Flood Insurance Act of 1968, as amended, 42 U.S.C. 4022, prohibits flood insurance coverage unless an appropriate public body adopts adequate floodplain management measures with effective enforcement measures. The communities listed no longer comply with the statutory requirements, and after the effective date, flood insurance will no longer be available in the communities unless they take remedial action.

Regulatory Classification

This final rule is not a significant regulatory action under the criteria of section 3(f) of Executive Order 12866 of September 30, 1993, Regulatory Planning and Review, 58 FR 51735.

Paperwork Reduction Act

This rule does not involve any collection of information for purposes of the Paperwork Reduction Act, 44 U.S.C. 3501 *et seq.*

Executive Order 12612, Federalism

This rule involves no policies that have federalism implications under Executive Order 12612, Federalism, October 26, 1987, 3 CFR, 1987 Comp.; p. 252.

Executive Order 12778, Civil Justice Reform

This rule meets the applicable standards of section 2(b)(2) of Executive Order 12778, October 25, 1991, 56 FR 55195, 3 CFR, 1991 Comp.; p. 309.

List of Subjects in 44 CFR Part 64

Flood insurance, Floodplains.

■ Accordingly, 44 CFR part 64 is amended as follows:

PART 64—[AMENDED]

■ 1. The authority citation for Part 64 continues to read as follows:

Authority: 42 U.S.C. 4001 *et seq.*; Reorganization Plan No. 3 of 1978, 3 CFR, 1978 Comp.; p. 329; E.O. 12127, 44 FR 19367, 3 CFR, 1979 Comp.; p. 376.

§ 64.6 [Amended]

■ 2. The tables published under the authority of § 64.6 are amended as follows:

State and location	Community No.	Effective date authorization/cancellation of sale of flood insurance in community	Current effective map date	Date certain Federal assistance no longer available in special flood hazard areas
Region VII				
Kansas:				
Manhattan, City of, Riley County and Pottawattamie County.	200300	January 3, 1974, Emerg; April 1, 1982, Reg; February 4, 2005, Susp.	Feb. 4, 2005	Feb. 4, 2005.
Odgen, City of, Riley County	200301	June 26, 1975, Emerg; October 15, 1981, Reg; February 4, 2005, Susp.	.....do	Do.
Riley County, Unincorporated Areas	200298	June 23, 1975, Emerg; April 1, 1982, Reg; February 4, 2005, Susp.	.....do	Do.
Nebraska: Battle Creek, Madison County	310145	March 7, 1975, Emerg; September 30, 1987, Reg; February 4, 2005, Susp.	.....do	Do.
Madison County, Unincorporated Areas	310455	July 25, 1977, Emerg; January 1, 1987, Reg; February 4, 2005, Susp.	.....do	Do.

Code for reading third column: Emerg.—Emergency; Reg.—Regular; Susp.—Suspension.

Dated: February 1, 2005.

David I. Maurstad,

Acting Mitigation Division Director, Emergency Preparedness and Response Directorate.

[FR Doc. 05–2257 Filed 2–4–05; 8:45 am]

BILLING CODE 9110–12–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 54

[WC Docket No. 02–60; FCC 04–289]

Rural Health Care Support Mechanism

AGENCY: Federal Communications Commission.

ACTION: Final rule; petition for reconsideration.

SUMMARY: In this document, we modify our rules to improve the effectiveness of the rural health care universal service support mechanism. Specifically, in this *Report and Order*, we change the Commission's definition of rural for the purposes of the rural health care support mechanism because the definition currently used by the Commission is no longer being updated with new Census Bureau data. We also revise our rules to expand funding for mobile rural health care services by subsidizing the difference between the rate for satellite service and the rate for an urban wireline service with a similar bandwidth. On reconsideration, we permit rural health care providers in states that are entirely rural, such as American Samoa, to receive support for advanced telecommunications and information services under section 254(h)(2)(A).

DATES: Effective April 8, 2005 except for §§ 54.609(e) and 54.621(c) 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: Regina Brown at (202) 418–0792 or Dana Bradford at (202) 418–1932, Wireline Competition Bureau, Telecommunications Access Policy Division, TTY (202) 418–0484.

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 December 17, 2004. 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. A companion *Further Notice of Proposed Rulemaking* in WC Docket No. 02–60 was also released on December 17, 2004.

