commenters, this compensation methodology is frequently used by hospitals, physician group practices, academic medical centers, and medical foundations. Several commenters pointed out that this aspect of the final rule, which is applicable to academic medical centers and medical foundations (among others), is inconsistent with the compensation methods permitted under the statute for many physician group practices and employed physicians (that is, neither section 1877(h)(4)(B)(i) of the Act nor section 1877(e)(2) of the Act contains the ''set in advance'' requirement). We understand that hospitals, academic medical centers, medical foundations and other health care entities would have to restructure or renegotiate thousands of physician contracts to comply with the language in § 411.354(d)(1) regarding percentage compensation arrangements.

Accordingly, we published a 1-year delay of the effective date of the last sentence in § 411.354(d)(1) in the **Federal Register** on December 3, 2001 (66 FR 60154), an additional 6-month delay in the effective date on November 22, 2002 (67 FR 70322), and a further 6-month delay on April 25, 2003 (68 FR 20347) in order to reconsider the definition of compensation that is ''set in advance'' as it relates to percentage compensation methodologies.

II. Provisions of this Final Rule

To avoid any unnecessary disruption to existing contractual arrangements while we consider modifying this provision, we are further postponing, for an additional 6 months, until July 7, 2004, the effective date of the last sentence of § 411.354(d)(1). This delay is intended to avoid disruptions in the health care industry, and potential attendant problems for Medicare beneficiaries, which could be caused by allowing the last sentence of § 411.354(d)(1) to become effective on January 7, 2004. In the meantime, compensation that is required to be ''set in advance'' for purposes of compliance with section 1877 of the Act may continue to be based on percentage compensation methodologies, including those in which the compensation is based on a percentage of a fluctuating or indeterminate measure. We note that the remaining provisions of § 411.354(d)(1) will still apply and that all other requirements for exceptions must be satisfied (including, for example, the fair market value and ''volume and value'' requirements.)

III. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking and invite public comment on the proposed rule. This procedure can be waived, however, if an agency finds good cause that the notice and comment rulemaking procedure is impracticable, unnecessary, or contrary to the public interest and if the agency incorporates in the rule a statement of such a finding and the reasons supporting that finding.

Our implementation of this action without opportunity for public comment is based on the good cause exception in 5 U.S.C. 553(b). We find that seeking public comment on this action would be impracticable and unnecessary. We believe public comment is unnecessary because we are implementing this additional delay of effective date as a result of our review of the public comments that we received on the January 4, 2001 physician self-referral final rule. As discussed above, we understand from those comments and the comments we received on the December 3, 2001 interim final rule that, unless we further delay the effective date of the last sentence of § 411.354(d)(1), hospitals, academic medical centers, and other entities will have to renegotiate numerous contracts for physician services, potentially causing significant disruption within the health care industry. We are concerned that the disruption could unnecessarily inconvenience Medicare beneficiaries or interfere with their medical care and treatment. We do not believe that it is necessary to offer yet another opportunity for public comment on the same issue in the limited context of whether to delay this sentence of the regulation. In addition, given the imminence of the January 7, 2004 effective date, we find that seeking public comment on this delay in effective date would be impracticable because it would generate uncertainty regarding an imminent effective date. This uncertainty could cause health care providers to renegotiate thousands of contracts with physicians in an effort to comply with the regulation by January 7, 2004 if the proposed delay is not finalized until after the opportunity for public comment. Thus, providing the opportunity for public comment could result in the very disruption that this delay of effective date is intended to avoid.

(Catalog of Federal Domestic Assistance Program No. 93.773 Medicare—Hospital Insurance Program; Program No. 93.774, Medicare—Supplementary Medical Insurance Program; and Program No. 93.778, Medical Assistance Program)

Dated: September 29, 2003.

Thomas A. Scully,

Administrator, Centers for Medicare & Medicaid Services.

Approved: October 27, 2003.

Tommy G. Thompson,

Secretary.

[FR Doc. 03–31469 Filed 12–23–03; 8:45 am]

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FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 54

[WC Docket No. 02–60, FCC 03–288]

Rural Health Care Support Mechanism

AGENCY: Federal Communications Commission.

ACTION: Final rule; denial of petition for reconsideration.

SUMMARY: In this document, the Commission modifies its 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, the Commission amends its 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. In addition, the Commission denies Mobile Satellite Ventures Subsidiary's petition for reconsideration of the *1997 Universal Service Order.*

DATES: Effective February 23, 2004 except for §§ 54.609(a)(2), 54.609(A)(3)(ii), and 54.621(a) which contain information collection requirements that have not been approved by the Office of Management Budget (OMB). The Commission will publish a document in the **Federal Register** announcing the effective date of those sections.

FOR FURTHER INFORMATION CONTACT: Shannon Lipp, Attorney, (202) 418–7400 or Regina Brown, Attorney, (202) 418–7400, Wireline Competition Bureau, Telecommunications Access Policy Division.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's *Report and Order and Order on Reconsideration*, in WC Docket No. 02–60 released On November 17, 2003. The full text of this document is available for

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 heath 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

prorated support, even when associated with a nursing home, hospice, or other long-term care facility.

7. In addition, at this time, we decline to expand the definition of rural health care provider to include any rural, non-profit health care entity with a certified Medicare and/or Medicare provider number as proposed by commenters. The record lacks sufficient information to identify the types of entities that would become eligible under this proposal, as Medicare/Medicaid supports a wide range of services, drugs, and products. We are concerned that by including such entities within the definition of ''health care provider'' we may exceed our statutory authority. Moreover, with the information in the record we are unable to determine the potential impact on the demand for support.

B. Eligible Services

1. Internet Access

8. Given the rapid development of the Internet's capacities, the proliferation of applications available on the Internet, and the increase in the number of Internet users since the *1997 Universal Service Order* was issued, we believe that it is now appropriate to provide funding for Internet access to rural health care providers. In particular, 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. The definition for Internet access that we adopt here is intended to provide rural health care providers considerable flexibility to utilize the resources available over the Internet that will assist them in fulfilling their health care needs.

