

Before the
Federal Communications Commission
Washington, D.C. 20554

In the Matter of)
)
COVID-19 Telehealth Program) WC Docket No. 20-89
)
Promoting Telehealth for Low-Income Consumers) WC Docket No. 18-213

REPORT AND ORDER AND ORDER ON RECONSIDERATION

Adopted: March 29, 2021

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By the Commission: Acting Chairwoman Rosenworcel and Commissioners Carr and Starks issuing separate statements.

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I. INTRODUCTION

1. In this Report and Order, we build upon the success of the Commission’s Coronavirus Disease 2019 (COVID-19) Telehealth Program (Program), established pursuant to the Coronavirus Aid, Relief, and Economic Security (CARES) Act. We adopt additional requirements and processes to further

fund telehealth and connected care services as required by Congress in the Consolidated Appropriations Act, 2021 (Consolidated Appropriations Act).¹ Over the course of the last year, in response to the COVID-19 pandemic, people across the country have migrated more aspects of their daily lives online, including health care visits and treatment, to slow the spread of the COVID-19 virus.² As a result, the use of telehealth has exploded and has become an increasingly vital tool for health care providers, enabling them to minimize the risk of exposure to COVID-19 while still providing patient care.³

2. On April 2, 2020, the Commission established the Program to administer \$200 million in funding appropriated by Congress in the CARES Act.⁴ Congress directed the Commission “to support efforts of health care providers to address coronavirus by providing telecommunications services, information services, and devices necessary to enable the provision of telehealth services” during the COVID-19 pandemic.⁵ For this initial round of funding (Round 1), the Commission geared the Program toward providing immediate assistance to eligible health care providers to provide telehealth and connected care services to patients at their homes or mobile locations.⁶ The Commission directed the Wireline Competition Bureau (Bureau) to evaluate applications on a rolling basis and to prioritize applications that targeted the areas hit hardest by COVID-19 and where the Program’s support would have the most impact on addressing health care needs.⁷ The Commission fully obligated the \$200 million by issuing awards for 539 applications from April 16, 2020 through July 8, 2020.⁸

¹ Consolidated Appropriations Act, 2021, Pub. L. No: 116-260, Division N-Additional Coronavirus Response and Relief, Title IX-Broadband Internet Access Service, § 903 “FCC COVID-19 Telehealth Program” (2020), available at <https://www.congress.gov/bill/116th-congress/house-bill/133/text> (Consolidated Appropriations Act); Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No 116-136, 134 Stat. 281 (2020) (CARES Act).

² The coronavirus COVID-19 pandemic is an outbreak of a respiratory illness that has spread throughout the United States. See Centers for Disease Control and Prevention, *COVID-19*, <https://www.cdc.gov/coronavirus/2019-ncov/index.html> (last visited Mar. 1, 2021).

³ See Centers for Disease Control and Prevention, *Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic*, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html> (last updated June 10, 2020); Lola Fadulu, *MedStar Health Reaches 500,000 Telehealth Visits During Pandemic*, Wash. Post (Nov. 2, 2020), https://www.washingtonpost.com/local/medstar-online-visits/2020/11/02/429e7672-1aed-11eb-bb35-2dcfdab0a345_story.html; Koonin LM, Hoots B, Tsang CA, et al., *Trends in the Use of Telehealth During the Emergence of the COVID-19 Pandemic — United States, January–March 2020*, Morbidity and Mortality Weekly Report, vol. 69, no. 8, 1595–1599 (Oct. 30, 2020), <http://dx.doi.org/10.15585/mmwr.mm6943a3> (finding by the weekly reporting series of the CDC that “telehealth encounters sharply increase[ed] in late March 2020” and telehealth “can serve an important role in pandemic planning and response.”).

⁴ *Promoting Telehealth for Low-Income Consumers; COVID-19 Telehealth Program*, WC Docket Nos. 18-213, 20-89, Report and Order, 35 FCC Rcd 3366 (2020) (*First COVID-19 Report and Order*).

⁵ CARES Act, 134 Stat. at 531.

⁶ *First COVID-19 Report and Order*, 35 FCC Rcd at 3375, para. 13. When the Commission established the COVID-19 Telehealth Program to target the immediate needs of health care providers during the COVID-19 pandemic, the Commission also created the Connected Care Pilot Program. The Pilot Program is designed to provide a longer-term study on how the Commission can best support the deployment of connected care services through the Universal Service Fund, particularly for low-income Americans and veterans. *First COVID-19 Report and Order*, 35 FCC Rcd at 3368-69, paras. 5-6.

⁷ *First COVID-19 Report and Order*, 35 FCC Rcd at 3381, para. 28.

⁸ Press Release, FCC, FCC Approves Final Set of COVID-19 Telehealth Program Applications (July 8, 2020), <https://www.fcc.gov/document/fcc-approves-final-set-covid-19-telehealth-program-applications>. As of March 16, 2021, the FCC has disbursed approximately \$150.8 million to awardees. The invoicing deadline for the first round of funding is set for July 31, 2021. *Wireline Competition Bureau and Office of the Managing Director set July 31, 2021 Invoicing Deadline for Covid-19 Telehealth Program and Provide Post-Program Guidance*, Public Notice, 35 FCC Rcd 14628 (WCB 2020).

3. Subsequently, in December 2020, as part of the Consolidated Appropriations Act,⁹ Congress appropriated \$249.95 million in additional funding for the Program.¹⁰ In January 2021, as required by the Consolidated Appropriations Act, the Bureau sought comment on application evaluation metrics to ensure the equitable distribution of these additional funds, including proposing and seeking comment on improvements to the initial application process.¹¹ Then, in February 2021, the Commission adopted a Report and Order expanding the responsibilities of the Universal Service Administration Company (USAC) to include the administration of the COVID-19 Telehealth Program.¹² Today, we establish requirements, processes, and procedures for the second round of Program funding appropriated under the Consolidated Appropriations Act (Round 2). We direct USAC to administer the Program and the Bureau and the Office of Managing Director (OMD) to provide oversight over USAC's activities consistent with this Report and Order.

II. BACKGROUND

4. Telehealth refers to a “broad range of health care-related applications that depend upon broadband connectivity,” and can include, “telemedicine; exchange of electronic health records; collection of data through Health Information Exchanges and other entities; exchange of large image files (e.g., X-ray, MRIs, and CAT scans); and the use of real-time and delayed video conferencing for a wide range of telemedicine, consultation, training, and other health care purposes.”¹³ The Commission has previously observed that health care providers use telehealth to respond to health challenges as varied as diabetes, pediatric heart disease, opioid dependency, strokes, high-risk pregnancies, cancer, and mental health treatment,¹⁴ and to provide such benefits as specialist consultations¹⁵ and ongoing patient monitoring.¹⁶ In addition to improving health outcomes for patients, telehealth technologies have the potential to significantly reduce health care costs.¹⁷ In the *First COVID-19 Report and Order*, the Commission defined “connected care services” as a subset of telehealth that “uses broadband Internet access service-enabled technologies to deliver remote medical, diagnostic, patient-centered, and treatment-related services directly to patients outside of traditional brick and mortar medical facilities—

⁹ See Consolidated Appropriations Act § 903.

¹⁰ *Id.* Section 903(b), *Additional Appropriation*, provides as follows: “Out of amounts in the Treasury not otherwise appropriated, there is appropriated \$249,950,000 in additional funds for the COVID-19 Telehealth Program, of which \$50,000 shall be transferred by the Commission to the Inspector General of the Commission for oversight of the COVID-19 Telehealth Program.” Section 903(a)(3), in turn, defines the term “COVID-19 Telehealth Program” to mean “the COVID-19 Telehealth Program established by the Commission under the authority provided under the heading ‘SALARIES AND EXPENSES’ under the heading ‘FEDERAL COMMUNICATIONS COMMISSION’ under the heading ‘INDEPENDENT AGENCIES’ in title V of Division B of the CARES Act (Public Law 116-136; 134 Stat. 531).” (case formatting in the statute).

¹¹ *Wireline Competition Bureau Seeks Comment on COVID-19 Telehealth Program Application Evaluation Metrics*, WC Docket No. 20-89, Public Notice, DA 21-14 (WCB Jan. 6, 2021) (*January 6th Public Notice*).

¹² *COVID-19 Telehealth Program*, WC Docket No. 20-89, Report and Order, FCC 21-24 (Feb. 2, 2021) (*USAC Delegation Order*).

¹³ *First COVID-19 Report and Order*, 35 FCC Rcd at 3385, para. 39 (defining “telehealth” for the purpose of the Connected Care Pilot Program). This definition does not preclude health care providers from using telecommunications services to provide telehealth in response to COVID-19, as telecommunications services are eligible for funding for Round 2 of the Program.

¹⁴ See *Promoting Telehealth for Low-Income Consumers*, WC Docket No. 18-213, Notice of Inquiry, 33 FCC Rcd 7825, 7825-26, para. 1 (2018) (*Connected Care Notice of Inquiry*).

¹⁵ See *Connected Care Notice of Inquiry*, 33 FCC Rcd at 7826, para. 3.

¹⁶ See *id.* at 7827-28, paras. 4-5.

¹⁷ *Id.* at 7829, paras. 7-8.

including specifically to patients at their mobile location or residence.”¹⁸ While the use of telehealth and connected care services are not new methods of providing health care,¹⁹ the deployment of these services has accelerated in response to the transmission risks of the coronavirus.²⁰

5. The first reported cases of COVID-19 were identified in the United States over one year ago.²¹ While development and distribution of effective vaccines has provided hope,²² a quick emergence from the spread of the virus is not a certainty and the needs of the health care community are still great.²³ As Congress recognized in the Consolidated Appropriations Act, providing health care providers the funds they need to deploy telehealth solutions for their patients thus remains as important as ever during this public emergency.²⁴

6. On December 27, 2020, the Consolidated Appropriations Act was signed into law, providing an additional \$249.95 million to the Commission to support the COVID-19 Telehealth Program.²⁵ This additional funding will allow the Commission to continue its efforts to expand telehealth and connected care services throughout the country and enable patients to access necessary health care services while helping slow the spread of the disease. In addition to appropriating \$249.95 million in new funds for the Program, the Consolidated Appropriations Act requires the Commission to consider several changes to the Program and to make several others. First, it directs the Commission to seek comment on the “metrics the Commission should use to evaluate applications for funding” and “how the Commission

¹⁸ *First COVID-19 Report and Order*, 35 FCC Rcd at 3375, para. 14.

¹⁹ *See Connected Care Notice of Inquiry*, 33 FCC Rcd at 7825-26, paras. 1-3.

²⁰ *See Centers for Disease Control and Prevention, Using Telehealth to Expand Access to Essential Health Services during the COVID-19 Pandemic*, <https://www.cdc.gov/coronavirus/2019-ncov/hcp/telehealth.html> (last updated June 10, 2020).

²¹ *See, e.g., Anna Boiko-Weyrauch, Ahead of 1 Year Mark, Remembering 1st U.S. Confirmed Case of COVID-19*, NPR (Jan. 19, 2021), <https://www.npr.org/2021/01/19/958253143/remembering-1st-u-s-confirmed-case-of-covid-19>; Sarah Nelson, *State Health Leaders Mark One Year Since First COVID-19 Case*, Indianapolis Star (Mar. 3, 2021), <https://www.indystar.com/story/news/health/2021/03/03/one-year-since-first-covid-19-case-indiana/6908543002/>; Elise Takahama, *One Year After Seeing First COVID-19 Death, Washington Expected to Surpass 5,000 This Week*, Seattle Times (Feb. 28, 2021), <https://www.seattletimes.com/seattle-news/health/one-year-after-seeing-first-covid-19-death-washington-expected-to-surpass-5000-this-week/>.

²² *See Centers for Disease Control and Prevention, Different COVID-19 Vaccines*, <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines.html> (last updated Mar. 3, 2021); *see also Centers for Disease Control and Prevention, Understanding How COVID-19 Vaccines Work*, <https://www.cdc.gov/coronavirus/2019-ncov/vaccines/different-vaccines/how-they-work.html> (last updated Jan. 13, 2021).

²³ *See Kathryn Watson and Audrey McNamara, Biden Says U.S. Will Have Enough COVID Vaccine Supply for All Adults by End of May*, CBS News (Mar. 2, 2021), <https://www.cbsnews.com/news/biden-covid-19-pandemic-statement-watch-live-stream-today-2021-03-02/> (reporting that President Biden announced that the U.S. will have enough vaccine supply for all adults by the end of May but that the COVID-19 pandemic could last until Spring 2022); Noah Higgins-Dunn, *Covid Variants Could ‘Undermine All of Our Efforts’ If Virus Spreads Globally*, CDC director says, CNBC (Feb. 24, 2021), <https://www.cnbc.com/2021/02/24/cdc-director-covid-variants-could-undermine-all-of-our-efforts.html>.

²⁴ Relatedly, on February 25, 2021, the Commission established the Emergency Broadband Benefit Program to provide discounted broadband services and devices to low-income households, helping them stay connected during the COVID-19 pandemic. *Emergency Broadband Benefit Program*, WC Docket No. 20-445, Report and Order, FCC 21-29 (Feb. 26, 2021).

²⁵ *See e.g., Steve Holland & Susan Cornwell, Trump Signs Pandemic Aid and Spending Bill, Averting Government Shutdown*, Reuters (Dec. 27, 2020), <https://www.reuters.com/article/us-usa-trump/trump-signs-pandemic-aid-and-spending-bill-averting-government-shutdown-idINKBN2910NA?edition-redirect=in>; Consolidated Appropriations Act § 903.

should treat applications filed during the funding rounds for awards from the [Program] using amounts appropriated under the CARES Act²⁶ Second, it instructs the Commission, to the extent feasible, to ensure that at least one applicant from all 50 states and the District of Columbia is awarded funds during either of the Program’s funding rounds.²⁷ Third, the Consolidated Appropriations Act directs the Commission to allow applicants from Round 1 the opportunity to update or amend their applications.²⁸ Fourth, it directs the Commission, to the extent feasible, to provide applicants, upon request, information on the status of their application and a rationale for the final funding decision.²⁹ And finally, it requires that the Commission “issue notice to the applicant of the intent of the Commission to deny the application and the grounds for that decision” and “provide the applicant with 10 days to submit any supplementary information that the applicant determines relevant,” which must be taken into account for the final funding decisions.³⁰

7. On January 6, 2021, the Bureau released a Public Notice that sought comment, as required by the Consolidated Appropriations Act, on improvements to the Program and lessons learned from Round 1.³¹ The Bureau first sought comment on which evaluation metrics to use during Round 2,³² and whether the Commission should continue to target funding to areas that were “hardest hit” by COVID-19 and where applicants were working under pre-existing strain.³³ The Bureau also asked whether the Commission should maintain the \$1 million cap per applicant on funding awards³⁴ and proposed establishing an application filing window rather than continuing to accept and evaluate applications on a rolling basis.³⁵ Next, the Bureau sought comment on how the Commission should treat

²⁶ Consolidated Appropriations Act § 903(c)(1).

²⁷ *See id.* at § 903(c)(2).

²⁸ *See id.* at § 903(c)(3).

²⁹ *Id.* at § 903(c)(4).

³⁰ *Id.* at § 903(c)(5).

³¹ *See January 6th Public Notice.* In the *First COVID-19 Report and Order*, the Commission determined that additional notice and comment was not necessary for two independent reasons: additional notice and comment procedures would be impracticable and contrary to the public interest under the Administrative Procedure Act’s “good cause” exception, and all or nearly all of the COVID-19 Telehealth Program was a logical outgrowth of the agency’s *Connected Care Notice*. *See First COVID-19 Report and Order*, 35 FCC Rcd at 3383, paras. 35-36 (citing, *inter alia*, 5 U.S.C. 553(b)). We reach a similar determination here. First, we find that our decision today is a logical outgrowth of the *Connected Care Notice*. Indeed, our decision constitutes a second round of the very same program for which the FCC properly proceeded to an order in April 2020. Second, we also find that the APA’s good cause exception to notice and comment is satisfied. In reaching this conclusion, we note that the Consolidated Appropriations Act specified that the Commission “shall issue a Public Notice seeking comment within ten days of enactment.” Consolidated Appropriations Act § 903(c)(1)(A). The Commission satisfied this directive when it sought comment through a Bureau-level Public Notice in January 2021. In any event, we find that there was good cause to seek comment through a Bureau-level Public Notice because of the unprecedented nature of this pandemic and the need for immediate action, and the fact that issuing a Commission-level Public Notice would have necessitated a delay in committing funds to providers who are addressing the COVID-19 pandemic. Indeed, issuing a Notice of Proposed Rulemaking in these circumstances would be unnecessary and therefore not required under the “good cause” exception of section 553(b)(B). *See* 5 U.S.C. § 553(b)(B) (permitting deviation from formal rulemaking procedures where the agency “for good cause” finds that they are “impracticable, unnecessary, or contrary to the public interest.”).

³² *See January 6th Public Notice* at 3-4, paras. 6-11.

³³ *Id.* at 3-4, paras. 7-8.

³⁴ *Id.* at 4, para. 9.

³⁵ *Id.* at 4, para. 12.

remaining, unfunded applications from Round 1,³⁶ and proposed requiring Round 1 applicants to update and resubmit their applications to be considered for Round 2. The Bureau further sought comment on additional improvements to the Program and proposed using USAC to assist in administering the remaining work necessary to complete Round 1,³⁷ as well as Round 2 application review, invoice review, and outreach.³⁸ Finally, the Bureau requested comment on how to improve the eligibility review processes for Round 2, both with respect to the eligibility of health care provider applicants and their requests for services and connected devices.³⁹

8. On February 2, 2020, the Commission acted on the *January 6th Public Notice* and decided to use USAC to administer the remainder of Round 1 and to administer all of Round 2 of the Program.⁴⁰ As with its role in administering the Universal Service Fund (USF) Programs, USAC will be limited to program administration and will not have the authority to make policy decisions.⁴¹

III. DISCUSSION

9. In this Report and Order, we adopt changes to the Program to implement the Consolidated Appropriations Act's requirements, improve the administration of the Program, and to establish the process by which USAC, with oversight from the Bureau, will award the additional appropriated funds to eligible health care providers. First, we establish an application filing window to provide a level playing field to all applicants, regardless of size or resource level. Second, we explain the application filing process for Round 2, including the process used to determine an applicant's eligibility. Third, we detail the application evaluation process, including the specific metrics USAC will use to prioritize and evaluate the Round 2 applications and provide additional information on the process to confirm the eligibility of requested items. Fourth, we explain the funding commitment process. Last, we direct USAC to conduct educational outreach efforts to explain the application process for Round 2, and to use the same reimbursement structure for Round 2 of the Program that was used for Round 1.

10. Through this Report and Order, we take steps to improve the COVID-19 Telehealth Program in accordance with Congressional guidance while building upon the lessons learned during Round 1. We modify some Program requirements but keep unchanged many others, including requirements regarding the eligibility of health care providers,⁴² funding limitations,⁴³ procurement,⁴⁴

³⁶ *Id.* at 5, paras. 14-17; Consolidated Appropriations Act § 903(c)(1)(A)(ii). The Consolidated Appropriations Act also requires the Commission to allow an applicant who filed an application during Round 1 “the opportunity to update or amend that application as necessary.” *Id.* § 903(c)(3).

³⁷ *January 6th Public Notice* at 6, para. 18.

³⁸ *Id.*

³⁹ *See id.* at 6-7, paras. 19-21.

⁴⁰ *See USAC Delegation Order; January 6th Public Notice* at 6, para. 18. On February 4, 2021, the Commission entered into an MOU with USAC in support of the Program. *See Memorandum of Understanding, FCC, https://www.fcc.gov/sites/default/files/fcc_usac_covid-19_telehealth_program_mou_02.04.2021.pdf* (last visited Mar. 24, 2021).

⁴¹ *USAC Delegation Order* at 3, para. 7.

⁴² *First COVID-19 Report and Order*, 35 FCC Rcd at 3378, para. 20 (limiting the program “to nonprofit and public eligible health care providers that fall within the categories of health care providers in section 254(h)(7)(B) of the 1996 Act: (1) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (2)”) We considered, but did not find persuasive, commenters’ arguments that we make additional types of health care providers eligible for COVID-19 Telehealth Program Support. *See infra* para. 21.

⁴³ *January 6th Public Notice* at 4, para. 9 (noting that in Round 1 the Commission “‘did not anticipate awarding more than \$1 million’ per applicant to ensure that as many applicants as possible receive funding” and seeking comment on maintaining the same approach for Round 2).

⁴⁴ *See First COVID-19 Report and Order*, 35 FCC Rcd at 3382, para. 31.

compliance audits,⁴⁵ and post-program feedback reports.⁴⁶ We caution applicants to carefully review the Program requirements and guidance. Applicants are ultimately responsible for compliance with Program requirements, including all deadlines and eligibility requirements.

A. Establishing an Application Filing Window

11. To facilitate a more efficient and equitable application review process, we first establish an application filing window after which USAC, with oversight from the Bureau, will review all applications from eligible applicants based on the pre-defined evaluation metrics we discuss in more detail below.⁴⁷ The Commission's *First COVID-19 Report and Order* established an application process for the first round of the COVID-19 Telehealth Program applicants that permitted applicants to file requests at any time after the start of the Program and required Commission staff to review, approve, and grant funding to applicants "as rapidly as possible on a *rolling basis* . . . until it ha[d] committed all COVID-19 Telehealth Program funding . . ."⁴⁸

12. During Round 1 of the Program, applications were submitted starting on April 13, 2020; the Bureau announced that it would no longer accept new applications on June 25, 2020.⁴⁹ At the same time, Commission staff reviewed and awarded funding on a rolling basis until all appropriated funding had been committed. While this process allowed funding to be committed immediately after the Program began, applications submitted later in the Program were not reviewed because the available funds had already been committed. There is also a concern that some smaller providers with more limited resources may have faced difficulties quickly completing their applications.⁵⁰ In the *January 6th Public Notice*, the Bureau proposed establishing an application filing window and awarding funding based on pre-defined evaluation metrics instead of reviewing applications and awarding funding on a rolling basis.⁵¹ Commenters overwhelmingly supported this approach,⁵² and we agree. Establishing a filing window is consistent with the plain language of the Consolidated Appropriations Act, is more equitable, and will allow USAC to review all applications before selecting the best-qualified applicants.

