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

MAILED
OCT -2 2006
FCC Mail Room

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

ORDER

Adopted: September 26, 2006 **Released: September 29, 2006**

By the Commission: Chairman Martin and Commissioners Copps, Adelstein, Tate, and McDowell issuing separate statements.

I. INTRODUCTION AND BACKGROUND

1. In this Order, pursuant to section 254(h)(2)(A) of the Telecommunications Act of 1996,[1] we establish a pilot program to examine how the rural health care (RHC) funding mechanism can be used to enhance public and non-profit health care providers' access to advanced telecommunications and information services. Specifically, the pilot program will provide funding to support the construction of state or regional broadband networks and services provided over those networks. These networks will be designed to bring the benefits of innovative telehealth and, in particular, telemedicine services to those areas of the country where the need for those benefits is most acute.[2]

2. In addition, the pilot program will provide funding to support the cost of connecting the state or regional networks to Internet2, a dedicated nationwide backbone. Internet2 links a number of government research institutions, as well as academic, public, and private health care institutions that are repositories of medical expertise and information.[3] By connecting to this dedicated national backbone, health care providers at the state and local levels will have the opportunity to benefit from advanced applications in continuing education and research. In addition, a ubiquitous nationwide broadband network dedicated to health care will enhance the health care community's ability to provide a rapid and coordinated response in the event of a national crisis.

3. Under this pilot program, all public and non-profit health care providers may apply for funding to construct a dedicated broadband network that connects health care providers in a state or region.[4] In particular, given the nature of the pilot program, we encourage multiple health care providers in a state or region to join together for the purpose of formulating and submitting proposals. In accordance with general principles of universal service, we will require applicants in the pilot program to

[1] 47 U.S.C. § 254(h)(2)(A).

[2] *See, e.g.*, National Academy of Sciences, "Quality Through Collaboration: The Future of Rural Health Care" at 149 http://www.nap.edu/catalog/11140.html (defining "telehealth" as a broad set of applications using communications technologies to support long-distance clinical care, consumer and professional health-related education, public health, health administration, research, and electronic health records and "telemedicine" as the provision of medical care from a distance using telecommunications technology").

[3] *See* http://www.internet2.edu/.

[4] For purposes of the pilot program, we will utilize the definition of "health care provider" in 47 C.F.R. § 54.601(a).

include in their proposed networks public and non-profit health care providers that serve rural areas. As detailed below, this program will provide funding for up to 85 percent of an applicant's costs of deploying a dedicated broadband network, including any necessary network design studies, as well as the costs of advanced telecommunications and information services that will ride over this network. We recognize that this funding percentage exceeds the funding percentages under our existing RHC mechanism, but find that this percentage is justified by the extraordinary benefits of universal service designed to spur broadband deployment dedicated to telehealth, including telemedicine services.[5] Moreover, we find that this percentage is economically reasonable because the funding is constrained by the program funding caps we describe below.[6]

4. The pilot program will lay the foundation for a future rulemaking proceeding that will explore permanent rules to enhance access to advanced services for public and non-profit health care providers. In particular, the goal of the pilot program will be to provide us with useful information as to the feasibility of revising the Commission's current RHC rules in a manner that best achieves the objectives set forth by Congress. If successful, increasing broadband connectivity among health care providers at the national, state and local levels would also provide vital links for disaster preparedness and emergency response and would likely facilitate the President's goal of implementing electronic medical records nationwide.

5. Broadband has enabled health care providers to vastly improve access to quality medical services in remote areas of the country. Among other things, telehealth applications allow patients to access critically needed medical specialists in a variety of practices, including cardiology, pediatrics, and radiology, without leaving their homes or their communities. Using video feeds over broadband and real-time patient information, intensive care doctors and nurses can monitor critically ill patients at multiple locations around the clock. Using this technology, a single medical professional is able to administer services to over a hundred patients, while cutting skyrocketing medical costs by shortening average hospital stays and reducing the need for additional tests and treatments.[7] The benefits of these technologies are particularly apparent in underserved areas of the country that may lack access to the breadth of medical expertise and advanced medical technologies available in other areas.

