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

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

REPORT AND ORDER

Adopted: March 31, 2020 **Released: April 2, 2020**

By the Commission: Chairman Pai and Commissioners Carr and Starks issuing separate statements; Commissioner O'Rielly approving in part, dissenting in part and issuing a statement; Commissioner Rosenworcel approving in part, concurring in part and issuing a statement:

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I. INTRODUCTION

1. The coronavirus disease 2019 (COVID-19) pandemic, and associated respiratory illness has spread throughout the United States in recent weeks.[1] Efforts to slow the spread of the disease and mitigate strain on the nation's health care system have resulted in dramatic disruption of many aspects of

[1] *See* Centers for Disease Control and Prevention, Coronavirus (COVID-19), https://www.cdc.gov/coronavirus/2019-ncov/index.html (last visited Mar. 15, 2020).

Americans' lives, including social distancing measures to prevent person-to-person transmission that precipitated the closure of numerous schools and workplaces throughout the United States. Across the country, people are turning to telemedicine, telework, and online learning to enable social distancing measures, which has only emphasized the importance of access to connected care technologies and services. In response to this pandemic, many health care providers are expanding existing telehealth services and implementing new telehealth services, and the demand for connected care services provided directly to patients in their homes or their mobile locations is skyrocketing.[2] As a result, many health care providers are facing new challenges in technical infrastructure and experiencing staffing issues.[3]

2. In response to the outbreak, on March 27, 2020, President Trump signed the Coronavirus Aid, Relief, and Economic Security (CARES) Act into law,[4] providing, among a panoply of other actions, $200 million to the FCC to support health care providers in the fight against the ongoing pandemic. In response to the public health emergency brought about by the COVID-19 pandemic, and to effectuate Congress' intent in enacting the CARES Act, we establish a COVID-19 Telehealth Program, distinct from the broader Connected Care Pilot Program we also adopt today, with a separate, congressionally appropriated budget of $200 million, to help eligible health care providers maximize their provision of connected care services during the COVID-19 pandemic.

3. Telehealth has assumed an increasingly critical role in health care delivery as technology and improved broadband connectivity have enabled patients to access health care services without needing to visit a health care provider's physical location. Advances in telehealth are transforming health care from a service delivered solely through traditional brick and mortar health care facilities to connected care options delivered via a broadband Internet access connection directly to the patient's home or mobile

[2] Reed Abelson, *Doctors and Patients Turn to Telemedicine in the Coronavirus Outbreak*, New York Times (Mar. 11, 2020), https://www.nytimes.com/2020/03/11/health/telemedicine-coronavirus.html ("[L]arge hospitals across the country are quickly expanding the use of telemedicine to safely screen and treat patients for coronavirus, and to try to contain the spread of infection while offering remote services."); Oliver Morrison, *Thousands of patients in Pittsburgh region have turned to telemedicine due to coronavirus fears*, Public Source (Mar. 17, 2020), https://www.publicsource.org/thousands-of-patients-in-pittsburgh-region-have-turned-to-telemedicine-due-to-covid-19-coronavirus-fears/ ("The Allegheny Health Network [AHN] on Saturday expanded its telemedicine service to 24 hours from ordinary business hours, and it's seen the number of patients increase from about 90 patients per month to more than 100 every 24 hours since, most asking about coronavirus, according to Dr. Amy Crawford-Faucher, the vice-chair for the department of family medicine at AHN."); Erin Brodwin & Casey Ross, *Surge in patients overwhelms telehealth services amid coronavirus pandemic*, STAT (Mar. 17, 2020), https://www.statnews.com/2020/03/17/telehealth-services-overwhelmed-amid-coronavirus-pandemic/ ("The flood of telehealth patients is driven by the health care system's effort to reserve hospitals and other health care facilities for people seriously ill with the coronavirus or other diseases, and by a crush of people worried they have symptoms caused by [COVID]-19.").

[3] Erin Brodwin & Casey Ross, S*urge in patients overwhelms telehealth services amid coronavirus pandemic*, STAT (Mar. 17, 2020), https://www.statnews.com/2020/03/17/telehealth-services-overwhelmed-amid-coronavirus-pandemic/ ("Telehealth services are sagging under the weight of an unprecedented surge in patients as hospitals scramble to shift routine care online in response to the coronavirus pandemic. The crisis is stressing major telehealth providers' technical infrastructure and the supply of physicians prepared to deliver care virtually. . . . There are also technology setup challenges for new users as well as a shortage of bandwidth as the internet groans under the strain of increasing use."); Christina Farr, *Telemedicine companies are struggling to serve 'extreme volumes' of patients as coronavirus calls surge*, CNBC (Mar. 16, 2020), https://www.cnbc.com/2020/03/16/telemedicine-companies-struggling-to-meet-coronavirus-demand.html ("Telemedicine services are more important now than ever. But some hospitals say their technology tools are breaking down, as huge volumes of people try to consult with a doctor about their symptoms. . . . [T]elehealth services . . . are generally seeing '(IT) loads quadruple" since Friday.'").

[4] CARES Act, Pub. L. No 116-136, 134 Stat. 281 (2020). The CARES Act appropriates $200 million to 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 pendency of the COVID-19 pandemic. *Id*.

location.[5] Connected care services can also help contain and treat health conditions during public health emergencies, such as the ongoing COVID-19 pandemic.[6] One important benefit of telehealth in these situations is that it enables providers to treat patients while maintaining physical separation, thereby minimizing the risk of further transmission.[7]

4. Despite the numerous benefits of connected care services to patients and health care providers alike, patients who cannot afford or who otherwise lack reliable, robust broadband Internet access connectivity, including many low-income Americans and veterans, are not realizing the benefits of these innovative telehealth technologies. The costs necessary to provide connected care services may also limit some health care providers' ability to treat patients, particularly low-income Americans and veterans, with connected care services. Accordingly, today we establish a $200 million emergency COVID-19 Telehealth Program to implement the CARES Act and ensure access to connected care services and devices in response to the ongoing COVID-19 pandemic and surge in demand for connected care services. The support provided through the COVID-19 Telehealth Program will help eligible health care providers purchase telecommunications services, information services, and devices necessary to provide critical connected care services, whether for treatment of coronavirus or other health conditions during the coronavirus pandemic. This COVID-19 Telehealth Program is funded through a $200 million appropriation signed into law as part of the CARES Act, and this program will not rely on USF support.

5. We also establish a longer-term Connected Care Pilot Program (Pilot Program) within the Universal Service Fund (USF or Fund) that will make available up to $100 million over three years to examine how the Fund can help support the trend towards connected care services, particularly for low-income Americans and veterans. The Pilot Program will help defray eligible health care providers' costs of providing connected care services, with a particular emphasis on supporting these services for eligible low-income Americans and veterans. We expect that the Pilot Program will benefit many low-income and veteran patients who are responding to a wide variety of health challenges such as diabetes management, opioid dependency, high-risk pregnancies, pediatric heart disease, mental health conditions, and cancer. We also expect that the Pilot Program will provide meaningful data that will help us better

[5] *See, e.g.*, David M. Levine et al., *Hospital-Level Care at Home for Acutely Ill Adults*, Annals of Internal Medicine (Dec. 17, 2019), https://www.ncbi.nlm.nih.gov/pubmed/31842232 (finding that substitutive home hospitalization for acutely ill individuals reduced cost, health care use, and readmissions while increasing physical activity compared with usual hospital care).

[6] Ricardo Alonso-Zaldivar, *As Coronavirus Spreads, Medicare Gets Telemedicine Option*, Seattle Times (Mar. 6, 2020), https://www.seattletimes.com/seattle-news/health/as-coronavirus-spreads-medicare-gets-telemedicine-option/ (explaining that "'[t]elehealth is really instrumental in containing and treating disease, particularly in a public health emergency,'" and "telemedicine would offer a way for Medicare recipients in outbreak areas to take care of ongoing medical issues without having to go to the doctor's office and risk coming into contact with someone who is sick."); Reed Abelson, *Doctors and Patients Turn to Telemedicine in the Coronavirus Outbreak*, New York Times (Mar. 11, 2020), https://www.nytimes.com/2020/03/11/health/telemedicine-coronavirus.html (stating that "[t]he use of telemedicine is going to be critical for management of this pandemic," and "[b]y using their phone or computer, patients will be able to get guidance about whether they need to be seen or tested instead of showing up unannounced at the emergency room or doctor's office. Patients, particularly those who would be at high risk for a serious illness if they were infected, can also opt to substitute a trip to a doctor's office with a virtual visit when it is a routine check in with a specialist or a primary care doctor. That way they can avoid crowded waiting rooms and potential infection.").

[7] Dr. Samant Virk, *Coronavirus and telemedicine: How it can help practices and patients with communicable diseases*, Medical Economics (Mar. 2, 2020), https://www.medicaleconomics.com/news/coronavirus-and-telemedicine-how-it-can-help-practices-and-patients-communicable-diseases ("Telemedicine reduces the spread of germs in several ways. It allows patients to seek medical care from home, saving them from spreading germs to others, for instance on public transportation, in their doctor's waiting room, and to the healthcare providers who attend to them. Televisits also aid in prompt detection and lead to effective isolation of potentially infectious patients.").

understand how USF funds can support health care provider and patient use of connected care services, and how supporting health care provider and patient use of connected care services can improve health outcomes and reduce health care costs. We anticipate that the data and information collected through this Pilot Program could also have the ancillary benefit of aiding policy makers and legislators in the consideration of broader reforms—such as statutory changes or updates to rules administered by other agencies—that could support this trend towards connected care.

6. While the COVID-19 Telehealth Program reflects our consideration of the immediate need for connected care services during this pandemic, and is designed to distribute the $200 million appropriation from Congress to help health care providers provide connected care services to patients at their homes or mobile locations in response to the COVID-19 pandemic, the broader Pilot Program we establish today reflects our careful consideration of the record, the Commission's statutory authority, relevant precedent for the existing USF programs, and the administrability of the Pilot Program. In establishing the Pilot Program, Commission staff have also engaged in discussions with the U.S. Department of Veterans Affairs' Veterans Health Administration (VHA), the U.S. Department of Agriculture (USDA), and the U.S. Department of Health and Human Services, including the Center for Medicare and Medicaid Innovation (CMMI). During the course of implementing and establishing these programs, we expect Commission staff to continue discussions and coordination with these and other federal agencies that operate health care programs or provide federal funding for telehealth. That work may include identifying additional waivers or other relief that those federal agencies can provide to increase the effectiveness of these programs.

7. In order to ensure that we can promptly support health care providers currently working to address the ongoing pandemic, we will begin accepting applications for the COVID-19 Telehealth Program immediately after publication of this Report and Order and notice of the Office of Management and Budget's (OMB) approval of the COVID-19 Telehealth Program information collection requirements in the Federal Register. We direct the Wireline Competition Bureau (Bureau) to review the COVID-19 Telehealth Program applications, select participants, and make funding awards on a rolling basis until the funding is exhausted or until the current pandemic has ended, consistent with the criteria outlined in this Report and Order. We also direct the Bureau to announce the selected applicants and funding awards for the COVID-19 Telehealth Program applicants. The deadline for filing applications for the Pilot Program will be 45 days from the effective date of the Pilot Program rules or 120 days from the release date of this Report and Order, whichever is later. We will review the applications and our pilot project selections will be guided by the criteria outlined in this Report and Order and our strong interest in targeting limited Pilot Program resources towards patient populations, health conditions, and geographic areas where we believe USF funding for connected care services is most needed. We will announce the selected pilot projects and our rationale for selecting specific pilot projects.