9. We agree with commenters 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 the 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 provide access to such a breadth of medical information may also help reduce isolation in rural communities. 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.

10. 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. We agree with commenters that Internet access provides a vital link to information and instantaneous communications in times of natural disasters and public health emergencies. National connectivity of telehealth and telemedicine networks could also promote the national defense by serving as vehicles for rapid, secure communications in times of emergency, due to outbreaks of disease or biological and chemical attacks.

11. Accordingly, for purposes of the rural health care support mechanism only, we define ''eligible Internet access'' as ''an information service that enables rural health care providers to post their own data, interact with stored data, generate new data, or communicate over the World Wide Web.'' Eligible Internet access provides access to the world-wide information resource of the Internet, and includes all features typically provided by Internet service providers to provide adequate functionality and performance. To qualify as Internet access under the definition we adopt today for the rural health care support mechanism, transmissions must traverse the Internet in some fashion. Internet access may provide transport of digital communications using any Internet-based protocols, including encapsulation of data, video, or voice.

12. We specifically decline to adopt the definition of Internet access currently used in the schools and libraries support mechanism. Under those rules, Internet access includes: This definition thus specifically precludes support for features that provide the capability to generate or alter the content of information. We believe adopting such a limitation for the rural health care program would significantly undercut the utility of providing support for Internet access to rural health care providers, because the ability to alter and interact with information over the Internet is precisely the feature that could facilitate improved medical care in rural areas. Under the rural health care support mechanism, we will provide support for Internet access, as long as it is reasonably related to the health care needs of the facility, and it is the most cost-effective method of meeting those needs. We will not provide support, however, for the purchase of internal connections, computer equipment or other telecommunications equipment, even when used to access the Internet, because such items are not information services.

13. We conclude that a flat discount percentage of twenty-five percent off the cost of monthly Internet access will assist health care providers seeking to purchase Internet access, while also providing incentives for rural health care providers to make prudent economic decisions concerning their telemedical needs. We agree with commenters that a flat discount, analogous to the operation of the schools and libraries support mechanism, will lead to greater predictability and fairness among health care providers. A flat discount is consistent with section 254(b)(5), which requires ''a specific, sufficient, and predictable mechanism * * * because it limits the amount of support that each health care provider may receive per month to a reasonable level.'' A flat discount is also easy to administer. Although it is difficult to estimate the impact of providing support for Internet access service due to the wide range of costs between and among the various types of Internet access services, we agree with commenters' projections that our actions today regarding Internet access are unlikely to result in program demand in excess of the cap. We act conservatively by choosing a twenty-five percent flat discount initially because it will provide an incentive for rural health care providers to choose a level of service appropriate to their needs, will provide more certainty that demand for Internet access support will not exceed the annual funding cap, and will deter wasteful expenditures. Furthermore, we find that a twenty-five percent discount is reasonable because provision of support to health care providers under the rural health care support mechanism is not contingent on economic need, similar to the twenty-five percent discount provided to the least disadvantaged rural schools and libraries. As we gain more experience with this aspect of the support mechanism, we will determine whether an increase in the discount is necessary or advisable. Finally, we disagree with WorldCom that support for Internet access must be based on the difference between urban and rural rates, because section 254(h)(2)(A) of the Act, the statutory provision dealing with information services, makes no reference to an urban-rural comparison, unlike section 254(h)(1)(A). The urban-rural comparison for telecommunications services that WorldCom cites to in section 254(h)(1)(A) does not apply to information services such as Internet

access. Provision of Internet access and other information services is governed by section 254(h)(2)(A).

14. Consistent with the Commission's long-standing principles of competitive neutrality, rural health care providers may receive discounts for the most cost-effective form of Internet access, regardless of the platform. Thus, a provider could opt for dial-up Internet access or broadband Internet access over wireline, cable, wireless, or satellite platforms. Health care providers must certify, however, that the particular Internet access service selected is the most cost-effective way of meeting the facility's health care needs. We believe this policy will provide flexibility to rural health care providers to purchase the most appropriate offerings for their health care needs and may also facilitate the deployment of facilities-based broadband deployment in rural areas.

15. Moreover, we will continue to provide support for toll charges incurred by health care providers that cannot obtain toll-free access to an ISP, limited to the lesser of $180.00 or 30 hours of usage per month. The *1997 Universal Service Order* stated that the proliferation of ISPs and the competitive marketplace ''soon should eliminate the need for such support.'' However, we are persuaded by commenters' showings that the need for such support still exists. Providing support for limited toll charges will place those providers who cannot reach an ISP without incurring toll charges on the same footing as other health care providers with respect to Internet access.

2. Other Services

16. We decline at this time to provide support for services other than telecommunications services, Internet access, and limited toll charges. In the *NPRM*, 67 FR 34653 (May 15, 2002) the Commission sought comment on whether we should establish new policies to enhance access to advanced telecommunications and information services for health care providers consistent with the scope of our authority under section 254(h)(2)(A). Commenters suggested that telecommunications equipment, surcharges imposed by statewide or regional networks, internal connections, and health care providers' travel costs should be eligible for universal service support. We find that providing support for telecommunications equipment, surcharges, and travel costs exceeds the scope of our statutory authority under section 254(h), because these items are neither telecommunications nor information services. In addition, we believe there is insufficient information in the record to provide support for internal connections. Moreover, given our experience with the schools and libraries support mechanism, we are concerned that providing support for internal connections may place an undue burden on the rural health care support mechanism.

C. Calculation of Discounted Services

1. Interpretation of ''Similar Services''

17. We 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. We agree with commenters that our current policy of comparing technically similar services does not take into account that certain telecommunications services offered in urban areas are not always available in rural areas. In particular, new technologies are often first deployed in urban areas, and such services may be less expensive than services in rural areas based on older technologies. 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. Eligible health care providers must purchase telecommunications services and compare their service to a functionally equivalent telecommunications service in order to receive this discount.