I. Introduction

1. In this *Report and Order* and *Order on Reconsideration* (*Second Report and Order*), we modify our rules to improve the effectiveness of the rural health care universal service support mechanism. The mechanism provides discounts to rural health care providers to access modern telecommunications for medical and health maintenance purposes. Specifically, in this *Second Report and*

Order, we change the Commission's definition of rural for the purposes of the rural health care support mechanism because the definition currently used by the Commission is no longer being updated with new Census Bureau data. We also revise our rules to expand funding for mobile rural health care services by subsidizing the difference between the rate for satellite service and the rate for an urban wireline service with a similar bandwidth. Furthermore, we improve our administrative process by establishing a fixed deadline for applications for support. On reconsideration, we permit rural health care providers in states that are entirely rural to receive support for advanced telecommunications and information services under section 254(h)(2)(A).

II. Report and Order

A. Definition of ''Rural Area''

2. We conclude that the record supports the adoption of a new definition of ''rural area'' for the rural health care program. We received several proposals from commenters for a new definition of rural. Most of those definitions are currently used by other Federal agencies to determine eligibility for other Federal programs. As we explain in further detail below, we find that those proposals are either over-inclusive or under-inclusive for our purpose. That is, based on an evaluation of the proposals contained in the record, such definitions would allow more areas to be considered rural than is appropriate for the rural health care program or would not include areas that are appropriately rural. The Commission should neither dilute the fund by using a methodology that is too broad, nor fail to achieve the goals of the 1996 Act by using a methodology that is not broad enough. As such, the Commission has built on commenters' proposals to develop a slightly more layered approach that more accurately defines the rural areas eligible for support under the rural health care mechanism.

3. Whether an area is ''rural'' is determined by applying the following test. If an area is outside of any Core Based Statistical Area (CBSA), it is rural. Areas within CBSAs can be either rural or non-rural, depending on the characteristics of the CBSA. Small CBSAs—those that do not contain an urban area with populations of 25,000 or more—are rural. Within large CBSAs—those that contain urban areas with populations of 25,000 or more—census tracts can be either rural or non-rural depending on the characteristics of the particular census tract. If a census tract in a large CBSA does not contain any part of a place or urban area with a population greater than 25,000, then that tract is rural. Alternatively, if a census tract in a large CBSA contains all or part of a place or urban area with a population that exceeds 25,000, then it is not rural.

4. To eliminate any confusion regarding implementation of this definition, the Commission will identify the areas that are rural and post the list on the Universal Service Administrative Company (USAC) Web site, as is done now. The list will include counties that are rural or partially rural. As now, for those counties that are partially rural, eligible census tracts will be listed. Applicants can determine their census tract using the link on the USAC web site or by calling USAC's helpline for assistance. As such, the process for rural health care providers to determine their eligibility will be the same with the new definition as with the definition currently in use. The new definition will be effective as of Funding Year 2005, which begins July 1, 2005.

5. The new definition of rural area furthers the goals of section 254 for several reasons. Our new definition uses a methodology similar to our current definition. Just like our prior definition, all counties that are not located in a CBSA are defined as rural. For those counties located in a CBSA, as under the current definition, a further analysis is conducted for certain counties that have both urban and rural areas. The Goldsmith methodology, however, only called for such further analysis for counties comprising a larger geographic area, while our new definition expands the review to include counties of all sizes. As such, we believe our new definition improves upon the method that we previously used to determine which areas are rural by more accurately carving out the rural areas within counties that are located in a CBSA. For example, Dungannon, Virginia, which has a population of 317, is located in the northeastern corner of Scott County, Virginia. Though Scott County is part of the Kingsport-Bristol-Bristol, TN-VA Metropolitan Statistical Area, Dungannon is 28 miles—about an hour drive—from Kingsport, TN, the nearest large urban area. Under our previous definition, Dungannon was not rural because it was located in a small county that was part of an MSA. Under our new definition, however, we conduct a more granular review of Scott County at the census tract level. The census tract in which Dungannon is located does not contain any part of a place or urban area with greater than a 25,000 population. Therefore, Dungannon is rural, and any health care provider located in Dungannon is eligible for support.

6. We selected 25,000 as the population threshold for the further analysis. While choosing the threshold is not an exact science, we believe urban areas above this size possess a critical mass of population and facilities. Although this standard may mean that some current eligible providers might no longer qualify, as noted below, we permit all health care providers that have received a funding commitment from USAC since 1998 to continue to qualify for funding for the next three years under the old definition. As we noted above, our new definition also allows rural health care providers to determine their eligibility in the same manner as under the old definition. Furthermore, because the definitions are similar, rural health care providers will not have to adjust to a new application process. An approach that simplifies the application process for rural health care providers will help ensure that applicants will not be deterred from applying for support due to administrative burdens.

