G. Submission to Congress and the General Accounting Office

The Congressional Review Act (CRA), 5 U.S.C. 801 *et seq.*, as added by the Small Business Regulatory Enforcement Fairness Act of 1996, generally provides that before a rule may take effect, the agency promulgating the rule must submit a rule report, which includes a copy of the rule, to each House of the Congress and to the Comptroller General of the United States. Section 808 allows the issuing agency to make a rule effective sooner than otherwise provided by the CRA if the agency makes a good cause finding that notice and public procedure is impracticable, unnecessary or contrary to the public interest. This determination must be supported by a brief statement. 5 U.S.C. 808(2). As stated previously, EPA has made a good cause finding, including reasons thereof, and established an effective date of December 15, 1999. EPA will submit a report containing this rule and other required information to the United States Senate, the House of Representatives, and the Comptroller General of the United States prior to publication of the rule in the **Federal Register**. This action is not a ''major rule'' as defined by U.S.C. 804(2).

List of Subjects in 40 CFR Part 52

Environmental protection, Air pollution control, Carbon monoxide, Hydrocarbons, Intergovernmental relations, Nitrogen dioxide, Ozone, Reporting and recordkeeping requirements.

Authority: 42 U.S.C. 7401 *et seq.*

Dated: November 15, 1999.

John P. DeVillars,

Regional Administrator, Region I.

[FR Doc. 99–30780 Filed 11–29–99; 8:45 am]

BILLING CODE 6560–50–P

GENERAL SERVICES ADMINISTRATION

41 CFR Part 102–34

[FPMR Amendment G–114]

RIN 3090–AG12

Motor Vehicle Management; Correction

AGENCY: Office of Governmentwide Policy, GSA.

ACTION: Final rule; correction.

SUMMARY: The General Services Administration (GSA) published a final rule on November 2, 1999, revising Federal Property Management Regulation (FPMR) coverage on motor vehicle management, and moving it into the Federal Management Regulation (FMR). This correction fixes an inadvertent error in one of the amendatory instructions of that final rule.

EFFECTIVE DATE: November 2, 1999.

FOR FURTHER INFORMATION CONTACT: Shari Kiser, Federal Acquisition Policy Division, (202) 501–2164.

SUPPLEMENTARY INFORMATION: The final rule published on November 2, 1999 (64 FR 59592), which revised the FPMR coverage on motor vehicle management and moved it into the FMR, inadvertently stated in one of the amendatory instructions that the new part 102–34 was added to subchapter D of 41 CFR chapter 102 when in fact it should have been added to subchapter B. This document corrects that error. Another correction to the same final rule is being published elsewhere in this issue of the **Federal Register.**

In rule document 99–27747 beginning on page 59592 in the issue of Tuesday, November 2, 1999, make the following correction:

CHAPTER 102—[CORRECTED]

On page 59592, in the second column, in amendatory instruction 3., correct ''subchapter D'' to read ''subchapter B''.

Dated: November 23, 1999.

Sharon A. Kiser,

Federal Acquisition Policy Division.

[FR Doc. 99–30933 Filed 11–29–99; 8:45 am]

BILLING CODE 6820–24–M

DEPARTMENT OF TRANSPORTATION

Coast Guard

46 CFR Part 69

[USCG–1999–5118]

RIN 2115–AF76

Standard Measurement System Exemption from Gross Tonnage

AGENCY: Coast Guard.

ACTION: Direct final rule; confirmation of effective date.

SUMMARY: On August 31, 1999, the Coast Guard published a direct final rule (64 FR 47402; USCG–1999–5118). This direct final rule notified the public of the Coast Guard's intent to amend its vessel tonnage regulations to reinstate a previously allowed method of holding tonnage opening cover plates in place. This amendment will increase flexibility and can decrease costs in vessel design and construction, while in no way diminishing vessel safety. The reinstated method was omitted in error during a comprehensive revision of the tonnage regulations in 1989. We have not received an adverse comment, or notice of intent to submit an adverse comment, objecting to this rule. Therefore, this rule will go into effect as scheduled.

DATES: The effective date of the direct final rule is confirmed as November 29, 1999.

FOR FURTHER INFORMATION CONTACT: For questions on this rule, call Mr. Peter Eareckson, Project Manager, Marine Safety Center, Coast Guard, telephone 202–366–6441.

SUPPLEMENTARY INFORMATION:

Discussion of Comment

We received one comment, which took issue with the prohibition against the use of battens, caulking, or gaskets in the installations of tonnage opening cover plates, citing maintenance concerns. While we sympathize with the concerns cited, we do not consider the comment to be an adverse comment to this rulemaking, as ''adverse comment'' is defined in 33 CFR 1.05–55(f). The underlying premise of this rulemaking is to reinstate a method of securing tonnage opening cover plates in place that was deleted in error in the 1989 revision. The prohibition against sealing tonnage openings is one of long-standing and predates the 1989 revision. Regardless of the merits of the request to eliminate this prohibition, it is outside the scope of this rulemaking.

Dated: November 19, 1999.

Jeffrey P. High,

Acting Assistant Commandant for Marine Safety & Environmental Protection.

[FR Doc. 99–30894 Filed 11–29–99; 8:45 am]

BILLING CODE 4910–15–M

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 54

[CC Docket Nos. 97–21 and 96–45; FCC 99–269]

Changes to the Board of Directors of the National Exchange Carrier Association, Inc. and Federal-State Joint Board on Universal Service

AGENCY: Federal Communications Commission.

ACTION: Final rule.

SUMMARY: This document concerning the Changes to the Board of Directors of the National Exchange Association, Inc. and Federal-State Joint Board simplifies the process for rural health care providers to receive support from the

universal service support mechanism, among other things, and adopts rules to permit the Universal Service Administrative Company to provide support for any commercially available telecommunications service, regardless of the bandwidth. It also requires USAC to calculate support based upon all actual distance-based charges, unless the rural health care provider or carrier requests a more comprehensive support calculation and substantiates that request.

DATES: Effective July 1, 2000.

FOR FURTHER INFORMATION CONTACT: Linda Armstrong, Assistant Division Chief, Common Carrier Bureau, Accounting Policy Division, (202) 418–7400.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Sixth Order on Reconsideration in CC Docket No. 97–21, Fifteenth Order on Reconsideration in CC Docket No. 96–45 released on November 1, 1999. The full text of this document is available for public inspection during regular business hours in the FCC Reference Center, Room CY–A257, 445 Twelfth Street, S.W., Washington, D.C., 20554.

