

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

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

ORDER AND NOTICE OF PROPOSED RULEMAKING

Adopted: June 20, 2011

Released: June 21, 2011

Comment Date: [30 days after Federal Register publication]

Reply Comment Date: [45 days after Federal Register publication]

By the Commission:

I. INTRODUCTION

1. In this Order, we adopt an interim rule¹ permitting health care providers that are located in a “rural area” under the definition used by the Commission prior to July 1, 2005, and that have received a funding commitment from the rural health care program prior to July 1, 2005, to continue to be treated as if they are located in “rural” areas for purposes of determining eligibility for all universal service rural health care programs.² In the accompanying Notice of Proposed Rulemaking (Notice), we seek comment on whether to make these “grandfathered” providers permanently eligible for discounted services under the rural health care program. Grandfathered providers do not currently qualify as “rural,” but play a key role in delivering health care services to surrounding regions that do qualify as “rural” today. Thus, we take these actions to ensure that health care providers located in rural areas can continue to benefit from connecting with grandfathered providers, and thereby provide health care to patients in rural areas.

II. BACKGROUND

2. From the inception of the rural health care mechanism in 1997 until July 2005, the Commission utilized the definition of “rural area” 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 (MSA/Goldsmith method).⁴ Subsequently, ORHP discontinued use of the MSA/Goldsmith method and instead adopted the Rural Urban Commuting Area (RUCA) system for rural designations.⁵ Additionally, after the Commission’s adoption of the MSA/Goldsmith definition of rural, OMB

¹ This interim rule shall be in effect until the Commission adopts permanent rules governing the eligibility of these grandfathered providers to receive discounted services under the rural health care program.

² Universal service rural health care programs include the existing Telecommunications Program, Internet Access Program, and the Pilot Program, as well as any future programs, such as those proposed in the *Rural Health Care Reform Notice*. See *Rural Health Care Universal Service Support Mechanism*, WC Docket No. 02-60, Notice of Proposed Rulemaking, 25 FCC Rcd 9371, 9373-74, para. 3 (2010) (*Rural Health Care Reform Notice*).

restructured its definitions of MSAs and non-MSAs by adding another category – the Micropolitan Statistical Area (MiSA).⁶ These changes rendered the rural health care program’s definition of “rural area” obsolete.⁷

3. In December 2004, in the *Second Report and Order*, the Commission adopted a new definition of “rural area” 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 that exceeds 25,000.⁹ The new definition became effective as of Funding Year 2005, which began July 1, 2005.¹⁰

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³ See *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, 24617, para. 8 (*Second Report and Order*) (2004) (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” for purposes of section 254 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).

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 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).

⁵ See ORHP, Geographic Eligibility for Rural Health Grant Programs, at <ftp://ftp.hrsa.gov/ruralhealth/Eligibility2005.pdf> (retrieved May 2, 2011).

⁶ An 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 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 24619-20, para. 12; 47 C.F.R. § 54.5 (definition of “rural area”). The Commission stated that based on an evaluation of the proposals contained in the record, other definitions proposed by commenters would either be over-inclusive, or would not include areas that are appropriately rural. In adopting the current definition, the Commission chose to implement a more layered approach to more accurately define rural areas. See *Second Report and Order*, 19 FCC Rcd at 24619-23, paras. 11-22.

⁹ 47 C.F.R. § 54.5. Specifically, “rural area” is defined 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.” “Core Based Statistical Area” and “Urban Area” are terms defined by the Census Bureau and “Places” are identified by the Census Bureau. See *Second Report and Order*, 19 FCC Rcd at 24619-20, para. 12 & nn.44-47 (explaining the basis for the current definition of “rural area”).

¹⁰ See *id.*, 19 FCC Rcd at 24620, para. 13.

4. In the *Second Report and Order*, the Commission recognized that the adoption of a new definition of “rural area” might result in some health care providers eligible under the old definition no longer qualifying for discounted services.¹¹ The Commission concluded that a transition period was necessary to allow rural health care providers to plan for the elimination of discounted services, as well as to provide the Commission time to review the effect of the new definition.¹² Therefore, the Commission “grandfathered” for three years all health care providers that were 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 the Universal Service Administrative Company (USAC) since 1998. These health care providers remained eligible for discounted services through the funding year ending on June 30, 2008.¹³ Thereafter, health care providers would be required to qualify under the Commission’s new definition of rural area to be eligible for support.¹⁴

5. In March 2005, the American Telemedicine Association (ATA) filed a petition for reconsideration of the *Second Report and Order*, requesting that the Commission grandfather, for an indefinite period of time, rural sites that would no longer be eligible for discounted services under the revised definition of “rural area.”¹⁵ ATA argued that the reduction in the population requirement for “urban” designation under the new definition (from 50,000 people to 25,000 people) would result in a loss of eligibility for health care providers that provide critical care for patients located in areas that are remote and rural to the location of health care services, and thus would result in the loss of health care services to such patients.¹⁶ The Commission addressed this petition in the 2008 *Order on Reconsideration*.¹⁷ The Commission found that additional time was needed to evaluate the effects of the revised definition on rural health care providers.¹⁸ The Commission declined to provide grandfather status for an indefinite period of time and instead extended the grandfather period for an additional three years.¹⁹

6. Absent further extension of the grandfathering period or a change in our rules, grandfathered providers will become ineligible for discounted services after June 30, 2011.²⁰ Currently, there are approximately 235 grandfathered providers. These providers, in the aggregate, received less than \$1.4 million in discounted services from the universal service fund annually between 1998 and 2009 (or less than \$6,000, on average, per provider per year).

