

5. Other Non-Substantive Rule Changes

32. In the *NECA Order*, 62 FR 41294 (August 1, 1997), the Commission directed the National Exchange Carrier Association (NECA) to establish the Rural Health Care Corporation to administer the rural health care support mechanism. Subsequently, the Commission directed the Rural Health Care Corporation to be merged into a division of USAC. In light of the Commission's prior actions, we hereby amend our rules to replace all references to the "Rural Health Care Corporation" with the "Rural Health Care Division." We also revise § 54.609(a)(1)(i) to conform to the *Fifteenth Order on Reconsideration*. We also adopt several other non-substantive rule changes to improve the clarity of the rules.

6. Implementation

33. Funding Year 2003 for the rural health care program ends June 30, 2003, and Funding Year 2004 begins July 1, 2004. Because we do not wish to introduce changes to the program in the middle of a funding year, the modifications to the program adopted in this Order will be implemented beginning with Funding Year 2004. We direct USAC to take the necessary operational steps to implement the improvements to the program adopted herein for Funding Year 2004.

III. Order on Reconsideration

34. Consistent with the policy objectives underlying our decision, we deny, to the extent indicated herein, Mobile Satellite Ventures' (MSV) petition for reconsideration of the *1997 Universal Service Order*. We decline to revise our policy, as MSV suggests, to subsidize satellite service at the same price as terrestrial mobile service. We agree with Verizon that equalizing these rates could undercut competition and competitive neutrality. Although we agree that MSV and similar carriers provide valuable services to rural areas, particularly insular areas unserved by wireline carriers, we are concerned that equalizing the rates for satellite and terrestrial mobile service could significantly increase program demand and disadvantage those carriers already providing functionally similar services at more competitive prices. Accordingly, we deny MSV's petition for reconsideration to the extent indicated herein.

IV. Procedural Matters

A. Regulatory Flexibility Analysis

35. As required by the Regulatory Flexibility Act of 1980, as amended (RFA), an Initial Regulatory Flexibility

Analysis (IRFA) was incorporated in the Notice of Proposed Rulemaking. The Commission sought written public comments on the proposals in the *NPRM*, including comment on the IRFA. The Commission received seventy-five comments, fourteen reply comments, and six *ex partes* in response to the *NPRM*. This present Final Regulatory Flexibility Analysis (FRFA) conforms to the RFA.

1. Need for, and Objectives of, the Report and Order

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

37. Specifically, in the *Report and Order*, we clarify the scope of entities eligible to receive discounts. 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 believe this clarification is necessary to give meaning to the term "public" health care provider under the rural health care program. Moreover, we also determine that dedicated emergency departments in for-profit rural hospitals constitute "rural health clinics." 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. Additionally, 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. 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. Further, 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 also adopt rules requiring such providers to allocate their discounts to prevent discounts from flowing to ineligible activities or providers of services.

38. We also provide funding for Internet access for rural health care providers. We conclude that support equal to twenty-five percent of the monthly cost for any form of Internet access reasonably related to the health care needs of the facility should be provided to rural health care providers. We believe that the Internet can serve as an invaluable resource, by providing on-line courses in health education, medical research, follow-up care, regulatory information such as compliance with Health Insurance Portability and Accountability Act of 1996, video conferencing, web-based electronic benefit claim systems including on-line billing, and other crucial business functions. The incredible potential of the Internet to access such a breadth of medical information may also help reduce isolation in rural communities. Furthermore, health care information shared over the Internet may enable rural health care providers to diagnose, treat, and contain possible outbreaks of disease or respond to health emergencies. Thus, in light of the development of medical applications for the Internet since 1997, we conclude that encouraging access to this information service will improve the level of care available in rural areas.

39. We also alter our current policy to allow rural health care providers to compare the urban and rural rates for functionally similar services as viewed from the perspective of the end user. This modification to our rules will better effectuate the mandate of Congress to ensure comparable services for rural areas, as provided in section 254 of the Act, by allowing rural health care providers to benefit from obtaining telecommunications services at rates equivalent to those in urban areas.