7. To ease the transition to the new definition, we permit all health care providers that have received a funding commitment from USAC since 1998 to continue to qualify for support under the universal service mechanism for health care providers for funding for the next three years under the old definition. Thereafter, health care providers must qualify under our new definition to receive funding. We find that this transition period is necessary to allow rural health care providers to plan for the elimination of support. In addition, the transition period will allow the Commission time to review the effect of this definition.

Support for Satellite Services for Mobile Rural Health Care Providers

8. Pursuant to section 254(h)(1)(A) of the Act, telecommunications carriers must provide telecommunications services to rural health care providers at ''rates that are reasonably comparable to rates charged for similar services in urban areas in that State.'' Under the Commission's prior policies, the cost of rural satellite service was compared to the cost of urban satellite service. For satellite services, however, the price typically does not vary by location. Therefore rural health care providers did not receive discounts on such service under the rural health care program. In the 2003 *Report and Order*, 68 FR 74492, December 24, 2003, we revised this policy to allow rural health care providers to receive discounts for satellite service even where wireline

services are available, but we capped the discount at the amount providers would have received if they purchased functionally similar wireline alternatives.

9. The situation of the mobile rural health care provider, however, is different. By definition, mobile rural health care providers do not stay in a fixed location. To receive telecommunications services, they would either have to install a wireline telecommunications service to every location they serve or use a satellite or other mobile service that can function in every location. In some cases, wireline services are not available because the locations are so remote. Even if a wireline service is technically available, the number of locations served results in what otherwise might be a more expensive satellite service becoming more cost-effective and more efficient. In those situations, as commenters note, for practical purposes no wireline service is available, so rural health care providers must use a satellite or other mobile telecommunications service.

10. *Cost benchmark for mobile rural health care provider.* Accordingly, after reviewing the record in this proceeding, we revise our rules to allow mobile rural health care providers to receive discounts for satellite services calculated by comparing the rate for the satellite service to the rate for an urban wireline service with a similar bandwidth. We will not cap the discount for the satellite service at an amount of a functionally similar wireline alternative for mobile rural health care providers. We conclude that this revision furthers the principle of competitive neutrality and recognizes the role that telecommunications services play in rural areas without unduly increasing the size of the fund. Further, consistent with section 254, it helps to provide an affordable rate for the services necessary for telemedicine in rural America, strengthens telemedicine and telehealth networks across the nation, helps improve the quality of health care services available in rural America, and better enables rural communities to rapidly diagnose, treat, and contain possible outbreaks of disease.

11. *Criteria for mobile rural health care providers.* Our current rules, combined with the requirement that health care providers remain responsible for a significant portion of service costs (*i.e.*, the urban rate), are adequate to ensure that rural health care providers select the most cost-effective services and will ensure that rural health care providers make prudent economic decisions. We agree, however, with commenters that suggest that certain parameters or procedures should be established for determining what constitutes a ''mobile'' rural health care provider so that providers cannot obtain satellite services where such services are not the most cost-effective option.

12. Because we believe some threshold must be established, however, mobile rural health care providers will be required to submit to USAC the number of sites the mobile rural health care provider will serve during the year. Where a mobile rural health care provider serves eight or more different sites in a year, we will presume that satellite services are most cost-effective. We conclude that where a mobile rural health care provider serves less than eight different sites per year, the mobile health care provider will be required to document and explain why satellite services are necessary to achieve the health care delivery goals of the mobile telemedicine project. In instances where a mobile rural health care provider serves less than eight different sites per year, USAC will determine on a case-by-case basis whether the telecommunications service selected by the mobile rural health care provider is the most cost-effective option for the telemedicine project in light of the limited number of sites served per year.

13. Additionally, mobile rural health care providers seeking discounts for satellite services will be required to certify that they are serving eligible rural areas. Providers must keep annual logs indicating: (i) The date and locations of each clinic stop; and (ii) the number of patients served at each such clinic stop. Mobile rural health care providers must maintain their annual logs for a period of five years and make such logs available to the Administrator and the Commission upon request.

14. In order to receive the discount, mobile rural health care providers will be required to provide to USAC documentation of the price for bandwidth equivalent wireline services in the urban area in the state to be covered by the project. Where a telemedicine project serves locations in different states, the provider must provide the price for bandwidth equivalent wireline services in the urban area, proportional to the locations served in each state. The method of cost allocation chosen by an applicant should be based on objective criteria, and reasonably reflect the eligible usage of the mobile health clinic. Where mobile rural health care provider is also serving patients in urban areas, prorated discounts will be provided commensurate only with the time the mobile rural health care provider is serving patients in rural areas. We also direct USAC to evaluate the allocation methods selected by program participants in the course of its audit activities to ensure program integrity and to ensure that providers are complying with the program's certification requirements. Additionally, pursuant to section 54.619(a) of the commission's rules, providers providing mobile health services must maintain records for their purchases of supported services for at least five years sufficient to document their compliance with all Commission requirements.