7. In July 2010, the Nebraska Public Service Commission (Nebraska PSC) filed a petition requesting that the Commission permanently grandfather health care providers that were temporarily

¹¹ *Id.*, 19 FCC Rcd at 24620-21, para. 15.

¹² *Id.*

¹³ *Id.*, 19 FCC Rcd at 24623-24, 24642, para. 23 & App. A (allowing grandfathered health care providers to continue to qualify for rural health care support for three years, beginning July 1, 2005).

¹⁴ *Id.*, 19 FCC Rcd at 24623-24, para. 23.

¹⁵ See *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order on Reconsideration, 23 FCC Rcd 2539, para. 1 (2008) (*Order on Reconsideration*).

¹⁶ *Id.*, 23 FCC Rcd at 2541-42, para. 5.

¹⁷ *Id.*, 23 FCC Rcd at 2539, para. 1.

¹⁸ *Id.*

¹⁹ *Id.*, 23 FCC Rcd at 2543, para. 8.

²⁰ *Id.*, 23 FCC Rcd at 2546, App. A (allowing grandfathered health care providers to qualify for rural health care support until June 30, 2011).

grandfathered until 2011.²¹ Nebraska PSC states that under the current definition of “rural,” three hub hospitals and one endpoint health care provider in the Nebraska Statewide Telehealth Network (NSTN) will become ineligible for discounted services on June 30, 2011. While these entities themselves are not physically located in “rural” areas, they do provide services *to* rural areas that are sparsely populated and geographically vast.²² Specifically, the grandfathered facilities receive support for 22 backbone lines that facilitate connections to the NSTN²³ – a network in which nearly 80 percent of health care providers qualify as “rural”²⁴ – for 32 eligible rural hospitals and eight local health departments. Discontinuance of this support would splinter Nebraska’s statewide network into isolated, “mini” networks, significantly impairing the utility of the network to qualifying rural providers.²⁵

8. In August 2010, the Tanana Chiefs Conference (Tanana Chiefs) filed a petition requesting an extension to the grandfather period beyond June 30, 2011.²⁶ Tanana Chiefs currently receives approximately \$60,000 of annual discounts to fund a 362-mile critical communications link between Chief Andrew Isaac Health Clinic in Fairbanks and the Alaska Native Medical Center in Anchorage, Alaska.²⁷ Tanana Chiefs states that this link serves not only Fairbanks, but facilitates health care access through Fairbanks to higher levels of care in Anchorage for 25 Interior Alaska communities.²⁸ Tanana Chiefs also projects a three to four-fold increase in bandwidth requirements due to recent initiatives under the National Broadband Plan, adoption of electronic health records meaningful use standards by HHS, and the Alaska Health Information Exchange Project.²⁹

9. On August 23, 2010, the Denali Center – Fairbanks Memorial Hospital (Fairbanks) also filed a petition requesting that the Commission permanently extend the grandfather exception.³⁰ Fairbanks states that it will become ineligible for discounted services unless the current rule is changed. Fairbanks states that it serves a remote area larger than many states, with the nearest hospital being located 360 miles away in Anchorage.³¹

²¹ Letter from Anne Boyle, Commissioner, Nebraska Public Service Commission, to Federal Communications Commission, WC Docket No. 02-60, at 1-2 (filed Jul. 26, 2010) (Nebraska PSC Petition).

²² *Id.*

²³ *Id.* Nebraska PSC states that these four sites, in the aggregate, receive approximately \$223,000 of annual rural health care support.

²⁴ NSTN Comments at 2.

²⁵ *Id.* at 3.

²⁶ Letter from Jerry Isaac, Tanana Chiefs Conference, to Federal Communications Commission, WC Docket No. 02-60, at 1 (filed Aug. 20, 2010) (Tanana Chiefs Petition). Tanana Chiefs also requests that the Commission reconsider the classification of Fairbanks, Alaska as an “urban area” pursuant to the current eligibility requirements under the rural health care support mechanism. We do not address this specific request here; this order is limited to consideration of the grandfather exception.

²⁷ *Id.*

²⁸ *Id.*

²⁹ *Id.*

³⁰ Letter from Carl J. Kegley, Denali Center – Fairbanks Memorial Hospital, to Federal Communications Commission, WC Docket No. 02-60, at 1 (filed Aug. 23, 2010) (Fairbanks Petition).

