

**STATEMENT OF
COMMISSIONER BRENDAN CARR**

Re: *Promoting Telehealth for Low-Income Consumers*, WC Docket No. 18-213, Notice of Proposed Rulemaking

I recently met Cathleen in Laurel Fork, Virginia, a town of about a 1,000 people that's nestled in the Blue Ridge Mountains in southwest Virginia. Laurel Fork—and the other rural communities in Carroll County—face a distinct set of health care challenges. Diabetes rates are about one third higher than the national average. And managing chronic conditions there is complicated by several factors. Income levels are about one third below the national average. The closest hospital is in another state. And the U.S. Department of Health and Human Services (HHS) has classified Laurel Fork as a health care provider shortage area for mental health and primary care services. Indeed, there's just one mental health provider available in the county per 2,700 people.

Cathleen told me that she struggled for years with uncontrolled diabetes. She was diagnosed five years ago and receiving treatment meant a two-hour, round trip drive to see a doctor. Finding transportation and getting to the clinic wasn't easy, so, like many others dealing with chronic conditions, Cathleen stopped going in for treatment for a few years. When she went back to the doctor, her A1C levels—the blood glucose levels used to indicate diabetes—had skyrocketed to 15.5. Levels that high are considered critical and are commonly followed by strokes and heart attacks.

So Cathleen's doctor signed her up for an innovative program that's run out of the community health center in Laurel Fork. That program uses telehealth and remote patient monitoring to treat diabetes. Thanks to these connected care technologies, patients like Cathleen don't go home from the clinic empty-handed. She's given an Internet-connected home monitor, which allows endocrinologists at the clinic to remotely monitor her blood glucose levels daily, as well as her diet and physical activity. The data can be uploaded straight from Cathleen's device at her home and analyzed in the cloud. The results can then be accessed by a team in Laurel Fork or by specialists at the University of Virginia through a secure connection.

Cathleen says that the program has worked wonders for her and has helped keep her treatment on track. She follows the tips and advice that her doctors send directly to her tablet about what to eat and when to exercise. Following the six-month program, her A1C levels fell to 7.5. She has more energy, and she says she can even run after her three grandkids, of whom she has custody—something that she would not have been able to do with chronic uncontrolled diabetes.

Cathleen's story is not unique. Dr. Santen, who oversees the program, reported that remote patient monitoring lowered patients' A1C levels by 2.2 points on average, which reduced their risk of heart, kidney, and eye problems by more than 50 percent.

And, on a recent trip to West Virginia with Senator Capito, I had the chance to visit the Charleston Area Medical Center. There, Dr. Kadikoy showed us how remote ophthalmology services are being used in rural communities to help diagnose diabetes. We also met with psychiatrists and pain management specialists who are now using telehealth and virtual visits to address opioid dependency. These online sessions are providing rural West Virginia communities with access to life changing care that might not otherwise be available.

Examples like these are part of a new trend in telehealth—a trend towards connected care everywhere. Inside many hospitals and clinics across the country, patients can now access connected and cutting-edge telehealth services. The FCC, through its Rural Health Care Program, has long supported the deployment of broadband to these facilities. But technology that's limited to the confines of a brick-and-mortar hospital does little to help communities or patients that are long miles and many hours away from those facilities.

More and more, remote technologies—whether enabled by a smartphone, tablet, or other device—are bringing high-quality, affordable care to communities across the country. The potential

benefits of connected care are significant. In communities across the country, I've seen firsthand how telehealth is improving patient health outcomes. For example, a study of 20 remote patient monitoring trials found a 20 percent reduction in all-cause mortalities and a 15 percent reduction in heart failure-related hospitalizations. The Veterans Health Administration's remote patient monitoring program resulted in a 25 percent reduction in days of inpatient care and a 19 percent reduction in hospital admission. Another remote patient monitoring initiative showed a 46 percent reduction in ER visits, a 53 percent reduction in hospital admissions, and a 25 percent shorter length of in-patient stay.

And the relatively limited trials to date are showing significant cost savings. A remote patient monitoring program run by the Veterans Health Administration, for example, cost \$1,600 per patient compared to the \$13,000 it costs for more traditional care. Another telehealth project in the northeastern U.S. found that every dollar spent on remote monitoring resulted in a \$3.30 return in savings. And a diabetes trial conducted by the University of Mississippi Medical Center resulted in nearly \$700,000 in annual savings due to reductions in hospital readmissions alone. Assuming just 20 percent of Mississippi's diabetic population enrolled in this program, Medicaid savings in the state would be \$189 million per year.

Given the significant cost savings and improved patient outcomes associated with connected care, we should align public policy in support of this movement in telehealth. It's the healthcare equivalent of moving from Blockbuster to Netflix. At the FCC, we can play a constructive role by helping to fund the connectivity needed to ensure that all communities get a fair shot at benefiting from new telehealth technologies. So I am glad to be leading the FCC's efforts to do just that through the Connected Care Pilot Program.

The Pilot would target funding for projects that benefit low-income patients, including those living in rural communities and veterans. We are proposing to allow eligible health care providers to obtain up to 85 percent of the costs of the broadband needed to provide remote patient monitoring and similar connected care technologies to their patients. The program would support a limited number of projects over a three-year period with controls in place to measure and verify the benefits, costs, and savings associated with connected care. This will help extend treatment beyond the four walls of the hospital and enable more patients to receive high-quality medical care wherever they are.

This vote builds on comments we received from the public after we first sought feedback on standing up this type of program last year. And there are a few more steps to go before we start accepting applications. But I want to invite all health care providers and the public to review the Notice and provide your feedback.

To be sure, the Pilot Program won't solve every challenge—there are licensing and reimbursement issues that are beyond our expertise. But we are coordinating with the Department of HHS, the VA, state and local entities, and private providers. And I hope that the Connected Care Pilot Program will help us obtain data that will allow policymakers to chip away at some of the broader set of barriers to telemedicine adoption.

From chronic disease management to pediatric cardiology, from PTSD to opioid dependency, this pilot has the potential to make a real difference for low-income individuals that currently lack access to quality health care. So I look forward to continuing to work with my colleagues at the FCC and all stakeholders as we work to stand up this program.

Finally, I want to thank the Wireline Competition Bureau for their work, especially Allison Baker, Rashann Duvall, Lauren Garry, Jodie Griffin, Trent Harkrader, Nicholas Page, Ryan Palmer, Joseph Schlingbaum, and Niki Wasserman, as well as the Office of General Counsel and the Office of Economics and Analytics for their significant contributions on the Notice we are voting on today.