6. In the Telecommunications Act of 1996, Congress specifically sought to provide rural health care providers "an affordable rate for the services necessary for the provision of telemedicine and instruction relating to such services."[8] In 1997, we implemented this directive by adopting the RHC support mechanism funded by monies collected through the Universal Service Fund. Our RHC program provides reduced rates to rural health care providers for their telecommunications and Internet services. The primary goal of our existing rules is to ensure that rural health care providers pay no more than their urban counterparts for their telecommunications needs in the provision of health care services.

---

[5] We also note that this funding percentage is less than the highest funding level under our e-rate program. 47 C.F.R. § 54.505(c).

[6] *See* paragraphs 11-12 *infra*.

[7] *See, e.g.*, Statement of David A. Powner, Director Information Technology Management Issues, "Health Information Technology: HHS is Continuing Efforts to Define a National Strategy," Testimony Before the Subcommittee on Federal Workforce and Agency Organization, Committee on Government Reform, House of Representatives, GAO-06-346T, March 15, 2006 (discussing the rising cost of health care and the potential for information technology in the health care sector to reduce costs and improve the quality of patient care).

[8] Joint Explanatory Statement of the Committee of Conference, 104th Cong., 2d Sess. at 133 (1996).

7. In section 254(h)(2)(A), Congress directed the Commission to "establish competitively neutral rules to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for ... health care providers."[9] Since 1997, the Commission has made several changes to the RHC support mechanism to make it more viable and to reflect technological changes. For example, the Commission has exercised its authority under section 254(h)(2)(A) to establish discounts and funding mechanisms for advanced services provided by both telecommunications carriers and non-telecommunications carriers.[10] We currently have an open proceeding seeking comment on further modifications to the existing RHC support mechanism.[11]

8. Despite the modifications the Commission has made to the rural health care mechanism, the program continues to be greatly underutilized and is not fully realizing the benefits intended by the statute and our rules. In 1997, we authorized $400 million dollars per year for funding of this program. Yet, in each of the past 10 years, the program generally has disbursed less than 10 percent of the authorized funds. Although there are a number of factors that may explain the underutilization of this important fund, it has become apparent that health care providers continue to lack access to the broadband facilities needed to support the types of advanced telehealth applications, like telemedicine, that are so vital to bringing medical expertise and the advantages of modern health care technology to rural areas of the country. In addition, many of these real-time telehealth applications require a dedicated broadband network that is more reliable and secure than the public Internet.[12] Although the Commission has taken a number of steps to spur deployment of the type of broadband facilities that would support advanced medical technologies, to date our rural health care funding mechanism has not adequately provided the type of support needed to encourage development of dedicated broadband networks among health care providers.

9. Because of the enormous benefits of telemedicine applications that ride over broadband facilities, it is essential that the Commission take additional steps to facilitate broadband deployment to health care providers. Before taking further action to revise or expand the current RHC program, however, we believe it is prudent to engage in a trial program that will provide us with a more complete and practical understanding of how to ensure the best use of these available funds. Results from such a pilot program will inform our examination of how we can more effectively use available funding to bring the benefits of broadband connectivity to health care providers and patients in those areas of the country

[9] 47 U.S.C. § 254(h)(2)(A). Although the Act does not define "advanced telecommunications and information services," section 706(c)(1) of the Telecommunications Act of 1996 defines a similar term – "advanced telecommunications capability" – as "high-speed, switched, broadband telecommunications capability that enables users to originate and receive high-quality voice, data, graphics, and video telecommunications using any technology." *See* 47 U.S.C. § 157 nt.

[10] *See, e.g., 2003 Rural Health Care Support Mechanism,* Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking,18 FCC Rcd 24546, 24557-62, ¶¶ 22-29 (*2003 Rural Health Care Report and Order and FNPRM*) (providing a 25 percent discount off the cost of monthly Internet access for eligible health care providers under section 254(h)(2)(A)). Under section 254(h)(2)(A) of the Act, rural health care providers in states that are entirely rural can receive support equal to 50 percent of the monthly cost of advanced telecommunications and information services. *2004 Rural Health Care Support Mechanism,* Second Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 19 FCC Rcd 24613, 24631-34, ¶¶ 38-44. (*2004 Rural Health Care Report and Order and FNPRM).*

[11] *2004 Rural Health Care Report and Order and FNPRM,* 19 FCC Rcd at 24635, ¶¶ 47-49.