18. Accordingly, we create ''safe harbor'' categories of functionally equivalent services based on the advertised speed and nature of the service. For purposes of the rural health care support mechanism only, we establish the following advertised speed categories as functionally equivalent: low—144–256 kbps; medium—257–768 kbps; high—769–1400 kbps (1.4 mbps); T–1—1.41–8 mbps; T–3—8.1–50 mbps. We will also consider whether a service is symmetrical or asymmetrical when determining functional equivalencies. Telecommunications services will be considered functionally similar when operated at advertised speeds within the same category (low, medium, high, T–1, or T–3) and when the nature of the service is the same (symmetrical or asymmetrical). For example, a symmetrical fractional T–1 service operating at an advertised speed of 144 kbps would be considered functionally similar to a symmetrical DSL transmission service with an advertised speed of 256 kbps. By developing ''safe harbor'' categories of functionally equivalent speeds, we hope to minimize the disparity in rates of services available in rural and urban areas in an administratively easy fashion. We will update these categories, as needed, to reflect technological developments.

2. Urban Area

19. We now revise section 54.605 of our rules to allow rural health care providers to compare rural rates to urban rates in any city with a population of at least 50,000 in the state, as opposed to the nearest city with a population of 50,000. The Commission originally required comparison to the nearest city with 50,000 people, in part, because they believed health care providers would likely connect to a point in that nearest large city. Based on our experience with the program and information in the record, health care providers may not always find the needed expertise in the nearest large city. Allowing comparison to rates in any city in the state acknowledges that rural health care providers may communicate with experts in other cities in the state. Such action also should allow rural health care providers to benefit from the lowest rates for services in the State, thereby providing additional support to develop better telemedicine links. Verizon asserts that, under this policy, rural health care providers may receive better rates than those available in some urban areas of the state. However, we believe that the public interest in providing more flexibility in utilizing telemedicine services and quality health care facilities outweighs any minimal advantage gained by rural health care providers over those health care providers located in certain urban areas. Further, we do not believe the urban rates within states differ so significantly that revising this rule will increase demand to the extent that we may risk exceeding the funding cap of $400 million.

3. Maximum Allowable Distance

20. We revise the Maximum Allowable Distance (MAD) to equal the distance between the rural health care provider and the farthest point on the jurisdictional boundary of the largest city in that State. Accordingly, for distance-based charges actually incurred, we modify our rules to provide support to rural health care providers to any location that exceeds the SUD and is less than this revised MAD. As the Commission indicated in the *NPRM,* our experience to date suggests that limiting rural heath care providers to discounts for distance-based charges to the nearest city of

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

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.

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 heath 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.

40. We also revise § 54.605 of our rules to allow rural health care providers to compare rural rates to urban rates in any city with a population of at least 50,000 in the state, as opposed to the nearest city with a population of 50,000. Allowing comparison to rates in any city in the state acknowledges that rural health care providers may communicate with experts in other cities in the state. Such action also should allow rural health care providers to benefit from the lowest rates for services in the State, thereby providing additional support to develop better telemedicine links.

41. Additionally, we revise the maximum allowable distance (MAD) to equal the distance between the rural health care provider and the farthest point on the jurisdictional boundary of the largest city in that State. Accordingly, for distance-based charges, we modify our rules to provide support to rural health care providers to any location (within or outside of the state) that exceeds the SUD and is less than this revised MAD. 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.

42. Lastly, 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. However, these discounts will be capped at the amount providers would have received if they purchased functionally similar terrestrial-based alternatives. 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.

2. Summary of Significant Issues Raised by Public Comments in Response to the IRFA

43. No petitions for reconsideration or comments were filed directly in response to the IRFA or on issues affecting small businesses.

3. Description and Estimate of the Number of Small Entities to Which Rules Will Apply

44. The RFA directs agencies to provide a description of, and where feasible, an estimate of the number of small entities that may be affected by the proposed rules, if adopted. The RFA generally defines the term ''small entity'' as having the same meaning as the terms ''small business,'' ''small organization,'' and ''small governmental jurisdiction.'' In addition, the term ''small business'' has the same meaning as the term ''small business concern'' under the Small Business Act. A ''small business concern'' is one which: (1) Is independently owned and operated; (2) is not dominant in its field of operation; and (3) satisfies any additional criteria established by the Small Business Administration (SBA).

45. A small organization is generally ''any not-for-profit enterprise which is independently owned and operated and is not dominant in its field.'' Nationwide, as of 1992, there were approximately 275,801 small organizations. The term ''small governmental jurisdiction'' is defined as ''governments of cities, counties, towns, townships, villages, school districts, or special districts, with a population of less than fifty thousand.'' As of 1997, there were approximately 87,453 government jurisdictions in the United States. This number includes 39,044 counties, municipal governments, and townships, of which 27,546 have populations of fewer than 50,000 and 11,498 counties, municipal governments, and townships have populations of 50,000 or more. Thus, we estimate that the number of small government jurisdictions must be 75,955 or fewer. Small entities potentially affected by the proposals herein include small rural health care providers, small local health departments and agencies, and small eligible service providers offering discounted services to rural health care providers, including telecommunications carriers and ISPs.

a. Rural Health Care Providers

46. Section 254(h)(5)(B) of the Act defines the term ''health care provider'' and sets forth seven categories of health care providers eligible to receive universal service support. Although SBA has not developed a specific size category for small, rural health care providers, recent data indicate that there are a total of 8,297 health care providers, consisting of: (1) 625 ''post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools;'' (2) 866 ''community health centers or health centers providing health care to migrants;'' (3) 1633 ''local health departments or agencies;'' (4) 950 ''community mental health centers;'' (5) 1951 ''not-for-profit hospitals;'' and (6) 2,272 ''rural health clinics.'' We have no additional data specifying the numbers of these health care providers that are small entities. In addition, non-profit entities that act as ''health care providers'' on a part-time basis will now be eligible to receive prorated support. However, we have no data specifying the number of potential new applicants. Consequently, using the data we do have, we estimate that there are 8,297 or fewer small health care providers potentially affected by the actions proposed in this Notice.