II. BACKGROUND

8. In the Telecommunications Act of 1996, Congress recognized the value of providing rural health care providers with "an affordable rate for the services necessary for the provision of telemedicine and instruction relating to such services."[8] It mandated that telecommunications carriers provide telecommunications services for health care purposes to rural public or nonprofit health care providers at rates that are "reasonably comparable" to rates in urban areas.[9] It also directed the Commission to establish competitively neutral rules to enhance, to the extent technically feasible and economically reasonable, access to "advanced telecommunications and information services" for public

[8] Joint Explanatory Statement of the Committee of Conference, 104th Cong., 2d Sess. at 133 (1996). *See also* 47 U.S.C. § 254(b)(3), (h)(1)(A); Telecommunications Act of 1996, Pub. L. No. 104-104, 110 Stat. 56 (1996). The 1996 Act amended the Communications Act of 1934 (Communications Act or Act).

[9] 47 U.S.C. § 254(h)(1)(A).

and nonprofit health care providers.[10] Based on this legislative mandate, the Commission established the Rural Health Care (RHC) Program, which is comprised of two distinct components that play an important role in improving the quality of health care and enabling health care innovation through communications services—the Telecommunications (Telecom) Program[11] and the Healthcare Connect Fund Program.[12] In 2006, the Commission launched an RHC Pilot Program that played a critical role in improving broadband connectivity for health care providers around the country by encouraging the formation of state and regional telehealth networks and providing support for the services provided over those networks.[13]

9. The Commission's RHC Program supports health care providers' access to communications technologies, but there are more recent developments in telehealth, including increased use of connected care services, that the Commission has not yet fully explored. With remote patient monitoring and mobile health applications that can be accessed on an end-user device like a smartphone or tablet, health care providers now have the ability to deliver quality health care directly to patients, regardless of where they are located. Thus, in August 2018, the Commission released a Notice of Inquiry seeking information on "how the Commission can help advance and support the movement in telehealth towards connected care everywhere and improve access to the life-saving broadband-enabled telehealth services it makes possible."[14] Subsequently, in July 2019 the Commission adopted a Notice of Proposed Rulemaking proposing a Pilot Program that would help defray health care provider costs of providing connected care services to low-income Americans and veterans and how best to implement such a Pilot Program.[15]

10. In the *Connected Care Notice of Inquiry* and the *Connected Care Notice*, the Commission explained that connected care services have been used to treat a wide range of health conditions, including diabetes, heart disease, opioid dependency, stroke, mental health conditions, high-risk

[10] 47 U.S.C. § 254(h)(2)(A).

[11] The Telecom Program, established in 1997 pursuant to section 254(h)(1)(A) of the 1996 Act, provides discounts on telecommunications services to ensure that rural health care providers pay no more than their urban counterparts. *See* 47 U.S.C. § 254(h)(a)(A); Federal-State Joint Board on Universal Service, CC Docket No. 96-45, Report and Order, 12 FCC Rcd 8776, 9093-9161, paras. 608-749 (1997) (*Universal Service First Report and Order*). In August 2019, the Commission adopted, among other things, significant reforms to the Telecom Program to promote transparency and predictability and further the efficient allocation of limited RHC Program resources. *See Promoting Telehealth in Rural America*, WC Docket No. 17-310, Report and Order, 34 FCC Rcd 7335 (2019).

[12] The Healthcare Connect Fund Program, established in 2012 pursuant to section 254(h)(2)(A) of the 1996 Act, provides a 65% discount on the cost of broadband connectivity to eligible health care providers to encourage the formation of state and regional telehealth networks. *See* 47 U.S.C. § 254(h)(2)(A); *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 27 FCC Rcd 16678, 16686, para. 19 (2012) (*Healthcare Connect Fund Order*).

[13] The RHC Pilot Program was established pursuant to section 254(h)(2)(A) of the 1996 Act and examined how the RHC Program funding mechanism could be used to enhance public and nonprofit health care providers' access to advanced telecommunications and information services. *See* 47 U.S.C. § 254(h)(2)(A); *Rural Health Care Support Mechanism*, WC Docket No. 02-60, Order, 21 FCC Rcd 11111, 11111, para. 1 (2006) (*RHC Pilot Program Order*); Rural Health Care Support Mechanism, WC Docket No. 02-60, 22 FCC Rcd 20360, 20361, paras. 1-2 (2007) (*RHC Pilot Program Selection Order*); *Wireline Competition Bureau Evaluation of Rural Health Care Pilot Program Staff Report*, WC Docket No. 02-60, Staff Report, 27 FCC Rcd 9387, 9389 (WCB 2012) (discussing the key benefits of the RHC Pilot Program). The RHC Pilot Program has ended and all funding has been disbursed under the RHC Pilot Program.

[14] *Promoting Telehealth for Low-Income Consumers*, WC Docket No. 18-213, Notice of Inquiry, 33 FCC Rcd 7825, 7825-28, paras. 1-2, 5 & n.15 (2018) (*Connected Care Notice of Inquiry or Notice of Inquiry*).

[15] *See generally Promoting Telehealth for Low-Income Consumers*, WC Docket No. 18-213, Notice of Proposed Rulemaking, 34 FCC Rcd 5620 (2019) (*Connected Care Notice*).

pregnancy, and cancer,[16] and have resulted in improved health outcomes for chronic conditions and significant cost savings for health care providers and patients.[17] Connected care and remote patient monitoring programs have demonstrated their significant impact on patients, including:

- The VHA's[18] three-year remote patient monitoring program involving more than 43,000 veterans with conditions like hypertension, congestive heart failure, chronic obstructive pulmonary disease, depression, and post-traumatic stress disorder (PTSD), which resulted in a 25% reduction in days of inpatient care and a 19% reduction in hospital admissions;[19]
- The Louisiana-based Ochsner Health System's[20] remote monitoring pilot program in 2015 that enabled patients to manage their hypertension via a smart watch, which resulted in program participants being twice as successful as non-participants in achieving their target blood pressure levels and showed improvement in patient engagement levels; and
- The University of Mississippi Medical Center's (UMMC)[21] partnership with a mobile broadband provider to remotely monitor diabetes patients in rural Mississippi via tablet computers. During the pilot, doctors and other health practitioners treated patients remotely at home using video streaming and other forms of two-way live communications,[22] which resulted in a marked decrease in blood glucose levels, early recognition of diabetes-related eye disease, and no diabetes-related hospitalizations or emergency room visits among the patients.

Commenters have likewise provided numerous examples of how connected care services have improved health outcomes.[23] Connected care services are also an indispensable tool for containing and treating

[16] *Connected Care Notice of Inquiry*, 33 FCC Rcd at 7825-26, para. 1.

[17] *See id.* at 7827-29, paras. 5-8; *Connected Care Notice*, 34 FCC Rcd at 5622-23, para. 9.

[18] *Connected Care Notice*, 34 FCC Rcd at 5623, para. 10; *Connected Care Notice of Inquiry*, 33 FCC Rcd at 7827-28, para. 5 (stating that the VHA conducted a three-year remote patient monitoring program involving more than 43,000 veterans with conditions like hypertension, congestive heart failure, chronic obstructive pulmonary disease, depression, and PTSD, and that the program resulted in a 25% reduction in days of inpatient care and a 19% reduction in hospital admissions).

[19] *Connected Care Notice of Inquiry*, 33 FCC Rcd at 7827, para. 5.

[20] *Connected Care Notice*, 34 FCC Rcd at 5623, para. 10; *Connected Care Notice of Inquiry*, 33 FCC Rcd at 7827-28, para. 5.

[21] *See, e.g.*, Neil Versel, *Mississippi Telehealth, Remote Monitoring Pays Dividends for Diabetics*, MedCityNews (Sept. 13, 2016), https://medcitynews.com/2016/09/mississippi-telehealth-remote-monitoring/; Testimony of Michael P. Adcock, FACHE, Executive Director, Center for Telehealth University of Mississippi Medical Center, Before the U.S. Senate Committee on Commerce, Science, and Transportation, Subcommittee on Communications, Technology, Innovation and the Internet, at 1-2 (Nov. 7, 2017), https://prodnet.www.neca.org/publicationsdocs/wwpdf/110717adcock.pdf; Letter from Senator Roger Wicker to Commissioner Brendan Carr, Federal Communications Commission (July 5, 2018) (noting that the UMMC pilot program enabled "rural patients to take preventative steps and avoid hospital stays, reducing costs and greatly improving patient outcomes").

[22] *UMMC Delta Diabetes Project Improves Use of Telehealth*, Clarion Ledger (Oct. 6, 2016), https://www.clarionledger.com/story/news/2016/10/08/delta-project-improves-use-telehealth-university-of-mississippi-medical-center/91670816/.

[23] *See, e.g.*, VTN Comments at 4 (stating that the University of Virginia (UVA)'s remote patient monitoring and care coordination program has "demonstrably improved patient engagement and outcomes for diabetic patients with elevated hemoglobin A1c levels," and that participating patients "reduce[d] their hemoglobin A1c levels from a mean of 9.9 percent (indicative of uncontrolled diabetes) to 7.7 percent (indicative of controlled diabetes)"); Mercy Virtual Comments at 5 (stating that Mercy Virtual's vEngagement program has "lowered hospitalizations by 50 percent and lowered costs by 30 percent" with patients reporting a 98% satisfaction rating); CHRISTUS Comments (continued….)

health conditions during public health emergencies by allowing patients to avoid traditional clinical settings where they could be exposed or expose other patients.[24]

11. In addition to improved health outcomes for patients, connected care has demonstrated significant costs savings for the health care system. The United States currently spends more than $3.5 trillion on health care every year.[25] Telehealth technologies are expected to create significant cost savings for chronic disease management, which accounts for over 85% of direct health care spending in the country.[26] Analysts further estimate that widespread use of remote patient technology and virtual doctor visits could save the American health care system $305 billion annually.[27] The examples above resulted in not only positive health outcomes, but cost savings as well:

- The VHA remote patient monitoring program's annual cost was $1,600 per patient compared to more than $13,000 per patient for VHA's home-based primary services;
- The UMMC remote patient monitoring pilot resulted in hundreds of thousands of dollars in savings in the first six months due to reduced hospitalizations and emergency room visits.[28]

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at 2-3 (stating that CHRISTUS Health's 2012 remote patient monitoring program for patients with hypertension and chronic heart conditions produced successful results after just one year with a 24% reduction in readmission, reductions in post-discharge complications and increased patient satisfaction and reduced costs of care for patients with congestive heart failure); UVAHealth Reply Comments at 3 (stating that UVA's heart failure remote monitoring and care coordination programs for high risk patients "have reduced 30 day readmission rates by 82 percent and ER visits by 77 percent" and that "the cost savings are estimated to be seven times the program's cost…."); CoBank Comments at 3-4 (stating that a CoBank sponsored connected care pilot for diabetics resulted in hemoglobin A1c level reductions in 75% of the patients who finished the program, with an average A1c level improvement of 2.5% (the average hemoglobin A1c level baseline at the start of the program was 11.3%), and that using average Medicare savings, a 2.5% average decrease in A1c levels "means an estimated reduction in healthcare costs by approximately $3,855 per patient per year and better outcomes."); AHA Comments at 6 (stating that in the first year of Banner Health's Intensive Ambulatory Care telehealth program, which included remote patient monitoring, "overall costs of care were reduced by 34.5%; hospitalizations were reduced by 49.5%; the length of hospital stays was reduced by 50%; and the 30-day readmission rate was reduced by 75%.").

[24] *See supra* note 2.

[25] Centers for Medicare and Medicaid Services, NHE Fact Sheet (Dec. 5, 2019), https://www.cms.gov/research-statistics-data-and-systems/statistics-trends-and-reports/nationalhealthexpenddata/nhe-fact-sheet.html.

