

50,000 or more may not be adequate for purposes of creating a comprehensive telehealth and telemedicine network. Further, commenters contend that the current MAD assumes that the rural health care provider will connect with specialists in the nearest urban area, which may not necessarily have the essential complement of specialists to provide telemedicine services. We believe, in most instances, calculating the MAD as described will provide more support for distance-based charges than our current rules, without creating additional administrative burdens for the Administrator. In addition, this modification should provide rural health care providers access to high levels of care and greater flexibility in developing appropriate telehealth networks.

21. Although commenters generally favor eliminating the MAD, we decline to do so at this time. We are concerned that eliminating the MAD could result in wasteful expenditures for the program, as providers could connect to more distant locations when a closer one would suffice. Expanding the MAD to the largest city in a state should provide support sufficient to enable rural health care providers to connect with health care facilities with a wide range of medical expertise, without introducing the potential for waste associated with eliminating the MAD or making the MAD equal to the furthest point in the state. Moreover, we decline to expand the MAD to equal the distance between the health care provider and the nearest center of tertiary care. Although this proposal may have a more direct relationship to health care services, we agree with commenters that the nearest point of tertiary care may not provide the required specialized expertise. In addition, this proposal would require the identification and continued monitoring of all tertiary care centers throughout the Nation, which would impose significant administrative burdens upon the Administrator of the program.

4. Satellite Services

22. We revise our policy to allow rural health care providers to receive discounts for satellite services even where alternative terrestrial-based services may be available. As suggested by commenters, however, these discounts will be capped at the amount providers would have received if they purchased functionally similar terrestrial-based alternatives. Providers seeking discounts for satellite services will be required to provide to the Administrator documentation of the

urban and rural rates for the terrestrial-based alternative services. We believe imposing a cap on support for satellite service is necessary because satellite services are often significantly more expensive than terrestrial-based services. Thus, pursuant to these changes, where rural health care providers opt for more expensive satellite-based services when a cheaper terrestrial-based alternative is available, the provider, and not the support mechanism, will be responsible for the additional cost. For example, if a health care provider pays \$100 per month for satellite service, the rural rate for a comparable wireline service plan is \$60 per month, and the urban rate is \$40 per month, the health care provider would receive \$20 per month towards the satellite service. We conclude this approach furthers the principle of competitive neutrality and recognizes the role that satellite services may play in rural areas without unduly increasing the size of the fund. We also seek further comment in the accompanying Further Notice on whether additional rule changes should be adopted to facilitate support for mobile rural health care providers.

5. Insular Areas

23. Although we continue to recognize that using urban rates within a State as the benchmark for reasonable rates may be ill-suited to certain insular areas, we believe that the proposal of some commenters to permit the comparison of insular rural rates to the nearest urban area outside the State is inconsistent with the statutory language set forth in section 254(h)(1)(A). As the Commission indicated in the *Fifteenth Order on Reconsideration*, 64 FR 66778 (November 30, 1999), Congress could have provided discounts for telecommunications services that connect rural health care providers to the nearest major hospital within or outside the State. Congress, however, explicitly provided that rates should be compared to the urban rate in that State. We continue to believe section 254(h)(1)(A) precludes us from designating an urban area outside of the State as the benchmark for comparison for remote, insular areas.

24. We also disagree with American Samoa Telecommunications Authority that section 254(h)(2)(A) authorizes the Commission to provide support for telecommunications links between American Samoa to an urban center outside the territory, such as Honolulu, Hawaii, without regard to the urban-rural rate difference. Section 254(h)(2)(A) authorizes the Commission to take action to increase access to

advanced telecommunications and information services. Support for telecommunications services, however, is provided subject to section 254(h)(1)(A) and as discussed herein, requires an urban to rural comparison within the State. Although we do not believe we can grant the request of providers in insular areas, we do provide support for Internet access for all eligible rural health care providers, including those in insular areas, which we believe will functionally provide significant support to health care providers in insular areas.

D. Other Changes to the Rural Health Care Support Mechanism

1. Allocation Guidelines and Record-Keeping Requirements

25. Because entities that engage in both eligible and ineligible activities or that collocate with an entity that provides ineligible services will now be eligible for prorated support, we adopt rules requiring such providers to allocate their discounts to prevent discounts from flowing to ineligible activities or providers of services. Prorated discounts will be provided commensurate only with entities' eligible activities. The method of cost allocation chosen by an applicant should be based on objective criteria, and reasonably reflect the eligible usage of the facilities. Thus, if telecommunications facilities are used jointly for eligible and ineligible purposes, the allocation should be based on the percentage of time the facility is used for eligible purposes or some other method that reasonably reflects eligible usage. Health care providers must keep documentation explaining their allocation methods for five years and present that information to Universal Service Administrative Company upon request. We also direct USAC to evaluate the allocation methods selected by program participants in the course of its audit activities to ensure program integrity. Additionally, we codify the requirement that health care providers must maintain records for their purchases of supported services for at least five years sufficient to document their compliance with all Commission requirements.

26. To illustrate the general principle of discount allocation, we provide several "safe harbor" examples of allocation methods. First, if a dedicated emergency department in a for-profit rural hospital shares access to a T-3 with the rest of the hospital, and the T-3 is used seventy-five hours per week related to EMTALA-emergency care and the education of health care