I. Introduction

1. In this *Fifteenth Order on Reconsideration,* we reconsider, on our own motion, some of the Commission's conclusions in the *Universal Service Order,* 62 FR 32862 (June 17, 1997), in order to simplify the process for rural health care providers to receive support from the universal service support mechanism. Specifically, we amend our rules to permit the Universal Service Administrative Company (USAC) to provide support for any commercially available telecommunications service, regardless of the bandwidth. We further modify our rules to require USAC to calculate support based upon all actual distance-based charges, unless the rural health care provider or carrier requests a more comprehensive support calculation and substantiates that request. We affirm the conclusion reached in the *Universal Service Order* that, despite the difficulties of allocating costs and preventing abuses, the benefits of permitting rural health care providers to join consortia with other subscribers of telecommunications service outweigh the danger that such arrangements will lead to significant abuse of the prohibition on resale. Accordingly, we clarify that new members may be added to a consortium at any time after the rural health care provider applies for universal service support, and we clarify our use of the term ''tariffed or market rate'' to permit a rural health care provider participating in a consortium with ineligible private sector members to receive support. Finally, in order to achieve a more equitable distribution of USAC's joint and common billing and collection costs, we clarify that USAC should include these costs in the projected administrative expenses of the high-cost, low-income, schools and libraries, and rural health care programs, based upon the volume of disbursements by each program.

II. Scope of Services Eligible for Support

A. Per-Location Funding Limit

2. We eliminate the per-location funding limit because it has made it more difficult for rural health care providers to receive the benefits of the rural health care support mechanism, and it is no longer necessary to ensure that demand for support remains below the $400 million per year cap that the Commission established in the *Universal Service Order.* We believe that eliminating the per-location funding limit will make it easier for rural health care providers to select and receive support for the telecommunications services that they need for telemedicine. We find that, even if USAC substantially underestimated the demand for support by rural health care providers, demand would still be well within the $400 million cap. Moreover, we find that the Commission's initial decision to limit support to a T–1 or some combination of lesser services was driven by two express concerns that are no longer relevant. We further find that, because the per-location funding limit imposes some cost and generates no apparent benefit, it would be contrary to the public interest to maintain it. Accordingly, we conclude that the universal service support mechanism for rural health care providers shall support any commercially available telecommunications services, necessary for the provision of health care services in a state, regardless of the bandwidth, and we revise § 54.613 of the Commission's rules to reflect this change.

3. Based upon the information in the record, we find that the Commission's initial demand estimate was much too high. Section 254(g) directs that universal service support mechanisms should be specific, predictable, and sufficient. The only qualification, in section 254(h)(1)(A), of the type of telecommunications service that may be supported is the requirement that the telecommunications service be ''necessary for the provision of health care services in a [s]tate.'' In order to establish a ''specific, predictable, and sufficient'' mechanism for a program with no track record, the Commission concluded that it must limit the telecommunications services that a rural health care provider may receive for the provision of health care services in a state.

4. The Commission's original estimate for the cost of the program predicted that maximum demand for support would be $366 million per year. The Commission arrived at this conclusion without the benefit of expert assessment of the cost of leaving rural health care providers free to purchase whatever telecommunications services they deemed necessary for the provision of health care. According to the USAC Report, ''[t]he best current estimates show that this Program is not likely to exceed $10 million in annual support level in the near term.'' Specifically, the USAC Report estimates that the total demand for support for rural health care providers will not exceed $3.1 million for the 18 month period from January 1, 1998 through June 30, 1999. USAC projects that the total demand for rural health care provider support for the second funding year (July 1, 1999 through June 30, 2000) will be no more than $9.3 million. Although armed with a significantly more comprehensive set of data than used in the *Universal Service Order,* USAC estimates that, even if we remove the per-location funding limit, demand would not exceed $10 million per year. Apparently, as the Advisory Committee believed, the urban rates for telecommunications services are costly enough to deter rural health care providers from demanding excessive levels of telecommunications service. USAC also reports that there are a number of other factors that have served to reduce demand, which we discuss. Accordingly, we conclude that, beginning with the third funding cycle, the universal service support mechanism for health care providers will support all commercially available telecommunications services necessary for the provision of health care services, and that this expansion of eligible telecommunications services will not increase demand beyond the funding cap.

5. The Commission's initial decision to limit support to a T–1 or some combination of lesser services was based upon two factors that are now irrelevant, given that there is little risk of demand exceeding the cap. First, the Commission's initial decision to limit support to a T–1 or some combination of lesser services was based in part upon

a finding that the record did not demonstrate that rural health care providers would require higher bandwidths than T–1. Specifically, the Commission found that the Advisory Committee and the majority of commenters who recommended a specific level of telecommunications bandwidth recommended a capacity of up to and including 1.544 Mbps or its equivalent. The Advisory Committee and the majority of commenters contended that rural health care providers did not need higher bandwidths for the provision of health care services, and that the cost of higher bandwidth connections would outweigh the benefits. It is still unclear to us whether rural health care providers need services with greater or lesser bandwidth than 1.544 Mbps for the provision of health care. On the one hand, the Rural Utilities Service (RUS) argues that the current supported bandwidth of 1.544 Mbps may be inadequate because, with the rapid evolution of high-speed broadband networks approaching the 1.544 Mbps capability, the medical community's needs are expected to significantly exceed this level in the near future. On the other hand, the National Rural Health Association (NRHA) asserts that it appears that many telehealth applications are moving away from dedicated point-to-point T–1 type services to switched, lower bandwidth applications such as ISDN and POTs. Further, a letter jointly filed by the American Telemedicine Association, the American College of Nurse Practitioners, the Association of Telemedicine Service Providers, and the NRHA states that:

> The program should include discounts for all forms of communications services when used in the delivery of health care to rural health care providers. As currently designed, services eligible for the rural health care program are effectively limited to a T1 line, largely because of the use of distance costs associated with this service. However, advancements over the past few years in technology and communications have enabled health care providers to transmit and receive information at speeds lower than that required of T1 lines. Although lower in cost, this still remains an impediment to many health providers due to the few resources available in support of rural health care.

