

Before the  
FEDERAL COMMUNICATIONS COMMISSION  
Washington, D.C. 20554

In the Matter of )  
 )  
Changes to the Board of ) CC Docket No. 97-21  
Directors of the National Exchange )  
Carrier Association, Inc. )  
 )  
Federal-State Joint Board on ) CC Docket No. 96-  
45 )  
Universal Service )  
 )

**SIXTH ORDER ON RECONSIDERATION in CC Docket No. 97-21**

**FIFTEENTH ORDER ON RECONSIDERATION in CC Docket No. 96-45**

**Adopted: September 30, 1999 Released: November 1, 1999**

By the Commission: Commissioner Ness issuing a statement.

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**I. INTRODUCTION**

1. In this *Fifteenth Order on Reconsideration*, we reconsider, on our own motion,<sup>1</sup> some of the Commission's conclusions in the *Universal Service Order*<sup>2</sup> in order to simplify the process for rural health care providers to receive support from the universal service support mechanism. Specifically, we amend our rules to permit the Universal Service Administrative Company (USAC) to provide support for any commercially available telecommunications service, regardless of the bandwidth. We further modify our rules to require USAC to calculate support based upon all actual distance-based charges, unless the rural health care provider or carrier requests a more comprehensive support calculation and substantiates that request. We affirm the conclusion reached in the *Universal Service Order* that, despite the difficulties of allocating costs and preventing abuses, the benefits of permitting rural health care providers to join consortia with other subscribers of telecommunications service outweigh the danger that such arrangements will lead to significant abuse of the prohibition on resale. Accordingly, we clarify that new members may be added to a consortium at any time after the rural health care provider applies for universal service support, and we clarify our use of the term "tariffed or market rate" to permit a rural health care provider participating in a consortium with ineligible private sector members to receive support. Finally, in order to achieve a more equitable distribution of USAC's joint and common billing and collection costs, we clarify that USAC should include these costs in the projected administrative expenses of the high-cost, low-income, schools

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<sup>1</sup> In light of pending petitions for reconsideration in this proceeding, the Commission retains jurisdiction to reconsider its own rules on its own motion. See 47 U.S.C. § 405, 47 C.F.R. § 1.108; see also *Central Florida Enterprises, Inc. v. FCC* 598 F.2d 37, 48 n.51 (D.C. Cir. 1978), cert. dismissed, 441 U.S. 957 (1979).

<sup>2</sup> *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776 (1997), as corrected by *Federal-State Joint Board on Universal Service, Errata*, CC Docket No. 96-45, FCC 97-157 (rel. June 4, 1997), affirmed, reversed, and remanded in part sub nom. *Texas Office of Public Utility Counsel v. FCC*, 183 F.3d 393 (5th Cir. 1999) motion for stay granted in part (Sept. 28, 1999), petitions for rehearing and rehearing en banc denied (Sept. 28, 1999) (*Universal Service Order*).

and libraries, and rural health care programs, based upon the volume of disbursements by each program.

## II. BACKGROUND

2. In the Telecommunications Act of 1996 (1996 Act),<sup>3</sup> Congress sought to provide rural Americans with affordable access to quality health care by giving rural health care providers the opportunity to obtain telecommunications services at urban rates. To accomplish this goal, Congress added new section 254 to the Communications Act of 1934 (the Act).<sup>4</sup> Section 254 directs telecommunications carriers to provide telecommunications services, to any rural public or non-profit health care provider, at rates that are reasonably comparable to rates charged for similar services in urban areas in the same state.<sup>5</sup> The Act further requires that universal service support mechanisms should be specific, predictable, and sufficient.<sup>6</sup>

3. Section 254 requires the Commission to institute and refer to a Federal-State Joint Board (Joint Board) under section 410(c), a proceeding to recommend changes to any of its regulations in order to implement section 254.<sup>7</sup> Accordingly, on

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<sup>3</sup> Pub. L. No. 104-104, 110 Stat. 56 (1996 Act).

<sup>4</sup> 47 U.S.C. §§ 151 *et seq.* (Act). (Hereinafter, all citations to the 1996 Act and the Act will be to the Act as it is codified in the United States Code.)

<sup>5</sup> 47 U.S.C. § 254(h)(1)(A).

<sup>6</sup> 47 U.S.C. § 254(d); *see also* 47 U.S.C. § 254(b)(5).

<sup>7</sup> 47 U.S.C. § 254(a)(1).

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March 8, 1996, the Commission adopted a *Notice of Proposed Rulemaking* in which it sought comment on ways in which to implement section 254 and referred the proceeding to the Joint Board.<sup>8</sup>

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<sup>8</sup> *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, NPRM and Order Establishing Joint Board, 11 FCC Rcd. 18092, (1996) (*Joint Board NPRM*).

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4. On June 12, 1996, the Commission established the Advisory Committee on Telecommunications and Health Care (Advisory Committee) to advise the Commission and the Joint Board on telemedicine.<sup>9</sup> The Advisory Committee, which was made up of thirty eight individuals with expertise and experience in the fields of health care, telecommunications and telemedicine, issued its report on October 15, 1996.<sup>10</sup>

5. On November 7, 1996, the Federal-State Joint Board adopted its *First Recommended Decision* regarding universal service.<sup>11</sup> In the *First Recommended Decision* the Joint Board made numerous recommendations on universal service issues including rural health care.<sup>12</sup>

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<sup>9</sup> *Universal Service Order*, 12 FCC Rcd at 9094, n.1556.

<sup>10</sup> FCC Advisory Committee on Telecommunications and Health Care, Findings and Recommendations (October 15, 1996) (Advisory Committee Report).

<sup>11</sup> *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Recommended Decision, 12 FCC Rcd 87 (1996) (*First Recommended Decision*).

<sup>12</sup> *Id.*

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6. On May 8, 1997, the Commission adopted the *Universal Service Order* beginning the implementation of section 254. The Commission concluded that any telecommunications service of a bandwidth capacity up to and including 1.544 Megabits per second (Mbps) that is necessary for the provision of health care services is eligible for support. Moreover, 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. The Commission also adopted mechanisms to provide support for limited toll-free access to an Internet service provider. Based upon generous estimates of the number of potentially eligible rural health care providers, and their service needs, and in an effort to establish support mechanisms that are specific, predictable, and sufficient, the Commission adopted an annual cap of \$400 million for universal service support for health care providers pursuant to sections 254(h)(1)(A) and 254(h)(2) of the Act.<sup>13</sup> The Commission subsequently limited the support for the first funding cycle to \$100 million.<sup>14</sup> The Commission appointed the Universal Service Administrative Company (USAC) to administer the program.<sup>15</sup>

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<sup>13</sup> *Universal Service Order*, 12 FCC Rcd at 9141, para. 705.

<sup>14</sup> *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Fifth Order on Reconsideration and Fourth Report and Order in CC Docket No. 96-45, 13 FCC Rcd 14915, 14928-14933 (1998) (*Fifth Order on Reconsideration*).

<sup>15</sup> *Changes to the Board of Directors of the National Exchange Carrier Association, Inc. and Federal-State Joint Board on Universal Service*, Second Report and Order and Second Order on Reconsideration, CC Docket No. 97-21 and 96-45, 12 FCC Rcd 18400 (1997) (*NECA Order*). In the *USAC Reorganization*

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*Order* released on November 20, 1998, the Commission directed USAC to assume responsibility for the schools and libraries support mechanism and the rural health care support mechanism effective January 1, 1999. See *Changes to the Board of Directors of the National Exchange Carrier Association, Inc., Federal-State Joint Board on Universal Service*, CC Docket Nos. 96-45, 97-21, Third Report and Order and Fourth Order on Reconsideration, and Eighth Order on Reconsideration, 13 FCC Rcd 25058 (1998) (*USAC Reorganization Order*). The Schools and Libraries Corporation (SLC) and the Rural Health Care Corporation (RHCC) previously administered these programs, respectively, which have since been merged into USAC in accordance with the *USAC Reorganization Order*. *Id.*



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7. In the first application period,<sup>16</sup> the Rural Health Care Division (RHCD) of USAC received approximately 2,500 initial applications from health care providers throughout the nation.<sup>17</sup> Yet only a small fraction of these applicants completed the application process and established their eligibility for the discounts.<sup>18</sup> RHCD estimated that no more than \$2 million would be committed to the support of rural health care providers for the first funding cycle.<sup>19</sup> Consequently, the Commission instructed USAC to: (1) evaluate ways to improve opportunities for eligible rural health care providers to take advantage of the support mechanism; (2) carefully review all of the administrative expenses associated with the rural health care mechanism, and determine where

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<sup>16</sup> The first funding cycle for the rural health care support mechanism covered the period from January 1, 1998 through June 30, 1999. *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Ninth Order on Reconsideration, FCC 98-346, (rel. Dec. 31, 1998) (*Ninth Order on Reconsideration*).

<sup>17</sup> See First Quarter 1999 Projected Demand and Expenses for the Rural Health Care Universal Service Support Program (filed Oct. 30, 1998). See also Universal Service Administrative Company Report to the FCC: Evaluation of the Rural Health Care Program at 40 (filed March 5, 1999) (USAC Report).

<sup>18</sup> USAC Report at 40. In order for a rural health care provider to receive telecommunications services at urban rates, the rural health care provider must submit a total of four forms to RHCD. USAC Report at 11-12.

(1) FCC Form 465. This is the first form that the rural health care provider must complete. It communicates the rural health care provider's interest in receiving support for telecommunications service for a new or existing telemedicine program. RHCD uses the FCC Form 465 to determine the eligibility of the rural health care provider and to solicit competitive bids for the service. 47 C.F.R. § 54.603.

(2) FCC Form 466. After the description of the service has been posted on RHCD's Internet web site for 28 days, the rural health care provider may select a carrier. The rural health care provider uses the FCC Form 466 to notify RHCD of the carrier selected.

(3) FCC Form 468. The rural health care provider must forward a FCC Form 468 to RHCD at the same time that it submits the FCC Form 466. The carrier must complete the FCC Form 468. It is used to verify the services offered and to calculate the urban/rural rate differential.

(4) FCC Form 467. A rural health care provider must submit the FCC Form 467 to RHCD after the rural health care provider begins receiving the supported services. FCC Form 467 verifies that the rural health care provider received supported services from the carrier.

<sup>19</sup> Letter from Lee E. Bailey, RHCC, to Kathryn Brown, FCC, dated October 28, 1998 (RHCC letter).

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reductions can be made, so that the expenses are commensurate with the size of the support mechanism; and (3) evaluate anticipated demand for 1999.<sup>20</sup>

8. On March 5, 1999 USAC, submitted a report with several recommendations for improving the rural health care program and for reducing administrative expenses.<sup>21</sup> USAC also provided additional information on anticipated demand.<sup>22</sup> On March 17, 1999, the Commission released a public notice seeking comments on the report.<sup>23</sup> We received eight comments and one reply comment.<sup>24</sup>

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<sup>20</sup> *Federal-State Joint Board on Universal Service, Proposed First Quarter 1999 Universal Service Contribution Factors and Proposed Actions*, CC Docket No. 96-45, Public Notice, FCC 98-318 (rel. Dec. 4, 1998).

<sup>21</sup> USAC Report at 2.

<sup>22</sup> *Id.*

<sup>23</sup> *Federal-State Joint Board on Universal Service, Universal Service Administrative Company Report to the FCC: Evaluation of the Rural Health Care Program, Pleading Cycle Established*, CC Docket Nos. 96-45 and 97-21, Public Notice, DA 99-521 (rel. March 17, 1999) (*USAC Report Public Notice*).

<sup>24</sup> See Appendix B for a list of commenters.

9. A number of the issues highlighted in the USAC Report have been, or are being, addressed elsewhere.<sup>25</sup> In this *Fifteenth Order on Reconsideration*, we reconsider, on our own motion, several of our prior conclusions with respect to the rural health care program, as highlighted by USAC and others. As a result, we clarify or make further findings to accomplish the following:

- eliminate the per-location funding limit;
- affirm that the rural health care mechanism will not provide additional support for long distance service;
- simplify the urban/rural rate calculation;
- affirm that the rural health care mechanism will not provide support for equipment;
- encourage participation in consortia;
- clarify that the definition of "health care provider" does not include nursing homes, hospices, or other long-term care facilities, and emergency medical service facilities; and
- re-allocate billing and collection expenses of the universal service support mechanisms by program size.

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<sup>25</sup> On August 5, 1999, the Commission adopted a Further Notice of Proposed Rulemaking to address the unique issues that may limit telecommunications deployment and subscribership on tribal lands and in insular areas. *Federal-State Joint Board on Universal Service, Promoting Deployment and Subscribership in Unserved, Tribal, and Insular Areas*, CC Docket No. 96-45, Further Notice of Proposed Rule, FCC 99-204 (rel. Sept. 3, 1999) (*Unserved, Tribal, and Insular Areas FNPRM*). On September 21, 1999, the Commission adopted the *Fourteenth Reconsideration Order*, in which the Commission determined that all telecommunications carriers that provide supported services to eligible health care providers under section 254(h)(1)(A), are entitled to have a credit against their universal service contribution obligation equal to the difference between the lower, urban rate they offer eligible health care providers for supported telecommunications services and the higher, rural rates that would normally be charged to these customers. *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, *Fourteenth Order On Reconsideration*, FCC 99-256 (adopted Sept. 21, 1999) (*Fourteenth Reconsideration Order*).

As a result of these modifications, we expect to improve opportunities for eligible rural health care providers to benefit from the support mechanism, and to reduce the administrative expenses associated with the mechanism. We are also hopeful that these changes will encourage more rural health care providers to participate in the rural health care program.

