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

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

ORDER ON RECONSIDERATION

Adopted: February 8, 2008 **Released: February 14, 2008**

By the Commission:

I. INTRODUCTION

1. In this Order on Reconsideration, we grant in part a Petition for Reconsideration by the American Telemedicine Association (ATA),[1] seeking limited reconsideration of the Commissions' Rural Health Care Support Mechanism *Second Report and Order*.[2] Specifically, we grant ATA's Petition for Reconsideration in part and extend for three years the Commission's prior determination to grandfather those health care providers who were eligible under the Commission's definition of "rural" prior to the *Second Report and Order*.

II. BACKGROUND

2. From the inception of the current universal service rural health care mechanism in 1997 to the effective date of the *Second Report and Order* in 2005, the Commission utilized the definition of "rural" that had been used by the U.S. Department of Health and Human Services, Health Resources and Services Administration, Office of Rural Health Policy (ORHP).[3] Under ORHP's definition, an area was considered rural if it was not located in a county within a Metropolitan Statistical Area (MSA) as defined by the Office of Management and Budget (OMB) or if it was specifically identified as "rural" in the Goldsmith Modification to the 1990 Census data.[4] ORHP, however, discontinued using the

[1] American Telemedicine Association Petition for Reconsideration of the Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, WC Docket No. 02-60 (filed March 7, 2005) (Petition).

[2] *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 (2004) (*Second Report and Order*).

[3] *See Second Report and Order*, 19 FCC Rcd at 24617, para. 8 (citing *Federal-State Joint Board on Universal Service*, CC Docket No. 96-45, Order, 12 FCC Rcd 8776, 9115-16, para. 649 (1997)). We note that the term "rural" is not defined in the statute; thus, Congress left it to the Commission to establish a reasonable definition. *See* 47 U.S.C. § 254; *NationsBank of North Carolina, N.A. v. Variable Annuity Life Ins. Co*., 513 U.S. 251, 257 (1995) (if an agency "defines a term in a way that is reasonable in light of the legislature's revealed design, we give [that] judgment 'controlling weight.'") (citation omitted). We also note that in its petition, ATA did not request reconsideration of the definition of "rural" adopted in the *Second Report and Order*. *See* Petition at 3. Thus, our actions in this Order do not address the change in the definition adopted in that order.

[4] *See* 47 C.F.R. § 54.5 (2003) ("A rural area is 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

(continued....)

MSA/Goldsmith method and adopted the Rural Urban Commuting Area (RUCA) system for rural designation.[5] Furthermore, since the Commission's adoption of the ORHP definition of rural, OMB had restructured its definitions of MSAs and non-MSAs by adding another category – the Micropolitan Statistical Area (MiSA).[6] Therefore, because the definition of "rural area" for the rural health care support mechanism became obsolete, the Commission sought comment on modifications to the definition of "rural area" for the rural health care universal service support mechanism in the *2003 Report and Order*.[7]

3. In the *Second Report and Order*, the Commission changed its definition of rural for the purposes of the rural health care support mechanism.[8] Under the new definition, a rural area is one that is not located within or near a large population base. Specifically, a "rural area" is an area that (a) is entirely outside of a Core Based Statistical Area (CBSA);[9] (b) is within a CBSA that does not have any urban area with a population of 25,000 or greater; [10] or (c) is in a CBSA that contains an urban area with a population of 25,000 or greater, but is within a specific census tract[11] that itself does not contain any part of a place

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recent Goldsmith Modification published by the Office of Rural Health Policy of the U.S. Department of Health and Human Services."). The Goldsmith Modification is a procedure for identifying isolated rural neighborhoods within large metropolitan counties. *See* Harold F. Goldsmith, Dena S. Puskin, and Dianne J. Stiles, *Improving the Operational Definition of "Rural Areas" for Federal Programs*, Federal Office of Rural Health Policy 1993, *available at* http://ruralhealth.hrsa.gov/pub/Goldsmith.htm (retrieved Oct. 5, 2007).

[5] *See* ORHP, Geographic Eligibility for Rural Health Grant Programs, *at* http://ruralhealth.hrsa.gov/funding/eligibilitytestv2.asp (retrieved Oct. 5, 2007).

