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

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

To: The Commission

COMMENTS OF THE PLACER COUNTY HEALTH AND HUMAN SERVICES ADMINISTRATION

The Placer County Health and Human Services Administration ("Placer"), by its attorneys and pursuant to Section 1.415 of the Commission's rules, hereby submits its comments in response to the *Further Notice of Proposed Rulemaking* in this important proceeding.[1] Placer applauds the Commission's decision to review the definition of "rural area" for purposes of the rural health care support mechanism.

Placer's reasons for submitting these comments are twofold. First, the data currently used by the Universal Service Administrative Company ("USAC") for determining program eligibility is inaccurate and should be corrected immediately. Second, the current FCC definition of "rural area" has many shortcomings, and Placer agrees with those commenters who urge a new definition. However, Placer disagrees that the Commission should adopt the Rural Urban Commuting Area ("RUCA") system as the sole acceptable definition of "rural area." Instead, Placer encourages the Commission to expand the current definition to include RUCA and any other generally accepted definition of "rural area" which is employed by a State or Federal health

[1] *Rural Health Care Support Mechanism, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking*, WC Docket No. 02-60, FCC 03-288 (rel. Nov. 17, 2003) ("*Further Notice*"). Public notice of this proceeding was published in the *Federal Register* on December 24, 2003. *See* 68 Fed. Reg. 74,538.

agency, including (but not limited to) the Medical Service Study Area ("MSSA") methodology employed by California health agencies.

I. Statement of Interest

Located in northern California, Placer serves over 260,000 residents from the county's border with Sacramento County to the Nevada state line. County communities include Roseville, Lincoln, Rocklin, Loomis, Auburn, Foresthill, Colfax, Tahoe City, and Kings Beach. As a public health care provider, Placer provides high quality primary medical, mental health, dental, and pharmacy care on an out-patient basis to adults and children throughout the County, regardless of the source of payment. While approximately half of these services are provided to individuals who qualify for Medi-Cal, the remainder are provided to uninsured individuals. The costs associated with serving the county's uninsured population are directly borne by taxpayers at the local level.

Placer is clearly the type of public health care provider that Congress envisioned benefiting when it enacted Section 254(h)(1) of the Communications Act of 1934, as amended (the "Communications Act"). However, Placer is currently unable to take full advantage of the Commission's rural health care program because many areas of Placer County are needlessly excluded from the Commission's current definition of "rural area."

II. USAC's Database Contains Errors that Must Be Corrected

Certain areas of Placer County are currently eligible for FCC rural health care funding. Specifically, according to the USAC website, only health care facilities located in census tracts 0201.01, 0201.02, 0202, 0203, 0204, 0216, 0217, 0219, and 0220 within Placer County are eligible.[2] There are glaring errors, however, in USAC's database. The United States Census

[2] *See* http://www.rhc.universalservice.org/eligibility/rurallist.asp (last updated Sept. 19, 2001).

from 1990 does not even contain census tracts 0217, 0219 or 0220 in Placer County.[3] Consequently, three of the nine census tracts listed in USAC's database are incorrect, thus calling into question the integrity of USAC's database.

In light of these inaccuracies, Placer urges the FCC to direct USAC to review and correct any errors in its database. Such errors are preventing Placer, and perhaps other rural health care providers, from fully benefiting from the Commission's program as Congress intended.

III. The Commission Should Adopt a New Definition of "Rural Area"

Even if the errors contained in USAC's database are corrected, Placer believes that the Commission's definition of "rural area" is inconsistent with the Communications Act. Moreover, the fact that the rural health care program has been so underused indicates that the Commission's current definition of "rural area" is too narrow.[4] Placer believes that many truly "rural" areas do not qualify under the current definition, and that health care facilities in those areas are excluded as a result.

A. The Focus Should Be on the Patient, Not the Facility

The current definition of "rural area" seems to be based on a fundamental misreading of the Communications Act. USAC determines eligibility based on the census tract location of the applicant. However, Section 254(h)(1)(A) states:

> Health care providers for rural areas.-- 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 instruction relating to such services, to any public or nonprofit health care provider that

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[3] *See* http://factfinder.census.gov/servlet/DTGeoSearchByListServlet?ds_name=DEC_1990_STF1_&_lang=en&_ts=94137145344. The 1990 Census lists 0219.01, 0219.02, 0220.01 and 0220.02, however.