[26] *See, e.g.*, Karen Schulder Rheuban & Elizabeth A. Krupinski, Understanding Telehealth 134 (1st ed. 2017). These cost savings have been borne out on a project level.

[27] *See* David Ronan & Kyle Conlee, *Internet of Things, Vol. 5, The Digital Revolution Comes to US Healthcare*, Goldman Sachs, at 12-13 (June 29, 2015), https://www.wur.nl/upload_mm/0/f/3/8fe8684c-2a84-4965-9dce-550584aae48c_Internet%20of%20Things%205%20-%20Digital%20Revolution%20Comes%20to%20US%20Healtcare.pdf. Another study found that remote monitoring saved on average $8,000 per patient. Press Release, Geneia, Geneia Study Finds Remote Patient Monitoring Could Save More Than $8,000 Per Patient Annually (June 15, 2016), https://www.geneia.com/news-events/press-releases/2016/june/geneia-study-finds-remote-patient-monitoring-could-save-more-than-8000-dollars-per-patient-annually.

[28] *See Connected Care Notice of Inquiry*, 33 FCC Rcd at 7829, para. 8. Assuming just 20% of Mississippi's diabetic population were to enroll in this type of remote patient monitoring program, Medicaid savings for the state would be approximately $189 million per year. *See id.*; Testimony of Michael P. Adcock, FACHE, Executive Director, Center for Telehealth University of Mississippi Medical Center, Before the U.S. Senate Committee on Commerce, Science, and Transportation, Subcommittee on Communications, Technology, Innovation and the Internet at 1-2 (Nov. 7, 2017), https://prodnet.www.neca.org/publicationsdocs/wwpdf/110717adcock.pdf; Heather Landi, , *Lessons Learned from the Mississippi Delta, Tackling Chronic Disease Through Remote Monitoring Technology*, Healthcare Innovation (Oct. 3, 2016), https://www.hcinnovationgroup.com/population-health-

(continued….)

12. The record discloses three primary barriers to telehealth deployment and adoption that universal service support has the potential to address. *First*, the costs of standing up, implementing, and providing connected care services, including the costs of services necessary to capture, transmit (including video visits), and store data for connected care services are an obstacle that has prevented many health care providers, particularly public and nonprofit health care providers that serve large numbers of low-income patients, from adopting connected care services.[29] *Second*, lack of mobile or residential broadband Internet access service for patients is also a major obstacle for patients and health care providers in adopting connected care services;[30] many low-income Americans and veterans do not have broadband Internet access.[31] In one survey nearly 20% of respondents reported connectivity issues as a barrier to increased telehealth adoption.[32] Patient access to broadband Internet access service is

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management/article/13026977/lessons-learned-from-the-mississippi-delta-tackling-chronic-disease-through-remote-monitoring-technology.

[29] *See, e.g.*, Mercy Virtual Comments at 7 (stating that "[t]he cost to stand up, implement, and utilize telemedicine is extremely high and serves as the primary barrier to adoption."); Ochsner Comments at 15 ("HCPs such as Ochsner bear the costs of the research, development, implementation, and distribution of wireless IT solutions, but are rarely financially incentivized to create new programs with the potential of improving clinical outcomes. When the cost of providing telehealth service to each patient goes up, the number of patients who can benefit from the HCP's telehealth program will decrease."); MH Comments at 2 ("Lack of funding is a clear barrier to health systems seeking to expand telehealth services. The qualifying costs to create new capabilities and the costs to maintain current access are significant[.]").

[30] *See, e.g.*, Mercy Virtual Comments at 7-8 ("Another major barrier to adopting telehealth services is the lack of available technology and services in patient homes. In our experience, patients frequently do not have access to broadband services, do not have the necessary level/speed of connectivity[.]"); VTN Comments at 4 ("Unfortunately, this nation's most vulnerable patient population—particularly low-income individuals and the elderly, but also veterans and rural communities—often lack access to the broadband connectivity necessary to benefit from such connected care services."). *See also Connected Care Notice*, 34 FCC Rcd at 5624, para. 13.

[31] *See, e.g.*, Nicole Ogrysko, *VA's Telehealth Program is already the Largest in the Nation. It's About to get Bigger*, Federal News Network (Dec. 6, 2018), https://federalnewsnetwork.com/veterans-affairs/2018/12/vas-telehealth-program-is-already-the-largest-in-the-nation-its-about-to-get-bigger/ (stating that many rural Veterans "'don't have broadband access in their home yet,' Scher said. '. . . either they can't afford it or it's not available where they live.'"); AHA Comments at 3 (stating "there remain substantial barriers to widespread adoption of connected care (and telehealth generally)" including "lack of patient access to affordable end-user devices and broadband connections capable of supporting connected care services, especially in rural areas"); AUA Comments at 3 (stating that current barriers to connected care for low-income patients include lack of access to broadband Internet access due to cost); HLC Comments at 1-2 ("Low income and rural Americans are more likely to lack the necessary broadband capabilities to utilize connected health technology."); Mercy Virtual Comments at 7-8 ("Another major barrier to adopting telehealth services is the lack of available technology and services in patient homes. In our experience, patients frequently do not have access to broadband services . . . ."); SC CTC Comments at 1 ("The lack of broadband connectivity, either wired or wireless, is a major impediment to patient participation in and adherence to, remote patient monitoring and connected care services, particularly for rural and low-income households.").

[32] *See* HealthTech Staff, *4 Non-technical Barriers to Telehealth – and How the Industry Can Overcome Them*, HealthTech (Feb. 21, 2018), https://healthtechmagazine.net/article/2018/02/4-non-technical-barriers-telehealth-and-how-industry-can-overcome-them (explaining that nearly 20% of respondents to a 2017 American Telemedicine Association survey reported connectivity issues as a barrier to increased telehealth adoption). *See also* Lily McCoy, *The Future of Digital Healthcare*, Connected Nation Ohio (Oct. 9, 2019), https://connectednation.org/ohio/2019/10/09/the-future-of-digital-healthcare/ ("'For patients, the major issues revolve around a lack of home broadband service that they can use for some telehealth applications. To have continual remote monitoring tools, patients need to have reliable internet service at all hours of the day and night[.]'"); Joyce Frieden, *Barriers to Telehealth Adoption Remain, Survey Finds*, MedPage Today (Apr. 12, 2019), https://www.medpagetoday.com/meetingcoverage/acp/79180 (stating that lack of patient access to health care technology is a leading barrier to telehealth adoption, and indicating that there is a concern that patients without access to broadband technology will be excluded from the benefits of telehealth).

therefore an important factor that health care providers must weigh when deciding whether to invest in connected care options for patients.[33] Aside from the U.S. Department of Veterans Affairs (VA)'s Home Telehealth Program (which provides a limited number of patient broadband connections targeted to veterans), there appears to be no federal agency that currently offers funding to health care providers expressly designated for use for patient connectivity in connected care.[34] *Third*, even in households with broadband, the service may be inadequate for health care needs. Some Americans may have a home broadband or mobile connection that is insufficient for connected care services, or lack the routers and wireless capability needed for connected care services.[35] There are other barriers to the adoption of connected care services, including insurance reimbursement policies and medical licensing laws, that are outside the Commission's regulatory authority.[36]

[33] *How Better Broadband Access Will Help Telemedicine Reach Its Full Potential*, InTouch Health, https://intouchhealth.com/how-broadband-will-help-telemedicine-reach-its-full-potential/ (last visited Mar. 25, 2020) ("Adoption rates are largely determined by patient demand. If a healthcare provider's patients can't access telehealth services because they don't have access to the internet, the provider won't view telehealth as a priority.")

[34] *See* AHA Comments at 9; Mercy Virtual Comments at 12 (stating that Medicare and other health insurance practices do not cover these types of costs). *See also* Eli Richman, *The VA Tried Loaning Out Thousands of iPads to Veterans for Telehealth. Now They Plan to Double the Program*, Fierce Healthcare (Sept. 19, 2018), https://www.fiercehealthcare.com/tech/va-expects-to-double-tablet-leasing-program-for-at-need-veterans-potentially-distributing-12 (discussing VA's challenge with funding patient wireless connections for its broadband-enabled tablet loan program which initially served 6,000 patients and is being expanded to serve double that number of patients). The VA's tablet program serves a very small percentage of the veterans who receive health care services from the VA. *See, e.g.*, FCC, Report on Promoting Broadband Internet Access Service for Veterans, Pursuant to the Repack Airwaves Yielding Better Access for Users of Modern Services Act of 2018 at 16-17 (WCB May 1, 2019), https://docs.fcc.gov/public/attachments/DOC-357270A1.pdf (*Veterans Broadband Report*) (stating that the VA has provided more than 2.29 million telehealth interactions to more than 782,000 veterans enrolled in the VA health care system, an increase of 7.5% from Fiscal Year 2017 services). *See also* U.S. Department of Veterans Affairs, VA Telehealth Services, Fact Sheet (2019) (VA Telehealth Services), https://connectedcare.va.gov/sites/default/files/OT_va-telehealth-factsheet-2019-01.pdf.

[35] *See* Elizabeth O'Dowd, *Rural Healthcare Network Connections Require IT Infrastructure Support*, HIT Infrastructure (Aug. 15, 2018), https://hitinfrastructure.com/news/rural-healthcare-network-connections-require-it-infrastructure-support ("Many Americans have internet that is not fast enough to support a high-quality video chat. In rural communities, service providers often have customers pay for internet by the gigabyte, which can result in high charges for video conferencing."); Elizabeth O'Dowd, *Broadband Supports Healthcare IoT Remote Connectivity, Volume*, HIT Infrastructure (Sept. 5, 2017), https://hitinfrastructure.com/news/broadband-supports-healthcare-iot-remote-connectivity-volume ("Remote care and telehealth programs that depended on the patient's home WiFi network were often unsuccessful, especially when clinicians were visiting patients in rural or underserved areas. Home WiFi connections were often unreliable and were not strong enough to transmit large files or stream video for conferencing."); AHA Comments at 9 (stating "lack of access to affordable, robust broadband connections is a persistent problem, particularly in rural areas" and concurring that "universal service funding can and should be explored as a means of addressing the connectivity problem"); Mercy Virtual Comments at 7-10 (stating that in Mercy's experience, patients frequently "do not have the necessary level/speed of connectivity," and that the transmission of a significant amount of data for telehealth can "quickly exceed the limits of a patient's personal wireless data plans [which] is especially true for patients in medically underserved areas").

[36] *See Connected Care Notice*, 34 FCC Rcd at 5623-24, para. 12 (discussing reimbursement and licensing issues); OCHIN Comments at 3 (discussing same); AHA Comments at 3; *see also* Joyce Frieden, *Barriers to Telehealth Adoption Remain, Survey Finds*, MedPage Today (Apr. 12, 2019), https://www.medpagetoday.com/meetingcoverage/acp/79180 (noting that, among survey respondents, the perceived barriers to adoption of telehealth include difficulties integrating it into the practice workflow, no patient access to the technology, concern about potential medical errors, and security and privacy of patient information).

III. DISCUSSION

13. Given the compelling evidence of the benefits of connected care services provided through broadband connections, we take the important step of establishing a Pilot Program, as we proposed in the *Connected Care Notice*, to explore whether and how the USF can help defray health care providers' costs of providing connected care services, particularly to low-income Americans and veterans. Recognizing also that the ongoing COVID-19 pandemic represents extraordinary and unprecedented public health challenges, we also adopt a COVID-19 Telehealth Program, funded through a recent congressional appropriation, to immediately support health care providers responding to the pandemic by providing funding for telecommunications services, information services, and devices necessary to enable the provision of telehealth services, on a temporary basis. This includes support for services and/or devices that generate and transmit patient-reported outcomes from patients to health care providers.[37] Such services could include an end-user device, such as a smartphone or tablet, that allows the patient to report his or her health conditions directly to a provider, independent or in conjunction with other connected medical monitoring devices. Such technology is an essential part in improving communications between health care providers and patients during this time in order to better monitor patients' health and improve their health outcomes. We expect the COVID-19 Telehealth Program will provide immediate assistance to help health care providers deploy connected care services in response to the COVID-19 pandemic, and that, in the longer term, the Pilot Program will provide us with a better understanding of the benefits, including cost savings, of connected care, and whether there are obstacles to connected care that could be addressed by the Commission's universal service programs.