Deadline Established for Filing FCC Form 466

15. In the 2002 *NPRM*, 67 FR 34653, May 15, 2002 and 2003 *Report and Order,* 68 FR 74492, December 24, 2003, we sought comment on ways to streamline the application process. We establish June 30 as the final deadline for filing FCC Forms 466 and 466–A for health care providers seeking discounts for a specific funding year under the rural health care universal service support mechanism. We conclude that providing an established deadline will provide specificity and finality to rural health care providers and will not require them to continue to check for Commission public notices. This deadline is also consistent with USAC's Rural Health Care Division (RHCD)'s efforts to provide specific guidance to health care providers when submitting applications for universal service support. Applicants have more than a year to submit the necessary documentation for their application for support. In addition, a deadline of June 30 for filing FCC Forms 466 and 466–A coincides with the end of the funding year. Under section 54.623 of our rules, USAC can still set the dates for the filing window for purposes of the annual cap.

III. Order on Reconsideration

16. We grant, to the extent indicated herein, ASTCA's Petition for Reconsideration of the 2003 *Report and Order,* 68 FR 74492, December 24, 2003. In light of the compelling and unique combination of circumstances facing ''entirely rural'' states, we believe that it is appropriate to establish a support mechanism under section 254(h)(2)(A) that will provide funding for the provision of advanced telecommunications and information services. We therefore amend our rules to provide support to health care providers in states that are ''entirely rural'' equal to 50 percent of the monthly cost of advanced telecommunications and information

services reasonably related to the health care needs of the facility.

17. We find that the Commission has authority to amend its rules for these specific circumstances under section 254(h)(2)(A). Section 254(h)(2)(A) directs the Commission to establish competitively neutral rules to enhance access to advanced telecommunications and information services for health care providers. Section 254(h)(2)(A) gives the Commission broad authority to fulfill this statutory mandate. Unlike Congress' directive to the Commission in section 254(h)(1)(A), however, the Commission's authority under section 254(h)(2)(A) is discretionary, not mandatory. We find that there is a special need for the Commission to use its discretion to establish rules that will enhance access to advanced telecommunications and information services for health care providers in entirely rural states.

18. This support is necessary to address the unique circumstances faced by health care providers and telecommunications carriers serving American Samoa and other similarly situated geographic areas. Geographic isolation and the lack of adequate local resources in ''entirely rural'' states can be mitigated by the availability and use of modern technology. Facilitating access to advanced telecommunications and information services would improve health care in geographically remote areas.

19. Section 254(h)(2)(A) directs the Commission to enhance access to advanced telecommunications and information services to the extent technically feasible and economically reasonable. We find that providing universal service support to these specific health care providers is technically feasible and economically reasonable. There is no dispute that access to advanced telecommunications and information services is technically feasible in these areas. In fact, such services are currently being provided. We believe our actions to enhance access are also economically reasonable. We do not believe this discount will significantly increase distributions from the underutilized rural health care fund because the number of eligible entities is so small. The funding amount also is unlikely to significantly increase in the future because the current list of eligible entirely rural areas is not likely to change.

20. Furthermore, we do not think that section 254(h)(1)(A) prohibits us from establishing this support. In the 2003 *Report and Order,* 68 FR 74492, December 24, 2003 the Commission determined that section 254(h)(2)(A) was linked to section 254(h)(1)(A), such that funding for advanced telecommunications services must also be based on the urban-rural rate comparison for telecommunications services found in section 254(h)(1)(A). Upon further review, however, we conclude that the two statutory provisions are not inextricably linked. The methodology we use to calculate support under section 254(h)(2)(A), therefore, does not have to be based on the urban-rural comparison.

21. Section 254(h)(2)(A), however, does not establish a methodology for calculating universal service support. The Commission provides a flat discount for Internet access for all eligible rural health care providers pursuant to section 254(h)(2)(A). We find that it is reasonable to use a similar methodology for support for entirely rural areas because we are relying on the same statutory provision. Therefore, we establish a 50 percent discount off the commercial rate for the purchase of advanced telecommunications and information services for states that are ''entirely rural.'' We emphasize that the *entire* state must meet the definition of rural, as described above, to be eligible to receive the 50 percent discount. Consistent with the Commission's principles of competitive neutrality, eligible health care providers may receive increased discounts for any advanced telecommunications and information service, regardless of the platform.