[6] A Metropolitan Statistical Area (MSA) is a Core Based Statistical Area (CBSA) associated with at least one urbanized area that has a population of at least 50,000. An MSA comprises the central county or counties containing the core (either an urbanized area or an urban cluster), plus adjacent outlying counties having a high degree of social and economic integration with the central county as measured through commuting. A Micropolitan Statistical Area (MiSA) is a CBSA associated with at least one urban cluster that has a population of at least 10,000, but less than 50,000. The MiSA comprises the central county or counties containing the core, plus adjacent outlying counties having a high degree of social and economic integration with the central county as measured through commuting. *Standards for Defining Metropolitan and Micropolitan Statistical Areas,* Office of Management and Budget, 65 FR 82228, no. 249 (Dec. 27, 2000).

[7] *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 18 FCC Rcd 24546, 24578, paras. 63-64 (2003) (*2003 Report and Order*).

[8] *See Second Report and Order*, 19 FCC Rcd at 24619-24620, para. 12.

[9] A CBSA is a statistical geographic entity consisting of the county or counties associated with at least one core (a densely settled concentration of population, comprising either an urbanized area (of 50,000 or more population) or an urban cluster (of 10,000 to 49,999 population) defined by the Census Bureau) of at least 10,000 people, plus adjacent counties having a high degree of social and economic integration with the core as measured through commuting ties with the counties containing the core. Metropolitan and Micropolitan Statistical areas are the two categories of CBSAs. *See Standards for Defining Metropolitan and Micropolitan Statistical Areas,* Office of Management and Budget, 65 FR 82228, no. 249 (Dec. 27, 2000).

[10] The urbanized population is the population contained in the urban area (urbanized area or urban cluster) at the core of the CBSA as well as all other urban areas in the CBSA. Urbanized areas and urban clusters are areas of "densely settled territory," as defined by the Census Bureau. *See* U.S. Census Bureau, 2000 Census of Population and Housing, Summary File 3: Technical Documentation, 2002, Appendix A. A list of urban areas for the 2000 Census can be found at http://www.census.gov/geo/www/ua/ctrlplace.html (retrieved Oct. 5, 2007).

[11] Census tracts are small, relatively permanent statistical subdivisions of a county or statistically equivalent entity. Tracts in the United States, Puerto Rico and the U.S. Virgin Islands generally have between 1,500 and 8,000 people, with an optimum size of 4,000. *See* U.S. Census Bureau, 2000 Census of Population and Housing, Summary File 3: Technical Documentation, 2002, Appendix A.

or urban area with a population of greater than 25,000.[12] The new definition became effective as of Funding Year 2005, which began July 1, 2005.[13]

4. The Commission, however, found it necessary to adopted a three year transition period during which those health care providers that previously participated in the rural health care mechanism could continue to do so.[14] The Commission recognized that its adoption of a new definition of rural for the rural health care mechanism might result in some eligible providers no longer qualifying for rural health care support.[15] The Commission noted that it would be difficult to determine which rural health care providers were no longer eligible because they were no longer rural and which were no longer eligible simply because of the Commission's revised definition.[16] To address this issue, and to ease the transition to the new definition, the Commission permitted all health care providers that had received a funding commitment from the Universal Service Administrative Company (USAC) since 1998 to continue to qualify for support under the rural health care support mechanism for funding for the next three years under the old definition.[17] Thereafter, health care providers would be required to qualify under the Commission's new definition to receive funding. The Commission found the transition period was necessary to allow rural health care providers to plan for the elimination of support, and also would allow the Commission time to review the effect of this definition.[18]

5. In March 2005, ATA filed its Petition for Reconsideration, in which it requested that the Commission grandfather, for an indefinite period of time, rural sites that were no longer eligible for rural health care support under the new definition of rural adopted in the *Second Report and Order*, but which were eligible for support prior to then.[19] In the *Second Report and Order*, the Commission selected 25,000 as the population threshold for the further analysis, finding that urban areas above this size possess a critical mass of population and facilities.[20] ATA argues that with the reduction in the population requirement for urban designation from 50,000 people to 25,000 people, the nation will lose currently eligible sites.[21] ATA argues that ceasing to provide previously eligible entities with rural health care universal service support mechanism subsidies for broadband access that, prior to the subsidies, were unaffordable, will result in the loss of health care services to populations that have unmet health care needs, that are remote and rural to the location of those services, and are most disparate.[22] Therefore, ATA requests that the Commission extend the three-year grandfather period indefinitely for all health care facilities located in sites that would have enabled them to be eligible for rural health care universal

[12] Places include census-designated places, consolidated cities and incorporated places. *See* U.S. Census Bureau, 2000 Census of Population and Housing, Summary File 3: Technical Documentation, 2002, Appendix A.

