STATEMENT OF
COMMISSIONER BRENDAN CARR

Re: *Promoting Telehealth for Low Income Americans*, WC Docket No. 18-213; *COVID-19 Telehealth Program*, WC Docket No. 20-89.

Since joining the Commission, I have spent a lot of time outside of D.C. I can think of no better way to inform the work we do here at the FCC than to hear directly from the Americans we serve in their own communities. Few trips have made as much of an impression on me as the time I spent in Mississippi with Senator Wicker

On one of those trips, I visited the Mississippi Delta, which sits in the northwest corner of the Magnolia State. It's a part of the country with a deep and rich history. And it is not exempt from the many healthcare challenges that Americans face in communities around the country. Take Ruleville, Mississippi which sees diabetes rates about twice the national average. It also has among some of the highest poverty rates in the country, only adding to the difficulty in finding adequate health care.

In Ruleville I met Miss Annie, a patient at the North Sunflower Medical Center. One day, Miss Annie suddenly woke up with blurred vision, and after seeing her doctor found out she had advanced diabetes. She tried treating it through traditional methods of care, but didn't see much progress. She then signed up for a ground-breaking telehealth program being run in conjunction with the University of Mississippi Medical Center. She was sent home with a tablet and a wireless-powered blood glucose monitor. Every morning her tablet chimes as a reminder, Miss Annie pricks her finger, and her tablet then displays her glucose number, which is then reported back via a wireless connection to her doctors. Based on that reading, an app on the tablet suggests appropriate actions—from a particular food or exercise, to watching a relevant video. If she forgets, she gets a call from a nurse. With this technology, her A1C levels have gone down, and Miss Annie says she's never felt better

As I've traveled around the country, I've seen just how widely these connected care and remote patient monitoring applications can be used to treat a variety of conditions. These tools help bring medical care directly to patients, no matter where they are. It's the health care equivalent of moving from Blockbuster to Netflix. Patients in rural regions often have to drive hours to see doctors at a major medical center, increasing the costs in both dollars and time—and making it less likely that they will diligently follow through on their treatment.

When I was in Laurel Fork, Virginia, which sits near the heart of Appalachia, I met a woman named Cathleen who told me that she struggled for years with uncontrolled diabetes. She had been diagnosed five years before, 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, her doctor signed her up for remote patient monitoring technologies similar to the ones that had been used by Miss Annie. Through those connected devices, Cathleen's vitals were monitored daily and checked by a team of endocrinologists and specialists at the Laurel Fork community health center and the University of Virginia. After six months her A1C dropped to 7.5, and she has enough energy to run and play with her three grandkids.

Connected Care is not just for treating chronic diseases like diabetes. At the UVA Children's Hospital, Dr. Karen Rheuban told me about their pediatric cardiology program, which brings high-tech care to the home. With a connected tablet and a Locus Health app, daily weight, heart rate, and oxygen levels can be tracked remotely, which decreases the need for high-risk pediatric patients to undergo ICU stays and invasive procedures. From diabetes, to heart disease, pulmonary disorders, mental health, high-risk pregnancy, and even pandemic response, Connected Care opens new opportunities for patients to get better results with less expense and hassle.

For years, the FCC has focused its telehealth work on funding high-speed connections to brick and mortar facilities. While that important work continues, I thought it was important that the FCC start a proceeding that supports this new trend in telehealth towards connected care everywhere. I am grateful that Chairman Pai asked me to lead this FCC initiative and for his strong commitment to this work. Notably, we are focusing this $100 million pilot on low-income Americans and veterans. This is important because as next-generation care rolls out across the country, this Pilot can play a role in helping to ensure every American has a fair shot at these potentially life-changing and life-saving technologies.

We also move forward today mindful of the coronavirus that is now spreading across the country. It has placed America in uncharted territory. It has disrupted our daily lives. It has cost many of our fellow countrymen their jobs and income. And it threatens to overwhelm our health care system. That's why we're also immediately establishing a COVID-19 Emergency Telehealth Support Program that will fast-track $200 million in support toward the use of connected care technologies to treat COVID-19 patients or to free up space and resources in health care facilities for COVID-19 patients.