[12] *See, e.g.,* "Telemedicine Strategic Planning Document," Department of Veterans Affairs, Veterans Health Administration, VHA NOTICE 99-04 (Oct. 3, 1999) at 17; Joseph Tracy et al., "A Guide to Getting Started in Telemedicine," University of Missouri School of Medicine, (2004) at 325; "OR2020 Workshop Report," ISIS Center, Georgetown University Medical Center, (March 2004) at Chapter 4.

most in need. Upon completion of the pilot program, we will issue a report detailing the results of the program and the status of the health care mechanism generally, and recommend any changes that are needed to improve the programs. In addition, we intend to incorporate the information we gather as part of this pilot program in the record of any subsequent proceeding.

II. PILOT PROGRAM

10. The pilot program will fund a significant portion of the costs of deploying a dedicated broadband network that connects multiple public and non-profit health care providers, within a state or region, as well as providing the "advanced telecommunications and information services" that ride over that network. Consistent with the mandate provided in section 254(h)(2)(A) and general principles of universal service, all eligible public and non-profit health care providers may apply to participate in the pilot program, but applicants must include in their proposed networks public and non-profit health care providers that serve rural areas. A comprehensive network will provide the health care communities access to the various technologies and medical expertise that reside in specific hospitals, medical schools, and health centers within a region or state.

11. The pilot program satisfies the requirements of section 254(h)(2)(A).[13] First, the program will be "competitively neutral," which "means that universal service support mechanisms and rules neither unfairly advantage nor disadvantage one provider over another, and neither unfairly favor nor disfavor one technology over another."[14] The pilot program meets that requirement because eligible health care providers are free to choose any technology and provider of the broadband connectivity needed to provide telehealth, including telemedicine, services. Second, the pilot program will be "technically feasible" because the program will not require development of any new technology. Rather, participants will be free to utilize any currently available technology. Third, the program will be "economically reasonable." In discussing economic reasonableness, the Commission has generally focused on the effect any new rules would have on growth in the rural support mechanism.[15] To ensure the pilot program is economically reasonable, we will work within the confines of the existing RHC program funding mechanism and will structure pilot program funding in a manner similar to the priority system provided for the E-rate program in the Commission's rules.[16]

---

[13] 47 U.S.C. § 254(h)(2)(A) directs the Commission to establish competitively neutral rules "to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for all public and non- profit ... health care providers[.]"

[14] *May 8th Universal Service Order*, 12 FCC Rcd 8776, 8801, ¶ 47 (1997). We have held, for example, that providing support to all health care providers for internet access toll charges is competitively neutral because "health care providers may request wireline or wireless telecommunications links . . . at local calling rates to obtain access to an Internet service provider." *Id.* at 9160, ¶ 748. Similarly, we have found that "[c]onsistent with the Commission's long-standing principles of competitive neutrality, rural health care providers may receive discounts for the most cost-effective form of Internet access, regardless of the platform." *2003 Rural Report and Order and FNPRM*, 18 FCC Rcd at 24561, ¶ 28.

[15] *See, e.g., 2004 Rural Health Care Report and Order and FNPRM*, 19 FCC Rcd 24613, 24632 at ¶ 41 ("We do not believe this discount will significantly increase distributions from the underutilized rural health care fund because the number of eligible entities is so small. The funding amount also is unlikely to significantly increase in the future because the current list of eligible entirely rural areas is not likely to change"); *May 8th Universal Service Order*, 12 FCC Rcd at 9160, ¶ 748 (finding that "the limits on the number of hours and dollar cap per provider create economically reasonable mechanisms").

[16] *See* 47 C.F.R. § 54.507(g) (establishing priority system for E-rate program applications).

