

public inspection during regular business hours in the FCC Reference Center, Room CY-A257, 445 12th Street, SW., Washington, DC 20554. There was also a companion Further Notice of Proposed Rulemaking in WC Docket No. 02-60 released on November 17, 2003.

I. Introduction

1. In this *Report and Order and Order on Reconsideration*, we modify our rules to improve the effectiveness of the rural health care support mechanism, which provides discounts to rural health care providers to access modern telecommunications for medical and health maintenance purposes. Because participation in the rural health care support mechanism has not met the Commission's initial projections, we amend our rules to improve the program, increase participation by rural health care providers, and ensure that the benefits of the program continue to be distributed in a fair and equitable manner. Specifically, we expand the scope of entities eligible to receive discounts, provide support for Internet access, and modify the way in which we calculate discounts to offer rural health care providers more flexibility. In addition, in the *Order on Reconsideration*, we deny Mobile Satellite Ventures Subsidiary's petition for reconsideration of the 1997 *Universal Service Order*, 62 FR 32862 (June 17, 1997). The actions we take encourage the development of public/private partnerships and other creative solutions to meet the needs of rural communities and increase participation in the rural health care mechanism.

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

II. Report and Order

A. Eligible Health Care Provider

3. We now further define the statutory term "public health care provider." We conclude that dedicated emergency departments of rural for-profit hospitals that participate in Medicare should be deemed "public" health care providers eligible to receive prorated rural health care support. We agree with commenters that this clarification is consistent with congressional intent and is necessary to give meaning to the term "public" health care provider under the rural health care program. Dedicated emergency departments in for-profit hospitals, including the emergency departments of critical access hospitals, are required, pursuant to the Emergency Medical Treatment and Labor Act (EMTALA), to provide medical screening examinations to all patients who present themselves and to stabilize or arrange for appropriate transfer of those patients with emergency conditions. Thus, such providers are "public" in nature by virtue of the persons they are required, pursuant to EMTALA, to examine and/or treat for emergency medical conditions.

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

5. Additionally, as suggested by several commenters, given the realities

of rural health care providers in offering quality health care services in rural areas, we clarify the entities listed in section 254(h)(7)(B) that qualify as rural "health care providers." We conclude that entities listed in section 254(h)(7)(B) include non-profit entities that function as one of the listed entities on a part-time basis. Pursuant to this modification, non-profit entities that provide ineligible services, even on a primary basis, would be able to receive prorated support commensurate with their provision of eligible rural health care services. For example, if a doctor operated a rural health clinic on a non-profit basis in a rural community one day per week or during evenings in the local community center, that community center would be able to receive prorated support, because it serves as a "rural health clinic" on a part-time basis. Similarly, if a non-profit community mental health center also operated as a for-profit pharmacy, that center would also be able to receive prorated support as a part-time "community mental health center." Our goal in implementing this proposal is two-fold—to encourage the development of public/private partnerships and other creative solutions to meet the needs of rural communities, and to increase participation in the rural health care support mechanism.

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