³¹ *Id.* The Wireline Competition Bureau sought comment on all three petitions via public notice. *See Comment Sought on Request to Permanently Grandfather Rural Health Care Providers that Received Funding Commitments Prior to July 1, 2005 so that They Will Remain Eligible for Universal Service Support*, WC Docket No. 02-60, Public Notice, 25 FCC Rcd 10872 (2010).

III. ORDER

10. In this order, we adopt an interim rule to allow all currently grandfathered health care providers to continue to qualify for discounted services until the Commission adopts permanent rules governing the eligibility of such providers to participate in rural health care programs.³² We find good cause to adopt this interim rule without notice and comment, and to make it effective upon publication in the Federal Register rather than 30 days afterwards.³³ For the reasons below, we find that it is unnecessary and contrary to the public interest to delay adoption of this interim rule.

11. Section 553 of the Administrative Procedure Act (APA) requires that agencies provide notice in the Federal Register and an opportunity for public comment on their proposed rules except, *inter alia*, “when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.”³⁴ Notice and comment have been excused in emergency situations or where delay could result in serious harm.³⁵ In addition, section 553(d) of the APA requires a substantive rule to be published not less than 30 days before its effective date, except “as otherwise provided by the agency for good cause found and published with the rule.”³⁶

12. Without a change in our rules before June 30, 2011, currently grandfathered providers will lose eligibility for discounted services. In 2008, the Commission found that discontinuing services to these providers would “serve only to endanger the continued availability of telemedicine and telehealth services that [these] health care facilities provide.”³⁷ For the reasons below, we find that such an outcome remains as likely to happen today as in 2008, and thus would be contrary to the public interest.

13. The record demonstrates that grandfathered facilities, while not located themselves in a “rural area” under current Commission definitions, play a key role in providing health care services to “fundamentally rural” areas.³⁸ These providers are not located in large urbanized areas.³⁹ In some instances, the grandfathered health care provider is a primary or secondary hub in a network that serves health care providers and patients located in areas that do qualify as “rural” under our current definition. Discontinuance of rural health care support would make vulnerable rural providers that connect to these

³² See App. B *infra*, § 54.601(a)(3)(i).

³³ See 5 U.S.C. § 553(b)(3)(B) (notice and comment not required “when the agency for good cause finds... that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest”), (d)(1) (exception to 30-day waiting period for a rule’s effectiveness where agency finds good cause and publishes finding with the rule).

³⁴ 5 U.S.C. § 553(b)(3)(B),(C).

³⁵ *Chamber of Commerce v. SEC*, 443 F.3d 890, 908 (D.C. Cir. 2006) (stating that the exception excuses notice and comment “when the very announcement of a proposed rule itself could be expected to precipitate activity by affected parties that would harm the public welfare”) (internal citations omitted).

³⁶ 5 U.S.C. § 553(d)(3).

³⁷ *Order on Reconsideration*, 23 FCC Rcd at 2542, para. 6.

³⁸ VTN Comments at 5. See *id.* at 4-5 (“these health care providers serve communities and populations that are rural in all practical respects and that face significant challenges in terms of obtaining affordable communications services”).

³⁹ 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.

hub sites.⁴⁰ For example, three grandfathered facilities in Nebraska are hub hospitals in the NSTN, a “hub-and-spoke” statewide telehealth network in which nearly 80 percent of providers are eligible for rural health care support. The Nebraska hub hospitals currently receive support for backbone lines that carry traffic for the entire NSTN, including traffic for rural sites, and the majority of interactions over the backbone lines benefit small rural health care providers and those they serve, not the hub site.⁴¹

14. The record also provides numerous examples of the critical services that the petitioners and other affected health care providers offer to their patients.⁴² By its nature, telehealth allows health care providers that are not themselves located in “rural” areas to provide services to patients that are located in rural areas. In particular, many grandfathered facilities are located in regions experiencing specialty health care shortages, which these facilities are seeking to remedy via telemedicine.⁴³ Services provided by grandfathered facilities include the following: emergency services, preventative care, interactive video, counseling, specialist consultations, oncology, psychiatry, neurology, tele-trauma, teleradiology, health professional and community education, and other telehealth and telemedicine applications.⁴⁴

15. Without continued funding, these facilities will likely be unable to continue providing telehealth services to rural areas. VTN states that many grandfathered providers do not enjoy the benefit of competitively priced broadband services and would likely no longer be able to afford to continue their telehealth programs without discounted services.⁴⁵ Similarly, NSTN states that if the Commission takes no action, its hub sites will be unable to sustain the costs of the backbone lines, which would directly sever the connection of 40 eligible rural sites from the NSTN.⁴⁶ According to the NSTN, these 40 sites would be unable to connect to tertiary care centers, which serve as their referring hospitals, and to other rural health sites. Access to specialized care via telehealth in rural Nebraska would be compromised, and in some cases, cease to exist.⁴⁷ More generally, ATA explains that the loss of existing facilities supported

⁴⁰ See Nebraska PSC Petition at 2; Tanana Chiefs Petition at 1; Good Samaritan Comments at 2; Kearney Comments at 2; Nebraska PSC Reply Comments at 3; Rock County Comments at 1; Valley County Comments at 1.