### III. SCOPE OF SERVICES ELIGIBLE FOR SUPPORT

#### A. Per-Location Funding Limit

##### 1. Background

10. The types of services eligible for universal service support limit the benefits available to rural health care providers. Section 254(c) gives the Commission and the Joint Board the responsibility for defining a group of core services eligible for federal universal service support.<sup>26</sup> Section 254(c)(3) also provides that, in addition to the "core" services described under the provisions of section 254(c)(1), the Commission "may designate additional services for such support mechanisms for . . . health care providers for the purposes of subsection (h)." Section 254(h)(1)(A) states:

Health care providers for rural areas.--A telecommunications carrier shall, upon receiving a bona fide request, provide telecommunications services which are necessary for the provision of health care services in a State, including instruction relating to such services, to any public or nonprofit health care provider that serves persons who reside in rural areas in that State at rates that are reasonably comparable to rates charged for similar services in urban areas in that State.<sup>27</sup>

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<sup>26</sup> 47 U.S.C. § 254(c)(1).

<sup>27</sup> 47 U.S.C. § 254(h)(1)(A).

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11. On October 15, 1996, the Advisory Committee issued a report that, among other things, recommended that the Commission limit universal service support to services of bandwidths up to and including 1.544 Mbps<sup>28</sup> or its equivalent.<sup>29</sup> The Advisory Committee explained that this is the minimum bandwidth necessary to allow eligible rural health care providers to access the basic set of telecommunications applications necessary for health care in rural areas.<sup>30</sup> The Advisory Committee developed a "market basket" of telemedicine services as a guide to estimate what level of telecommunications services would be necessary to support rural telemedicine.<sup>31</sup>

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<sup>28</sup> 1.544 Mbps is a digital rate of data transmission of 1,544,000 bits per second.

<sup>29</sup> Advisory Committee Report at 1-2.

<sup>30</sup> *Id.*

<sup>31</sup> *Id.* at 6. The "market basket" included the following telemedicine applications: (1) health care provider to health care provider consultation; (2) health care provider to patient consultation; (3) continuing medical education; (4) access to the most current medical information through the Internet; (5) support from on-call physicians and specialists at urban centers or at local physician offices; (6) transmission of high speed data and high quality images to urban medical centers for specialty services; and (7) interaction with health care providers at the site of emergencies. *Id.*

The Advisory Committee stressed that the minimum package should not be limited to telemedicine applications in the "market basket."<sup>32</sup> According to the Advisory Committee, "[t]he eligible health care provider should be able to use the telecommunications services in the minimum package for any telemedicine applications the health care provider determines necessary."<sup>33</sup> The Advisory Committee noted that "this is especially important since needed applications in rural areas may differ from those needed in urban areas."<sup>34</sup> The Advisory Committee believed that "prices of services, even at discounted rates, will serve to self-monitor use of discounted services."<sup>35</sup> Accordingly, the Advisory Committee recommended that rural health care providers be given support for any telecommunications services that they choose within bandwidths up to and including 1.544 Mbps.<sup>36</sup>

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<sup>32</sup> *Id.* at 7.

<sup>33</sup> *Id.*

<sup>34</sup> *Id.*

<sup>35</sup> *Id.*

<sup>36</sup> *Id.*

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12. The Joint Board recommended support for telecommunications services, and made no recommendation as to the exact scope of services to be supported.<sup>37</sup> Instead, the Joint Board recommended seeking further information on this topic.<sup>38</sup> Consistent with the Joint Board's recommendation, the Commission issued a *Recommended Decision Public Notice* seeking information about the exact scope of services that should be included in the definition of services "necessary for the provision of health care in a State."<sup>39</sup> The Commission also requested input on the relative costs and benefits of supporting technologies and services that require bandwidths higher than 1.544 Mbps.<sup>40</sup>

13. Based upon the recommendations of the Advisory Committee and the majority of commenters, the Commission found that higher bandwidth services were not necessary for the provision of health care services in a state.<sup>41</sup> The Commission also found that the record "indicates vastly higher costs implicated in supporting services that employ bandwidths higher than 1.544 Mbps."<sup>42</sup> The Commission noted:

We are mindful of the need to balance the needs of persons residing in rural areas of the state for telecommunications services necessary for the provision of health care with the costs of such services. This need for balance, coupled with most commenters' assertions that services with bandwidth greater than 1.544 Mbps are presently unnecessary for the provision of health care leads us to conclude that the cost of supporting such higher bandwidth services greatly exceeds the potential benefits of supporting such services at this time.<sup>43</sup>

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<sup>37</sup> *First Recommended Decision*, 12 FCC Rcd at 421, para. 656.

<sup>38</sup> *Id.*

<sup>39</sup> *Federal-State Joint Board on Universal Service, FCC Common Carrier Bureau Public Notice Seeking Comment on Universal Service Recommended Decision*, CC Docket No. 96-45, Public Notice, DA 96-1891 (rel. Nov. 18, 1996).

<sup>40</sup> *Id.* at 2.

<sup>41</sup> *Universal Service Order*, 12 FCC Rcd at 9103, para. 622.

<sup>42</sup> *Id.*

<sup>43</sup> *Id.* (citations omitted).

Accordingly, the Commission concluded that rural health care providers would be eligible to receive support only for telecommunications service employing a transmission speed up to 1.544 Mbps (T-1).<sup>44</sup> The Commission further concluded that "telecommunications carriers should not determine what telecommunications services health care providers should use or which should be eligible for support, because we believe that health care providers are best able to determine what telecommunications best meet their needs and are within their budgets."<sup>45</sup>

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<sup>44</sup> *Id.*

<sup>45</sup> *Universal Service Order*, 12 FCC Rcd at 9103, para. 622 (citations omitted).



14. Section 54.613 of the Commission's rules provides that each rural health care provider is limited to one supported T-1 connection.<sup>46</sup> A rural health care provider may purchase more than one T-1 connection, but only one, within the Commission's distance limitation, would be supported by universal service funds.<sup>47</sup> If a rural health care provider chooses to subscribe to service with a lesser bandwidth, it may purchase more than one connection subject to universal service support, but the total annual support for these connections may not exceed the annual amount of support that would be available for one T-1 connection.<sup>48</sup> This amount, equal to the annual support for one T-1 connection, constitutes the maximum annual support amount or the "per location funding limit" (PLFL).<sup>49</sup> Eligible services with a lesser bandwidth include Frame Relay, Private Line Transport, ISDN, satellite communications, unlicensed spread spectrum, non-consumer point-to-point, and similar services.<sup>50</sup>

15. USAC reports that this limitation on eligible services has severely limited the benefits available to rural health care providers in the program.<sup>51</sup> Specifically, USAC notes that the rural health care providers indicate that:

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<sup>46</sup> 47 C.F.R. § 54.613.

<sup>47</sup> *Id.*

<sup>48</sup> *Id.*

<sup>49</sup> *Id.*

<sup>50</sup> *Universal Service Order*, 12 FCC Rcd at 9104, para. 624.

<sup>51</sup> USAC Report at 36.

While a number of services are included in the Program such as plain old telephone service (POTS), ISDN, Frame Relay, T-1, 56k, Centrex, and toll charges for Internet service providers, actual support is limited to the portions of those services with a mileage component which is provided by the ETCs.<sup>52</sup> RHCD staff has found that POTS rates are generally the same in rural and urban areas and consequently are not eligible for support under this Program. Support for ISDN, Frame Relay, and Centrex is limited to the mileage-based link extension. In the case of Internet service providers, service is generally provided on a toll-free basis, so actual support is minimal.<sup>53</sup>

16. Further, USAC has discovered that, in some cases, although there may be no difference between the urban and rural rates for a T-1, there is a difference between the urban and rural rates for certain services with a lesser bandwidth.<sup>54</sup> A survey

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<sup>52</sup> ETC is an acronym for eligible telecommunications carrier. Section 214(e)(1)(A) requires an ETC to "offer the services that are supported by Federal universal service support mechanisms under section 254(c)." 47 U.S.C. § 214(e)(1)(A). Pursuant to section 254(c), the Commission, based on the recommendation of the Federal-State Joint Board, determined that the following services or functionalities will be supported by universal service mechanisms: voice-grade access to the public switched network; local usage; dual tone multi-frequency signaling; single-party service; access to emergency services; access to operator services; access to interexchange service; access to directory assistance; and toll limitation for qualifying low-income customers. See 47 C.F.R. § 54.101(a)(1)-(9). Accordingly, in order to be designated as an ETC, a carrier must offer each of these services or functionalities.

<sup>53</sup> USAC Report at 36.

<sup>54</sup> *Id.* at 21.

conducted by the Rural Policy Research Institute (RUPRI) confirms that few rural health care providers participated in the rural health care program because of the per-location funding limit.<sup>55</sup>

## 2. Discussion

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<sup>55</sup> RUPRI comments at 2.

17. We eliminate the per-location funding limit because it has made it more difficult for rural health care providers to receive the benefits of the rural health care support mechanism, and it is no longer necessary to ensure that demand for support remains below the \$400 million per year cap that the Commission established in the *Universal Service Order*. We believe that eliminating the per-location funding limit will make it easier for rural health care providers to select and receive support for the telecommunications services that they need for telemedicine. We find that, even if USAC substantially underestimated the demand for support by rural health care providers, demand would still be well within the \$400 million cap. Moreover, we find that the Commission's initial decision to limit support to a T-1 or some combination of lesser services was driven by two express concerns that are no longer relevant.<sup>56</sup> We further find that, because the per-location funding limit imposes some cost and generates no apparent benefit, it would be contrary to the public interest to maintain it. Accordingly, we conclude that the universal service support mechanism for rural health care providers shall support any commercially available telecommunications services, necessary for the provision of health care services in a state, regardless of the bandwidth, and we revise section 54.613 of the Commission's rules to reflect this change.

18. Based upon the information in the record, we find that the Commission's initial demand estimate was much too high. Section 254(g) directs that universal service support mechanisms should be specific, predictable, and sufficient.<sup>57</sup> The only qualification, in section 254(h)(1)(A), of the type of telecommunications service that may be supported is the requirement that the telecommunications service be "necessary for the provision of health care services in a [s]tate."<sup>58</sup> In order to establish a "specific, predictable, and sufficient" mechanism for a program with no track record, the Commission concluded that it must limit the telecommunications services that a rural health care provider may receive for the provision of health care services in a state.

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<sup>56</sup> See *Universal Service Order*, 12 FCC Rcd at 9104, para. 623.

<sup>57</sup> 47 U.S.C. § 254(g).

<sup>58</sup> See 47 U.S.C. § 254(h)(1)(A).

19. The Commission's original estimate for the cost of the program predicted that maximum demand for support would be \$366 million per year.<sup>59</sup> The Commission arrived at this conclusion without the benefit of expert assessment of the cost of leaving rural health care providers free to purchase whatever telecommunications services they deemed necessary for the provision of health care.<sup>60</sup> According to the USAC Report, "[t]he best current estimates show that this Program is not likely to exceed \$10 million in annual support level in the near term."<sup>61</sup> Specifically, the USAC Report estimates that the total demand for support for rural health care providers will not exceed \$3.1 million for the 18 month period from January 1, 1998 through June 30, 1999.<sup>62</sup> USAC projects that the total demand for rural health care provider support for the second funding year (July 1, 1999 through June 30, 2000) will be no more than \$9.3 million.<sup>63</sup> Although armed with a significantly more comprehensive set of data than used in the *Universal Service Order*, USAC estimates that, even if we remove the per-location funding limit, demand would not exceed \$10 million per year. Apparently, as the Advisory Committee believed, the urban rates for telecommunications services are costly enough to deter rural health care providers from demanding excessive levels of telecommunications service.<sup>64</sup> USAC also reports that there are a number of other factors that have served

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*Universal Service Order*, 12 FCC Rcd at 9142, para. 707.

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*Universal Service Order*, 12 FCC Rcd at 9141, para. 705.

61

USAC Report at 3.

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*Id.* at 2.

63

*Id.*

64

See Advisory Committee Report at 1-2.

to reduce demand, which we discuss below. Accordingly, we conclude that, beginning with the third funding cycle, the universal service support mechanism for health care providers will support all commercially available telecommunications services necessary for the provision of health care services, and that this expansion of eligible telecommunications services will not increase demand beyond the funding cap.

20. The Commission's initial decision to limit support to a T-1 or some combination of lesser services was based upon two factors that are now irrelevant, given that there is little risk of demand exceeding the cap. First, the Commission's initial decision to limit support to a T-1 or some combination of lesser services was based in part upon a finding that the record did not demonstrate that rural health care providers would require higher bandwidths than T-1.<sup>65</sup> Specifically, the Commission found that the Advisory Committee and the majority of commenters who recommended a specific level of telecommunications bandwidth recommended a capacity of up to and including 1.544 Mbps or its equivalent.<sup>66</sup> The Advisory Committee and the majority of commenters contended that rural health care providers did not need higher bandwidths for the provision of health care services, and that the cost of higher bandwidth connections would outweigh the benefits.<sup>67</sup> It is still unclear to us whether rural health care providers need services with greater or lesser bandwidth than 1.544 Mbps for the provision of health care. On the one hand, the Rural Utilities Service (RUS) argues that the current supported bandwidth of 1.544 Mbps may be inadequate because, with the rapid evolution of high-speed broadband networks approaching the 1.544 Mbps capability, the medical community's needs are expected to significantly exceed this level in the near future.<sup>68</sup> On the other hand, the National Rural Health Association (NRHA) asserts that it appears that many telehealth applications are moving away from dedicated point-to-point T-1 type services to switched, lower bandwidth applications such as ISDN and POTs.<sup>69</sup> Further, a letter jointly filed by the American Telemedicine Association, the American College of Nurse Practitioners, the Association of Telemedicine Service Providers, and the NRHA states that:

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<sup>65</sup> *Universal Service Order* at 9103, para. 622 (citations omitted).