47. As noted, non-profit businesses and small governmental units are considered ''small entities'' within the RFA. In addition, we note that census categories and associated generic SBA small business size categories provide the following descriptions of small entities. The broad category of Ambulatory Health Care Services consists of further categories and the following SBA small business size standards. The categories of providers with annual receipts of $6 million or less consists of: Offices of Dentists; Offices of Chiropractors; Offices of Optometrists; Offices of Mental Health Practitioners (except Physicians); Offices of Physical, Occupational and Speech Therapists and Audiologists; Offices of Podiatrists; Offices of All Other Miscellaneous Health Practitioners; and Ambulance Services. The category of Ambulatory Health Care Services providers with $8.5 million or less in annual receipts consists of: Offices of Physicians; Family Planning Centers; Outpatient Mental Health and Substance Abuse Centers; Health Maintenance Organization Medical Centers; Freestanding Ambulatory Surgical and Emergency Centers; All Other Outpatient Care Centers, Blood and Organ Banks; and All Other Miscellaneous Ambulatory Health Care Services. The category of Ambulatory Health Care Services providers with $11.5 million or less in annual receipts consists of: Medical Laboratories; Diagnostic Imaging Centers; and Home Health Care Services. The category of Ambulatory Health Care Services providers with $29 million or less in annual receipts consists of Kidney Dialysis Centers. For all of these Ambulatory Health Care Service Providers, census data indicate that there is a combined total of 345,476 firms that operated in 1997. Of these, 339,911 had receipts for that year of less than $5 million. In addition, an additional 3414 firms had annual receipts of $5 million to $9.99 million; and additional 1475 firms had receipts of $10 million to $24.99 million; and an additional 401 had receipts of $25

million to $49.99 million. We therefore estimate that virtually all Ambulatory Health Care Services providers are small, given SBA's size categories. In addition, we have no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

48. The broad category of Hospitals consists of the following categories and the following small business providers with annual receipts of $29 million or less: General Medical and Surgical Hospitals, Psychiatric and Substance Abuse Hospitals; and Specialty Hospitals. For all of these health care providers, census data indicate that there is a combined total of 330 firms that operated in 1997, of which 237 or fewer had revenues of less than $25 million. An additional 45 firms had annual receipts of $25 million to $49.99 million. We therefore estimate that most Hospitals are small, given SBA's size categories. In addition, we have no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

49. The broad category of Nursing and Residential Care Facilities consists of the following categories and the following small business size standards. The category of Nursing and Residential Care Facilities with annual receipts of $6 million or less consists of: Residential Mental Health and Substance Abuse Facilities; Homes for the Elderly; and Other Residential Care Facilities. The category of Nursing and Residential Care Facilities with annual receipts of $8.5 million or less consists of Residential Mental Retardation Facilities. The category of Nursing and Residential Care Facilities with annual receipts of less than $11.5 million consists of Nursing Care Facilities and Continuing Care Retirement Communities. For all of these health care providers, census data indicates that there are a combined total of 18,011 firms that operated in 1997. Of these, 16,165 or fewer firms had annual receipts of below $5 million. In addition, 1205 firms had annual receipts of $5 million to $9.99 million, and 450 firms had receipts of $10 million to $24.99 million. We therefore estimate that a great majority of Nursing and Residential Care Facilities are small, given SBA's size categories. In addition, we have no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

50. The broad category of Social Assistance consists of the category of Emergency and Other Relief Services and small business size standard of annual receipts of $6 million or less. For all of these health care providers, census data indicates that there are a combined total of 37,778 firms that operated in 1997. Of these, 37,649 or fewer firms had annual receipts of below $5 million. An additional 73 firms had annual receipts of $5 million to $9.99 million. We therefore estimate that virtually all Social Assistance providers are small, given SBA's size categories. In addition, we have no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

b. Providers of Telecommunications and Other Services

51. We have included small incumbent local exchange carriers in this present RFA analysis. As noted, a ''small business'' under the RFA is one that, inter alia, meets the pertinent small business size standard (*e.g.*, a telephone communications business having 1,500 or fewer employees), and ''is not dominant in its field of operation.'' The SBA's Office of Advocacy contends that, for RFA purposes, small incumbent local exchange carriers are not dominant in their field of operation because any such dominance is not ''national'' in scope. We have therefore included small incumbent local exchange carriers in this RFA analysis, although we emphasize that this RFA action has no effect on Commission analyses and determinations in other, non-RFA contexts.

52. Total Number of Telephone Companies Affected. The United States Bureau of the Census (the ''Census Bureau'') reports that, at the end of 1997, there were 6,239 firms engaged in providing telephone services, as defined therein. This number contains a variety of different categories of carriers, including local exchange carriers, interexchange carriers, competitive access providers, cellular carriers, mobile service carriers, operator service providers, pay telephone operators, PCS providers, covered SMR providers, and resellers. It seems certain that some of those 6,239 telephone service firms may not qualify as small entities because they are not ''independently owned and operated.'' For example, a PCS provider that is affiliated with an interexchange carrier having more than 1,500 employees would not meet the definition of a small business. It seems reasonable to conclude, therefore, that 6,239 or fewer telephone service firms are small entity telephone service firms that may be affected by the decisions and rules adopted in this *Report and Order.*

