

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

In the Matter of)	
)	
Rural Health Care Support Mechanism)	WC Docket No. 02-60
)	
Nebraska Public Service Commission)	DA 10-1516
Request to Permanently Grandfather Rural)	
Health Care Providers)	

INITIAL COMMENTS

The National Telecommunications Cooperative Association (NTCA)¹ responds to the August 13, 2010, Public Notice (Public Notice) by the Federal Communications Commission (Commission or FCC) seeking comment on the July 26, 2010 Nebraska Public Service Commission Petition to grandfather rural health care providers so they remain eligible for Universal Service Fund (USF) support under the existing Rural Health Care Support Mechanism.²

In its *Second Report and Order* in this proceeding, the Commission modified the definition of “rural” for purposes of the rural health care support mechanism, such that certain health care providers previously deemed “rural” would no longer qualify for support. The Commission recognized, however, the concerns that could result from such a change for those providers who had previously received funding commitments, and it therefore grandfathered

¹ NTCA is a premier industry association representing rural telecommunications providers. Established in 1954 by eight rural telephone companies, today NTCA represents 585 rural rate-of-return regulated telecommunications providers. All of NTCA’s members are full service rural local exchange carriers (LECs) and many of its members provide wireless, cable, Internet, satellite and long distance services to their communities. Each member is a “rural telephone company” as defined in the Communications Act of 1934, as amended (Act). NTCA’s members are dedicated to providing competitive modern telecommunications services and ensuring the economic future of their rural communities.

² *Wireline Competition Bureau Seeks Comment on Nebraska Public Service Commission Request to Permanently Grandfather Rural Health Care Providers*, WC Docket No. 02-60, Public Notice (rel. Aug. 13, 2010) (*Public Notice*); *Nebraska Public Service Commission Request to Permanently Grandfather Rural Health Care Providers*, WC Docket No. 02-60 (filed July 26, 2010) (*Nebraska Petition*).

such providers for three years.³ In 2008, the Commission grandfathered these providers for an additional three years (*i.e.*, to June 30, 2011).⁴ The Nebraska Public Service Commission has asked the FCC to extend indefinitely this grandfather period and thereby permit certain Nebraska rural health care providers who qualified for USF support under the former definition of “rural” to continue qualifying for rural health care support permanently.⁵ The state commission contended that, absent FCC action to extend or grandfather, the identified Nebraska hospitals and endpoint will lose approximately \$223,000 annually in USF funding.⁶

The Nebraska Public Service Commission correctly observed that the current extension date, June 30, 2011, is fast approaching, and that hospitals and other rural health care providers need to remain eligible for USF rural health care support to serve their communities and satisfy their missions. Rural consumers in Nebraska and elsewhere, many of whom are customers of NTCA’s member companies, will be harmed by the loss of rural health care funding. Consequently, the Commission should grant the Nebraska Petition and should permanently grandfather or waive application of the new “rural” USF health care definition for *all* rural health care providers that were eligible under the former “rural” definition. In the alternative and at a minimum, the Commission should extend the effective date of the new “rural” definition to June 30, 2014.

I. RURAL HEALTH CARE PROVIDERS FACE POSSIBLE LOSS OF USF SUPPORT IF THE COMMISSION DOES NOT GRANDFATHER, WAIVE, OR EXTEND “RURAL” ELIGIBILITY.

The Commission created its first standard of “rural” for the USF rural health care support mechanism in its 1997 *Universal Service Order*:

³ *Rural Health Care Support Mechanism*, Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, WC Docket No. 02-60, 19 FCC Rcd 24613 (2004) (*Second Report and Order*), ¶ 4.

⁴ *Rural Health Care Support Mechanism*, Order on Reconsideration, WC Docket No. 02-60, 23 FCC Rcd 2539 (2008) (*2008 Order on Reconsideration*), ¶ 4.

⁵ Nebraska Petition at 2.