13. We also find that the Consolidated Appropriations Act effectively compels us to open a filing window that treats all applications received during the window as timely and requires the review in full of all such applications. Were we to accept applications on a rolling basis and commit funding once an application was received and reviewed, it would be impossible to compare all applications against each other and use an objective set of evaluation metrics. Instead, the earliest-filed applications that met a quality threshold would be awarded funding, while later-filed applications that scored higher based on a set of objective metrics could be denied the same funding.

14. The Consolidated Appropriations Act also directs the Commission to ensure that, to the extent feasible, at least one applicant in each state and the District of Columbia receives Program funding.⁵³ Adopting a filing window and objective evaluation metrics allows us to fulfill this statutory directive by comparing all applicants against each other, and committing funding to the top-scoring

⁴⁵ *Id.*

⁴⁶ *See id.* at 3383, para. 34.

⁴⁷ *See infra* Section III.C (Application Evaluation Process).

⁴⁸ *First COVID-19 Report and Order*, 35 FCC Rcd at 3377, para. 19 (emphasis added).

⁴⁹ *Wireline Competition Bureau Announces Close of Filing Window for COVID-19 Telehealth Program*, Public Notice, 35 FCC Rcd 6515 (WCB 2020).

⁵⁰ *See, e.g.*, SHLB Comments at 6.

⁵¹ *January 6th Public Notice* at 4, para. 12.

⁵² *See, e.g.*, USTelecom Comments at 2-3; UnityPoint Health Comments at 1-2.

⁵³ Consolidated Appropriations Act § 903(c)(2).

applicant in each state. It would not be possible to follow this statutory directive if we accepted applications on a rolling basis, as we would risk exhausting all funding before an acceptable application from a certain state was received. By adopting a filing window, we are able to ensure that funding will be committed to applicants in each state and territory, as we discuss in more detail below.⁵⁴

15. A filing window also enables us to more easily implement other new procedures required by Congress in Round 2. Congress provided that if the Commission intends to deny any Round 2 applications, it is required to issue notice to the applicant, provide the grounds for the denial, and give the applicant 10 days to submit any supplementary information.⁵⁵ Congress also instructed the Commission to provide, to the extent feasible, applicants with information about the status of their application and the rationale for a final funding decision.⁵⁶ If applications were accepted on a rolling basis, compliance with these statutory directives would not be feasible, as commitments would be awarded as soon as an application was approved and likely would be exhausted by the time unsuccessful applicants were able to supplement their applications. In short, awarding commitments on a rolling basis would completely undermine the requirement that we provide applications to be denied the ability to submit new information. Instead, we adopt an application filing window and a series of simple, transparent metrics to evaluate applications. This approach will allow all properly filed applications to be reviewed, and it will also allow for advance notice of an applicant's potential denial to be provided.

16. Commenters overwhelmingly supported a filing window. Commenters argued that accepting applications on a rolling basis disadvantaged smaller providers who lacked the resources to quickly complete applications,⁵⁷ and that awarding funding on a "first-come, first-served" basis meant that many applications would not be evaluated.⁵⁸ While a few commenters supported awarding Round 2 funding on a rolling basis because it would allow for funding to be awarded more quickly,⁵⁹ we believe the Consolidated Appropriations Act requires a funding window and also, based on our experience administering Round 1, all applications should be reviewed first, before funding decisions are made, to ensure that funding is awarded to the most deserving applicants. A filing window will therefore enable us to accomplish Congress's objectives. At the same time, and to address in part concerns about the ability to quickly commit funding, we establish an abbreviated application filing window of seven calendar days for Round 2 of the Program.⁶⁰

17. Given the short duration of the Round 2 application filing window, we direct the Bureau to publicly provide notice of the opening of the Round 2 application filing window at least two weeks before it opens. We believe this two-week notice period, along with outreach associated with the Program, will provide potential applicants enough time to ready applications for filing during the window. We also expect that the Round 2 application filing window will open within 30 days of release of this Report and Order. Accordingly, we direct the Bureau to issue a Public Notice announcing the

⁵⁴ See *infra* para. 47.

⁵⁵ Consolidated Appropriations Act § 903(c)(5)(A)-(C).

⁵⁶ *Id.* § 903(c)(4)(A)-(B).

⁵⁷ See, e.g., SHLB Comments at 6.

⁵⁸ See, e.g., Marana Health Comments at 1.

⁵⁹ See, e.g., *Id.*

⁶⁰ Commenters also requested additional guidance, including technical webinars, for Round 2 of the COVID-19 Telehealth Program. See, e.g., Hudson Headwaters Health Comments at 4. As we discuss in more detail below, see *infra* Section III.E (Round 2 Outreach), we instruct USAC to conduct outreach and education for a period of at least three weeks before the filing window opens to prepare potential applicants for the application filing window.

opening and closing dates for the Round 2 application filing window as soon as possible, consistent with the effective date of this Program.⁶¹

B. Application Filing Process

18. In the *January 6th Public Notice*, the Bureau sought comment on a number of application-related issues, including whether Round 1 applicants would be required to resubmit their applications for Round 2,⁶² whether Round 1 applicants that received funding awards (funding awardees) should be eligible to participate in Round 2,⁶³ and whether applicants should be required to complete the FCC Form 460.⁶⁴ As we discuss in more detail below, Round 1 applicants that did not receive funding during the initial round are required to submit a new application for Round 2; Round 1 funding awardees are eligible to apply for Round 2 of the Program, subject to a \$1 million cap per applicant for Round 2; and all Round 2 applicants without an approved eligibility determination through the FCC Form 460 process will be required to submit FCC Forms 460.

1. Round 1 Applicants' Eligibility

19. Congress made it clear that at least some applicants who had applied for funding in Round 1 were to be eligible for Round 2 of the Program,⁶⁵ and it instructed the Commission to seek comment on how to treat Round 1 applicants during Round 2.⁶⁶ To fulfill Congress's directives, the *January 6th Public Notice* sought comment on specific issues, and proposed requiring Round 1 applicants who wished to participate in Round 2 to update and resubmit their applications to be considered for Round 2 funding.⁶⁷ Commenters overwhelmingly supported the Bureau's proposal that Round 1 applicants should be able to update and resubmit their applications to receive Round 2 funding,⁶⁸ and we adopt this requirement. Many commenters agreed that applications filed during Round 1 contain stale, outdated information, and therefore require updating.⁶⁹ While some commenters suggested that it should be optional for Round 1 applicants to resubmit their applications,⁷⁰ and others suggested a more streamlined application or review process for Round 1 applicants,⁷¹ including a priority review process for such applications, we disagree with these suggestions. By requiring Round 1 applicants to resubmit their applications for Round 2, we can ensure that funding is not awarded based on outdated, incorrect information, and ensure equitable review of all Round 2 applications. Finally, as discussed later, Round 1

⁶¹ The rules for this Program will become effective upon Federal Register publication, and we expect that process to occur expeditiously after adoption of this Report and Order.

⁶² *January 6th Public Notice* at 5, para. 15.

⁶³ *Id.* at 4, 5, paras. 10, 17 (asking whether applicants from Round 1 that received \$1 million should be eligible to participate in Round 2 and whether Round 1 awardees who received their requested funding should be eligible to participate in Round 2).

⁶⁴ *Id.* at 6, para. 19.

⁶⁵ Consolidated Appropriations Act § 903(c)(3) (directing the Commission to allow applicants that filed an application during Round 1 of the Telehealth Program "the opportunity to update or amend that application as necessary").

⁶⁶ *Id.* § 903(c)(A)(ii) ("... the Commission will seek comments on- ... (ii) how the Commission should treat applications filed during the funding rounds for awards from the COVID-19 Telehealth Program using amounts appropriated under the CARES Act ..."); *see also January 6th Public Notice* at 2, para. 5.

⁶⁷ *January 6th Public Notice* at 5, paras. 15-16.

⁶⁸ *See, e.g., Parkview Health Comments* at 2.

⁶⁹ *See, e.g., Wexner Medical Comments* at 4; *Marana Health Comments* at 2.

⁷⁰ *See, e.g., Eagle View Comments (Express)*.

⁷¹ *See, e.g., Children's Hosp. Assoc. Comments (Express)*.

applicants that were not awarded funding will also receive an increase in points in Round 2 which are not available to other Round 2 applicants.⁷²

20. The *January 6th Public Notice* also specifically sought comment on whether Round 1 participants that were awarded \$1 million in Round 1 should be eligible to participate in Round 2,⁷³ and whether we should continue the approach of not awarding more than \$1 million per applicant.⁷⁴ We conclude that we will maintain our commitment to not award more than \$1 million total per applicant in Round 2 to distribute funding to more applicants. While the record was mixed on limiting support to \$1 million across both rounds,⁷⁵ we conclude that the limitation should only apply to Round 2. Thus, all eligible Round 2 applicants may qualify for the full commitment amount per application. We believe that many applicants, even those receiving Round 1 funding, continue to need program support given the passage of time between last year's commitments and Round 2, and that the application evaluation metrics we adopt below⁷⁶ will sufficiently ensure equitable, nationwide distribution of funding, and a blanket prohibition on applicants who received \$1 million in Round 1 could lead to providers who badly need funding being unable to receive it.

2. Eligibility and Application Requirements

a. Health Care Provider Eligibility

21. We will also continue to use the Rural Health Care (RHC) program's statutory categories to determine the eligibility of health care providers for Round 2 of the Program, including non-profit and public health care providers, as defined in section 254(h)(7)(B) of the Communications Act.⁷⁷ Accordingly, we direct USAC, with oversight from the Bureau and OMD, to only award funding to applications from eligible health care providers.⁷⁸ We remind health care providers interested in applying for Round 2 of the Program that for-profit entities are not eligible for funding.⁷⁹ The Program remains open to eligible health care providers regardless of whether they are located in a rural or non-rural location. Based on its extensive experience administering the RHC Program, the Commission concluded that instituting the same eligibility criteria for Round 1 would facilitate the administration of the COVID-19 Telehealth Program.⁸⁰ We find that this conclusion was correct.

⁷² See *infra* Section III.C.2 (Round 2 Evaluation Metrics).

⁷³ *January 6th Public Notice* at 4, para. 10.

⁷⁴ *Id.* at 6, para. 19.

⁷⁵ Compare Ochsner Health Comments at 9-12; Connected Health Initiative Comments at 5 (arguing against making providers who received \$1 million in Round 1 ineligible for round 2) with *e.g.*, CPCA Comments at 4; Wexner Medical Comments at 2 (arguing that the \$1 million cap should be applied across both rounds).

⁷⁶ See *infra* Section III.C.2 (Round 2 Evaluation Metrics).

⁷⁷ 47 U.S.C. § 254(h)(7)(B); see also *First COVID-19 Report and Order*, 35 FCC Rcd at 3378, para. 20 (citing 47 U.S.C. § 254(h)(7)(B)). The American Hospital Association filed a partial petition for reconsideration requesting that the Commission extend eligibility to "all types of hospitals and other direct patient care facilities, regardless of their size, location, or for-profit or non-profit status," Petition of the American Hospital Association for Partial Reconsideration at 1, WC Docket No. 20-89 (Apr. 9, 2020). We deny that petition here in an Order on Reconsideration.

⁷⁸ 47 U.S.C. § 254(h)(7)(B).

⁷⁹ With the limited exception of dedicated emergency departments of rural for-profit hospitals that participate in Medicare, which are also eligible to participate in the RHC program, and were therefore eligible for Round 1 funding. See *Rural Health Care Support Mechanism*, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 18 FCC Rcd 24546, 24553-54, para. 13 (2003).

⁸⁰ *First COVID-19 Report and Order*, 35 FCC Rcd at 3378, para. 20.

22. Several commenters recommended expanding the eligibility for Round 2 to include other health care providers, such as physician-office-based practices.⁸¹ We disagree. As we explain in more detail below,⁸² Program participation is limited to the providers enumerated in section 254(h)(7)(B) of the Communications Act to maintain consistent eligibility with Round 1 and to provide clarity to program participants. Keeping Program eligibility requirements the same across both Rounds will result in more efficient review of applications. Maintaining the same eligibility rules will also ensure that funding is targeted to health care providers that are likely to need it most to respond to this pandemic while allowing us to ensure that funding is used for its intended purposes.⁸³ Accordingly, Round 2 funding should only be provided to non-profit and public eligible health care providers that fall within the categories of health care providers⁸⁴ in section 254(h)(7)(B) of the Communications Act.⁸⁵

b. Round 2 Application Requirements

23. During Round 1, the Commission required any health care provider interested in participating in the Program that did not already have an eligibility determination for the RHC Program to file an FCC Form 460 to receive an eligibility determination and an HCP number for each site included on its application.⁸⁶ While we retain the previously adopted eligibility rules for applicants in Round 2, we modify the previous requirement that applicants obtain an eligibility determination for each site listed on its application by filling out an FCC Form 460 for each site. Instead, we will only require applicants to obtain an approved eligibility determination for the lead health care provider listed on the application.⁸⁷ Applicants requesting funding for multiple eligible health care provider sites in a single application do not need to receive eligibility determinations for every site that will receive funding during Round 2 of the Program, but instead will be required only to certify under penalty of perjury that all other health care sites that would receive Program funding are eligible for Program funding. Additionally, although applicants may still file their applications while their FCC Forms 460 are pending USAC's review, during Round 2 all applicants must have a health care provider number (HCP Number) assigned to them by USAC at the beginning of the FCC Form 460 application process before they can submit their application.⁸⁸ Health care providers submitting FCC Forms 460 in anticipation of participation in Round

⁸¹ See, e.g., TMA Comments at 1; Chamber of Commerce Comments at 1; JFNA Comments at 2-3; PAI Comments at 2.

⁸² See *infra* Section IV (Order on Reconsideration).

⁸³ *First COVID-19 Report and Order*, 35 FCC Rcd at 3378, para. 20.

⁸⁴ The statutory categories of health care providers include: (1) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (2) community health centers or health centers providing health care to migrants; (3) local health departments or agencies; (4) community mental health centers; (5) not-for-profit hospitals; (6) rural health clinics; (7) skilled nursing facilities; or (8) consortia of health care providers consisting of one or more entities falling into the first seven categories.

⁸⁵ For purposes of the COVID-19 Telehealth Program, which is authorized by the CARES Act, and not the 1996 Telecommunications Act, both rural and non-rural health clinics are eligible to receive funding. See FCC, *COVID-19 Telehealth Program Frequently Asked Questions*, Question 12, <https://www.fcc.gov/covid-19-telehealth-program-frequently-asked-questions-faqs> (last updated Dec. 2, 2020) (COVID-19 Telehealth Program FAQs).

⁸⁶ *First COVID-19 Report and Order*, 35 FCC Rcd at 3378, para. 22 & n.50; *Wireline Competition Bureau Provides Guidance on the COVID-19 Telehealth Application Process*, Public Notice, 35 FCC Rcd 3052, 3053 (WCB 2020) (2020 Application Public Notice).

⁸⁷ *First COVID-19 Report and Order*, 35 FCC Rcd at 3378-79, para. 22. We expect the lead health care provider site listed on each application to ensure that it has an approved eligibility determination from USAC. If it does not already have an approved eligibility determination, the lead health care provider should file an FCC Form 460 with USAC.

⁸⁸ *First COVID-19 Report and Order*, 35 FCC Rcd at 3378-79, para. 22.

2 of the Program should indicate on their FCC Forms 460 that they are applying for the COVID-19 Telehealth Program to expedite the review of their FCC Forms 460.

24. While requiring applicants to submit FCC Forms 460 for each site in their applications during Round 1 assisted with funding eligible locations, it also delayed review of many applications, particularly for applications with a large number of sites, each of which required its own eligibility determination.⁸⁹ This requirement also imposed a substantial burden on applicants with multiple sites. In the *January 6th Public Notice* we sought comment on ways to streamline the application process, including directing USAC to include eligibility review as part of the application process and potentially ending the requirement that applicants submit FCC Forms 460.⁹⁰ In conjunction with seeking comment on ending the requirement that applicants submit the FCC Form 460, we sought comment on other methods of determining an applicant's eligibility for the Program.⁹¹

25. After a careful review of the record, we retain the requirement that each new applicant submit an FCC Form 460.⁹² While some commenters argued that filing an FCC Form 460 is a burdensome and unnecessary process,⁹³ we conclude that the FCC Form 460 remains a necessary tool that will enable USAC to quickly and efficiently determine an applicant's eligibility, and we strongly encourage prospective applicants that have not already obtained an eligibility determination to file an FCC Form 460 as soon as possible.

26. We conclude that the FCC Form 460 remains necessary because the information contained on the form is essential for determining an applicant's eligibility for the Program. As a threshold matter, the FCC Form 460 was designed specifically to capture the relevant information to determine an applicant's eligibility for the RHC Program. Because the RHC Program and the COVID-19 Telehealth Program have nearly identical eligibility criteria, we believe that the FCC Form 460 is similarly essential for determining the eligibility of a Program applicant. The FCC Form 460 requires an applicant to provide its contact and location information, along with its basis for qualifying for the Program. All of this information is essential to determining an applicant's eligibility; requiring that information to be provided via some medium other than the FCC Form 460 would be less efficient than simply using the FCC Form 460, which was designed to make eligibility determination as efficient as possible for both applicants and reviewers.

27. We also conclude that requiring the lead applicant to submit an FCC Form 460 is an important Program safeguard because it allows for reviewers to ensure that only eligible health care providers receive funding. This conclusion is supported by our experience in Round 1 when many ineligible applicants filed the FCC Forms 460 and incorrectly certified their eligibility.⁹⁴ Ineligible applicants also contributed to the FCC Forms 460 processing backlog that many commenters noted.⁹⁵ We are confident that with more extensive outreach and education before the filing window opens, fewer ineligible applicants will submit the FCC Form 460. While some commenters suggested applicant certifications combined with post-disbursement audits would be sufficient to ensure program integrity,⁹⁶

⁸⁹ *January 6th Public Notice* at 6, para. 19.

⁹⁰ *January 6th Public Notice* at 6, para. 19.

⁹¹ *Id.*

⁹² We note that Round 1 applicants who submitted an FCC Form 460 and were deemed eligible do not need to submit a new Form; if any applicant's FCC Form 460 is no longer accurate, however, they must update the Form's information.

⁹³ *See, e.g., Parkview Health Comments* at 3.

⁹⁴ *January 6th Public Notice* at 5, para. 15.

⁹⁵ *See, e.g., USA Health Comments* at 1-2.

⁹⁶ *See, e.g., Parkview Health Comments* at 3.

we disagree. Even if disbursements to ineligible applicants were discovered during audits and the improper payments were recouped, this approach would still thwart Congress's clear intent of quickly distributing funding to the eligible health care providers who need it the most. Such a delay, in the midst of a pandemic, would harm the public interest. We conclude that eligibility reviews must be conducted before funds are awarded to make sure that funds go to those eligible providers who need them the most.

28. Our review of the record also convinces us that a better alternative to the FCC Form 460 is not available. Many commenters opined that filing the FCC Form 460 was an unnecessary burden, yet none identified an adequate alternative to verify an applicant's eligibility for purposes of this Program. While some commenters suggested using an applicant's Tax ID number or National Provider Identifier (NPI) number,⁹⁷ we do not believe that either identifier, standing alone, would be sufficient to determine an applicant's eligibility because an NPI number does not provide information needed to determine an applicant's Program eligibility, such as an applicant's non-profit status. Other commenters suggested using an applicant's HCP number.⁹⁸ We note that a health care provider that already has an HCP number and an approved eligibility determination, whether obtained from USAC for this Program or the RHC program after filling out an FCC Form 460, does not need to file an additional FCC Form 460 application. Additionally, we agree with those commenters who noted that Round 1 applicants are already familiar with the Program's application procedures, and new eligibility determination procedures for Round 2 would lead to confusion for applicants.⁹⁹

29. At the same time, we recognize that requiring a separate FCC Form 460 for each site in an application created a significant burden on both applicants and reviewers. To streamline application review for this round of the Program while still retaining the protections that the FCC Form 460 provides, we will no longer require applicants whose applications contain multiple sites to submit a separate FCC Form 460 for each site. Instead, applicants will only be required to submit the form for the application's lead health care provider. In instances where the applicant is not a health care provider, applicants are required to receive an eligibility determination for the lead health care provider. We conclude that requiring only one FCC Form 460 per applicant will significantly reduce the burdens on applicants and on reviewers.¹⁰⁰ This decision is similar to the approach used in the Rural Health Care Pilot Program, when we allowed applicants to submit only one FCC Form 465¹⁰¹ for all sites and briefly explain why each health care provider listed on an application was eligible for the program. At the time, we concluded that "[r]equiring the filing of a separate FCC Form 465 for each health care provider location would result in thousands of FCC Forms 465 being filed with USAC, creating a substantial administrative burden for both USAC and the selected participants. By contrast, in permitting selected participants to file a single FCC Form 465 per application with an attachment detailing all participating health care providers, the Commission intends to ease the administrative burden on both USAC and selected participants."¹⁰² After reviewing the record, we conclude that given the limited, emergency nature of the Program, similar administrative burden concerns justify the different eligibility determination approach that we adopt solely for purposes of the COVID-19 Telehealth Program.

30. To further expedite the FCC Form 460 review process, we expect health care providers undergoing the FCC Form 460 review process for Round 2 of the Program to respond to any questions

⁹⁷ See, e.g., USA Health Comments at 4.

⁹⁸ See, e.g., CT Children's Comments at 5.

⁹⁹ See Duke Health Comments at 4-5.

¹⁰⁰ See Marana Health Comments at 2; NACHC Comments at 1; Wexner Medical Comments at 4 (noting the burdens of filling out a separate Form 460 for each site in an application).

¹⁰¹ The FCC Form 465 was used to determine an applicant's eligibility before the FCC's Form 460 was created. See *Rural Healthcare Support Mechanism*, Report and Order, 27 FCC Rcd 16678, 16774, para. 214 (2012).

¹⁰² *Rural Health Care Support Mechanism*, Order, 22 FCC Rcd 20360, 20405-6, para. 86 & n.282 (2007).

from USAC about their FCC Form 460 on an accelerated timetable. Accordingly, we direct USAC to only require health care providers seeking eligibility determinations for Round 2 of the Program to respond to written information requests from USAC, such as requests for clarification about an applicant's responses on their FCC Form 460, within two business days. USAC can provide an extension of two additional business days upon request, but may deny an FCC Form 460 if the health care provider does not timely respond to written information requests. If an FCC Form 460 request is rejected because the applicant did not timely respond to these written information requests, the applicant may file a new FCC Form 460. We establish this deadline to set expectations for health care providers and to allow USAC to more quickly review and process the FCC Forms 460 filed in anticipation of Round 2 of the Program.