12. Specifically, to ensure that there is sufficient funding for the existing rural health care program, we will ensure applications for RHC support under the existing program receive priority funding. Once we have determined the funding needs for the existing program, we will fund the pilot program in an amount that does not exceed the difference between the amount committed under our existing program for the current year and $100 million (*i.e.*, 25 percent of the total $400 million annual RHC cap). Thus, if funding for RHC support under the existing program is $35 million in a year, $65 million will be available for the pilot program.[17] By capping the combination of applications for RHC support under the existing program and under the pilot program at $100 million (or 25 percent of the annual $400 million cap), we will ensure that the pilot program is economically reasonable. This will ensure that rural health care provider telecommunications needs under the current program are given priority and that the pilot program funding is capped at a reasonable level. We recognize that this prioritization may limit the amount of support provided to the pilot program in the event demand for the RHC program increases dramatically, but this outcome appears unlikely given our experience to date with this fund.

13. Because we recognize that we will need the experience of more than one year to fully evaluate the results of the pilot program, the pilot program we establish herein is limited to two years.[18] For purposes of this pilot program, we are reopening the filing window for Funding Year 2006. Funding under this pilot program for Funding Year 2006 will be available until June 30, 2007. Participants that receive funds in Funding Year 2006 must reapply to the extent they seek additional funds in Funding Year 2007. Applicants not selected in Funding Year 2006 may apply for funds during our normal filing window for Funding Year 2007.[19]

14. The funding provided under this pilot program may be used to fund up to 85% of the costs incurred by the applicants to deploy a state or regional dedicated broadband health care network, and to connect that network to Internet2.[20] Selected applicants must use these funds for the purposes specified in the application award. Authorized purposes will include the costs of deploying transmission facilities and advanced telecommunications and information services, including and associated non-recurring and recurring costs. We find that section 254(h)(2)(A), which requires the Commission "to enhance ... access to advanced telecommunications and information services," authorizes support for construction of facilities for the purposes of this pilot program. This is consistent with the Commission's conclusion in the May 8th Universal Service Order that we have authority to implement a program of universal service support for infrastructure development as a method to enhance access to advanced services under section 254(h)(2)(A).[21] Because many health care providers would be unable to access certain telehealth services

[17] Based on our past experience and estimates of funding requests received under the current program for funding year 2006, we estimate that approximately $55-60 million will be available for this pilot program in 2006.

[18] Although this pilot program is limited to two years, we will continue to fund those applicants already accepted into the program, upon request, and subject to the availability of funds.

[19] After selection, participants in the pilot program will be required to follow the normal RHC program procedures, including the requirement to submit the Form 465, Form 466, Form 466A, and Form 467.

[20] Connection to Internet2 can be at the nearest Gigapop or at the location of the nearest Internet2 member. For a list of members, *see* http://www.internet2.edu/membership/.

[21] *May 8th Universal Service Order,* 12 FCC Rcd at 9109, ¶ 634.

without deployment of new broadband facilities, the pilot program will support construction of those facilities.[22]

15. For purposes of this pilot program, we will permit funding to be used to conduct initial network design studies. These studies will enhance access to advanced telecommunications and information services by enabling applicants to determine how best to deploy an efficient network that includes multiple locations and various technologies. We recognize that funding initial network design studies in the pilot program goes beyond the services normally eligible for support in the RHC program. Consistent with our authority in section 252(h)(2)(A), we conclude that funding these studies is in the public interest for the purposes of this pilot program because it will enable program participants to explore more efficient, effective means of delivering telemedicine in rural areas. In light of the historical trend of the RHC program to operate at 10% or less of the total amount authorized, as well as the funding cap described earlier, we find that funding network design studies for pilot program participants will be economically reasonable. We find that these justifications apply equally to supporting infrastructure deployment, which is also not covered under the existing program.

16. We will select a limited number of participants from applications that meet the criteria outlined below. We expect each applicant to present a strategy for aggregating the specific needs of health care providers, including providers that serve rural areas, within a state or region, and leveraging existing technology to adopt the most efficient and cost effective means of connecting those providers. Applicants should indicate in their application how they plan to fully utilize a newly created dedicated broadband network to provide health care services. We anticipate that successful applicants will be able to demonstrate that they have a viable strategic plan for aggregating usage among health care providers within their state or region. In choosing participants for the program, we will consider whether the applicant has a successful track record in developing, coordinating, and implementing a successful telehealth/telemedicine program within their state or region. In addition, because the purpose of this program is to encourage health care providers to aggregate their connection needs to form a comprehensive statewide or regional dedicated health care network, we will also consider the number of health care providers that would be included in the proposed network. In particular, we will give considerable weight to applications that propose to connect the rural health care providers in a given state or region. A proposal that connects only a *de minimis* number of rural health care providers will not be accepted.