⁶ *Ibid.*

[T]elecommunications carriers must charge eligible rural health care providers a rate for each supported service that is no higher than the highest tariffed or publicly available commercial rate for a similar service in the closest city in the state with a population of 50,000 or more people, taking distance charges into account. The Commission also adopted mechanisms to provide support for limited toll-free access to an Internet service provider. Finally, the Commission adopted an annual cap of \$400 million for universal service support for rural health care providers. The Commission based its conclusions on analysis of the condition of the rural health care community and technology at that time.⁷

In 2004, the Commission changed one aspect of this definition of “rural” – reducing the relevant population count from 50,000 to 25,000 – for purposes of the USF rural health care support mechanism. Specifically, the new definition is as follows:

Whether an area is “rural” is determined by applying the following test. If an area is outside of any Core Based Statistical Area (CBSA), it is rural. Areas within CBSAs can be either rural or nonrural, depending on the characteristics of the CBSA. Small CBSAs – those that do not contain an urban area with populations of 25,000 or more – are rural. Within large CBSAs – those that contain urban areas with populations of 25,000 or more – census tracts can be either rural or non-rural depending on the characteristics of the particular census tract. If a census tract in a large CBSA does not contain any part of a place or urban area with a population greater than 25,000, then that tract is rural. Alternatively, if a census tract in a large CBSA contains all or part of a place or urban area with a population that exceeds 25,000, then it is not rural.⁸

The Commission made this and other changes to the rural health care support mechanism “to make it more viable and to reflect technological changes.”⁹ These changes went into effect on July 1, 2005, although all rural health care providers that had previously received support commitments were given until June 30, 2008 to satisfy the new definition of “rural” or lose support.¹⁰

On February 14, 2008, the Commission once again extended the grandfather period (to June 30, 2011) for “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

⁷ Second Report and Order, ¶ 4 (citing *1997 Universal Service Order*, 12 FCC Rcd 8776, ¶ 608).

⁸ Second Report and Order, ¶ 12.

⁹ *Id.* ¶ 5.

¹⁰ *Id.* ¶¶ 13, 23.

the *Second Report and Order*.”¹¹ The Commission said additional time was needed to evaluate the effects of the new “rural” definition on rural health care providers before they lost support.¹² The FCC observed in the 2008 *Order on Reconsideration* that this additional three-year extension was warranted because “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*.” The same reasoning rings true today for *all* affected health care providers – those in Nebraska and elsewhere – who have relied upon these funding commitments to obtain state-of-the-art services to support their missions from providers such as NTCA members.¹³

II. THE COMMISSION SHOULD PERMANENTLY GRANDFATHER OR WAIVE THE “RURAL” DEFINITION FOR ELIGIBLE RURAL HEALTH CARE PROVIDERS, OR AT LEAST GRANT ANOTHER THREE-YEAR EXTENSION.

Rural hospitals in Nebraska and elsewhere depend on USF support through the rural health care mechanism to provide emergency services, preventative care, telemedicine, and other critical health needs for the rural communities, many of which NTCA member companies serve. The FCC should grant the Nebraska Petition and extend a permanent waiver of the modified “rural” definition to all eligible rural health care providers or, at a minimum, grandfather these entities for an additional three years.

The FCC noted that the definition of “rural” as it relates to eligibility may be considered in the upcoming *Rural Health Care Notice of Proposed Rulemaking* (NPRM) in this docket, which seeks comments on its Rural Health Care Pilot Program and various rural health care funding elements: “We expect that this post-Pilot Program review would include an examination of the definition of rural.”¹⁴ The Nebraska Petition, like the 2005 American Telemedicine Association (ATA) Petition that sought the prior grandfather period, describes some “specific,

¹¹ *Id.* ¶ 6.

¹² *Id.* ¶ 7.

¹³ Nebraska Petition at 2.

¹⁴ 2008 Order on Reconsideration, ¶ 7.

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 undersal servicee rural health care support.”¹⁵ Additional specific instances of potential harm may be forthcoming from other commenters in this docket, or in the upcoming NPRM. The Commission should find this evidence provides more than adequate basis to either permanently grandfather or extend for three more years, to June 30, 2014, the eligibility of rural health care providers for USF support under the previous definition of “rural.”