53. Local Exchange Carriers, Interexchange Carriers, Competitive Access Providers, Operator Service Providers, Payphone Providers, and Resellers. Neither the Commission nor SBA has developed a definition particular to small local exchange carriers (LECs), interexchange carriers (IXCs), competitive access providers (CAPs), operator service providers (OSPs), payphone providers or resellers. The closest applicable definition for these carrier-types under SBA rules is for telephone communications companies other than radiotelephone (wireless) companies. The most reliable source of information regarding the number of these carriers nationwide of which we are aware appears to be the data that we collect annually on the Form 499–A. According to our most recent data, there are 1,335 incumbent LECs, 349 CAPs, 204 IXCs, 21 OSPs, 758 payphone providers and 454 resellers. Although it seems certain that some of these carriers are not independently owned and operated, or have more than 1,500 employees, we are unable at this time to estimate with greater precision the number of these carriers that would qualify as small business concerns under SBA's definition. Consequently, we estimate that there are fewer than 1,335 incumbent LECs, 349 CAPs, 204 IXCs, 21 OSPs, 758 payphone providers, and 541 resellers that may be affected by the decisions and rules adopted in this *Report and Order.*

54. Internet Service Providers. The SBA has developed a small business size standard for ''On-Line Information Services,'' NAICS code 514191. This category comprises establishments ''primarily engaged in providing direct access through telecommunications networks to computer-held information compiled or published by others.'' Under this small business size standard, a small business is one having annual receipts of $18 million or less. Based on firm size data provided by the Bureau of the Census, 3,123 firms are small under SBA's $18 million size standard for this category code. Although some of these Internet Service Providers (ISPs) might not be independently owned and operated, we are unable at this time to estimate with greater precision the number of ISPs that would qualify as small business concerns under SBA's small business size standard. Consequently, we estimate that there are 3,123 or fewer small entity ISPs that may be affected.

55. Satellite Service Carriers. The SBA has developed a definition for small businesses within the category of Satellite Telecommunications. According to SBA regulations, a small business under the category of Satellite communications is one having annual receipts of $12.5 million or less. According to SBA's most recent data,

there are a total of 371 firms with annual receipts of $9,999,999 or less, and an additional 69 firms with annual receipts of $10,000,000 or more. Thus, the number of Satellite Telecommunications firms that are small under the SBA's $12 million size standard is between 371 and 440. Further, some of these Satellite Service Carriers might not be independently owned and operated. Consequently, we estimate that there are fewer than 440 small entity ISPs that may be affected by the decisions and rules of the present action.

56. Wireless Service Providers. The SBA has developed a definition for small businesses within the two separate categories of Cellular and Other Wireless Telecommunications or Paging. Under that SBA definition, such a business is small if it has 1,500 or fewer employees. According to the Commission's most recent Telephone Trends Report data, 1,495 companies reported that they were engaged in the provision of wireless service. Of these 1,495 companies, 989 reported that they have 1,500 or fewer employees and 506 reported that, alone or in combination with affiliates, they have more than 1,500 employees. We do not have data specifying the number of these carriers that are not independently owned and operated, and thus are unable at this time to estimate with greater precision the number of wireless service providers that would qualify as small business concerns under the SBA's definition. Consequently, we estimate that there are 989 or fewer small wireless service providers that may be affected by the rules.

57. Cable and Other Subscription Programming or Other Program Distribution and Related Entities. The SBA has developed small business size standards which include all such companies generating $12.5 million or less in revenue annually. These standards cover two categories of Cable Services: Cable and Other Subscription Programming; and Cable and Other Program Distribution.

58. Cable and Other Subscription Programming. This industry comprises establishments primarily engaged in operating studios and facilities for the broadcasting of programs on a subscription or fee basis. These establishments produce programming in their own facilities or acquire programming from external sources. The programming material is usually delivered to a third party, such as cable systems or direct-to-home satellite systems, for transmission to viewers. According to Census Bureau data for 1997, there were a total of 234 firms in this category, total, that had operated for the entire year. Of this total, 188 firms had annual receipts of under $10 million. Consequently, the Commission estimates that the majority of providers in this service category are small businesses that may be affected by the rules and policies adopted herein.

59. Cable and Other Program Distribution. This category includes cable systems operators, closed circuit television services, direct broadcast satellite services, multipoint distribution systems, satellite master antenna systems, and subscription television services. According to Census Bureau data for 1997, there were a total of 1,311 firms in this category, total, that had operated for the entire year. Of this total, 1,180 firms had annual receipts of under $10 million and an additional 52 firms had receipts of $10 million or more but less than $25 million. Consequently, the Commission estimates that the majority of providers in this service category are small businesses that may be affected by the rules and policies adopted herein.

4. Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements

60. The *Report and Order* adopts 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. As articulated, in the *Report and Order*, we clarify the scope of entities eligible to receive discounts. Specifically, because entities that engage in 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. Health care providers are required to maintain documentation explaining their allocation methods for five years and present that information to USAC upon request. The method of cost allocation chosen by an applicant should be based on objective criteria and reasonably reflect the eligible usage of the facilities. Additionally, health care providers must maintain for their purchases of supported services procurement records for at least five years sufficient to document their compliance with all Commission requirements.

5. Steps Taken To Minimize Significant Economic Impact on Small Entities, and Significant Alternatives Considered

61. The RFA requires an agency to describe any significant alternatives that it has considered in reaching its proposed approach impacting small business, which may include the following four alternatives (among others): (1) the establishment of differing compliance and reporting requirements or timetables that take into account the resources available to small entities; (2) the clarification, consolidation, or simplification of compliance or reporting requirements under the rule for small entities; (3) the use of performance, rather than design, standards; and (4) an exemption from coverage of the rule, or part thereof, for small entities.

62. In this *Report and Order*, 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. The actions taken in the *Report and Order* 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. Thus, rural health care providers stand to benefit directly from the modifications to our rules and policies.