17. To be eligible for participation in the pilot program, interested parties should submit applications that:

1) Identify the organization that will be legally and financially responsible for the conduct of activities supported by the fund;
2) Identify the goals and objectives of the proposed network;
3) Estimate the network's total costs for each year;
4) Describe how for-profit network participants will pay their fair share of the network costs;
5) Identify the source of financial support and anticipated revenues that will pay for costs not covered by the fund;
6) List the health care facilities that will be included in the network;

[22] We note that whether the Commission's existing RHC rules should be modified to permit funding of such facilities is under consideration in an open proceeding. *2004 Rural Health Care FNPRM*, 19 FCC Rcd 24613, at 24636-37, ¶¶ 51-53.

7) Provide the address, zip code, Rural Urban Commuting Area (RUCA) code and phone number for each health care facility participating in the network;
8) Indicate previous experience in developing and managing telemedicine programs;
9) Provide a project management plan outlining the project's leadership and management structure, as well as its work plan, schedule, and budget.
10) Indicate how the telemedicine program will be coordinated throughout the state or region; and
11) Indicate to what extent the network can be self-sustaining once established.

18. Applicants will be required to comply with the existing competitive bidding requirements, certification requirements, and other measures intended to ensure funds are used for their intended purpose. We recognize that we may need to waive additional rules in order to implement this pilot program, and we request that applicants identify in their application any rules that they would like us to waive for purposes of this pilot program.[23]

19. This document contains new or modified information collection requirements subject to the Paperwork Reduction Act of 1995 (PRA), Public Law 104-13. It will be submitted to the Office of Management and Budget (OMB) for review under Section 3507 of the PRA. OMB, the general public, and other federal agencies are invited to comment on the new information collection requirements contained in this proceeding. In addition, pursuant to the Small Business Paperwork Relief Act of 2002, Public Law 107-198, see 44 U.S.C. 3506(c)(4), we seek specific comment on how we might "further reduce the information collection burden for small business concerns with fewer than 25 employees."

20. Applications to participate in the pilot program will be due 30 days from the receipt of OMB approval.

21. Instructions for Filing. Applications should reference WC Docket No. 02-60 only, and may be filed using (1) the Commission's Electronic Comment Filing System (ECFS), or (2) by filing paper copies.

- Electronic Filers: Applications may be filed electronically using the Internet by accessing the ECFS at http://www.fcc.gov/cgb/ecfs/. Applicants should follow the same instructions provided on the website for submitting comments. In completing the transmittal screen, ECFS filers should include their full name, U.S. Postal Service mailing address, and the applicable docket or rulemaking number. To get filing instructions for e-mail applications, commenters should send and e-mail to ecfs@fcc.gov and should include the following words in the body of the message, "get form <your e-mail address>." A sample form and directions will be sent in reply.

- Paper Filers: Parties who choose to file by paper must file an original and four copies of each application. Applications can be sent by hand or messenger delivery, by commercial overnight courier, or by first-class or overnight U.S. Postal Service mail (although we continue to experience delays in receiving U.S. Postal Service mail). All filings must be addressed to the Commission's Secretary, Office of the Secretary, Federal Communications Commission.

[23] 47 C.F.R. § 1.3, provides that "[a]ny provision of the rules may be waived by the Commission on its own motion or on petition if good cause therefore is shown." Waiver of the Commission's rules is therefore appropriate only if special circumstances warrant a deviation from the general rule, and such deviation will serve the public interest. *Northeast Cellular Telephone Co. v. FCC*, 897 F.2d 1164, 1166 (D.C. Cir. 1990).

22. The Commission's contractor will receive hand-delivered or messenger-delivered paper filings for the Commission's Secretary at 236 Massachusetts Avenue, NE, Suite 110, Washington, DC 20002. The filing hours at this location 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 should be addressed to 445 12th Street, SW, Washington DC 20554.