14. For purposes of this Report and Order, we broadly define "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—including specifically to patients at their mobile location or residence. Examples of connected care services delivered to patients at their residence or mobile location rather than a health care provider's physical location include, but are not limited to, remote patient monitoring (e.g., use of patient reporting outcome platforms, glucometers, pulse oximeters, sphygmomanometers, chest straps, wearables, passive sensors, or other devices to consistently monitor patient vitals), patient health education, store and forward services (e.g., asynchronous transfer of patient images and data for interpretation by a physician), and synchronous video consultations and visits.[38]

A. COVID-19 Telehealth Program

15. The COVID-19 Telehealth Program is one piece of a comprehensive approach to reducing barriers to telehealth services for health care providers and their patients throughout the country in response to the COVID-19 pandemic.[39] The steps we take complement the work of other agencies

[37] According to the Food and Drug Administration and National Institutes of Health, a patient reported outcome (PRO) is report from a patient to a health care provider about the patient's health status. *BEST (Biomarkers, EndpointS, and other Tools) Resource*, FDA-NIH Biomarkers Working Group (2016), https://www.ncbi.nlm.nih.gov/books/NBK338448/. PRO can include patient questionnaires, numeric symptom ratings, and counts of medical events. *Id.*

[38] *See, e.g.*, Karen Schulder Rheuban & Elizabeth A. Krupinski, Understanding Telehealth 18 (1st ed. 2017) (describing the types of telehealth-related services). *See also* Lily McCoy, *The Future of Digital Healthcare*, Connected Nation Ohio (Oct. 9, 2019), https://connectednation.org/ohio/2019/10/09/the-future-of-digital-healthcare/ ("The various forms of telehealth that providers are using include; live video conferencing, store-and-forward video conferencing, remote patient monitoring, and mobile health.").

[39] Telehealth and in-home care may be especially important for COVID-19 patients. WHO guidelines suggest that health care provider implement at-contact and airborne precautions (gown, eye protection, gloves, respirator or N95 mask, negative pressure room) during procedures likely to create aerosols (i.e., to create airborne droplets in which the virus can live)—such as endotracheal intubation, bronchoscopy, open suctioning, nebulizer treatment administration, manual ventilation, or even turning the patient to a prone position. *See* WHO Infection Prevention

(continued….)

addressing the pandemic as well. On March 17, 2020, the Centers for Medicare and Medicaid Services (CMS) announced that it will relax telehealth restrictions on Medicare and will allow program funds to be spent on telehealth services to broaden the number of patients who can be treated and reduce the need for sick patients to travel for treatment to or within major population centers.[40] The relaxed rules extend treatment to patients' homes, and do not limit the relief only to patients in remote areas, as was previously the case. This rule change to Medicare—a health care program supporting treatment for some of the country's most at-risk population—will have a meaningful impact on this country's coronavirus response. The Department of Health and Human Services (HHS) also announced that it will waive potential penalties for inadvertent and good faith violations of the Health Insurance Portability and Accountability Act, to encourage health care providers to use telehealth services to treat potentially sick patients.[41] HHS further encouraged the broader use of telehealth by notifying health care providers that they do not need to collect the usually required co-pays for patients receiving health care from an HHS program.[42] On March 24, 2020, HHS awarded $100 million to 1,381 health centers funded through the Health Resources and Services Administration (HRSA) "to address screening and testing needs, acquire medical supplies and boost telehealth capacity" in response to the coronavirus pandemic.[43]

16. Working in step with these other federal efforts to provide relief related to the COVID-19 pandemic, the COVID-19 Telehealth Program will be open to eligible health care providers, whether located in rural or non-rural areas, and will provide eligible health care providers support to purchase telecommunications, information services, and connected devices to provide connected care services in response to the coronavirus pandemic. The COVID-19 Telehealth Program will only fund monitoring devices (e.g., pulse-ox, BP monitoring devices), that are themselves connected. The COVID-19 Telehealth Program will not fund unconnected devices that patients can use at home and then share the results with their medical professional remotely.

17. The COVID-19 Telehealth Program will provide selected applicants full funding for eligible services and devices. The COVID-19 Telehealth Program has a congressionally appropriated

(Continued from previous page)
and Control Guidance for COVID-19, https://www.who.int/emergencies/diseases/novel-coronavirus-2019/technical-guidance/infection-prevention-and-control (last visited Mar. 30, 2020). Meanwhile, the CDC recommends airborne precautions for any situation involving the care of COVID-19 patients. *See* Centers for Disease Control and Prevention Interim Infection Prevention and Control Recommendations for Patients with Suspected or Confirmed Coronavirus Disease 2019 (COVID-19) in Healthcare Settings, https://www.cdc.gov/coronavirus/2019-ncov/infection-control/control-recommendations.html (last visited Mar. 30, 2020). Because such personal protective equipment should normally be removed and discarded after each interaction, even short in-patient care could become a significant drain on limited health care provider resources.

[40] *See* Centers for Medicare and Medicaid Services, Medicare Telemedicine Health Care Provider Fact Sheet (Mar. 17, 2020), https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet; Press Release, Centers for Medicare and Medicaid Services, President Trump Expands Telehealth Benefits to Medicare Beneficiaries During COVID-19 Outbreak (Mar. 17, 2020), https://www.cms.gov/newsroom/press-releases/president-trump-expands-telehealth-benefits-medicare-beneficiaries-during-covid-19-outbreak.

[41] *See* U.S. Dept. of Health and Human Services, Notification of Enforcement Discretion for telehealth remote communications during the COVID-19 nationwide public health emergency (last updated Mar. 17, 2020), https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html.

[42] *See* U.S. Dept. of Health and Human Services, Office of Inspector General, OIG Policy Statement Regarding Physicians and Other Practitioners That Reduce or Waive Amounts Owed by Federal Health Care Program Beneficiaries for Telehealth Services During the 2019 Novel Coronavirus (COVID-19) Outbreak (Mar. 17, 2020), https://oig.hhs.gov/fraud/docs/alertsandbulletins/2020/policy-telehealth-2020.pdf.

[43] Press Release, U.S. Dept. of Health and Human Services, HHS Awards $100 Million to Health Centers for COVID-19 Response (Mar. 24, 2020), https://www.hhs.gov/about/news/2020/03/24/hhs-awards-100-million-to-health-centers-for-covid-19-response.html.

$200 million budget, and these funds will be available until they are expended or until the current pandemic has ended. In order to ensure as many applicants as possible receive available funding, we do not anticipate awarding more than $1 million to any single applicant.[44] We will award support to eligible applicants based on the estimated costs of the supported services and connected devices they intend to purchase, as described in each health care provider's respective application. However, in order to give each health care provider maximum flexibility to respond to changing circumstances during the pandemic, we do not require applicants to purchase only the services and connected devices identified in their applications. They may rather use awarded support to purchase any necessary eligible services and connected devices. In addition, applicants that have exhausted initially awarded funding may request additional support.

1. Application, Evaluation, and Selection Process

18. Because of the urgency attendant in combating the COVID-19 outbreak, we establish a streamlined application process for the COVID-19 Telehealth Program, separate from the longer application process we adopt for the broader Connected Care Pilot Program. There are clear and important differences between the COVID-19 Telehealth Program and the Connected Care Pilot Program warranting differing treatment of applications. While the primary focus of the Pilot Program is to select projects that will help the Commission study how universal service funds can support connected care and telehealth generally over the long term, the purpose of the COVID-19 Telehealth Program is to take immediate steps that will have an immediate impact on health care providers and their patients dealing with the current pandemic. Applications will be accepted after publication of this Report and Order and notice of OMB's approval of the COVID-19 Telehealth Program information collection requirements in the Federal Register.[45]

19. We direct the Bureau to review the applications, in consultation with the FCC's Connect2Health Task Force and its medical and public health experts, and announce selected participants and funding amounts for each selected applicant as rapidly as possible on a rolling basis, and continue reviewing additional applications and selecting participants until it has committed all COVID-19 Telehealth Program funding or the current pandemic has ended.[46] In reviewing applications, we have a strong interest in targeting funding towards areas that have been hardest hit by COVID-19.[47] In addition, given the public health emergency and widespread scope of the coronavirus pandemic, unlike the broader Connected Care Pilot Program, we will not target COVID-19 Telehealth Program funding toward specific medical conditions, patient populations, or geographic areas. However, we strongly encourage selected applicants to target the funding they receive through the COVID-19 Telehealth Program to high-risk and vulnerable patients to the extent practicable. We recognize that some health care providers may have been under pre-existing strain (e.g., large underserved or low-income patient population; health care provider shortages; rural hospital closures; limited broadband access and/or Internet adoption) and we encourage applicants to document such factors in their applications. While health care providers may use the COVID-19 Telehealth Program to treat patients that have COVID-19, the program is not limited to

[44] The budget for the COVID-19 Telehealth Program is from a congressional appropriation and is separate from the up to $100 million budget for the Connected Care Pilot Program.

[45] Pursuant to the Paperwork Reduction Act of 1995 (PRA), the Commission plans to seek OMB approval for a COVID-19 Telehealth Program Application and Request for Funding Form for applicants to use when submitting their applications to the Commission.

[46] The $200 million budget for the COVID-19 Telehealth Program refers to the total maximum authorized disbursement amount and does not include administrative fees for operating and administering the COVID-19 Telehealth Program. We expect the Bureau to ensure the efficient, cost-effective administration of the COVID-19 Telehealth Program.

[47] We will use publicly available resources to help us identify these areas, such as data released by the Centers for Disease Control and Prevention, in addition to information provided by applicants.

treating those types of patients as long as program funds are used "to prevent, prepare for, and respond to coronavirus."[48] For instance, treating other types of conditions or patient groups through the Commission's COVID-19 Telehealth Program could free up resources, including physical space and equipment in a brick-and-mortar health care facility, allow health care providers to remotely treat patients with other conditions who could risk contracting coronavirus by visiting a health care facility, and could reduce health care professionals' unnecessary exposure to coronavirus. We will also consider as part of a health care provider's application a showing that telemedicine directly aids in the prevention of pandemic spread by facilitating social distancing and similar measures in the community. Connected devices and services like patient-reported outcome platforms funded through the COVID-19 Telehealth Program must be integral to patient care.

20. *Eligible Health Care Providers.* Consistent with the 1996 Act and the CARES Act, we limit 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) 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.[49] The Commission has more than two decades of experience administering its RHC Program for these types of health care providers, and limiting the COVID-19 Telehealth Program to public and nonprofit health care providers that fall within these statutory categories is in the public interest because it will facilitate the administration of this program and 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.

21. We conclude that it is in the public interest to support connected care services being provided to patients by eligible health care providers even when provided from a temporary or mobile location that is operated by the eligible health care provider. During this unprecedented period, we expect there could be a need for eligible health care providers to expand beyond their traditional facilities to effectively treat patients.

22. Interested health care providers that do not already have an eligibility determination can obtain one by filing an FCC Form 460 with the Universal Service Administrative Company (USAC).[50]

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[48] CARES Act, Pub. L. No 116-136, 134 Stat. 281 (2020).