31. *Required Application Information.* To provide applicants with additional assistance, we attach, as Appendix C to this Order, an application process guidance document which sets forth the complete list of information that should be included in each application. Similar to the application requirements in Round 1, Round 2 applications must contain, at a minimum, the following information:

- The name, physical address, county, and the HCP number,¹⁰³ for the lead health care provider seeking funding from the COVID-19 Telehealth Program application.
- Contact information for the individual who will be responsible for the application (telephone number, mailing address, and email address), as well as the contact information for the project manager.
- A list of the telecommunications services, information services, or connected "devices necessary to enable the provision of telehealth services" requested, the cost for each service or connected device, and the total amount of funding requested.
- Supporting documentation for the costs indicated in the application, such as a vendor or service provider quote, invoice, or similar information.

32. *SAM Registration.* All entities that intend to apply to the Program must also register with the System for Award Management (SAM). SAM is a web-based, government-wide application that collects, validates, stores, and disseminates business information about the federal government's partners in support of federal awards, grants, and electronic payment processes. Registration in SAM provides the Commission with an authoritative source for information necessary to provide funding to applicants and to ensure accurate reporting pursuant to the Federal Funding Accountability and Transparency Act of 2006, as amended by the Digital Accountability and Transparency Act of 2014 (collectively the Transparency Act or FFATA/DATA Act).¹⁰⁴ Only those entities registered in SAM will be able to receive reimbursement from the Program. Potential applicants that are already registered with SAM do not need to re-register with that system. Active SAM registration, however, is required for an awardee to receive a payment from the Treasury.¹⁰⁵ Furthermore, Program awardees may be subject to further FFATA/DATA Act reporting requirements to the extent that awardees subaward the payments they

¹⁰³ USAC assigns a health care provider number when an applicant files an FCC Form 460. As discussed in more detail below, an HCP number, and approved eligibility determination, is only required for an application's lead health care provider site.

¹⁰⁴ Pub. L. No. 109-282, 120 Stat. 1186 (2006) and Pub. L. No. 113-101, 128 Stat. 114 (2014), codified at 31 U.S.C. § 6101 note. In August 2020, the Office of Management and Budget updated the rules governing compliance with the Transparency Act as part of wider ranging revisions to title 2 of the Code of Federal Regulations. 85 FR 49506 (published Aug. 13, 2020) (including revisions to 2 CFR Parts 25, 170, 183, and 200). OMB explained that the SAM registration requirements were expanded "beyond grants and cooperative agreements to include other types of financial assistance" to ensure compliance with FFATA. 85 Fed. Reg. 49506, 49517.

¹⁰⁵ To register with the system, go to <https://www.sam.gov/SAM/> and provide the requested information.

receive from the Program, as defined by FFATA/DATA Act regulations. Awardees may be required to submit data on those subawards.¹⁰⁶

33. *Do Not Pay*. Pursuant to the requirements of the Payment Integrity Information Act of 2019 (PIIA), the Commission is required to ensure that a thorough review of available databases with relevant information on eligibility occurs to determine program or award eligibility and prevent improper payments before the release of any federal funds.¹⁰⁷ To meet this requirement, the Commission and USAC will make full use of the Do Not Pay system administered by the Treasury’s Bureau of the Fiscal Service. If a check of the Do Not Pay system results in a finding that a Program awardee should not be paid, the Commission will withhold issuing commitments and payments.¹⁰⁸ USAC may work with the Program awardee to give it an opportunity to resolve its listing in the Do Not Pay system if the awardee can produce evidence that its listing in the Do Not Pay system should be removed. However, the awardee will be responsible for working with the relevant agency to correct its information before a reimbursement payment will be issued by the Treasury.¹⁰⁹

C. Application Evaluation Process

1. Application Evaluation Metrics

34. The Consolidated Appropriations Act directs the Commission to seek public comment on “the metrics the Commission should use to evaluate applications for funding” as well as “how the Commission should treat applications filed during” Round 1 that did not receive CARES Act funding, should those applicants wish to apply for funding during Round 2.¹¹⁰ The Consolidated Appropriations Act also requires the Commission to provide notice to Congress of what metrics we intend to use to evaluate applications.¹¹¹

35. The *January 6th Public Notice* sought comment on how to evaluate and prioritize applications during Round 2;¹¹² whether the Commission “should continue to target funding to health care providers in areas ‘hardest hit’ by COVID-19,” particularly given the broader infection rate across the nation;¹¹³ and whether there are “any other metrics we should use to prioritize applications during the evaluation process.”¹¹⁴ It also sought comment on prioritizing applications from providers who treat

¹⁰⁶ 2 CFR Part 170, App. A.

¹⁰⁷ Payment Integrity Information Act (PIIA), Pub. L. No. 116-117, 134 Stat. 113 (2019). PIIA recodifies and amends the prior improper payment statutes (*i.e.*, The Improper Payments Information Act of 2002, Pub. L. 107-300; The Improper Payments Elimination and Recovery Act of 2010, Pub. L. No. 114-204; The Improper Payments Elimination and Recovery Improvement Act of 2012, Pub. L. No. 112-248; and The Fraud Reduction and Data Analytics Act of 2015, Pub. L. No. 114-186).

¹⁰⁸ U.S. Bureau of the Fiscal Service, *Do Not Pay*, <https://fiscal.treasury.gov/DNP/> (last visited Mar. 24, 2021).

¹⁰⁹ U.S. Bureau of the Fiscal Service, *Privacy Program*, <https://fiscal.treasury.gov/dnp/privacy-program.html#data-correction-process> (last visited Mar. 24, 2021).

¹¹⁰ Consolidated Appropriations Act, § 903(c)(1)(A)(i)-(ii).

¹¹¹ See Consolidated Appropriations Act § 903(c)(1)(B) (requiring the Commission to provide, not later than 15 days before first committing Program funds, “notice to the appropriate congressional committees of the metrics the Commission plans to use to evaluate applications for those funds.”). We intend to timely fulfill this obligation.

¹¹² *January 6th Public Notice* at 3-5, paras. 6–17.

¹¹³ *Id.* at 3, para. 7.

¹¹⁴ *Id.* at 4, para. 11.

“specific at-risk populations, such as Tribal, low-income, or rural communities,”¹¹⁵ and sought comment on defining the populations that each metric represents.¹¹⁶

36. In response, stakeholders recommended that the Commission use a variety of factors to evaluate Round 2 applications, including: application quality,¹¹⁷ treatment of specific types of patients,¹¹⁸ underserved and at-risk communities,¹¹⁹ treatment of low-income and impoverished patients (regardless of rural or urban location),¹²⁰ mental and behavioral health facilities,¹²¹ large percentage of COVID-19 patients,¹²² institutions with telehealth experience,¹²³ and teaching hospitals.¹²⁴ Commenters were generally supportive of prioritizing applicants who serve at-risk populations.¹²⁵ Other commenters stressed that Round 1 funding was disproportionately awarded to urban areas.¹²⁶

37. We agree with commenters who supported using a set of evaluation metrics, and we establish an objective and transparent application evaluation process for Round 2. After reviewing the record and considering the lessons learned during the Round 1 application review process, we conclude that Round 2 application evaluation metrics should prioritize the overall performance goals of the Program to fund: (1) eligible health care providers that will benefit most from telehealth funding; (2) as many eligible health care providers as possible; (3) Tribal, rural, and low-income communities to ensure that this additional support will be directed to communities where the funding would have the most impact; and (4) hardest hit areas to make sure that funding continues to support health care providers in areas most impacted by the COVID-19 pandemic. Each metric is assigned its own objective scoring mechanism, which will allow USAC to score applications. We acknowledge that some of the metrics overlap and applications could receive points under multiple metrics for the same factor (e.g., serving a low-income population), which could make certain applications more likely to receive funding. This result is reasonable because it ensures that the providers who need funding the most will be prioritized. Finally, to enhance transparency, we select application evaluation metrics that can be verified using publicly available information. To reduce the administrative burden during the review process, we are adopting application evaluation metrics that will be simple to quantify and evaluate. We direct USAC to apply these evaluation metrics during the Round 2 application review process.

¹¹⁵ *Id.*

¹¹⁶ *Id.*

¹¹⁷ *See, e.g.*, AUCH Comments at 3-4; CPCA Comments at 2-3.

¹¹⁸ *See, e.g.*, Planned Parenthood Comments at 3-5 (recommending prioritizing providers that focus on reproductive health); Alzheimer’s Association Comments at 2 (recommending prioritizing funding for long-term care institutions); 19Labs Comments at 2, 4 (recommending, among other things, prioritizing the timeliness of implementation and dollars awarded per population covered); Netsmart Comments at 1 (recommending, among other things, prioritizing mental and behavioral health providers).

¹¹⁹ *See, e.g.*, CUSOM Comments at 1; OCHIN Comments at 1; WU Physicians Comments at 2; Blessing Corporate Comments at 1; NACRHHS Comments 2-3; CHI Comments at 3 (high risk, low-income, rural providers).

¹²⁰ *See, e.g.*, USA Health Comments at 2; Blessing Corporate Comments at 1; Russell Doyle Comments at 3; Wexner Medical Comments at 3.

¹²¹ *See, e.g.*, SHLB Comments at 5-6; Centerstone Comments at 1-2; JFNA Comments at 2-3; Netsmart Comments at 1.

¹²² *See, e.g.*, UAB Hospital Comments at 5; Wexner Medical Comments at 3.

¹²³ *See, e.g.*, Southcoast Health Comments at 2; LCMC Health Comments at 2; Stel Life Comments at 1-2; Trinity Health Comments at 1; MBCHC Comments at 3.

¹²⁴ *See, e.g.*, Wexner Medical Comments at 3; SBHA Comments at 2.

¹²⁵ *See, e.g.*, Hudson Headwaters Health Comments at 4; SHLB Comments at 5; Blessing Corporate Comments at 1.

¹²⁶ *See, e.g.*, Gundersen Health Comments at 2; Hospital Sisters Health Comments at 2-3.

2. Round 2 Evaluation Metrics

38. We direct USAC to prioritize applications from eligible health care providers that demonstrate that they qualify for the following evaluation metrics: Hardest Hit Area; Low-Income Area; Round 1 Unfunded Applicant; Tribal Community; Critical Access Hospital; Federally Qualified Health Center, Federally Qualified Health Center Look-Alike, or Disproportionate Share Hospital; Healthcare Provider Shortage Area; Round 2 New Applicant; and Rural County. We find that these objective metrics will allow us to award funding to the providers that need it most without imposing an undue burden on applicants. To provide stakeholders with clarity regarding the Round 2 application evaluation process, we provide a list of both the metrics and the prioritization points for those metrics in the table below.

Round 2 Evaluation Metrics

Factor	Information Required	Points
Hardest Hit Area	Applicants must provide health care provider county	Up to 15
Low-Income Area	Applicants must provide health care provider physical address and county	Up to 15
Round 1 Unfunded Applicant	Applicants must provide unique application number from Round 1 ¹²⁷	15
Tribal Community	Applicants must provide physical address and/or provide supporting documentation to verify Indian Health Service or Tribal affiliation	15
Critical Access Hospital	Applicants must provide proof of Critical Access Hospital certification	10
Federally Qualified Health Center / Federally Qualified Health Center Look-Alike / Disproportionate Share Hospital	Applicants must (1) provide proof of Federally Qualified Health Center certification, or (2) demonstrate qualification as a Federally Qualified Health Center Look-Alike, or (3) demonstrate qualification as a Disproportionate Share Hospital	10
Healthcare Provider Shortage Area	Applicants must provide Healthcare Provider Shortage Area ID number or health care provider county	Up to 10
Round 2 New Applicant	Applicants must certify, under penalty of perjury, that the applicant has not previously applied for Program funding	5
Rural County	Applicants must provide health care provider county	5

¹²⁷ For applicants that applied during Round 1, the application number started with “GRA” followed by seven numbers (e.g., GRA0000123). Some applications submitted via e-mail during Round 1 did not receive a GRA number. If the applicant did not receive an application number, USAC may accept proof of an email submission in lieu of the application number.

39. *Hardest Hit Area.* In response to the *January 6th Public Notice*, several commenters supported using the “hardest hit” factor to prioritize applications during Round 2.¹²⁸ We agree, as this metric ensures that Program funding is prioritized to health care providers responding directly to the COVID-19 pandemic. While some commenters expressed concern that prioritizing applications based on areas that are “hardest hit” may favor large, urban institutions,¹²⁹ and others argued that “hardest hit” is no longer a useful metric because the virus has spread exponentially since last April and most locations could be considered “hardest hit,”¹³⁰ we find it appropriate to continue to prioritize funding to eligible health care providers located in areas that are most-impacted by the COVID-19 pandemic. To limit support only to those areas most affected by the COVID-19 pandemic, we define “hardest hit” as areas designated as either a “sustained hotspot,” or a “hotspot,” on the COVID-19 Community Profile Report, Area of Concern Continuum by County dataset provided by the U.S. Department of Health and Human Services (HHS).¹³¹ A “sustained hotspot” is defined by HHS as a community that has “a high sustained case burden and may be higher risk for experiencing health care limitations.”¹³² Hotspots are defined by HHS as “communities that have reached a threshold of disease activity considered as being of high burden.”¹³³ For Round 2, we direct USAC to rely on publicly available COVID-19 infection rates from the day the application filing window closes, specifically using the U.S. Department of Health and Human Services dataset identified above, which breaks down different levels of community spread of COVID-19, and award prioritization points to applications in which an eligible health care provider is located in a county defined as a “sustained hotspot” or a “hotspot.” We also find that this factor warrants a generous point assignment because it is the only metric directly linked to the geographic area of the applicant as it relates to the spread of the virus. Accordingly, we direct USAC to award seven (7) points to applications that demonstrate that an eligible health care provider is located in a “hotspot” and 15 points to applications that demonstrate that an eligible health care provider is located in a “sustained hotspot.”

40. *Low-Income Area.* In response to the *January 6th Public Notice*, many commenters recommended prioritizing applications from health care providers that are located in low-income areas.¹³⁴

¹²⁸ See, e.g., OCHIN Comments at 2 (encouraging FCC to use “hardest hit” at the time of funding decision); WU Physicians Comments at 2 (“FCC should consider the broader COVID-19 infection rate in the U.S. and pandemic-related strains when defining parameters to target Round 2 funding.”); Gunderson Health Comments at 2; Marana Health Comments at 1.

¹²⁹ See, e.g., NACRHHS Comments at 1 (“the initial award of funds for the program was heavily tilted toward large urban areas ... with urban areas being hardest hit”); Hospital Sisters Health Comments at 2-3 (“applying the same first round criteria ... may result in funding being awarded predominantly to providers serving urban metropolitan areas.”).

¹³⁰ See, e.g., Duke Health Comments at 1; CPCA Comments at 4; Ochsner Health Comments at 3-6; MBCHC Comments at 2.

¹³¹ See U.S. Department of Health and Human Services, *Community Profile Report*, at 13 (Mar. 11, 2021), <https://beta.healthdata.gov/Health/COVID-19-Community-Profile-Report/gqxm-d9w9> (Area of Concern Continuum by County). We direct USAC to use the county tab of the report generated on the date of the close of the application filing window for this prioritization factor.

¹³² *Id.*

¹³³ *Id.*

¹³⁴ See, e.g., USA Health Comments at 2 (stating that prioritization should be given to patients that live at or below the “Federal Poverty Level”); Ethan Whitener Comments 2-3; Blessing Corporate Comments at 1; Wexner Medical Comments at 2 (encouraging FCC to prioritize low-income communities, but not necessarily just rural communities). We find using this evaluation metric is sufficient to target funding to low-income areas, and decline to also use Qualified Opportunity Zones as an additional evaluation metric to target funding to low-income areas because we believe that the U.S. Census Bureau, Small Area Income and Poverty Estimates dataset more accurately represents a location’s economic reality, and using both low-income areas and Qualified Opportunity Zones as evaluation metrics would be redundant. *But see*, Hospital Sisters Health Comments at 3 (“The Commission should (continued....)”).

We agree that health care providers located in low-income areas should be prioritized because such areas contain underserved and at-risk populations. Poverty rates serve as useful benchmarks to identify these low-income areas. Accordingly, we direct USAC to use Census Bureau data to determine which health care providers are located in low-income areas.¹³⁵ We direct USAC to use both county and census tract poverty data because county data alone may not sufficiently capture highly concentrated low-income communities in urban areas or the poverty level of communities within counties where there are large income gaps.¹³⁶ In such areas, considering both county and census tract poverty rates provides greater flexibility and will identify low-income communities that may otherwise be obscured in county-level data. The median poverty rate for a county is 13.4%, and the 75th percentile poverty rate for a county is 17.5%. For census tracts, the median poverty rate is 11.5%, and the 75th percentile poverty rate is 19.8%.¹³⁷ We direct USAC to determine the poverty rate of both the county and the census tract for the eligible health care provider site the applicant has designated for this metric.¹³⁸ If an application would be eligible for more points using the census tract poverty rate than using the county-level poverty rate (or vice versa), we direct USAC to award the application the higher points available between the two. We direct USAC to award 7 points to applications that demonstrate that an eligible health care provider is located in a county or census tract where the poverty rate is equal to or greater than the median poverty rate and less than the 75th percentile for poverty for that geographic area, and 15 points to applications that demonstrate that an eligible health care provider is located in a county or census tract where the poverty rate is in the 75th percentile or greater for that geographic area..

41. *Round 1 Unfunded Applicants.* During Round 1, we received thousands of applications from health care providers nationwide. The Commission awarded funding commitments to 539

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consider prioritizing Round 2 applications and awards that ... [a]re located by address in an economically distressed Opportunity Zone”).

¹³⁵ See U.S. Census Bureau, *Small Area Income and Poverty Estimates*, Interactive Map, https://www.census.gov/data-tools/demo/saipe/#/?map_geoSelector=aa_c (last updated Dec. 2020) (Interactive map and data set reflecting poverty rates for the United States and counties within the United States as of 2019); U.S. Census Bureau, *American Community Survey: Poverty Status in the Past Twelve Months*, <https://data.census.gov/cedsci/table?q=povrty&tid=ACSS1Y2019.S1701&hidePreview=false> (last visited Mar. 23, 2021). County-level median and 75th percentile poverty rates are calculated from the Small Area Income and Poverty Estimates data, and census tract rates are calculated from the American Community Survey data. These resulting levels vary because the Small Area Income and Poverty Estimates include additional information related to participation in the Supplemental Nutrition Assistance Program and individual income tax return data, and because the distributions of rates among each geographic area are different.

¹³⁶ An average poverty rate in a county may fail to reveal substantially higher poverty rates in smaller geographic areas within a county. For example, Cook County, Illinois has a county-level poverty rate of 13%; however, over 53% of the census tracts within the county have poverty rates greater than the tract-level nationwide median rate of 11.5% and approximately 31% of the tracts have tract-level poverty rates greater than the 75th percentile rate of 19.8%. If only county-level poverty data were used, eligible health care providers in those low-income census tracts would be ineligible for any low-income prioritization points. Similar differences in county and census tract poverty rates occur in other counties across the United States, e.g., Los Angeles County, California; Allegheny County, Pennsylvania; Mecklenburg County, North Carolina; Erie County, New York.

¹³⁷ The Small Area Income and Poverty Estimates do not include estimates for U.S. territories. For consistency, we exclude Puerto Rico from the American Community Survey census tract poverty rates. To the extent information for U.S. territories and protectorates is not available in these datasets, we direct USAC to rely on other U.S. Census Bureau data sets or other publicly available information to estimate poverty rates.

¹³⁸ We direct USAC to determine the relevant census tract for a health care provider by geocoding the applicant-submitted physical address using standard Geographic Information Systems processes. The census tract where an eligible health care provider is located is geographically limited and may not reflect the provider’s complete service area. We therefore direct USAC to develop a methodology to consider poverty rates in adjacent census tracts in awarding points for this metric.

applications during Round 1, which left a substantial number of Round 1 applications unfunded.¹³⁹ In response to the high number of applications that did not receive funding, and the Consolidated Appropriations Act, the *January 6th Public Notice* sought comment on prioritizing the applications of eligible health care providers who applied for, but did not receive, Round 1 funding.¹⁴⁰ The majority of commenters supported prioritizing these applicants.¹⁴¹ While some commenters did not believe that these applicants should be prioritized,¹⁴² we conclude that it is appropriate to prioritize eligible applicants who applied for but did not receive Round 1 funding. We believe that equitable distribution of Program funds is essential, and thus find that prioritizing eligible health care providers that did not receive funding during Round 1 over eligible health care providers that did receive Round 1 funding is consistent with our goal of distributing funding as widely as possible. Accordingly, we direct USAC to prioritize eligible health care providers that applied for Round 1 funding but did not receive it, and award 15 points to applications that demonstrate they applied for, but did not receive, Round 1 funding. Furthermore, we also assign a sizable points allocation to this metric to reflect the importance of encouraging unfunded Round 1 applicants to file in Round 2 and the statutory requirement that Round 1 applicants are able to file in Round 2.

42. *Tribal Community.* We next prioritize applications to serve sites located in Tribal areas because those areas are generally most in need of support to enhance broadband connectivity. While broadband in urban areas is nearly ubiquitous, as of the end of 2019, “approximately 17% of Americans in rural areas and 21% of Americans in Tribal lands lack coverage from fixed terrestrial 25/3 broadband.”¹⁴³ The absence of broadband availability in these areas also makes it more difficult for telehealth to be provided, and we conclude that prioritizing these factors will help to address this discrepancy. Additionally, we have previously recognized that “there are significant health care shortages in rural areas and Tribal lands,”¹⁴⁴ and seek to address this issue by prioritizing Tribal participation in this Program. Accordingly, our decision to prioritize applicants located on Tribal lands is rooted in both commenters’ support and the “significant obstacles to broadband deployment” that Tribal lands still face.¹⁴⁵ While broadband deployment is nearly ubiquitous in urban areas, broadband deployment “on certain Tribal lands, particularly rural Tribal lands, lags behind deployment in other, non-Tribal areas.”¹⁴⁶ Additionally, Tribal populations face a significantly higher risk from the COVID-19 pandemic,¹⁴⁷ and facilitating a more robust telehealth infrastructure could help to address this disparity. For Round 2, we adopt the definition of Tribal lands provided in the Commission’s Lifeline program rules,¹⁴⁸ and direct

¹³⁹ Notably, only about 2,500 of these are from institutions that may be eligible for Program funding. Many applications were received from for-profit or otherwise ineligible providers.