6. Report to Congress

63. The Commission will send a copy of the *Report and Order and Order on Reconsideration* including this FRFA, in a report to be sent to Congress pursuant to the Congressional Review Act. In addition, the Commission will send a copy of the *Report and Order and Order on Reconsideration* including this FRFA, to the Chief Counsel for Advocacy of the Small Business Administration. A copy of the *Report and Order and Order on Reconsideration* and FRFA (or summaries thereof) will also be published in the **Federal Register**.

B. Paperwork Reduction Act Analysis

64. The action contained herein has been analyzed with respect to the Paperwork Reduction Act of 1995 and found to impose new or modified reporting and recordkeeping requirements or burdens on the public. Implementation of these new or

modified reported and recordkeeping requirements will be subject to approval by the Office of Management and Budget (OMB) as prescribed by the Act, and will go into effect upon announcement in the **Federal Register** of OMB approval.

C. Further Information

65. Alternative formats (computer diskette, large print, audio recording, and Braille) are available to persons with disabilities by contacting Brian Millin at (202) 418–7426 voice, (202) 418–7365 TTY, or *bmillin@fcc.gov*. This *Report and Order* can also be downloaded in Microsoft Word and ASCII formats at <*http://www.fcc.gov/ccb/universalservice/highcost*>.

66. For further information, contact Shannon Lipp at (202) 418–7954 or Regina Brown at (202) 418–0792 in the Telecommunications Access Policy Division, Wireline Competition Bureau.

V. Ordering Clauses

67. Pursuant to the authority contained in sections 1, 4(i), 4(j), 201–205, 214, 254, and 403 of the Communications Act of 1934, as amended, 47 U.S.C. 151, 154(i), 154(j), 201–205, 214, 254, and 403, this *Report and Order and Order on Reconsideration* is adopted.

68. Pursuant to the authority contained in section 405, of the Communications Act of 1934, as amended, 47 U.S.C. 405, and 0.291 and 1.429 of the Commission's rules, Mobile Satellite Ventures Subsidiary's Petition for Clarification or Reconsideration is denied to the extent indicated herein.

69. Part 54 of the Commission's rules, is amended, effective January 23, 2004 except for §§ 54.609(a)(2), 54.609(A)(3)(ii), and 54.621(a) which contain information collection requirements that have not been approved by the Office of Management and Budget (OMB). The Commission will publish a document in the **Federal Register** announcing the effective date of those sections.

70. The Commission's Consumer and Governmental Affairs Bureau, Reference Information Center, shall send a copy of this *Report and Order and Order on Reconsideration*, including the Final Regulatory Flexibility Analysis and Initial Regulatory Flexibility Analysis, to the Chief Counsel for Advocacy of the Small Business Administration.

List of Subjects in 47 CFR Part 54

Libraries, Reporting and recordkeeping requirements, Schools, Telecommunications, Telephone.

Federal Communications Commission.

Marlene H. Dortch,

Secretary.

Final Rules

■ For the reasons discussed in the preamble, the Federal Communications Commission amends 47 CFR part 54 as follows:

PART 54—UNIVERSAL SERVICE

■ 1. The authority citation for Part 54 continues to read as follows:

Authority: 47 U.S.C. 1, 4(i), 201, 205, 214, and 254 unless otherwise noted.

■ 2. Amend § 54.601 by removing paragraphs (a)(3), (b)(3), and (b)(4), redesignating paragraphs (a)(4) and (a)(5) as (a)(3) and (a)(4), revising paragraphs (a)(1), newly designated (a)(3) and (c), and by adding paragraph (d) to read as follows:

§ 54.601 Eligibility.

(a) * * *

(1) Except with regard to those services provided under § 54.621(b), only an entity that is either a public or non-profit rural health care provider, as defined in this section, shall be eligible to receive supported services under this subpart.

* * * * *

(3) For purposes of this subpart, a rural health care provider is a public or non-profit health care provider located in a rural area, as defined in this subpart.

* * * * *

(c) *Services.* (1) Any telecommunications service that is the subject of a properly completed bona fide request by a rural health care provider shall be eligible for universal service support, subject to the limitations described in this paragraph. The length of a supported telecommunications service may not exceed the distance between the health care provider and the point farthest from that provider on the jurisdictional boundary of the largest city in a state as defined in § 54.625(a).

(2) Internet access and limited toll-free access to internet. (i) For purposes of this subpart, eligible Internet access is an information service that enables rural health care providers to post their own data, interact with stored data, generate new data, or communicate over the World Wide Web.

(ii) Internet access shall be eligible for universal service support under § 54.621(a).

(iii) Limited toll-free access to an Internet service provider shall be eligible for universal service support under § 54.621(b).

(d) *Allocation of discounts.* An eligible health care provider that engages in eligible and ineligible activities or that collocates with an entity that provides ineligible services shall allocate eligible and ineligible activities in order to receive a prorated discount for eligible activities. Health care providers shall choose a method of cost allocation that is based on objective criteria and reasonably reflects the eligible usage of the facilities.

§ 54.603 [Amended]

■ 3. Amend § 54.603 by revising the term ''Rural Health Care Corporation'' in paragraphs (b)(1), (b)(2), (b)(3), (b)(4), and (b)(5) to read ''Rural Health Care Division.''

■ 4. Amend § 54.605 by removing paragraph (c), redesignating paragraphs (d) and (e) as paragraphs (c) and (d), and revising paragraphs (a) and (b) to read as follows:

§ 54.605 Determining the urban rate.

(a) If a rural health care provider requests an eligible service to be provided over a distance that is less than or equal to the ''standard urban distance,'' as defined in paragraph (c) of this section, for the state in which it is located, the urban rate for that service shall be a rate no higher than the highest tariffed or publicly-available rate charged to a commercial customer for a functionally similar service in any city with a population of 50,000 or more in that state, calculated as if it were provided between two points within the city.

