

**Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554**

)	
)	
In the Matter of)	
)	
Rural Health Care)	WC Docket No. 02-60
Support Mechanism)	
)	
)	
)	

REPLY COMMENTS OF VERIZON

Michael E. Glover
Edward Shakin
Ann H. Rakestraw
VERIZON
1515 North Courthouse Road
Suite 500
Arlington, VA 22201-2909
(703) 351-3174

Jeffrey S. Linder
Bradley K. Gillen
WILEY REIN & FIELDING LLP
1776 K Street, N.W.
Washington, D.C. 20006
(202) 719-7000

April 7, 2004

Attorneys for the
Verizon telephone companies

TABLE OF CONTENTS

I.	UNTIL THE JOINT BOARD OR A RURAL TASK FORCE CAN CONDUCT FURTHER STUDY AND RECOMMEND A MORE PERMANENT DEFINITION OF “RURAL,” THE COMMISSION SHOULD ADOPT AN INTERIM DEFINITION THAT MINIMIZES DISRUPTION TO THE PROGRAM.....	3
II.	THE COMMISSION SHOULD NOT GRANDFATHER RECIPIENTS THAT NO LONGER FIT THE DEFINITION OF “RURAL,” OR CREATE A FORMAL APPEALS PROCESS	9
III.	THE COMMISSION SHOULD NOT ADOPT SPECIALIZED RULES FOR MOBILE CLINICS, OR OTHER PROPOSALS TO EXPAND THE RURAL HEALTH CARE PROGRAM.....	11
IV.	THE COMMISSION SHOULD REJECT REQUESTS TO FURTHER EXPAND THE SERVICES ELIGIBLE FOR SUPPORT	13

**Before the
FEDERAL COMMUNICATIONS COMMISSION
Washington, D.C. 20554**

)	
)	
In the Matter of)	
)	
Rural Health Care)	WC Docket No. 02-60
Support Mechanism)	
)	
)	
)	

REPLY COMMENTS OF VERIZON¹

Based on the current record, the Commission does not have enough factual information to adopt a new definition of “rural.” Many commenters propose new definitions that are either grossly overbroad, not easily verifiable, or do not analyze the impact to the rural health care program (“Program”). The Commission should ask the Joint Board or a Rural Task Force/Advisory Committee to collect data and make a recommendation on the definition of “rural” that should be used for both this Program and the schools and libraries program. Until the Joint Board makes a recommendation, the Commission should operate under an interim definition, allowing applicants to qualify for rural support if they meet either the old criteria (with the Goldsmith Modification to 1990 census data), or would be considered “rural” based on the 2000 census data, which has no Goldsmith Modification. Such an interim step would minimize disruption to applicants, and give a clear standard that is workable until a more permanent solution can be reached.

¹ The Verizon telephone companies (“Verizon”) are the local exchange carriers affiliated with Verizon Communications, Inc., and are listed in Attachment A.

The Commission also should not adopt commenters' suggestions for expansion of eligible services, such as new rules for mobile clinics. The Commission just last November adopted new rules that broadly expanded the services that will be eligible for support under the Program, and it should gain experience with those rules, and analyze the impact they have on Program funding requirements, before it considers any broader expansion.

I. UNTIL THE JOINT BOARD OR A RURAL TASK FORCE CAN CONDUCT FURTHER STUDY AND RECOMMEND A MORE PERMANENT DEFINITION OF "RURAL," THE COMMISSION SHOULD ADOPT AN INTERIM DEFINITION THAT MINIMIZES DISRUPTION TO THE PROGRAM

In its initial comments, Verizon articulated four general principles that should guide the Commission's selection of any definition of "rural": accuracy, ease of administration, transparency, and consistency. *See* Comments of Verizon, WC Docket No. 02-60, at 5-6 (Feb. 23, 2004) ("*Verizon*"). As explained below, all of the proposals for new definitions of "rural" fail to meet some or all of these criteria. Moreover, no commenter was able to predict with any certainty the effect that moving to a new definition would have on the number of entities that would be deemed "rural," and thus has not been able to make any meaningful prediction of the effect any of the proposed definitions would have on the fund size. Particularly if the Commission decides to adopt the same definition of "rural" for both this Program and the schools and libraries program, any new test that is overly inclusive would threaten the sustainability of the universal service fund.