¹⁴⁰ *January 6th Public Notice* at 5, para. 17.

¹⁴¹ *See, e.g.*, Children’s Wis. Comments at 2; Savoy Medical Comments at 2.

¹⁴² *See, e.g.*, Mount Sinai Comments at 4.

¹⁴³ *Inquiry Concerning Deployment of Advanced Telecommunications Capability to All Americans in a Reasonable and Timely Fashion*, GN Docket No. 20-269, Fourteenth Broadband Deployment Report, FCC 21-18, at 19-20, para. 33 (Jan. 19, 2021) (*Fourteenth Broadband Deployment Report*).

¹⁴⁴ *Promoting Telehealth for Low-Income Consumers*, Notice of Proposed Rulemaking, 34 FCC Rcd 5620, 5646, para. 57 (2019).

¹⁴⁵ *Fourteenth Broadband Deployment Report* at 11-12, para. 20.

¹⁴⁶ *Id.*

¹⁴⁷ *See* Centers for Disease Control and Prevention, *CDC Data Shows Disproportionate COVID-19 Impact on American Indian/Alaskan Native Populations*, <https://www.cdc.gov/media/releases/2020/p0819-covid-19-impact-american-indian-alaska-native.html> (updated Aug. 19, 2020).

¹⁴⁸ 47 CFR § 54.400(e) (defining Tribal lands as “any federally recognized Indian tribe’s reservation, pueblo, or colony, including former reservations in Oklahoma; Alaska Native regions established pursuant to the Alaska Native (continued....)”).

Program applicants to use USAC's Tribal PDF map or the reference shapefile to determine whether they are located on Tribal lands.¹⁴⁹ Consistent with the eligibility determinations made using the FCC Form 460, we direct USAC to award 15 points to applications that demonstrate that an eligible health care provider site is either located on Tribal lands or is operated by the Indian Health Service or is otherwise affiliated with a Tribe.¹⁵⁰ We direct applicants that are otherwise affiliated with a Tribe to provide supporting documentation sufficient to verify their Tribal affiliation. Finally, in recognition of the importance of funding applicants on Tribal lands, we assign the largest point allocation to these applications.

43. *Critical Access Hospital.*¹⁵¹ In response to the *January 6th Public Notice*, several commenters suggested considering whether an applicant is a Critical Access Hospital (CAH).¹⁵² A CAH designation is given to eligible rural hospitals in participating states by the Centers for Medicare and Medicaid Services.¹⁵³ As defined by statute, a CAH is a hospital that is located in a rural area and that: (1) has 25 or fewer acute care inpatient beds; (2) is located more than 35 miles from another hospital (although exceptions to this requirement apply); (3) maintains an annual average length of stay of 96 hours or less for acute care patients; and (4) provides 24/7 emergency care services.¹⁵⁴ Small health care providers like CAHs frequently struggle to access the resources and capacity to set up their own telehealth infrastructure.¹⁵⁵ We find that these characteristics place CAHs among the health care providers that need funding from this Program, as they would benefit from telehealth and are frequently the only health care institutions in their nearby vicinities. Accordingly, we direct USAC to award 10 points to applications that demonstrate an eligible health care provider qualifies as a Critical Access Hospital. We award these entities points to reflect the importance of these facilities, but we assign a modest allocation of points because we anticipate that this metric will overlap with other metrics.

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Claims Settlement Act (85 Stat. 688); Indian allotments; Hawaiian Home Lands—areas held in trust for Native Hawaiians by the state of Hawaii, pursuant to the Hawaiian Homes Commission Act, 1920 July 9, 1921, 42 Stat. 108, *et. seq.*, as amended”). We also include the Eastern Navajo Agency lands that have previously been designated as eligible for Lifeline and are included in the shapefile and map posted on USAC's website. *See Federal-State Joint Board on Universal Service, Smith Bagley, Inc., Petition for Waiver of Section 54.400(e) of the Commission's Rules*, Memorandum Opinion and Order, 20 FCC Rcd 7701 (2005) and *Sacred Wind Communication*, Order, 21 FCC Rcd 9227 (WCB 2006).

¹⁴⁹ USAC, *Enhanced Tribal Benefit, Eligible Tribal Lands Maps and Shapefile*, <https://www.usac.org/lifeline/get-started/enhanced-tribal-benefit/#Eligible> (last updated Jan. 22, 2021) (providing link to eligible Tribal lands map and shapefile for reference purposes).

¹⁵⁰ *See First COVID-19 Report and Order*, 35 FCC Rcd at 3406, para. 68 (establishing the same criteria for “Tribal” for the Connected Care Pilot Program).

¹⁵¹ Critical Access Hospitals are located in states that have established a State Medicare Rural Hospital Flexibility Program. Applicants should review their state's department of health websites for additional information, and must include some identifier or proof of CAH certification in their application. Centers for Medicare and Medicaid Services, *Critical Access Hospitals*, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/CAHs> (last updated Apr. 9, 2013); Flex Monitoring Team, *Critical Access Hospitals Locations List*, <https://www.flexmonitoring.org/critical-access-hospital-locations-list> (last updated Aug. 1, 2020) (The Flex Monitoring Team consists of researchers from the Universities of Minnesota, North Carolina, and Southern Maine and is funded by the Federal Office of Rural Health Policy).

¹⁵² *See, e.g.*, NACRHHS Comments at 2-3, Rush Health Comments (Express).

¹⁵³ Rural Health Information Hub, *Critical Access Hospitals*, <https://www.ruralhealthinfo.org/topics/critical-access-hospitals> (last updated Aug. 20, 2019) (defining and discussing Critical Access Hospitals).

¹⁵⁴ 42 U.S.C. § 1395i-4(c)(2)(B)(i)-(iv).

¹⁵⁵ *See, e.g.*, Letter from Joe Manchin III *et al.*, Senators, U.S. Senate, to Jessica Rosenworcel, Chairwoman, FCC, WCB Docket No. 20-89, at 2 (Jan. 25, 2021) (Senator Manchin Letter).

44. *Federally Qualified Health Center, Federally Qualified Health Center Look-Alike, or Disproportionate Share Hospital.*¹⁵⁶ In response to the *January 6th Public Notice*, commenters recommended prioritizing applications that include health care providers that qualify as a Federally Qualified Health Center (FQHC),¹⁵⁷ a FQHC Look-Alike,¹⁵⁸ or a Disproportionate Share Hospital (DSH).¹⁵⁹ A Federally Qualified Health Center is a community-based health care provider that receives funds from the Health Resources and Services Administration (HRSA) Health Center Program to provide primary care services in underserved areas.¹⁶⁰ They are also referred to as the “backbone of the nation’s health care safety net.”¹⁶¹ These entities must: (1) offer services to all, regardless of the person’s ability to pay; (2) establish a sliding fee discount program; (3) be a nonprofit or public organization; (4) be community-based, with the majority of its governing board of directors composed of patients; (5) serve a Medically Underserved Area or Population; (6) provide comprehensive primary care services; and (7) have an ongoing quality assurance program.¹⁶² Federally Qualified Health Centers provide health care services to at-risk and vulnerable patients supporting low-income and underserved communities in both urban and rural areas. FQHC Look-Alikes meet the same HRSA Health Center Program qualifications required of FQHCs,¹⁶³ and they provide primary care services in underserved areas (like traditional FQHCs), provide care on a sliding fee scale based on ability to pay, and operate under a governing board that includes patients.¹⁶⁴ A DSH must serve a significantly disproportionate number of low-income patients and receive payments from the Centers for Medicaid and Medicare Services to cover the costs of

¹⁵⁶ Applicants shall verify whether they qualify for this metric by providing either their Federally Qualified Health Center ID number or BHCMSID/UDS numbers. See Health Resources and Services Administration, *About the Health Center Program*, <https://bphc.hrsa.gov/about/index.html> (last visited Mar. 24, 2021).

¹⁵⁷ See, e.g., OCHIN Comments at 2 (stating that many FQHCs and CHCs did not receive funding from Round 1, which went to larger institutions, because the first come first serve process disadvantaged smaller health care centers that were already under strain and burden from providing health care to services to the most vulnerable patients); WU Physicians Comments at 2; Gunderson Health Comments at 2; Marana Health Comments at 1; NACRHHS Comments at 2-3; Butler Healthcare Comments at 2; True Health Comments at 1; CHI Comments at 3; AUCH Comments at 4-5; CPCA Comments at 4; CHAD Comments at 4.

¹⁵⁸ 42 U.S.C. § 1396d(l)(2)(B); see OCHIN Comments at 1. Applicants can verify their eligibility as a Look-Alike on the Health Resources and Services Administration website. See Health Resources and Services Administration, *FQHCs and LALs by State: Federally Qualified Health Centers and Look-Alikes*, <https://data.hrsa.gov/data/reports/datagrid?gridName=FQHCs> (last visited Mar. 24, 2021).

¹⁵⁹ See Southcoast Health Comments at 2; Letter from Kali P. Chaudhuri, MD, Founder & Chairman, KPC Health, and Peter Baronoff, Chief Executive Officer, KPC Health, to FCC Commissioners, WC Docket No. 20-89, at 2 (filed Jan. 22, 2021).

¹⁶⁰ Health Resources and Services Administration, *Federally Qualified Health Centers*, <https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc/index.html> (last visited Mar. 12, 2021) (defining Federally Qualified Health Centers).

¹⁶¹ CHAD Comments at 2; CCHN Comments at 1.

¹⁶² 42 U.S.C. § 254b; see Rural Health Information Hub, *Federally Qualified Health Centers and Health Center Program*, <https://www.ruralhealthinfo.org/topics/federally-qualified-health-centers> (last visited Mar. 12, 2021).

¹⁶³ See Health Resources and Services Administration, *Federally Qualified Health Center Look-Alike Eligibility*, <https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc-look-alikes/index.html> (last visited Mar. 12, 2021).

¹⁶⁴ See Health Resources and Services Administration, *Federally Qualified Health Center Look-Alike Eligibility*, <https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc-look-alikes/index.html> (last visited Mar. 12, 2021); Health Resources and Services Administration, *Health Center Program Look-Alikes*, <https://bphc.hrsa.gov/programopportunities/lookalike/index.html> (last visited Mar. 12, 2021).

providing care to uninsured patients.¹⁶⁵ After careful review of the record, we find that directing Program funding to FQHCs, FQHC Look-Alikes, and DSHs will meet our above-stated objectives of directing Program funding to entities that target funding to at-risk and low-income communities and would most benefit from telehealth services.¹⁶⁶ Accordingly, we direct USAC to award 10 points to applications that demonstrate that an eligible health care provider qualifies as (1) an FQHC, (2) an FQHC Look-Alike, or (3) a DSH.

45. *Healthcare Provider Shortage Area.*¹⁶⁷ In response to the *January 6th Public Notice*, some commenters suggested prioritizing health care providers located in a Healthcare Provider Shortage Area (HPSA).¹⁶⁸ HPSAs do not have enough health care providers to adequately serve their community. Support for telehealth and connected care services is especially needed in these areas to help health care providers serve more patients at a greater distance. We direct applicants and USAC to the Health Resources and Services Administration (HRSA), which is an agency that provides health care to people who are geographically isolated, and economically or medically vulnerable. HRSA uses a health care provider's geographic area and the medical services it provides to award an HPSA score that ranges from 1 to 25.¹⁶⁹ Applicants should use the HRSA website to find their HPSA score under the "primary care" category, and to provide on their application either the county information or the HPSA ID number for the eligible health care provider site for this prioritization factor. We direct USAC to award 5 points to applications that include this information on their application and qualify for this factor with an HPSA score of 1-12; and to award 10 prioritization points to applications that include this information on their application and qualify for this factor with an HPSA score of 13-25.

46. *Round 2 New Applicants.* Because we conclude that equitable and widespread distribution of Program funds is essential, we also direct USAC to prioritize applicants that are new to the Program over applicants who were awarded funding in Round 1. New applicants, however, will receive a smaller point allocation than Round 1 applicants who did not receive any funding. There was support in the record for this idea, given the time and effort that these applicants devoted in submitting applications in both Rounds of the Program.¹⁷⁰ Moreover, this approach acknowledges that because of the high demand, "[a] lot of organizations [in Round 1] who did not receive funding have great ideas to which this funding could be used in meaningful ways,"¹⁷¹ and will help distribute funding to as many providers as possible. Accordingly, we direct USAC to award 5 points to applicants who did not apply for Round 1 funding.

¹⁶⁵ 42 U.S.C. § 1395ww(d)(1)(B); see Health Resources and Services Administration, *Disproportionate Share Hospitals*, <https://www.hrsa.gov/opa/eligibility-and-registration/hospitals/disproportionate-share-hospitals/index.html> (last visited Mar. 12, 2021).

¹⁶⁶ See, e.g., Senator Manchin Letter; OCHIN Comments at 1 ("HRSA-funded health centers serve 1 in 3 people who are experiencing poverty in the United States. In 2019, more than 91% of FQHC patients and 89% of LAL patients had incomes at or below 200% of the Federal Poverty line.").

¹⁶⁷ Applicants should use the HPSA score for primary care, which is publicly available on the Health Resources and Services Administration website. Health Resources and Services Administration, *Find Shortage Area*, <https://data.hrsa.gov/tools/shortage-area> (last visited March 12, 2021).

¹⁶⁸ See, e.g., NACRHHS Comments at 2; Hospital Sisters Health Comments at 3, 7.

¹⁶⁹ Health Provider Shortage Area, *HPSA Acumen, Frequently Asked Questions*, <https://hpsa.us/faqs/> (last visited Mar. 12, 2021) ("HPSA Scores are developed for use by the National Health Services Corps (NHSC) and Health Resources and Services Administration (HRSA) to prioritize the need of designations. Based on the severity of a health professional shortage, scores range from 1 to 25 for primary care The higher the score, the greater the need for additional medical services, which increases an area's priority for placement of new practitioners.").

¹⁷⁰ See, e.g., CUSOM Comments at 2.

¹⁷¹ *Id.* at 1-2.

47. *Rural County.* We also prioritize applicants that are located in rural areas, as defined by the Rural Healthcare Program.¹⁷² Although other application evaluation metrics, such as whether an applicant is a Critical Access Hospital, already take into consideration the rurality of health care providers for Round 2 funding, we direct USAC to consider this evaluation metric independently as well to ensure that applications representing health care providers in rural areas are prioritized. Given that multiple other evaluation metrics also target funding to rural areas, however, we attach fewer prioritization points to the Rural Area metric to account for the expected overlap between evaluation metrics. Applicants should use USAC's Eligible Rural Areas Search tool to determine if an eligible health care provider is located in a rural area, and provide the physical address of the qualifying health care provider in their application.¹⁷³ We direct USAC to award 5 points to applications that demonstrate that an eligible health care provider site is located in a rural area.

48. *Ensuring Equitable Nationwide Distribution of COVID-19 Telehealth Program Funding.* The Consolidated Appropriations Act directs the Commission, to the extent feasible, to ensure "that not less than 1 applicant in each of the 50 States and the District of Columbia has received funding" from the Program since the Program's inception, "unless there is no such applicant eligible for assistance in a State or in the District of Columbia."¹⁷⁴ The *January 6th Public Notice* sought comment on different ways to accomplish this directive, and proposed adopting an application filing window, which would allow for applications from states, the District of Columbia, or territories where a lead applicant did not receive Round 1 funding to be prioritized.¹⁷⁵ We also sought comment on ways to ensure that lead applicants from each state and the District of Columbia would receive Round 2 funding.¹⁷⁶ We now adopt these proposals and seek to ensure that at least two applications with lead health care providers from every state, territory, and the District of Columbia receive Program funding, if such applications exist. After applications are scored, we direct USAC, with Bureau and OMD oversight, to first commit funding to the top-scoring Round 2 application with an eligible lead health care provider located in a state or territory¹⁷⁷ that did not have a lead health care provider receive funding during Round 1,¹⁷⁸ if feasible.¹⁷⁹ We then direct USAC, with Bureau and OMD oversight, to commit funding to the top-scoring¹⁸⁰ Round 2

¹⁷² 47 CFR § 54.600(e) (defining a rural area as "an area that is entirely outside of a Core Based Statistical Area; is within a Core Based Statistical Area that does not have any Urban Area with a population of 25,000 or greater; or is in a Core Based Statistical Area that contains an Urban Area with a population of 25,000 or greater, but is within a specific census tract that itself does not contain any part of a Place or Urban Area with a population of greater than 25,000.").

¹⁷³ USAC, *Eligible Rural Areas Search*, <https://apps.usac.org/rhc/tools/Rural/search/search.asp> (last visited Mar. 12, 2021). To the extent information for U.S. territories and protectorates is not available in this dataset, we direct USAC to rely on other publicly available information, e.g., urbanization codes, to confirm that the health care provider is located in a rural area.

¹⁷⁴ Consolidated Appropriations Act § 903(c)(2).

¹⁷⁵ *January 6th Public Notice* at 4, para. 12.

¹⁷⁶ *Id.* at 4, para. 13.

¹⁷⁷ See UHPBTRC Comments at 2 (suggesting that funding should be guaranteed for territories such as the Mariana Islands); Telecom Bureau of Puerto Rico Comments at 1-2.

¹⁷⁸ Those states are Alaska, Hawaii, and Montana, and the territories are American Samoa, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands.

¹⁷⁹ See *infra* Section III.D (Funding Commitment Process) for a discussion of the two award windows.

¹⁸⁰ If there is more than one application with the same highest or second-highest total score in a location, then the application with the highest score for only the four most valuable metrics, each of which is worth 15 points, will receive the equitable distribution commitment. Those metrics are Hardest Hit, Low-Income Area, Round 1 Unfunded Applicant, and Tribal Area. Applications may have a maximum of 60 points across those four metrics, and the tiebreaker between applications is which application scores higher considering only those four metrics.

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application in the states and territories where an application with a lead health care provider was awarded Round 1 funding, and to award funding to the second-ranked application in the states where no lead health care provider received Round 1 funding.¹⁸¹ This will result in funding for at least two applications with lead health care providers in each state, territory, or the District of Columbia across both rounds of the Program, if such applications exist.

49. We believe that committing funding to the top-scoring application in states and territories where a lead health care provider was not awarded Round 1 funding is dictated by the statute's unambiguous language. Because we have already committed to using an application filing window,¹⁸² it is feasible to ensure that the highest-scoring applicant with a lead health care provider in the states and territories where a lead health care provider was not awarded Round 1 funding will receive funding in Round 2. We also believe that guaranteeing each state, territory, and the District of Columbia Round 2 funding is consistent with the statutory goal of nationwide equitable distribution of Program funding.¹⁸³ While this decision could result in some lower-scoring applications receiving funding commitments at the outset of the Program, we note that applications with lead health care providers in 47 states, the District of Columbia, and Guam received Round 1 funding without separate prioritization, and we anticipate a similar geographic distribution of Round 2 applications.

50. *Pre-Existing Strain.* In the *January 6th Public Notice*, we sought comment on whether to prioritize health care providers that are experiencing pre-existing strain, which, we said, could include "providing care for a large underserved or low-income patient population, facing health care provider shortages, or dealing with rural hospital closures."¹⁸⁴ While some commenters supported using the metric,¹⁸⁵ most disagreed, and pointed out that the COVID-19 pandemic has placed many health care providers under significant strain.¹⁸⁶ After careful consideration of the record, we decline to use pre-existing strain as an application evaluation metric because that factor, as described in the *First COVID-19 Report and Order*, is difficult to verify. Instead, we adopt metrics that the Commission previously

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Making this the first tiebreaker reflects our view that the most important factors should determine the commitment in the event of identical scores for applications in the same geographic location. If two or more applications remain tied after considering only the four most valuable metrics, then the application with the highest score only for the next most valuable metrics, each worth 10 points: Critical Access Hospital; Federally Qualified Health Center, Federally Qualified Health Center Look-Alike, or Disproportionate Share Hospital; and Healthcare Provider Shortage Area, will receive the equitable distribution commitment. Applications may get a total of 30 points from those three metrics, and the next tiebreaker between applications is which application scores higher among those three metrics.

¹⁸¹ See *supra* note 178.

¹⁸² See *supra* Section III.A (Establishing an Application Filing Window).

¹⁸³ See Consolidated Appropriations Act § 903(c)(2). We decline to adopt SHLB's proposal to use a "proportional allocation of funds based on state and territory population." SHLB Comments at 4. The application process adopted in this Report and Order provides a simpler solution, and satisfies the Consolidated Appropriations Act requirement. We also decline to adopt UAB Hospital's suggestion that we set aside \$250,000 for each state. UAB Hospital Comments at 2-3. Establishing an application filing window will allow USAC to commit funds to applicants of each state without the Commission separately setting aside funds for this purpose. Finally, we decline to adopt Northern Light Health's proposal that we commit a minimum of three awards to applicants in each state where an applicant did not receive funding during Round 1. Northern Light Health Comments at 2.

¹⁸⁴ *January 6th Public Notice* at 3, para. 6.

¹⁸⁵ See, e.g., CPCA Comments at 3-4.

¹⁸⁶ See, e.g., SBHA Comments at 2.

identified as factors that contribute to pre-existing strain, e.g., areas with low-income patient population and health care provider shortages to target the communities where funding is most needed.¹⁸⁷

51. Applicants are required to use the publicly available resources specified in the table above to determine whether they qualify for points in any of the application evaluation metrics, and should also include any information that is necessary to verify these factors on their applications. Applicants must also certify, under penalty of perjury, to the accuracy of their applications, and we direct USAC to verify these qualifications during the application review process using the same publicly available datasets. We anticipate that, just as in Round 1, many applications will include multiple health care provider sites, and an eligible health care provider may only appear on one application. Applications may only receive the associated prioritization points once for each factor. In instances in which the application requests funding for multiple eligible health care provider sites, and the health care provider site that qualifies for one or more factors is not the lead health care provider on the application, the applicant must provide the information of the qualifying health care provider site, in addition to the lead health care provider's information, to receive points for that evaluation metric. We direct USAC not to award points to applicants that do not include sufficient information on their application.