[49] *See* 47 U.S.C § 254(h)(7)(B). Sections 254(h)(1)(A) and (h)(2)(A) of the Act limit USF support for eligible health care providers to eligible nonprofit or public health care providers. *See* 47 U.S.C § 254(h)(1)(A), 254(h)(2)(A). The CARES Act permits the Commission to rely on Part 54 of the Commission's rules as needed in disbursing funding. CARES Act, Pub. L. No 116-136, 134 Stat. 281 (2020) ("[T]he Federal Communications Commission may rely on the rules of the Commission under part 54 of title 47, Code of the Federal Regulations, in administering the amount provided under the heading in this Act if the Commission determines that such administration is in the public interest.").

[50] *See* USAC, Rural Health Care Program, Healthcare Connect Fund Program, Determine Eligibility of Your Site, https://www.usac.org/rural-health-care/healthcare-connect-fund-program/step-1-determine-eligibility-of-your-site/ (last visited Mar. 24, 2020) (describing the process for submitting an FCC Form 460 to receive an eligibility determination for a health care provider site). The FCC Form 460 can be accessed through the Commission's website at https://www.fcc.gov/licensing-databases/forms (last visited Mar. 24, 2020). Each separate site or location of a health care provider is considered an individual health care provider site for eligibility determination purposes. *See* 47 CFR § 54.601(a)(2). As detailed above, the COVID-19 Telehealth Program is open to eligible health care providers in both rural and non-rural areas—eligible health care providers located in non-rural areas do not need to be part of a consortium to participate in the COVID-19 Telehealth Program. For any questions concerning the FCC Form 460, health care providers should call USAC's RHC Program staff at RHC-Assist@usac.org or by phone at (800) 453-1546. Pursuant to the Paperwork Reduction Act of 1995 (PRA), the Commission plans to seek OMB approval to use the FCC Form 460 and attachments for the COVID-19 Telehealth Program.

We direct USAC to review and process eligibility forms for health care providers interested in participating in the COVID-19 Telehealth Program as expeditiously as possible. Health care providers that are interested in the COVID-19 Telehealth Program, but do not yet have an eligibility determination from USAC, can still submit applications for the COVID-19 Telehealth Program while their FCC Form 460 is pending.

23. *Application Process*. For purposes of the COVID-19 Telehealth Program, we establish a separate, streamlined application process in order to more expeditiously address the needs of eligible health care providers impacted by the coronavirus pandemic. Specifically, under the COVID-19 Telehealth Program, eligible health care providers must submit an application to the Bureau with sufficient information that will allow the Bureau to make selections and funding amount determinations.

24. To be considered for participation in the COVID-19 Telehealth Program, interested eligible health care providers must submit applications that, at a minimum, contain the information detailed below.[51]

- Names, addresses, county, and health care provider numbers (if available),[52] for health care providers seeking funding through the COVID-19 Telehealth Program application and the lead health care provider for applications involving multiple health care providers.
- Contact information for the individual that will be responsible for the application (telephone number, mailing address, and email address).
- Description of the anticipated connected care services to be provided, the conditions to be treated, and the goals and objectives. This should include a brief description of how COVID-19 has impacted your area, your patient population, and the approximate number of patients that could be treated by the health care provider's connected care services during the COVID-19 pandemic. If you intend to use the COVID-19 Telehealth Program funding to treat patients without COVID-19, describe how this would free up your resources that will be used to treat COVID-19 and/or how this would otherwise prevent, prepare for, or respond to the disease by, for example, facilitating social distancing.
- Description of the estimated number of patients to be treated.
- Description of the telecommunications services, information services, or "devices necessary to enable the provision of telehealth services" requested, the total amount of funding requested, as well as the total monthly amount of funding requested for each eligible item. If requesting funding for devices, description of all types of devices for which funding is requested, how the devices are integral to patient care, and whether the devices are for patient use or for the health care provider's use. As noted above, monitoring devices (e.g., pulse-ox, BP monitoring devices) will only be funded if they are themselves connected.
- Supporting documentation for the costs indicated in your application, such as a vendor or service provider quote, invoice, or similar information.
- A timeline for deployment of the proposed service(s) and a summary of the factors the applicant intends to track that can help measure the real impact of supported services and devices.

[51] We recognize that some applications could contain confidential information. Applicants may request that any materials or information submitted to the Commission in its application be withheld from public inspection pursuant to the procedures set forth in section 0.459 of the Commission's rules. *See* 47 CFR § 0.459.

[52] USAC assigns a health care provider number for each health care providers site it determines to be eligible for support based on the FCC Form 460 submission and related documentation.

25. Additionally, COVID-19 Telehealth Program applicants will also be required, at the time of submission of their application, to certify, among other things, that they will comply with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy and reimbursement laws and regulations, and applicable medical licensing laws and regulations, as waived or modified in connection with the COVID-19 pandemic, as well as all applicable COVID-19 Telehealth Program requirements and procedures, including the requirement to retain records to demonstrate compliance with the COVID-19 Telehealth Program requirements and procedures for three years following the last date of service, subject to audit. This document retention period appropriately balances the interests of program integrity while minimizing administrative burdens on health care providers during this emergency. Health care providers that participate in the COVID-19 Telehealth Program must also comply with all applicable federal and state laws, including the False Claims Act, the Anti-Kickback Statute, and the Civil Monetary Penalties Law, as waived or modified in connection with the COVID-19 pandemic.[53] Further, applicants will also be required to certify that they are not already receiving or expecting to receive other federal or state funding for the exact same services or devices for which they are requesting support under the COVID-19 Telehealth Program.[54]

26. Applications for the COVID-19 Telehealth Program must be submitted through the Commission's Electronic Comment Filing System (ECFS) under **WC Docket No. 20-89**. The Commission will begin accepting applications for the COVID-19 Telehealth Program after publication of this Report and Order and notice of OMB's approval of the COVID-19 Telehealth Program information collection requirements in the Federal Register. Interested parties should not submit applications for the COVID-19 Telehealth Program prior to publication of notice of OMB's approval of the COVID-19 Telehealth Program information collection requirements and this Report and Order in the Federal Register. In order to facilitate the application process, the Bureau will provide, upon publication of notice of OMB's approval of the COVID-19 Telehealth Program information collection requirements and this Report in Order in the Federal Register, an application form titled "COVID-19 Telehealth Program Application and Request for Funding" that applicants must use when submitting their applications to the Commission. Applicants will be required to complete each section of the application and make the required certifications at the end of the application. Applicants may request that any materials or information submitted to the Commission in its application be withheld from public inspection pursuant to the procedures set forth in section 0.459 of the Commission's rules.

27. *Instructions for Filing Applications*. COVID-19 Telehealth Program applications must reference **WC Docket No. 20-89**, and must be filed electronically using the Internet by accessing ECFS, https://www.fcc.gov/ecfs, *see Electronic Filing of Documents in Rulemaking Proceedings*, 63 FR 24121 (1998). All filings must be addressed to the Commission's Secretary, Office of the Secretary, Federal Communications Commission. The Commission's hand-delivery filing location is closed for the foreseeable future and cannot be used to submit applications for the COVID-19 Telehealth Program.[55]

[53] *See* False Claims Act, 31 U.S.C. §§ 3729-3733; Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b); Civil Monetary Penalties Law, 42 U.S.C. § 1320a-7a. We understand that health care providers must routinely navigate these laws in other contexts. Thus, health care providers that are interested in applying for the COVID-19 Telehealth Program should speak to their compliance experts prior to submitting an application to participate in the COVID-19 Telehealth Program.

[54] In the event that after we select applicants, new federal or state funding sources become available for the services or devices that are funded through the COVID-19 Telehealth Program, participants cannot receive duplicate federal or state funding for those exact same items. If such new federal or state funding sources become available, participants will need to decide whether to continue receiving funding for the eligible services or devices through the COVID-19 Telehealth Program, or to instead receive the funding for these exact same items through any such new federal or state sources.

[55] *See FCC Announces Closure of FCC Headquarters Open Window and Change in Hand-Delivery Filing*, Public Notice, DA-20-304 (OSEC Mar. 19, 2020).

Applicants must also send a courtesy copy of their application via email to EmergencyTelehealthSupport@fcc.gov. For questions, please contact (1) Rashann Duvall at (202) 418-1438, Rashann.Duvall@fcc.gov or (2) Hayley Steffen at (202) 418-1586, Hayley.Steffen@fcc.gov.

28. *Evaluation of Applications and Selection Process.* The Bureau, in consultation with the FCC's Connect2Health Task Force, will evaluate the COVID-19 Telehealth Program applications and will select participants based on applicants' responses to the criteria listed above. Our goal is to select applications that target areas that have been hardest hit by COVID-19 and where the support will have the most impact on addressing the health care needs. As indicated above, the funds for the COVID-19 Telehealth Program will be awarded on a rolling basis until they are exhausted or until the current pandemic ends. In selecting applicants, we direct the Bureau to consider the funding sought by each applicant compared to the total COVID-19 Telehealth Program budget. This does not mean that the Bureau will evaluate applications based solely on requested funding, but the Bureau will seek to select as many applicants as reasonably possible within the COVID-19 Telehealth Program's limited budget. Upon selection, the Bureau will provide additional guidance to program participants, as necessary, to facilitate the implementation of the COVID-19 Telehealth Program. Applicants who are selected for the COVID-19 Telehealth Program may later submit applications to participate in the broader Connected Care Pilot Program, but may not request funding for the same exact services from both programs at the same time.[56]

2. Administrative Matters

29. *Requesting Funding, Invoicing, and Disbursements*. We direct the Bureau and the Office of the Managing Director (OMD) to develop processes for selected applicants to submit invoices and receive reimbursements for services and devices supported through the COVID-19 Telehealth Program, and any necessary subsequent filings. We also direct OMD and the Bureau to include in the application forms or subsequent filings by program participants any information necessary to satisfy the Commission's oversight responsibilities and/or agency-specific/government-wide reporting obligations associated with the $200 million appropriation by Congress.[57] After receiving the eligible services and/or equipment, health care providers will submit invoicing forms on a monthly basis[58] and supporting documentation to the Commission to receive reimbursement for the cost of the eligible services and/or devices they have received from their applicable service providers or vendors under the COVID-19 Telehealth Program. The Bureau and OMD shall develop a process for reviewing the monthly invoicing forms and supporting documentation and for issuing disbursements directly to the participating health care providers rather than to the applicable service providers or vendors. COVID-19 Telehealth Program health care provider participants will be required to make certifications as part of the invoicing form submission to ensure that COVID-19 Telehealth Program funds are used for their intended purpose.

30. This funding and disbursement process is designed to provide funds to participating eligible health care providers as soon as possible due to the rapid spread of COVID-19 across the country and the increasing need for connected care services to assist in the diagnosis, treatment, and prevention of the coronavirus disease. We recognize that more extensive administrative requirements could delay the provision and use of COVID-19 Telehealth Program funds to assist in combatting this pandemic and could result in serious harm to patients, and we desire to help health care providers proceed as rapidly as

[56] For example, a health care provider receiving COVID-19 Telehealth Program funding for broadband Internet access service for patient use could not request Pilot Program funding for the same exact broadband Internet access service for patient use for the same period, but could request funding for additional broadband Internet access for patient use or funding for patient broadband Internet access use for a different time period.

[57] CARES Act, Public Law 116-136 (March 27, 2020), DIVISION B, entitled "Emergency Appropriations for Coronavirus Health Response And Agency Operations," Title V, Sec, 15011.