23. Applicants must also send a courtesy copy of their application to each of the following individuals: 1) Jeremy Marcus, (202) 418 0059, jeremy.marcus@fcc.gov; 2) Thomas Buckley, (202) 418-0725, thomas.buckley@fcc.gov; and 3) Erika Olsen, (202) 418-2868, erika.olsen@fcc.gov. Each is located in the Telecommunications Access Policy Division, Wireline Competition Bureau, Federal Communications Commission, 445 12th Street, SW, Washington, DC 20554.

III. ORDERING CLAUSE

24. Accordingly, IT IS 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, this Order IS ADOPTED, and SHALL BECOME EFFECTIVE immediately upon release of this Order, pursuant to 47 U.S.C. § 408, except that the information collections contained in the Order will become effective following OMB approval. Applications to participate in the pilot program SHALL BE FILED 30 days from the receipt of OMB approval. The Commission will issue a public notice announcing the date upon which the information collection requirements set forth in this Order shall become effective following receipt of such approval.

FEDERAL COMMUNICATIONS COMMISSION

Marlene H. Dortch

Marlene H. Dortch
Secretary

STATEMENT OF
CHAIRMAN KEVIN J. MARTIN

Re: *In the Matter of Rural Health Care Support Mechanism*, WC Docket No. 02-60

The Commission's action today is an important step towards the creation of a ubiquitous, nationwide, broadband network dedicated to health care. The deployment of such a network will create numerous opportunities for delivering telehealth services, including telemedicine applications, that have the potential to revolutionize the current healthcare system throughout the nation. This is particularly true in rural and underserved areas, where distance often separates patients from the medical care they need. Under the pilot program we adopt today, patients anywhere on the network will have greater access to critically needed specialists in a variety of specialties. For example, through the use of telemedicine, doctors in urban hospitals can read radiology images of patients in rural trauma centers and provide real-time consultations. This ability to diagnose, treat, and monitor patients from a distance will reduce the length of hospital stays, lower medical expenses, and improve the quality of health care.

A dedicated national broadband healthcare network will also facilitate the President's goal of implementing electronic medical records nationwide. A dedicated network is critical to maintaining security and privacy when transmitting electronic medical records.

Our current rural health care program is greatly underutilized. Although the Commission has allotted $400 million a year for this fund, only about 10 percent of this amount is ever used. And, despite past Commission efforts to improve the existing program, health care providers, particularly those in rural and underserved areas, continue to lack sufficient access to advanced telecommunications and information services. By taking steps to foster the deployment of statewide and regional broadband networks connecting public and non-profit health care providers, the Commission can best achieve the health care objectives set forth by Congress.

At the same time, however, we are careful to appropriately cap the expenditures associated with this pilot program. Specifically, we limit the funding for this program to an amount that will not exceed the difference between the amount committed under our existing program and 25% of the funds currently allocated for rural health care. By capping the funding, we make sure that rural health care provider telecommunications needs under the existing program are given priority and that the expenditures under the pilot program do not exceed a reasonable level.

I look forward to learning from this pilot program how we can ensure that all Americans, including those in the most remote areas of the country, receive first-rate medical care.

STATEMENT OF COMMISSIONER MICHAEL J. COPPS

Re: *In the Matter of Rural Health Care Support Mechanism*, WC Docket No. 02-60

It is still the unfortunate truth that rural America lags behind the rest of the country in access to first rate health care. That's bad news for so prosperous a nation as ours. So I am pleased that the pilot program we establish today to build a dedicated broadband network for health care providers creatively pushes the envelope in an effort to spur the development of tele-medicine programs to better serve rural America.

The need for new thinking in this area is clear. Over the last 10 years, the rural health care mechanism has disbursed less than 10 percent of the $400 million authorized for the program each year. I don't believe the foregone potential of this program is what Congress or the Commission had in mind when the rural health care mechanism was launched. Missed opportunities are all the more worrisome at a time when bioterror, naturally-occurring health threats such as E-coli 0157H7, an avian flu pandemic, or a natural disaster like Hurricane Katrina can wreak havoc anywhere in America. One thing is for sure—if a health catastrophe visited many of our rural areas today, our rural health care system is not generally equipped to deal with it.