The Commission, in its 2008 Order on Reconsideration, declined to grant a request for permanent grandfathering.¹⁶ If the Commission declines here again to grant a permanent waiver of the eligibility rules for certain rural health care providers, then it should at least grant a three-year waiver or extension to June 30, 2014. The pending Rural Health Care NPRM may examine yet again the definition of “rural” (which created the need for previous extensions), and commenters in the NPRM will most likely provide additional supporting evidence that shows the potential adverse impacts to enforcing the current “rural” definition. The Nebraska Petition demonstrates that modifying the definition will raise the bar for rural health care providers to qualify for USF rural health care support. Providing and reviewing that evidence, considering ways to minimize impacts on small business entities per the Regulatory Flexibility Act,¹⁷ and then constructing and finalizing new rules will take at least a year. The adversely affected rural hospitals, medical clinics, and other health care providers will need a reasonable transition period thereafter to accommodate for any lost USF revenues and to comply with the new eligibility and procedural rules. Rather than compelling these existing participants to scramble for alternative technology solutions and funding sources at the same time that the Commission is re-examining

¹⁵ *Ibid*; *American Telemedicine Association Petition for Reconsideration of the Rural Health Care Support Mechanism, Second Report and Order*, WC Docket No. 02-60 (filed Mar. 7, 2005) (ATA Petition).

¹⁶ 2008 Order on Reconsideration, ¶ 8; ATA Petition.

¹⁷ 5 U.S.C. § 604.

this program, an extension of the grandfather period to at least June 30, 2014, is warranted and appropriate.¹⁸

III. CONCLUSION.

For these reasons, the Commission should grant the Nebraska Petition and should permanently grandfather or waive the new “rural” USF health care definition for *all* rural health care providers that are eligible under the former “rural” definition. In the alternative, the Commission should extend the effective date of the new “rural” definition to June 30, 2014 while it completes its broader re-examination of the rural health care mechanism.

Respectfully submitted,



By: /s/ Michael Romano
Michael Romano
Senior Vice President - Policy

By: /s/ Karlen Reed
Karlen Reed
Senior Regulatory Counsel - Policy

Its Attorneys

4121 Wilson Boulevard, 10th Floor
Arlington, VA 22203
(703) 351-2000

August 30, 2010

¹⁸ The Commission should also clarify that the USF rural health care definition of “rural” does not necessarily apply to other USF programs. *See* Reply Comments of NTCA, WC Docket No. 02-60 (filed May 14, 2007), at 4-6.

CERTIFICATE OF SERVICE

I, Adrienne L. Rolls, certify that a copy of the foregoing Comments of the National Telecommunications Cooperative Association in WC Docket No. 02-60, DA 10-1516, was served on this 30th day of August 2010 via electronic mail to the following persons:

Julius Genachowski, Chairman
Federal Communications Commission
445 12th Street, SW, Room 8-B201
Washington, D.C. 20554
Julius.Genachowski@fcc.gov

Commissioner Michael J. Copps
Federal Communications Commission
445 12th Street, SW, Room 8-B115
Washington, D.C. 20554
Michael.Copps@fcc.gov

Commissioner Robert M. McDowell
Federal Communications Commission
445 12th Street, SW, Room 8-C302
Washington, D.C. 20554
Robert.McDowell@fcc.gov

Commissioner Mignon Clyburn
Federal Communications Commission
445 12th Street, SW, Room 8-A302
Washington, D.C. 20554
Mignon.Clyburn@fcc.gov

Commissioner Meredith Attwell Baker
Federal Communications Commission
445 12th Street, SW, Room 8-A204
Washington, D.C. 20554
Meredith.Baker@fcc.gov

Best Copy and Printing, Inc.
Federal Communications Commission
445 12th Street, SW, Room CY-B402
Washington, D.C. 20554
fcc@bcpiweb.com

Erica Myers
Federal Communications Commission
Telecommunications Access Policy Division
Wireline Competition Bureau
445 12th Street, S.W., Room 5-B432
Washington, D.C. 20554
Erica.Myers@fcc.gov

Charles Tyler
Federal Communications Commission
Telecommunications Access Policy Division
Wireline Competition Bureau
445 12th Street, S.W., Room 5-B521
Washington, D.C. 20554
Charles.Tyler@fcc.gov

/s/ Adrienne L. Rolls
Adrienne L. Rolls