The Commission should direct the Joint Board or Rural Task Force/Advisory Committee to conduct further study into the proper definition of "rural," including the impact any proposed

definitions would have on the fund size.² Until the Commission has a chance to rule on the Joint Board or Rural Task Force/Advisory Committee's recommendation on this issue, the Commission should work under interim rules, allowing applicants to qualify for rural support if they meet either the old criteria (including the Goldsmith Modification to 1990 census data), or would be considered "rural" based on the newer 2000 census data, which has no Goldsmith Modification.³ Such interim rules would minimize the disruption to the fund, because they would preserve the status quo for current applicants' eligibility, but also allow some updating for current census data.

The Commission should reject suggestions for the adoption of open-ended or overly broad definitions of "rural," which would greatly increase the universe of facilities eligible for Program support to include facilities that are not "rural," and fail to satisfy any of the four principles articulated above. For example, Placer County Health and Human Services

² In June 1996, the Commission established the Advisory Committee on Telecommunications and Health Care to advise the Commission and the Joint Board on telemedicine issues. *Federal State Joint Board on Universal Service, Report and Order*, 12 FCC Rcd 8776, ¶ 611, n. 1556 (1997) ("*Universal Service First Report and Order*"). The Advisory Committee, consisting of thirty-eight individuals with expertise and experience in the fields of health care, telecommunications and telemedicine, issued its findings and recommendations in October 1996, including a recommended definition of "rural." FCC Advisory Committee on Telecommunications and Health Care, *Findings and Recommendations*, CC Docket No. 96-45, at 3-4 (Oct. 16, 1996). A similar Rural Task Force/Advisory Committee - including experts in the fields of health care, education, telecommunications, and rural policy - could be assembled to evaluate and recommend a definition of "rural" for the schools and libraries and rural health care programs.

³ As under the current rules, both definitions would use the OMB metropolitan service area categorization of census data. See 47 C.F.R. § 54.5 (defining "rural area" as "a non-metropolitan 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").

Administration suggests that Program eligibility should be determined on the location of patients, not the actual facility.⁴ This approach would be unworkable and would grossly expand the pool of eligible providers. The low standard suggested by Placer County – two patients that reside in rural areas establish eligibility – would result in virtually every health care facility in the country from Mt. Sinai to Johns Hopkins being eligible for discounts under the Program directly contrary to Congress’ specific intent to limit support to *rural* health care providers. *Placer County* at 7-8.

American Telemedicine Association (“ATA”) suggests that its proposal to adopt the USDA’s Rural Broadband Program “rural” definition would “provide further benefits to healthcare providers not previously eligible.”⁵ Specifically, ATA, and a number of other parties, support the recently expanded definition of “rural” under the USDA Rural Broadband Grant Program, which categorizes all areas lacking an incorporated city or town with a population over 20,000 as rural.⁶ However, UVA Medical Center has indicated that Falls Church, Virginia – inside the Washington, D.C. Beltway – would be eligible under such a definition.⁷ Accordingly, the USDA approach is overly broad, and fails to satisfy the accuracy requirement, and should not be adopted by the Commission.

⁴ Comments of Placer County Health and Human Services Administration, WC Docket No. 02-60, at 3-4 (Feb. 23, 2004) (“*Placer County*”).

⁵ Comments of The American Telemedicine Association, WC Docket No. 02-60, at 4 (Feb. 23, 2004) (“*ATA*”).

⁶ See Comments of The California Healthcare Association, WC Docket No. 02-60, at 4 (Feb. 23, 2004) (“*California Healthcare Association*”).

⁷ Comments of the UVA Medical Center, WC Docket No. 02-60, at 15 (Feb. 6, 2004) (“*UVA Medical Center*”).

