving rural communities.

Last year, we addressed several problems concerning the availability and calculation of discounts on telecommunications services, and we created a new discount for Internet access services. In this Second Report and Order, we correct the most significant remaining deficiency — the definition of a "rural area." The previous definition inadvertently denied support to a number of communities that bear all the usual hallmarks of rural areas (sparse populations, no large cities in the vicinity, etc.) and have a demonstrable need for support. I am confident that our revised approach will eliminate these anomalies and target funding more effectively.

I am also pleased that the Commission has developed a means of funding satellite services for mobile rural health clinics. Mobile mammography clinics operated by Healthcare Anywhere and other entities offer an invaluable service to women living on tribal lands and in other rural areas. More generally, mobile clinics can deliver cutting-edge technology and specialty care to citizens living in remote areas that lack sophisticated diagnostic tools. Mobile clinics literally can mean the difference between life and death for many people who are unable to travel long distances to see a physician. In our Further Notice issued last November, I identified this issue as a priority, and I appreciate the efforts of the staff and my colleagues to include it within the support mechanism.

Finally, I support the decision to extend support to American Samoa and other insular areas. Based on a statutory quirk, these "entirely rural" areas do not qualify for discounts under the principal support mechanism established by section 254(h)(1). But, fortunately, section 254(h)(2) authorizes the Commission to meet the needs of the insular territories.

All of these programmatic changes will translate into improved health care for millions of Americans, and are well worth celebrating.

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

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

I am pleased to support today's decision updating the Commission's rural health care support mechanism. I especially am pleased that we update our definition of rural. Our outdated and cramped definition actually disqualified communities that are considered rural under other well-established state and federal agency programs. So getting this definition right is fundamental. I hope as we move forward we can work with state and local officials for further assurance that our definition is adequate. I also am pleased that in today's decision we extend support for satellite services for mobile health clinics. There are already proposals to use this support to expand cancer screening on tribal lands. This is a great example of the creative medical services this program can inspire.

Ultimately, though, these initiatives deserve to be part of a more comprehensive goal. In the wake of 9/11 we must be awake to the heightened threat of health catastrophe and rededicate ourselves to doing something about it. In the past year, I have visited hospitals and emergency responders in big cities and small towns. I also have visited the Center for Disease Control in Atlanta. They are all attuned to the importance of fast and reliable communications, especially in the wake of a biological attack. We can continue to dance at the margins of our rural health care mechanism, or we can set a bold goal and seek to use our statutory authority to help attain it. I think that we need to demonstrate how healthcare communications are important to homeland security and our goal should be that every hospital and health center in this country has a broadband connection by 2010 and is fully integrated into the emergency response communications system. We can do this; this is the program to do it; and what a contribution that would be.

Thanks to the Bureau for bringing us this good item and for continuing work to achieve what this program is capable of achieving.

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

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

I'm pleased to support this Order which updates and strengthens the Rural Health Care program established by Congress in Section 254 of the Act. During my time as an FCC Commissioner, I have seen first hand the positive effects that telemedicine programs can have on rural communities. Telemedicine programs enable rural residents to bridge distances that might otherwise be unaffordable or physically impracticable to cross. The funding provided by the Rural Health Care program is crucial to the sustainability of many telemedicine programs. Our work on this program is what makes our jobs as public servants rewarding and should help the program fulfill its enormous potential to improve the quality of health care in Rural America.

In this Order, we take an important step by updating the definition of "rural areas" that are eligible for funding under the Rural Health Care program. Many parties argued persuasively that our prior definition of "rural areas" was overly restrictive and obsolete. I am hopeful that the definition adopted here will facilitate access to health care services for greater numbers of our underserved Americans who reside in rural areas, but understand that none of the proposed definitions was perfect. To that end, I am pleased that this Order grandfathers existing funding recipients for three years. This will give the Commission ample opportunity to gauge the effectiveness of our new definition.

The Commission takes other notable steps to improve the effectiveness of the Rural Health Care program in this Order. In particular, I am pleased that we expand funding for mobile rural health care services in this Order. The ability of mobile rural health care providers to reach hard-to-serve customers is increasingly important. For example, these services are being used to deliver high quality, real-time digital mammography services to Native American tribes in my home state of South Dakota. The Commission appropriately recognizes that satellite services may be the most cost-effective and efficient way of delivering advanced telemedicine services to mobile rural health care providers and revises the funding mechanism for these services. In addition, the Commission permits rural health care providers in entirely rural states to receive support under the program. This decision is particularly important to address the unique circumstances of health care providers serving geographically isolated areas.

Finally, I am pleased that we are continuing to look for ways to improve this program through a Further Notice. In this item, we seek comment on whether to increase the percentage discount that rural health care providers receive for Internet access and whether infrastructure development should be funded. I eagerly await the ideas that health care and service providers will offer in response to our request for more information.

My commitment to universal service is based on the fundamental belief that a chain is only as strong as its weakest link. Today we further fortify the links in our communications network and, in so doing, we strengthen our nation as a whole. That effort is worthy of the strong support we are giving this initiative today.