(b) If a rural health care provider requests an eligible service to be provided over a distance that is greater than the ''standard urban distance,'' as defined in paragraph (c) of this section, for the state in which it is located, the urban rate for that service shall be a rate no higher than the highest tariffed or publicly-available rate charged to a commercial customer for a functionally similar service provided over the standard urban distance in any city with a population of 50,000 or more in that state, calculated as if the service were provided between two points within the city.

* * * * *

■ 5. Revise § 54.609 to read as follows:

§ 54.609 Calculating support.

(a) Except with regard to services provided under § 54.621 and subject to the limitations set forth in this subpart, the amount of universal service support for an eligible service provided to a public or non-profit rural health care provider shall be the difference, if any,

between the urban rate and the rural rate charged for the service, as defined herein. In addition, all reasonable charges that are incurred by taking such services, such as state and federal taxes shall be eligible for universal service support. Charges for termination liability, penalty surcharges, and other charges not included in the cost of taking such service shall not be covered by the universal service support mechanisms. Rural health care providers may choose one of the following two support options.

(1) *Distance based support.* The Administrator shall consider the base rates for telecommunications services in rural areas to be reasonably comparable to the base rates charged for functionally similar telecommunications service in urban areas in that state, and, therefore, the Administrator shall not include these charges in calculating the support. The Administrator shall include, in the support calculation, all other charges specified, and all actual distance-based charges as follows:

(i) If the requested service distance is less than or equal to the SUD for the state, the distance-based charges for the rural health care provider are reasonably comparable to those in urban areas, so the health care provider will not receive distance-based support.

(ii) If the requested service distance is greater than the SUD for the state, but less than the maximum allowable distance, the distance-based charge actually incurred for that service can be no higher than the distance-based charges for a functionally similar service in any city in that state with a population of 50,000 or more over the SUD.

(iii) ''Distance-based charges'' are charges based on a unit of distance, such as mileage-based charges.

(iv) Except with regard to services provided under § 54.621, a telecommunications carrier that provides telecommunications service to a rural health care provider participating in an eligible health care consortium, and the consortium must establish the actual distance-based charges for the health care provider's portion of the shared telecommunications services.

(2) *Base rate support.* If a telecommunications carrier, health care provider, and/or consortium of health care providers reasonably determines that the base rates for telecommunications services in rural areas are not reasonably comparable to the base rates charged for functionally similar telecommunications service in urban areas in that state, the telecommunications carrier, health care provider, and/or consortium of health care providers may request that the Administrator perform a more comprehensive support calculation. The requester shall provide to the Administrator the information to establish both the urban and rural rates consistent with § 54.605 and § 54.607, and submit to the Administrator with Form 466 all of the documentation necessary to substantiate the request.

(3) *Base rate support-consortium.* Except with regard to services provided under § 54.621, a telecommunications carrier that provides telecommunications service to a rural health care provider participating in an eligible health care consortium, and the consortium must establish the applicable rural base rates for telecommunications service for the health care provider's portion of the shared telecommunications services, as well as the applicable urban base rates for the telecommunications service.

(b) Absent documentation justifying the amount of universal service support requested for health care providers participating in a consortium, the Administrator shall not allow telecommunications carriers to offset, or receive reimbursement for, the amount eligible for universal service support.

(c) The universal service support mechanisms shall provide support for intrastate telecommunications services, as set forth in § 54.101(a), provided to rural health care providers as well as interstate telecommunications services.

(d) *Satellite services.* (1) Rural public and non-profit health care providers may receive support for rural satellite services, even when another functionally similar terrestrial-based service is available in that rural area. Discounts for satellite services shall be capped at the amount the rural health care provider would have received if they purchased a functionally similar terrestrial-based alternative.

(2) Rural health care providers seeking discounts for satellite services shall provide to the Administrator with the Form 466 documentation of the urban and rural rates for the terrestrial-based alternatives.

(3) Where a rural health care provider seeks a more expensive satellite-based service when a less expensive terrestrial-based alternative is available, the rural health care provider shall be responsible for the additional cost.

■ 6. Amend § 54.613 by revising paragraph (a) to read as follows:

§ 54.613 Limitations on supported services for rural health care providers.

(a) Upon submitting a bona fide request to a telecommunications carrier, each eligible rural health care provider is entitled to receive the most cost-effective, commercially-available telecommunications service at a rate no higher than the highest urban rate, as defined in § 54.605, at a distance not to exceed the distance between the eligible health care provider's site and the farthest point on the jurisdictional boundary of the city in that state with the largest population.

* * * * *

■ 7. Revise § 54.619 to read as follows:

§ 54.619 Audits and recordkeeping.

(a) *Health care providers. Recordkeeping.* Health care providers shall maintain for their purchases of services supported under this subpart documentation for five years from the end of the funding year sufficient to establish compliance with all rules in this subpart. Documentation must include, among other things, records of allocations for consortia and entities that engage in eligible and ineligible activities, if applicable.

(b) *Production of records.* Health care providers shall produce such records at the request of any auditor appointed by the Administrator or any other state or federal agency with jurisdiction.

(c) *Random audits.* Health care providers shall be subject to random compliance audits to ensure that requesters are complying with the certification requirements set forth in § 54.615(c) and are otherwise eligible to receive universal service support and that rates charged comply with the statute and regulations.

(d) *Annual report.* The Administrator shall use the information obtained under paragraphs (a), (b) and (c) of this section to evaluate the effects of the regulations adopted in this subpart and shall report its findings to the Commission on the first business day in May of each year.

■ 8. Revise § 54.621 to read as follows:

§ 54.621 Access to advanced telecommunications and information services.

(a) Twenty-five percent of the monthly cost of eligible Internet access shall be eligible for universal support. Health care providers shall certify that the Internet access selected is the most cost-effective method for their health care needs as defined in § 54.615(c)(7), and that purchase of the Internet access is reasonably related to the health care needs of the rural health care provider.