UVA Medical, as well as number of other Virginia-based entities, proposes a modification to the USDA definition that they assert cures this over-inclusive problem.⁸ Specifically, they propose to add a population density requirement (250 persons per square mile) to the definition. These entities, however, have failed to quantify the impact of this modification, to provide evidence that any other federal or state agency incorporates that definition of “rural” in its programs, or to demonstrate that such a definition could be easily administered or made transparent to the administrator or health care providers.

A number of parties suggest that health care providers should be free to establish their eligibility based on any definition of “rural” in any other federal program, or under any state definition if recognized by a federal agency.⁹ Combining the definition and eligibility requirements of all federal and state definitions amounts to no definition at all. Unsurprisingly, proponents of such an approach make no effort to quantify the impact such a broad definition would have on the number of eligible entities nationwide or the demand on finite Program resources. Moreover, this approach also fails all four principles. Allowing providers to definition-shop plainly would result in a broad expansion of eligibility, beyond truly rural facilities. It also would be unworkable and impossible to administer. The Program administrator would be in the unenviable position of determining the qualifying conditions for all possible rural definitions at the federal level and in 50 different states and the District of Columbia and of

⁸ *UVA Medical Center* at 15; Comments of Rep. Boucher, WC Docket No. 02-60, at 9 (Feb. 23, 2004) (“*Rep. Boucher*”); Comments of the Virginia Department of Health, WC Docket No. 02-60, at 2 (Feb. 20, 2004) (“*Virginia Department of Health*”).

⁹ For instance, several parties suggest that California’s Medical Service Study Area (“MSSA”) program should be used as a means to establish eligibility under the Program. Comments of Blue Cross of California, WC Docket No. 02-60, at 2 (Feb. 23, 2004) (“*Blue Cross of California*”).

tracking and evaluating any change to those definitions over time. The administrator lacks the necessary resources to audit and oversee such an expanded Program.

Moreover, such a choose-your-own definition policy defers too much to the health care providers and the states, and runs directly counter to the Commission's finding that the current definition of "rural" provides "a mechanism that includes the largest reasonably practicable number of rural health care providers." *Universal Service First Report and Order*, ¶ 649. The Commission is directed explicitly to provide support under the Program only to "rural" areas, not to maximize eligibility under the Program regardless of location. In addition, essentially delegating eligibility requirement to the states is problematic both under the Act and from an administrative standpoint.¹⁰ Specifically, the reliance on state definitions has practical problems in that different rules would apply in different states, eliminating a national definition of "rural" as contemplated by the Act. States would also have the perverse incentive to broaden intrastate definitions of "rural" to guarantee wider federal funding.

And while some commenters argue that modifications to the current rules are necessary in order to preserve funding to the same entities as received it in the past, most do not clarify whether it is the definitional change, or a change in demographics, that makes the formerly "rural" areas now not rural.¹¹ In other words, if those areas no longer meet the definition of

¹⁰ *UVA Medical Center*, at 18-20, as well as *Virginia Department of Health*, at 4, and *Rep. Boucher*, at 9, suggests that states also be given the opportunity to designate specific critical need hospitals as rural, regardless of the geographic or demographic nature of the facility. This proposal is facially inconsistent with the requirement of the Act to provide support only to rural health care providers. Congress could have chosen to provide funding to all vital health care facilities, or all community-based hospitals, but it did not. The Program must be limited to providing funding for *rural* health care providers.

¹¹ *See, e.g., ATA* at 4. ATA admits that "significantly fewer healthcare facilities will be eligible to receive discounts under the program" due to updated census data, which recognizes dramatic growth in many former rural communities. A general shift in demographics that results in a decrease in the number of rural areas nationwide, however, does not warrant a

“rural” because they have grown into urban areas, they should not continue to receive funding simply because they were rural in the past. *See* Section II, *infra*.

The only proposed definition of “rural” that is worth consideration comes from Dr. Patricia Taylor, formally of the Office of Rural Health Care Policy.¹² Dr. Taylor suggests incorporating Rural Urban Commuting Area (“RUCA”) codes on top of the current OMB metropolitan-area based definition, as a replacement for the Goldsmith Modification.¹³ She states that “the number of organizations losing geographic eligibility due to this change will be relative small number,” and indicates that the number of “rural” persons under RUCA codes is far greater – 13.7 million more – than the number under the Goldsmith Modification. *Id.* at 2-3. Dr. Taylor played a prominent role in the selection of the current rural definition, and her experience, expertise, and impartiality are an important factor to consider when looking at this new proposed definition.