⁴¹ See Nebraska PSC Petition at 2 (“The rural areas these organizations serve are sparsely populated and geographically vast”). Similarly, Tanana Chiefs indicates that its funded link serves not only Fairbanks, but facilitates health care access for 25 interior Alaska communities, and Fairbanks Memorial Hospital states that it serves a remote area larger than many states, with the nearest hospital being 360 miles away. Tanana Chiefs Petition at 1; Fairbanks Petition at 1.

⁴² See Nebraska PSC Petition at 1; Tanana Chiefs Petition at 1; Good Samaritan Comments at 1-2, Kearney Comments at 2; NTCA Comments at 4; Tri Valley Comments at 1; UVA Comments at 4-5; Valley County Comments at 1-2; VTN Comments at 3-4, 8-9.

⁴³ VTN Comments at 8-9; *see also* Nebraska PSC Reply at 2 (noting that NSTN saved Nebraska hospitals an estimated \$1.8 million in travel time and mileage costs in 2009).

⁴⁴ See Good Samaritan Comments at 1-2; Kearney Comments at 2; NTCA Comments at 4; Rock County Comments at 1; Tri Valley Comments at 1; UVA Comments at 1-2; Valley County Comments at 1; VTN Comments at 1.

⁴⁵ VTN Comments at 7; *see also* Tanana Chiefs Petition at 1 (“although Fairbanks’ status has changed to ‘urban,’ the burden of provisioning long-haul, secure telecommunications links 362 miles to Anchorage remains consistent with ‘rural’ health care communications costs”).

⁴⁶ NSTN Comments at 2-3. The 40 sites include 32 rural hospitals and eight health departments. Nebraska PSC states that other plans are being considered that allow continued connection of rural eligible sites to tertiary care centers if the Commission does not change the definition of rural, but those plans would require additional filings, paperwork, and higher costs. Nebraska PSC Petition at 2.

⁴⁷ NSTN Comments at 2-3; Good Samaritan Comments at 2 (arguing that universal service fund (USF)-funded backbone lines are essential to the connection of all hospitals and public health departments in the NSTN, and losing funding will result in access to healthcare services from across the state being cut off for Good Samaritan and the

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by universal service could “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.”⁴⁸ Thus, we find that discontinuance of funding could result in serious harm to affected rural health care providers and their patient populations, and such harm would be contrary to the public interest.

16. We note that continued grandfathering on an interim basis will also support important Commission, federal, and state health information technology (health IT) priorities. For example, Tanana Chiefs states that continued funding is needed to meet bandwidth requirements created by National Broadband Plan initiatives, adoption of electronic health record meaningful use requirements by HHS, and Alaska’s statewide health information exchange initiative.⁴⁹ VTN and UVA explain that Virginia was recently awarded two federal rural health IT grants to create a demonstration tele-stroke network and to deliver high risk obstetric services. Both Virginia projects include grandfathered health care providers as partners, and elimination of discounted services to these providers would adversely impact the projects’ ability to sustain the federal grants.⁵⁰ Similarly, NSTN states it has been successful in developing a model, comprehensive, statewide network in which the federal government has invested over \$1.4 million, but the discontinuance of funding to Nebraska’s grandfathered hub hospitals would result in the transformation of this statewide network into isolated “mini” networks.⁵¹

17. We also find that notice-and-comment and 30-day advance publication in the Federal Register is unnecessary for this interim rule. The purpose of the notice-and-comment requirement is to allow interested parties to respond to the proposed rule and participate in the rulemaking process.⁵² In this proceeding, the Wireline Competition Bureau issued a public notice requesting comment on whether the Commission should grant the relief sought by the Nebraska PSC, either through permanent grandfather, permanent waiver, or other action, and interested parties had an opportunity to respond to the public notice.⁵³ We note that all commenters, including all affected health care providers, support at least an interim extension of the grandfathering period.⁵⁴ The 30-day advance publication requirement of section 553(d) is intended to inform affected parties of the proposed rule and afford them a reasonable time to adjust to the new regulations.⁵⁵ The purpose of our interim rule, however, is to maintain the *status quo* while we consider amending our rules permanently. Thus, as a practical matter, there is no “new” regulation to which grandfathered health care providers must adjust. Indeed, NTCA argues that *without* the interim extension, grandfathered entities would be left without a needed “transition period . . . to accommodate for any lost USF revenues and to comply with” new requirements, and would be forced to “scramble for alternative technology solutions and funding sources.”⁵⁶ In addition, as discussed above,

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end point sites that connect into Good Samaritan); Rock County Comments at 1; Tri Valley Comments at 1; Valley County Comments at 1.

⁴⁸ ATA Comments at 1.

⁴⁹ Tanana Chiefs Petition at 1.

⁵⁰ UVA Comments at 8; VTN Comments at 8.

⁵¹ NSTN Comments at 2-3.

⁵² *Am. Fed’n of Govt. Employees v. Block*, 655 F.2d 1153, 1156 (D.C. Cir. 1981)

⁵³ See n.31 *supra*.

