Before the
Federal Communications Commission
Washington, D.C. 20554

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

ORDER

Adopted: June 4, 2024 **Released: June 4, 2024**

By the Chief, Wireline Competition Bureau:

I. INTRODUCTION

1. In this Order, pursuant to section 54.600(e) of the Commission's rules,[1] the Wireline Competition Bureau (Bureau) updates the list of rural areas used to determine eligibility in the Rural Health Care (RHC) Program to reflect results of the 2020 decennial United States census. To ease the transition, the Bureau grants a waiver for funding year 2025 to allow health care providers whose status has changed from rural to urban to continue to participate in the RHC Program as if they were rural.

II. BACKGROUND

2. The Commission's RHC Program consists of two component mechanisms: (1) the Healthcare Connect Fund (HCF) Program and (2) the Telecommunications (Telecom) Program. The HCF Program promotes the use of broadband services and facilitates the formation of health care provider consortia that include both rural and urban health care providers by providing a flat 65% discount on an array of advanced telecommunications and information services.[2] The Telecom Program subsidizes the difference between the rates in the health care provider's rural area and rates for comparable services available in urban areas within the health care provider's state.[3]

3. Eligible health care providers, as defined in the Telecommunications Act of 1996 (1996 Act), are limited to (1) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (2) community health centers or health centers providing health care to migrants; (3) local health departments or agencies; (4) community mental health centers; (5) not-for-profit hospitals; (6) rural health clinics; (7) skilled nursing facilities; and (8) consortia of HCPs consisting of one or more entities falling into the first seven categories.[4] In addition, eligible health care providers must be non-profit or public.[5]

4. Pursuant to the Act and the Commission's rules, each individual health care provider site must be located in a rural area to receive support in the Telecom Program.[6] Similarly, individual

[1] 47 CFR § 54.600(e).

[2] *See* 47 U.S.C. § 254(h)(2)(A); 47 CFR §§ 54.611, 54.612; *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 27 FCC Rcd 16678, 16680-81, paras. 1-3 (2012) (*Healthcare Connect Fund Order*).

[3] *See* 47 U.S.C. § 254(h)(1)(A); *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776, 9093-161, paras. 608-749 (1997) (*Universal Service First Report and Order*).

[4] 47 U.S.C. § 254(h)(7)(B).

[5] 47 U.S.C. §§ 254(h)(4), (h)(7)(B).

[6] *See* 47 U.S.C. § 254(h)(1)(A) ("A telecommunications carrier shall, upon receiving a bona fide request, provide telecommunications services which are necessary for the provision of health care services in a State, including

(continued….)

applicants in the HCF Program must also be located in a rural area.[7] A consortium in the HCF Program may include urban health care provider sites but must be comprised of a majority of health care provider sites located in rural areas.[8]

5. The Commission's rules define a "rural area" as 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.[9] The Commission's rules specify that Core Based Statistical Areas, Urban Areas, and Places follow Census Bureau definitions.[10]

6. After data from each census becomes available, the Office of Management and Budget updates designations for Core Based Statistical Areas.[11] Updates to reflect 2020 Census results are complete.[12] After the release of updated data from the 2010 Census, the Bureau updated rurality

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instruction relating to such services, to any public or nonprofit health care provider that serves persons who reside in rural areas in that State . . . .").

[7] *See also* 47 CFR § 54.607(a) ("Under the Healthcare Connect Fund, an eligible rural healthcare provider may receive universal service support by applying individually . . . .").

[8] *See* 47 CFR § 54.607(b) ("An eligible non-rural health care provider site may receive universal service support only as part of a consortium that includes more than 50 percent eligible rural health care provider sites.").

[9] *See* 47 CFR § 54.600(e). For purposes of prioritizing funding in the event demand exceeds available funding, the Commission subdivides rural areas into an Extremely Rural Tier (areas entirely outside of a Core Based Statistical Area), a Rural Tier (areas within a Core Based Statistical Area that does not have an urban area or urban cluster with a population equal to or greater than 25,000), and a Less Rural Tier (areas within a Core Based Statistical Area with an urban area or urban cluster with a population equal to or greater than 25,000, but where the census tract does not contain any part of an urban area or urban cluster with population equal to or greater than 25,000). 47 CFR § 54.621(b)(2). The Commission's original definition for the RHC Program defined "rural areas" as a "nonmetropolitan county or county equivalent, as defined by [the Office of Management and Budget (OMB)] and identifiable from the most recent MSA list released by OMB, or any census tract or block numbered area, or contiguous group of such tracts or areas, within an [Metropolitan Statistical Area]-listed metropolitan county identified in the most recent Goldsmith Modification published by [the U.S. Department of Health and Humans Services Office for Human Research Protections]." *Universal Service First Report and Order*, 12 FCC Rcd at 9116, para. 649. In 2004, the Commission adopted of the current standard for rural areas based on Core Based Statistical Areas for purposes of the RHC Program. *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 19 FCC Rcd 24613, 24619-20, paras. 11-12 (2004) (*2004 Rural Definition Order*). To ease the transition for health care providers losing their rural status under the new definition, the Commission permitted all entities losing their rural status to continue to receive funding as if they were rural for the next three years. *See id.* at 24624, para. 23.