IV. Procedural Matters

A. Regulatory Flexibility Analysis

22. As required by the Regulatory Flexibility Act of 1980, as amended (RFA), an Initial Regulatory Flexibility Analysis (IRFA) was incorporated in the 2003 *Further Notice of Proposed Rulemaking,* 68 FR 74538, December 24, 2003. The Commission sought public comments on the proposals in the *Further Notice of Proposed Rulemaking,* including comment on the IRFA. This present Final Regulatory Flexibility Analysis (FRFA) conforms to the RFA.

B. Need for, and Objectives of, the Second Report and Order

23. 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 programs, the Commission adopted a program 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, such as technological advances and the increasing variety of needs of the rural health care community, have prompted us to review the rural health care universal service support mechanism. In this *Second 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.

24. Specifically, in this *Second Report and Order,* we change the Commission's definition of rural for the purposes of the rural health care support mechanism because the definition currently used by the Commission is no longer being updated with new Census Bureau data by the Office of Rural Health Care Policy, the agency that developed the definition. Specifically, the new definition improves upon the previous method of determining which areas are rural by more accurately identifying the rural areas within counties. We also revise our rules to allow mobile rural health care providers to receive discounts for satellite services calculated by comparing the rate for the satellite service to the rate for an urban wireline service with a similar bandwidth. Mobile rural health care providers travel to remote areas of the country to deliver health care services to underserved populations for particular health conditions that may go unnoticed or untreated due to the lack of health care facilities in such areas. Thus, this approach will provide the support necessary to make mobile telemedicine economical for rural health care providers to provide health care to rural and remote areas, and to make telecommunications rates for public and non-profit rural health care providers comparable to those paid in urban areas. Furthermore, to provide specificity and finality to rural health care providers, we improve our administrative process by establishing a fixed deadline for applications for support.

25. On reconsideration, we permit rural health care providers in states that are entirely rural, such as American Samoa, to receive support for advanced telecommunications and information services under section 254(h)(2)(A). Under the Commission's current policy, health care providers in these areas do not receive universal service funding for the provision of telecommunications services because no urban-rural rate

difference exists within the state or territory upon which to base the discount calculation. Telemedicine and other forms of treatment supported by advanced telecommunications services and information services eliminate the need for referrals to other locations by allowing local physicians to consult much more easily and frequently with physicians at fully equipped health care facilities. We expect this rule change will strengthen the ability of health care providers in states and territories that are entirely rural to provide critical health care services and improve health care for rural residents.

26. We believe that such actions will improve significantly the ability of rural health care providers to respond to the medical needs of their communities, provide needed aid to 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. In addition, these changes will equalize access to quality health care between rural and urban areas and will support telemedicine networks if needed for a national emergency. Enhancing access to an integrated nationwide telecommunications network for rural health care providers will further the Commission's core responsibility to make available a rapid nationwide network for the purpose of the national defense, particularly with the increased awareness of the possibility of 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.

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

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

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

28. 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 rules. 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. Rural Health Care Providers

29. 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 the 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 nor do we know how many are located in areas we have defined as rural. In addition, non-profit entities that act as ''health care providers'' on a part-time basis are eligible to receive prorated support and we have no ability to quantify how many potential eligible applicants fall into this category. 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.

30. As noted earlier, 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 small business 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 small business 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 3,414 firms had annual receipts of $5 million to $9.99 million; and additional 1,475 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. We note, however, that our rules affect non-profit and public healthcare providers, and many of the providers noted above would not be considered ''public'' or ''non-profit.'' In addition, we have no data specifying the numbers of these health care providers that are rural and meet other criteria of the Act.

31. 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 (Except Psychiatric and Substance Abuse) 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.

32. 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

33. We have included small incumbent local exchange carriers in this present RFA analysis. As noted above, 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.

34. *Total Number of Telephone Companies Affected.* The Wireline Competition Bureau reports that, as of October 22, 2003, there were 4,748 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 4,748 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 4,748 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.

35. *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 Wired Telecommunications Carriers having less than 1,500 employees. 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.

36. *Internet Service Providers.* The SBA has developed a small business size standard for ''On-Line Information Services,'' NAICS code 518111. 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 $21 million or less. Based on firm size data provided by the Bureau of the Census, 3,123 firms are small under SBA's $21 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.

37. *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.

38. *Wireless Service Providers.* The SBA has developed a definition for small businesses within the two separate categories of Cellular and Other Wireless Telecommunications. 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.