[4] The Commission recently acknowledged that the program is underused. In announcing the *Further Notice*, the Commission noted that only 3.5% of the possible discounts were distributed in Funding Year 2001. *See FCC Adjusts Universal Service Rural Health Care Rules to Broaden the Benefits of Telemedicine Program*, News at 1 (rel. Nov. 13, 2003).

serves persons who reside in rural areas in that State at rates that are reasonably comparable to rates charged for similar services in urban areas in that State.[5]

The focus of the statute is not on the location of the health care facility, but on whether a facility's *patients* reside in a rural area. Thus, if two or more "persons" who reside in rural areas are served by a public or nonprofit health care provider, then that provider should be deemed eligible for funding, regardless of its physical location.

Many health care providers, including Placer, serve both rural and urban patients. The fact that a provider serves both kinds of patients does not render the provider ineligible for funding under the statute. Indeed, as long as a provider serves two or more "persons who reside in a rural area," the provider should be eligible for program funding.

Accordingly, Placer urges the Commission to abandon its current definition as inconsistent with the Communications Act. Any new definition of "rural area" should focus on the patients served by a provider, not on the provider's physical location.

B. The MSSA Methodology Should be Included

Under current FCC guidelines, an area qualifies as "rural" only if it is located in a non-metropolitan county as defined by the Office of Management and Budget or is specifically identified in the Goldsmith Modification to the 1990 Census data published by the Office of Rural Health Care Policy ("ORHP").[6]

Placer submits that this definition is too narrow, because it is based on a county-wide assessment and thus assumes that all areas of a county are alike. Many counties, particularly in the western part of the United States, are geographically large areas, encompassing vast areas of

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[5] 47 U.S.C. § 254(h)(1)(A) (emphasis added).

[6] *Further Notice*, para. 63; *see also Federal-State Joint Board on Universal Service*, Report and Order, CC Docket No. 96-45, FCC 97-157, paras. 649-652 (rel. May 8, 1997) ("*Universal Service Order*).

low population as well as decidedly urban areas. The current definition therefore omits many non-urban areas which, objectively considered, are rural.

In addition, Placer believes that Congress intended the Commission to adopt a broader definition of "rural area," one which should not be constrained to one federal agency definition of that term. Rather, a broader definition of "rural area" should include any generally accepted definition of "rural area" which is employed by a State or Federal health agency.

For example, the definition of "rural area" should incorporate the geographic units known as Medical Service Study Areas ("MSSAs"). The California Health Manpower Policy Commission created MSSAs and defined them as areas that have a population density of 250 persons or less per square mile and have no incorporated area greater then 50,000 persons. This definition conforms to the HRSA Shortage Designation Branch definition of a "rational service area" for purposes of determining Health Professional Shortage Areas.

To exemplify the usefulness of the MSSA definition, Placer offers the following. Placer County totals 1503 square miles, but only 214 square miles have population densities of 250 or more persons per square mile, comprising 30 census tracts, primarily located in the lower elevations adjacent to Sacramento County. The remaining 20 census tracts, primarily located in the Sierra Foothills and Sierra Nevada mountains, and which comprise 86% of the county area, is more sparsely populated, due in part to the geography of the region. In an area as geographically diverse as Placer, the MSSA concept is effective since it takes geographic barriers into consideration when determining "rational service area," as well as socioeconomic considerations that are applicable to both rural and urban areas. While other existing methologies may be better suited to other states, the inclusion of MSSAs as an acceptable definition of a "rural area" will

allow geographically and socioeconomically diverse counties such as Placer County to be considered for rural health care funding.

C. The Burden of Proving "Ruralness" Should Rest With the Applicant

Placer is sensitive to the fact that USAC's procedures for determining "rural area" need to be streamlined. Therefore, Placer proposes that rural health care applicants should bear the burden of proving that they serve residents of "rural areas," as redefined to include any generally accepted definition of that term which is employed by a Federal or State health care agency.