[10] *See* 47 CFR § 54.600(e); *see also* United States Census Bureau, Redefining Areas Following the 2020 Census (2022), https://www.census.gov/newsroom/blogs/random-samplings/2022/12/redefining-urban-areas-following-2020-census.html; United States Census Bureau, Glossary (2024), https://www.census.gov/programs-surveys/geography/about/glossary.html (defining a Core Based Statistical Area as a county or counties associated with an urban area with a population of at least 10,000; defining an Urban Area as an area with a population threshold of 5,000 or more; defining Place as a locally recognized community that be incorporated or census-designated).

[11] *See* Executive Office of the President, Office of Management and Budget, OMB Bulletin No. 23-01, Revised Delineations of Metropolitan Statistical Areas, Micropolitan Statistical Areas, and Combined Statistical Areas, and Guidance on Uses of the Delineations of These Areas (2023), https://www.whitehouse.gov/wp-content/uploads/2023/07/OMB-Bulletin-23-01.pdf.

[12] *Id.*

designations to reflect the census changes and issued a waiver to allow sites that were re-designated from rural to urban to continue participating in the RHC Program for a limited period.[13]

III. DISCUSSION

7. Consistent with section 54.600(e) of the Commission's rules, and in accordance with furthering the Commission's goals of increasing telecommunications and broadband access for eligible health care providers, particularly those in rural areas,[14] we direct USAC to update the areas that it designates as rural areas to reflect the 2020 decennial census data, including the most recent Core Based Statistical Area designations, effective in funding year 2025. To ensure a smooth transition, we waive section 5.600(e) of the Commission's rules to permit health care providers that are currently classified as rural but will be re-classified as urban to maintain the benefits of their rural status for funding year 2025 funding requests.[15]

8. To effectuate this change, we direct USAC to review all existing eligibility determinations and update the rural status of sites to reflect the new qualifications for "rural areas" using 2020 census data for funding year 2025. We also direct USAC to use results from the 2020 census for all new eligibility determinations made on or after July 1, 2024. We note that this Order does not modify the definition of "rural areas" in the RHC Program, but instead merely implements the existing rule and reminds applicants that the list of qualifying rural areas will be maintained and updated periodically as required by the Commission's rules.

9. On our own motion and consistent with precedent, we grant a limited waiver of section 54.600(e) of the Commission's rules to allow those health care providers that have already received an eligibility determination and whose status will change from rural to urban as a result of this update to continue to participate in the RHC Program as if they were rural for funding year 2025.[16] This waiver will allow health care providers that will lose their rural status time to plan how they will meet their telecommunications and broadband needs in the future. We expect this waiver to apply to less than one percent of health care provider sites.[17]

10. The Commission's rules may be waived for good cause shown.[18] The Commission may exercise its discretion to waive a rule where the particular facts make strict compliance inconsistent with

[13] *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 29 FCC Rcd 8609 (2014) (*2014 Rural Areas Update Order*).

[14] *See Healthcare Connect Fund Order*, 27 FCC Rcd at 16695, 16815, paras. 32, 344 (adopting performance goals for both the HCF and Telecom Programs).

[15] In this Order, "urban areas" and "urban health care providers" refer to areas and health care providers outside of rural area as "rural area" is defined in section 54.600(e) of the Commission's rules. *See* 47 CFR 54.600(e).

[16] *See 2014 Rural Areas Update Order*, 29 FCC Rcd 8609 (allowing health care providers that would be re-designated as urban after updates to rurality from the 2010 census to continue to receive funding as if they were rural for the remainder of funding years 2014 and 2015).

[17] Preliminary analysis indicates that less than one percent of the health care providers that recently participated in the RHC Program will change from rural to urban following the updating of the providers designated by USAC as rural participants as directed by this Order. Of the 34,741 health care providers that filed an FCC Form 460 or 465 in funding years 2012-23, approximately 312 would shift from rural to urban after this update, while 485 would shift from urban to rural. *See* Letter from Mark Sweeney, Vice President, Rural Health Care Division, USAC to Jodie C. Griffin, Chief, and Bryan P. Boyle, Deputy Chief, Telecommunications Access Policy Division, Wireline Competition Bureau, Federal Communications Commission, WC Docket No. 02-60 (filed June 3, 2024). We also note that updates to the list of sites USAC designates as rural may change the status of areas that were previously urban to rural. Health care providers in these newly rural areas will be eligible to seek RHC support for funding year 2025, assuming they meet all other requirements of the RHC Program.