39. *Vendors of Infrastructure Development or ''Network Buildout.''* The Commission has not developed a small business size standard specifically directed toward manufacturers of network facilities. The closest applicable definition of a small entity are the size standards under the SBA rules applicable to manufacturers of ''Radio and Television Broadcasting and Communications Equipment'' (RTB) and ''Other Communications Equipment.'' According to the SBA's regulations, manufacturers of RTB or other communications equipment must have 750 or fewer employees in order to qualify as a small business. The most recent available Census Bureau data indicates that there are 1,187 establishments with fewer than 1,000

employees in the United States that manufacture radio and television broadcasting and communications equipment, and 271 companies with less than 1,000 employees that manufacture other communications equipment. Some of these manufacturers might not be independently owned and operated. Consequently, we estimate that the majority of the 1,458 internal connections manufacturers are small.

40. *Cable and Other Program Distribution.* The SBA has developed a small business size standard which includes all such companies generating $12.5 million or less in revenue annually. This standard covers Cable and Other Program Distribution. Only businesses in Cable and Other Program Distribution category can be affected by the rules and policies adopted herein. 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.

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

41. This *Second 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. First, as articulated above, in this *Second Report and Order,* we change the Commission's definition of rural for the purposes of the rural health care support mechanism. The new definition will not impact reporting or recordkeeping requirements. It does, however, change the overall pool of eligible applicants. Second, this *Second Report and Order* expands funding for mobile rural health care services by subsidizing the difference between the actual rate of satellite service for mobile rural health care providers and the rate for an urban wireline service with a similar bandwidth. Because mobile rural health care providers will now be eligible for support, we adopt rules requiring such providers to submit an estimated number of sites the mobile health care provider will serve during the year. Additionally, mobile rural health care providers seeking discounts for satellite services will be required to certify that they are serving eligible rural areas. Providers must keep annual logs indicating: (i) The date and locations of each clinic stop; and (ii) the number of patients served at each such clinic stop. Mobile rural health care providers must maintain their annual logs for a period of five years and make such logs available to the Administrator and the Commission upon request. Further, in order to receive the discount, mobile rural health care providers will be required to provide to USAC documentation of the price for bandwidth equivalent wireline services in the urban area in the state to be covered by the project.

42. These reporting and recordkeeping requirements will minimally impact both small and large entities. However, even though the minimal impact may be more financially burdensome for smaller entities, the minimal impact of such requirements is outweighed by the benefit of providing support necessary to make mobile telemedicine economical for rural health care providers to provide health care to rural and remote areas, and to make telecommunications rates for public and non-profit rural health care providers comparable to those paid in urban areas. Further, these requirements are necessary to ensure that the statutory goals of section 254 of the Telecommunications Act of 1996 are met without waste, fraud, or abuse.

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

43. 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.

44. In this *Second 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. The actions taken in this *Second Report and Order* help improve 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.

45. We have taken the following steps to minimize the impact on small entities. First, to ease the transition to the new definition, we permit all health care providers that have received a funding commitment from USAC since 1998 to continue to qualify for funding for the next three years under the old definition. Thereafter, health care providers must qualify under our new definition to receive funding. We find that this transition period is necessary to allow rural health care providers to plan for the elimination of support. The alternative of not providing for a transition period was considered but rejected because we believe a transition period is necessary to allow rural health care providers to plan for the elimination of support, thus minimizing any adverse or unfair impact on smaller entities. In addition, this transition period will allow us time to review the effect of this definition on smaller entities. Second, our new definition allows rural health care providers to determine their eligibility in the same manner as under the old definition. Because the old and new definitions are similar, rural health care providers will not have to adjust to a new application process. The alternative of not allowing rural health care providers to determine their eligibility in the same manner was also considered but rejected because we wanted to minimize confusion on the part of applicants. An approach that simplifies the application process for rural health care providers will help ensure that applicants, including small entities, will not be deterred from applying for support due to administrative burdens. Lastly, for mobile rural health care services, we have established a presumption that will minimize administrative burdens for all applicants, including smaller entities. Mobile rural health care providers will be required to submit to USAC an estimated number of sites the mobile rural health care provider will serve during the year. Where a mobile rural health care provider serves eight or more sites in a year, we will presume

that satellite services are most cost-effective and we will not require a further showing from such providers.

G. Report to Congress

46. The Commission will send a copy of this *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 this *Report and Order* and *Order on Reconsideration* and FRFA (or summaries thereof) will also be published in the **Federal Register**.