[58] Monthly invoice submissions are an important safeguard that will help the Commission track the amount of funding remaining and monitor expenditures in order to guard against waste, fraud, and abuse.

possible in addressing this public health crises. For this reason, we find that the benefit to the American public in using this streamlined invoicing process outweighs any administrative concerns in processing and distributing funds in this manner. The COVID-19 Telehealth Program will not provide funding for health care provider administrative costs associated with participating in the COVID-19 Telehealth Program (e.g., costs associated with completing COVID-19 Telehealth Program applications and other submissions) or other miscellaneous expenses (e.g., doctor and staff time spent on the COVID-19 Telehealth Program and outreach). We emphasize that COVID-19 Telehealth Program funds may only be used for services and devices covered under the CARES Act. The costs of ineligible items must not be included in the reimbursement requests for the COVID-19 Telehealth Program. To guard against potential waste, fraud, and abuse, we make clear that participating health care providers are prohibited from selling, reselling, or transferring services or devices funded through the COVID-19 Telehealth Program in consideration for money or any other thing of value.[59]

31. *Procurement for COVID-19 Telehealth Program-Supported Services and Equipment, and Document Retention*. As detailed above, the COVID-19 Telehealth Program is funded through a congressional appropriation and not the USF. Given the immediate need to award and disburse the COVID-19 Telehealth Program funding to health care providers, we will not require COVID-19 Telehealth Program participants to conduct a competitive bidding process to solicit and select eligible services or devices, or otherwise comply with the competitive bidding requirements that apply to the RHC Program and the broader Connected Care Pilot Program. We find that, in light of the coronavirus pandemic and ongoing community efforts to slow its spread, requiring COVID-19 Telehealth Program participants to seek competitive bids prior to requesting funding would cause unnecessary delays and pose an unreasonable burden on health care providers during this unprecedented time. Because we recognize the importance of connected care services during this pandemic, we do not believe that the public interest would be served by requiring health care providers to follow the competitive bidding requirements that we have traditionally required for the RHC Program, including submitting Request for Services and Request for Proposals (RFP) (as applicable) to USAC to post on its website, seeking bids,[60] waiting 28 days before selecting a service provider,[61] conducting a bid evaluation to select a service provider,[62] and then selecting the most-cost effective service[63] prior to providing essential health care support to patients. We also find that it would not be in the public interest during this national health crisis to prohibit participating health care providers from receiving gifts or things of value from service providers valued at over $20, including, but not limited to devices, equipment, free upgrades or other items.[64]

[59] This restriction is consistent with the spirit of section 254(h)(3) of the 1996 Act, which applies to the RHC Program, and is an important safeguard for the COVID-19 Telehealth Program. *See* 47 U.S.C. § 254(h)(3) ("Telecommunications services and network capacity provided to a public telecommunications user under this section may not be sold, resold, or transferred by such user in consideration for money or any other thing of value."). This restriction does not preclude health care providers participating in the COVID-19 Telehealth Program from providing their patients with devices or broadband services funded through the COVID-19 Telehealth Program or transferring funded devices from one patient to another in order to address health care needs.

[60] 47 CFR § 54.622(e).

[61] 47 CFR § 54.622(g).

[62] 47 CFR § 54.622(d)

[63] 47 CFR § 54.622(c).

[64] We note that the Bureau has already waived a number of rules applicable to the USF programs to assist entities impacted by COVID-19. *See, e.g.*, *Rural Health Care Universal Service Support Mechanism, Schools and Libraries Universal Service Support Mechanism,* Order, Docket Nos. WC 02-60, CC 02-6, DA 20-290A, para. 1 (WCB Mar. 18, 2020) (waiving the Commission's gift rules in sections 54.622(h) and 54.503(d) of the Commission's rules, respectively applicable to the RHC Program and the Schools and Libraries (E-Rate) Program to assist health care providers and schools and libraries affected by the coronavirus disease). Consistent with past practice in this regard, COVID-19 Telehealth Program participants receiving such gifts should retain records of any gifts received for the

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32. While we will not require health care providers to conduct a competitive procurement process to receive COVID-19 Telehealth Program funding, we are committed to ensuring the integrity and fiscal responsibility of the COVID-19 Telehealth Program funds and will guard against waste, fraud, and abuse. We thus strongly encourage applicants to purchase cost-effective eligible services and devices to the extent practicable during this time. We also emphasize that health care providers and service providers must comply with the requirements applicable to the COVID-19 Telehealth Program. To help us guard against potential waste, fraud, and abuse, participants in the COVID-19 Telehealth Program must maintain records related to their participation in the COVID-19 Telehealth Program to demonstrate their compliance with the program requirements for at least three years from the last date of service under this program and must present that information to the Commission or its delegates upon request. Health care providers participating in the COVID-19 Telehealth Program may also be subject to compliance audits in order to ensure compliance with the rules and requirements for the COVID-19 Telehealth Program and must provide documentation related to their participation in the COVID-19 Telehealth Program in connection with any such audit.

33. *Outreach for COVID-19 Telehealth Program.* Upon release of this Report and Order, in order to ensure that health care providers are aware of available funding under the COVID-19 Telehealth Program, the Commission will, to the extent possible, coordinate with other federal agencies to distribute information about this program to the health care community. We also direct the Bureau to coordinate with the FCC's Connect2Health Task Force and USAC as necessary to promote and announce the COVID-19 Telehealth Program to interested stakeholders including service providers and health care providers. We are committed to doing our part in addressing the needs of health care providers as demand for connected care services increases to address the coronavirus pandemic, and believe that such coordination and outreach will improve the overall efficacy of the COVID-19 Telehealth Program. We also encourage selected participants to contact the Bureau with any questions regarding their funding awards or the invoicing and disbursement processes.

34. *Post-Program Feedback.* Within six months after the conclusion of the COVID-19 Telehealth Program, COVID-19 Telehealth Program participants should provide a report to the Commission in a format to be determined by the Bureau on the effectiveness of the COVID-19 Telehealth Program funding on health outcomes, patient treatment, health care facility administration, and any other relevant aspects of the pandemic. Such information could include feedback on the application and invoicing processes, in what ways funding was helpful in providing or expending telehealth services, including anonymized patient accounts, how funding promoted innovation and improved health outcomes, and other areas for improvement. Specific information about how to provide feedback and associated deadlines will be provided to COVID-19 Telehealth Program participants at a later time. This information will assist efforts to respond to pandemics and other national emergencies in the future.

35. *Administrative Procedure Act Exception*. While all or nearly all of the COVID-19 Telehealth Program is a logical outgrowth of issues we sought comment on in the *Connected Care Notice*, we also determine, out of an abundance of caution, that using additional notice and comment procedures for this emergency relief, and thereby delaying its effectiveness by at least several months, would be impracticable and contrary to the public interest.[65] The good cause exception to the notice and comment procedures of the Administrative Procedure Act "excuses notice and comment in emergency situations, or where delay could result in serious harm."[66] "In determining whether good cause exists, an agency should 'balance the necessity for immediate implementation against principles of fundamental fairness which

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three year document retention period applicable to health care providers participating in the COVID-19 Telehealth Program. *Id.*

[65] 5 U.S.C. § 553(b).

[66] *Jifry v. FAA*, 370 F.3d 1174, 1179 (D.C. Cir. 2004) (citations omitted).

require that all affected persons be afforded a reasonable amount of time to prepare for the effective date of its ruling.'"[67]

36. As a general matter, we believe that public notice 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 for foregoing the usual administrative procedures in this situation to the extent the *Connected Care Notice* does not provide the requisite notice. In light of the rapid spread of COVID-19 and the increasing need to address this public health crises, any further 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. This emergency relief imposes a minimal regulatory burden on any parties but merely offers funds to help health care providers combat this global pandemic. Waiting an additional 30 days to make this relief available "would undermine the public interest by delaying" much needed expansion of telemedicine resources.[68] We further find good cause to make the rules granting this relief effective immediately upon publication of this Report and Order in the Federal Register.[69]

B. Connected Care Pilot Program

37. The Pilot Program we adopt today is a discrete, limited duration program that will provide universal service support to help defray health care providers' qualifying costs of providing connected care services, with a primary focus on providing these services to low-income or veteran patients. We will support selected pilot projects to help health care providers improve health outcomes and reduce health care costs, thereby supporting efforts to advance connected care initiatives. The structure we adopt for this Pilot Program reflects our careful consideration of the record, our statutory authority, and the administrability of the Pilot Program and our discussions with the USDA and expert federal health agencies, including the VA and HHS. The structure we adopt today also aims to incentivize participation from a wide range of eligible health care providers, their patients, and a variety of broadband service providers. This in turn will maximize the potential for the Pilot Program to provide meaningful data about the benefits of connected care, and how and whether Universal Service Fund support could be used more broadly in the future to enable the adoption of connected care services among patients and their health care providers.

38. The Pilot Program is structured to target funding to eligible health care providers, with a primary focus on pilot projects serving patients that are most likely to need USF support for connected care services, and to ensure that the Pilot Program provides meaningful, measurable data. All eligible nonprofit and public health care providers that fall within the statutory categories under section 254(h)(7)(B), regardless of whether they are non-rural or rural, can apply for the Pilot Program. Eligible health care providers can receive support for the qualifying costs of providing connected care services to patients participating in their pilot projects. We emphasize that we intend to target funding towards pilot projects that would primarily benefit low-income or veteran patients. The Pilot Program will make available up to $100 million over a three-year funding period and will be separate from the budgets of the existing universal service programs. The Pilot Program will provide funding for selected pilot projects to cover 85% of the eligible costs of broadband connectivity, network equipment, and information services necessary to provide connected care services to the intended patient population. To participate in the Pilot Program, an eligible health care provider must first submit an application to the Commission describing, among other things, its proposed pilot project and how the pilot project will use connected care services to serve the health care needs of participating patients. The Pilot Program is designed to be health care provider-driven—eligible health care providers will design their proposed pilot projects, select

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

[68] *Id.*

[69] 5 U.S.C. § 553(d). *See* 47 C.F.R. §§ 1.103(a), 1.427(b).

the service providers for the supported services and network equipment, and identify and enroll the qualifying, participating patients. After careful evaluation of the applications, the Commission will announce the selected pilot projects and rationale for selecting the projects and also provide further information on the requirements for the Pilot Program, including, but not limited to, the requirements for requesting funding, invoicing, data reporting, and programmatic safeguards including document retention and audit requirements.

39. For purposes of the Pilot Program, we consider "connected care" as a subset of telehealth that uses broadband Internet access service-enabled technologies to deliver directly to patients remote medical, diagnostic, and treatment-related services outside of traditional brick and mortar medical facilities—specifically to patients at their mobile location or residence.[70] For purposes of the Pilot Program, we also define "telehealth" as the broad range of health care-related applications that depend upon broadband connectivity, including 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.[71] Connected care services can be provided by doctors, nurses, or other health care professionals. Health care providers will have the flexibility to identify the medical conditions to be treated through their proposed pilot projects, and whether to treat a single medical condition or multiple medical conditions. For purposes of the Pilot Program, we use the U.S. Department of Health and Human Services' definition of "medical condition" to identify the types of health conditions that can be treated through the Pilot—"any condition, whether physical or mental, including but not limited to any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation."[72] However, in reviewing applications, the Commission is interested in targeting limited pilot program funding towards pilot projects that are primarily focused on treating public health epidemics,[73] opioid dependency, mental

[70] *See supra* para. 14.