3. Confirming Eligibility of Requested Services and Devices

52. Consistent with the review process established in Round 1, we direct USAC to conduct an eligibility review of the services and devices applicants request on their applications. This review is an important safeguard and allows us to ensure that funding awards are based on the cost of eligible services and devices, which in turn ensures funding is available to as many health care providers as possible. Moreover, as supported by the record, we continue to allow applicants who are awarded funds the flexibility to purchase, in the course of implementing their telehealth and connected care programs, any necessary eligible services and connected devices, and do not limit them to receiving funding for only the eligible services and connected devices listed in their applications. Finally, to provide applicants with additional clarity regarding the eligibility of various products and services, and to enhance the transparency of the application review process, we provide applicants with a list of eligible and ineligible services, attached as Appendix B.

53. *Maintaining Flexibility.* In the *January 6th Public Notice*, the Bureau sought comment on whether the Commission should continue providing applicants that receive funding commitments the flexibility to respond to changing circumstances by not limiting them to the vendors, eligible services, and eligible devices identified in their applications, as long as the total amount sought for reimbursement does not exceed the commitment amount.¹⁸⁸ Commenters unanimously supported the Bureau's suggestion.¹⁸⁹ Many commenters noted that this flexibility provided significant help to funding recipients in Round 1.¹⁹⁰ Other commenters explained that this policy was still necessary because the COVID-19 pandemic continued to present a rapidly changing and evolving situation for health care providers to manage,¹⁹¹ and still other commenters specified that they expect to continue facing equipment shortages.¹⁹² We maintain

¹⁸⁷ *First COVID-19 Report and Order*, 35 FCC Rcd at 3377, para. 19.

¹⁸⁸ *See January 6th Public Notice* at 6-7, paras. 20-21.

¹⁸⁹ *See, e.g.*, LoneStar Comments (Express); MBCHC Comments at 4; SHLB Comments at 8; True Health Comments at 1; UAB Hospital Comments at 5.

¹⁹⁰ AUCH Comments at 5 ("FQHCs and their consortia who receive Round One funding benefitted greatly from the flexibility to change which devices and services they would purchase with FCC funds, in response to changing circumstances."); CPCA Comments at 5; CCHN Comments at 2; CHAD Comments at 6; FACHC Comments at 6; Great Mines Health Comments (Express); IPCA Comments at 6; NACHC Comments at 5; TPCA Comments at 5.

¹⁹¹ *See* MUSC Center Comments at 2; Ochsner Health Comments at 12-13; Stel Life Comments at 3; Wexner Medical Comments at 4-5.

¹⁹² *See* IFH Comments at 1; LCMC Health Comments at 2; SBHA Comments at 3.

this policy from Round 1 because we believe that providing funding recipients this flexibility will allow them to best provide care for their patients in response to the COVID-19 pandemic. However, consistent with the Commission's process in Round 1, we direct USAC, subject to Bureau oversight, to review the eligibility of each service or connected device that a funding awardee proposes to substitute at the reimbursement request stage to ensure that Program funds are used only for authorized purposes.¹⁹³

54. *Funding Request Review.* The Bureau also sought comment in the *January 6th Public Notice* on whether, if the Commission maintained this flexibility for applicants, the Commission should also streamline the application process by eliminating the requirement that applicants submit supporting documentation on the eligibility of connected devices and services in their applications.¹⁹⁴ During the Round 1 application process, applicants were required to answer several questions about the anticipated uses and eligibility of their requested services and devices, and they were required to submit documentation supporting the estimated costs for their funding requests.¹⁹⁵ As a result of this process, efforts by Commission staff to review each application to determine the eligibility of the services and devices requested were often hampered by the lack of adequate information in the application. Because applicants commonly did not include enough information on their applications about each of their requested services and connected devices, reviewers conducted substantial outreach to determine what items were being requested and whether those items were eligible for funding. Commission staff also completed a second eligibility review after Round 1 funding awardees filed their reimbursement requests.

55. The record was mixed in response to the Bureau's suggestion to only require applicants to demonstrate the eligibility of services and connected devices during the reimbursement phase.¹⁹⁶ We conclude, however, that conducting this eligibility review during the invoicing review process, including requiring applicants to provide supporting documentation with their applications, is in the public interest. Therefore, to promote the integrity of each funding award and to ensure that COVID-19 Telehealth Program funds are distributed in a fiscally responsible manner, Round 2 applicants are still required to submit information about the telecommunications services, information services, and connected devices that they anticipate purchasing using Program funds, along with documentation supporting the estimated costs for their requests with their applications. However, we direct USAC to work with the Bureau, to the extent feasible, to improve the process by which reviewers determine the eligibility of the services and connected devices requested. We believe the process will be improved by requiring applicants to provide itemized lists of products and services, specifying quantity and cost for each, on their application. As part of this effort, we also direct USAC to include in its outreach program guidance on the eligible services and connected devices and tutorials on filling out the application.

¹⁹³ As part of this review, we permit USAC to request a brief explanation from a funding awardee about the reason for the substitution and/or an explanation on how the substituted items are eligible.

¹⁹⁴ *January 6th Public Notice* at 6-7, paras. 20-21.

¹⁹⁵ See *2020 Application Public Notice*, 35 FCC Rcd at 3056-57; *First COVID-19 Report and Order*, 35 FCC Rcd at 3379, para. 24.

¹⁹⁶ See AUCH Comments at 5 ("Require applicants to demonstrate the eligibility of devices/ services only during the invoicing process."); CPCA Comments at 5; CCHN Comments at 2; CHAD Comments at 6; Elite Program Comments at 3-4; FACHC Comments at 6; Great Mines Health Comments (Express); IPCA Comments at 6; Lewis County Comments (Express); NACHC Comments at 5; Ochsner Health Comments at 12-13; TPCA Comments at 5. *But see* Duke Health Comments at 6 ("[I]t is reasonable for applicants to be asked to submit some documentation throughout the process supporting the eligibility of the equipment they are proposing to purchase. Otherwise, one could foresee patently unrealistic applications being submitted that could result in unclaimed dollars being committed to projects that were not adequately thought through."); SHLB Comments at 10 ("The Round 1 process was not particularly burdensome with respect to applicant support for the eligibility of devices and services. Some documentation of eligibility at the beginning of the process should help ensure that funds are awarded appropriately."); Marana Health Comments at 2; MBCHC Comments at 4.

56. *Eligible Services List.* In the *January 6th Public Notice*, the Bureau also sought comment on whether the Commission should “publish a list of eligible and ineligible equipment and services to provide applicants with specific guidance on what may be requested for reimbursement.”¹⁹⁷ Commenters largely supported this idea.¹⁹⁸ We agree, because an eligible services list will help address the concerns of commenters that advocated for the Commission to develop “guidance on eligible expenses” more generally,¹⁹⁹ and will help applicants prepare better applications with this knowledge, which in turn will facilitate USAC’s application review. Commenters that opposed the Commission publishing an eligible services list argued that it may unintentionally exclude services or connected devices,²⁰⁰ that COVID-19 still presents too rapidly evolving of a situation for there to be a fixed list of eligible and ineligible services,²⁰¹ and finally that the Commission should only publish an ineligible services list to provide applicants needed flexibility in their applications.²⁰²

57. To address these concerns, we used our experience from Round 1 to develop an eligible services list, attached as Appendix B, that is broad enough to provide illustrative guidance on eligible telecommunications services, information services, and connected devices applicants may include in their applications. This approach provides stakeholders with the flexibility needed to respond to rapidly evolving situations. The eligible services list also includes guidance on ineligible services. Moreover, we note that we continue to allow applicants to substitute eligible services and connected devices prior to seeking reimbursement, which provides adequate flexibility to account for the challenging conditions that the COVID-19 pandemic has created.

¹⁹⁷ *January 6th Public Notice* at 7, para. 21.

¹⁹⁸ See Butler Healthcare Comments at 2-3 (“BMH further recommends the FCC publish a list of eligible and ineligible services and equipment, which would reduce burden on both the FCC and providers.”); CT Children’s Comments at 6; Duke Health Comments at 6; LCMC Health Comments at 2; Mount Sinai Comments at 5; OCHIN Comments at 3; San Francisco Comments at 3; Stel Life Comments at 2; Trinity Health Comments at 2; True Health Comments at 1; UnityPoint Health Comments at 2; UAB Hospital Comments at 5; CUSOM Comments at 2. See also LoneStar Comments (Express) (“Regarding the publications of eligible and in-eligible, equipment and services, if this is in the format of the HCF it would be very helpful. If it is in the format of the Schools and Libraries Program it would be much too complicated and would delay application preparation.”); Marana Health Comments at 2 (“FCC can spell out eligible/non-eligible equipment and services in the RFP.”).

¹⁹⁹ See AUCH Comments at 5 (writing that to “ensure program integrity” the Commission should “require additional certifications and publish lists of eligible/ ineligible items as appropriate” and to “ensure program integrity, and to provide clarity to grantees, the FCC should develop certifications, guidance on eligible expenses, etc.”); CPCA Comments at 5; CCHN Comments at 2; CHAD Comments at 6; FACHC Comments at 6; Great Mines Health Comments (Express); IPCA Comments at 6; Lewis County Comments (Express); NACHC Comments at 5; TPCA Comments at 5. See also MBCHC Comments at 4 (“Based on FCC experience with Round 1, the FCC could provide best practice guidance as to devices and services that have proven to be most effective in fulfilling the objectives of the Program”); SBHA Comments at 3 (“publish clear guidance regarding types of equipment and platforms . . .”).

²⁰⁰ Elite Program Comments at 3-4 (“Generating an exhaustive list of eligible expenses would be an unrealistic expectation and may result in unintentionally excluding viable and potentially more cost-efficient solutions.”); Ochsner Health Comments at 14.

²⁰¹ Wexner Medical Comments at 4-5 (“Our organization is still experiencing supply chain shortages and delays, which could impede our ability to stick to only the items and services listed on our application. For the same reason, we do not believe the FCC should publish a fixed list of eligible and ineligible services. The FCC should maintain flexibility with eligible services while the COVID-19 pandemic is an emerging, rapidly evolving situation.”).

²⁰² See Ethan Whitener Comments at 5 (“The FCC should publish a list of ineligible equipment and services but otherwise tie eligible purchases to use case based on the broader goals of the funding announcement.”); Hospital Sisters Health Comments at 10; Melissa Griggs Comments at 6.

58. We make no additional changes to the types of services and connected devices eligible under the Program. A number of commenters requested we make additional services or devices eligible for funds, such as administrative costs or indirect costs.²⁰³ We note that the CARES Act directs Program funding to “telecommunications services, information services, and devices necessary to enable the provision of telehealth services” during the pendency of the COVID-19 pandemic,²⁰⁴ and, thus, we are prohibited from expanding the services and equipment that are eligible for Program funding during Round 2.

59. We direct USAC, subject to Bureau oversight, to review the services and equipment listed on each application, and award only as much funding as is supported by the application and associated documentation. The Consolidated Appropriations Act appropriated additional funding to the Program, but is silent regarding the eligibility of services and devices eligible for the additional funding.²⁰⁵ Under the CARES Act, the Program awards funds to eligible health care providers to support the purchase of “telecommunications services, information services, and devices necessary” to provide telehealth and connected care in response to the COVID-19 pandemic.²⁰⁶ Consistent with Round 1, we interpret this language to include only connected devices (e.g., Bluetooth-enabled pulse-oximeters or remote blood pressure monitoring devices).²⁰⁷ Personnel costs, marketing costs, administrative expenses, or training costs continue to be ineligible for Program funding.²⁰⁸ Program funding may be used to

²⁰³ See, e.g., 19Labs Comments at 3 (“The funds should support CAPEX for equipment including telemedicine platform equipment and diagnostic devices, and the OPEX for connectivity and platform service necessary to support telehealth in these locations and to these patients.”); Centerstone Comments at 3 (“Please consider broadening allowable expenses to include remote monitoring of client health and care, such as smart watches, as well as those devices, services, and other costs that enable/facilitate the provision of telehealth services, such as cables, surge protectors, and non-connected accessories.”); Duke Health Comments at 5 (“Another improvement that would be helpful . . . is for applicants to be able to use some percentage of the total award (perhaps set at maximum of 10%) of the total award for indirect costs associated with the management of the equipment needed for the project.”); Henry Ford Health Comments at 2 (“[S]upportive of funding being applicable for any expenses associated with delivering telehealth and virtual care, which includes but is not limited to hardware, software, software licensing, network/connection, support staff (i.e. scheduling, patient outreach, technical support, support staff, etc.), infrastructure, patient communication, digital tools (i.e. applications), etc.”); NACRHHS Comments at 3 (“FCC should allow awardees to use a capped portion of their funds to cover administrative costs. In the past, the FCC has generally not allowed this, which means applicants must absorb the overhead of procuring broadband or other services. Most programs that provide federal support recognize limited administrative support as allowable costs. Failure to do so may prevent under-resourced communities from applying.”); OCHIN Comments at 4 (“We respectfully request that the Commission make technical assistance services eligible for reimbursement under Round 2, especially those provided by community health workers, bilingual help desk workers, information technology specialists, and project management personnel.”).

²⁰⁴ See CARES Act, 134 Stat. at 531.

²⁰⁵ See generally Consolidated Appropriations Act § 903.

²⁰⁶ CARES Act, 134 Stat. at 531; *First COVID-19 Report and Order*, 35 FCC Rcd at 3376, para. 16. Because the Program is a “Federal subsidy made available through a program administered by the Commission,” program funding may not be used to “purchase, rent, lease, or otherwise obtain any communications equipment or service . . . identified and published on the Covered List.” See *Protecting Against National Security Threats to the Communications Supply Chain Through FCC Programs*, WC Docket No. 18-89, Second Report and Order, 35 FCC Rcd 14284, 14326, paras. 94-95 (2020); see also 47 CFR § 54.10; *Public Safety and Homeland Security Bureau Announces Publication of the List of Equipment and Services Covered by Section 2 of the Secure Networks Act*, WC Docket No. 18-89, Public Notice, DA 21-309 (PSHSB Mar. 12, 2021).

²⁰⁷ See *First COVID-19 Report and Order*, 35 FCC Rcd at 3376, para. 16. An example of a non-connected medical device is a non-connected digital thermometer. COVID-19 Telehealth Program FAQs, Question 27. See Appendix B for additional examples.

²⁰⁸ COVID-19 Telehealth Program FAQs, Question 27.

support connected care services and devices, but may not be used to support the development of new websites, systems, or platforms.²⁰⁹ Applicants may apply to receive retroactive funding for eligible services and devices purchased on or after March 13, 2020, so long as they did not receive Round 1 funding for those eligible services and devices.²¹⁰ Any services must have been purchased in response to the COVID-19 pandemic, but can include pandemic-related upgrades to existing services.²¹¹

60. We next address how long applicants may receive funding for eligible recurring services. During Round 1, having uncertainty as to how long the pandemic would last, we allowed applicants to request reimbursement for up to six months of eligible recurring services, but allowed applicants to request reimbursement for annual license agreements because of the one-time, up-front nature of those costs. We now anticipate that health care providers will likely continue to rely on telehealth and connected care services as a critical means of addressing the COVID-19 pandemic through at least a good portion of 2022.²¹² Accordingly, for Round 2, applicants may receive Program funding to support up to 12 months of eligible recurring services as well as eligible annual license agreements (only one one-year term will be funded).²¹³ This change will also provide more certainty to applicants and reduce confusion about the funding period.

D. Funding Commitment Process

61. Funding for Round 2 of the Program will be awarded in two phases in order to satisfy the statutory requirement that applicants be given an opportunity to provide additional information if their application is going to be denied, and in recognition that funding commitments must be awarded as soon as possible. In the initial commitment phase, at least \$150 million will be awarded to the highest-scoring applicants. Once the initial group of awardees is identified, applications outside that group will be provided a ten-day period to supplement their application. After that ten-day period, USAC will re-rank the remaining applications and award the remaining funding in the final commitment window. Bifurcating the funding awards allows us to expeditiously commit funding to the highest-scoring applicants while simultaneously complying with the statutory language requiring us to provide applicants an opportunity to supplement their applications.²¹⁴

1. Initial Commitments

62. We direct USAC, subject to Bureau and OMD oversight, to award at least \$150 million during the initial commitment phase. After the application filing window closes, USAC will score each application using the metrics we adopt above. After the applications are scored, USAC will rank all of the applications in descending order by the score assigned to each application. The initial funding

²⁰⁹ *Id.* at Question 28.

²¹⁰ *Id.* at Question 29.

²¹¹ *Id.* at Question 30. *See also* COVID-19 Telehealth Program FAQs, Question 31 (listing examples of ineligible items).

²¹² *See, e.g.,* Zeke Miller, Linda A. Johnson, & Jonathan Lemire, *Biden Stands By May Timeline for Vaccines for All US Adults*, Associated Press (Mar. 3, 2021), <https://apnews.com/article/joe-biden-coronavirus-pandemic-25738fba2ff638be1a1253d96199578> (reporting that President Biden hopes the country “return[s] to normal” sometime before early 2022, but would not provide a firm answer); Julie Steenhuisen & Kate Kelland, *When Will It End?: How a Changing Virus is Reshaping Scientists’ Views on COVID-19*, Reuters (Mar. 3, 2021), <https://www.reuters.com/article/us-health-coronavirus-variants-insight/when-will-it-end-how-a-changing-virus-is-reshaping-scientists-views-on-covid-19-idUSKBN2AV1T1>.

²¹³ CHI Comments at 2, n.4 (“The Commission should consider extending its programs to deploy internet connectivity past the six-month mark.”); *see also* Butler Healthcare Comments at 2-3 (“[F]urther clarity by the FCC regarding the time frame surrounding Round 2 and expense coverage would be valuable.”); Trinity Health Comments at 2.

²¹⁴ Consolidated Appropriations Act §§ 903(c)(5)(A)-(C).

commitments will then be made in two steps: the first equitable distribution step, as required by the Consolidated Appropriations Act, will ensure that applications with lead health care providers in every state, territory, and the District of Columbia are awarded funding commitments. The second step will award funding to the highest-scoring applications regardless of geographic location of the lead health care provider.

63. *Equitable Distribution.* USAC will first, as discussed above,²¹⁵ commit funding to the highest-scoring application with a lead health care provider in a state or territory that did not have an application with a lead health care provider from that state or territory receive Round 1 funding. Next, USAC will commit funding to the highest scoring application from each state, territory, and the District of Columbia, in which a lead health care provider applicant from that geographic location did receive Round 1 funding. Finally, USAC will commit funding to the second-highest-scoring application with a lead health care provider in a state or territory that did not have an application with a lead health care provider from that state or territory receive Round 1 funding.

64. *Highest-Scoring Applications.* After ensuring that funding is committed across all states, territories, and the District of Columbia, USAC, with oversight from the Bureau and OMD, will then begin to commit funding to the highest-scoring applications, in descending order, until at least \$150 million has been committed in the initial commitment window.²¹⁶ Once \$150 million in funding has been committed, any applications with the same score as the last application to receive a funding commitment will also receive a funding commitment, and the remaining appropriated funds will be rolled over into the final commitment window. Once the initial commitment awardees have been determined, we direct the Bureau to issue a Public Notice announcing those awardees, the amount of their awards, and the remaining funding available for the final commitment window.

2. Notifications of Intent to Deny and Opportunity to Supplement

65. Upon the Bureau's release of the Public Notice identifying the eligible health care providers awarded funding during the initial commitment phase, we direct USAC, with oversight from the Bureau, to issue notices of intent to deny to all Round 2 applications that did not receive funding awards during the initial commitment phase. In the Consolidated Appropriations Act, Congress directs the Commission to "issue notice to the applicant of the intent of the Commission to deny the application and the grounds for that decision" for any application the Commission chooses to deny and to "provide the applicant with 10 days to submit any supplementary information that the applicant determines relevant," which must be taken into account for the final funding decisions.²¹⁷ Accordingly, each notice will include a denial justification so that the applicant may know why its application was not funded during the initial commitment phase.²¹⁸ We direct the Bureau to provide guidance on how applicants may supplement their applications in the Public Notice announcing the winners from the initial commitment phase. As provided in the statute, applicants will have ten days from the date that this Public Notice is issued to supplement their applications. We direct USAC to consider the supplemental information before issuing the remaining funding awards.

66. We stress, however, that it is important for applicants to accurately fill out their applications at the time of initial submission, before they have an opportunity to supplement them. If an

²¹⁵ See *supra* para. 47.

²¹⁶ As an example, if \$10 million was awarded during the equitable distribution step of the initial commitment window, when funding commitments are awarded in each state, territory, and the District of Columbia, there would be at least \$140 million available for the highest-scoring applications.

²¹⁷ Consolidated Appropriations Act § 903(c)(5).

²¹⁸ We note that while we are required by statute to send every applicant that does not receive funding during the initial window a notice of our intent to deny their application, some of those applicants will ultimately receive funding.

applicant supplements its application and receives a score that would have qualified it for funding during the initial funding window, the initial funding commitments will not change and that application will only be eligible to receive funding during the final commitment window to the extent there are remaining funds.²¹⁹

3. Final Commitments

67. After the 10-day period during which unfunded Round 2 applicants may supplement their applications, we direct USAC, subject to Bureau oversight, to review any supplemental information submitted during the 10-day period for each applicant, make changes to prioritization scores as necessary, and re-rank the unfunded Round 2 applications according to the same prioritization scoring metrics used during the initial commitment phase. This process will include an evaluation of all remaining unfunded Round 2 applications, regardless of whether an applicant has chosen to supplement its application. After the applications are re-scored, we direct USAC, with oversight from the Bureau and OMD, to document the commitment of the remaining Round 2 funding to the highest scoring eligible applications with eligible funding requests, in descending order by score, until there is insufficient funding available.

68. If there are insufficient remaining funds to award the final eligible, qualifying application with the highest remaining prioritization score the entirety of its funding request, the application will receive the remaining funds in the Program. In the event there is more than one eligible, qualifying application with the same highest remaining prioritization score, the remaining funds will be split proportionally among each application in this final scoring tier.²²⁰ We believe that this is the fairest approach to distributing the remaining funds to these applicants. Because this will result in the remaining applicants each receiving a partial award of funds, we expect the Bureau to work with affected applicants to determine if the proposed commitment meets the needs of the applicant and if the applicant is still interested in receiving a portion of the requested Program support.