⁵⁴ See, e.g., ATA Comments at 1; Good Samaritan Comments at 2; Kearney Comments at 1; NTCA Comments at 2; NSTN Comments at 3; UVA Comments at 4; Rock County Comments at 2; Tri Valley Comments at 1; Valley County Comments at 2; VTN Comments at 1; Windstream Reply at 1-2. The California PUC recommended that the Commission grant only a defined time, rather than indefinite, extension. See California PUC Comments at 5.

⁵⁵ *Am. Fed’n of Govt. Employees v. Block*, 655 F.2d 1153, 1156 (D.C. Cir. 1981)

⁵⁶ NTCA Comments at 5.

grandfathered providers, in the aggregate, have historically received less than \$1.4 million annually in discounted services, or less than 0.02 percent of the approximately \$8 billion universal service fund. Therefore, we find that the interim rule will not materially affect entities that contribute to the universal service fund, because their individual contributions will not change significantly. Based on the foregoing, we find good cause to adopt this interim rule without notice and comment.⁵⁷

IV. NOTICE OF PROPOSED RULEMAKING

18. All but one of the parties in this proceeding support permanent grandfathering to allow the petitioners and other similarly situated health care providers to continue to participate in rural health care programs.⁵⁸ These parties argue that funding for grandfathered providers promotes telemedicine and other uses of broadband for rural health care purposes,⁵⁹ and describe how rural communities would lose access to key health care services if such support were to cease.⁶⁰ The parties also assert that the Commission should provide certainty and stability by granting permanent grandfathering relief rather than setting a pattern of piecemeal extensions.⁶¹ VTN states that uncertainty about future eligibility limits providers' ability to respond to the needs of their patients, take advantage of new innovations, and utilize the cost savings of long-term contracts.⁶² Furthermore, commenters state that permanent grandfathering would preserve eligibility for facilities located in areas that remain unchanged in their essentially rural character, but whose urban/rural designations could shift back and forth based on minor population shifts.⁶³

19. We propose to permanently grandfather the approximately 235 health care providers that are located in a "rural area" as defined by the Commission prior to July 1, 2005, and received a funding commitment from the rural health care program prior to July 1, 2005.⁶⁴ Under our proposed rule, these

⁵⁷ 5 U.S.C. § 553(b)(B).

⁵⁸ See n.54 *supra*.

⁵⁹ See NSTN Comments at 3 (arguing that continuing to allow currently eligible rural health care providers to remain part of the program and continue the growth of the services they provide would fit within the purpose and mission the FCC has outlined for the rural health care program without causing the funding mechanism to be overburdened); VTN Comments at 14 (arguing that terminating support to grandfathered facilities would "set back the Commission's asserted interest in encouraging use of available funds and promoting telemedicine and the use of broadband to further health care"); ATA Comments at 1 (arguing that preserving grandfathered facilities is even more important today as the nation implements health reform, the Commission focuses on broadband deployment, the aging of the population provides a growing need to expand care and reduce costs and the downturn of the economy presents even greater pressure on rural communities).

⁶⁰ See paras. 13-16 *supra*.

⁶¹ Nebraska PSC Reply at 3; see also Nebraska PSC Petition at 2 (arguing that permanent grandfathering is the "most sensible, orderly, and efficient" solution); Fairbanks Comments at 1 (arguing that permanent grandfathering is a remedy that is "sensible plus time and cost efficient"); VTN Comments at 14.

⁶² VTN Comments at 14.

⁶³ *Id.* at 14-15; see also UVA Comments at 7-8 (noting that minor population shifts have resulted in a small Appalachian hospital in rural Virginia shifting between urban and rural status, which is "confusing" and "surely counter to the intent of the statute," and that neither the nature of the community nor its numbers of specialty healthcare providers has changed during the time period of record). We disagree with the California PUC that the fast-changing demographics in and around formerly rural communities militates against permanent grandfathering; rather, they reinforce the need to provide certainty to health care providers in the face of such fluctuations. See California PUC Comments at 4-5.

⁶⁴ When the new definition of "rural" became effective on July 1, 2005, the Commission grandfathered health care providers that had been qualified as "rural" and had received a funding commitment prior to that date. *Second Report and Order*, 19 FCC Rcd at 24620, 24623-24, paras. 13, 23. In 2008, the Commission granted these providers

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health care providers would continue to be treated as if they are located in “rural” areas for the purposes of determining eligibility for all universal service rural health care programs.