[71] *See Rural Health Care Support Mechanism*, WC Docket No. 02-60, Report and Order, 27 FCC Rcd 16678, 16680, para 1 & n.1 (2012). Telehealth services can include a wide variety of remote health care services beyond the doctor-patient relationship; for example, involving services provided by nurses, pharmacists, or social workers. *See FCC Seeks Comment and Data on Actions to Accelerate Adoption and Accessibility of Broadband-Enabled Health Care Solutions and Advanced Technologies*, GN Docket No. 16-46, Public Notice, 32 FCC Rcd 3660, 3662 & n.9 (2017) (*Broadband-Enabled Health Care Solutions and Advanced Technologies Public Notice*); CHRISTUS Comments at 4. For purposes of the Pilot Program, "telemedicine" is a subset of telehealth and we define telemedicine as using broadband Internet access service-enabled technologies to support the delivery of medical, diagnostic, and treatment-related services, usually by doctors. *See Broadband-Enabled Health Care Solutions and Advanced Technologies Public Notice*, 32 FCC Rcd at 3662 & n.9. Commenters largely support the definitions we adopt today for the Pilot Program. *See, e.g.*, AAFP Comments at 2 (agreeing with proposed definition of "telemedicine"); CHRISTUS Comments at 4 (supporting the proposed definition of "telehealth" and "telemedicine"); CoBank Comments at 6 (concurring with proposed definition of "connected care"); GRTI Comments at 1-2 (agreeing with proposed definitions of "connected care" and "telehealth"); myNexus Comments at 7 (encouraging the Commission to proceed with its proposed definition of "connected care"); Colorado Comments at 9 (agreeing with the proposed definition of "telehealth," "telemedicine," and "connected care"); VTN Comments at 11 (indicating that the proposed definitions are appropriate). Connected care services, as defined in this Report and Order, can include telemedicine, but also include broadband-enabled health care services provided directly to patients in their homes by medical professionals who are not doctors.

[72] *See* 45 CFR § 144.103 (codifying the definition of "health condition" that the U.S. Department of Health and Human Services (HHS) relies upon); VTN Comments at 11 (suggesting the Commission adopt HHS's definition of "health condition" for the Pilot Program).

[73] The coronavirus pandemic highlights the important role that connected care services can play during public health epidemics with respect to treating patients and containing disease or other health conditions. *See, e.g.*, Dr. Samant Virk, *Coronavirus and Telemedicine: How it Can Help Practices and Patients with Communicable Diseases*, Medical Economics (Mar. 2, 2020), https://www.medicaleconomics.com/news/coronavirus-and-

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health conditions,[74] high-risk pregnancy, or chronic or recurring conditions that typically require at least several months to treat, including, but not limited to, diabetes, cancer, kidney disease, heart disease, and stroke recovery.

40. While we acknowledge that connected care services can benefit a wide array of health conditions, we nevertheless believe that focusing Pilot Program funding on these conditions identified above best ensures that we target limited Pilot Program resources to populations that are most in need.[75] Moreover, we believe that targeting these types of health conditions, which impact large segments of the population, and often require several months or more of treatment, or are public health crises,[76] will

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telemedicine-how-it-can-help-practices-and-patients-communicable-diseases ("From influenza to the coronavirus (COVID-19), televisits are an increasingly valuable tool in the fight against the spread of infection. Sick patients get the care they need from the comfort of home and physicians can treat more patients, helping to mitigate the spread of disease without sacrificing the quality of care[,]" while also aiding "in prompt detection and lead to effective isolation of potentially infectious patients."); Centers for Disease Control and Prevention, Interim Guidance for Healthcare Facilities: Preparing for Community Transmission of Covid-19 in the United States (last updated Feb. 29, 2020), https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/guidance-hcf.html (recommending that health care providers explore alternatives to face-to-face visits and triage, including "identify staff to conduct telephonic and telehealth interactions with patients," to avoid unnecessary health care visits and minimize the spread of respiratory illness in a facility).

[74] For purposes of the Pilot Program, the term "mental health" includes behavioral health. The U.S. Department of Health and Human Services provides a general overview of the mental and behavioral disorders that fall within mental health. *See* U.S. Dept. of Health and Human Services, MentalHealth.gov, *What to Look For*, https://www.mentalhealth.gov/what-to-look-for (last visited Mar. 25, 2020).

[75] *See, e.g.*, AMIA Comments at 2-3 (stating that people with chronic and mental health conditions are responsible for 90% of the national's $3.3 trillion annual health care expenditures and that these conditions should be targeted with further research support); Centers for Disease Control and Prevention, Health and Economic Costs of Chronic Diseases, https://www.cdc.gov/chronicdisease/about/costs/index.htm (last visited Mar. 25, 2020) ("90% of the nation's $3.5 trillion in annual health care expenditures are for people with chronic and mental health conditions."); National Alliance on Mental Illness, FY 2018 Funding for Mental Health (2017), https://www.nami.org/getattachment/Get-Involved/NAMI-National-Convention/Convention-Program-Schedule/Hill-Day-2017/FINAL-Hill-Day-17-Leave-Behind-all-(1).pdf (stating that the costs of untreated mental health are estimated to be as high as $300 billion annually due to lost productivity).

[76] The COVID-19 pandemic demonstrates the significant impacts of public health epidemics on patients and the health care system. We also note that maternal mortality and opioid dependency are health crises in America. *See, e.g.*, Gaby Galvin, *The U.S. Has a Maternal Mortality Rate Again. Here's Why That Matters,* US News (Jan. 30, 2020) https://www.usnews.com/news/healthiest-communities/articles/2020-01-30/why-the-new-us-maternal-mortality-rate-is-important (stating that the U.S. maternal mortality rate was 17.4 deaths per 100,000 births in 2018), March of Dimes, *Nowhere to Go Maternity Care Deserts Across the U.S.*, at 1 (2018), https://www.marchofdimes.org/materials/Nowhere_to_Go_Final.pdf (stating that the U.S. maternal mortality rate is higher than most other high-income countries and has increased in recent years); Rachel Jones, *American Women are Still Dying From Alarming Rates While Giving Birth*, National Geographic (Dec. 13, 2018), https://www.nationalgeographic.com/culture/2018/12/maternal-mortality-usa-health-motherhood/ (providing chart comparing U.S. mortality rate to other countries and stating "[m]ore than 700 women die each year in the U.S. from causes related to pregnancy or childbirth . . . . At least 60 percent of maternal deaths are preventable."); Centers for Disease Control, Pregnancy-Related Deaths, Centers for Disease Control, Pregnancy Mortality Surveillance System, https://www.cdc.gov/reproductivehealth/maternalinfanthealth/pregnancy-mortality-surveillance-system.htm (last visited Mar. 25, 2020) (providing graph of increases in maternal mortality rate in the U.S. and stating "[m]any studies show that an increasing number of pregnant women in the United States have chronic health conditions such as hypertension, diabetes, and chronic heart disease. These conditions may put a pregnant woman at higher risk of pregnancy complications."); Karen Appold, *Addressing the Opioid Crisis in 2020*, Drug Topics (Jan. 15. 2020), https://www.drugtopics.com/article/addressing-opioid-crisis-2020 ("The opioid crisis continues to be one of the worst public health crises that the United States has ever seen. . . .According to the CDC, opioids were involved in 47, 600 overdose deaths in 2017 or 67.8% of all drug overdose deaths. Approximately 2.1 million Americans live
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provide more meaningful data[77] to track progress towards the Pilot Program goals of helping health care providers to improve health outcomes and reduce costs. We believe that health conditions that we are not targeting, including health conditions that are not health crises, or do not require at least several months of treatment, conversely, are less likely to provide the type of meaningful data on which we can track progress towards the Pilot Program goals and base future decisions. Focusing the Pilot Program to health conditions that are most likely to provide meaningful data also promotes the efficient, fiscally responsible use of universal service funds.

1. Budget, Number of Pilot Projects and Support Amount Per Project, Funding Duration, and Discount Level

41. *Budget.* The Pilot Program will make available up to $100 million over three years for selected pilot projects.[78] Based on the broad support in the record, we believe that targeting this amount of funding for qualifying eligible services and equipment under the Pilot Program is sufficient to allow us to obtain meaningful data and ensure significant interest from a wide range of participants.[79] Our decision to fund the Pilot Program in this manner will not significantly increase the contributions burden on consumers and will not impact the budgets of, or disbursements for, the other existing universal service programs.

42. To secure the funds for the Pilot Program, we direct USAC to separately collect funds for the Pilot Program each quarter beginning with the demand filing for the fourth quarter of 2020.[80] USAC

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with opioid abuse disorder."); Khary K. Rigg, Shannon M. Monmat, & Melody N. Chavez, *Opioid-related Mortality in Rural America: Geographic Heterogeneity and Intervention Struggles*, 57 Int'l J. of Drug Pol'y, 119, 119 (2018), https://www.hub.ki/collections/post/959/download/Opioid-related_mortality_in_rural_America.International_J_Drug_Policy_2018.pdf ("Over the last two decades, opioid-related mortality rates have increased dramatically to become a major public health crises in the United States. In 2016 alone, opioids were involved in 45,838 deaths, an increase over 400% since 1999. Additionally, since 2005, the national rate of opioid-related inpatient hospital stays has increased by 64%, and the rate of opioid-related emergency department (ED) visits has increased by 99%.") (internal citations omitted); National Institutes of Health, National Institute on Drug Abuse website, Opioid Overdose Crisis, https://www.drugabuse.gov/drugs-abuse/opioids/opioid-overdose-crisis (last visited Mar. 17, 2020) ("The Centers for Disease Control and Prevention estimates that the total 'economic burden' of prescription opioid misuse alone in the United States is $78.5 billion a year, including the costs of healthcare, lost productivity, addiction treatment, and criminal justice involvement."); Dept. of Health and Human Services, The Opioid Epidemic by the Numbers, https://www.hhs.gov/opioids/sites/default/files/2019-01/opioids-infographic_1.pdf (last visited Mar. 25, 2020) (stating an estimated more than 130 people die each day from opioid-related drug overdoses and 2.1 million people had an opioid misuse disorder).

[77] Meaningful data is information that can be used to evaluate the efficacy of a program. Such data should be accurate, reliable, timely, relevant, and complete. *See, e.g.*, Picard Center for Child Development and Lifelong Learning, What is Meaningful Data and How to Measure It at 4, https://picardcenter.louisiana.edu/sites/picardcenter/files/What%20is%20Meaningful%20Data%20and%20How%20to%20Measure%20It.pptx (last visited Mar. 25, 2020).

[78] The budget for the Pilot Program refers to the total maximum authorized disbursement amount and does not include USAC's administrative fees for operating and administering the Pilot Program. We expect USAC to administer the Pilot Program in an efficient, cost-effective manner.

[79] *See, e.g.*, AHA Comments at 21; CCC Comments at 2; VTN Comments at 6-8; GRTI Comments at 3; ConnectME Comments at 4. *See also Connected Care Notice*, 34 FCC Rcd at 5631, para. 28 & n.57. *But see* CCHP Comments at 1 (stating that the proposed $100 million budget is inadequate); Netsmart Comments at 5 (recommended increasing the budget to $300 million in order to fully accomplish the goals of the pilot program); MercatusGMU/Rhoads Comments at 2 (stating that the proposed budget is a "very high price tag").