<sup>66</sup> *Id.* at 9101, para. 621 (citations omitted).

<sup>67</sup> *Id.* at 9103, para. 622 (citations omitted).

<sup>68</sup> RUS comments at 4.

<sup>69</sup> NRHA comments at 1.

The program should include discounts for all forms of communications services when used in the delivery of health care to rural health care providers. As currently designed, services eligible for the rural health care program are effectively limited to a T1 line, largely because of the use of distance costs associated with this service. However, advancements over the past few years in technology and communications have enabled health care providers to transmit and receive information at speeds lower than that required of T1 lines. Although lower in cost, this still remains an impediment to many health providers due to the few resources available in support of rural health care.<sup>70</sup>

21. We, therefore, affirm our finding in the *Universal Service Order* that rural health care providers are best able to determine what telecommunications services best meet their needs;<sup>71</sup> moreover, we find that allowing rural health care providers to choose the transmission speeds necessary for health care services in rural areas, outweigh our need to determine with certainty the required bandwidth. Accordingly, we conclude that, given that the per-location funding limit is not necessary for keeping demand on the fund within the \$400 million cap, as long as the telecommunications services are necessary for health care services in rural areas, there is little reason to ascertain definitively whether rural health care providers need telecommunications services with greater or lesser bandwidth than T-1.

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USAC Report at Appendix B, page 54.

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See *Universal Service Order*, 12 FCC Rcd at 9103, para. 622 (citations omitted).

22. The second reason that the Commission decided to support only bandwidths up to 1.544 Mbps was because it agreed with the parties who weighed the cost of higher services against the benefits<sup>72</sup> and found that the limited data suggested that the cost of higher bandwidths could unnecessarily increase the cost of the program by a significant amount.<sup>73</sup> While very few respondents to the *USAC Report Public Notice* discussed the cost of supporting higher services, the USAC Report suggests that the cost of higher bandwidths would not unnecessarily increase the cost of the program by a significant amount.<sup>74</sup>

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*Id.*

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*Id.* at n.1617.

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USAC Report at 41-42.



23. More importantly, it appears from the record, particularly the USAC Report, that maintaining the current limits on services does not adequately serve the public interest. That is, regardless of whether rural health care providers need services with greater or lower bandwidth, the public interest would be better served by allowing rural health care providers to have affordable access to all modern telecommunications services necessary to provide medical services. The majority of interested parties in this proceeding assert that the per-location funding limit imposed by the Commission's rules increases the cost of participating in the program, while reducing the value of the potential benefit that a rural health care provider may receive. For example, USAC reports that one of the costs of the restriction is that it discourages some rural health care providers from seeking services.<sup>75</sup> This is in part because of the complexity of securing some combination of services of less than 1.544 bandwidth.<sup>76</sup> Specifically, in May 1999, USAC reported that "calculation of the PLFL for each applicant to this program has taken a significant amount of effort by carriers and RHCD staff."<sup>77</sup>

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*Id.* at 35. See also RUS comments at 4; Letter from James Bradford Ramsay, the National Association of Regulatory Utility Commissioners, to Irene Flannery, FCC (filed Sept. 9, 1999).

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Alaska comments at 4.

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Letter from Robert Haga, USAC, to Magalie Roman Salas, FCC, at 5 (filed May 14, 1999) (USAC letter). USAC further reported that,

carriers filling out Form 468 typically calculate the PLFL using the actual circuit distance

Consistent with the findings reported by USAC, RUS asserts that the Commission's rules significantly limit the value of the support provided by the program.<sup>78</sup>

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rather than the maximum allowable distance (MAD), as specified in the Form 468 instructions. If the circuit distance is very short or zero (for some services, the metered circuit distance may be zero or only to the carrier's nearest office), the PLFL may appear very small. To recalculate the PLFL using the MAD, we must contact carriers to determine what a hypothetical T-1 to the MAD would cost. This may be complicated as the carrier may not offer a T-1 circuit and/or does not know the rate beyond their territory. We must then go to additional carriers in the state to complete the calculation.

*Id.*  
78

RUS comments at 4.

24. Finally, we reject the argument by USTA that any change to the Commission's rules that would expand the class of eligible services would be inconsistent with the Act.<sup>79</sup> Although USTA admits that the per-location funding limit could be made simpler to administer,<sup>80</sup> USTA argues that the Commission should not expand the scope of eligible services for the sole purpose of increasing demand to the level that we previously anticipated would be reached.<sup>81</sup> We agree with USTA that the Commission should not expand the scope of eligible services solely for the sake of increasing demand. Instead, we expand the scope of eligible services because the current restrictions are in large part the result of the per-location funding limit, and for the reasons discussed above, we now reject the per-location funding limit. The per-location funding limit is not necessary to ensure that demand for support remains below the \$400 million per year cap. We find that demand will be sufficiently limited by the statutory requirement that supported telecommunications services must be necessary for the provision of health care. Moreover, as previously discussed, we find that a rural health care provider is ill served by our current rule, which further limits the rural health care provider's choices to telecommunications services within bandwidths up to and including 1.544 Mbps, and limits the total amount of support that a rural health care provider can receive to the cost of one T-1 connection.<sup>82</sup> We believe that a rural health care provider may under some circumstances need, for the provision of health care services, telecommunications services with a higher bandwidth than 1.544 Mbps; a single service with a lesser bandwidth that requires more support than a T-1; or a number of services with lesser bandwidth that together require more support than one T-1. Accordingly, while we recognize that removing the per-location funding limit will potentially increase the amount of support for services that are already eligible for support, and expand the list of eligible services, we conclude that this result is consistent with the Act.

## B. Long Distance Charges

### 1. Background

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See USTA comments at 7.

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Notice of *Ex Parte* Presentation, from Mary Henze, USTA, to Magalie Roman Salas, FCC (April 29, 1999) at 2 (USTA *ex parte*).

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*Id.*

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See 47 C.F.R. § 54.613(b).

25. When the Commission first sought to identify which services to support, the Joint Board declined to recommend support for charges for transmissions crossing LATA boundaries, because the record had insufficient information about the cost of reducing or eliminating such charges to justify such a recommendation.<sup>83</sup> After seeking further comment on these issues, the Commission found no need for the rural health care mechanism to provide support for LATA crossing charges,<sup>84</sup> because the statute already requires that rates charged to health care providers in rural areas be no higher than the rates charged in urban areas.<sup>85</sup> In addition, the Commission noted that, to the extent that the term "LATA-crossing charges" refers to access charges for a service provided to a rural customer, the mechanisms adopted in the *Universal Service Order* would support such charges by supporting the difference between the rural rate and the urban rate.<sup>86</sup> Finally, the Commission noted that, with increasing competition, charges

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*First Recommended Decision*, 12 FCC Rcd at 428, para. 672.

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*Universal Service Order*, 12 FCC Rcd at 9132, para. 682.

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*Id.* Section 254(g) states:

rates charged by providers of interexchange telecommunications services to subscribers in rural and high cost areas shall be no higher than the rates charged by each such provider to its subscribers in urban areas.

47 U.S.C. § 254(g).

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related to LATA crossing are likely to become less burdensome.<sup>87</sup> On the other hand, USAC reports that one of the barriers to greater participation in the rural health care support program is the lack of support for long distance service.<sup>88</sup>

## 2. Discussion

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<sup>87</sup> *Universal Service Order*, 12 FCC Rcd at 9132, para. 682.

<sup>88</sup> *Id.* at para. 683.

USAC Report at 4.

26. Based upon the information in this record, we remain unconvinced that the rural health care program should provide additional support for long distance and toll charges, with the exception of support for toll charges incurred by accessing an Internet service provider (for those unable to secure toll-free Internet access). We find that section 254(h)(1)(A) does not obligate telecommunications carriers to deliver service to rural health care providers at rates that are less than those charged to urban health care providers. We note that section 254(h)(1)(A) directs telecommunications carriers to deliver service to rural health care providers at rates that are reasonably comparable to those charged to health care providers in urban areas of the state. Further, we note that, although many of the commenters argue that using long distance service makes it more expensive for rural health care providers to engage in the practice of telemedicine, none have argued that telecommunications carriers charge more for long distance service provided to rural health care providers than for similar service provided to urban residents.<sup>89</sup> Based on the record before us, therefore, we find no basis for providing additional support for long distance and toll charges.

### C. Urban/Rural Rate Calculation

#### 1. Background

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For example, the Utah Department of Health argues that the long-distance telecommunications cost is more of an issue for rural health care providers than the cost of the services provided. Utah Department of Health comments at 1. The Office for the Advancement of Telehealth, Health Resources and Services Administration of the Health and Human Services Department (OAT) reports that "the program's eligible telecommunications services do not cover important services such as toll services or the distance component of ISDN or frame relay," and that these services are "critical to many telemedicine projects and often more costly for users in rural areas." OAT comments at 2. RUS similarly argues that "[l]ong distance and toll charges are among the increased costs of rural telemedicine compared to urban telemedicine," and that "the medical expertise available in most urban centers is more than just a local call away from rural areas." RUS comments at 4.

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27. Section 254(h)(1)(A) states that "[a] telecommunications carrier shall ... provide telecommunications services ... to any public or non-profit health care provider ... at rates that are reasonably comparable to rates charged for similar services in urban areas in that State."<sup>90</sup>

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47 U.S.C. § 254(h)(1)(A).

The Joint Board recommended that the Commission define the "urban rate" as the highest tariffed or publicly available rate actually being charged to commercial customers within the jurisdictional boundary of the nearest large city in the same state as the rural health care provider.<sup>91</sup> The Joint Board further recommended that "comparable" be defined as no higher than the highest rate charged in the nearest large city.<sup>92</sup> Although the Advisory Committee stated that support for some distance-based charges is necessary to ensure that rates charged to rural health care providers are "reasonably comparable" to urban rates,<sup>93</sup> the Joint Board declined to recommend support for distance-based charges because it concluded that the record lacked sufficient evidence upon which to base such a recommendation.<sup>94</sup>

28. The Commission agreed with the Joint Board and interpreted section 254(h)(1)(A) as requiring telecommunications carriers to charge rural health care providers a rate for supported service that is no higher than the highest tariffed or publicly available rate charged by a carrier to a commercial customer for a similar service, in the state's closest city.<sup>95</sup> Based upon the recommendation of the Joint Board, the Commission also determined that the closest city would be the city,

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*First Recommended Decision*, 12 FCC Rcd at 426, para. 667; see also *Universal Service Order*, 12 FCC Rcd at 9124, para. 667.

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*Id.*

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Advisory Committee Report at 2.

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*First Recommended Decision*, 12 FCC Rcd at 428, para. 672; see also *Universal Service Order*, 12 FCC Rcd at 9124, para. 668.

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



measured by airline miles from the rural health care provider's location to the closest point on the city's boundary, with a population of at least 50,000.<sup>96</sup>

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*Id.* at 9121, para 670.

29. After gathering additional information, the Commission concluded that the rural health care support mechanism shall include, in the calculation for support, the distance-based charges for the distance between the rural health care provider and the nearest large city.<sup>97</sup> The Commission defined "distance-based charges" as charges based on a unit of distance, such as mileage-based charges.<sup>98</sup> Recognizing that urban health care providers are not exempt from distance-based charges in connection with their purchase of telecommunications services, the Commission took into account the potential distance-based charges paid by urban providers on a statewide basis. The Commission did this by directing the Administrator to take the longest diameters of all cities with a population of 50,000 or more within each state, and to average them to arrive at each state's standard urban distance (SUD).<sup>99</sup> The Commission then instructed the Administrator to treat a rural health care provider as if it is located in the nearest large city in the state.<sup>100</sup> That is, if a rural health care provider requested that a service be provided over a distance that is less than or equal to its state's SUD, then the rural health care provider would have to pay the actual rate charged for a similar service provided over the same distance in the nearest large city.<sup>101</sup> If the rural health care provider requested that a service be provided over a distance that is greater than its state SUD, the rural health care provider would only have to pay the rate charged for a similar service provided over the SUD.<sup>102</sup>

30. The Commission explained that it is consistent with the statute to consider distance-based charges because, "many, if not most, base rates for telecommunications services are averaged across a state or study area. It is often distance-based charges, not differences between base rates for service elements, that create great disparities in the overall cost of telecommunications services between urban and rural areas."<sup>103</sup> The Commission further noted that several local exchange carriers (LECs) contend that a

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*Id.* at 9128, para. 674.

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*Id.*

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*Id.* at 9131, para. 680.

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*Id.*

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*Id.* at 9131, para. 681.

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*Id.*

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*Id.* at 9128, para. 675 (citations omitted).

rural rate is "reasonably comparable" to an urban rate provided that per-mile charges are the same for rural and urban areas.<sup>104</sup> Based upon this record, the Commission determined that ensuring that rates charged to rural health care providers are "reasonably comparable" to urban rates requires support for not only the difference in base rates, but for some distance-based charges as well.<sup>105</sup>

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*Id.*

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*Id.*

31. According to the USAC Report, the current method of calculating support is so complex and time consuming that many rural health care providers and carriers have been reluctant to participate in the program.<sup>106</sup> USAC proposes resolving the problems associated with ascertaining the rate differential in one of two ways: (1) by establishing statewide average discount percentages to apply to the rural base rates and/or distance sensitive charges for eligible services; or (2) by recognizing that long-distance charges represent a rate difference between urban and rural service, and, therefore, using long-distance charges as the basis for support.<sup>107</sup> USTA, on the other hand, proposes that the Commission determine that most charges, other than mileage, for telecommunications service in rural areas are already comparable to those in urban areas.<sup>108</sup> USTA, therefore, urges the Commission to focus on supporting all actual distance-based charges, minus a "standardized standard urban distance," up to a maximum allowable distance.<sup>109</sup> USTA further suggests that, in the few cases where there is a difference between the base rates for services in urban and rural areas, the Commission should give rural health care providers the option to request a more comprehensive rate comparability calculation along the lines of the current process.<sup>110</sup>

## 2. Discussion

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USAC Report at 5.

