

**STATEMENT OF
COMMISSIONER MICHAEL O'RIELLY**

Re: *Promoting Telehealth in Rural America*, WC Docket No. 17-310.

At the outset, the Telecom Program arm of the Rural Health Care program has played a valuable role in improving access to health services in some of the most remote parts of our country, and I am firmly committed to protecting its viability, per our statutory requirement. Due to circumstances that predate this Commission, vague rules and inefficiencies have plagued the program, and the need for a systematic overhaul has become evident. I therefore commend the Chairman, staff, and stakeholders for coming up with a plan that will hopefully establish much better predictability and efficiency in the program. As in the case of the previous mapping item, I certainly have some concerns over USAC's ability to complete the seemingly-gargantuan task of developing urban and rural rate databases envisioned by the draft in time for Funding Year 2021—especially given all the other work we assign the Administrator today. Despite this, the item can potentially serve as a serious step in the right direction.

When the original draft circulated, I raised doubts about the applicability of the new tiered structure to a state like Alaska—so geographically vast and challenging that it truly exists in a category of its own. As I saw from my own visit to that state when I first joined the Commission, many villages are outside the road system and are accessible only by air or water and are in turn extremely complicated and expensive to serve. From the original draft's own map, it was clear that the vast majority of the state would fall into a single tier, creating problematic outcomes for the most isolated villages—both as a matter of policy and in view of our statutory duty to ensure access to rates that are reasonably comparable to those in urban areas of the state.

The Commission previously recognized the need for unique treatment of Alaska in numerous instances over the years, including in our High Cost program, and I believe it is crucial to carve out state-specific rules here as well. I thank the Chairman and staff for their work in adapting the tiered approach to the unique circumstances in Alaska and arriving at a reasonable and administratively feasible landing spot. I also appreciate that the Chairman agreed to strike the heightened waiver standard as initially proposed, should a strict application of the rules prove problematic in specific instances. Parties always have the right to petition the Commission under our existing standard, and it would not be fair to apply a more heightened standard—particularly one that imposes a task as burdensome as a cost study—in selective cases.

I am also thankful to the Chairman's office for agreeing to strike—at my behest—the decision to import a very problematic E-Rate rule into the Rural Health Care Program. While cost-effectiveness should no doubt drive the Commission's competitive bidding processes, the “price as the primary factor” rule has done a *terrible* job in selecting E-Rate projects that are *actually* cost-effective. To the extent that the rule is applied myopically within the confines of a singular bidding matrix, it completely fails to take into account whether a given project would be cost-effective for the USF as a whole. That has led to USAC permitting very wasteful overbuilds in the E-Rate program—often involving recipients of funding under the Commission's own High Cost program—and we should not import those problems over here. And, doing so would be especially inappropriate given an ongoing proceeding on changing the E-Rate rules to address the rule's role in enabling FCC-funded overbuilding. I therefore thank the Chairman for agreeing to remove that problematic section from the draft and look forward to addressing broader overbuilding issues in due course.

While I am hopeful that the new rules will inject much more predictability and efficiency into the program, I remain dismayed by our continued decision to fund urban applicants, even if the latter remain on the lowest rungs of priority when demand exceeds available funding. I was not on the Commission when it originally decided in 2012 to allow urban provider participation, and while I am well-aware of the policy arguments that have been made in favor of that decision, the bottom line remains that our statutory mandate under section 254(h) is restricted to health care providers in *rural* areas. While phasing out the three-year grace period for majority-rural participation in consortia is a positive step, I hope that our next

action with respect to this program will be to remove urban funding altogether. Absent Congress changing the law, the money now allocated for urban providers could be used to fund a lot of good in needy rural areas.

On a related and final note, I think it is important to recognize that the application of this item is on a prospective basis, with the rate database not going into effect until Funding Year 2021. Indeed, when the Commission recognizes that its rules are not meeting expectations, it makes all the sense in the world to modify a program on a going-forward basis. However, this principle also raises questions regarding efforts to retroactively alter payments previously committed to providers under rules that we acknowledge today are vague and unclear. At some point, the Commission is expected to act on a petition to reconsider those recent decisions, and as such, based on the information I have seen so far and the many meetings I have conducted, I have significant concerns regarding our decisions so far.

For the reasons mentioned, I will support the item.