

## **UNIVERSAL SERVICES FUND FOR RURAL HEALTH SUMMARY OF RECENT CHANGES**

On November 13, 2003, the FCC adopted new rules to increase participation in the Universal Services Rural Health Care (RHCD) support program. The RHCD program, with an annual availability of \$400 million, has created a demand of only about \$20 million annually. This program has been in existence for six years, with an estimated 8,000 to 9,000 eligible health care providers, but only 1,800 are currently participating.

Another Notice of Proposed Rule Making will soon be posted seeking comments on: 1) the definition of a rural area; 2) support for satellite services for mobile rural health clinics; 3) further streamlining of the application process, and; 4) the need for additional outreach efforts to rural providers. Our web site, [www.aimpros.com](http://www.aimpros.com), includes direct links to the pages on the FCC web site where you can read the NPRM and then post your comments. After going to [www.aimpros.com](http://www.aimpros.com), click on "Telecomm", then scroll down to the section on the NPRM.

Below is a summary of the recent changes.

### **A. Eligible Health Care Provider**

In the 1997 Universal Service Order, the commission declined to expand the definition of rural health care providers (HCPs) beyond the original seven categories: 1) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; 2) community health centers or health centers providing health care to migrants; 3) local health departments or agencies; 4) community mental health centers; 5) not-for-profit hospitals; 6) rural health clinics; and 7) consortia of HCP's consisting of one or more of these entities (e.g. networks including urban medical centers).

The new rule expands eligible HCP's to include dedicated emergency departments of rural for-profit hospitals that participate in Medicare. According to the American Hospital Association, 174 more sites are now eligible due to this change. This ruling includes emergency departments of for-profit Critical Access Hospitals. To meet this requirement, medical screening examinations must be provided to all patients who present themselves as well as the stabilization and arrangement for appropriate transfer of those patients with emergency conditions. This makes them a "public" entity and, therefore, eligible for funding under the RHCD program.

Non-profit entities functioning as HCP's, even on a part time basis, will be eligible to receive pro-rated support. If a community center, for example, were used one day a week by a non-profit entity, it would be considered a "rural health care clinic" and eligible for support for that day.

### **B. Support for Internet Access**

In the past, only toll charges to reach the Internet Service Provider (ISP) were allowed at a rate of \$180.00, or 30 hours per month, whichever was less. The new ruling provides an additional 25% funding support for the actual service provided by the ISP.

While the new ruling will defray a portion of the monthly charges, it will not cover costs of internal connections, computer equipment, or other telecommunication equipment, even if used to access the Internet.

### **C. Calculation of Discounted Services**

Prior to the new ruling, comparisons were made on “technically” similar services versus “functionally” similar services. A technically similar service does not take into account the fact that certain telecommunications services are not always available in rural areas. Because certain services are available in urban areas, and not rural areas, the ruling is being amended to include “functionally” similar services, as viewed by the end user. This allows rural HCP’s to get services at a comparable rate to the urban provider. The rural HCP, however, must be able to compare their services to a functionally equivalent service in order to receive the discount. “Safe harbor” categories will be created based on the speed and nature of the telecommunication services used. Telecommunication services will be functionally similar when operated at the same speed, within the same category, and when the nature of the service is the same.

### **D. Maximum Allowable Distance**

The Maximum Allowable Distance has been changed from the nearest city in the state with a population of at least 50,000 to the city with the largest population in the state. This change should result in better rates for the rural HCP and will also allow them to connect to health care facilities that have a wider range of expertise.

### **E. Satellite Services**

In the past, the cost of rural satellite service was compared only to the cost of urban satellite service. Since the price of satellite service typically does not vary by location, rural HCP’s using satellite did not receive discounts and were disadvantaged under that policy. This new rule allows HCP’s to receive discounts for satellite services but only up to what the HCP’s would have received had they purchased similar terrestrial based alternatives. When the rural HCP selects the more expensive satellite service, they will be required to provide documentation of the urban and rural rates for the terrestrial-based alternatives. Funding support will be based on the difference between these two amounts. The HCP will be responsible for any additional charges for satellite service, over and above this urban/rural difference.

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