107

*Id.* at 4.

108

USTA *ex parte* at 2.

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*Id.*

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*Id.*

32. In light of the entire record now before us, we determine that most of the base rates for telecommunications service elements charged to rural health care providers are already reasonably comparable to those charged in urban areas. This position is consistent with USTA's recommendation.<sup>111</sup> Accordingly, we conclude that the Administrator need not compare the tariffed or publicly available base rates for telecommunications service elements to determine the amount of support that it can provide for the benefit of a rural health care provider. We, therefore, direct that, beginning with the third funding cycle, the Administrator must calculate support based upon all actual distance-based charges.

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See USTA *ex parte* at 3.

33. At the time that the rural health care program was established, the Commission did not realize the extent to which directing the parties to identify the highest tariffed or publicly available rate actually being charged to urban customers, in order to set rates for telecommunications services "that are reasonably comparable to rates charged for similar services in urban areas in that State," would consume an unwarranted amount of resources for very little benefit. In the *Universal Service Order*, the Commission specifically acknowledged that most base rates for telecommunications services are averaged across a state or study area, and concluded, therefore, that it is often the distance-based charges that account for the difference between the urban and rural rates charged to rural health care providers.<sup>112</sup> As a result, the Commission directed that, in addition to providing rural health care providers with support for the difference between the highest tariffed or publicly available rate actually being charged to urban customers and the rate charged to the rural health care providers (i.e. the base rates for telecommunications service elements), the Administrator must also provide support for distance-based charges.<sup>113</sup> We have since learned that, because of the need to refer to the various tariffs,<sup>114</sup> calculating the difference between the urban and

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*Universal Service Order*, 12 FCC Rcd at 9129, para. 675.

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*Id.*

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See 47 C.F.R. § 54.605(b). Section 54.605(b) of the Commission's rules provides that:

If a rural health care provider requests an eligible service to be provided over a distance that is greater than the "standard urban distance" for the state in which it is located, the

rural base rates for telecommunications service elements is extremely labor intensive.<sup>115</sup> For many carriers and rural health care providers, the cost of calculating the difference between the urban and rural base rates for telecommunications service elements outweighs the benefits of participating in the rural health care program, because it is the distance charges that account for the rate differences of any significance.<sup>116</sup> For example, Alaska argues that FCC Forms 466 and 468 should be simplified because,

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urban rate shall be no higher than the highest tariffed or publicly-available rate charged to a commercial customer for a similar service provided over the standard urban distance in the nearest large city in the state, calculated as if the service were provided between two points within the city.

*Id.*  
115

116 See USAC letter at 5; USAC Report at 33.

USTA *ex parte* at 2.

[r]equirements for detailed diagramming of circuits have proven confusing and time-consuming to some LECs in Alaska. Rural health care providers throughout the State have often encountered complaints or resistance from telecommunications carriers with respect to this task. Moreover, the information is also of questionable value, particularly when the rate for the service provided is not distance-sensitive.<sup>117</sup>

Because the failure to properly calculate the difference between the urban and rural base rates for telecommunications service elements must be corrected by the Administrator, this activity has proven to be a burden for the Administrator as well.<sup>118</sup>

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Alaska comments at 4.

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USAC letter at 5; USAC Report at 5.



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34. We, therefore, simplify the method for calculating support found in section 54.609 of the Commission's rules.<sup>119</sup> Consistent with the approach proposed by USTA in response to the *USAC Report Public Notice*, we direct the Administrator to consider the base rates for telecommunications services elements in rural areas to be reasonably comparable to the base rates charged for similar telecommunications service elements in urban areas in that state. The Administrator, therefore, shall not include these charges in calculating support. In addition, we direct the Administrator to treat a rural health care provider as if it is located in the nearest large city in the state, in the same manner as it does under the current rules.<sup>120</sup> That is, if the requested service distance is less than or equal to the SUD for the state, the distance-based charge for that service

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The process for calculating support under the current rules is as follows. According to section 54.609 of the Commission's rules, the amount of support due to a carrier for providing an eligible telecommunications service to an eligible rural health care provider is equal to the difference between the urban and rural rates. 47 C.F.R. § 54.609. The urban rate depends on the standard urban distance of the state in which the health care provider is located. 47 C.F.R. § 54.605. It is the responsibility of RHCD to establish the "standard urban distance." *Id.* The standard urban distance is the average of the longest diameters of all cities with a population of 50,000 or more within the state. *Id.* If the requested service distance is less than or equal to the "standard urban distance" for the state, the charge for that service can be no higher than the rate charged for a similar service transmitted the length of the "standard urban distance" in the large city nearest to the rural health care provider (urban rate). *Id.* If the requested service distance is greater than the "standard urban distance" for the state, but less than the maximum allowable distance (i.e., the distance between the rural health care provider and the point on the boundary of the nearest large city, that is most distant from the location of the rural health care provider), the charge for that service can be no higher than the rate charged for a similar service in the large city nearest to the health care provider (urban rate) over the standard urban distance. *Id.* If the requested service distance is greater than the maximum allowable distance, the charge for that service can be no more than the rate charged for a similar service, transmitted the length of the SUD, in the large city nearest to that rural health care provider (urban rate), plus the distance charges based on the rural rate for the distance that exceeds the allowable distance. *Id.*

Carriers can determine the amount of credit or reimbursement for which they qualify by subtracting from the rural rate the urban rate that would have been charged to the eligible rural health care provider if it were an urban subscriber to the service. 47 C.F.R. § 54.609. The rural rate, used to determine the credit or reimbursement that must be given to a carrier, is the average of the rates charged to commercial customers, other than health care providers, for identical or similar services in the same rural area in which the rural health care provider is located. 47 C.F.R. § 54.607. If there are no tariffed or publicly available rates for such services in the rural area, or if the carrier reasonably determines that the method for calculating the rural rate is unfair, the carrier can, in accordance with section 54.607(b)(1)-(2) of the Commission's rules, submit for the state commission's approval (for intrastate rates) or the Commission's approval (for interstate rates), a cost-based rate for providing the service in the most economically efficient, reasonably available manner. *Id.*

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See 47 C.F.R. § 54.605.

can be no higher than the distance-based charged for a similar service over the same distance in the large city nearest to the rural health care provider.<sup>121</sup> If the requested service distance is greater than the SUD for the state, but less than the maximum allowable distance, the distance-based charge for that service can be no higher than the distance-based charged for a similar service, transmitted the length of the SUD, in the large city nearest to the rural health care.<sup>122</sup>

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*Id.*

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*Id.* The following examples illustrate the application of this method of calculating support. If the SUD is 10 miles, and the distance from the nearest large city to the rural health care provider is 9 miles, the rural health care provider would not qualify for support for the distance-based charges, because the distance-based charges would amount to no more than would generally be required of a health care provider located within the nearest large city. If the distance from the nearest large city to another rural health care provider is 110 miles, the carrier must treat the rural health care provider as if it is located in the nearest large city, and, therefore, may not charge that rural health care provider for a distance greater than the SUD (10 miles). Consequently, if the carrier charges \$10 per mile, it may only charge the second rural health care provider \$100. The carrier must send an invoice to RHCD to obtain reimbursement for the balance (\$1,000). In the event that the maximum allowable distance is 100 miles, RHCD may not consider any distance above 100 miles in calculating the support. As in the previous scenario, treating the rural health care provider as if it is located within the nearest large city would require the rural health care provider to pay \$100; however, because RHCD would not authorize reimbursement for any mileage greater than the MAD, the carrier would also charge the rural health care provider for the extra 10 miles. Consequently, the rural health care provider would have to pay a total of \$200, and the carrier would be entitled to reimbursement for \$900.

35. Consistent with the approach proposed by USTA, we also conclude that, in the event a rural health care provider or carrier can establish that there is a difference between the urban and rural base rates charged for a telecommunications service, the rural health care provider or the telecommunications carrier may request a more comprehensive rate comparability calculation consistent with the Commission's current rules.<sup>123</sup> We note that it would not be feasible for the Administrator to document the tariffed or publicly available urban rates for all commercially available telecommunications services to establish a benchmark for comparison of the base rates of telecommunications service elements. Consequently, in the rare instance where there is a difference between the urban and rural base rates for services, we require the rural health care provider or carrier to provide the evidence thereof.

36. We do not modify our rules to require the Administrator to deduct a standardized SUD from the total distance-based charge. We believe that such an approach would generally result in establishing a national SUD to calculate the support amount. We reject this approach because the Administrator has already established the average of the longest diameters of all cities with a population of 50,000 or more within each state, and adding the state averages together to ultimately arrive at a national SUD would not be as accurate as using each state's SUD. We also reject this suggestion because we believe that it would not result in rural health care providers paying distance-based charges that are reasonably comparable to those required of urban subscribers as required by section 254(h)(1)(A), since it would require a rural health care provider to pay the balance of the distance-based charge. We find that this balance would generally be more than urban subscribers are required to pay.

37. We reject USAC's proposal to establish statewide average discount percentages to apply to the rural base rates and/or distance sensitive charges for eligible services.<sup>124</sup> Section 254(h)(1)(A) requires the Commission to adopt mechanisms designed to make telecommunications services available to rural health care providers at rates reasonably comparable to "*rates charged*" for similar services in

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See 47 C.F.R. §§ 54.605, 54.607.

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See USAC Report at 4.

urban areas."<sup>125</sup> As the Joint Board previously stated, however, use of an average rate "would entitle some rural customers to rates below those paid by some urban customers, creating fairness problems for those urban customers and arguably going farther with this mechanism than Congress intended."<sup>126</sup>

**D. Equipment**

**1. Background**

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

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*First Recommended Decision*, 12 FCC Rcd at 428, para. 672.

38. Section 254(c)(3) provides that, in addition to the "core" services described under the provisions of section 254(c)(1), the Commission "may designate additional services for such support mechanisms for . . . health care providers for the purposes of subsection (h)."<sup>127</sup> The Joint Board made no recommendation as to the exact scope of services to be supported, and recommended, instead, that the Commission solicit information and expert advice on the exact scope of services that are "necessary for the provision of health care in a state."<sup>128</sup> The Joint Board recommended support only for telecommunications services, and not for internal connections or customer premises equipment.<sup>129</sup> Consistent with the recommendation of the Joint Board, the Commission issued the *Recommended Decision Public Notice*, seeking information about the exact scope of services that should be included in the definition of services "necessary for the provision of health care in a State," and the most cost-effective way to provide such services.<sup>130</sup> The Commission ultimately agreed with the Joint Board and declined to provide universal service support for equipment.<sup>131</sup>

39. The USAC Report, however, again raises the issue of support for equipment. The USAC Report notes that, because equipment purchases for telemedicine can be a major investment, some rural health care providers cannot afford to acquire the equipment, and, therefore, cannot take advantage of the support for

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47 U.S.C. § 254(c)(1).

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*First Recommended Decision*, 12 FCC Rcd at 421, para.656.

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*Id.*

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*Recommended Decision Public Notice* at 2.

131

*Universal Service Order*, 12 FCC Rcd at 9105, para. 626.

telecommunications services offered by the program.<sup>132</sup> The USAC Report makes no recommendation regarding support for equipment.

**2. Discussion**

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<sup>132</sup>

USAC Report at 37.

40. Section 254(h)(1)(A) does not authorize the provision of universal service support for equipment needed by rural health care providers to establish telemedicine programs. We note that section 254(h)(1)(A) directs telecommunications carriers to provide telecommunications services to rural health care providers at a discounted rate, and permits the telecommunications carriers to have the amount of the discount treated as part of their obligation to participate in the mechanisms to preserve and advance universal service. There is nothing in section 254(h)(1)(A) that authorizes the provision of universal service support for the purchase of equipment by rural health care providers. Indeed, the Joint Explanatory Statement indicates that Congress' intent was 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."<sup>133</sup> Consistent with the Joint Explanatory Statement, USTA argues that it would be inappropriate and unlawful to provide support for equipment, or any other non-telecommunications service component of telemedicine.<sup>134</sup> RUS similarly opposes providing support to reduce the cost of any non-telecommunications service expenses of telemedicine.<sup>135</sup> RUS notes that other federal programs, such as the RUS Distance Learning and Telemedicine Loan and Grant Program are available to assist with the financing of end-user hardware and facilities used in telemedicine projects.<sup>136</sup> Under these circumstances, we conclude that the rural health care support mechanism cannot assist in reducing the cost of the equipment necessary for rural health care providers to provide telemedicine services.

#### E. Insular Areas

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Joint Explanatory Statement of the Committee of the Conference (H.R. Rep. No. 458, 104th Cong., 2d Sess.) (Joint Explanatory Statement) at 133.

134

USTA comments at 7.

135

RUS comments at 4.