Under this proposal, an individual health care provider may submit evidence with its application showing that two or more of its patients reside in a "rural area" under established Federal or State guidelines. For example, a facility located in Placer County could submit documentation that it serves people who reside in areas identified as "rural" by the California Office of Rural Health Care Policy. Such evidence would constitute *prima facie* evidence that the facility serves residents of "rural areas" for purposes of the Commission's rural health care support mechanism.

This proposal is consistent with the Commission's deferral to state law for certain determinations in connection with the Schools and Libraries Program.[7] Moreover, it would forward the Commission's statutory mandate of ensuring that "health care providers in rural areas . . . have affordable access to modern telecommunications services that will enable them to provide medical . . . services to all parts of the Nation."[8] Finally, the proposal would minimize the burden placed on USAC, since applicants would be responsible for submitting "rural area"

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[7] *See* 47 C.F.R. § 54.500(b) (FCC looks to state law to determine whether a school is an "elementary school" for purposes of universal service).

[8] *Universal Service Order*, para. 610 (quoting Congressional Joint Explanatory Statement at 132).

evidence. To the extent that this burden is not met by an applicant, USAC may reject its application.

D. RUCA Should Not Be the Sole Method of Determining "Rural Areas"

Placer opposes the adoption of a Rural Urban Commuting Area ("RUCA") methodology as the sole acceptable determinant of "rural areas." RUCAs are based on commuting distances and are flawed because of the intangible nature of changing commuting patterns. The problem is heightened in western states, where commuting distances are much further than in eastern states. Under a RUCA system, therefore, many zip codes which should be considered rural are grouped in with urban area zip codes. Indeed, it is possible, under a RUCA system, that a very few individuals who reside in rural areas but commute long distances to urban areas could throw off a RUCA calculation and render a rural area urban. For these reasons, the RUCA methodology should not be adopted as the sole acceptable determinant of "rural areas."

In addition, while many residents of California commute long distances in pursuit of employment, the underserved low-income individuals whom government programs were intended to benefit are rarely included in that demographic group. Lack of transportation is a primary barrier to employment for many low-income individuals. Under current FCC guidelines, and under an exclusive RUCA methodology, a facility serving such low-income individuals may be penalized due to the inclusion of affluent individuals who commute.

Moreover, the adoption of RUCAs would likely contract the pool of health care providers considered eligible for funding under the Commission's program. As the Commission recognized, the rural health care funding program is underutilized now, with only 3.5 percent of possible discounts being distributed in 2001. Using a RUCA methodology would only exacerbate the problem of a funding program intended for many but available to few.

Finally, because the Communications Act focuses on whether a facility's patients are rural residents, and not on whether the facility itself is located in a rural area, the Commission should not make eligibility solely dependent on commuting patterns. Even if a person commutes from a rural area to an urban area for employment purposes, that person nonetheless continues to *reside* in a rural area for purposes of the Communications Act.[9]

IV. Multi-year Applications Should Be Permitted

The Commission also invited comments on additional steps that USAC could take to make the application process easier.[10] Placer supports the implementation of multi-year applications, so that beneficiaries do not need to apply every funding year. Very little changes on a year-to-year basis in terms of an applicant's eligibility, yet applicants are required to reapply with essentially the same information each year.

To simplify the process, Placer suggests that the Commission implement an abbreviated annual recertification document in lieu of the full application. This approach is similar to other Federal funding programs for rural health care facilities, including the Federally Qualified Health Center Look-Alike application process, as described in OMB No. 0915-0142, which states that the public reporting burden is 100 hours for the application and 20 hours for recertification.

V. Conclusion

For the reasons set forth above, Placer urges the Commission, as a preliminary matter, to direct USAC to correct any errors contained in its database, particularly with respect to Placer County, California. Placer also encourages the Commission to adopt a more expansive definition of "rural area" to include any generally accepted Federal or State definition of that

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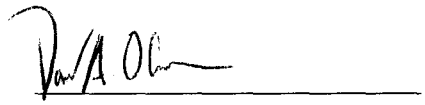
[9] 47 U.S.C. § 254(h)(1)(A).
[10] NPRM para. 69.

term, so that more health care facilities may take advantage of the universal support mechanism as Congress envisioned. Finally, Placer urges the adoption of an annual recertification process.

Respectfully submitted,

PLACER COUNTY HEALTH AND
HUMAN SERVICES ADMINISTRATION



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