20. We seek comment on petitioners’ and commenters’ assertions that permanently grandfathering these providers will promote our goal of advancing access to broadband connectivity for health care purposes.⁶⁵ We believe that discontinuance of discounted services would jeopardize the ability of grandfathered providers to continue offering essential health care services to rural areas. As noted above, grandfathered health care providers are not located in large urbanized areas, and the record indicates that grandfathered providers provide valuable services to areas identified as experiencing health care shortages.⁶⁶ In some states, grandfathered health care providers are hub hospitals that play a central role in connecting rural providers and patients to a statewide or regional telehealth network.⁶⁷ We believe that a permanent grandfather is consistent with our broad discretion to define the term “rural.”⁶⁸

21. We seek comment on whether this is the appropriate time to permanently extend eligibility for grandfathered providers. In the *Second Report and Order*, the Commission grandfathered these providers in order to ease the transition to the new definition of “rural,” allow providers to plan for the elimination of discounted services, and give the Commission time to review the effect of the new definition.⁶⁹ In 2008, the Commission extended the grandfathering period for three years based on uncontested evidence of specific harms that would result if discounted services were to be discontinued. At that time, the Commission also noted the need for additional time to evaluate the effect of new “rural” definition on health care providers and its planned review of the Pilot Program.

22. While our consideration of broader reforms to the rural health care program remains pending,⁷⁰ grandfathered providers have demonstrated over the past six years that they provide important services to areas and patients that do qualify as “rural.”⁷¹ Issuing another temporary extension would

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a three-year extension of eligibility. *Order on Reconsideration*, 23 FCC Rcd at 2542, para. 6. We note that no parties objected to using July 1, 2005 as the demarcation point.

⁶⁵ VTN Comments at 11-12 (arguing that strict compliance with the existing definition of “rural” would harm the public interest by denying needed health care funding, and impede Congressional goal of providing access to telecommunications and information services to low-income consumers and those in rural, insular, and high cost areas and promoting availability of advanced services to health care providers); Windstream Reply at 2; Tanana Chiefs Petition at 1; ATA Comments at 1; *cf.* 47 U.S.C. § 254(h)(2) (directing the Commission to establish rules to “enhance ... access to advanced telecommunications and information services for all public and nonprofit ... health care providers”); 47 U.S.C. § 254(c)(1)(A) (when defining services supported by the Fund, the Commission shall “consider the extent to which such telecommunications services [] are essential to education, public health, and public safety”); *Rural Health Care Reform Notice*, 25 FCC Rcd at 9372, paras. 1-2 (stating that “improving the health care system is one of the most important tasks facing the nation,” and that “greater broadband connectivity has the potential to revolutionize health care delivery”).

⁶⁶ *See* para. 14 *supra*.

⁶⁷ *Id.*

⁶⁸ *Order on Reconsideration*, 23 FCC Rcd at 2542, para. 6; *see* n.3 *supra*.

⁶⁹ *Second Report and Order*, 19 FCC Rcd at 24624, para. 9.

⁷⁰ *See Rural Health Care Reform Notice*; Letter from Sharon E. Gillett, Chief, Wireline Competition Bureau, FCC, to Scott Barash, Acting CEO, USAC, 26 FCC Rcd 1722 (2011) (directing USAC to develop evaluation plan for the Pilot Program); *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, DA 11-819 (Wir. Com. Bur. May 3, 2011) (extending for one year the deadline for Pilot Program participants to choose a vendor, request funding commitments from USAC, and file invoices).

⁷¹ *See* paras. 13-16 *supra*.

merely create ongoing and unnecessary uncertainty for program participants.⁷² Furthermore, the federal and Commission health IT policy priorities discussed above strongly weigh in favor of providing these grandfathered providers with the stability and certainty of a permanent rule modification.⁷³ Commenters state that such certainty will assist grandfathered providers in moving forward with important initiatives (e.g., Virginia’s demonstration tele-stroke network), better respond to the needs of patients, and to continue to provide innovative telehealth care to needy populations in the most cost-effective manner.⁷⁴ Thus, we disagree with the California PUC’s position that we should only grant a defined time extension until we have had time to evaluate the Pilot Program and the progress under the current definition of “rural.”⁷⁵ Finally, as noted above, annual support for discounted services to grandfathered providers currently constitutes less than one-half percent of the \$400 million program cap, and there is no evidence that any currently eligible rural health care provider has been disadvantaged by the temporary grandfathering extensions. Therefore, we do not anticipate that health care providers eligible under our current rural definition will be disadvantaged by our permitting this limited universe of additional entities to remain eligible to receive discounted services.⁷⁶ We seek comment on this analysis.

V. PROCEDURAL MATTERS

A. Filing Requirements

23. *Ex Parte Rules.* The proceeding this Notice initiates shall be treated as a “permit-but-disclose” proceeding in accordance with the Commission’s *ex parte* rules.⁷⁷ Persons making *ex parte* presentations must file a copy of any written presentation or a memorandum summarizing any oral presentation within two business days after the presentation (unless a different deadline applicable to the Sunshine period applies). Persons making oral *ex parte* presentations are reminded that memoranda summarizing the presentation must (1) list all persons attending or otherwise participating in the meeting at which the *ex parte* presentation was made, and (2) summarize all data presented and arguments made during the presentation. If the presentation consisted in whole or in part of the presentation of data or arguments already reflected in the presenter’s written comments, memoranda or other filings in the proceeding, the presenter may provide citations to such data or arguments in his or her prior comments, memoranda, or other filings (specifying the relevant page and/or paragraph numbers where such data or arguments can be found) in lieu of summarizing them in the memorandum. Documents shown or given to Commission staff during *ex parte* meetings are deemed to be written *ex parte* presentations and must

⁷² See Nebraska PSC Petition at 2; VTN Comments at 14-15; Windstream Reply at 4.