H. Paperwork Reduction Act Analysis

47. This document contains modified information collection requirements subject to the Paperwork Reduction Act of 1995 (PRA), Public Law 104–13. It will be submitted to the Office of Management and Budget (OMB) for review under section 3507(d) of the PRA. OMB, the general public, and other Federal agencies are invited to comment on the modified information collection requirements contained in this proceeding. In addition, we note that pursuant to the Small Business Paperwork Relief Act of 2002, Public Law 107–198, *see* 44 U.S.C. 3506(c)(4), we previously sought specific comment on how the Commission might ''further reduce the information collection burden for small business concerns with fewer than 25 employees.''

48. In this present document, we have assessed the effects of the measures adopted to protect against waste, fraud and abuse in the administration of the rural health care universal service support mechanism. We find that the modified information and record retention requirements for mobile rural health care providers and the modified certification requirements for health care providers in states that are entirely rural will not be unduly burdensome on small businesses.

49. The full text of this document is available for public inspection and copying during regular business hours at the FCC Reference Information Center, Portals II, 445 12th Street, SW., Room CY–A257, Washington, DC 20554. This document may also be purchased from the Commission's duplicating contractor, Best Copy and Printing, Portals II, 445 12th Street, SW., Room CY–B402, Washington, DC 20554, telephone (202) 488–5300, facsimile (202) 488–5563, or via e-mail *qualexint@aol.com.*

I. Further Information

50. 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 Order can also be downloaded in Microsoft Word and ASCII formats at *http://www.fcc.gov/ccb/universalservice/highcost.*

51. For further information, contact Regina Brown at (202) 418–0792 or Dana Bradford at (202) 418–1932, in the Telecommunications Access Policy Division, Wireline Competition Bureau.

V. Ordering Clauses

52. 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.

53. 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, 47 CFR 0.291 and 1.429, American Samoa Telecommunications Authority's Petition for Reconsideration is granted to the extent indicated herein.

54. It is further ordered that part 54 of the Commission's rules, 47 CFR part 54, except §§ 54.609 and 54.619 which will become effective upon Office of Management and Budget approval, is amended as set forth in Appendix A attached hereto, effective thirty (30) days after the publication of this *Report and Order* and *Order on Reconsideration* in the **Federal Register**.

55. It is further ordered that 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 to the Chief Counsel for Advocacy of the Small Business Administration.

List of Subjects in 47 CFR Part 54

Health Facilities, 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 § 54.5 by revising the definition of ''Rural area'' to read as follows:

§ 54.5 Terms and definitions.

* * * * *

Rural area. For purposes of the schools and libraries universal support mechanism, a ''rural area'' is a nonmetropolitan county or county equivalent, as defined in the Office of Management and Budget's (OMB) Revised Standards for Defining Metropolitan Areas in the 1990s and identifiable from the most recent Metropolitan Statistical Area (MSA) list released by OMB, or any contiguous non-urban Census Tract or Block Numbered Area within an MSA-listed metropolitan county identified in the most recent Goldsmith Modification published by the Office of Rural Health Policy of the U.S. Department of Health and Human Services. For purposes of the rural health care universal service support mechanism, a ''rural area'' is an area that is entirely outside of a Core Based Statistical Area; is within a Core Based Statistical Area that does not have any Urban Area with a population of 25,000 or greater; or is in a Core Based Statistical Area that contains an Urban Area with a population of 25,000 or greater, but is within a specific census tract that itself does not contain any part of a Place or Urban Area with a population of greater than 25,000. ''Core Based Statistical Area'' and ''Urban Area'' are as defined by the Census Bureau and ''Place'' is as identified by the Census Bureau.

* * * * *

■ 3. Amend § 54.601 by adding paragraphs (a)(3)(i), (a)(3)(ii), and (c)(3) to read as follows:

§ 54.601 Eligibility.

(a) * * *

(3) * * *

(i) Any health care provider that was located in a rural area under the definition used by the Commission prior to July 1, 2005, and that had received a funding commitment from USAC since 1998, shall continue to qualify for support under the universal service mechanism for health care providers for a period of three years, beginning July 1, 2005.

(ii) [Reserved]

* * * * *

(c) * * *

(3) Advanced telecommunications and information services as provided under § 54.621.

* * * * *

■ 4. Amend § 54.609 by adding paragraph (e) to read as follows:

§ 54.609 Calculating support.

* * * * *

(e) *Mobile rural health care providers.* (1) *Calculation of support.* Mobile rural health care providers may receive discounts for satellite services calculated by comparing the rate for the satellite service to the rate for an urban wireline service with a similar bandwidth. Discounts for satellite services shall not be capped at an amount of a functionally similar wireline alternative. Where the mobile rural health care provider provides service in more than one state, the calculation shall be based on the urban areas in each state, proportional to the number of locations served in each state.

