**SEPARATE STATEMENT OF**
**COMMISSIONER MICHAEL J. COPPS**

Re: *Rural Health Care Support Mechanism (WC Docket No. 02-60)*

I am pleased—very pleased—to see this rural health care item on our agenda today. This is a program that we need to put to work. We need to put it to work because rural America lags the rest of the country in access to premium health care, and we need to do it now more than ever because of the heightened threats of bio-terrorism and health catastrophe that follow in the wake of 9/11. Rural America wasn't where it should have been in access to good health services before 9/11, and if terror visited there now, all the reports tell us, rural America is less-equipped to deal with it than we are in the metropolitan areas, and goodness knows we need a lot of improvements here, too.

For those who are interested in seeing how rural health care providers can make use of telecommunications infrastructure to provide needed services, it's there to see. In growing numbers of places, you can see telemedicine and telehealth improving the quality of life in rural communities by providing patients in remote areas with access to services that would otherwise have been unavailable. We are seeing patient diagnostic services, patient follow-up care, educational offerings for rural health care professionals, and the dissemination of all sorts of critical health–related information.

Last week, I had the opportunity to learn about this first-hand when I spent some quality time in the south central Wisconsin town of Beaver Dam, at the Beaver Dam Community Hospital. I had the opportunity there to have a long conversation with the people who run this rural facility and the people responsible for the telecommunications technologies used to provide patient care.

Here at the Commission we now understand that our Rural Health Care Program has not lived up to its potential. We set aside as much as $400 million annually, but in the first five years of the program, just over $30 million was disbursed to rural facilities. This is not on the scale of what I suspect the Commission had in mind when the program was first set up, and it is certainly not on the scale of what Congress had in mind when it directed the Commission to ensure that health care providers serving rural communities have access to services on par with those available in urban areas. And, as I said a minute ago, it falls even farther short of what it should be in light of 9/11.

In response, we change our rules today. In particular, we expand our interpretation of eligible health care providers, provide flat support for Internet access and revise our standard for urban area rate comparisons. I support these changes because I believe they will improve the Rural Health Care Program in a manner that is consistent with our statutory mandate.

But other problems—serious problems—remain and they keep this program from being utilized the way it should be utilized. My conversations in Beaver Dam, and my

earlier conversations in the remote town of Levelock, Alaska, convince me that basic lack of outreach and a cumbersome application process may be the real culprits here.

The Rural Health Care Program is only as strong as the community that knows about it. And you know what? A lot of communities don't know about this program. So, for openers, we need to work much more closely with the American Hospital Association, state health care organizations, rural government associations and telecommunications carriers serving rural communities to get the word out. Like so many of our universal service programs designed for end-user beneficiaries—without outreach they risk irrelevance, perhaps even extinction.

Then there is the application process. It needs a major overhaul. At Beaver Dam Community Hospital, they spent six months to secure what wound up being only a single month of funding. Figuring out the appropriate discount rate, securing necessary information from telecommunications carriers and completing the mountain of related forms is a time consuming and arduous task. The application calls on health care professionals to master the complexities of such things as total billed miles and the intricacies of all sorts of convoluted tariff rates. These rural hospitals have limited staff, they have urgent priorities, and in a matter like this, where months of work translate into a couple thousand dollars of one-month support, they question if the paper chase is at all worth it. From what I saw, I don't blame them. And I fear Beaver Dam's experience is not unusual. I know that USAC has recently made some improvements, including a new database of urban rates and enhanced electronic filing capabilities and also making the second year application easier, and I congratulate them for that. But we can, we should, and we must do more. We are justifiably concerned with deterring waste and abuse, but we should recognize that the complexity of the process here is deterring worthy applicants—and that is really waste and abuse.

I commend the Chairman and the Wireline Competition Bureau for developing this item today, and I am encouraged that the Chairman and Commissioner Abernathy made a trip last week to visit the University of Virginia Office of Telemedicine. Raising the profile of this program helps. Today's Order helps. And tackling some of these other problems would help. This program involves national security and our national well-being. We can all be zealous advocates for this cause. I look forward to working with my colleagues, the Bureau, rural health care providers and the industry to make this program what it deserves to be.