6. We, therefore, affirm our finding in the *Universal Service Order* that rural health care providers are best able to determine what telecommunications services best meet their needs; moreover, we find that allowing rural health care providers to choose the transmission speeds necessary for health care services in rural areas, outweigh our need to determine with certainty the required bandwidth. Accordingly, we conclude that, given that the per-location funding limit is not necessary for keeping demand on the fund within the $400 million cap, as long as the telecommunications services are necessary for health care services in rural areas, there is little reason to ascertain definitively whether rural health care providers need telecommunications services with greater or lesser bandwidth than T–1.

7. The second reason that the Commission decided to support only bandwidths up to 1.544 Mbps was because it agreed with the parties who weighed the cost of higher services against the benefits and found that the limited data suggested that the cost of higher bandwidths could unnecessarily increase the cost of the program by a significant amount. While very few respondents to the *USAC Report Public Notice* discussed the cost of supporting higher services, the USAC Report suggests that the cost of higher bandwidths would not unnecessarily increase the cost of the program by a significant amount.

8. More importantly, it appears from the record, particularly the USAC Report, that maintaining the current limits on services does not adequately serve the public interest. That is, regardless of whether rural health care providers need services with greater or lower bandwidth, the public interest would be better served by allowing rural health care providers to have affordable access to all modern telecommunications services necessary to provide medical services. The majority of interested parties in this proceeding assert that the per-location funding limit imposed by the Commission's rules increases the cost of participating in the program, while reducing the value of the potential benefit that a rural health care provider may receive. For example, USAC reports that one of the costs of the restriction is that it discourages some rural health care providers from seeking services. This is in part because of the complexity of securing some combination of services of less than 1.544 bandwidth. Specifically, in May 1999, USAC reported that ''calculation of the PLFL for each applicant to this program has taken a significant amount of effort by carriers and RHCD staff.'' Consistent with the findings reported by USAC, RUS asserts that the Commission's rules significantly limit the value of the support provided by the program.

9. Finally, we reject the argument by USTA that any change to the Commission's rules that would expand the class of eligible services would be inconsistent with the Act. Although USTA admits that the per-location funding limit could be made simpler to administer, USTA argues that the Commission should not expand the scope of eligible services for the sole purpose of increasing demand to the level that we previously anticipated would be reached. We agree with USTA that the Commission should not expand the scope of eligible services solely for the sake of increasing demand. Instead, we expand the scope of eligible services because the current restrictions are in large part the result of the per-location funding limit, and for the reasons discussed, we now reject the per-location funding limit. The per-location funding limit is not necessary to ensure that demand for support remains below the $400 million per year cap. We find that demand will be sufficiently limited by the statutory requirement that supported telecommunications services must be necessary for the provision of health care. Moreover, as previously discussed, we find that a rural health care provider is ill served by our current rule, which further limits the rural health care provider's choices to telecommunications services within bandwidths up to and including 1.544 Mbps, and limits the total amount of support that a rural health care provider can receive to the cost of one T–1 connection. We believe that a rural health care provider may under some circumstances need, for the provision of health care services, telecommunications services with a higher bandwidth than 1.544 Mbps; a single service with a lesser bandwidth that requires more support than a T–1; or a number of services with lesser bandwidth that together require more support than one T–1. Accordingly, while we recognize that removing the per-location funding limit will potentially increase the amount of support for services that are already eligible for support, and expand the list of eligible services, we conclude that this result is consistent with the Act.

B. Long Distance Charges

10. Based upon the information in this record, we remain unconvinced that the rural health care program should provide additional support for long distance and toll charges, with the exception of support for toll charges incurred by accessing an Internet service provider (for those unable to secure toll-free Internet access). We find that section 254(h)(1)(A) does not obligate telecommunications carriers to deliver service to rural health care providers at rates that are *less* than those

charged to urban health care providers. We note that section 254(h)(1)(A) directs telecommunications carriers to deliver service to rural health care providers at rates that are *reasonably comparable* to those charged to health care providers in urban areas of the state. Further, we note that, although many of the commenters argue that using long distance service makes it more expensive for rural health care providers to engage in the practice of telemedicine, none have argued that telecommunications carriers charge more for long distance service provided to rural health care providers than for similar service provided to urban residents. Based on the record before us, therefore, we find no basis for providing additional support for long distance and toll charges.

C. Urban/Rural Rate Calculation

11. In light of the entire record now before us, we determine that most of the base rates for telecommunications service elements charged to rural health care providers are already reasonably comparable to those charged in urban areas. This position is consistent with USTA's recommendation. Accordingly, we conclude that the Administrator need not compare the tariffed or publicly available base rates for telecommunications service elements to determine the amount of support that it can provide for the benefit of a rural health care provider. We, therefore, direct that, beginning with the third funding cycle, the Administrator must calculate support based upon all actual distance-based charges.

12. At the time that the rural health care program was established, the Commission did not realize the extent to which directing the parties to identify the highest tariffed or publicly available rate actually being charged to urban customers, in order to set rates for telecommunications services ''that are reasonably comparable to rates charged for similar services in urban areas in that State,'' would consume an unwarranted amount of resources for very little benefit. In the *Universal Service Order,* the Commission specifically acknowledged that most base rates for telecommunications services are averaged across a state or study area, and concluded, therefore, that it is often the distance-based charges that account for the difference between the urban and rural rates charged to rural health care providers. As a result, the Commission directed that, in addition to providing rural health care providers with support for the difference between the highest tariffed or publicly available rate actually being charged to urban customers and the rate charged to the rural health care providers (i.e. the base rates for telecommunications service elements), the Administrator must also provide support for distance-based charges. We have since learned that, because of the need to refer to the various tariffs, calculating the difference between the urban and rural base rates for telecommunications service elements is extremely labor intensive. For many carriers and rural health care providers, the cost of calculating the difference between the urban and rural base rates for telecommunications service elements outweighs the benefits of participating in the rural health care program, because it is the distance charges that account for the rate differences of any significance. For example, Alaska argues that FCC Forms 466 and 468 should be simplified because,

> [r]equirements for detailed diagramming of circuits have proven confusing and time-consuming to some LECs in Alaska. Rural health care providers throughout the State have often encountered complaints or resistance from telecommunications carriers with respect to this task. Moreover, the information is also of questionable value, particularly when the rate for the service provided is not distance-sensitive.

Because the failure to properly calculate the difference between the urban and rural base rates for telecommunications service elements must be corrected by the Administrator, this activity has proven to be a burden for the Administrator as well.