136

*Id.*

**1. Background**

41. Section 254(h)(1)(A) directs telecommunications carriers to 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*."<sup>137</sup> Consistent with the recommendation of the Joint Board, the Commission defined the "urban area" to mean the city in the state with a population of at least 50,000 nearest to the rural health care provider's site.<sup>138</sup> In the *Universal Service Order*, the Commission noted that the provisions of section 254(h)(1)(A) apply to insular areas, because the Act defines "State" to include all United States "[t]erritories and possessions."<sup>139</sup> The Commission found, however, that most insular areas do not have a city with a population as large as 50,000, and hence have no recognizable urban area.<sup>140</sup> Therefore, the Commission designated the largest population centers in the insular areas as urban areas, for purposes of calculating the urban/rural rate differential, that would form the basis for determining the amount of universal service support received by rural health care providers in insular areas.<sup>141</sup> The Commission further acknowledged that, because of the lack of information in the record regarding the telecommunications needs of insular areas and the costs of supporting such services, the Commission would issue a public notice to better address those issues.<sup>142</sup>

42. Since issuing the *Universal Service Order*, the Commission has learned that, as currently calculated, there is very little difference between the rates for telecommunications services in the "urban" and "rural" parts of the insular areas.<sup>143</sup> As a result, the rural health care providers in these areas will receive very little support for

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<sup>137</sup> 47 U.S.C. § 254(h)(1)(A) (emphasis added).  
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<sup>139</sup> *Universal Service Order*, 122 FCC Rcd at 9125, para. 669.

<sup>140</sup> 47 U.S.C. § 153(40); see *Universal Service Order*, 12 FCC Rcd at 9135, para. 692. The term "insular area," as used in the *Universal Service Order*, includes but is not limited to, American Samoa, the U.S. Virgin Islands, Commonwealth of the Northern Mariana Islands (CNMI), Guam, and Puerto Rico. *Universal Service Order*, 12 FCC Rcd at 9136, para. 695 n. 1820.

<sup>141</sup> *Universal Service Order*, 12 FCC Rcd at 9136, para. 694.

<sup>142</sup> *Id.* at 9136-38, paras. 693-699.

<sup>143</sup> *Id.* at 9137, para. 696.

See USAC Report at 37.



the first and second funding years of the program.<sup>144</sup> In addition, a number of the rural health care providers in these insular areas have indicated that advanced medical services are often unavailable within the insular areas, so there would be little medical benefit to having access to modern telecommunications services that permit connection only to medical facilities within the insular areas.<sup>145</sup> Accordingly, these rural health care providers seek rates that are reasonably comparable to rates charged for similar telecommunications services in urban areas *outside of the insular areas*.<sup>146</sup>

## 2. Discussion

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144

*Id.*

145 RUS comments at 5; CNMI comments at 1-3.

146 CNMI comments at 4 (emphasis added).

43. Because we still lack sufficient information to ensure that health care providers located in the insular areas have access to the telecommunications services available in urban areas in the country at affordable rates, on August 5, 1999, the Commission adopted the *Unserved, Tribal, and Insular Areas FNPRM* seeking public input on these and many related issues.<sup>147</sup> We note that the record here contains insufficient information about the status and availability of health care services and telemedicine in most of the insular areas.

44. We are concerned that, to the extent that section 254(h)(1)(A) was intended solely to help equalize the rates paid by residents of urban and rural areas within a state, the Commission would be constrained in its ability to provide relief to rural health care providers in the insular areas. We note that Congress could have provided discounts on the telecommunications service that rural health care providers use to connect to the nearest *major urban hospital within or outside the state* when rural health care providers rely on such hospitals for consultations. This approach would have directed assistance to rural health care providers hindered by the high costs of linking to major hospitals they need to reach outside of their states. Moreover, the Act could have sought to equalize rates paid by rural health care providers in different states, ensuring that no rural health care provider paid significantly more than hospitals in the largest urban areas, regardless of state boundaries. The language of section 254(h)(1)(A), however, merely directs the Commission to provide universal service support to rural health care providers to enable them to pay rates similar to those paid in urban areas of *their states*.<sup>148</sup>

45. On the other hand, we have always recognized that our method for determining the amount of support that a rural health care provider may receive is ill suited to insular areas. In the *Universal Service Order*, for example, we noted that ninety-five percent of American Samoa's population of 56,000 lives on the island of Tutuila, where the territory's single hospital is located.<sup>149</sup> Since we designated Tutuila as an urban area for purposes of setting the urban rate, rural health care providers in

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See note 29 *supra*.

148

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

149

*Universal Service Order*, 12 FCC Rcd at 9137, para. 695.

American Samoa will be constrained in their ability to take full advantage of the benefits of the rural health care support mechanism.

46. The Commission concluded in the *Universal Service Order* that section 254(h)(2)(A) authorizes the Commission to adopt special mechanisms to calculate support for the insular areas.<sup>150</sup> Section 254(h)(2)(A) directs the Commission, in part, to establish competitively neutral rules "to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications ... services for all public and nonprofit ... health care providers."<sup>151</sup> In order to implement the statute's directives, among other things, we need to identify the necessary services and determine what is "technically feasible and economically reasonable." That is, we need additional data about the specific needs of insular areas in this context, as well as the estimated cost of providing such support for those needs. We also note that, were we to grant support for links between rural health care providers in insular areas and the nearest advanced health care facilities in some other jurisdiction, we would need to set standards for identifying such facilities. We would also need to ensure that such rules would not be inconsistent with state physician licensing requirements that might preclude a rural health care provider from establishing a telemedicine connection with an advanced facility in the nearest large city in another state. Consequently, we encourage interested parties to submit their comments in the *Unserved, Tribal, and Insular Areas FNPRM* proceeding that we initiated on August 5, 1999,<sup>152</sup> as we will be addressing these issues in the near future.

#### IV. ELIGIBILITY OF HEALTH CARE PROVIDERS

##### A. Definition of Health Care Provider

###### 1. Background

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*Id.* at 9135, para. 692.

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47 U.S.C. § 254(h)(2)(A).

152

See note 29 *supra*.

47. Section 254(h)(1)(A) authorizes telecommunications carriers to provide discounted telecommunications services to any public or non-profit health care provider that serves rural areas in a state. Section 254(h)(5)(B) lists seven categories of entities that are included in the definition of "health care provider."<sup>153</sup> The Advisory Committee suggested including non-profit nursing homes and other long-term care facilities, as well

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Section 254(h)(5)(B) defines the term "health care provider" as:

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

47 U.S.C. § 254(h)(5)(B).

as non-profit home health care providers in rural areas.<sup>154</sup> The Advisory Committee argued that this group of health care providers can use telecommunications services for making electronic house-calls to the elderly, chronically ill, and homebound mentally ill.<sup>155</sup> The Joint Board found that the statute adequately describes the entities intended by Congress to be eligible for universal service support, and recommended that the Commission attempt no further clarification of the term "health care provider."<sup>156</sup> The Commission adopted the Joint Board's recommendation and used the list from the statute to define "health care provider."<sup>157</sup> USAC reports that many rural health care providers believe that the Commission has too narrowly defined the term "health care provider,"<sup>158</sup> and it suggests that the Commission expand or clarify the definition to include rural nursing homes, hospices, or other long-term care facilities, and emergency medical service facilities.<sup>159</sup>

## 2. Discussion

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154

Advisory Committee Report at 14.

155

*Id.* at 15.

156

*First Recommended Decision*, 12 FCC Rcd at 444, para.711.

157

See 47 C.F.R. § 54.604.

158

USAC Report at 36.

159

*Id.*

48. We affirm our initial conclusion that section 254(h)(5)(B) adequately describes those entities Congress intended to be eligible for universal service support.<sup>160</sup> We find that, given the specific categories of health care providers listed in section 254(h)(5)(B), if Congress had intended to include nursing homes, hospices, or other long-term care facilities, and emergency medical service facilities, it would have done so explicitly.<sup>161</sup> Thus, we find that the definition of "health care provider" does not include nursing homes, hospices, or other long-term care facilities, and emergency medical service facilities.

49. Moreover, we clarify that a rural nursing home is ineligible to receive universal service support from the rural health care support mechanism, whether or not it is part of a not-for-profit hospital or rural health clinic. We are not persuaded that an entity omitted from the list in the statute should be allowed to apply for and receive the benefits of the program directly from the universal service support mechanism simply because of the relationship between the ineligible and eligible entity. Moreover, we find no rational basis for distinguishing between a rural nursing home that is part of a not-for-profit hospital or rural health clinic and a rural nursing home that is associated with any of the other categories of eligible entities listed in the statute. Finally, we believe that allowing nursing homes to receive support directly from the rural health care support mechanism based upon their association with eligible entities would very likely result in a flood of other types of ineligible entities requesting similar treatment, and thus would render meaningless the limitations imposed by Congress in section 254(h)(5)(B). We find, therefore, that, to the extent that the instructions for the current version of the FCC Form 465 state that nursing homes that are "part of a not-for-profit hospital or rural health care clinic" are health care providers eligible to receive support, those instructions are incorrect.

## **B. Restrictions on Resale and Aggregated Purchases**

### **1. Background**

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160

See *Universal Service Order*, 12 FCC Rcd at 9117, para. 653.

161

See *Universal Service Order*, 12 FCC Rcd at 9119, para. 656 (citations omitted).

50. Section 254(h)(3) states that "telecommunications services and network capacity provided to a public institutional telecommunications user under this subsection may not be sold, resold, or otherwise transferred by such user in consideration for money or any other thing of value."<sup>162</sup> While the Joint Board urged the Commission to strictly enforce section 254(h)(3), it also emphasized that this prohibition should not restrict or inhibit joint purchasing and network-sharing arrangements with both public and private entities and individuals.<sup>163</sup> Indeed, the Joint Board recommended that health care providers be encouraged to enter into aggregate purchasing and maintenance agreements for telecommunications services with other public and private entities and individuals, as long as the entities and individuals not eligible for universal service support pay the full contract rates for their portion of the services.<sup>164</sup>

51. The Commission agreed with the Joint Board and the many commenters who noted that aggregated purchase of network sharing arrangements could substantially reduce costs and, in some cases, are necessary to sustain certain rural telecommunications networks.<sup>165</sup> Consistent with its directives to schools and libraries, however, the Commission concluded that an eligible rural health care provider participating in a consortium that includes private sector members may receive support only if the consortium is receiving tariffed rates or market rates.<sup>166</sup> The Commission explained that "this prohibition will deter ineligible, private entities from entering into

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47 U.S.C. § 254(h)(3).

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*First Recommended Decision*, 12 FCC Rcd at 455, para. 735.

164

*Id.*

165

*Universal Service Order*, 12 FCC Rcd at 9146, para. 719 (citations omitted).

166

*Id.* at 9147, paras. 719-20.

aggregated purchase arrangements with rural health care providers to receive below-tariff or below-market rates that they otherwise would not be entitled to receive.<sup>167</sup> The Commission further explained that it did not believe that such a limitation would inhibit the ability of eligible health care providers to participate in advanced telecommunications services, nor would it deny rural health care providers access to community-based telecommunications facilities.<sup>168</sup>

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*Id.* at 9147, para. 719.

168

*Id.* at 9148, para. 722.



52. The USAC Report confirms that, in some rural states, rural health care providers bring the only advanced telecommunications networks to their communities.<sup>169</sup> As a result, they are receiving requests to share their networks, throughout the year, from entities such as the National Guard, Girl Scouts, universities, and other public and non-profit community organizations.<sup>170</sup> Based upon the USAC Report, it appears that USAC does not allow rural health care providers to change their applications to add consortium members after USAC determines that the rural health care provider is eligible for support and the rural health care provider submits its selection of a carrier (Form 466). This is presumably because the addition of an ineligible private sector entity would require USAC to redetermine the eligibility of the rural health care provider, and could render a rural health care provider ineligible for support if the consortium was receiving services at less than the published tariff or market rates.

## 2. Discussion

53. We affirm the conclusion that we reached in the *Universal Service Order* that, despite the difficulties of allocating costs and preventing abuses, the benefits of permitting rural health care providers to join consortia with other subscribers of telecommunications service outweigh the danger that such arrangements will lead to abuse of the prohibition on resale.<sup>171</sup> Accordingly, we clarify that new members may be added to a consortium at any time after the rural health care provider applies for universal service support. We note that the Commission's rules do not restrict a rural health care provider's ability to join a consortium with other eligible health care providers, or public sector governmental entities (such as schools and libraries).<sup>172</sup> The Commission's rules also do not restrict a rural health care provider's ability to continue to participate in a consortium to which any of the above are added after the rural health care provider applies for universal service support.<sup>173</sup> The Commission's rules limit a rural health care provider's ability to receive universal service support only if the

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169

USAC Report at 36.

170

*Id.*

171

*See Universal Service Order*, 12 FCC Rcd at 9146, para. 719.

172

See 47 C.F.R. § 54.601(b).

173

*Id.*

consortium includes a private sector entity.<sup>174</sup> Section 54.601(b) of the Commission's rules state that, in the event that a consortium includes a private sector entity, a rural health care provider may receive support only if the consortium is paying tariffed or market rates for the subject services.<sup>175</sup> We believe that our interpretation is consistent with both the section 254(h)(1)(A) requirement to ensure that health care providers located in rural areas have access to telecommunications services at rates available to urban residents, and the section 254(h)(3) prohibition against the sale, resale, or other transfer of supported services for money.<sup>176</sup>

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174

*Id.*

175

*Id.*

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47 U.S.C. §§ 254(h)(1)(A), 254(h)(3). The Commission's rules provide that the Administrator may not approve support unless it can be demonstrated that the average rate that members of a consortium pay is greater than the applicable urban rate. See *Universal Service Order*, 12 FCC Rcd at 9148, para. 722. We note that, as a practical matter, the risks associated with our clarification are minimal because it is unlikely that many of the carriers providing telecommunications services under a consortium arrangement could be eligible for support under section 254(h)(1)(A) because, rural health care providers obtaining services at rates that include volume discounts are unlikely to be paying more than the urban rate. See *Universal Service Order*, 12 FCC Rcd at 9148, para. 722; see also OAT comments at 2.