The COVID-19 Emergency Telehealth Support Program and Connected Care Pilot are linked. We were able to move so quickly on the COVID-19 Program—acting just days after the CARES Act was signed into law providing the $200 million in funding for that program—because of the work we have been doing at the FCC over the past two years on the Connected Care Pilot. The rulemaking record we developed in the Connected Care Pilot proceeding provides the vehicle that now enables us to enact the COVID-19 Program. Without the Connected Care Pilot, we would not have been able to adopt the COVID-19 Program today. That would have needlessly delayed the positive impact that this funding will play in quickly supporting our health care heroes in their work to combat the coronavirus. So I am glad that our prior legwork is paying off today.

I am also pleased that we are moving forward now with the Connected Care Pilot for another reason. This $100 million program can make a real difference on its own in supporting care for low-income Americans and veterans. Putting off the day that these funds can start supporting quality and affordable care, when the need remains so great, would not have been the right call. And the ideas we adopt in this portion of our decision are familiar ones—having been vetted through both a Notice of Inquiry and Notice of Proposed Rulemaking process.

Both programs also rest squarely within the FCC's legal authority. With respect to the Connected Care Pilot, in particular, Section 254(h)(2)(A) of the Communications Act expressly directs the Commission to "establish competitively neutral rules[ ] to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for all public and nonprofit . . . health care providers." As the Order explains, the specific services and network equipment funded under the Connected Care Pilot Program are within the scope of our statutory directive under section 254(h)(2)(A) to enhance eligible health care providers' access to advanced telecommunications and information services. Indeed, the FCC previously relied on this grant of authority when it established an earlier telehealth pilot program.

Given the scope of our authority here, the Connected Care Pilot Program will support a variety of health care providers in their experiments to build on the successes we've already seen in improving patient outcomes, while lowering costs. For instance, the Veterans Health Administration's remote patient monitoring program resulted in a 25% reduction in days of inpatient care and a 19% reduction in hospital admission for more than 43,000 veterans. It also cost $1,600 per patient compared to more than $13,000 per patient for VHA's home-based primary services. Another remote patient monitoring initiative showed a 46% reduction in ER visits, a 53% reduction in hospital admissions, and a 25% shorter length of stay. Analysts estimate that the widespread use of remote patient technology and virtual doctor visits could save the American health care system $305 billion annually. I am very excited to see these results replicated throughout the country, so all Americans can reap the benefits.

I want to thank Chairman Pai for fast-tracking the FCC's consideration of this initiative and my FCC colleagues for moving quickly to vote on this important decision. While the two programs have much in common, they also different in a few respects. For example, we are able to fund connected

devices in the COVID-19 program given the specific language in the CARES Act, while the $100 million Connected Care initiative does not provide funding for them. The Order itself lays out additional differences.

In standing up today's decision, we have engaged with other expert agencies, including the Department of Health and Human Services and the Department of Veteran Affairs. The Order before us today benefited greatly from the ideas and perspectives shared by health care experts in those agencies.

I also want to extend my gratitude to the FCC team that worked so hard on this Order both in the past few days and weeks, but also over the past two years that allowed us to reach this decision today.

Thank you to Allison Baker, Regina Brown, Rashann Duvall, Darren Fernandez, Trent Harkrader, Kris Monteith, Ryan Palmer, Joseph Schlingbaum, and Hayley Steffen in the Wireline Competition Bureau; Malena Barzilai, Michael Carlson, Thomas Johnson, Andrea Kelly, Richard Mallen, and Linda Oliver in the Office of General Counsel; Octavian Carare, Stacey Jordan, Giulia McHenry, Eric Ralph, Steven Rosenberg, Emily Talaga, and Tracy Waldon in the Office of Economics and Analytics; Deena Shetler and Cara Voth in the Office of the Managing Director; and Dr. David Ahern, Ben Bartolome, Michele Ellison, Dr. Chris Gibbons, and Karen Onyeije on the Connect2Health Task Force.

I look forward to working with health care providers that want to apply for funding under these initiatives and seeing the positive impact that will be made.