

Title	Number of respondents	Frequency of response	Total annual burden
Total Annual Burden: Total Annual Costs: \$0	.....	.....	369,200

*Needs and Uses:* In the FNPRM, we seek comment on ways to streamline further the application process and expand outreach efforts. In the companion *Report and Order*, we note that USAC has implemented many steps to streamline the application process and has increased its outreach efforts, since the *NPRM*, 67 FR 34653, May 15, 2002, was released in 2002. Among other things, USAC has implemented on-line application filing and has arranged for electronic forms to be filled automatically with the previous year's information for repeat on-line filers. Nevertheless, we seek comment on what additional steps the Universal Service Administrative Commission (USAC) could take to ease further the burdens associated with the application process. For example, what would be the advantages and disadvantages of implementing multi-year applications, so that beneficiaries would not need to apply every funding year? We also seek comment on whether there are additional outreach efforts that USAC could take to inform eligible applicants of the benefits of the program. For instance, should USAC conduct focus groups among rural health care providers to develop ideas on how to identify providers that operate only on a part-time basis? Should USAC contact service providers in rural areas to solicit suggestions for potential eligible users in the area? All rural health care providers applying for discounts on eligible telecommunications and information services must currently file FCC Forms 465, 466, 466-A, and 467. The purpose of these forms is for rural health care providers to certify their eligibility, describe program needs so that service providers are able to bid on the services, indicate that they have selected the most cost-effective methods, apply for discounts, and inform the program's administrator that they have begun to receive or stopped receiving services for which support was allocated.

## I. Further Notice of Proposed Rulemaking

### A. Definition of "rural area"

1. In this FNPRM, we seek comment on modifications to the definition of "rural area" for the rural health care universal service support mechanism. Currently, an area qualifies as rural if it

is located in a non-metropolitan county as defined by the Office of Management and Budget or is specifically identified in the Goldsmith Modification to 1990 Census data published by the Office of Rural Health Care Policy (ORHP). In response to the NPRM, several commenters state that ORHP no longer utilizes the definition adopted by the Commission in 1997 and that there will be no Goldsmith Modification to the most recent 2000 Census data. Several commenters suggest that the Commission adopt the rural designation system currently utilized by ORHP, the Rural Urban Commuting Area (RUCA) system. Others propose to define rural as non-urbanized areas, as specified by the Census Bureau. Finally, some commenters assert that if the Commission adopts a new definition of rural, it should grandfather existing areas that currently qualify as rural, if they would no longer qualify under the new definition.

2. We seek comment on whether we should adopt a new definition of rural area for the rural health care program, and, if so, what that new definition should be. We seek comment on whether there are any definitions for rural areas used by other government agencies or medical organizations that would be appropriate for the rural health care program. In addition to describing any proposed new definitions, we ask commenters to address the specific proposals that have already been raised in the record. Commenters are encouraged to describe the effects of any new definition to the program, e.g. how many existing rural areas would become non-rural and vice versa. We also seek comment on whether there are reasons we should or should not use the same definition of "rural" for both the rural health care and schools and libraries support mechanisms.

### B. Support for Satellite Services for Mobile Rural Health Clinics

3. We also seek comment on whether additional modifications to our rules are appropriate to facilitate the provision of support to mobile rural health clinics for satellite services. Satellite services may be used by mobile rural health clinics that operate in vans or boats to deliver telemedical services via satellite to residents in rural areas. For example, one non-profit entity is launching the

first mobile telemammography van to diagnose breast cancer in women in four rural tribal lands in North and South Dakota early next year. This van will conduct mammograms and deliver results to rural American Indian women while they wait. The van's clinician will send the mammogram via satellite, which is contained in sixty-four megabytes of data, to doctors at the University of Colorado, who will diagnose any abnormalities and email the van with the patient's results. The van will serve approximately 12,000 women among the four tribes, at a rate of ten to twelve women a day. The van will be stationed at each reservation for approximately two weeks at a time and will travel approximately 200–300 days a year, depending on travel time and maintenance and repairs to the van. Satellite service for the van will cost approximately \$10,000 a month.

4. In the companion *Report and Order*, we conclude that support for satellite services should be capped at the amount a provider would receive if it received functionally-similar terrestrial-based services. We seek comment on whether it is appropriate to apply this rule to mobile rural health care providers, which by their very nature, are unlikely to be able to utilize terrestrially-based services effectively. In particular, due to the mobile nature of a telemedical unit and the large volume of data it will likely send, would a satellite connection be the most cost-effective method of providing service, even if a terrestrial alternative is available? Should a terrestrial alternative be deemed available and "functionally similar," if by its nature it is tied to a fixed location? We seek comment on how mobile health care providers should make a cost-effective determination for satellite services and whether they should consider the installation and disconnection charges that would be incurred if the mobile rural health clinic were to order a wireline connection at each docking location. Commenters should also discuss whether mobile rural health clinics should be required to service a specific number of locations before satellite services are deemed cost-effective.

5. In the event we conclude that the cap on the provision of support for satellite services where terrestrial service is available should not apply in