54. We also clarify that a tariffed or market rate received by a consortium of eligible and ineligible entities may include a volume discount, or otherwise reflect consideration of the unique characteristics of the subscribers, to the extent that characteristic is not a rural health care provider's eligibility to receive support from the rural health care program. This is because the Commission's restriction on consortium membership was intended to prohibit ineligible private entities from receiving the benefits of the rural health care support mechanism. The *Universal Service Order* clearly states that the Commission and the Joint Board supported broad-based participation in consortia and intended to encourage their growth.<sup>177</sup> The Commission explained, in the *Universal Service Order*, that this restriction is necessary to "deter ineligible, private entities from entering into aggregated purchase arrangements with rural health care providers to receive below-tariff or below-market rates that they otherwise would not be entitled to receive."<sup>178</sup> We find that an ineligible private entity that enters into an aggregated purchase arrangement with a rural health care provider, and receives a tariff or market rate that includes a volume discount, would not be receiving a below-tariff or below-market rate because of the eligibility status of a rural health care provider participating in the consortium. We, therefore, find that such an arrangement would not violate our rules, as long as entities and individuals not eligible for universal service support pay the full contract rates for their portion of the services.

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*Universal Service Order*, 12 FCC Rcd at 9145-9148, paras. 717-22.

178

*Id.*

55. The section of the *Universal Service Order* that addresses the universal service support mechanism for schools and libraries offers an additional reason for the Commission's restriction on consortium membership, which would not be contradicted by the finding above.<sup>179</sup> In the section of the *Universal Service Order* that discusses the universal service support mechanism for schools and libraries, the Commission noted that it was concerned that "permitting large private sector firms to join with eligible schools and libraries to seek prices below tariffed rates could compromise both the federal and state policies of non-discriminatory pricing."<sup>180</sup> The Commission found congressional support for permitting eligible schools and libraries to secure prices below tariffed rates, and no basis for extending that exception to enable all private sector firms to secure such prices.<sup>181</sup> The Commission concluded that eligible schools and libraries would generally qualify for universal service discounts and prices below tariffed rates for interstate services, only if any consortia they join include only other eligible schools, libraries, rural health care providers, and public sector customers.<sup>182</sup> Although the *Universal Service Order* does not define the term "tariffed rates," the definition of the term "pre-discount price," and the explanation of the Commission's intent in the schools and libraries section of the *Universal Service Order* is instructive in determining whether permitting a consortium of eligible and ineligible entities to obtain tariff rates that include a volume discount could compromise the policies of non-discriminatory pricing. The *Universal Service Order* defines pre-discount price as the price of services to schools and libraries prior to the application of a discount from the universal service support mechanism.<sup>183</sup> It is "the total amount that carriers will receive for the services they sell to schools and libraries: the sum of the discounted price paid by a school or library and the discount amount that the carrier can recover from universal service support mechanisms for providing such services."<sup>184</sup> The *Universal Service Order* explains:

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*See id.* at 9028, para. 477.

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*Universal Service Order*, 12 FCC Rcd at 9028, para. 477.

181

*Id.*

182

*Id.* at 9028, para. 478.

183

*Id.* at 9026, para. 473.

184

*Id.*

Although consortia-negotiated prices might commonly be characterized as "discounted prices," because they are lower than the prices that individual members of the consortia would be able to secure on their own, we still characterize them as "pre-discount prices" for the purposes of section 254(h) because they are the prices eligible schools and libraries could obtain even without application of the relevant universal service support discounts. All members of such consortia, including those ineligible for universal service support, would benefit from these lower "pre-discount" prices produced by such statewide, regional, or large group contracts.... While those consortium participants ineligible for support would pay the lower pre-discount prices negotiated by the consortium, only eligible schools and libraries would receive the added benefit of universal service discount mechanisms.<sup>185</sup>

It is clear from this statement that the Commission's intent as expressed in both the rural health care and schools and libraries sections of the *Universal Service Order* is the same; to wit, to ensure that only eligible entities receive the benefit of the universal service support mechanism, not to prohibit a consortium from taking advantage of the tariff or other publicly available rates that reflect the economies of scale. Accordingly, we conclude that it would not violate section 254, or compromise Federal and state policies of non-discriminatory pricing to permit a rural health care provider to benefit from the rural universal service support mechanism, where the rural health care provider is a member of a consortium of eligible and ineligible entities receiving service at tariffed or other publicly available rates that include a volume discount.

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185

*Id.* at 9072-73, para 563.

56. The fact that the Commission's rules prohibit a rural health care provider from receiving support if it is in a consortium that includes private sector members, unless the consortium is receiving tariffed rates or market rates,<sup>186</sup> has apparently largely been erroneously interpreted as requiring the consortium members to be paying rates that do not include volume discounts.<sup>187</sup> As a result, commenters such as the Rural Telecommunications Policy Working Group (RTP) and the Health Care Systemic Change Initiative (HCSCI) believe that the Commission's treatment of consortia discourages community-based telecommunications facilities.<sup>188</sup> Consequently, they request that the Commission generally encourage the community use of telecommunications service facilities that the rural health care providers use for telemedicine.<sup>189</sup> Similarly, RUS argues that community use should be allowed because it is not resale.<sup>190</sup>

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*Id.* at 9147, para. 719; 47 C.F.R. § 54.601(b).

187

See, e.g., OAT comments at 1.

188

*Id.*

189

See, e.g., RTP/HCSCI comments at 3; RUS comments at 6.

190

RUS comments at 6.

57. We find that, to the extent that the Commission's exception is being narrowly interpreted as requiring a rural health care provider in a consortium with ineligible private entities to receive rates that do not include a volume discount, the interpretation largely defeats the purpose of participating in a consortium, and, therefore, is inconsistent with our intention to encourage participation in consortia. OAT and NTIA provide ample justification for rejecting the narrow interpretation of the terms "tariffed rates" and "market rates." OAT and NTIA indicate that together they support over 400 rural telemedicine sites in the United States, and about ninety percent of those sites organize their networks into formal and informal consortia to achieve greater economic efficiency.<sup>191</sup> They further indicate that the consortium typically includes an urban "hub" site such as a medical college, urban hospital, medical center, or state governmental unit associated with several small rural "spoke" sites.<sup>192</sup> According to OAT and NTIA, many rural health care providers use telecommunication infrastructures established and maintained by the "hub" site.<sup>193</sup> We are not convinced that requiring a consortium to receive tariffed or market rates should mean that the rate cannot take volume into consideration, and reflect the economies of scale. We believe that a better interpretation is one that recognizes that there are tariffed and market rates that include volume discounts, just as there are tariffed and market rates that recognize the unique characteristics of other subscribers of telecommunications service. Consequently, we conclude that entities not explicitly eligible for support cannot gain eligibility for support by participating in consortia with those that are eligible, but every member of the consortium may receive the benefits otherwise available to them in tariffed or other publicly available rates without jeopardizing a rural health care provider's eligibility to receive the benefits of the rural health care support mechanism.

58. Because of the difficulties of allocating costs and preventing abuses, we also find that, in addition to telecommunications carriers, health care providers and consortia of health care providers must share in the responsibility for calculating and justifying the request for support by maintaining documentation of the amount of support for which each member of a consortium is eligible. Health care providers and consortia

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OAT and NTIA joint comments at 1.

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*Id.*; see also OAT comments at 5.

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*Id.*

of health care providers must also carefully maintain complete records of how they allocate the costs of shared facilities among consortium participants in order to charge eligible health care providers the correct amounts. Accordingly, we revise section 54.601 of the Commission's rules to extend the record-keeping requirement to health care providers and consortia of health care providers. Finally, to the extent that a telecommunications carrier will not be applying the discount directly to a billing telephone number in the name of the rural health care provider, the rural health care provider and the lead member of the consortium must certify to the proper disposition of the benefits of the rural health care support mechanism.

59. Based upon the information in the record, we also clarify that it is not necessary to set a time limit for rural health care providers to report the identities of all of the consortia participants in order to enforce the statutory prohibition against the resale of telecommunications services by rural health care providers, or to otherwise ensure that the support provided by the rural health care universal service support mechanism is used for the purposes intended by Congress. We find that USAC should permit a rural health care provider to add new consortium members by submitting a new form 465 that the Administrator will use to re-evaluate the eligibility of the rural health care provider. The rural health care provider must satisfy anew the competitive bidding requirements only if the addition of a new consortium member would be more than a minor change in the contract or other arrangement for service from the carrier.<sup>194</sup> Consistent with the *Fourth Reconsideration Order*, a rural health care provider must look to state or local procurement laws and regulations to determine whether a proposed contract modification would be considered minor, and, therefore, exempt from state or local competitive bid processes.<sup>195</sup> If a proposed modification would be exempt from state or local competitive bid requirements, the applicant would not be required to undertake an additional competitive bid process in connection with the applicant's request to add a new member to the consortium. Similarly, if a proposed modification would have to be re-bid under state or local competitive bid requirements, then the applicant would also be required to comply anew with the Commission's universal service competitive bid requirements in order to be eligible to receive the benefits of the rural health care program. Consistent with the *Fourth Reconsideration Order*, where state and local procurement laws and regulations are silent, or otherwise inapplicable

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<sup>194</sup> See *Federal-State Joint Board on Universal Service, Access Charge Reform, Price Cap Performance Review for Local Exchange Carriers, Transport Rate Structure and Pricing, End User Common Line Charge*, Fourth Order on Reconsideration, CC Docket Nos. 96-45, 96-262, 94-1, 91-213, 95-72, 13 FCC Rcd 5318, 5448-5451 at paras. 223-30 (1997) (*Fourth Reconsideration Order*).

<sup>195</sup>

*Id.* at 5450, para. 225.



with respect to whether a proposed contract modification must be re-bid under state or local competitive bid processes, the Commission will look to the "cardinal change doctrine" to determine whether the contract modification requires re-bidding.<sup>196</sup> The "cardinal change doctrine" generally examines the extent to which a modification exceeds the scope of the original contract.<sup>197</sup> We understand that USAC might prefer that rural health care providers list all possible participants in their initial applications, thus, permitting USAC to evaluate all participants at once. We, however, are not persuaded that the administrative difficulties are so great as to warrant restricting joint purchasing and network-sharing arrangements.

## V. ADMINISTRATION

### A. Billing and Collection

#### 1. Background

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*Id.* at para. 226.

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*Id.* at 5449-5450, paras. 226-28.

60. On July 18, 1997, the Commission released the *NECA Order* establishing the structure of the three corporations that the Commission initially charged with administering the federal universal service support mechanisms.<sup>198</sup> In the *NECA Order*, the Commission directed the National Exchange Carrier Association, Inc. (NECA) to create USAC to administer the high cost and low-income support mechanisms, SLC to administer the schools and libraries support mechanism, and RHCC to administer the rural health care providers support mechanism.<sup>199</sup> The Commission directed that USAC perform billing, collection, and disbursement functions for all of the universal service support mechanisms.<sup>200</sup> It further required USAC to identify the costs that can be directly attributed to the high cost, low-income, schools and libraries, and rural health care programs, and to include those costs in the projected administrative expenses of each of the programs respectively.<sup>201</sup> The Commission further directed USAC to include one-fourth of USAC's joint and common billing and collection costs in the projected administrative expenses of the high cost, low-income, schools and libraries, and rural health care programs respectively.<sup>202</sup>

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*Changes to the Board of Directors of the National Exchange Carrier Association, Inc. and Federal-State Joint Board on Universal Service*, Second Report and Order and Second Order on Reconsideration, CC Docket No. 97-21 and 96-45, 12 FCC Rcd 18400 (*NECA Order*).

199

*NECA Order*, 12 FCC Rcd at 18418, para. 30.

200

*Id.*

201

*Id.* at 18426, para. 47.

202

*Id.*

61. In its *May 8, 1998 Report to Congress*, the Commission proposed merging the SLC and RHCC into USAC as the single entity responsible for administering all of the universal service support mechanisms on a permanent basis.<sup>203</sup> In preparation for reorganizing the structure of the universal service support mechanisms, the Commission directed USAC to prepare and submit a plan for reorganization.<sup>204</sup> USAC filed its Plan for Reorganization (USAC Plan) on July 1, 1998. Among other things, the USAC Plan recommended that USAC submit a proposed allocation method to the Commission for approval, in order to ensure a fair and accurate allocation of costs to the four support mechanisms.<sup>205</sup> On November 20, 1998, the Commission issued an order revising the organizational structure of the universal service support mechanisms.<sup>206</sup> Based upon the USAC Plan, the Commission directed USAC to submit to the Commission for approval, by December 31, 1998, a proposed method for

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*Federal-State Joint Board on Universal Service, Report in Response to Senate Bill 1768 and Conference Report on H.R. 3579*, CC Docket No. 96-45, Report to Congress, 13 FCC Rcd. 11810, 11815 at para. 8 (May 8, 1998) (*May 8, 1998 Report to Congress*).

204

Letter from Kathy Brown, Chief, Common Carrier Bureau, FCC, to the board of directors of the Universal Service Administrative Company, the Schools and Libraries Corporation, and the Rural Health Care Corporation, dated May 15, 1998.

205

USAC Plan, Appendix A-3 at 25.

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See *USAC Reorganization Order*, 13 FCC Rcd at 25059, para. 1. As of January 1, 1999 USAC serves as the single entity responsible for administering all of the universal service support mechanisms. *Id.*

allocating costs among the four support mechanisms that would be consistent with the Commission's rule.<sup>207</sup>

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*USAC Reorganization Order*, 13 FCC Rcd at 25090, para. 61.