So I welcome this initiative and I hope we will consider other innovative ways to use this program to advance rural health care. And let me also say how pleased I am that the Chairman and my colleagues have agreed to include a requirement for the Commission to issue a report based on over a decade of FCC experience that can advise Congress and others of what we have learned, what has worked well, and where legislative or administrative improvements may be needed.

I would note that this new initiative deserves a serious outreach effort so that all interested parties can participate; an expeditious but totally transparent application process; and careful selection of recipients. The item envisions a short timeframe for applicants so the Bureau needs to do some extraordinary outreach here beginning today. A swift application process has real benefits but it must not come at the expense of a diverse pool of applicants from all across the country who could benefit from this initiative.

Finally, after our last rural health care order in 2004, legitimate concerns were raised that our current rules are not as expansive as they should be when it comes to the types of providers, services, and technologies that are covered by the program. I would hope that the Commission will quickly address these items as they could immediately result in wider participation in the program.

There is no question that healthcare communications is vital to both the homeland security and economic security of our citizens. As I have said before, I want to see this Agency commit to ensuring that every hospital and health center in America has a broadband connection by 2010 and is fully integrated into an emergency response communications system. What a powerful achievement that would be. We take an important step towards this goal today, and I am pleased to support this item.

STATEMENT OF COMMISSIONER JONATHAN S. ADELSTEIN

Re: *In the Matter of Rural Health Care Support Mechanism*, WC Docket No. 02-60

In this Order, we expand the Federal Universal Service Rural Health Care program to include a pilot program to fund the construction of broadband infrastructure to connect rural health care providers. The telemedicine programs funded through the Rural Health Care program can have dramatic benefits for rural communities, and I have repeatedly supported efforts to improve the connectivity of rural health care providers.

I have been privileged during my time as an FCC Commissioner to have seen first hand the way that telemedicine programs enable rural residents to bridge distances that might otherwise be unaffordable or physically impractical to cross. The telemedicine applications funded through the Rural Health Care program may be the only viable link to vital diagnostic services and specialized care for many patients. With advances in digital imaging, rural health care providers are increasingly able to send medical records, CAT scans, and other lab results to specialists in distant locations. Connecting our health care providers can also play a critical role in promoting continuing education through distance learning for our health care professionals.

More than ever it is critical that we expand the connectivity of our health care providers to improve our ability to respond to disasters, natural and man-made. As we have seen repeatedly in the past few years, our communications systems are a critical factor in our ability to respond quickly and in a coordinated fashion.

The funding provided by the Rural Health Care program is crucial to the sustainability of many telemedicine programs. Without universal service, the high cost of telemedicine services might put them out of reach of many small communities. Yet, the Rural Health Care program has consistently been underutilized despite widely-varying levels of connectivity among rural health care providers. So, I was pleased to support our 2004 Notice of Proposed Rulemaking in which we sought comment on whether to fund infrastructure development for rural health care providers, and I am pleased that we take a step in that direction today. A well-tailored pilot program has the potential to give us critical information about the needs of health care providers and the resources required to establish connectivity.

While I support our efforts to make additional funds available for telemedicine uses, I have had some concerns about the specific implementation of this program – some of which have been addressed, while others still give me pause. One area where the item could be improved is in its articulation of criteria for selecting program participants among the potentially myriad well-qualified applicants who may seek funding. While I appreciate my colleagues' willingness to amend the criteria to give weight to applications that serve rural areas, this Order could do more to explicitly prioritize projects that target services to rural areas. Nor does the Order assign any apparent weight to the selection of applicants willing to deploy facilities to unserved areas, or applicants targeting service to the most needy or hardest-to-serve areas. Had we sought comment on whether to create a pilot program and how to tailor it, we likely would have greater clarity and transparency here but, unfortunately, that is not the case.