(2) *Documentation of support.* (i) Mobile rural health care providers shall provide to the Administrator documentation of the price of bandwidth equivalent wireline services in the urban area in the state or states where the service is provided. Mobile rural health care providers shall provide to the Administrator the number of sites the mobile health care provider will serve during the funding year.

(ii) Where a mobile rural health care provider serves less than eight different sites per year, the mobile rural health care provider shall provide to the Administrator documentation of the price of bandwidth equivalent wireline services. In such case, the Administrator shall determine on a case-by-case basis whether the telecommunications service selected by the mobile rural health care provider is the most cost-effective option. Where a mobile rural health care provider seeks a more expensive satellite-based service when a less expensive wireline alternative is most cost-effective, the mobile rural health care provider shall be responsible for the additional cost.

■ 5. Amend § 54.615 by revising paragraph (c)(2) to read as follows:

§ 54.615 Obtaining services.

* * * * *

(c) * * *

(2) The requester is physically located in a rural area, unless the health care provider is requesting services provided under § 54.621; or, if the requester is a mobile rural health care provider requesting services under § 54.609(e), that the requester has certified that it is serving eligible rural areas.

* * * * *

■ 6. Amend § 54.619 by revising paragraph (a) to read as follows:

§ 54.619 Audits and recordkeeping.

(a) *Health care providers.* (1) 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. Mobile rural health care providers shall maintain annual logs indicating: The date and locations of each clinic stop; and the number of patients served at each such clinic stop.

(2) Mobile rural health care providers shall maintain its annual logs for a period of five years. Mobile rural health care providers shall make its logs available to the Administrator and the Commission upon request.

* * * * *

■ 7. Amend § 54.621 by adding paragraph (c) to read as follows:

§ 54.621 Access to advanced telecommunications and information services.

* * * * *

(c) Health care providers located in States that are entirely rural shall be eligible to receive universal service support equal to 50 percent of the monthly cost of advanced telecommunications and information services reasonably related to the health care needs of the facility.

■ 8. Amend § 54.623 by revising paragraphs (a), (b), (c)(2), and (c)(3) to read as follows:

§ 54.623 Cap.

(a) *Amount of the annual cap.* The annual cap on federal universal service support for health care providers shall be $400 million per funding year, with the following exceptions.

(b) *Funding year.* A funding year for purposes of the health care providers cap shall be the period July 1 through June 30.

(c) * * *

(2) For each funding year, which will begin on July 1, the Administrator shall implement a filing period that treats all health care providers filing within that period as if they were simultaneously received. The filing period shall begin on the date that the Administrator begins to receive applications for support, and shall conclude on a date to be determined by the Administrator.

(3) The Administrator may implement such additional filing periods as it deems necessary. The deadline for all required forms to be filed with the Administrator is June 30 for the funding year that begins on the previous July 1.

* * * * *

[FR Doc. 05–2269 Filed 2–4–05; 8:45 am]

BILLING CODE 6712–01–U

DEPARTMENT OF DEFENSE

48 CFR Part 219

[DFARS Case 2003–D063]

Defense Federal Acquisition Regulation Supplement; Small Business Competitiveness Demonstration Program

AGENCY: Department of Defense (DoD).

ACTION: Final rule.

SUMMARY: DoD has issued a final rule amending the Defense Federal Acquisition Regulation Supplement (DFARS) to revise text regarding identification of contract awards under the Small Business Competitiveness Demonstration Program. This rule is a result of an initiative undertaken by DoD to dramatically change the purpose and content of the DFARS.

EFFECTIVE DATE: February 7, 2005.

FOR FURTHER INFORMATION CONTACT: Ms. Michele Peterson, Defense Acquisition Regulations Council, OUSD(AT&L)DPAP (DAR), IMD 3C132, 3062 Defense Pentagon, Washington, DC 20301–3062. Telephone (703) 602–0311; facsimile (703) 602–0350. Please cite DFARS Case 2003–D063.

SUPPLEMENTARY INFORMATION:

A. Background

DFARS Transformation is a major DoD initiative to dramatically change the purpose and content of the DFARS. The objective is to improve the efficiency and effectiveness of the acquisition process, while allowing the acquisition workforce the flexibility to innovate. The transformed DFARS will contain only requirements of law, DoD-wide policies, delegations of FAR authorities, deviations from FAR requirements, and policies/procedures that have a significant effect beyond the internal operating procedures of DoD or a significant cost or administrative impact on contractors or offerors. Additional information on the DFARS Transformation initiative is available at