69. Finally, we direct the Bureau and OMD to release a second Public Notice announcing the final list of awardees and funding commitments from both phases. Additionally, we direct USAC, with oversight from the Bureau, to issue final denials to each unfunded Round 2 applicant providing the justification for the denial of its application.

E. Round 2 Outreach

70. We remain committed to doing our part to help health care providers address the COVID-19 pandemic as demand for telehealth and connected care services increases, and we believe that coordination and outreach with health care providers before the application filing window opens will improve the overall efficacy of Round 2 of the Program. Upon release of this Report and Order, to ensure that health care providers are aware of the available funding under the Round 2 of the Program, we direct USAC to coordinate with the FCC's Connect2Health Task Force, as necessary, to promote and announce Round 2 to interested stakeholders, including service providers and health care providers. We direct USAC to respond to any questions from health care providers regarding Round 2, including, but not limited to, questions about the eligibility and application processes, application status, funding awards, and request for reimbursement process.

²¹⁹ If an applicant determines that they made an error on their application and this has resulted in an incorrectly high prioritization score, however, they are responsible for notifying the Commission as soon as they discover the error, and the funding that was awarded to that applicant may be made available during the final commitment phase, or at a later point.

²²⁰ We refer to applications with the same prioritization score as being in the same "scoring tier."

71. *Outreach to Tribal Communities.* American Indians and Alaska Natives (AI/AN) are among the racial and ethnic minority groups at highest risk from COVID-19.²²¹ The CDC found that in 23 selected states, the cumulative incidence of laboratory-confirmed COVID-19 cases among cases among AI/AN was 3.5 times that of non-Hispanic whites.²²² To address these issues, we direct USAC to also focus its outreach efforts on Tribal communities and health care providers in those areas.

72. We also direct USAC to coordinate with the Commission's Consumer and Governmental Affairs Bureau and its Office of Native Affairs and Policy, as necessary, to promote and announce Round 2 of the Program throughout Tribal health care communities. We direct USAC to use its Tribal Liaison to assist with Tribal-specific outreach, training, and assistance for Round 2.²²³ The Tribal Liaison should provide direct communication with Tribal health care providers throughout the application and invoicing processes, help conduct and coordinate Tribal-specific trainings and training materials, and field questions from Tribal health care providers. By directing USAC to leverage the existing connections of its Tribal Liaison, we help ensure that Tribal health care providers can fully participate and effectively access funding during Round 2.

F. Round 2 Invoicing and Disbursements

73. *Invoicing and Disbursements.* We direct USAC, with Bureau and OMD oversight, to use the same reimbursement structure for Round 2 as was used for Round 1. We conclude that using the same reimbursement structure will allow us to use the existing invoicing systems, processes, and procedures already in use for Round 1. The current system is effective, and it would be impractical to expend limited resources to develop an entirely new invoicing system, processes, and procedures solely for Round 2. Accordingly, Round 2 funding recipients must submit their requests for reimbursement, and any necessary subsequent filings (to include any information necessary to satisfy the Commission's oversight responsibilities and/or agency-specific/government-wide reporting obligations associated with the appropriation by Congress)²²⁴ through the Invoice Processing Platform (IPP), which is part of the U.S. Department of the Treasury's Bureau of Fiscal Services. Funding recipients must first pay the vendor or service provider for the costs of the eligible services and/or connected devices received before requesting reimbursement for those costs from the COVID-19 Telehealth Program.²²⁵ The COVID-19 Telehealth Program will not directly pay a health care provider's service providers or vendors.

74. Upon receipt of services and/or connected devices and subsequent payment by the health care provider(s) of the costs of the eligible services and/or connected devices to the service provider or vendor, a funding recipient shall submit its requests for reimbursement and supporting documentation to receive reimbursement for the cost of the eligible services and/or devices they have received from their

²²¹ Centers for Disease Control and Prevention, *CDC Data Shows Disproportionate COVID-19 Impact on American Indian/Alaskan Native Populations*, <https://www.cdc.gov/media/releases/2020/p0819-covid-19-impact-american-indian-alaska-native.html> (updated Aug. 19, 2020).

²²² *See id.*

²²³ *See* Universal Service Administrative Company, *Tribal Nations*, <https://www.usac.org/about/tribal-nations/> (last visited Mar. 15, 2021).

²²⁴ CARES Act, Public Law 116-136 (Mar. 27, 2020), DIVISION B, entitled "Emergency Appropriations for Coronavirus Health Response and Agency Operations," Title V, Sec. 15011.

²²⁵ *See* Mount Sinai Comments at 4. We decline to adopt the suggestion that we allow applicants to access committed funds prior to first purchasing the eligible services and connected devices and request reimbursement. *See* Elite Program Comments at 4; Mount Sinai Comments at 4; SHLB Comments at 9. We also decline to adopt the suggestion that we use "a two-phased approach, wherein a smaller amount of initial seed funding is provided with continued support predicated on meeting performance goals or other milestones." Hudson Headwaters Health Comments at 4. We are mindful of our responsibility to prevent waste, fraud, and abuse of Program funding, and we believe that verifying each applicant's purchase of eligible services and connected devices prior to reimbursement is an important part of this responsibility.

applicable service providers or vendors under the Program.²²⁶ We emphasize that Program funds shall only be used for services and devices eligible under the CARES Act. The cost of ineligible items must not be included in the reimbursement requests for the Program. To guard against potential waste, fraud, and abuse, we reiterate that participating health care providers are prohibited from selling, reselling, or transferring services or devices funded through the Program in consideration for money or any other things of value.²²⁷ Moreover, we remind applicants that they shall not use Program funding to pay for the non-discount share of services purchased under the Rural Healthcare Program. Finally, we remind applicants that they must certify, under penalty of perjury, that they have not received and may not receive duplicative funding for the same services from state, local, or federal sources twice. For example, applicants may not receive funding from both the Program and the Connected Care Pilot Program for the same services or connected devices. Applicants must agree to withdraw their Round 2 application if they receive duplicative funding from another source.

75. In reviewing requests for reimbursement, USAC shall ensure that funding is only awarded after receiving documentation that demonstrates the eligibility of the requested items and substantiates the cost of those items. USAC will review the request for reimbursement forms along with all supporting documentation, and approve requests for reimbursement for eligible items that are supported by invoice documentation. We direct USAC not to accept requests for reimbursement that do not contain the required certifications as part of the Request for Reimbursement Form to ensure that Program funds are used for their intended purpose. We delegate to the Bureau, in coordination with OMD, the authority to make changes to the Request for Reimbursement Form that was used in COVID-19 Telehealth Program Round 1 to facilitate Program administration and to better track expenditures under the COVID-19 Telehealth Program.²²⁸

76. *Red Light Rule.* Additionally, we find that it remains in the public interest, and good cause still exists, to waive the Commission's "red light" rule with respect to applications to the Program.²²⁹ As part of the collection and disbursement rules associated with the Debt Collection Improvement Act,²³⁰ the Commission may withhold action on applications and requests made by any entity found to be delinquent in its debt to the Commission until full payment or resolution of such debt.²³¹ This is commonly referred to as the Commission's "red light" rule. For Round 1 of the Program, OMD and the Bureau found that it was in the public interest and good cause existed to waive the "red light" rule because of the extremely unusual circumstances the COVID-19 pandemic presented for health care providers.²³² We find that this reasoning remains true today; therefore, we continue the waiver of the

²²⁶ Applicants that distribute Program funding to other health care provider sites must submit Letter(s) of Authorization with their request for reimbursement form to demonstrate that the lead health care provider has been given permission to distribute the requested funding to the other health care provider sites listed on its application.

²²⁷ *First COVID-19 Report and Order*, 35 FCC Rcd at 3382, para. 30.

²²⁸ Pursuant to section 903(e) of the Consolidated Appropriations Act, the collection of information sponsored or conducted under the regulations promulgated in this Report and Order is deemed not to constitute a collection of information for the purposes of the Paperwork Reduction Act, 44 U.S.C. §§ 3501-3521. Accordingly, any changes made to the Request for Reimbursement Form for Round 2 do not require PRA approval.

²²⁹ *The Office of Managing Director and Wireline Competition Bureau Suspend the Red Light Rule for the COVID-19 Telehealth Program*, WC Docket No. 20-89, Public Notice, 35 FCC Rcd 3685 (WCB and OMD 2020) (*Red Light Rule Waiver COVID-19 Public Notice*).

²³⁰ Debt Collection Improvement Act of 1996, Pub. L. No. 104-134, 110 Stat. 1321, 1358 (1996); *Amendment of Parts 0 and 1 of the Commission's Rules/Implementation of the Debt Collection Improvement Act of 1996 and Adoption of Rules Governing Applications or Requests for Benefits by Delinquent Debtors*, Report and Order, 19 FCC Rcd 6540 (2004).

²³¹ 47 CFR § 1.1910(b)(2).

²³² *Red Light Rule Waiver COVID-19 Public Notice*, 35 FCC Rcd at 3686.

Commission's "red light" rule for Round 2 applicants. As with Round 1, we do not expect there to be a large number of applicants to the Program that are delinquent in their debt to the Commission, and we reiterate that this waiver is limited to COVID-19 Telehealth Program applicants. This waiver does not affect the Commission's right or obligation to collect any debt owed by an applicant by any other means available to the Commission, including by referral to the U.S. Treasury for collection.

77. *Post-Program Reporting and Feedback.* Throughout this Report and Order, we reviewed stakeholder comments as guideposts for our decisions related to the telecommunications services, information services, and connected devices needs of eligible health care providers and their ability to obtain those services to assist their patients throughout this pandemic.²³³ We adopt reporting obligations for USAC and for COVID-19 Telehealth Program Round 2 participants that will enable us to measure the funding impact. While we identify specific reporting obligations, we delegate authority to the Bureau, in coordination with OMD, to finalize the format of those reporting obligations.²³⁴

78. We further direct USAC to collect, within six months after the conclusion of the COVID-19 Telehealth Program Round 2,²³⁵ feedback on the Program from Round 2 funding awardees. After collecting this feedback, USAC shall provide a report to the Commission in a format to be approved by the Bureau on the effectiveness of the COVID-19 Telehealth Program funding on health outcomes, patient treatment, health care facility administration, benefits from services and connected devices on patients treatments and outcomes, administration, and health care providers overall expanded telehealth programs, and any other relevant aspects of the COVID-19 pandemic. Such information could include: feedback on the application and invoicing processes; a description of how funding was helpful in providing or expanding telehealth services, including anonymized patient accounts; a description of how funding promoted innovation and improved health outcomes; and other areas for improvement. We delegate authority to the Bureau to update the Post-Program Feedback Report Template based on its experience with Round 1 Post-Program Feedback Reports. We direct the Bureau to provide specific information about how to provide feedback, and associated deadlines, to Round 2 funding recipients. This information will assist Commission efforts to respond to pandemics and other national emergencies in the future.²³⁶

79. *Audits.* While we seek to ease the burdens upon applicants and service providers, we are mindful of our commitment to ensuring the Program's integrity by protecting against waste, fraud, and abuse. We believe that proper documentation is crucial for demonstrating health care providers' compliance with the COVID-19 Telehealth Program rules, and for uncovering waste, fraud, and abuse in the Program, whether through compliance audits or investigations. The Commission's Office of

²³³ See, e.g., IFH Comments at 1 ("We encourage FCC to continue to offer applicants flexibility in modifying their purchases based on supply chain issues and/or evolving program needs."); Butler Healthcare Comments at 2-3 ("BMH further recommends that FCC publish a list of eligible and ineligible services and equipment which would reduce the burden on both the FCC and providers.").

²³⁴ In doing so, OMD and the Bureau will ensure that such reporting satisfies the CARES Act oversight provisions incorporated by Congress by reference in the Consolidated Appropriations Act. Consolidated Appropriations Act, 2021, H.R. 133, div. O, tit. VIII—Pandemic Response Accountability Committee Amendments § 801, Amendment to the Pandemic Response Accountability Committee (2020).

²³⁵ This deadline will be calculated from the invoice filing deadline for Round 2. We direct the Bureau to issue a Public Notice announcing the post-program feedback report deadline and to provide a reporting template and instructions on how to submit the final reports for Round 2 funding.

²³⁶ Pursuant to section 903(e) of the Consolidated Appropriations Act, the collection of information sponsored or conducted under the regulations promulgated in this Report and Order is deemed not to constitute a collection of information for the purposes of the Paperwork Reduction Act, 44 U.S.C. §§ 3501-3521. Accordingly, any changes made to the Post-Program Feedback Report for Round 2 do not require PRA approval.

Inspector General was allocated Program funds to provide oversight,²³⁷ and we will provide further guidance about audit procedures at a later date. In this regard, we note that in Round 1 the Commission leveraged audits conducted under the Single Audit Act to oversee the program.²³⁸

80. To that end, we delegate authority to OMD to develop and implement an audit process of participating health care providers that complies with the requirements and procedures of the COVID-19 Telehealth Program. OMD may obtain the assistance of third parties, including but not limited to USAC, in carrying out this effort. Consistent with our experience with the Universal Service Fund, we find that audits are the most effective way to ensure compliance with our rule requirements.²³⁹ Funding recipients are required to maintain documentation sufficient to demonstrate their compliance with program rules for six years after the last date of delivery of services or connected devices supported through the COVID-19 Telehealth Program. Upon request, COVID-19 Telehealth Program participants must submit documents sufficient to demonstrate compliance with Program rules, including, at a minimum, applications, contracts, communications related to Program services, invoices, delivery records, and purchase and receipt records. Additionally, certain health care providers participating in the COVID-19 Telehealth Program that meet the thresholds for being audited under the Single Audit Act are subject to a single audit that contains the FCC compliance supplement for the COVID-19 Telehealth Program.²⁴⁰

81. *Administrative Procedure Act Exception.* The Administrative Procedure Act (APA) provides that with a showing of “good cause,” an agency is permitted to make rules effective before 30 days after publication in the Federal Register.²⁴¹ “In determining whether good cause exists, an agency should ‘balance the necessity for immediate implementation against principles of fundamental fairness which require that all affected persons be afforded a reasonable amount of time to prepare for the effective date of its ruling.’”²⁴² As a general matter, we believe that the APA requirements are an essential component of our rulemaking process. In this case, however, because of the unprecedented nature of this pandemic and the need for immediate action, we find there is good cause to make the Program rules effective upon publication of this Report and Order in the Federal Register.²⁴³ In light of the continued spread of COVID-19 and the increasing need to address this public health crisis, any further

²³⁷ Consolidated Appropriations Act § 903(b). In addition, the section 903 appropriation, like all other Division N appropriations, is subject to the same oversight provisions included in the CARES Act, Consolidated Appropriations Act, 2021, H.R. 133, div. O, tit. VIII—Pandemic Response Accountability Committee Amendments § 801, Amendment to the Pandemic Response Accountability Committee (2020). OMB guidance on such provisions also continues to apply. See OMB Memorandum M-20-21, Implementation Guidance for Supplemental Funding Provided in Response to the Coronavirus Disease 2019 (COVID-19).

²³⁸ The Single Audit Act is codified, as amended, at 31 U.S.C. §§ 7501-06, and implementing Office of Management and Budget (OMB) guidance is reprinted in 2 CFR Part 200 (2020).

²³⁹ See Secure and Trusted Communications Networks Act of 2019, Pub. L. No. 116-124, 133 Stat. 158, § 4(e)(3)(A) (2020) (codified as amended at 47 U.S.C. §§ 1601–1609) (Secure Networks Act); *Protecting Against National Security Threats to the Communications Supply Chain Through FCC Programs*, WC Docket No. 18-89, Report and Order, Further Notice of Proposed Rulemaking, and Order, 34 FCC Rcd 11423, 11454, para. 80 (2019).

²⁴⁰ For health care providers subject to a single audit, the CFDA number for the COVID-19 Telehealth Program is 32.006. The Single Audit Act is codified, as amended, at 31 U.S.C. §§ 7501-06, and implementing Office of Management and Budget (OMB) guidance is reprinted in 2 CFR Part 200 (2020). Federal award recipients that expend \$750,000 or more in federal awards in a fiscal year are required to undergo a single audit, which is an audit of an entity’s financial statements and federal awards, or a program-specific audit, for the fiscal year. 31 U.S.C. § 7502; 31 CFR § 200.501 (2020).

²⁴¹ 5 U.S.C. § 553(d)(3).

²⁴² *Omnipoint Corp. v. FCC*, 78 F.3d 620, 630 (D.C. Cir. 1996) (citation omitted).

²⁴³ 5 U.S.C. § 553(d). See 47 CFR §§ 1.103(a), 1.427(b).

delay in the use of these funds to assist health care providers in meeting the health care needs of their patients could impede efforts to mitigate the spread of the disease. Waiting an additional 30 days to make this relief available “would undermine the public interest by delaying” much needed expansion of telemedicine resources.²⁴⁴

IV. ORDER ON RECONSIDERATION

82. On April 9, 2020, the American Hospital Association (AHA) filed a Petition for Partial Reconsideration of the Commission’s *First COVID-19 Report and Order*.²⁴⁵ AHA’s petition was limited to the Commission’s decision to limit eligibility in the Program to the statutorily enumerated providers who are eligible for the Rural Health Care Program.²⁴⁶ More specifically, AHA’s petition sought to extend Program eligibility to “all types of hospitals and other direct patient care facilities regardless of their size, location or for-profit or not-for-profit status.” Several commenters filed responses in support of the petition.²⁴⁷

83. We conclude that granting the petition for reconsideration would be contrary to the public interest and that our decision here is consistent with Congressional intent. Accordingly, we deny the petition. In the CARES Act, Congress gave the Commission the authority to rely on its already-existing rules to administer Round 1 of the Program,²⁴⁸ and, consistent with that authority, the Commission adopted the definition of “health care provider” as set out in the Communications Act and our rules.²⁴⁹ The Commission reached this conclusion because it was consistent with both the Communications Act and the CARES Act, and because it would help us “ensure that funding is targeted to health care providers that are likely to be most in need of funding to respond to this pandemic while helping us ensure that funding is used for its intended purposes.”²⁵⁰ We reach the same conclusion today, and conclude that directing Program funding away from non-profit providers would be contrary to the public interest.

84. In limiting eligibility of health care providers under the Universal Service Fund (USF) to certain categories of health care providers, Congress effectively expressed its view that these providers were those most in need of USF support. Accordingly, the Commission has limited RHC Program support to these entities. Similarly, during this pandemic, we have no reason to conclude that these providers are not also the most in need of support for telehealth. Particularly where the demand for these COVID-19 telehealth funds is much greater than availability, as it was in Round 1, we reiterate our conclusion that it is in the public interest to limit eligibility to those entities listed by Congress in section 254(h)(7)(B), including the limitation to not-for-profit hospitals.

85. This conclusion is bolstered by recent Congressional action through the Consolidated Appropriations Act, when Congress appropriated additional funding for a second round of the Program. By directing these funds to “the COVID–19 Telehealth Program established by the Commission” under

²⁴⁴ *Id.*

²⁴⁵ Petition of the American Hospital Association for Partial Reconsideration at 1, WC Docket No. 20-89 (Apr. 9, 2020) (Petition).

²⁴⁶ *Id.* at 1.

²⁴⁷ See e.g., Letter from Nancy E. Taylor, Counsel, Rural Hospital Coalition, to Commissioner Michael O’Rielly, FCC, WC Docket No. 20-89 (filed May 5, 2020) (Rural Hospital Coalition *Ex Parte*); Letter from Clif Gaus, President and CEO, National Association of Accountable Care Organizations, to Chairman Ajit Pai, FCC, WC Docket No. 20-89 (filed May 6, 2020) (NAACOS *Ex Parte*).

²⁴⁸ CARES Act, 134 Stat. at 531.

²⁴⁹ *First COVID-19 Report and Order*, 35 FCC Rcd at 3378, para. 20; 47 U.S.C. § 254(h)(7)(B).

²⁵⁰ *Id.*

the authority of the CARES Act,²⁵¹ without modifying the eligibility requirements, Congress indicated that it saw no need to change these requirements, especially in light of the fact that Congress chose to mandate a number of other changes to the Program.

86. AHA argues that the COVID-19 pandemic has financially impacted all health care providers,²⁵² and that many smaller hospitals operate as part of a larger health care system, which could also render these hospitals ineligible for the Program. Additionally, AHA argues that because the Commission has previously “determined that emergency departments of for-profit hospitals that participate in Medicare should be deemed ‘public’ health care providers within the meaning of section 254(h)(7)(B) of the Act,”²⁵³ it has previously acknowledged the importance of for-profit hospitals, and that those providers are “public” by nature of their obligation to treat all emergency patients. We find these arguments unpersuasive. Our previous conclusion that emergency departments of for-profit hospitals that participate in Medicare can participate in the Rural Health Care Program reflected a careful balance of multiple considerations, and those same emergency departments remain eligible for the Program as well.²⁵⁴ Similarly, while we acknowledge the important role played by smaller hospitals who operate as part of a larger health care system, we note that by definition these smaller hospitals have available to them the resources of a larger, for-profit health care system. Finally, Congress has had occasion as recently as 2016 to revisit the health care providers who should be eligible for the Rural Health Care program, and to date it has not included for-profit hospitals as eligible.²⁵⁵ While we do not dispute that all health care providers have been impacted by the COVID-19 pandemic, that does not alter our conclusion that our limited funding is best directed towards those entities listed by Congress in section 254(h)(7)(B).

V. PROCEDURAL MATTERS

87. *Paperwork Reduction Act.* Pursuant to section 903(e) of the Consolidated Appropriations Act, the collection of information sponsored or conducted under the regulations promulgated in this Report and Order is deemed not to constitute a collection of information for the purposes of the Paperwork Reduction Act, 44 U.S.C. §§ 3501-3521.²⁵⁶

88. *Congressional Review Act.* The Commission has determined, and the Administrator of the Office of Information and Regulatory Affairs, Office of Management Budget (OMB), concurs that the rules implementing the COVID-19 Telehealth Program are “major” under the Congressional Review Act, 5 U.S.C. § 804(2). Because we find good cause that compliance with the notice and public procedure requirements of the Administrative Procedure Act on the rules adopted herein is impracticable, unnecessary, or contrary to the public interest, this Report and Order will become effective immediately upon publication of this Report and Order in the Federal Register pursuant to 5 U.S.C. § 808(2). The Commission will send a copy of this Report and Order to Congress and the Government Accountability Office pursuant to § 801(a)(1)(A).