Based on Dr. Taylor’s analysis, the RUCA approach appears to be accurate and consistent, two of the principles necessary for an effective system. However, even this approach has its problems. Neither Dr. Taylor nor any other proponent of RUCA codes has offered any specific means by which RUCA codes can be made easy to administer and transparent to eligible providers. The Commission may need to work with the Office of Rural Health Care Policy – the originator of RUCA codes – and other interested agencies in developing a database or other

corresponding broadening of Program eligibility to maintain a certain number of eligible health care providers.

¹² Letter from Dr. Patricia Taylor to Federal Communications Commission, WC Docket No. 02-60 (Feb. 23, 2004) (“*Taylor*”).

¹³ *Taylor* at 1. A number other parties support the adoption of the RUCAs, including National Organization of State Offices of Rural Health and the Bayside Community Hospital and Clinic.

centralized source that would afford providers and administrators an easy-to-use mechanism for determining eligibility. The Commission also should investigate specific criticisms of RUCA codes that allege that such an approach would be under-inclusive and overly reliant on commuting patterns.¹⁴ Thus, while the proposal merits further study by the Joint Board or Rural Task Force, it has shortcomings that must be resolved before it can be adopted as a workable definition.

II. THE COMMISSION SHOULD NOT GRANDFATHER RECIPIENTS THAT NO LONGER FIT THE DEFINITION OF “RURAL,” OR CREATE A FORMAL APPEALS PROCESS

If the Commission does adopt a revised definition of “rural,” there is no basis to grandfather current Program recipients who do not meet the new definition.¹⁵ Dr. Taylor correctly notes that it is “important for the Commission to recognize that many formerly eligible areas will lose their eligibility not because of the change in definition of ‘rural areas’, but rather

¹⁴ Comments of Mayers Memorial Hospital District, WC Docket No. 02-60 (Feb. 12, 2004); Comments of The Shasta Consortium of Community Health Centers, WC Docket No. 02-60, at 1-2 (Feb. 23, 2004) (“*Shasta Consortium*”). Of course, the fact that the total number of rural areas under RUCA is not as broad or inclusive as under other proposals is not alone a valid attack. Critics must provide concrete reasons and accurate statistics demonstrating that RUCA codes are not an appropriate indicator of rural status. For instance, the California Department of Health Services contends that 84 rural clinics, or 20 percent of California’s clinics, would be stripped of their rural designation under RUCA codes. Comments of The California Department of Health Services, WC Docket No. 02-60, at 1 (Feb. 18, 2004) (“*California Department of Health Services*”). It is unclear if the drop in eligible clinics is a result of inadequacies with the RUCA approach or based on actual metropolitan growth in formerly rural areas.

¹⁵ See e.g., Comments of The California State Rural Health Association, WC Docket No. 02-60 (Feb. 10, 2004) (“*California State Rural Health Association*”); Comments of The California Primary Care Association, WC Docket No. 02-60 (Feb. 23, 2004) (“*California Primary Care Association*”); Comments of The Iowa Utilities Board, WC Docket No. 02-60 (Feb. 23, 2004) (“*Iowa Utilities Board*”); *Shasta Consortium*; *ATA*; *Blue Cross of California*; Comments of Northeastern Rural Health Clinics, WC Docket No. 02-60 (Feb. 12, 2004) (“*Northeastern Rural Health Clinics*”).

because of the growth of Metropolitan Areas.” *Taylor* at 3. The Program is explicitly limited by statute to support health care providers in rural areas, and to the extent that health care facilities are located in areas that are no longer rural, they are no longer eligible to receive support under the Act. *See* 47 U.S.C. § 254(h)(1)(A). Moreover, if the facility is located in an area no longer classified as rural, there is no policy reason to continue such funding.¹⁶ Once an area is no longer deemed rural, it is likely that universal service support is no longer necessary to ensure that the facility’s telecommunications rates are comparable with urban rates.