(b) Each eligible health care provider that cannot obtain toll-free access to an Internet service provider shall be entitled to receive the lesser of the toll charges incurred for 30 hours of access

per month to an Internet service provider or $180 per month in toll charge credits for toll charges imposed for connecting to an Internet service provider.

■ 9. Amend § 54.625 by revising paragraph (a) to read as follows:

§ 54.625 Support for services beyond the maximum supported distance for rural health care providers.

(a) The maximum support distance is the distance from the health care provider to the farthest point on the jurisdictional boundary of the city in that state with the largest population, as calculated by the Administrator.

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[FR Doc. 03–31683 Filed 12–23–03; 8:45 am]

BILLING CODE 6712–01–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 64

[CC Docket No. 98–67; FCC 00–56]

Telecommunications Relay Services and Speech-to-Speech Services for Individuals With Hearing and Speech Disabilities

AGENCY: Federal Communications Commission.

ACTION: Final rule; announcement of effective date.

SUMMARY: In this document, the Commission announces the effective date of the amendments to the Commission's rules for governing telecommunications relay services (TRS) and related customer premises equipment for persons with disabilities that contained information collection requirements.

DATES: 47 CFR 64.604(b)(2), (c)(1), (c)(5)(i) and 64.605(f) published at 65 FR 38432, June 21, 2000, are effective June 29, 2000.

FOR FURTHER INFORMATION CONTACT: Cheryl King, Consumer & Governmental Affairs Bureau, Disability Rights Office, (202) 418–2517 (voice), (202) 418–0416 (TTY).

SUPPLEMENTARY INFORMATION: On March 6, 2000, the Commission released a *Report and Order*, published at 65 FR 38432, June 21, 2002, in CC Docket No. 98–67; FCC 00–56. The information collections contained in the *Report and Order* were approved by OMB on June 20, 2000. The OMB approval of the information collections contained in the *Report and Order* was announced in the **Federal Register** on June 29, 2000. *See* 65 FR 40093, June 29, 2000.

Pursuant to the Paperwork Reduction Act of 1995, Public Law 104–13, an agency may not conduct or sponsor a collection of information unless it displays a currently valid control number. Notwithstanding any other provisions of law, no persons shall be subject to any penalty for failing to comply with a collection of information subject to the Paperwork Reduction Act (PRA) that does not display a valid control number. Questions concerning the OMB control numbers and expiration dates should be directed to Les Smith, Federal Communications Commission, (202) 418–0217. The OMB Control Number is 3060–0463.

Synopsis

In the *Report and Order*, the Commission amended its rules governing the delivery of TRS to expand the kinds of relay services available to consumers and to improve the quality of relay service. The Commission also amended its rules to better conform to the statutory mandate that TRS must be ''functionally equivalent'' to voice telecommunications service to the extent possible. Among other things, these rules are intended to improve the speed at which calls are answered and conversations relayed.

List of Subjects in 47 CFR Part 64

Individuals with disabilities, Telecommunications relay service.

Federal Communications Commission.

Marlene H. Dortch,

Secretary.

[FR Doc. 03–31767 Filed 12–23–03; 8:45 am]

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DEPARTMENT OF COMMERCE

National Oceanic and Atmospheric Administration

50 CFR Part 635

[Docket No.031028268–3321–02; I.D. 091603F]

RIN 0648–AR12

Atlantic Highly Migratory Species; Bluefin Tuna Season and Size Limit Adjustments

AGENCY: National Marine Fisheries Service (NMFS), National Oceanic and Atmospheric Administration (NOAA), Commerce.

ACTION: Final rule.

SUMMARY: Under the framework provisions of the Fishery Management Plan for Atlantic Tunas, Swordfish, and Sharks (HMS FMP) governing the Atlantic bluefin tuna (BFT) fishery, NMFS amends the regulations regarding the opening date of the Purse seine category, closure dates of the Harpoon and General categories, and size tolerances of large medium BFT for the Purse seine and Harpoon categories. The intent of this final rule is to further achieve domestic management objectives under the HMS FMP and Magnuson-Stevens Fishery Conservation and Management Act (Magnuson-Stevens Act) and to implement recommendations of the International Commission for the Conservation of Atlantic Tunas (ICCAT) pursuant to the Atlantic Tunas Convention Act (ATCA).

DATES: This rule is effective on January 23, 2004, except for § 635.27(a)(1)(i)(C) which is effective December 24, 2003.

ADDRESSES: Copies of the supporting documents including the Environmental Assessment/Regulatory Impact Review/ Final Regulatory Flexibility Analysis (EA/RIR/FRFA) and the Fishery Management Plan for Atlantic Tunas, Swordfish, and Sharks (HMS FMP) may be obtained from Dianne Stephan, Highly Migratory Species Management Division, NMFS, Northeast Regional Office, One Blackburn Drive, Gloucester, MA 01930. These documents are also available from the Highly Migratory Species Division Web site at *http://www.nmfs.noaa.gov/sfa/hmspg.html*.

FOR FURTHER INFORMATION CONTACT: Dianne Stephan at (978) 281–9397.

SUPPLEMENTARY INFORMATION: Atlantic tunas are managed under the dual authority of the Magnuson-Stevens Act and ATCA. ATCA authorizes the Secretary of Commerce (Secretary) to implement binding recommendations of ICCAT. The authority to issue regulations under the Magnuson-Stevens Act and ATCA has been delegated from the Secretary to the Assistant Administrator for Fisheries, NOAA (AA).

Background information regarding these regulatory changes was provided in the preamble to the proposed rule (68 FR 63747, November 10, 2003), and is not repeated here. By this final rule, NMFS announces the new Purse seine start date of July 15; the new Harpoon category closure date of November 15 or when the quota is reached, whichever comes first; the General category closure date of January 31 or when the quota is reached, whichever comes first; and new large medium BFT tolerances for the Purse seine and Harpoon categories. The large medium tolerance limit for each vessel in the Purse seine category is 15 percent by weight of that vessel's