62. The proposal submitted by USAC in December 1998 did not recommend any changes in the method of allocating USAC's joint and common costs. USAC apparently felt constrained in its ability to change the allocation of joint and common billing and collection costs to the four support mechanisms because of the language in the *NECA Order*.<sup>208</sup> In the USAC Report, USAC recommends that the Commission reallocate billing and collections costs.<sup>209</sup> Specifically, USAC notes that, although the original method of allocation, which is based on development costs for 1998 and early 1999, may have been appropriate for the first year of the programs, in the future it would be better to use an allocator that is based on the actual size of the programs because that information is now available.<sup>210</sup> USAC explains that the continued use of equal allocations will make the rural health care program responsible for too much of the joint and common costs associated with billing and collection.<sup>211</sup> According to USAC, if allocations were based on program size for all four programs, the rural health care support mechanism would only be responsible for 0.1 percent of the total cost of the billing, collection, and disbursement functions that USAC performs on behalf of all of the programs.<sup>212</sup> USAC, therefore, urges the Commission to revise the method of allocation of billing and collection costs so that it is based upon the volume of disbursements by each program.<sup>213</sup>

## 2. Discussion

63. Consistent with the USAC Report, we direct USAC to include its joint and common billing and collection costs in the projected administrative expenses of the high cost, low-income, schools and libraries, and rural health care programs, based upon the volume of disbursements by each program, beginning January 1, 2000. We agree with USAC that, in order to ensure a fair and accurate allocation of billing and collection costs among the four support mechanisms, it is better to use an allocator that takes into

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*See NECA Order*, 12 FCC Rcd at 18426, para. 47.

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USAC Report at 3.

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*Id.* at 45.

211

*Id.*

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*Id.*

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*Id.* at 3.

account the actual size of the programs. The Commission did not know, in 1997, the actual size of the individual programs, or the extent of the difference in their sizes. Based upon the information in the record, we find that there is no longer any rational basis for requiring the rural health care program to be responsible for twenty-five percent of the joint and common billing and collection costs in question. We further find that continuing to include one-fourth of USAC's joint and common billing and collection costs in the projected administrative expenses of the rural health care program would place a disproportionate burden on the rural health care support mechanism.

## B. Consolidation of Support Mechanisms

### 1. Background

64. As previously noted, in its *May 8, 1998 Report to Congress*, the Commission proposed merging the SLC and RHCC into USAC as the single entity responsible for administering all of the universal service support mechanisms on a permanent basis,<sup>214</sup> and USAC submitted a plan for accomplishing that task. USAC's plan proposed that, where efficiencies can be achieved, functions and operations that are common to the administration of all three universal service support mechanisms would be consolidated.<sup>215</sup> The USAC Plan further proposed maintaining the separate operation of those functions that are unique to a particular support mechanism because, for those functions, greater efficiencies would be achieved through separate operations.<sup>216</sup> The USAC Plan noted, however, that certain operations would be kept separate only for a transitional period to maintain continuity for employees and the

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*May 8, 1998 Report to Congress*, 13 FCC Rcd at 11815, para. 8.

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USAC Plan at 8; *see also USAC Reorganization Order*, 13 FCC Rcd at 25085, para. 50. For example, the USAC Plan proposed consolidating the administration of its finances; audits; budget submission; liaison with the Commission and contributing carriers; regulatory filings; outside counsel; invoice processing system; website; and human resources. USAC Plan at 9-12; *see also USAC Reorganization Order*, 13 FCC Rcd at 25085-89, paras. 50-58.

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USAC Plan at 8; *see also USAC Reorganization Order*, 13 FCC Rcd at 25085, para. 50. For example, the USAC Plan proposed maintaining separately the process for ensuring the integrity of and evaluating the progress of each support mechanism. USAC Plan at 12; *see also USAC Reorganization Order*, 13 FCC Rcd at 25087-88, para. 56.

public, and to allow for the expiration or assignment of certain existing contracts that were operating effectively.<sup>217</sup>

65. The Commission found that the USAC Plan would result in administrative efficiencies, and that establishing each corporation as a division within USAC would preserve the distinct mission of each support mechanism.<sup>218</sup> Subject to a few modifications and clarifications, the Commission adopted the USAC Plan's proposals for the new USAC.<sup>219</sup> The Commission noted, however, that we will review USAC's performance after one year from the merger to assess whether USAC has succeeded in eliminating duplicative functions, and whether it has succeeded in maintaining the distinct missions of the schools and libraries and rural health care support mechanisms.<sup>220</sup> Moreover, the *USAC Reorganization Order* states that the Commission would continue to evaluate ways of achieving greater efficiency, effectiveness, and accountability in the administration of the universal service support mechanisms.<sup>221</sup>

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USAC Plan at 8; *see also USAC Reorganization Order*, 13 FCC Rcd at 25085, para. 50. For example, the USAC Plan proposed temporarily maintaining separate websites and client support centers. USAC Plan at 12; *see also USAC Reorganization Order*, 13 FCC Rcd at 25087-88, paras. 56-7.

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*USAC Reorganization Order*, 13 FCC Rcd at 25065, para. 12.

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*Id.* at 25089, para. 59.

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*Id.* at 25090, para. 63.

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*Id.*

66. The USAC Report notes that, although USAC has combined some functions as a result of the merger, there are additional program and process consolidations that could reduce administrative expenses.<sup>222</sup> USAC recommends further consolidating vendor support for web site maintenance; provision of help desk services; application handling; and outreach.<sup>223</sup> USAC reports that, if programs and processes are sufficiently consolidated, the Commission should direct that RHCD be merged into one of the other divisions.<sup>224</sup> USAC indicates that there would be two options: merging RHCD with the Schools and Libraries Division (SLD), or with the High Cost/Low Income Division.<sup>225</sup> USAC suggests that the current SLD and RHCD programs and processes have more in common, and therefore, would be the best combination.<sup>226</sup> USAC indicates that, in the event that there are significant changes in the rural health care support mechanism, the best option could be to merge RHCD with the High Cost/Low Income Division.<sup>227</sup>

## 2. Discussion

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USAC Report at 45.

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*Id.*

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*Id.* at 46.

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*Id.*

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*Id.*

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*Id.*



67. Consistent with the *USAC Reorganization Order*, we conclude that, where efficiencies can be achieved, USAC should consolidate the functions and operations that are common to the administration of all three universal service support mechanisms.<sup>228</sup> We decline, however, to further direct the consolidation of any additional specific functions and operations at this time. There is very little information in the record upon which to base any decision to further consolidate additional functions of the various universal service support mechanisms. Although both the schools and libraries, and rural health care programs have completed their first funding cycle, there will be enough changes to the rural health care program as a result of this Order, that the rural health care program will, in essence, be repeating its first program year. We believe that, under these circumstances, not only would it be difficult to identify with any certainty the division with which we should merge RHCD, we find that there would be little benefit to merging RHCD with any of the other divisions of USAC while RHCD is undergoing significant change. Moreover, as we indicated in the *USAC Reorganization Order*, we will review USAC's performance after one year from the merger to assess whether USAC has succeeded in eliminating duplicative functions, and whether it has succeeded in preserving the distinct missions of the schools and libraries, and rural health care support mechanisms.<sup>229</sup> Given that it has been less than one year since the merger, we conclude that it would be premature to further direct the consolidation of additional functions and operations that are common to the administration of the support mechanisms.

## VI. CONCLUSION

68. In this *Fifteenth Order on Reconsideration* we reconsider three categories of issues that limited the effectiveness of the rural health care support mechanism: (1) services eligible for support; (2) entities eligible for support; and (3) the administration of the rural health care support mechanism.

69. We eliminate the per-location funding limit because it is no longer necessary to ensure that demand for support remains below the \$400 million per year cap that the Commission established in the *Universal Service Order*, and it is unduly interfering with the ability of the rural health care providers to receive all of the benefits of the rural health care support program. We, therefore, direct USAC to provide support for any commercially available telecommunications services regardless of the bandwidth, and we revise section 54.613 of the Commission's rules to reflect this

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<sup>228</sup> See *USAC Reorganization Order*, 13 FCC Rcd at 25085, para. 50.

<sup>229</sup> *Id.* at 25090, para. 63.

change. We also determine that most of the base rates for telecommunications service elements charged to rural health care providers are already reasonably comparable to those charged in urban areas, thus, there is generally no need for USAC to compare the tariffed or publicly-available base rates for telecommunications service elements to determine the amount of support that it can provide for the benefit of a rural health care provider. Accordingly, we direct that the Administrator must calculate support based upon all actual distance-based charges.

70. We clarify our intention regarding entities eligible for support by affirming the conclusion that we reached in the *Universal Service Order* that, despite the difficulties of allocating costs and preventing abuses, the benefits of permitting rural health care providers to join consortium with other subscribers of telecommunications service outweigh the danger that such arrangements will lead to significant abuse of the prohibition on resale.<sup>230</sup> Accordingly, we find that new members may be added to a consortium at any time after the rural health care provider applies for universal service support. We also conclude that, a rural health care provider participating in a consortium with ineligible private sector members may receive support, even if the consortium is receiving a tariffed or market rate that includes a volume discount.

71. Finally, we modify the administration of the rural health care support mechanism by adopting USAC's proposal for a more equitable distribution of USAC's joint and common billing and collection costs. Specifically, we direct USAC to include its joint and common billing and collection costs in the projected administrative expenses of the high cost, low-income, schools and libraries, and rural health care programs, based upon the volume of disbursements by each program.

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See *Universal Service Order*, 12 FCC Rcd at 9146, para. 719.

## VII. SUPPLEMENTAL FINAL REGULATORY FLEXIBILITY ANALYSIS

72. In compliance with the Regulatory Flexibility Act (RFA),<sup>231</sup> this Supplemental Final Regulatory Flexibility Analysis (SFRFA) supplements the Final Regulatory Flexibility Analysis (FRFA) included in the *Universal Service Order*<sup>232</sup> only to the extent that changes to that Order adopted herein on reconsideration require changes in the conclusions reached in the FRFA. As required by section 603 RFA, 5 U.S.C. § 603, the FRFA was preceded by an Initial Regulatory Flexibility Analysis (IRFA) incorporated in the Notice of Proposed Rulemaking and Order Establishing the Joint Board (NPRM), and an IRFA, prepared in connection with the Recommended Decision, which sought written public comment on the proposals in the NPRM and the Recommended Decision.<sup>233</sup>

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<sup>231</sup> See 5 U.S.C. § 604. The Regulatory Flexibility Act, 5 U.S.C. § 601 *et seq.*, was amended by the "Small Business Regulatory Enforcement Act of 1996" (SBREFA), Subtitle II of the Contract with America Advancement Act of 1996, Pub. L. No. 104-121, 110 Stat. 847 (1996).

<sup>232</sup>

*Universal Service Order*, 12 FCC Rcd at 9219-9260, paras. 870-983.

<sup>233</sup>

61 Fed. Reg. 63,778, 63,796 (1996).

73. *Need for and Objective of this Order.* The Commission is required by section 254 of the Act to promulgate rules to implement promptly the universal service provisions of section 254. On May 8, 1997, the Commission adopted rules whose principle goal is to reform our system of universal service support mechanisms so that universal service is preserved and advanced as markets move toward competition. In this Order, we reconsider two aspects of those rules and clarify one aspect of those rules. First, we direct USAC to provide support for any commercially available telecommunications service necessary for health care in rural areas, regardless of the bandwidth.<sup>234</sup> Second, we find that the Administrator need not compare the tariffed or publicly-available base rates for telecommunications service elements to ensure that rural health care providers are receiving rates that are reasonably comparable to those in urban areas, and we direct the Administrator to calculate support based upon all actual distance-based charges.<sup>235</sup> Finally, we clarify that new members may be added to a consortia at any time after the rural health care provider applies for universal service support.<sup>236</sup> We also conclude that, a rural health care provider participating in a consortium with eligible private sector members may receive support, even if the consortium is receiving a tariffed or market rate that includes a volume discount.<sup>237</sup> Because of the difficulties of allocating costs and preventing abuses, we find that, in addition to telecommunications carriers, health care providers, and consortia of health care providers must share in the responsibility for calculating and justifying the request for support by maintaining documentation of the amount of support for which each member of a consortium is eligible.<sup>238</sup>

74. *Summary and Analysis of the Significant Issues Raised by Public Comments in Response to the IRFA.* In this Order, the Commission simplifies the process for rural health care providers to receive support from the universal service support mechanism. The Commission reconsiders, on its own motion, the rules that define the services that are eligible for support, and clarifies the definition of the entities eligible to receive the benefits of that support. In addition, the Commission clarifies the

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See para. 17 *supra*.

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See para. 32 *supra*.

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See para. 53 *supra*.

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*Id.*

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See para. 58 *supra*.

rules associated with the administration of the universal service support mechanisms. Specifically, the Order modifies the rules to allow the universal service mechanism for rural health care providers to support any commercially available telecommunications service regardless of the bandwidth, and allow the Administrator to calculate support based solely upon all actual distance-based charges. The Order clarifies the rules to allow a rural health care provider participating in a consortium with ineligible private sector members to be able to receive support even if the consortium is receiving a tariffed or market rate that includes a volume discount. It also clarifies the rules to enable USAC to include its joint and common billing and collection costs in the projected administrative expenses of the high cost, low-income, schools and libraries, and rural health care programs, based upon the volume of disbursements by each program.

75. *Description and Estimates of the Number of Small Entities to Which the Rules Adopted in this Order will Apply.* The RFA directs agencies to provide a description of and, where feasible, an estimate of the number of small entities that may be affected by the proposed rules, if adopted.<sup>239</sup> The RFA generally defines the term "small entity" as having the same meaning as the terms "small business," "small organization," and "small governmental jurisdiction."<sup>240</sup> In addition, the term "small business" has the same meaning as the term "small business concern" under the Small Business Act.<sup>241</sup> 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).<sup>242</sup> A small organization is generally "any not-for-profit enterprise which is independently owned and operated and is not dominant in its field."<sup>243</sup>

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5 U.S.C. § 603(b)(3).