Nor is there a need to adopt a specific appeals process as suggested by some parties.¹⁷ Once the Commission selects the most accurate, easy to administer, transparent, and consistent definition of “rural,” there is no policy or practical reason to allow non-qualifying providers to expand the Program to non-rural areas. Proponents of implementing a formal appeals process have failed to establish that current protections are inadequate. In particular, applicants that believe they qualify under the Program’s definition but are denied funding by the administrator can seek a waiver of the Commission’s rules or seek review of the administrator’s decision. In addition, the proposed appeals procedures would place significant stress on USAC’s resources by demanding that USAC consider all rejected applicants’ eligibility under other federal or state programs, or based on a “[p]resentation of factors that would otherwise define the community as rural.” *Blue Cross of California* at 4; *California Healthcare Association* at 8. The Commission

¹⁶ *See also* Comments of The Rural School and Community Trust, CC Docket No. 02-6, at 6 (Mar. 10, 2004) (arguing that “it is illogical to ‘grandfather’ E-Rate applicants currently designated as rural. Population shifts and broader changes in demographics underscore the need for recategorization. Were the rural status of a school or library to be maintained, regardless of continued suburbanization, the integrity of the program could be questioned.”).

¹⁷ *See e.g., California Healthcare Association* at 5; *Blue Cross of California* at 4; *California State Rural Health Association*; Comments of The California Telemedicine and eHealth Center, WC Docket No. 02-60 (Feb. 20, 2004); *California Primary Care Association*; *Northeastern Rural Health Clinics*; *Mountain Valleys Health Centers*.

has correctly refused attempts in the past to provide support to health care facilities that fail to meet the Program's "rural" definition.¹⁸

III. THE COMMISSION SHOULD NOT ADOPT SPECIALIZED RULES FOR MOBILE CLINICS, OR OTHER PROPOSALS TO EXPAND THE RURAL HEALTH CARE PROGRAM

It was only last November that the Commission greatly expanded the reach of the Program, in an effort to encourage greater participation by rural health care providers.¹⁹ The Commission should allow time for rural health care providers and service providers to gain experience with the new rules, and for USAC to track the effect these rule changes have on the size of the fund, before it considers any requests for further significant modifications to the Program.

For example, while the Commission should continue to explore opportunities to encourage the development of mobile clinics, any action to modify the Program's rules for mobile clinics at this time would be premature and unsupported by the record. The Commission's new rules already provide greater access to satellite services in instances where terrestrial-based solutions are unavailable. *Order*, ¶¶ 42-44. Among the clear beneficiaries of such reforms are mobile clinics, whose need for mobility may limit the availability of traditional

¹⁸ *Federal-State Joint Board on Universal Service*, Memorandum Opinion and Order, 13 FCC Rcd 274 (1998) (rejecting waiver request of Pennsylvania Public Utility Commission which would allow certain health care providers to participate in the Program despite failing to meet definition of rural); *see also Federal State Joint Board on Universal Service*, Memorandum Opinion and Order, 13 FCC Rcd 24968, ¶ 13 (1998) (rejecting request of seven school districts to be classified as rural even though they failed to satisfy the FCC's definition because "[a] significant benefit of adopting the MSA/Goldsmith approach was to provide a clear and certain standard for determining whether an entity is rural.").

¹⁹ *Rural Health Care Support Mechanism*, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 18 FCC Rcd 24546 (2003) ("*Order*" or "*Notice*").

wireline solutions. As a result, no further modifications explicitly designed for mobile clinics are warranted.

Healthcare Anywhere, the entity referenced in the *Notice*, is the only mobile clinic operator that indicates its intention to seek support under the Program, and it is also the only commenter to express support for wholesale modifications to Program rules to encourage mobile clinic participation.²⁰ However, there is no evidence that any mobile clinics, including Healthcare Anywhere's clinics, could not already receive adequate support under the new rules, or on a case-by-case basis through a waiver request. A wholesale rule change, just to support mobile rural health clinics, simply is not warranted.