⁷³ We note that HHS has permanently grandfathered certain federally funded telemedicine sites as eligible “originating sites” for purposes of Medicare reimbursement without regard to their geographic location, and has also permanently grandfathered “rural” status for other types of providers that previously qualified as rural. See VTN Comments at n.36. We also note that Congress authorized permanent grandfathering of federal telehealth grantee sites funded by the Health Resources and Services Administration as eligible consult origination sites for purposes of Medicare reimbursement regardless of evolving rurality status, in the Medicaid and SCHIP Benefits Improvement and Protection Act of 2000. See UVA Comments at 9.

⁷⁴ See paras. 16, 18 *supra*.

⁷⁵ CPUC Comments at 5.

⁷⁶ See *Order on Reconsideration*, 23 FCC Rcd at 2543, para. 7. We note that in 2010, USAC issued 106 funding commitments totaling over \$90 million and disbursed over \$24 million. See USAC 2010 Annual Report at 16, available at <http://www.usac.org/about/governance/annual-reports/2010.html>. Historically, spending in the rural health care program has been well below the annual \$400 million funding cap. See *Rural Health Care Reform Notice*, 25 FCC Rcd at 9376-77, para. 9.

⁷⁷ 47 C.F.R. §§ 1.1200 *et seq.*

be filed consistent with rule 1.1206(b). In proceedings governed by rule 1.49(f) or for which the Commission has made available a method of electronic filing, written *ex parte* presentations and memoranda summarizing oral *ex parte* presentations, and all attachments thereto, must be filed through the electronic comment filing system available for that proceeding, and must be filed in their native format (e.g., .doc, .xml, .ppt, searchable .pdf). Participants in this proceeding should familiarize themselves with the Commission's *ex parte* rules.

24. *Comments and Reply Comments.* Pursuant to sections 1.415 and 1.419 of the Commission's rules,⁷⁸ interested persons may file comments and replies regarding the Notice within 30 days after publication in the Federal Register and may file reply comments within 45 days after publication in the Federal Register. **All filings related to the Notice should refer to WC Docket No. 02-60.** Comments may be filed using the Commission's Electronic Comment Filing System (ECFS). See *Electronic Filing of Documents in Rulemaking Proceedings*, 63 FR 24121 (1998).

- Electronic Filers: Comments may be filed electronically using the Internet by accessing the ECFS: <http://fjallfoss.fcc.gov/ecfs2/>.
- Paper Filers: Parties who choose to file by paper must file an original and one copy of each filing. If more than one docket or rulemaking number appears in the caption of this proceeding, filers must submit two additional copies for each additional docket or rulemaking number.

Filings can be sent by hand or messenger delivery, by commercial overnight courier, or by first-class or overnight U.S. Postal Service mail. All filings must be addressed to the Commission's Secretary, Office of the Secretary, Federal Communications Commission.

- All hand-delivered or messenger-delivered paper filings for the Commission's Secretary must be delivered to FCC Headquarters at 445 12th St., SW, Room TW-A325, Washington, DC 20554. The filing hours are 8:00 a.m. to 7:00 p.m. All hand deliveries must be held together with rubber bands or fasteners. Any envelopes must be disposed of before entering the building.
- Commercial overnight mail (other than U.S. Postal Service Express Mail and Priority Mail) must be sent to 9300 East Hampton Drive, Capitol Heights, MD 20743.
- U.S. Postal Service first-class, Express, and Priority mail must be addressed to 445 12th Street, SW, Washington DC 20554.
- In addition, one copy of each paper filing must be sent to each of the following: (i) the Commission's copy contractor, Best Copy and Printing, Inc. (BCPI), Portals II, 445 12th Street, S.W., Room CY-B402, Washington, D.C. 20554, (202) 488-5300 or via e-mail to fcc@bcpiweb.com; (ii) Chin Yoo, Telecommunications Access Policy Division, Wireline Competition Bureau, 445 12th Street, SW, Room 5-A441, Washington, DC 20554, email: Chin.Yoo@fcc.gov; and (iii) Charles Tyler, Telecommunications Access Policy Division, Wireline Competition Bureau, 445 12th Street, SW, Room 5-A452, Washington, DC 20554, e-mail: Charles.Tyler@fcc.gov.

25. *People with Disabilities:* To request materials in accessible formats for people with disabilities (Braille, large print, electronic files, audio format), send an e-mail to fcc504@fcc.gov or call

⁷⁸ 47 C.F.R. §§ 1.415, 1.419.

the Consumer and Governmental Affairs Bureau at 202-418-0530 (voice) or 202-418-0432 (TTY). Contact the FCC to request reasonable accommodations for filing comments (accessible format documents, sign language interpreters, CART, etc.) by e-mail: FCC504@fcc.gov; phone: 202-418-0530 or TTY: 202-418-0432.