[18] 47 CFR § 1.3.

the public interest.[19] In addition, the Commission may take into account considerations of hardship, equity, or more effective implementation of overall policy on an individual basis.[20] Waiver of the Commission's rules is appropriate if both (i) special circumstances warrant a deviation from the general rule and (ii) such deviation will serve the public interest.[21]

11. This once-per-decade update to areas identified as rural creates special circumstances justifying our action to ease impacted health care providers' transitions. Many of these sites play an important role in delivering health care and a sudden change in eligibility due to the loss of a health care provider's rural status could have a serious effect on its ability to deliver needed health care services to patients in a given area. Further, easing the transition for formerly rural sites serves the public interest because it provides health care providers currently participating in the RHC Program with sufficient time to determine whether their status as a rural site will change, and to address any implications of this in their business operations. Transitioning health care providers will remain connected as they consider how best to go forward, either on their own or potentially as part of an HCF Program-supported network.[22] Thus, this support will help maintain the status quo for many patients and communities that benefit from the telemedicine and telehealth applicants provided by the health care providers participating in the RHC Program.

12. This waiver applies across all aspects of the RHC Program for funding year 2025 requests for support and reimbursement, including to the consortium majority rural requirement and multi-year commitments. HCF Program consortia must be comprised of a majority of rural sites.[23] Sites that have received a funding commitment as part of a consortium in funding year 2025 or earlier and had their status change to urban as a result of today's action will count as rural toward the consortium's majority rural requirement through the end of funding year 2025.[24] Participants in the HCF Program may receive a funding commitment for up to three years.[25] Health care providers that are treated as urban under this waiver will retain that treatment for the full duration of their multi-year commitment, up to three years, subject to all other requirements for multi-year commitments.[26]

13. Finally, we direct USAC to conduct outreach to sites that will transition from rural to urban and vice versa, as well as to the lead for consortia with sites that will transition from rural to urban and vice versa. This outreach will ensure that impacted sites will be aware of their change in status and have sufficient time to prepare for future funding requests that reflect their new status. USAC must conduct individual outreach to impacted sites that received a funding commitment since funding year 2021 and also address these changes in outreach materials for a general RHC Program audience.

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[19] *Northeast Cellular Tel. Co. v. FCC*, 897 F.2d 1164, 1166 (D.C. Cir. 1990) (*Northeast Cellular*).

[20] *WAIT Radio v. FCC*, 418 F.2d 1153, 1159 (D.C. Cir. 1969); *Northeast Cellular*, 897 F.2d at 1166.

[21] *Northeast Cellular*, 897 F.2d at 1166.

[22] In the HCF Program, a site whose status changes from rural to urban can still potentially receive RHC support if it is part of a consortium that is majority rural. *Healthcare Connect Fund Order*, 27 FCC Rcd at 16705-07, paras. 59, 61; *see also* 47 CFR § 54.630(b) ("An eligible non-rural health care provider may receive universal service support only as part of a consortium that includes more than 50 percent eligible rural health care provider sites.").

[23] *See* 47 CFR § 54.607(b).

[24] Because our action to re-classify sites that will change to rural as a result of today's action applies for funding year 2025, those sites will also qualify as rural for funding year 2025.

[25] *See* 47 CFR § 54.620(c).

[26] *See, e.g.*, 47 CFR § 54.621(b)(1)(i) (applying prioritization to the second and third year of multi-year commitments when demand exceeds available funding).

IV. ORDERING CLAUSES

14. Accordingly, IT IS ORDERED that, pursuant to the authority contained in sections 1-4 and 254 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151-154 and 254, and sections 0.91, 0.201(d), and 0.291 of the Commission's rules, 47 CFR §§ 0.91, 0.201(d), and 0.291, this Order IS ADOPTED.

15. IT IS FURTHER ORDERED that, pursuant to sections 0.91, 0.291, and 1.3 of the Commission's rules, 47 CFR §§ 0.91, 0.291, 1.3, section 54.600(e) of the Commission's rules, 47 CFR § 54.600(e), IS WAIVED to the extent described above.

16. IT IS FURTHER ORDERED that, pursuant to the authority contained in section 1.102(b)(1) of the Commission's rules, 47 CFR § 1.102(b)(1), this Order SHALL BE EFFECTIVE upon release.

FEDERAL COMMUNICATIONS COMMISSION

Trent B. Harkrader
Chief
Wireline Competition Bureau