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5 U.S.C. § 601(6).

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5 U.S.C. § 601(3) (incorporating by reference the definition of "small business concern" in 15 U.S.C. § 632). Pursuant to the RFA, 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." 5 U.S.C. § 601(3).

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Small Business Act, 15 U.S.C. § 632 (1996).

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5 U.S.C. § 601(4).

76. In the FRFA of the *Universal Service Order*, we estimated and described in detail the number of small entities that might be affected by the new universal service rules.<sup>244</sup> The rules adopted in this Order, however, would affect primarily rural health care providers. Specifically, the Commission modifies the rules that define the services that are eligible for support. Health care providers will now receive universal service support for any commercially available telecommunications services, necessary for the provision of health care services in a state, regardless of the bandwidth. The Commission also revises the rules that calculate support based on the urban/rural rate. Rural health care providers' universal service support will now be calculated using actual distance-based charges. Finally, the Commission clarifies the rules that define limitations on supported services for rural health care providers. Rural health care providers are allowed to participate in a consortium with ineligible private sector members and will be able to receive support even if the consortium is receiving a tariffed or market rate that includes a volume discount. The adopted rules will allow rural health care providers to benefit more fully from the rural health care universal service support mechanism, constituting a positive economic impact on these small entities.

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See *Universal Service Order*, 12 FCC Rcd at 9242, para. 925.

77. As noted above, small entities includes "small businesses," "small organizations," and "small governmental jurisdictions." All three types of small entities may also constitute rural health care providers for the purpose of this analysis. "Small governmental jurisdiction" generally means "governments of cities, counties, towns, townships, villages, school districts, or special districts, with a population of less than 50,000."<sup>245</sup> As of 1992, there were approximately 85,006 such jurisdictions in the United States.<sup>246</sup> This number includes 38,978 counties, cities, and towns; of these, 37,566, or 96 percent, have populations of fewer than 50,000.<sup>247</sup> The Census Bureau estimates that this ratio is approximately accurate for all governmental entities. Thus, of the 85,006 governmental entities, we estimate that 81,600 (91 percent) are small entities. As for "small organizations," as of 1992, there were approximately 275,801.<sup>248</sup>

78. In addition, the Commission noted in the *Universal Service Order* that neither the Commission nor the SBA has developed a definition of small, rural health care providers. Section 254(h)(5)(B) defines the term "health care provider" and sets forth the seven categories of health care providers eligible to receive universal service support.<sup>249</sup> We estimated that there is less than 12,296 health care providers potentially

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<sup>245</sup>

5 U.S.C. § 601(5).

<sup>246</sup>

U.S. Dept. of Commerce, Bureau of the Census, "1992 Census of Governments."

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U.S. Dept. of Commerce, Bureau of the Census, "1992 Census of Governments."

<sup>248</sup>

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

<sup>249</sup>

See 47 U.S.C. § 254(h)(5)(B).

affected by the rules in the *Universal Service Order*.<sup>250</sup> We note that these small entities may potentially be affected by the rules adopted in this Order.

79. *Summary Analysis of the Projected Reporting, Record keeping, and Other Compliance Requirements and Significant Alternatives.* In the FRFA to the *Universal Service Order*, we described the projected reporting, record keeping, and other compliance requirements and significant alternatives associated with the Schools and Libraries section, the Rural Health Care Provider section, and the Administration section of the *Universal Service Order*. Because the rules adopted herein may only affect those requirements in a marginal way, we incorporate by reference paragraphs 956-60, 968-71, and 980 of the *Universal Service Order*, which describe those requirements and provide the following analysis of the new requirements adopted herein.<sup>251</sup>

80. Under the rules adopted herein, we revise the rules governing the eligibility of services that the universal service support mechanism will support. We find that regardless of whether rural health care providers need services with greater or lower bandwidths, the public interest would be better served by allowing rural health care providers to have affordable access to all modern telecommunications service to provide medical services without regard for the bandwidth thereof. We also revise the rules to allow the Administrator to calculate the support based upon all distance-based charges. We've learned that because of the need to refer to the various tariffs, calculating the difference between the urban and rural base rates for telecommunications is extremely labor intensive. We have determined that most of the base rates for telecommunications service elements charged to rural health care providers are already comparable to those charged in urban areas so there is no need to continue to require the comparison of tariffs to other publicly available rates. Finally, we revise the rules to show that a rural health care provider participating in a consortium with ineligible private sector members may receive support even if the consortium is receiving a tariffed or market rate that includes a volume discount. We find that, an ineligible private entity that enters into an aggregated purchase agreement with a rural health care provider, and receives a tariff or market rate that includes a volume discount, would not be receiving a below-tariff or below-market rate because of the eligibility status of an rural health care provider participating in the consortium. We also find that new members may be added to a consortium even after the rural health care

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See *Universal Service Order*, 12 FCC Rcd at 9242, para. 924.

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*Id.* at 9259.



provider submits its application for support. Finally, because of the difficulties of allocating costs and preventing abuses in consortium arrangements, we find that, in addition to telecommunications carriers, health care providers and consortia of health care providers must maintain documentation of the amount of support for which each member of a consortium is eligible. These changes will not have a significant impact on the reporting, record keeping, and other compliance requirements for participation in the rural health care support program.

81. *Steps Taken to Minimize the Significant Economic Impact on a Substantial Number of Small Entities Consistent with Stated Objectives.* In the FRFA to the *Universal Service Order*, we described the steps taken to minimize the significant economic impact on a substantial number of small entities consistent with stated objectives associated with the Schools and Libraries section, the Rural Health Care Provider section, and the Administration section of the *Universal Service Order*. Because the rules adopted herein may only affect those requirements in a marginal way, we incorporate by reference paragraphs 961-67, 972-76, and 981-82 of the *Universal Service Order*, which describe those requirements and provide the following analysis of the new requirements adopted herein.<sup>252</sup>

82. Our decision to simplify the process for rural health care providers to receive support from the universal service support mechanism, will benefit rural health care providers, as well as their chosen service providers, who may be small entities. We also find that this approach should permit all parties to use fewer resources (i.e. less time and labor) to access the benefits of the universal service support program.

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*Id.*

**VIII. ORDERING CLAUSES**

83. Accordingly, IT IS ORDERED that, pursuant to the authority contained in sections 1-4, 201-205, 218-220, 254, 303(r), 403, and 405 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151-154, 201-205, 218-220, 254, 303(r), 403, and 405, section 1.108 of the Commission's rules, 47 C.F.R. § 1.108, the Fifteenth Order on Reconsideration IS ADOPTED.

84. IT IS FURTHER ORDERED that, pursuant to the authority contained in sections 1-4, 201-205, 218-220, 254, 303(r), 403, and 405 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151-154, 201-205, 218-220, 254, 303(r), 403, and 405, section 1.108 of the Commission's rules, 47 C.F.R. § 1.108, Part 54 of the Commission's rules, 47 C.F.R. Part 54, ARE AMENDED as set forth in Appendix A attached hereto.

85. IT IS FURTHER ORDERED that, unless otherwise noted in this Fifteenth Order on Reconsideration, the rule changes set forth in Appendix A ARE EFFECTIVE beginning with the third funding cycle of the rural health care universal service support program.

86. IT IS FURTHER ORDERED that the Commission's Office of Public Affairs, Reference Operations Division, SHALL SEND a copy of this Fifteenth Order on Reconsideration, including the Supplemental Final Regulatory Flexibility Analysis, to the Chief Counsel for Advocacy of the Small Business Administration.

FEDERAL COMMUNICATIONS COMMISSION

Magalie Roman Salas  
Secretary

**APPENDIX A -- RULE CHANGES**

Part 54 of Title 47 of the Code of Federal Regulations is amended as follows:

Part 54 -- UNIVERSAL SERVICE

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

Authority:47 USC Secs. 1, 4(i), 201, 205, 214, and 254 unless otherwise noted.

**§ 54.601 Eligibility.**

2. Amend section 54.601 by revising sections 54.601(b)(3), 54.601(b)(4), and 54.601(c)(1) to read as follows:

- (a) \* \* \*
- (1) \* \* \*
- (2) \* \* \*
- (i) \* \* \*
- (ii) \* \* \*
- (iii) \* \* \*
- (iv) \* \* \*
- (v) \* \* \*
- (vi) \* \* \*
- (vii) \* \* \*
- (3) \* \* \*
- (4) \* \* \*
- (5) \* \* \*

(b) *Consortia.*

(1) \* \* \*

(2) \* \* \*

(3) Telecommunications carriers, health care providers, and consortia of health care providers shall carefully maintain complete records of how they allocate the costs of shared facilities among consortium participants in order to charge eligible health care providers the correct amounts. Such records shall be available for public inspection.

(4) Telecommunications carriers, health care providers, and consortia of health care providers shall calculate and justify with supporting documentation the amount of support for which each member of a consortium is eligible.

(c) *Services.*

(1) Any telecommunications service that is the subject of a properly completed bona fide request by a rural health care provider shall be eligible for universal service support, subject to the limitations described in this subpart. The length of a supported telecommunications service may not exceed the distance between the health care provider and the point farthest from that provider on the jurisdictional boundary of the nearest large city as defined in § 54.605(c).

(2) \* \* \*

\* \* \* \*

**§ 54.609**

**Calculating support.**

3. Amend section 54.609 by adding sections 54.609(a)(1), 54.609(a)(2), and 54.609(b), and revising 54.609(c) to read as follows:

(a) \* \* \*

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(1) With one exception, the Administrator shall consider the base rates for telecommunications services elements in rural areas to be reasonably comparable to the base rates charged for similar telecommunications service elements in urban areas in that state, and, therefore, the Administrator shall not include these charges in calculating the support. The Administrator shall include, in the support calculation, all other charges specified above, and all actual distance-based charges as follows:

distance is less than or equal to the SUD for charge for that service can be no higher than the distance-based charged for a similar service over the same distance in the large city nearest to the rural health care provider;

(i) if the requested service the state, the distance-based distance-based charged

distance is greater than the SUD for the allowable distance, the distance-based charge than the distance-based charged for a similar the rural health care provider over the SUD.

(ii) if the requested service state, but less than the maximum for that service can be no higher service in the large city nearest to

are charges based on a unit of distance,

(iii) "Distance-based charges" such as mileage-based charges.

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

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

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

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

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

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

4. Amend section 54.613 by revising 54.613(a), and deleting 54.613(b) to read as follows:

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

(b) This section shall not affect a rural health care provider's ability to obtain supported services under § 54.621.

**Appendix B -- PARTIES FILING IN RESPONSE TO THE UNIVERSAL SERVICE  
ADMINISTRATIVE COMPANY REPORT TO THE FCC: EVALUATION OF THE  
RURAL HEALTH CARE PROGRAM  
(MARCH 17, 1999 PUBLIC NOTICE)  
CC Docket Nos. 96-45 and 97-21**

| <u>Party</u>                        |     | <u>Document Filed</u>   |
|-------------------------------------|-----|---|
| State of Alaska                     |     | Comments of the State of Alaska on USAC's Report "Evaluation of the Rural Health Care Program"  |
| Commonwealth of the Northern        | Ma  | Comments of the Commonwealth of the Northern Mariana Islands  |
| National Rural Health               |     | Letter to William Kennard, Chairman, Federal Communications Commission dated March 29, 1999 REF: Universal Service Administrative Company Report to FCC, Evaluation of the Rural Health Care Program  |
| Office for the Advancement of       | Tel | Letter to William Kennard dated April 1, 1999 in response to the Federal Communications Commission's Public Notice: DA 99-521 regarding the Universal Service Administrative Company Report to the FCC, "Evaluation of the Rural Health Care Program" |
| Rural Utilities Service             |     | Reply Comments of the Rural Utilities Service   |
| United States Telephone             |     | Comments of the United States Telephone Association   |
| United States Telephone Association |     | <i>Notice of Ex Parte</i> Presentation, from Mary Henze, USTA, to Magalie Roman Salas, FCC (April 30, 1999)Letter   |

Utah Department of Health

regarding Universal Service  
Administrative Company Report to FCC  
on the Rural health Care Program

**Federal Communications Commission**

**FCC 99-269**

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**Separate Statement  
of**

**Commissioner Susan Ness**

*Re: 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, 96-45)*

I support today's decision to adopt modifications to the rural health care support mechanism that will streamline administrative processes and enhance the overall program. I care deeply about the success of the rural health care program and have been concerned that our efforts have thus far not been as fruitful as they could have been. We need to do more to ensure that the universal service provisions of the Telecommunications Act are implemented as Congress envisioned. More specifically, we need to ensure that our rural areas -- in this instance rural health care providers -- have access to telecommunications services "at rates that are reasonably comparable to rates charged for similar services in urban areas."<sup>253</sup>

With respect to the companion order on eligible telecommunications carriers (ETCs), I support the Commission's decision to reconsider the ETC requirement. Based on comments filed in this proceeding, it is clear to me that the ETC requirement we adopted previously created significant barriers for the rural health care providers that

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<sup>253</sup> 47 U.S.C. § 254(h)(1)(A).



were meant to benefit under the program. Although our earlier decision reflected a prudent approach based on our knowledge at that time, I believe that the expanded interpretation of the rural health care provisions is supported by the statutory language and reflects policy determinations that will better effectuate the goals of the 1996 Act.

For these reasons, I vote in favor of both reconsideration orders, and I am optimistic that our actions today will infuse new life into the rural health care program.