[13] *See Second Report and Order*, 19 FCC Rcd at 24620, para. 13.

[14] *See Second Report and Order*, 19 FCC Rcd at 24623-24624, para. 23.

[15] *See Second Report and Order,* 19 FCC Rcd at 24620-24621, para. 15.

[16] As stated above, ORHP no longer uses the MSA/Goldsmith method and has not developed the Goldsmith Modification to the most recent 2000 Census data. *See supra* para. 2. Therefore, we have no way to compute the old definition to the new definition with updated Census data.

[17] 47 C.F.R. § 54.501(a)(3)(i) as adopted herein.

[18] *See Second Report and Order,* 19 FCC Rcd at 24624, para 23.

[19] *See* Petition at 3, para. 3.

[20] *See Second Report and Order,* 19 FCC Rcd at 24620-24621, para 15.

[21] *See* Petition at 12.

[22] *See* Petition at 12.

service support prior to the *Second Report and Order*.[23] All commenters support the ATA Petition for Reconsideration.[24]

III. DISCUSSION

6. We find that it is in the public interest to grant ATA's Petition for Reconsideration in part and extend for three years the Commission's prior determination to grandfather those health care providers who were eligible to participate in the Commission's rural health care mechanism under the Commission's definition of "rural" prior to the *Second Report and Order*. Given our broad discretion to define the term "rural," we also find that it is within our authority to continue providing funding to those health care entities that were previously eligible under the Commission's definition of that term.[25] In particular, we find it is premature to discontinue support at this time to those health care providers who were eligible under the definition of "rural" prior to the *Second Report and Order*. ATA and commenters proffered specific, uncontested evidence that the application of the new definition of rural in the *Second Report and Order* would result in specific harms to entities that previously were eligible for universal service rural health care support.[26] For example, in its petition, ATA identifies multiple health care facilities that participate in telehealth communications networks in Nebraska and Montana that would be adversely affected by the loss in universal service rural health care funding if the new definition of rural were applied to their rural health care funding applications.[27] This, in turn, would serve only to endanger the continued availability of telemedicine and telehealth services that these health care facilities provide.[28] Indeed, the Coordinator for Telehealth Services at Avera St. Luke's Hospital in Aberdeen, South Dakota specifically commented that "if we lose USAC support of our telecommunication infrastructure[,] the impact on our facility, our community [of several hundred people], our region and our patients would be devastating. Telehealth Services, including extensive telemedicine, would face significant cuts if not termination."[29]

7. We believe as commenters suggest that additional time is necessary for the Commission to evaluate the effect of the new definition on health care providers before they lose support as a result of the modified definition of rural adopted in the *Second Report and Order* became effective in March 2005.[30] Only two funding years have concluded since the new definition went into effect. It would be premature for us to remove previously eligible entities from the mechanism after this limited amount of time, particularly when (as described below) there remains sufficient available funding. Further, in November 2007, the Commission released the *Universal Service Rural Health Care Pilot Program Selection Order* (*2007 RHC PP Selection Order*),[31] which selected 69 organizations to participate in the Rural Health Care

[23] *See* Petition at 13.

[24] *See, e.g.*, Northern Sierra Comments at 1; NTN Comments at 1; Time Warner Reply at 1; *but see Second Report and Order, Order on Reconsideration, and FNPRM*; Verizon Comments at 2, 6-7; Verizon Reply at 9 (arguing that the Commission may not legally fund applicant that do not meet the definition of rural).

[25] *See supra* note 3. Additionally, the discussion of the term rural in this Order relates only to the existing Rural Health Care Mechanism. *See* NTCA Reply at 4.