VI. ORDERING CLAUSES

89. Accordingly, IT IS ORDERED that, pursuant to the authority contained in sections 201, 254, 303(r), and 403 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 201, 254, 303(r), and

²⁵¹ Consolidated Appropriations Act § 903(a)(3).

²⁵² Petition at 4-5.

²⁵³ *Id.* at 5.

²⁵⁴ *See supra* note 79.

²⁵⁵ *See* Frank R. Lautenberg Chemical Safety for the 21st Century Act, Title II – Rural Healthcare Connectivity, Pub. L. No. 114-182 (2016) (*Rural Health Care Connectivity Act of 2016*) (amending section 254 to include skilled nursing facilities as eligible health care providers under the RHC program).

²⁵⁶ *See* Consolidated Appropriations Act, div. N, tit. IX, § 903(e).

403, DIVISION B of the Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No 116-136, 134 Stat. 281, and DIVISION N of the Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, 134 Stat. 1182, this Report and Order IS ADOPTED.

90. IT IS FURTHER ORDERED that, pursuant to the authority contained in section 808(2) of the Congressional Review Act, 5 U.S.C. § 808(2), and 5 U.S.C. § 553(d), this Report and Order SHALL BECOME EFFECTIVE immediately upon publication in the Federal Register.

91. IT IS FURTHER ORDERED that the Commission SHALL SEND a copy of this Report and Order to the appropriate Congressional Committees identified in the Consolidation Appropriations Act to provide notice of the application evaluation metrics.

92. IT IS FURTHER ORDERED that the Commission SHALL SEND a copy of this Report and Order to Congress and the Government Accountability Office pursuant to the Congressional Review Act, *see* 5 U.S.C. § 801(a)(1)(A).

93. IT IS FURTHER ORDERED that, pursuant to sections 4(i) and 405 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 154(i), 405, and section 1.429 of the Commission's rules, 47 CFR § 1.429, the Petition for Partial Reconsideration filed by the American Hospital Association is DENIED.

FEDERAL COMMUNICATIONS COMMISSION

Marlene H. Dortch
Secretary

APPENDIX A

LIST OF COMMENTERS

*Wireline Competition Bureau Seeks Comment on COVID-19 Telehealth Program Application
Evaluation Metrics (January 6th Public Notice)*

Comments

<i>Commenter</i>	<i>Abbreviation</i>	<i>Date Filed</i>
19Labs	19Labs	Jan. 19, 2021
Alzheimer's Association and the Alzheimer's Impact Movement	Alzheimer's Association	Jan. 19, 2021
American Dental Association	ADA	Jan. 19, 2021
Association for Utah Community Health	AUCH	Jan. 19, 2021
Blessing Corporate Services	Blessing Corporate	Jan. 19, 2021
Butler Healthcare Providers, dba, Butler Memorial Hospital	Butler Healthcare	Jan. 19, 2021
California Primary Care Association	CPCA	Jan. 22, 2021
Centerstone	Centerstone	Jan. 19, 2021
Central Florida Family Health Center, Inc., True Health	True Health	Jan. 14, 2021
Children's Hospital Association	Children's Hosp. Assoc.	Jan. 19, 2021
Children's Wisconsin	Children's Wis.	Jan. 19, 2021
College of Healthcare Information Management Executives	CHIME	Jan. 19, 2021
Colorado Community Health Network	CCHN	Jan. 19, 2021
Community HealthCare Association of the Dakotas	CHAD	Jan. 19, 2021
Compass Health Center	Compass Health	Jan. 22, 2021
Connected Health Initiative	CHI	Jan. 19, 2021
Connecticut Children's	CT Children's	Jan. 19, 2021
Covenant Health	Covenant Health	Jan. 22, 2021
Duke Health	Duke Health	Jan. 22, 2021
Eagle View Community Health System	Eagle View	Jan. 19, 2021
Elite Program Specialists	Elite Program	Jan. 19, 2021
Ethan Whitener	Ethan Whitener	Jan. 7, 2021
Florida Association of Community Health Centers	FACHC	Jan. 19, 2021
Great Mines Health Center	Great Mines Health	Jan. 19, 2021
Gundersen Health System	Gundersen Health	Jan. 19, 2021
Hawai'i Pacific Health	Hawai'i Pacific Health	Jan. 19, 2021
Health Facilities Planning & Development	HFPD	Jan. 21, 2021
Henry Ford Health System	Henry Ford Health	Jan. 19, 2021
Horizon Health Services	Horizon Health	Jan. 12, 2021
Hospital Sisters Health System	Hospital Sisters Health	Jan. 19, 2021
Hudson Headwaters Health Network	Hudson Headwaters Health	Jan. 19, 2021
Icahn School of Medicine at Mount Sinai	Mount Sinai	Jan. 13, 2021
Institute for Family Health	IFH	Jan. 19, 2021
Iowa Primary Care Association	IPCA	Jan. 19, 2021
Jewish Federations of North America	JFNA	Jan. 22, 2021
Kokua Kalihi Valley Comprehensive Family Services	Kokua Kalihi Valley	Jan. 19, 2021
LCMC Health	LCMC Health	Jan. 19, 2021
Lewis County Community Health Services dba Valley View Health Center	Lewis County	Jan. 19, 2021
LoneStar Healthcare Communications Consortium	LoneStar	Jan. 21, 2021
Marana Health Center, Inc.	Marana Health	Jan. 19, 2021
Masimo	Masimo	Jan. 19, 2021
Medical University of South Carolina (MUSC) Center for	MUSC Center	Jan. 19, 2021

Telehealth		
Melissa Griggs	Melissa Griggs	Jan. 19, 2021
Miami Beach Community Health Center	MBCHC	Jan. 19, 2021
Montefiore Health System	Montefiore Health	Jan. 14, 2021
National Advisory Committee on Rural Health and Human Services	NACRHHS	Jan. 19, 2021
National Association of Community Health Centers, Inc.	NACHC	Jan. 19, 2021
National Healthy Start Association	NHSA	Jan. 19, 2021
Netsmart	Netsmart	Jan. 19, 2021
Northern Light Health	Northern Light Health	Jan. 19, 2021
OCHIN	OCHIN	Jan. 19, 2021
Ochsner Health System	Ochsner Health	Jan. 22, 2021
Paradise Valley Estates	Paradise Valley	Jan. 19, 2021
Parkview Health, Inc.	Parkview Health	Jan. 15, 2021
Physicians Advocacy Institute	PAI	Jan. 19, 2021
Planned Parenthood Federation of America.	Planned Parenthood	Jan. 22, 2021
Rush Health Systems	Rush Health	Jan. 19, 2021
Rush University Medical Center	Rush University	Jan. 20, 2021
Russell Doyle	Russell Doyle	Jan. 19, 2021
San Francisco Department of Technology	San Francisco	Jan. 21, 2021
Savoy Medical Management Group, Inc.	Savoy Medical	Jan. 19, 2021
School-Based Health Alliance	SBHA	Jan. 19, 2021
Schools, Health & Libraries Broadband Coalition	SHLB	Jan. 19, 2021
SOC Telemed	SOC Telemed	Jan. 22, 2021
Southcoast Hospitals Group	Southcoast Health	Jan. 19, 2021
Stel Life, Inc.	Stel Life	Jan. 19, 2021
St. Luke's Hospital	St. Luke's Hospital	Jan. 22, 2021
Telecommunications for the Deaf and Hard of Hearing, Inc., Deaf Seniors of America, National Cued Speech Association, National Association of the Deaf, Rehabilitation Engineering Research Center on Technology for the Deaf and Hard of Hearing, Cerebral Palsy and Deaf Organization, Registry of Interpreters for the Deaf, Inc., Association of Late-Deafened Adults, CueSign, Inc., National Black Deaf Advocates, Clear2Connect Coalition, Rehabilitation Engineering Research Center on Universal Interface & Information Technology Access, California Coalition of Agencies Serving the Deaf and Hard of Hearing, Hearing Loss Association of America, National Association of State Administrators of the Deaf and Hard of Hearing	TDI et al.	Jan. 22, 2021
Telecommunications Regulatory Bureau of Puerto Rico	Telecom Bureau of Puerto Rico	Jan. 19, 2021
Tennessee Primary Care Association	TPCA	Jan. 19, 2021
Texas Medical Association	TMA	Jan. 14, 2021
The Ohio State University Wexner Medical and its affiliate OSUPhysicians, Inc.	Wexner Medical	Jan. 19, 2021
Trinity Health	Trinity Health	Jan. 19, 2021
U.S. Chamber of Commerce	Chamber of Commerce	Jan. 19, 2021
UnityPoint Health	UnityPoint Health	Jan. 19, 2021
University of Alabama at Birmingham Hospital	UAB Hospital	Jan. 19, 2021
University of Colorado, School of Medicine	CUSOM	Jan. 19, 2021
University of Hawaii Pacific Basin Telehealth Resource	UHPBTRC	Jan. 22, 2021

Center		
USA Health, University of South Alabama, University of South Alabama Health Care Authority	USA Health	Jan. 22, 2021
USTelecom - The Broadband Association	USTelecom	Jan. 22, 2021
Virginia Community Healthcare Association	VCHA	Mar. 2, 2021
Virginia Telehealth Network	VTN	Jan. 19, 2021
Washington University Physicians at Washington University School of Medicine in St. Louis	WU Physicians	Jan. 19, 2021

Ex Parte Filings

<i>Ex Parte Filer</i>	<i>Abbreviation</i>	<i>Date Filed</i>
Charles N. Kahn III, President and CEO, Federation of American Hospitals	FAH <i>Ex Parte</i>	Apr. 10, 2020
Clif Gaus, President and CEO, National Association of Accountable Care Organizations	NAACOS <i>Ex Parte</i>	May 6, 2020
Kali P. Chaudhuri, MD, Founder & Chairman, KPC Health, and Peter Baronoff, Chief Executive Officer, KPC Health	KPC Health <i>Ex Parte</i>	Jan. 22, 2021
Marty Paslick, Chief Information Officer, HCA Healthcare	HCA <i>Ex Parte</i>	Apr. 27, 2020
Nancy E. Taylor, Counsel, Rural Hospital Coalition	Rural Hospital Coalition <i>Ex Parte</i>	May 5, 2020

APPENDIX B

ELIGIBLE SERVICES LIST FOR COVID-19 TELEHEALTH PROGRAM: ROUND 2

The Federal Communications Commission (FCC) provides this list as guidance for applicants on the services and devices that are eligible for funding under the COVID-19 Telehealth Program (Program). Pursuant to the CARES Act, the Program awards funds to eligible health care providers to support the purchase of “telecommunications services, information services, and devices necessary” to provide telehealth and connected care in response to the COVID-19 pandemic. Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No 116-136, 134 Stat. 281 (2020) (CARES Act). Congress appropriated \$249.95 million in additional funding for the Program in December 2020. Consolidated Appropriations Act, 2021, Pub. L. No: 116-260, Division N-Additional Coronavirus Response and Relief, Title IX-Broadband Internet Access Service, § 903 “FCC COVID19 Telehealth Program” (2020). The Telecommunications services, information services, and connected devices funded through the Program must be integral to patient care.

We caution applicants to carefully review all Program guidance. Applicants are ultimately responsible for compliance with Program requirements, including all deadlines and eligibility requirements.

Eligible Services and Devices

Consistent with Round 1, the Commission interprets the language regarding devices to include only connected devices but not devices that patients use at their homes that do not have a connection to the internet, even if those devices allow the patient to manually report information to their medical professionals remotely. *Promoting Telehealth for Low-Income Consumers; COVID-19 Telehealth Program*, WC Docket Nos. 18-213, 20-89, Report and Order, 35 FCC Rcd 3366, 3376, para. 16 (2020). Connected devices may include Bluetooth or Wi-Fi enabled devices, or that connect to the Internet directly, including devices/peripherals (e.g., web cameras, stethoscopes) that connect to a consumer’s phone or other connected device for purposes of providing telehealth services. Network equipment needed to use telecommunications services, information services, or connected devices are also eligible. The costs for taxes, shipping, and installation or integration of eligible devices and services, are also eligible expenses.

Examples of eligible services and connected devices include:

- **Telecommunications Services and Broadband Connectivity Services:** Voice services and Internet connectivity services for health care providers or their patients. These expenses are eligible for up to 12 months of funding.
- **Information Services:** Remote patient monitoring platforms and services; patient reported outcome platforms; store and forward services, such as asynchronous transfer of patient images and data for interpretation by a physician; platforms and services to provide synchronous video consultation. These expenses are eligible for up to 12 months of funding.
- **Connected Devices:** Tablets, smart phones, or connected devices to provide telehealth services (e.g., broadband, Wi-Fi, or Bluetooth enabled blood pressure monitors; pulse-oximeters) for patient or health care provider use; telemedicine kiosks/carts for health care provider site. General office scanners and printers are not considered connected devices for purposes of this Program.

Ineligible Costs

The Program does not support funding for personnel costs, marketing costs, administrative expenses, training costs, or indirect costs. Program funds are to support the purchase of telecommunications services, information services, and connected devices to provide telehealth services in response to the COVID-19 pandemic and are not intended to fund the development of new websites, systems, or platforms. Applicants may still apply to receive retroactive funding for eligible services and connected devices purchased on or after March 13, 2020. Such services or devices must have been purchased to

provide telehealth or connected care services in response to the COVID-19 pandemic and can include pandemic-related upgrades to existing services. Because the Program is a “Federal subsidy made available through a program administered by the Commission,” program funding may not be used to “purchase, rent, lease, or otherwise obtain any communications equipment or service . . . identified and published on the Covered List.” See *Protecting Against National Security Threats to the Communications Supply Chain Through FCC Programs*, WC Docket No. 18-89, Second Report and Order, 35 FCC Rcd 14284, 14326, paras. 94-95 (2020); see also 47 CFR § 54.10; *Public Safety and Homeland Security Bureau Announces Publication of the List of Equipment and Services Covered by Section 2 of the Secure Networks Act*, WC Docket No. 18-89, Public Notice, DA 21-309 (PSHSB Mar. 12, 2021).

Examples of ineligible services and devices include:

- Services or devices purchased or implemented prior to March 13, 2020.
- Administrative costs, e.g., personnel expenses, consultant fees, payroll, training, customer service, project management, records management, reprocessing and logistics, and doctor’s costs, etc.
- Technical support, maintenance costs, separate costs for warranties and protection plans.
- Separate costs for non-connected accessories, e.g., cases, mouse pads, cable clips, laptop bags, tablet stands, wall mounts, and charging stations, etc.
- Smart watches and fitness trackers.
- Back-up Power Equipment, e.g., back-up batteries, redundant power cords, Uninterruptible Power Supply (UPS), generators, and surge protectors, etc.
- Non-connected medical devices or supplies, e.g., non-connected digital thermometers, testing strips, lancets, disposable covers, and personal protective equipment, etc.
- Construction costs, e.g., fiber/ethernet/cable network constructions, facility alterations, and temporary site location structures, etc.
- Non-telehealth items, e.g., office furniture and supplies, desks, security systems, and indirect costs, etc.

-FCC-

APPENDIX C

APPLICATION PROCESS GUIDANCE

The COVID-19 Telehealth Program (Program) will provide an additional \$249.95 million in funding, appropriated by Congress as part of the Consolidated Appropriations Act, 2021,¹ to help health care providers provide connected care services to patients at their homes or mobile locations in response to the novel Coronavirus 2019 disease (COVID-19) pandemic. The second round of the Program (Round 2), will provide immediate support to eligible health care providers responding to the COVID-19 pandemic by fully funding their telecommunications services, information services, and devices necessary to provide critical connected care services until the Program's funds have been expended or the COVID-19 pandemic has ended.

Interested health care providers must complete several steps to apply for Round 2 funding through the Program. This guidance is aimed at assisting applicants. There are three steps interested providers can take immediately to prepare to apply for the Program: (1) obtain an eligibility determination from the Universal Service Administrative Company (USAC); (2) obtain an FCC Registration Number (FRN); and (3) register with System for Award Management. If an interested party does not already have these steps and accompanying components completed, they must gather the necessary information and begin to complete other necessary steps now, so that they are prepared to submit applications for program funding as soon as applications can be accepted for filing. The various components are described below.

Eligibility Determination

Health care providers seeking to participate in Round 2 of the Program must obtain an eligibility determination from the Universal Service Administrative Company (USAC) for the lead health care provider site that they include in their application.² Health care provider sites that USAC has already deemed eligible to participate in the Commission's existing Rural Health Care Programs or to participate in the initial round of the Program (Round 1) may rely on that eligibility determination for Round 2 of the Program. Interested health care providers that do not already have an eligibility determination may obtain one by filing an FCC Form 460 (Eligibility and Registration Form) with USAC.³ **Applicants must have obtained a health care provider number to submit an application for Round 2 of the Program. However, applicants that do not yet have an eligibility determination from USAC can still file an application for Round 2 of the Program while their FCC Form 460 is pending with USAC.**

The FCC Form 460 can be found at: <https://www.usac.org/rural-health-care/resources/forms/>. The FCC Form 460 requires applicants to provide basic information about the individual health care provider, such as:

¹ Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No 116-136, 134 Stat. 281 (2020) (CARES Act); Consolidated Appropriations Act, 2021, Pub. L. No: 116-260, Division N-Additional Coronavirus Response and Relief, Title IX-Broadband Internet Access Service, § 903 "FCC COVID-19 Telehealth Program" (2020), <https://www.congress.gov/bill/116th-congress/house-bill/133/text> (Consolidated Appropriations Act).

² Consistent with the Telecommunications Act of 1996, the COVID-19 Telehealth Program limits participation to nonprofit and public eligible health care providers that fall within the following categories: (1) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (2) community health centers or health centers providing health care to migrants; (3) local health departments or agencies; (4) community mental health centers; (5) not-for-profit hospitals; (6) rural health clinics; (7) skilled nursing facilities; or (8) consortia of health care providers consisting of one or more entities falling into the first seven categories. See 47 U.S.C. §§ 254(h)(1)(A), (h)(2)(A), and (h)(7)(B).

³ As explained in the *Report and Order*, the COVID-19 Telehealth Program is open to rural and non-rural providers. Non-rural providers do not need to be part of a consortium to participate in the program. *Telehealth Program Round 2 Report & Order* at 10, para. 21.

- Address and contact information;
- Health care provider type;
- Brief explanation as to why the health care provider is eligible under the categories in section 254(h)(7)(B) of the Communications Act;
- Health care provider identifying number, such as a National Provider Identifier (NPI) code and/or taxonomy code; and
- Supporting documentation demonstrating the health care provider's eligibility.

Contact USAC for specific questions about eligibility and completing the eligibility form (FCC Form 460) via telephone at (800) 453-1546 or via email at: RHC-Assist@usac.org.

Application and Request for Funding and Registering to Receive Payments Through COVID-19 Telehealth Program

To submit an application, the applicant must first obtain an FCC Registration Number (FRN). Additionally, to receive payment through the Program, applicants must be registered with the federal System for Award Management. While interested parties do not need to be registered with the System for Award Management in to submit an application, applicants are strongly encouraged to start that process early.

Interested parties must submit an application through the COVID-19 Telehealth Program Application Portal, which applicants can find under the "Application" tab on the Commission's website, here: <https://www.fcc.gov/covid-19-telehealth-program>.

Obtaining an FCC Registration Number (FRN)

All applicants, like all other entities doing business with the Commission, must register for an FRN in the Commission Registration System (CORES). An FRN is a 10-digit number that is assigned to a business or individual registering with the FCC. This unique FRN is used to identify the registrant's business dealings with the FCC.

To register with CORES, please use the following link: <https://apps.fcc.gov/cores/userLogin.do>. The first step to setting up an account in CORES is creating a username and account in the FCC User Registration System. Before the account is activated, the user will receive an automated email titled "FCC Account Request Verification" and must verify its account email address as prompted. Once the user is logged in to CORES, the user should select the "Register New FRN" or "Associate Username to FRN" option as applicable from the menu options that appear and provide the information as prompted by CORES. Users will need to provide their Taxpayer Identification Number (TIN) to register. The TIN is a nine-digit number that the Internal Revenue Service (IRS) requires of all individuals, businesses, and other employers to identify their tax accounts with the IRS. Once the user provides the information required in CORES and clicks "Submit," CORES will generate a new FRN or associate the user's existing FRN with its account.

Required Information for Application for COVID-19 Telehealth Program Round 2

Applicants are required to submit the following information on their application for Round 2 of the Program. The actual wording on the electronic application may vary slightly from the wording in this Appendix to the Report and Order:

Applicant Information

- Applicant Name
- Applicant FCC Registration Number (FRN)
- Federal Employer Identification Number (EIN/Tax ID)

- Data Universal Number System Number (DUNS)⁴
- Business Type (from Data Accountability and Transparency (DATA) Act⁵ Business Types) – Applicants may provide up to three business types
- DATA Act Service Area – This information will be required for each line item for which funding is requested. Applicants must enter name of the applicable state(s) or “nationwide”

Contact Information

- Contact name for the primary and secondary individuals that are responsible for timely answering questions about the application
- Email addresses
- Phone numbers
- Position title
- Mailing address

Health Care Provider Information

- Lead health care provider name
- Facility name
- Indicate whether facility is a hospital
- Physical address, city, state, zip code
- County
- FCC Registration Number (FRN)
- Healthcare provider number⁶
- Eligibility type⁷

Conditions to be Treated with COVID-19 Telehealth Funding

- Whether the applicant will treat COVID-19 patients directly
- Whether the applicant will treat patients without COVID-19 symptoms or conditions (applicants will check all that apply):
 - Other infectious diseases
 - Emergency/Urgent Care
 - Routine, Non-Urgent Care
 - Mental Health Services (non-emergency)
 - Other conditions

⁴ A DUNS number is a unique nine-character number used to identify your organization. The federal government uses the DUNS number to track how federal money is allocated. Most large organizations, libraries, colleges, and research universities already have a DUNS number. Applicants should contact their grant administrator, financial department, chief financial officer, or authorizing official to identify their organization’s DUNS number. If your organization does not yet have a DUNS number, or no one knows it, visit the Dun & Bradstreet (D&B) website: <https://fedgov.dnb.com/webform/displayHomePage.do> or call 1-866-705-5711 to register or search for a DUNS number. Registering for a DUNS number is free of charge.