Moreover, commenters have failed to provide necessary details as to the business plans or operational conditions of mobile clinics, *i.e.*, the number of communities served, the bandwidth and technological needs of such clinics, and the number of mobile clinics operating today. Without this factual record, the FCC cannot ensure that funding of the Program remains predictable and sufficient. 47 U.S.C. § 254(b)(5).

Moreover, Healthcare Anywhere proposes that the Commission create a virtually standard-less set of rules that would apply only to mobile clinics. In doing so, Healthcare Anywhere has overlooked the Commission's statutory obligation to maintain competitively neutral rules, to limit Program support to rural providers serving rural areas, and to minimize opportunities for waste, fraud, and abuse. For instance, Healthcare Anywhere opposes ATA's call for a minimum number of communities served, suggesting that mobile clinics need the flexibility to determine the number and types of communities served. Comments of Healthcare Anywhere, WC Docket No. 02-60, at 12 (Feb. 23, 2004) ("*Healthcare Anywhere*"). Healthcare

²⁰ ATA supports rural health care clinics' ability to receive support for satellite services, but refrains from suggesting wholesale changes. *ATA* at 4.

Anywhere further suggests that mobile health care clinics “support should not be capped at the amount a provider would receive if it received functionally similar terrestrial based service.” *Id.*, at 8.²¹ This is contrary to recent Commission findings that “equalizing the rates for satellite and terrestrial mobile service could significantly increase Program demand and disadvantage those carriers already providing functionally similar services at more competitive prices.”²² The FCC’s commendable desire to encourage deployment of mobile clinics must be balanced with its statutory obligation to maintain a sustainable and predictable universal service program and to provide service under the Program only to *rural* health care providers. If the Commission were to adopt rules geared to mobile clinics in the future, a number of minimum requirements must be included to protect the integrity of the Program.²³

IV. THE COMMISSION SHOULD REJECT REQUESTS TO FURTHER EXPAND THE SERVICES ELIGIBLE FOR SUPPORT

ATA and the Pan-Pacific Education and Communications Experiments by Satellite (“PEACESAT”) suggest further expansion of the Program beyond the issues presented in the *Notice*. ATA suggests that the current 25 percent discount available for Internet access under the Program should be increased to 100 percent. *ATA* at 5. To the extent ATA is seeking

²¹ Healthcare Anywhere’s reference to emergency response and homeland security functionalities of its clinics - however beneficial to the public at large - is irrelevant for funding purposes under the Program, which is limited by law to provide service to rural communities. *Healthcare Anywhere* at 15-16.

²² *Order*, ¶ 62. ATA has also recognized that support must be capped “at the amount a clinic would receive if it received functionality similar terrestrial based services.” *ATA* at 4.

²³ For example, Avera Health correctly notes that a proportional or percentage discount system would have to be developed so mobile clinics receive discounted service only for services provided to rural communities. *Avera Health* at 3-4.

reconsideration of the Commission’s decision establishing the discount, ATA failed to follow the procedural requirements for reconsideration. 47 C.F.R. § 1.106.

Regardless, there is no basis to allow full recovery of all Internet access support. The Commission rejected similar calls for greater discounts, instead selecting a “twenty-five percent flat discount initially because it will provide an incentive for rural health care providers to choose a level of service appropriate to their needs, will provide more certainty that demand for Internet access support will not exceed the annual funding cap, and will deter wasteful expenditures.” *Order*, ¶ 27. ATA focuses its comments on encouraging further participation in the Program without adequately responding to the Commission’s concerns about wasteful expenditures or excessive Program growth. The Commission suggested that after it gained “more experience with this aspect of the support mechanism, we will determine whether an increase in the discount is necessary or advisable.” *Order*, ¶ 27. However, ATA’s premature call to revisit this decision – before *any* experience has been gained with the new criteria – must be rejected.