[26] *See, e.g.*, NPSC Comments at 3-4; CPCA Comments at 1; UVA Comments at 8.

[27] *See* Petition at 6-8.

[28] *Id*.

[29] *See* Avera Comments at 1.

[30] *See Second Report and Order*, 19 FCC Rcd at 24624, para. 23 ("the transition period will allow the Commission time to review the effect of this [new] definition"); ATA Comments at 11-12; Letter from Cathy Wasem, to Marlene H. Dortch, Secretary, FCC, WC Docket No. 02-60 (filed May 17, 2007).

[31] *See Rural Heath Care Support Mechanism*, WC Docket No. 02-60, Order, 22 FCC Rcd 20,360 (2007) (*2007 RHC PP Selection Order).*

Pilot Program (Pilot Program), initiated by the Commission in September 2006, to facilitate the creation of a nationwide broadband network dedicated to health care, connecting public and private non-profit health care providers in rural and urban locations.[32] A goal of the Pilot Program is to provide the Commission with a more complete and practical understanding of how to ensure the best use of the available RHC support mechanism funds to support a broadband, nationwide health care network (expressly including rural areas).[33] Upon completion of the Pilot Program, among other things, the Commission intends to use the information it learns to fundamentally reexamine the entire universal service rural health care mechanism.[34] We expect that this post-Pilot Program review would include an examination of the definition of rural. Further, because only $40.5 million was disbursed for the rural health care mechanism in 2006 and available Pilot Program support will be approximately $139 million per funding year, well below the $400 million annual cap for the rural health care mechanism, health care providers eligible under the rural definition adopted in the *Second Report and Order* would not be disadvantaged by our permitting this limited universe of additional entities to remain eligible to receive rural health care support.[35]

8. We do not, however, as requested by ATA, grandfather indefinitely those health care providers who were eligible to participate in the Commission's rural health care mechanism under the Commission's definition of "rural" prior to the *Second Report and Order*. Instead, we find a three-year extension provides the appropriate timeframe for the Commission to evaluate the effect of the changes in the definition of "rural" on health care providers and for the Commission to engage in the anticipated reexamination of the rural health care mechanism upon completion of the Pilot Program. Accordingly, health care providers that are no longer eligible to participate in the rural health care program due to the expiration of the three year transition period adopted in the *Second Report and Order* will remain eligible for support under the Rural Health Care Program for an additional three year period through the funding year ending on June 30, 2011.

IV. FINAL REGULATORY FLEXIBILITY CERTIFICATION

9. The Regulatory Flexibility Act of 1980, as amended (RFA),[36] requires that a regulatory flexibility analysis be prepared for notice-and-comment rule making proceedings, unless the agency certifies that "the rule will not, if promulgated, have a significant economic impact on a substantial number of small entities."[37] The RFA generally defines the term "small entity" as having the same meaning as the terms "small business," "small organization," and "small governmental jurisdiction."[38] In

[32] *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 21 FCC Rcd 11111 (2006) (*2006 Pilot Program Order*).

[33] *2007 RHC PP Selection Order*, 22 FCC Rcd at 20366-67, para. 15; *2006 Pilot Program Order,* 21 FCC Rcd at 11113, para. 9 (2006). Specifically, upon completion of the Pilot Program, the Commission intends to issue a report detailing the results of the Pilot Program and the status of the RHC support mechanism generally, and to recommend any changes necessary to improve existing RHC program. In addition, the Commission intends to incorporate the information it gathers as part of the Pilot Program into the record of any subsequent proceeding. *See id*.

[34] *2007 RHC PP Selection Order*, 22 FCC Rcd at 20367, n. 42; *2006 Pilot Program Order,* 21 FCC Rcd at 11113.

[35] *See 2007 RHC PP Selection Order*, 22 FCC Rcd at 20370, para. 23 (making $139 million available to Pilot Program Participants over a three year commitment period beginning in Funding Year 2007 and ending Funding Year 2009 of the existing RHC support mechanism); USAC, Annual Report 2006 at 5, *available at* http://www.usac.org/_res/documents/about/pdf/usac-annual-report-2006.pdf (retrieved Feb. 6, 2008); *See* 47 C.F.R. § 54.623; *Universal Service First Report and Order*, 12 FCC Rcd at 9141, para. 705.