13. We, therefore, simplify the method for calculating support found in § 54.609 of the Commission's rules. Consistent with the approach proposed by USTA in response to the *USAC Report Public Notice,* we direct the Administrator to consider the base rates for telecommunications services elements in rural areas to be reasonably comparable to the base rates charged for similar telecommunications service elements in urban areas in that state. The Administrator, therefore, shall not include these charges in calculating support. In addition, we direct the Administrator to treat a rural health care provider as if it is located in the nearest large city in the state, in the same manner as it does under the current rules. That is, if the requested service distance is less than or equal to the SUD for the state, the distance-based charge for that service can be no higher than the distance-based charged for a similar service over the same distance in the large city nearest to the rural health care provider. If the requested service distance is greater than the SUD for the state, but less than the maximum allowable distance, the distance-based charge for that service can be no higher than the distance-based charged for a similar service, transmitted the length of the SUD, in the large city nearest to the rural health care.

14. Consistent with the approach proposed by USTA, we also conclude that, in the event a rural health care provider or carrier can establish that there is a difference between the urban and rural base rates charged for a telecommunications service, the rural health care provider or the telecommunications carrier may request a more comprehensive rate comparability calculation consistent with the Commission's current rules. We note that it would not be feasible for the Administrator to document the tariffed or publicly available urban rates for all commercially available telecommunications services to establish a benchmark for comparison of the base rates of telecommunications service elements. Consequently, in the rare instance where there is a difference between the urban and rural base rates for services, we require the rural health care provider or carrier to provide the evidence thereof.

15. We do not modify our rules to require the Administrator to deduct a standardized SUD from the total distance-based charge. We believe that such an approach would generally result in establishing a national SUD to calculate the support amount. We reject this approach because the Administrator has already established the average of the longest diameters of all cities with a population of 50,000 or more within each state, and adding the state averages together to ultimately arrive at a national SUD would not be as accurate as using each state's SUD. We also reject this suggestion because we believe that it would not result in rural health care providers paying distance-based charges that are reasonably comparable to those required of urban subscribers as required by section 254(h)(1)(A), since it would require a rural health care provider to pay the balance of the distance-based charge. We find that this balance would generally be more than urban subscribers are required to pay.

16. We reject USAC's proposal to establish statewide average discount percentages to apply to the rural base rates and/or distance sensitive charges for eligible services. Section 254(h)(1)(A) requires the Commission to adopt mechanisms designed to make telecommunications services available to rural health care providers at rates reasonably comparable to ''*rates charged* for similar services in urban

areas.'' As the Joint Board previously stated, however, use of an average rate ''would entitle some rural customers to rates below those paid by some urban customers, creating fairness problems for those urban customers and arguably going farther with this mechanism than Congress intended.''

D. Equipment

17. Section 254(h)(1)(A) does not authorize the provision of universal service support for equipment needed by rural health care providers to establish telemedicine programs. We note that section 254(h)(1)(A) directs telecommunications carriers to provide telecommunications services to rural health care providers at a discounted rate, and permits the telecommunications carriers to have the amount of the discount treated as part of their obligation to participate in the mechanisms to preserve and advance universal service. There is nothing in section 254(h)(1)(A) that authorizes the provision of universal service support for the purchase of equipment by rural health care providers. Indeed, the Joint Explanatory Statement indicates that Congress' intent was that ''the rural health care provider receive an affordable rate for the services necessary for the purposes of telemedicine and instruction relating to such services.'' Consistent with the Joint Explanatory Statement, USTA argues that it would be inappropriate and unlawful to provide support for equipment, or any other non-telecommunications service component of telemedicine. RUS similarly opposes providing support to reduce the cost of any non-telecommunications service expenses of telemedicine. RUS notes that other federal programs, such as the RUS Distance Learning and Telemedicine Loan and Grant Program are available to assist with the financing of end-user hardware and facilities used in telemedicine projects. Under these circumstances, we conclude that the rural health care support mechanism cannot assist in reducing the cost of the equipment necessary for rural health care providers to provide telemedicine services.

E. Insular Areas

18. Because we still lack sufficient information to ensure that health care providers located in the insular areas have access to the telecommunications services available in urban areas in the country at affordable rates, on August 5, 1999, the Commission adopted the *Unserved, Tribal, and Insular Areas FNPRM,* 64 FR 52738 (September 30, 1999), seeking public input on these and many related issues. We note that the record here contains insufficient information about the status and availability of health care services and telemedicine in most of the insular areas.

19. We are concerned that, to the extent that section 254(h)(1)(A) was intended solely to help equalize the rates paid by residents of urban and rural areas within a state, the Commission would be constrained in its ability to provide relief to rural health care providers in the insular areas. We note that Congress could have provided discounts on the telecommunications service that rural health care providers use to connect to the nearest *major urban hospital within or outside the state* when rural health care providers rely on such hospitals for consultations. This approach would have directed assistance to rural health care providers hindered by the high costs of linking to major hospitals they need to reach outside of their states. Moreover, the Act could have sought to equalize rates paid by rural health care providers in different states, ensuring that no rural health care provider paid significantly more than hospitals in the largest urban areas, regardless of state boundaries. The language of section 254(h)(1)(A), however, merely directs the Commission to provide universal service support to rural health care providers to enable them to pay rates similar to those paid in urban areas *of their states.*

20. On the other hand, we have always recognized that our method for determining the amount of support that a rural health care provider may receive is ill suited to insular areas. In the *Universal Service Order,* for example, we noted that ninety-five percent of American Samoa's population of 56,000 lives on the island of Tutuila, where the territory's single hospital is located. Since we designated Tutuila as an urban area for purposes of setting the urban rate, rural health care providers in American Samoa will be constrained in their ability to take full advantage of the benefits of the rural health care support mechanism.

21. The Commission concluded in the *Universal Service Order* that section 254(h)(2)(A) authorizes the Commission to adopt special mechanisms to calculate support for the insular areas. Section 254(h)(2)(A) directs the Commission, in part, to establish competitively neutral rules ''to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications . . . services for all public and nonprofit . . . health care providers.'' In order to implement the statute's directives, among other things, we need to identify the necessary services and determine what is ''technically feasible and economically reasonable.'' That is, we need additional data about the specific needs of insular areas in this context, as well as the estimated cost of providing such support for those needs. We also note that, were we to grant support for links between rural health care providers in insular areas and the nearest advanced health care facilities in some other jurisdiction, we would need to set standards for identifying such facilities. We would also need to ensure that such rules would not be inconsistent with state physician licensing requirements that might preclude a rural health care provider from establishing a telemedicine connection with an advanced facility in the nearest large city in another state. Consequently, we encourage interested parties to submit their comments in the *Unserved, Tribal, and Insular Areas FNPRM* proceeding that we initiated on August 5, 1999, as we will be addressing these issues in the near future.

