

**STATEMENT OF
COMMISSIONER BRENDAN CARR**

Re: *Promoting Telehealth in Rural America*, Further Notice of Proposed Rulemaking, WC Docket No. 17-310, (February 18, 2022).

Manokotak, Alaska, is a remote, one-street village that sits roughly 340 miles southwest of Anchorage. Your Waze app won't help you get there. And there isn't a lot of traffic on the town's dirt road because the community is completely cut off from the highway system. The village is nestled between a small mountain called Acorn Peak and one of the meandering bends of the Igushik River. It can only be accessed by air or water. And that presents a unique set of challenges for the 440 or so people—mostly Alaska Natives—that live there. Access to affordable, high-quality healthcare has long been one of those challenges.

The closest hospital is in Dillingham (pop. 2,249), and I had the chance to travel to Manokotak from Dillingham in 2018. After taking a commercial flight to Dillingham from Anchorage, we climbed a few rickety steps up into an old Grumman Goose that was built in 1944. Despite its age, the pilot assured us that it the plane was still a very airworthy craft. Good news from my perspective is that we didn't need to get that far off the ground during the roughly 15-minute commuter flight. We landed at Manokotak's gravel runway and hopped in a car for the one-mile drive down rough roads to the village center. That's where we met up with the healthcare professionals that work at the Manokotak Village Clinic. The team there talked about the value that a high-speed Internet connection brings to their small operation and to other remote parts of Alaska. Rather than incurring the expense and time associated with life-fighting someone out of the village—an experience that only isolates a patient from their family and community—Manokotak's Internet connection allows the clinics to tap virtually into the health care specialists back in Dillingham or Anchorage. That means more patients are able to access affordable and quality care while getting to stay with their loved ones in their home community. That is a good thing.

Vital telehealth connections like this are often only possible with support from the FCC's Rural Health Care Program. Ensuring that this program has the sufficient and predictable levels of support it needs is not just a nice policy goal—it's a statutory obligation for the FCC. And on this score, the agency has not always gotten it right. In the past, the FCC's support mechanism has led to unpredictable funding levels and inconsistent rates. Demand for funding has outstripped the program's annual budget. And the process of administering the program and processing funding requests has led to backlogs and delays.

Senator Sullivan and others have been strong advocates for ensuring that the FCC corrects for these mistakes and stands up a program that meets the agency's statutory obligations. I have welcomed the chance to work with my FCC colleagues on doing just that. In 2018, for instance, we raised the overall cap of the program and established a process to annually adjust the cap to reflect inflation. In 2020, we waived the FCC's cap on upfront payments and multi-year commitments to ensure that all program requests could be funded in full during the COVID-19 pandemic. And in January and April of 2021, we issued waivers to address anomalies in the Telecom Program's rates database—anomalies that would have contributed to an inadequate and inconsistent level of support for providers. We have also waived a number of other program rules to provide relief to program participants and alleviate administrative burdens throughout the COVID-19 pandemic.

While these have been important steps in the right direction, it is clear that the FCC must embrace more fundamental—and permanent—changes to our Rural Health Care Program. This item explores how we can do just that. I am pleased in particular that we are seeking comment on new ways of calculating rural rates that will not lead to the types of anomalies discovered in the rates database. I am also pleased that today's item now seeks comment on whether the existing funding cap is sufficient to satisfy future demand for the program or whether we should increase it. After all, serving remote health care clinics like the one in Manokotak requires expensive, years' long investments. We must ensure that the program provides the required certainty to providers year after year as demand for these types of services continues to explode.

Finally, I am grateful that my colleagues agreed to expand the item so that it now seeks comment on some of the administrative delays and other burdens that providers continue to face at USAC during the application and appeals processes. Over the years, we have heard numerous complaints that USAC takes too long to process applications and make funding decisions. Today, we seek comment on whether there are additional actions the FCC can take to expedite application processing or to require USAC to make funding commitment decisions in a more timely manner. We also seek comment on whether USAC or the FCC should be required to act on appeals of such decisions in a certain timeframe—particularly when such appeals are tied to the administrative errors of USAC—and whether there are other steps we can take to reduce administrative burdens and costs for providers while maintaining the integrity of the program.

I want to express my thanks to Chairwoman Rosenworcel for bringing this item forward for a vote. I am confident we can work together to strengthen the rules to the benefit of rural health care providers across the country. And finally, I want to thank the staff of the Wireline Competition Bureau for their hard work on the item. It has my support.