⁵ Digital Accountability and Transparency Act of 2014 (DATA Act), Pub. L. No. 113-101, 128 Stat. 1146 (2014).

⁶ USAC assigns the health care provider number when the FCC Form 460 is filed. See Universal Service Administrative Company, *Rural Health Care, Forms*, <https://www.usac.org/rural-health-care/resources/forms/> (last visited Mar. 24, 2021).

⁷ Eligibility type (e.g., hospital) is determined and confirmed by USAC when an entity files an FCC Form 460 and is deemed to be eligible.

Application Evaluation Metrics

- **Hardest Hit** - Whether the lead health care provider listed on the application, or an eligible health care provider that the applicant is applying on behalf of, is located in a hotspot or a sustained hotspot county⁸
 - If the qualifying entity is an eligible health care provider site that the applicant is applying on behalf of, the name, physical address, city, state, zip code, and county of the qualifying eligible health care provider site
- **Low-Income Area** - Whether the lead health care provider listed on the application, or an eligible health care provider that the applicant is applying on behalf of, is located in a low-income area⁹
 - If the qualifying entity is an eligible health care provider that the applicant is applying on behalf of, the name, physical address, city, state, zip code, and county of the qualifying eligible health care provider site; if the health care provider is located in Puerto Rico, the application must also provide the urbanization code
- **Round 1 Unfunded Applicant** - Whether the applicant applied for, but did not receive, funding during Round 1 of the Program
 - The Application Number¹⁰ of the Round 1 application or proof of an e-mailed application submission
 - Whether the applicant received funding during Round 1 of the Program
- **Tribal Community** - Whether the lead health care provider listed on the application, or an eligible health care provider that the applicant is applying on behalf of, is a health care provider that qualifies under the Tribal Community metric¹¹
 - If the qualifying entity is an eligible health care provider site that the applicant is applying on behalf of, the name, physical address, city, state, zip code, and county of the qualifying eligible health care provider

⁸ U.S. Department of Health and Human Services, *Community Profile Report*, at 13 (Mar. 11, 2021), <https://beta.healthdata.gov/Health/COVID-19-Community-Profile-Report/gqxm-d9w9> (Area of Concern Continuum by County).

⁹ See U. S. Census Bureau, *Small Area Income and Poverty Estimates*, Interactive Map, https://www.census.gov/data-tools/demo/saippe/#/?map_geoSelector=aa_c (last updated Dec. 2020) (Interactive map and data set reflecting poverty rates for the United States and counties within the United States as of 2019).

¹⁰ For applicants that applied during Round 1, the application number started with “GRA” followed by seven numbers (e.g., GRA0000123). Some applications submitted via e-mail during Round 1 did not receive a GRA number. If the applicant did not receive an application number, USAC may accept proof of an email submission in lieu of the application number.

¹¹ USAC, *Enhanced Tribal Benefit, Eligible Tribal Lands Maps and Shapefile*, <https://www.usac.org/lifeline/get-started/enhanced-tribal-benefit/#Eligible> (last updated Jan. 22, 2021) (providing link to eligible Tribal lands map and shapefile for reference purposes). See also 47 CFR § 54.400(e) (defining Tribal lands as “any federally recognized Indian tribe’s reservation, pueblo, or colony, including former reservations in Oklahoma; Alaska Native regions established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688); Indian allotments; Hawaiian Home Lands—areas held in trust for Native Hawaiians by the state of Hawaii, pursuant to the Hawaiian Homes Commission Act, 1920 July 9, 1921, 42 Stat. 108, et. seq., as amended”). We also include the Eastern Navajo Agency lands that have previously been designated as eligible for Lifeline and are included in the shapefile and map posted on USAC’s website. See *Federal-State Joint Board on Universal Service, Smith Bagley, Inc., Petition for Waiver of Section 54.400(e) of the Commission’s Rules*, Memorandum Opinion and Order, 20 FCC Rcd 7701 (2005) and *Sacred Wind Communication*, Order, 21 FCC Rcd 9227 (WCB 2006).

- If applicable, supporting documentation to verify that the qualifying entity is operated by the Indian Health Service or otherwise affiliated with a Tribe
- **Critical Access Hospital** - Whether the lead health care provider listed on the application, or an eligible health care provider that the applicant is applying on behalf of, qualifies as a Critical Access Hospital (CAH)¹²
 - Proof of CAH certification
- **Federally Qualified Health Center / Federally Qualified Health Center Look-Alike / Disproportionate Share Hospital** - Whether the lead health care provider listed on the application, or an eligible health care provider that the applicant is applying on behalf of, qualifies as a Federally Qualified Health Center (FQHC),¹³ as a FQHC Look-Alike (LAL),¹⁴ or as a Disproportionate Share Hospital (DSH)¹⁵
 - Proof of FQHC certification
 - Proof of qualification as a FQHC LAL¹⁶ or
 - Proof of DSH certification
- **Health Care Provider Shortage Area** - Whether the lead health care provider listed on the application, or an eligible health care provider that the applicant is applying on behalf of, is located in a Healthcare Provider Shortage Area (HPSA)¹⁷
 - HPSA Score, and
 - HPSA ID number, or
 - If the qualifying entity is an eligible health care provider that the applicant is applying on behalf of, the name, physical address, city, state, zip code, and county of the qualifying eligible health care provider site
- **Round 2 New Applicant** - Whether the applicant is applying to the Program for the first time
 - If applicable, applicants must certify, under penalty of perjury, that the applicant has not previously applied for Program funding

¹² Centers for Medicare and Medicaid Services, *Critical Access Hospitals*, <https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/CAHs> (last updated Apr. 9, 2013); Flex Monitoring Team, *Critical Access Hospitals Locations List*, <https://www.flexmonitoring.org/critical-access-hospital-locations-list> (last updated Aug. 1, 2020).

¹³ Health Resources and Services Administration, *Federally Qualified Health Centers*, <https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc/index.html> (last visited Mar. 12, 2021) (defining Federally Qualified Health Centers).

¹⁴ Health Resources and Services Administration, *Federally Qualified Health Center Look-Alike Eligibility*, <https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc-look-alikes/index.html> (last visited Mar. 12, 2021); Health Resources and Services Administration, *Health Center Program Look-Alikes*, <https://bphc.hrsa.gov/programopportunities/lookalike/index.html> (last visited Mar. 12, 2021).

¹⁵ Health Resources and Services Administration, *Disproportionate Share Hospitals Eligibility*, <https://www.hrsa.gov/opa/eligibility-and-registration/hospitals/disproportionate-share-hospitals/index.html> (last visited Mar. 24, 2021) (describing eligibility criteria for a Disproportionate Share Hospital).

¹⁶ A list of FQHCs and LALs is available on the Health Resources and Services Administration website. Health Resources and Services Administration, *FQHCs and LALs by State*, <https://data.hrsa.gov/data/reports/datagrid?gridName=FQHCs> (last visited Mar. 12, 2021).

¹⁷ Applicants should use the HPSA score for primary care, which is publicly available on the Health Resources and Services Administration website. Health Resources and Services Administration, *Find Shortage Area*, <https://data.hrsa.gov/tools/shortage-area> (last visited Mar. 12, 2021).

- **Rural County** - Whether the lead health care provider listed on the application, or an eligible health care provider that the applicant is applying on behalf of, is located in a rural county¹⁸
 - If the qualifying entity is an eligible health care provider that the applicant is applying on behalf of, the name, physical address, city, state, zip code, and county of the qualifying eligible health care provider

Requested Funding Items

- Funding Request Details:
 - Category
 - Description of Service(s) and/or connected device(s)
 - Quantities
 - Supporting documentation, which should summarize the expected costs of the eligible services and connected devices requested and may include documentation such as an invoice or quote from a vendor or service provider (or similar information). **Such information should be specific enough to identify both the eligibility of and the cost of each line item to facilitate swift review of the application.**
- Total amount of funding requested

Registering with System for Award Management

To receive payments through Round 2 of the Program, applicants must be registered with the federal System for Award Management. The System for Award Management is a web-based, government-wide application that collects, validates, stores, and disseminates business information about the federal government's partners in support of federal awards, grants, and electronic payment processes.

Many applicants may already be registered with the System for Award Management and do not need to re-register with that system in order to receive payment through Round 2 of the Program. Health care providers not yet registered with the System for Award Management may still submit an application. However, the Bureau strongly recommends unregistered health care providers to start that registration process now because it may take up to 10 business days for your registration to become active and an additional 24 hours before that registration information is available in other government systems.

To register with the system, go to <https://www.sam.gov/SAM/> with the following information: (1) DUNS number; (2) Taxpayer Identification Number (TIN) or Employment Identification Number (EIN); and (3) Your bank's routing number, your bank account number, and your bank account type, *i.e.* checking or savings, to set up Electronic Funds Transfer (EFT). You will receive a confirmation email once the registration is activated. **Only applicants registered through the System for Award Management will be able to receive Program funding.** Registration in the System for Award Management provides the FCC with an authoritative source for information necessary to provide funding to applicants and to ensure accurate reporting pursuant to the DATA Act, Pub. L. 113-101.

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¹⁸ 47 CFR § 54.600(e) (defining a rural area as "an area that is entirely outside of a Core Based Statistical Area; is within a Core Based Statistical Area that does not have any Urban Area with a population of 25,000 or greater; or is in a Core Based Statistical Area that contains an Urban Area with a population of 25,000 or greater, but is within a specific census tract that itself does not contain any part of a Place or Urban Area with a population of greater than 25,000"). Universal Service Administrative Company, *Eligible Rural Areas Search*, <https://apps.usac.org/rhc/tools/Rural/search/search.asp> (last visited Mar. 24, 2021).

**STATEMENT OF
ACTING CHAIRWOMAN JESSICA ROSENWORCEL**

Re: *In the Matter of COVID-19 Telehealth Program*, WC Docket No. 20-89, *Promoting Telehealth for Low Income Americans*, WC Docket No. 18-213; Report and Order and Order on Reconsideration

During the last year our nation's healthcare providers—the hospitals, the clinics, and the heroic staff who run those institutions—have been on the frontlines battling a cruel pandemic. This crisis has presented extraordinary new challenges. But it has also created new opportunities. From patients struggling to remotely connect with a health care professional to manage their chronic conditions, to doctors having to rethink their care models, health care providers have innovated at a rapid pace. In many ways that innovation has led to better and safer care for patients. These professionals deserve our gratitude, our prayers, and every possible tool we can provide them to make their efforts a success.

Last year, Congress provided the Federal Communications Commission with a way to help. By providing \$249.95 million to support the next round of the COVID-19 Telehealth Program, on top of the \$200 million Congress made available to the agency earlier in the year, we have real resources to contribute to the fight against this pandemic. With this new round of funding, Congress provided additional direction to the FCC. We were charged with establishing new metrics to evaluate applications, increasing program transparency, and setting up a system to consider requests from health care providers that sought support in the earlier round of funding. Today's decision accomplishes these new tasks—and does so with unanimous support.

Why is this important? This program will provide funding for connected devices hospitals can use to safely screen, diagnose and treat patients. It will support remote monitoring equipment so patients can continue to maintain care for themselves without risking a trip to the hospital or clinic. In addition, it will fund telehealth platforms and video equipment that allow health care professionals to conduct remote patient visits, as well as share x-rays and other medical images, communicate with patients, and even submit prescriptions to pharmacies.

For this round of funding, in response to Congress, we will use the new metrics and criteria adopted today. When we do so, we will take into consideration a variety of factors about each health care provider, such as the impact of the pandemic on the area it serves, whether it operates on Tribal lands or in an area with a high level of poverty, and if it is located in an area with health care shortages. In addition, we commit to having this program reach providers across the country, provided we receive qualified applications from every state, territory, and the District of Columbia.

What happens next? We will very shortly announce the date for the application window to open. Before doing so we will reach out to applicants from the last round of funding and other interested providers. We will also focus our outreach efforts on Tribal communities and the facilities that serve them. To further assist with this process and improve transparency, we are releasing a list of eligible devices and services as well as a separate guidance document that will help providers with preparing and submitting applications.

This is terrific progress and I want to thank Congress for supporting the FCC and its telehealth work. I also want to thank my colleagues for their careful review of this decision and especially for the adjustments made to the low-income metric by Commissioner Starks. Finally, I am especially grateful for the incredible expertise of the agency staff and their efforts to expand the reach of communications and the possibilities of telehealth with this new program.

**STATEMENT OF
COMMISSIONER BRENDAN CARR**

Re: *In the Matter of COVID-19 Telehealth Program*, WC Docket No. 20-89, *Promoting Telehealth for Low Income Americans*, WC Docket No. 18-213; Report and Order and Order on Reconsideration

Over two years ago, we identified a new trend in telehealth. The delivery of high-quality care is no longer limited to the confines of traditional brick-and-mortar facilities. With smartphones and other connected devices, Americans can now access health care services right from their homes or anywhere they have an Internet connection.

It's the healthcare equivalent of shifting from Blockbuster to Netflix.

Since then, I have been working with my FCC colleagues and stakeholders to support this new trend in telehealth by standing up the FCC's Connected Care Pilot Program, which selected its initial tranche of awardees back in January. I first saw the promise of these services on a visit to the Mississippi Delta. That's where I met patients with diabetes that saw their lives improve through the use of connected care offerings. Indeed, the limited trials to date show that connected care technologies consistently reduce the costs of care while improving patient outcomes.

During the coronavirus pandemic, the benefits of these telehealth services and the offering of care at a distance have been brought into even sharper focus. Building off the FCC's efforts to stand up the Connected Care Pilot Program, the FCC established its COVID-19 Telehealth Program last year just days after Congress appropriated \$200 million in round one funding through the CARES Act. In December 2020, Congress recognized the success of the FCC's efforts and appropriated an additional \$250 million in round two funding.

I have had the chance to meet with at least eight of the health care providers that received round one funding and to hear directly from them on visits to six different states. Every one of these awardees credited the FCC's Telehealth Program with providing the resources necessary for them to meet a massive spike in telehealth visits as COVID-19 spread across the country.

Today, we take a crucial step in the implementation of round two of the Commission's successful COVID-19 Telehealth Program. The program requirements we adopt today strike the right balance between ensuring a wide and equitable distribution of funding and promoting the widest possible participation of health care providers. I would like to thank my colleagues for agreeing to edits that strengthened the program in this regard, including ensuring that all round one awardees are eligible to submit applications in round two as well.

This additional funding will have a significant and lasting impact across the country. The reliance on telehealth technology will continue to grow, even as the nation starts to see relief from this devastating pandemic. While we are in a much stronger position than we were when the COVID-19 Telehealth Program was initially adopted, we are not out of the woods yet. That is why we must continue to move swiftly on this second round of awards.

**STATEMENT OF
COMMISSIONER GEOFFREY STARKS**

Re: *In the Matter of COVID-19 Telehealth Program*, WC Docket No. 20-89, *Promoting Telehealth for Low Income Americans*, WC Docket No. 18-213; Report and Order and Order on Reconsideration

When we launched the COVID-19 Telehealth Program last April, it was clear that telehealth would play a critical role in addressing COVID-19. Even early in the pandemic, experts agreed that receiving care remotely could both meet many patients' needs and help prevent community spread of the coronavirus. I have been a proud champion of telehealth, and I was pleased that we were able to launch the program so quickly in those early days. And I remain proud that our first phase of grants has helped improve the healthcare available to so many Americans.

Today, nearly a year later, we have ample evidence that telehealth made an enormous difference in our nation's pandemic response. Researchers at the Urban Institute found that during the first six months of the pandemic one-third of Americans had a telehealth visit to discuss their own healthcare.¹ There have been particularly striking increases in telehealth use by low-income Americans. Between March and June 2020, the Centers for Medicare and Medicaid Services found that telehealth visits for Medicaid and Children's Health Insurance Program beneficiaries increased by more than 2600 percent compared to the same period in 2019.² Those beneficiaries received more than 34 million telehealth services in just four months. Those strong adoption rates are truly remarkable!

Through tens of millions of virtual visits, patients and healthcare providers have reduced in-person contacts and maintained social distancing—important measures to prevent spread of the coronavirus. But patients clearly saw other benefits that had piqued interest in telehealth even before the pandemic—increasing access to specialists, mitigating challenges like travel and health conditions that keep people from seeing doctors, and reducing costs. Those benefits are likely to make expanded access to telehealth a lasting legacy; three-quarters of people who used telehealth during the pandemic say they are very or somewhat likely to continue doing so.³

Telehealth can make a difference for all Americans, particularly low-income communities of color. Rush University Medical Center is located in a majority Black neighborhood on the West Side of Chicago, the city with the largest gap in life expectancy in the United States: nearly 30 years.⁴ When I visited Rush before the pandemic, I learned about its novel use of telehealth to treat cancer and diabetes in its neighborhood. But the hospital's telehealth efforts went into overdrive during the pandemic, as Rush became ground zero in Chicago's fight against COVID-19. Between April and May 2020, it received more than 600 patient transfers from surrounding safety net hospitals, most of whom were COVID-19 positive, and many of whom were either uninsured or on Medicaid.⁵ In response, Rush invested in

¹ Urban Institute, *One in Three Adults Used Telehealth during the First Six Months of the Pandemic, but Unmet Needs for Care Persisted* (January 2021), https://www.urban.org/sites/default/files/publication/103457/one-in-three-adults-used-telehealth-during-the-first-six-months-of-the-pandemic-but-unmet-needs-for-care-persisted_1.pdf.

² Centers for Medicare and Medicaid, *Services Delivered via Telehealth Among Medicaid & CHIP Beneficiaries During COVID-19 at 6* (2020), <https://www.medicaid.gov/resources-for-states/downloads/medicaid-chip-beneficiaries-COVID-19-snapshot-data-through-20200630.pdf>.

³ The Harris Poll, *Telehealth: The Coming 'New Normal' for Healthcare*, <https://theharrispoll.com/telehealth-new-normal-healthcare/> (last visited Mar. 29, 2021).

⁴ Press Release, NYU Langone Health, *Large Life Expectancy Gaps in U.S. Cities Linked to Racial & Ethnic Segregation by Neighborhood* (June 5, 2019), <https://nyulangone.org/news/large-life-expectancy-gaps-us-cities-linked-racial-ethnic-segregation-neighborhood>.

⁵ Bill Siwicki, *At Rush, patient engagement suite increases pandemic-era rounds by 247%* (Aug. 13, 2020), <https://www.healthcareitnews.com/news/rush-patient-engagement-suite-increases-pandemic-era-rounds-247>.

telehealth technology that allowed doctors and staff to monitor and communicate with COVID-19 patients from the patients' homes. The hospital used the same technology to maintain continuity of care for patients with other conditions who couldn't visit the hospital because of social distancing restrictions.

It's also important to acknowledge the emotional toll of the last year. Communities of color have been affected in many ways by the COVID-19 pandemic, not only with disproportionate losses of employment and businesses, but also with higher rates of infection and death.⁶ Yet these same communities lack equal access to mental health and substance abuse resources.⁷ Telehealth has proven it can be a valuable tool to connect our most vulnerable with the resources they need to receive treatment and stay in touch with counselors and other support.

With all these benefits in mind, I am pleased to approve today's Order, which extends the COVID-19 telehealth program and adds important transparency to the process. In this Order, applicants and other interested parties will be able to see with particularity how their proposals will be evaluated. I am especially pleased, given the disproportionate burden low-income Americans have borne during this pandemic, that we will give significant weight to applications proposing to serve low-income communities. In particular, I thank my colleagues for agreeing to my edits that will allow us to more accurately credit an applicant's service to impoverished communities. The draft order initially measured poverty only at the county level. But we know that this method can sometimes fail to identify poverty in urban areas within a more affluent county. For example, the city of Buffalo, New York is located in Erie County. Under the draft's original language, applications from Erie County would not have received points for serving a low-income area because it has a poverty rate of 13.3 percent, just below the national median.⁸ While this figure is significant, Buffalo's city-wide poverty rate is over 30 percent.⁹ As discussed below, it's the same story in cities across the country.

The changes we made to the draft will better ensure that the highest poverty areas receive a high level of our attention. Today's Order ensures that these areas will not be overlooked by directing USAC to determine the poverty rate of both the county and the census tract for health care provider applicants. In assessing an application, if it would receive more points using the census tract poverty rate instead of the county measure (or vice versa), USAC will award the application the higher points available between the two. Here is a sampling of cities with such census tracts:

⁶ Centers for Disease Control and Prevention, *Health Equality Considerations and Racial and Ethnic Minority Groups* (Feb. 12, 2021), <https://www.cdc.gov/coronavirus/2019-ncov/community/health-equity/race-ethnicity.html>.

⁷ The Office of Minority Health at the U.S. Department of Health and Human Services, *Minority Mental Health Awareness Month*, <https://www.minorityhealth.hhs.gov/omh/content.aspx?ID=9447> (last visited Mar. 29, 2021).

⁸ United States Census Bureau, *Quick Facts: Erie County, New York*, <https://www.census.gov/quickfacts/eriecountynyork> (last visited Mar. 29, 2021).

⁹ United States Census Bureau, *Quick Facts: Buffalo city, New York*, <https://www.census.gov/quickfacts/buffalocitynewyork> (last visited Mar. 29, 2021).

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- Anaheim, CA
 - Anchorage, AK
 - Ann Arbor, MI
 - Arlington, VA
 - Austin, TX
 - Buffalo, NY
 - Carlsbad, NM
 - Charleston, SC
 - Charlotte, NC
 - Chicago, IL
 - Denver, CO
 - Honolulu, HI
 - Huntsville, AL
 - Kansas City, MO
 - Madison, WI
 - Marietta, GA
 - Minneapolis, MN
 - New Haven, CT
 - Phoenix, AZ
 - Pittsburgh, PA
 - Reno, NV
 - Seattle, WA
 - Sioux Falls, SD
 - Worcester, MA

With vaccination numbers increasing, the end of the coronavirus pandemic is hopefully in sight. In the midst of those welcome developments, we must be mindful that there are still difficult months ahead. I thank all the Commission staff who developed this Order so that the COVID-19 telehealth program can support more healthcare providers and patients as we work to put the pandemic behind us.