III. Eligibility of Health Care Providers

A. Definition of Health Care Provider

22. We affirm our initial conclusion that section 254(h)(5)(B) adequately describes those entities Congress intended to be eligible for universal service support. We find that, given the specific categories of health care providers listed in section 254(h)(5)(B), if Congress had intended to include nursing homes, hospices, or other long-term care facilities, and emergency medical service facilities, it would have done so explicitly. Thus, we find that the definition of ''health care provider'' does not include nursing homes, hospices, or other long-term care facilities, and emergency medical service facilities.

23. Moreover, we clarify that a rural nursing home is ineligible to receive universal service support from the rural health care support mechanism, whether or not it is part of a not-for-profit hospital or rural health clinic. We are not persuaded that an entity omitted from the list in the statute should be allowed to apply for and receive the benefits of the program directly from the universal service support mechanism simply because of the relationship between the ineligible and eligible entity. Moreover, we find no rational basis for distinguishing between a rural nursing home that is part of a not-for-profit hospital or rural health clinic and a rural nursing home that is associated with any of the other categories of

eligible entities listed in the statute. Finally, we believe that allowing nursing homes to receive support directly from the rural health care support mechanism based upon their association with eligible entities would very likely result in a flood of other types of ineligible entities requesting similar treatment, and thus would render meaningless the limitations imposed by Congress in section 254(h)(5)(B). We find, therefore, that, to the extent that the instructions for the current version of the FCC Form 465 state that nursing homes that are ''part of a not-for-profit hospital or rural health care clinic'' are health care providers eligible to receive support, those instructions are incorrect.

B. Restrictions on Resale and Aggregated Purchases

24. We affirm the conclusion that we reached in the *Universal Service Order* that, despite the difficulties of allocating costs and preventing abuses, the benefits of permitting rural health care providers to join consortia with other subscribers of telecommunications service outweigh the danger that such arrangements will lead to abuse of the prohibition on resale. Accordingly, we clarify that new members may be added to a consortium at any time after the rural health care provider applies for universal service support. We note that the Commission's rules do not restrict a rural health care provider's ability to join a consortium with other eligible health care providers, or public sector governmental entities (such as schools and libraries). The Commission's rules also do not restrict a rural health care provider's ability to continue to participate in a consortium to which any of the above are added after the rural health care provider applies for universal service support. The Commission's rules limit a rural health care provider's ability to receive universal service support only if the consortium includes a private sector entity. Section 54.601(b) of the Commission's rules state that, in the event that a consortium includes a private sector entity, a rural health care provider may receive support only if the consortium is paying tariffed or market rates for the subject services. We believe that our interpretation is consistent with both the section 254(h)(1)(A) requirement to ensure that health care providers located in rural areas have access to telecommunications services at rates available to urban residents, and the section 254(h)(3) prohibition against the sale, resale, or other transfer of supported services for money.

25. We also clarify that a tariffed or market rate received by a consortium of eligible and ineligible entities may include a volume discount, or otherwise reflect consideration of the unique characteristics of the subscribers, to the extent that characteristic is not a rural health care provider's eligibility to receive support from the rural health care program. This is because the Commission's restriction on consortium membership was intended to prohibit ineligible private entities from receiving the benefits of the rural health care support mechanism. The *Universal Service Order* clearly states that the Commission and the Joint Board supported broad-based participation in consortia and intended to encourage their growth. The Commission explained, in the *Universal Service Order,* that this restriction is necessary to ''deter ineligible, private entities from entering into aggregated purchase arrangements with rural health care providers to receive below-tariff or below-market rates that they otherwise would not be entitled to receive.'' We find that an ineligible private entity that enters into an aggregated purchase arrangement with a rural health care provider, and receives a tariff or market rate that includes a volume discount, would not be receiving a below-tariff or below-market rate because of the eligibility status of a rural health care provider participating in the consortium. We, therefore, find that such an arrangement would not violate our rules, as long as entities and individuals not eligible for universal service support pay the full contract rates for their portion of the services.

26. The section of the *Universal Service Order* that addresses the universal service support mechanism for schools and libraries offers an additional reason for the Commission's restriction on consortium membership, which would not be contradicted by the finding. In the section of the *Universal Service Order* that discusses the universal service support mechanism for schools and libraries, the Commission noted that it was concerned that ''permitting large private sector firms to join with eligible schools and libraries to seek prices below tariffed rates could compromise both the federal and state policies of non-discriminatory pricing.'' The Commission found congressional support for permitting eligible schools and libraries to secure prices below tariffed rates, and no basis for extending that exception to enable all private sector firms to secure such prices. The Commission concluded that eligible schools and libraries would generally qualify for universal service discounts and prices below tariffed rates for interstate services, only if any consortia they join include only other eligible schools, libraries, rural health care providers, and public sector customers. Although the *Universal Service Order* does not define the term ''tariffed rates,'' the definition of the term ''pre-discount price,'' and the explanation of the Commission's intent in the schools and libraries section of the *Universal Service Order* is instructive in determining whether permitting a consortium of eligible and ineligible entities to obtain tariff rates that include a volume discount could compromise the policies of non-discriminatory pricing. The *Universal Service Order* defines pre-discount price as the price of services to schools and libraries prior to the application of a discount from the universal service support mechanism. It is ''the total amount that carriers will receive for the services they sell to schools and libraries: the sum of the discounted price paid by a school or library and the discount amount that the carrier can recover from universal service support mechanisms for providing such services.'' The *Universal Service Order* explains:

> Although consortia-negotiated prices might commonly be characterized as ''discounted prices,'' because they are lower than the prices that individual members of the consortia would be able to secure on their own, we still characterize them as ''pre-discount prices'' for the purposes of section 254(h) because they are the prices eligible schools and libraries could obtain even without application of the relevant universal service support discounts. All members of such consortia, including those ineligible for universal service support, would benefit from these lower ''pre-discount'' prices produced by such statewide, regional, or large group contracts. . . . While those consortium participants ineligible for support would pay the lower pre-discount prices negotiated by the consortium, only eligible schools and libraries would receive the added benefit of universal service discount mechanisms.