With an entirely new program, and given the importance of this effort, I also would have preferred a longer application window. Even in a more established program like our Schools and Libraries program we give applicants sixty days to file their funding requests from our publication of the Eligible Services List. But I appreciate the Chairman's commitment to extend the application deadline for interested parties who would like to participate but may require additional time. It will also be critical

for us to do as much outreach as possible to solicit a wide variety of applicants. We all want to improve the connectivity of our health care providers as quickly as possible, but if we are trying to create a program that is above reproach and that truly is open to all -- including small communities and Tribal providers who may not have the resources to assemble proposals on a moment's notice -- we must give health care providers a meaningful opportunity to participate and the Commission's selection processes should be as transparent as possible.

This program is so important, we've got to get the details right. So, I thank my colleagues for their willingness to accommodate some of my concerns and look forward to working together to further Congress' goal of connectivity for rural health care providers.

STATEMENT OF COMMISSIONER DEBORAH TAYLOR TATE

Re: *In the Matter of Rural Health Care Support Mechanism*, WC Docket No. 02-60

I am pleased to support today's item because it acknowledges and encourages the incredible benefits broadband can bring to our nation's public and non-profit healthcare facilities. Section 254 of the Act recognizes the importance of rural health care facilities to the deployment of broadband throughout our nation. The item we adopt today helps to advance that goal. The pilot program initiated by today's item is an inventive approach to encourage innovative health practices, especially in the rural and remote areas of the country where health care has often been more difficult and expensive to provide.

The FCC has a far broader role in health care than most Americans think. From approving waivers for specialized implant devices to promoting the advancement of broadband networks that support telehealth services spreading the reach of the latest health technology and services. It has been exciting for me to see first-hand how new technologies combined with broadband enable everything from remote surgery to telepsychiatry, and teledentistry. I have witnessed first-hand how the technology at both a research hospital and one of the most remote communities in the U.S. links up and works together not only to improve people's health and lives, but also to narrow the miles between doctor and patient.

Likewise, with regard to mental health, I have been able to see how broadband and new technologies are improving access to behavioral health treatment for clients in the most rural and isolated parts of our nation. Even in the wilds of Alaska – hundreds of miles from anywhere and reachable only by snowmobile, airplane or dogsled – telepsychiatry helps psychiatrists maintain regular contact through video observation and live interaction with their patients. Centerstone, the largest behavioral health provider in Tennessee, is leading efforts toward improved outcomes through electronic medical records and sharing research-based "best practices" with mental health centers across the country.

These benefits pertain, of course, to people in rural and remote parts of our country who will benefit from the access to specialists and research that, until recently, was often only available in urban centers. We must also keep in mind that these technologies will also keep our nation on the leading edge of our rapidly changing world. We must ensure that our nation remains competitive in a global environment including not only technology and industry, but also in terms of consumer welfare, education, and health care. Today's item promises to explore a way to further support the broadband networks for health care that can truly make a difference in people's lives. I look forward to hearing and seeing exciting ideas and projects envisioned by rural healthcare providers, which in turn, will hopefully improve the care patients may receive no matter where they may choose to live.

STATEMENT OF COMMISSIONER ROBERT M. McDOWELL

Re: *In the Matter of Rural Health Care Support Mechanism*, WC Docket No. 02-60

My congratulations to the Chairman on his leadership on this thoughtful and creative proposal to make more effective the Rural Health Care program. And congratulations to the Wireline Competition Bureau and OSP in preparing these revisions to the program.

Advanced healthcare should be available to all Americans, regardless of whether they live in rural or urban areas. Congress has mandated that the Commission enhance the availability of advanced telecommunications and information services for rural health care providers. This program in its current form has been underutilized, however.

In light of these factors, we should take all steps necessary to make sure that our statutory mandate is fulfilled, so that rural health care providers have access to the most current and advanced health care information and services. This becomes particularly critical when considering the possibility of a nationwide, and even worldwide, flu pandemic.

This two-year pilot project provides a vehicle to determine the extent of the need for advanced services to meet the rural health care objective and how we can tailor the rural health care support mechanism toward that end. It also gives new options for developing regional, state and national networks dedicated to health care.

Several protections are important to incorporate into the pilot project: One is that the program is competitively and technologically neutral. The other is that the broadband networks being funded be built to include service to rural areas.

Therefore, Mr. Chairman, I support this item and look forward to the positive results of this pilot project.