26. *Further Information:* For further information, contact Chin Yoo at (202) 418-0295, Wireline Competition Bureau.

B. Final Regulatory Flexibility Certification

27. *Interim Rule.* The interim rule adopted in this *Order* is being adopted without notice and comment, and therefore is not subject to Regulatory Flexibility Act analysis under 5 U.S.C. § 604(a).

28. *Proposed Permanent Rule.* The Regulatory Flexibility Act of 1980, as amended (RFA),⁷⁹ 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.”⁸⁰ The RFA generally defines the term “small entity” as having the same meaning as the terms “small business,” “small organization,” and “small governmental jurisdiction.”⁸¹ In addition, the term “small business” has the same meaning as the term “small business concern” under the Small Business Act.⁸² 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).⁸³

29. An initial regulatory flexibility analysis (IRFA) was incorporated in the *Second Report and Order*.⁸⁴ 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.

30. In this *Order*, we now indefinitely extend, and propose to adopt permanently, 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*.⁸⁵ 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.

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

⁷⁹ 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).

⁸⁰ 5 U.S.C. § 605(b).

⁸¹ 5 U.S.C. § 601(6).

⁸² 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.”

⁸³ 15 U.S.C. § 632.

⁸⁴ *Second Report and Order*, 19 FCC Rcd at 24647-54, Appendix C.

⁸⁵ *See* para. 4 *supra*.

32. In addition, the Order and Notice of Proposed Rulemaking and this final certification will be sent to the Chief Counsel for Advocacy of the SBA, and will be published in the Federal Register.⁸⁶

C. Other Matters

33. *Congressional Review Act.* The Commission will send a copy of this Order in a report to be sent to Congress and the Government Accountability Office pursuant to the Congressional Review Act. *See* 5 U.S.C. § 801(a)(1)(A). The interim rule contained in this Order shall take effect upon publication of a summary of the *Order* in the Federal Register for the reasons stated therein. *See id.* § 808(2).

34. *Paperwork Reduction Act of 1995.* This document does not contain proposed information collection(s) subject to the Paperwork Reduction Act of 1995 (PRA), Public Law 104-13. In addition, therefore, it does not contain any new or modified information collection burden for small business concerns with fewer than 25 employees, pursuant to the Small Business Paperwork Relief Act of 2002, Public Law 107-198, *see* 44 U.S.C. § 3506(c)(4).

VI. ORDERING CLAUSES

35. Accordingly, IT IS ORDERED that, pursuant to 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, 403, this Order and Notice of Proposed Rulemaking IS ADOPTED.

36. IT IS FURTHER ORDERED that this Order and Notice of Proposed Rulemaking SHALL BE EFFECTIVE upon publication of a summary thereof in the Federal Register, pursuant to 5 U.S.C. § 553(d)(3) and sections 1.427(b), 1.4(b)(1) and 1.103(a) of the Commission's rules, 47 C.F.R. §§ 1.427(b), 1.4(b)(1), 1.103(a).

37. IT IS FURTHER ORDERED that Part 54 of the Commission's rules IS AMENDED as set forth in Appendix C.

38. IT IS FURTHER ORDERED that interested parties MAY FILE comments no later than 30 days after publication and replies no more than 45 days after publication in the Federal Register.

39. 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, 403, the petitions filed by petitioners listed in Appendix A ARE GRANTED to the extent described herein.

40. IT IS FURTHER ORDERED that the Commission's Consumer & Governmental Affairs Bureau, Reference Information Center, SHALL SEND a copy of this Order and Notice of Proposed Rulemaking, including the Final Regulatory Flexibility Certification, to the Chief Counsel for Advocacy of the Small Business Administration.

FEDERAL COMMUNICATIONS COMMISSION

Marlene H. Dortch
Secretary

⁸⁶ *See* 5 U.S.C. § 605(b).

APPENDIX A**List of Commenters****Comments****Commenter**

1. American Telemedicine Association
2. California Public Utilities Commission
3. Good Samaritan Hospital Association
4. Kearney County Health Services
5. National Telecommunications Cooperative Association
6. Nebraska Statewide Telehealth Network
7. Office of Telemedicine of the University of Virginia Health System
8. Rock County Hospital
9. Tri Valley Health System
10. Valley County Health System
11. Virginia Telehealth Network

Abbreviation

ATA
California PUC
Good Samaritan
Kearney
NTCA
NSTN
UVA
Rock County
Tri Valley
Valley County
VTN

Reply Comments**Commenter**

1. Nebraska Public Service Commission
2. Windstream Communications, Inc.

Abbreviation

Nebraska PSC
Windstream

APPENDIX B**Interim and Proposed Final Rule**

Part 54 of Title 47 of the Code of Federal Regulations is amended as follows:

PART 54 – UNIVERSAL SERVICE

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

§54.601 Eligibility.

(a)***

(3)***

(i) Notwithstanding the definition of “rural area” in § 54.5, any health care provider that is located in a “rural area” under the definition used by the Commission prior to July 1, 2005, and received a funding commitment from the rural health care program prior to July 1, 2005, is eligible for support under this subpart.