It is clear from this statement that the Commission's intent as expressed in both the rural health care and schools and libraries sections of the *Universal Service Order* is the same; to wit, to ensure that only eligible entities receive the benefit of the universal service support mechanism, not to prohibit a consortium from taking advantage of the tariff or other publicly available rates that reflect the economies of scale. Accordingly, we conclude that it would not violate section 254, or compromise Federal and state policies of non-discriminatory pricing to permit a rural health care provider to benefit from the

rural universal service support mechanism, where the rural health care provider is a member of a consortium of eligible and ineligible entities receiving service at tariffed or other publicly available rates that include a volume discount.

27. The fact that the Commission's rules prohibit a rural health care provider from receiving support if it is in a consortium that includes private sector members, unless the consortium is receiving tariffed rates or market rates, has apparently largely been erroneously interpreted as requiring the consortium members to be paying rates that do not include volume discounts. As a result, commenters such as the Rural Telecommunications Policy Working Group (RTP) and the Health Care Systemic Change Initiative (HCSCI) believe that the Commission's treatment of consortia discourages community-based telecommunications facilities. Consequently, they request that the Commission generally encourage the community use of telecommunications service facilities that the rural health care providers use for telemedicine. Similarly, RUS argues that community use should be allowed because it is not resale.

28. We find that, to the extent that the Commission's exception is being narrowly interpreted as requiring a rural health care provider in a consortium with ineligible private entities to receive rates that do not include a volume discount, the interpretation largely defeats the purpose of participating in a consortium, and, therefore, is inconsistent with our intention to encourage participation in consortia. OAT and NTIA provide ample justification for rejecting the narrow interpretation of the terms ''tariffed rates'' and ''market rates.'' OAT and NTIA indicate that together they support over 400 rural telemedicine sites in the United States, and about ninety percent of those sites organize their networks into formal and informal consortia to achieve greater economic efficiency. They further indicate that the consortium typically includes an urban ''hub'' site such as a medical college, urban hospital, medical center, or state governmental unit associated with several small rural ''spoke'' sites. According to OAT and NTIA, many rural health care providers use telecommunication infrastructures established and maintained by the ''hub'' site. We are not convinced that requiring a consortium to receive tariffed or market rates should mean that the rate cannot take volume into consideration, and reflect the economies of scale. We believe that a better interpretation is one that recognizes that there are tariffed and market rates that include volume discounts, just as there are tariffed and market rates that recognize the unique characteristics of other subscribers of telecommunications service. Consequently, we conclude that entities not explicitly eligible for support cannot gain eligibility for support by participating in consortia with those that are eligible, but every member of the consortium may receive the benefits otherwise available to them in tariffed or other publicly available rates without jeopardizing a rural health care provider's eligibility to receive the benefits of the rural health care support mechanism.

29. Because of the difficulties of allocating costs and preventing abuses, we also find that, in addition to telecommunications carriers, health care providers and consortia of health care providers must share in the responsibility for calculating and justifying the request for support by maintaining documentation of the amount of support for which each member of a consortium is eligible. Health care providers and consortia of health care providers must also carefully maintain complete records of how they allocate the costs of shared facilities among consortium participants in order to charge eligible health care providers the correct amounts. Accordingly, we revise § 54.601 of the Commission's rules to extend the record-keeping requirement to health care providers and consortia of health care providers. Finally, to the extent that a telecommunications carrier will not be applying the discount directly to a billing telephone number in the name of the rural health care provider, the rural health care provider and the lead member of the consortium must certify to the proper disposition of the benefits of the rural health care support mechanism.

30. Based upon the information in the record, we also clarify that it is not necessary to set a time limit for rural health care providers to report the identities of all of the consortia participants in order to enforce the statutory prohibition against the resale of telecommunications services by rural health care providers, or to otherwise ensure that the support provided by the rural health care universal service support mechanism is used for the purposes intended by Congress. We find that USAC should permit a rural health care provider to add new consortium members by submitting a new form 465 that the Administrator will use to re-evaluate the eligibility of the rural health care provider. The rural health care provider must satisfy anew the competitive bidding requirements only if the addition of a new consortium member would be more than a minor change in the contract or other arrangement for service from the carrier. Consistent with the *Fourth Reconsideration Order,* a rural health care provider must look to state or local procurement laws and regulations to determine whether a proposed contract modification would be considered minor, and, therefore, exempt from state or local competitive bid processes. If a proposed modification would be exempt from state or local competitive bid requirements, the applicant would not be required to undertake an additional competitive bid process in connection with the applicant's request to add a new member to the consortium. Similarly, if a proposed modification would have to be re-bid under state or local competitive bid requirements, then the applicant would also be required to comply anew with the Commission's universal service competitive bid requirements in order to be eligible to receive the benefits of the rural health care program. Consistent with the *Fourth Reconsideration Order,* 63 FR 2093 (January 13, 1998), where state and local procurement laws and regulations are silent, or otherwise inapplicable with respect to whether a proposed contract modification must be re-bid under state or local competitive bid processes, the Commission will look to the ''cardinal change doctrine'' to determine whether the contract modification requires re-bidding. The ''cardinal change doctrine'' generally examines the extent to which a modification exceeds the scope of the original contract. We understand that USAC might prefer that rural health care providers list all possible participants in their initial applications, thus, permitting USAC to evaluate all participants at once. We, however, are not persuaded that the administrative difficulties are so great as to warrant restricting joint purchasing and network-sharing arrangements.

IV. Administration

A. Billing and Collection

31. Consistent with the USAC Report, we direct USAC to include its joint and common billing and collection costs in the projected administrative expenses of the high cost, low-income, schools and libraries, and rural health care programs, based upon the volume of disbursements by each program, beginning January 1, 2000. We agree with USAC that, in order to ensure a fair and accurate allocation of billing and

collection costs among the four support mechanisms, it is better to use an allocator that takes into account the actual size of the programs. The Commission did not know, in 1997, the actual size of the individual programs, or the extent of the difference in their sizes. Based upon the information in the record, we find that there is no longer any rational basis for requiring the rural health care program to be responsible for twenty-five percent of the joint and common billing and collection costs in question. We further find that continuing to include one-fourth of USAC's joint and common billing and collection costs in the projected administrative expenses of the rural health care program would place a disproportionate burden on the rural health care support mechanism.

