

**STATEMENT OF
COMMISSIONER JESSICA ROSENWORCEL,
APPROVING IN PART, DISSENTING IN PART**

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

I have seen rural clinics in Montana that use their connectivity to exchange electronic medical records on both sides of the continental divide. I have watched as pediatric surgeons in California share their expertise via video with patients many miles away. I have witnessed village clinics in rural Alaska use broadband to provide first-class care to patients in some of this country's most remote communities. These experiences amaze because they can challenge our traditional notions of healthcare. They make clear that telemedicine can collapse distance and time and enhance the quality of care while also improving outcomes and lowering costs.

This is why the Rural Health Care Program is so important. It uses the power of communications to bridge vast distances and help bring care to places where it is most needed. Of course, when this program got its start two decades ago, neither communications nor medicine looked much like they do today. Virtual reality, prescription vending machines controlled by doctors at a distance, and electronic health records were the stuff of science fiction. But today, they've become standard medical training and practice.

So a year and a half ago, the Federal Communications Commission embarked on an effort to update this program. Along the way, we raised the program cap to keep up with new demand. Today, the agency finishes that update. We make improvements to program administration. For instance, we codify a gift rule to guard against graft. We also clarify program procedures, provide additional time for applicants to conduct competitive bidding, extend service delivery deadlines, and make program data more accessible. These are smart changes. They have my support.

But in other respects, this decision falls short. It puts in place a new funding scheme for the Telecommunications Program that has never been tested, modeled, or assessed for its impact on the rural health facilities that rely on the program today. This creates a truckload of uncertainty for rural America. That's not fair, so on this aspect of the decision, I dissent.

The Telecommunications Program is the very first program the FCC developed for rural healthcare support. The demand for its resources now makes up about half of the more than \$500 million provided in assistance annually under the entire Rural Health Care Program. It is the program relied on by the most rural and remote healthcare facilities in this country. By statute, the agency provides support to rural healthcare providers for the difference between the rates they are charged and those for comparable services in urban areas. Over the years, as a result of policy changes and advancements in technology, it has become more difficult to perform this calculation.

In response, today the FCC creates a new funding regime based on the median rates for services in a mix of rural and urban areas in each state. This is complex, so it is hard to unpack the consequences. But for starters, limiting support based on median rates could very easily cut off the most far-flung health facilities in remote locations that depend on these funds for operation. Plus, the map the FCC offered to explain its tiers for rural rates is not all illuminating. It offers no detail, is not searchable and it originally omitted one state entirely. On top of this, late last night, the agency added another tier to its mix of state urban and rural areas, making it even harder to understand the real consequences on the ground.

I think a data-driven agency should offer some data about the impact of these changes. I think we should model how it will change the support this program provides to health care operations in some of our most remote areas. We have not done so. Because there is no model, we don't know how this will reduce the support available to some rural communities. Without a model, we don't know how these changes could cut off rural health care in Alaska, Texas, Wisconsin, Mississippi, North Dakota and many more places. Furthermore, I am concerned about the extent to which this agency puts this new regime in the hands of our program administrator.

It would be cruel if as a result of our tinkering in Washington we shutter health care operations in some of our most remote communities. It didn't have to be like this. There was a way to fix these problems. There was a way to address this uncertainty. These portions of today's order should be put out for rulemaking and comment. This would give us time to model the impact of these changes before unleashing consequences on the patients who rely on this program for basic healthcare. It would give us time to get it right. This is why a bipartisan group of 15 Senators—Senators Wyden, Hoeven, Udall, Cornyn, Capito, Baldwin, Brown, Murkowski, Cramer, Bennet, King, Heinrich, Manchin, Collins, and Sullivan—urged us to fix this situation before any healthcare facilities are forced to close in rural areas. But I regret that is not what we do today.