PEACESAT asks that health care providers be eligible to share access with schools and libraries.²⁴ Under the FCC’s consortium rules, eligible health care providers already may share access and technical resources with schools and libraries. *Universal Service First Report and Order*, ¶ 719. However, PEACESAT’s suggestion that health care providers receive *free* access is directly contrary to the Act, the Program, and the schools and libraries program’s rules and requirements. Section 254 of the Act only provides support under the schools and libraries program only for “educational purposes.” 47 U.S.C. § 254(h)(1)(B). In the *Alaska Order*, the Commission granted a limited waiver to allow remote Alaskan communities with *no* Internet

²⁴ Comments of the Pan-Pacific Education and Communication Experiments by Satellite, WC Docket No. 02-60, at 4 (Feb. 24, 2004) (“PEACESAT”).

access to make use of services provided under the schools and libraries program subject to specific limitations and conditions.²⁵ In this instance, however, PEACESAT has not sought a waiver, and also fails to satisfy the specific conditions set out in the *Alaska Order*. Contrary to the conditions in Alaska, PEACESAT admits that “Internet access is available in these locations.” *PEACESAT* at 3. Indeed, rather than providing connectivity to the Internet for isolated communities, PEACESAT seeks to augment the cost of Internet service already in place and to provide higher bandwidth applications to health care facilities. PEACESAT’s request threatens the integrity of the schools and libraries program by opening the door for schools and libraries to seek greater bandwidth and services than necessary for educational purposes, and placing greater pressure on USAC to monitor instances of waste, fraud, and abuse. Access can be shared only if ineligible recipients pay their undiscounted proportional share of the service costs.²⁶ PEACESAT provide no support to justify a departure from that well-established principle.

²⁵ *Federal-State Joint Board on Universal Service, Petition of the State of Alaska for Waiver for the Utilization of Schools and Libraries Internet Point-of-Presence in Rural Remote Alaska Villages Where No Local Access Exists and Request for Declaratory Ruling*, Order, 16 FCC Rcd 21511 (2001). The waiver was granted because: (1) there was *no* local or toll-free Internet access available in the community; (2) the school or library had not requested more services than necessary for educational purposes; (3) no additional costs were incurred; (4) any use for non-educational purposes was limited to hours in which the school or library was not open; and (5) the excess services were made available to all capable service providers in a neutral manner that did not require or take into account any commitments or promises from the service providers.

²⁶ 47 C.F.R. § 54.501(d); *see generally* Cost Allocation Guidelines for Consortia Comprising Eligible and Ineligible Entities, <http://www.sl.universalservice.org/reference/costaloc.asp>, (last visited Mar. 30, 2004).

Conclusion

The Commission should study the possible adoption of a “rural” definition incorporating RUCA codes, and should monitor the development of mobile clinics to determine if any rules changes may become necessary.

Respectfully submitted,

By: /s/ Jeffrey S. Linder

Michael E. Glover
Edward Shakin
Ann H. Rakestraw
VERIZON
1515 North Courthouse Road
Suite 500
Arlington, VA 22201-2909
(703) 351-3174

Jeffrey S. Linder
Bradley K. Gillen
WILEY REIN & FIELDING LLP
1776 K Street, N.W.
Washington, D.C. 20006
(202) 719-7000

April 7, 2004

Attorneys for the
Verizon Telephone Companies

THE VERIZON TELEPHONE COMPANIES

The Verizon telephone companies are the local exchange carriers affiliated with Verizon Communications, Inc. These are:

Contel of the South, Inc. d/b/a/ Verizon Mid-States
GTE Midwest Incorporated d/b/a/ Verizon Midwest
GTE Southwest Incorporated d/b/a/ Verizon Southwest
The Micronesian Telecommunications Corporation
Verizon California Inc.
Verizon Delaware Inc.
Verizon Florida Inc.
Verizon Hawaii Inc.
Verizon Maryland Inc.
Verizon New England Inc.
Verizon New Jersey Inc.
Verizon New York Inc.
Verizon North Inc.
Verizon Northwest Inc.
Verizon Pennsylvania Inc.
Verizon South Inc.
Verizon Virginia Inc.
Verizon Washington, DC Inc.
Verizon West Coast Inc.
Verizon West Virginia Inc.