[36] The RFA, *see* 5 U.S.C. § 601 – 612, has been amended by the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA), Pub. L. No. 104-121, Title II, 110 Stat. 857 (1996).

[37] 5 U.S.C. § 605(b).

[38] 5 U.S.C. § 601(6).

addition, the term "small business" has the same meaning as the term "small business concern" under the Small Business Act.[39] 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).[40]

10. An initial regulatory flexibility analysis (IRFA) was incorporated in the *Second Report and Order*.[41] The Commission sought written public comment on the proposals in the *Second Report and Order*, including comment on the IRFA. No comments were received to the *Second Report and Order* or IRFA that specifically raised the issue of the impact of the proposed rules on small entities.

11. In this Order, we now extend, for three years, the Commission's prior determination to grandfather those health care providers who were eligible under the Commission's definition of "rural" prior to the *Second Report and Order*.[42] This has no effect on any parties that do not currently participate in the rural health care support program. It does not create any additional burden on small entities. We believe that this action imposes a minimal burden on the vast majority of entities, small and large, that are affected by this action.

12. Therefore, we certify that the requirements of the order will not have a significant economic impact on a substantial number of small entities.

13. In addition, the order and this final certification will be sent to the Chief Counsel for Advocacy of the SBA, and will be published in the Federal Register.[43]

V. ORDERING CLAUSES

14. Accordingly, IT IS ORDERED that, 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 Order on Reconsideration IS ADOPTED.

15. IT IS FURTHER ORDERED that, pursuant to the authority contained in sections [1, 4(i), 4(j), 10, 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,] the Petition for Reconsideration filed by the American Telemedicine Association on March 7, 2005 IS GRANTED to the extent described herein.

16. IT IS FURTHER ORDERED that Part 54 of the Commission's rules, 47 C.F.R. Part 54, IS AMENDED as set forth in Appendix A attached hereto, effective thirty (30) days after the publication of this Order on Reconsideration in the Federal Register.

[39] 5 U.S.C. § 601(3) (incorporating by reference the definition of "small-business concern" in the Small Business Act, 15 U.S.C. § 632). Pursuant to 5 U.S.C. § 601(3), the statutory definition of a small business applies "unless an agency, after consultation with the Office of Advocacy of the Small Business Administration and after opportunity for public comment, establishes one or more definitions of such term which are appropriate to the activities of the agency and publishes such definition(s) in the Federal Register."

[40] 15 U.S.C. § 632.

[41] *Second Report and Order*, 19 FCC Rcd at 24647-24654, Appendix C.

[42] *See supra* para. 6.

[43] *See* 5 U.S.C. § 605(b).

17. IT IS FURTHER ORDERED that the Commission's Consumer and Governmental Affairs Bureau, Reference Information Center, SHALL SEND a copy of this *Order on Reconsideration*, to the Chief Counsel for Advocacy of the Small Business Administration.

FEDERAL COMMUNICATIONS COMMISSION

Marlene H. Dortch
Secretary

APPENDIX A

Final Rules

For the reasons discussed in the preamble, the Federal Communications Commission amends 47 C.F.R. Part 54 as follows:

PART 54 – UNIVERSAL SERVICE

1. Amend § 54.601 by adding paragraph (a)(3)(i) to read as follows:

§54.601 Eligibility.

(a)***

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(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, remain eligible for support under this subpart though the funding year ending on June 30, 2011.

APPENDIX B

List of Commenters

Comments

1. Avera St. Luke's Hospital (Avera)
2. California Primary Care Association (CPCA)
3. Faith Regional Health Services
4. Good Samaritan Hospital
5. Heartland Health Alliance Network
6. Nebraska Public Service Commission (NPSC)
7. Nebraska Telehealth Network (NTN)
8. Northern Sierra Rural Health Network (Northern Sierra)
9. Office of Telemedicine of the University of Virginia Medical Center (UVA)
10. Saint Elizabeth Health System
11. South River Consultants, LLC
12. VA Pacific Island Health Care System

Reply Comments

1. National Telecommunications Cooperative Association (NTCA)
2. Telecommunications and Information Policy Group of the University of Hawaii
3. Time Warner Telecom, Inc. (Time Warner)