B. Consolidation of Support Mechanisms

32. Consistent with the *USAC Reorganization Order,* we conclude that, where efficiencies can be achieved, USAC should consolidate the functions and operations that are common to the administration of all three universal service support mechanisms. We decline, however, to further direct the consolidation of any additional specific functions and operations at this time. There is very little information in the record upon which to base any decision to further consolidate additional functions of the various universal service support mechanisms. Although both the schools and libraries, and rural health care programs have completed their first funding cycle, there will be enough changes to the rural health care program as a result of this Order, that the rural health care program will, in essence, be repeating its first program year. We believe that, under these circumstances, not only would it be difficult to identify with any certainty the division with which we should merge RHCD, we find that there would be little benefit to merging RHCD with any of the other divisions of USAC while RHCD is undergoing significant change. Moreover, as we indicated in the *USAC Reorganization Order,* we will review USAC's performance after one year from the merger to assess whether USAC has succeeded in eliminating duplicative functions, and whether it has succeeded in preserving the distinct missions of the schools and libraries, and rural health care support mechanisms. Given that it has been less than one year since the merger, we conclude that it would be premature to further direct the consolidation of additional functions and operations that are common to the administration of the support mechanisms.

V. Supplemental Final Regulatory Flexibility Analysis

33. In compliance with the Regulatory Flexibility Act (RFA), this Supplemental Final Regulatory Flexibility Analysis (SFRFA) supplements the Final Regulatory Flexibility Analysis (FRFA) included in the *Universal Service Order* only to the extent that changes to that Order adopted herein on reconsideration require changes in the conclusions reached in the FRFA. As required by 603 RFA, 5 U.S.C. 603, the FRFA was preceded by an Initial Regulatory Flexibility Analysis (IRFA) incorporated in the Notice of Proposed Rulemaking and Order Establishing the Joint Board (NPRM), and an IRFA, prepared in connection with the Recommended Decision, which sought written public comment on the proposals in the NPRM and the Recommended Decision.

34. *Need for and Objective of this Order.* The Commission is required by section 254 of the Act to promulgate rules to implement promptly the universal service provisions of section 254. On May 8, 1997, the Commission adopted rules whose principle goal is to reform our system of universal service support mechanisms so that universal service is preserved and advanced as markets move toward competition. In this Order, we reconsider two aspects of those rules and clarify one aspect of those rules. First, we direct USAC to provide support for any commercially available telecommunications service necessary for health care in rural areas, regardless of the bandwidth. Second, we find that the Administrator need not compare the tariffed or publicly-available base rates for telecommunications service elements to ensure that rural health care providers are receiving rates that are reasonably comparable to those in urban areas, and we direct the Administrator to calculate support based upon all actual distance-based charges. Finally, we clarify that new members may be added to a consortia at any time after the rural health care provider applies for universal service support. We also conclude that, a rural health care provider participating in a consortium with eligible private sector members may receive support, even if the consortium is receiving a tariffed or market rate that includes a volume discount. Because of the difficulties of allocating costs and preventing abuses, we find that, in addition to telecommunications carriers, health care providers, and consortia of health care providers must share in the responsibility for calculating and justifying the request for support by maintaining documentation of the amount of support for which each member of a consortium is eligible.

35. *Summary and Analysis of the Significant Issues Raised by Public Comments in Response to the IRFA.* In this Order, the Commission simplifies the process for rural health care providers to receive support from the universal service support mechanism. The Commission reconsiders, on its own motion, the rules that define the services that are eligible for support, and clarifies the definition of the entities eligible to receive the benefits of that support. In addition, the Commission clarifies the rules associated with the administration of the universal service support mechanisms. Specifically, the Order modifies the rules to allow the universal service mechanism for rural health care providers to support any commercially available telecommunications service regardless of the bandwidth, and allow the Administrator to calculate support based solely upon all actual distance-based charges. The Order clarifies the rules to allow a rural health care provider participating in a consortium with ineligible private sector members to be able to receive support even if the consortium is receiving a tariffed or market rate that includes a volume discount. It also clarifies the rules to enable USAC to include its joint and common billing and collection costs in the projected administrative expenses of the high cost, low-income, schools and libraries, and rural health care programs, based upon the volume of disbursements by each program.

36. *Description and Estimates of the Number of Small Entities to Which the Rules Adopted in This Order Will Apply.* 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). A small organization is generally ''any not-for-profit enterprise which is independently

owned and operated and is not dominant in its field.''

37. In the FRFA of the *Universal Service Order,* we estimated and described in detail the number of small entities that might be affected by the new universal service rules. The rules adopted in this Order, however, would affect primarily rural health care providers. Specifically, the Commission modifies the rules that define the services that are eligible for support. Health care providers will now receive universal service support for any commercially available telecommunications services, necessary for the provision of health care services in a state, regardless of the bandwidth. The Commission also revises the rules that calculate support based on the urban/rural rate. Rural health care providers' universal service support will now be calculated using actual distance-based charges. Finally, the Commission clarifies the rules that define limitations on supported services for rural health care providers. Rural health care providers are allowed to participate in a consortium with ineligible private sector members and will be able to receive support even if the consortium is receiving a tariffed or market rate that includes a volume discount. The adopted rules will allow rural health care providers to benefit more fully from the rural health care universal service support mechanism, constituting a positive economic impact on these small entities.

38. As noted, small entities includes ''small businesses,'' ''small organizations,'' and ''small governmental jurisdictions.'' All three types of small entities may also constitute rural health care providers for the purpose of this analysis. ''Small governmental jurisdiction'' generally means ''governments of cities, counties, towns, townships, villages, school districts, or special districts, with a population of less than 50,000.'' As of 1992, there were approximately 85,006 such jurisdictions in the United States. This number includes 38,978 counties, cities, and towns; of these, 37,566, or 96 percent, have populations of fewer than 50,000. The Census Bureau estimates that this ratio is approximately accurate for all governmental entities. Thus, of the 85,006 governmental entities, we estimate that 81,600 (91 percent) are small entities. As for ''small organizations,'' as of 1992, there were approximately 275,801.

39. In addition, the Commission noted in the *Universal Service Order* that neither the Commission nor the SBA has developed a definition of small, rural health care providers. Section 254(h)(5)(B) defines the term ''health care provider'' and sets forth the seven categories of health care providers eligible to receive universal service support. We estimated that there is less than 12,296 health care providers potentially affected by the rules in the *Universal Service Order.* We note that these small entities may potentially be affected by the rules adopted in this Order.

