

professionals who work in the dedicated emergency department and fifty hours per week related to other hospital use, the T-3 would be used for eligible purposes sixty percent of the time (seventy-five hours of use by emergency department divided by 125 total hours of use by the entire hospital). Therefore, the eligible dedicated emergency department would receive sixty percent of the difference between the urban and rural rate for the T-3. Second, another dedicated emergency department in a for-profit rural hospital that shares access to a T-3 with the rest of the hospital, might choose to allocate discounts based on employee hours. For example, if the emergency department staff, including on-call physicians, is staffed at 3,360 hours per week (twenty employees covering 168 hours per week), and the rest of the hospital is staffed at 4,000 hours per week (100 employees covering 40 hours per week), the emergency department would receive forty-six percent of the difference between the urban and rural T-3 rate (3,360 emergency staff hours divided by 7,360 total staff hours). Third, if a non-profit rural health clinic operates in a local community center for five hours one evening per week and uses the community center's T-1 line, and the community center's normal operating hours are 10 a.m.-10 p.m., Monday through Saturday, the T-1 would be used for eligible purposes seven percent of the time (five hours divided by eighty-four open hours in a week). Therefore, the eligible non-profit rural health clinic would receive seven percent of the difference between the urban and rural rate for the T-1. Fourth, if a dedicated emergency department in a for-profit rural hospital shares access to a T-1 with the rest of the hospital, and the dedicated emergency department occupies 250 square feet and the hospital occupies 2,500 square feet, the T-1 would be used for eligible purposes ten percent of the time (250 square feet divided by 2,500 square feet). Therefore, the eligible dedicated emergency department would receive ten percent of the difference between the urban and rural rate for the T-1. If a rural health care provider can document that it adopted an allocation method consistent with one of these four examples, we will consider the method compliant with our requirements. Rural health care providers may choose a different allocation method, but will bear the burden of demonstrating, in the event of an audit or otherwise, that the chosen method was based on objective criteria

and reasonably reflects the eligible usage of the facilities.

27. Conversely, when services are used solely by an eligible entity for eligible purposes, no allocation would be necessary. For example, if a T-1 is located solely in the dedicated emergency room and is used only for medical or educational purposes, the dedicated emergency room would be able to receive the full discount based on the difference between the urban and rural rate. Similarly, if there is a phone line in a private room at the community center that is dedicated exclusively to a rural health care clinic, no allocation would be necessary because the personnel staffing the part-time rural health care clinic would be the only ones to use the phone.

2. Streamlining the Application Process

28. Since the *NPRM* was released, USAC has streamlined the application process significantly in response to the numerous comments submitted in this proceeding on this issue. For example, USAC has implemented electronic filing and e-certification for all forms and has arranged for electronic forms to be filled automatically with the previous year's information for repeat on-line filers. USAC has also created a database of urban rates on its Web site. As a result, a health care provider can now bypass the arduous step of having to retrieve this information from its carrier. In addition, USAC has significantly expanded its outreach efforts, such as by sending mailings to carriers and health care providers to alert them to changes in the program, holding monthly conference calls for carriers and health care providers to ask questions and raise concerns, and setting up a toll-free access number where carriers and health care providers can call at their convenience. Finally, USAC has eliminated the form submitted by service providers, FCC Form 468, by combining the relevant information into FCC Form 466, which is submitted by applicants. This modification to the reimbursement process has reduced to a great extent the interval between receipt of service and payments to service providers, thereby mitigating commenters' concerns.

29. We believe USAC's efforts to ease the burdens of applying to the program have been exemplary, as further evidenced by the number of completed applications received by USAC in Funding Year 2003 compared to Funding Year 2002. Nevertheless, in the Further Notice of Proposed Rulemaking, we seek comment on ways in which USAC could further streamline the application process and expand

outreach efforts. In addition, we note that the Commission, through the Consumer & Governmental Affairs Bureau, will endeavor through its educational and outreach efforts, to ensure that those most likely affected are informed about the actions taken in this Order. In addition to making fact sheets and other informational materials available for dissemination through the Commission's Web site, the Commission will include the dissemination of such information as part of its on-going, grassroots outreach efforts directed at rural America and undertaken in coordination with other federal and state agencies.

3. Pro-Rata Reductions if Annual Cap Exceeded

30. Based on our estimates and the comments we have received, we continue to believe that our current rules requiring pro-rata distribution of funds if requests exceed the cap, are the most effective and equitable means of distributing limited funds in accordance with the goals and purposes of the statute. Therefore, we agree with the majority of commenters that the current rules should be maintained. We note that the rules adopted in this Order could increase the level of discounts requested in a year, so applicants are encouraged to submit applications during the filing window to secure their universal service funding. We disagree with the commenter that suggested we prioritize universal service support for telecommunication services over information services. We do not think such a measure is necessary at this time because program demand has never approached the cap. Moreover, prioritization would add another level of unnecessary administrative complexity to the support mechanism.

4. Ensuring the Selection of Cost-Effective Services

31. We agree with commenters that the current rules are adequate to ensure that health care providers select the most cost-effective services. Our certification requirements, combined with the requirement that health care providers remain responsible for a significant portion of service costs (*i.e.*, the urban rate of telecommunications services and 75% of Internet access) will ensure that rural health care providers make prudent economic decisions. We also agree with commenters that applicants should not be required to use the lowest-cost technology because factors other than cost, such as reliability and quality, may be relevant to fulfill their telemedical needs.