40. *Summary Analysis of the Projected Reporting, Record keeping, and Other Compliance Requirements and Significant Alternatives.* In the FRFA to the *Universal Service Order,* we described the projected reporting, record keeping, and other compliance requirements and significant alternatives associated with the Schools and Libraries section, the Rural Health Care Provider section, and the Administration section of the *Universal Service Order.* Because the rules adopted herein may only affect those requirements in a marginal way, we incorporate by reference paragraphs 956 through 960, 968 through 971, and 980 of the *Universal Service Order,* which describe those requirements and provide the following analysis of the new requirements adopted herein.

41. Under the rules adopted herein, we revise the rules governing the eligibility of services that the universal service support mechanism will support. We find that regardless of whether rural health care providers need services with greater or lower bandwidths, the public interest would be better served by allowing rural health care providers to have affordable access to all modern telecommunications service to provide medical services without regard for the bandwidth thereof. We also revise the rules to allow the Administrator to calculate the support based upon all distance-based charges. We've learned that because of the need to refer to the various tariffs, calculating the difference between the urban and rural base rates for telecommunications is extremely labor intensive. We have determined that most of the base rates for telecommunications service elements charged to rural health care providers are already comparable to those charged in urban areas so there is no need to continue to require the comparison of tariffs to other publicly available rates. Finally, we revise the rules to show that a rural health care provider participating in a consortium with ineligible private sector members may receive support even if the consortium is receiving a tariffed or market rate that includes a volume discount. We find that, an ineligible private entity that enters into an aggregated purchase agreement with a rural health care provider, and receives a tariff or market rate that includes a volume discount, would not be receiving a below-tariff or below-market rate because of the eligibility status of a rural health care provider participating in the consortium. We also find that new members may be added to a consortium even after the rural health care provider submits it application for support. Finally, because of the difficulties of allocating costs and preventing abuses in consortium arrangements, we find that, in addition to telecommunications carriers, health care providers and consortia of health care providers must maintain documentation of the amount of support for which each member of a consortium is eligible. These changes will not have a significant impact on the reporting, record keeping, and other compliance requirements for participation in the rural health care support program.

42. *Steps Taken To Minimize the Significant Economic Impact on a Substantial Number of Small Entities Consistent With Stated Objectives.* In the FRFA to the *Universal Service Order,* we described the steps taken to minimize the significant economic impact on a substantial number of small entities consistent with stated objectives associated with the Schools and Libraries section, the Rural Health Care Provider section, and the Administration section of the *Universal Service Order.* Because the rules adopted herein may only affect those requirements in a marginal way, we incorporate by reference paragraphs 961 through 967, 972 through 976, and 981 through 982 of the *Universal Service Order,* which describe those requirements and provide the following analysis of the new requirements adopted herein.

43. Our decision to simplify the process for rural health care providers to receive support from the universal service support mechanism, will benefit rural health care providers, as well as their chosen service providers, who may be small entities. We also find that this approach should permit all parties to use fewer resources (*i.e.* less time and labor) to access the benefits of the universal service support program.

VI. Ordering Clauses

44. The authority contained in 1–4, 201–205, 218–220, 254, 303(r), 403, and 405 of the Communications Act of 1934, as amended, 47 U.S.C. 151–154, 201–205, 218–220, 254, 303(r), 403, and 405, § 1.108 of the Commission's rules, 47

CFR 1.108, the Fifteenth Order on Reconsideration is adopted.

45. The authority contained in 1–4, 201–205, 218–220, 254, 303(r), 403, and 405 of the Communications Act of 1934, as amended, 47 U.S.C. 151–154, 201–205, 218–220, 254, 303(r), 403, and 405, § 1.108 of the Commission's rules, 47 CFR 1.108, Part 54 of the Commission's rules, 47 CFR Part 54, are amended.

46. This Fifteenth Order on Reconsideration, the rule changes set forth are effective beginning with the third funding cycle of the rural health care universal service support program.

47. The Commission's Office of Public Affairs, Reference Operations Division, shall send a copy of this Fifteenth Order on Reconsideration, including the Supplemental Final Regulatory Flexibility Analysis, to the Chief Counsel for Advocacy of the Small Business Administration.

List of Subjects in 47 CFR Part 54

Universal service.

Federal Communications Commission.

Magalie Roman Salas,

Secretary.

Rule Changes

Part 54 of Title 47 of the Code of Federal Regulations is amended as follows:

PART 54—UNIVERSAL SERVICE

1. The authority 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 revising paragraphs (b)(3), (b)(4), and (c)(1) to read as follows:

§ 54.601 Eligibility.

* * * * *

(b) * * *

(3) Telecommunications carriers, health care providers, and consortia of health care providers shall carefully maintain complete records of how they allocate the costs of shared facilities among consortium participants in order to charge eligible health care providers the correct amounts. Such records shall be available for public inspection.

(4) Telecommunications carriers, health care providers, and consortia of health care providers shall calculate and justify with supporting documentation the amount of support for which each member of a consortium is eligible.

(c) * * *

(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 nearest large city as defined in § 54.605(c).

* * * * *

3. Amend § 54.609 by adding paragraphs (a)(1), (a)(2), and by revising paragraphs (b) and (c) to read as follows:

§ 54.609 Calculating support.

(a) * * *

(1) With one exception, the Administrator shall consider the base rates for telecommunications services elements in rural areas to be reasonably comparable to the base rates charged for similar telecommunications service elements 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 charge for that service can be no higher than the distance-based charged for a similar service over the same distance in the large city nearest to the rural health care provider;

(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 for that service can be no higher than the distance-based charged for a similar service in the large city nearest to the rural health care provider 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) If a telecommunications carrier, health care provider, and/or consortium of health care providers reasonably determines that the base rates for telecommunications services elements in rural areas are *not* reasonably comparable to the base rates charged for similar telecommunications service elements 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 all of the documentation necessary to substantiate the request.

(i) 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 elements for the health care provider's portion of the shared telecommunications services, as well as the applicable urban base rates for the telecommunications service elements.

(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 paragraph (a), provided to rural health care providers as well as interstate telecommunications services.

4. Revise § 54.613 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 this paragraph, at a distance not to exceed the distance between the eligible health care provider's site and the farthest point from that site that is on the jurisdictional boundary of the nearest large city, as defined in § 54.605(c).

(b) This section shall not affect a rural health care provider's ability to obtain supported services under § 54.621.

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