[80] Pursuant to section 54.709(a)(3) of the Commission's rules, as part of the process by which the Commission establishes the quarterly contribution factor, USAC must provide the Commission each quarter with its projection of total demand and administrative expenses for the universal service support mechanism. *See* 47 CFR § 54.709(a)(3).

should collect necessary funds up to the amount of the budget over the entire three-year period in order to minimize any impact on the contribution factor. We anticipate this collection schedule would increase the quarterly contribution factor by approximately 0.11%.[81] Moreover, by starting the collection before we select the pilot projects, USAC will have funding on hand as soon as the pilot projects begin to seek support. We also recognize that requests for funding may vary year to year and therefore we will not require that Pilot Program funding be distributed evenly each year. While we anticipate that there will be significant participation in the Pilot Program, total amount disbursed will depend upon those funds ultimately committed by USAC, invoiced, and disbursed. Similar to existing Commission rules, unused collected Pilot Program funds will be carried forward to subsequent quarters over the duration of the Pilot Program for use by pilot projects and need not be returned to offset future collections.[82] Any unused funds that remain at the end of the Pilot Program will be used to reduce collections for the ongoing universal service programs.[83]

43. *Discount Level.* The Pilot Program will provide universal service support for 85% of the cost of eligible services and equipment funded by the Pilot Program. We believe this support amount will allow us to fund a sufficient number of pilot projects to provide meaningful data and provide substantial financial incentive for health care providers to participate in the Pilot Program. This is also the same level of support the Commission provided under the RHC Pilot Program.[84] Although some commenters suggested a different support level than 85%, commenters largely support a consistent level of support for all services and equipment and explained that there are benefits to requiring participants to contribute a portion of the qualifying costs.[85] Based on the Commission's experience with the Schools and Libraries (E-Rate) Program and the Healthcare Connect Fund Program, we agree that there are significant advantages to providing a set support amount that requires participants to contribute a portion of the eligible costs, including being administratively simple, predictable, and equitable, as well as incentivizing participants to choose the most cost-effective services and equipment and refrain from purchasing a higher level of service or equipment than needed.[86] Consistent with the Commission's existing rules for

[81] If the Pilot Program funds are collected over a three-year period, using the Second Quarter 2020 projected collected revenues of approximately $10.87 billion, we estimate that the proposed Pilot Program budget would result in an approximate 0.11% increase in the contribution factor. *See Proposed Second Quarter 2020 Universal Service Contribution Factor*, CC Docket No. 96-45, Public Notice, DA20-269A1, at 2 (OMD Mar. 13, 2020). For purposes of this estimate, we assume an equal collection of funds over a three-year period, however, the actual timing of the collection and amounts per year may vary depending on the needs of the Pilot Program.

[82] *See* 47 CFR § 54.619(a)(4) (stating RHC Program rules concerning unused funds); 47 CFR § 54.507(a)(6) (stating E-Rate Program rules concerning unused funds).

[83] *See* 47 CFR § 54.709(b).

[84] *See RHC Pilot Program Order*, 21 FCC Rcd at 11111; FCC, Rural Health Care Pilot Program, Frequently Asked Questions, https://www.fcc.gov/general/rural-health-care-pilot-program#faq1 (last visited Mar. 25, 2020).

[85] *See, e.g.*, AH Comments at 4; APTA Comments at 2; LHN Comments at 9; myNexus Comments at 10; Netsmart Comments at 4-5; VTN Comments at 8. *But see* CL Reply Comments at 2 (recommending lowering the 85% support amount); Verizon Comments at 4 (recommending a lower support amount such as 65% to maximize the number of pilot projects that can be funded).

[86] *See, e.g., Healthcare Connect Fund Order*, 27 FCC Rcd at 16716, para. 82 ("A flat, uniform percentage contribution is administratively simple, predictable, and equitable and has broad support in the record. Requiring a significant contribution will provide incentives for HCPs to choose the most cost-effective form of connectivity, design their networks efficiently, and refrain from purchasing unneeded capacity. Vendors will also have an incentive to offer services at competitive prices, knowing that HCPs will be unwilling to increase unnecessarily their out-of-pocket expenses."). We also note that USDA's Distance Learning and Telemedicine Program, which provides grants to help expand telemedicine in rural areas, provides grant awardees 85% of the funding and requires a 15% match from grant awardees. *See* 7 CFR § 1734.22(a) (requiring grant applicants to provide a minimum matching contribution equal to 15% of the grant amount requested).

the Healthcare Connect Fund Program, health care providers must contribute their portion of the eligible costs from eligible sources (e.g., the applicant, eligible health care provider, participating patients, or state, federal, or Tribal funding or grants)[87] and cannot use ineligible sources (e.g., direct payments from vendors or service providers) to pay their share of the requested services.[88]

44. *Number of Pilot Projects and Support Amount Per Project.* Based on the record, we decline to set a limit on the number of pilot projects selected for the Pilot Program or the amount of support requested per pilot project.[89] As noted in the *Connected Care Notice*, setting a fixed number of pilot projects will not serve the goals of the Pilot Program because it will artificially limit the number of pilot projects to be funded even before pilot project proposals are submitted and evaluated.[90]

45. In addition, limiting the amount of support requested per pilot project before evaluation and selection will arbitrarily limit the scope of potential pilot projects and the data collected. Some commenters suggest the Commission provide a set number of pilot projects to fund and a set per-project support amount or a minimum support amount per project.[91] We decline to adopt those proposals in the interest of maximizing our flexibility to select a diverse group of pilot projects. Not setting these types of limits also allows us to better focus on selecting quality pilot projects that can provide meaningful data. While we do not establish a set limit on the number of pilot projects selected, we intend to be mindful of the total Pilot Program budget and the funding needs of each pilot project when selecting pilot projects to ensure that each pilot project will have enough financial support to be successful. At the same time, while we do not establish a set per project support limit, we do not anticipate allocating all of the Pilot Program funds on one or two large projects. In reviewing pilot project applications, we will be mindful of the reasonableness of the estimated total support amount indicated in each application, looking specifically at the proportion to the total Pilot Program budget and individual project size. It would not be reasonable or produce useful data for the Commission to let one or a few projects eclipse the Pilot Program.

46. *Duration.* The Pilot Program will provide selected pilot projects support for a three-year funding period with separate transition periods of up to six months before and after the three-year funding period to give pilot projects time to complete set up, close out, and address other administrative matters related to the implementation of the pilot projects. Specifically, selected pilot participants will have up to six months from the date of their initial funding commitment letter from USAC to organize and start their pilot projects (including, but not limited to procuring eligible services or network equipment), and up to six months after the funding end date on their final funding commitment letters to wind down their pilot

[87] *See* 47 CFR § 54.611(b)(1) ("Eligible sources include the applicant or eligible health care provider participants, state grants, appropriations, or other sources of state funding; federal funding, grants, loans or appropriations except for other federal universal service funding, or other sources of federal funding; Tribal government funding; and other grants, including private grants."); 47 CFR § 54.611(b)(2) ("Ineligible sources include (but are not limited to) in-kind or implied contributions from health care providers; direct payments from service providers, including contractors and consultants to such entities; and for-profit entities.").

[88] 47 CFR § 54.611(b)(2) ("Ineligible sources include (but are not limited to) in-kind or implied contributions from health care providers; direct payments from service providers, including contractors and consultants to such entities; and for-profit entities.").

[89] Many commenters support not establishing a limit on the number of pilot projects selected for the Pilot Program or not setting a fixed funding amount for each pilot project. *See, e.g.*, AHA Comments at 20; myNexus Comments at 10-11; GRTI Comments at 4; MCN Comments at 3; FACHC Reply Comments at 4; NACHC Reply Comments at 3; Ochsner Reply Comments at 13; VCHA Reply Comments at 2.

[90] *Connected Care Notice*, 34 FCC Rcd at 5632-634, paras. 30-33.

[91] *See, e.g.*, CHI Comments at 9 (advocating for funding only five pilot projects); UMMC Comments at 2 (advocating for funding only five pilot projects); CHRISTUS Comments at 5 (advocating for at least $1 million in support each year for selected pilot projects); VTN Comments at 5-6 (advocating for limiting the number of pilot projects and per project funding amount); Hughes Comments at 4 (advocating for funding 20 pilot projects).

projects and complete any necessary administrative tasks. Many commenters agree that a three-year funding period is reasonable and will allow the Commission to obtain sufficient, meaningful data from the selected pilot projects.[92] While most commenters also support separate six-month ramp-up and wind-down periods outside of the three-year funding period,[93] other commenters suggest that the Pilot Program should include a shorter or longer ramp-up time period.[94] Based on the record, we believe that providing a ramp up period of up to six months will allow sufficient time for health care providers to implement pilot project plans and begin offering connected care services. Moreover, we are mindful that extending the Pilot Program for too long risks stale data and find that providing selected pilot projects up to six months to ramp and up to six months to wind down will ensure a reasonable timeframe to obtain meaningful, current data.[95] We understand, however, that there may be unforeseen circumstances that arise when implementing or operating the pilot projects, we therefore delegate authority to the Bureau to, consistent with the goals of the Pilot Program, grant limited extensions of deadlines for some or, if necessary, all of the projects in order to ensure the successful operation of the Pilot Program.

2. Eligible Health Care Providers, Patients, and Service Providers

47. *Eligible Health Care Providers*. We establish this Pilot Program pursuant to our legal authority under section 254(h)(2)(A), which directs the Commission to establish competitively neutral rules to enhance, to the extent technically feasible and economically reasonable, access to "advanced telecommunications and information services" for public and nonprofit health care providers.[96] Accordingly, for purposes of the Pilot Program, we limit participation to the statutorily-enumerated categories of "health care provider." Eligible nonprofit or public[97] 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.[98]

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[92] *See, e.g.*, CHRISTUS Comments at 4-5; ConnectME Comments at 4; Hughes Comments at 4; LHN Comments at 11; Mercy Virtual Comments at 13-14; MCN Comments at 4; Ochsner Comments at 31; mHealth Comments at 4; VTN Comments at 5. *But see* OCHIN Comments at 3 (recommending that the Pilot Program should run for five years, because three years is too short to determine the true return on investment).

[93] *See, e.g.*, CHRISTUS Comments at 5 (supporting separate ramp-up and wind-down periods of six months each); LHN Comments at 11 (agreeing with six month ramp-up and wind-down periods); myNexus Comments at 11 (agreeing with the proposal for separate ramp-up and wind down periods of six months each); Ochsner Comments at 31 (stating that six month ramp-up and wind-down periods make sense); VTN Comments at 5 (supporting the proposed six month ramp-up and wind-down periods).

[94] *See, e.g.*, MetroHealth Comments at 2 (recommending a wind-up period of up to 12 months); mHealth Reply Comments at 2 (recommending three months for onboarding).

[95] *See* USTelecom NOI Comments at 5 (cautioning that a duration longer than three years, plus a ramp-up and wind-down and evaluation period, "risks having the findings become obsolete by the time they could be effectuated").

[96] 47 U.S.C. § 254(h)(2)(A).

[97] 47 U.S.C. § 254(h)(1)(A), (h)(2)(A), (h)(4).

[98] 47 U.S.C. § 254(h)(7)(B). Commission rules 54.600(b) and 54.601 include the statutory limitations for eligible health care providers, therefore we extend these rules to the Pilot Program. *See* 47 CFR § 54.600(b) and § 54.601. We also retain the Commissions' earlier conclusion that dedicated emergency rooms of rural for-profit hospitals qualify as public health care providers and rural health clinics. *Rural Health Care Mechanism*, WC Docket No. 02-60, Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 18 FCC Rcd 24546, 24553-54, para. 13 (2003) (*2003 RHC Report and Order*).

48. Some commenters advocate for using a different definition of health care provider,[99] or suggest that we allow for-profit and investor-owned hospitals to participate in the Pilot Program.[100] Other commenters argue in favor of funding emergency medical technicians and school clinics.[101] We decline to adopt these proposals. The statutorily designated categories of health care provider were established by Congress, and applying these categories to the Pilot Program is consistent with section 254(h)(2)(A) as our authority to establish the Pilot Program. The Commission has previously declined to expand the definition of "health care provider" statutory categories, concluding that, had Congress intended any other entities to qualify, it would have included them in the list explicitly.[102] Moreover, many entities are already familiar with the statutorily-designated categories used in the RHC Program, and thus using the existing categories for the Pilot Program will facilitate the administration of the Pilot Program and will allow the Pilot Program to leverage existing processes and procedures for determining health care provider eligibility. Further, providing funding for entities that fall outside of the statutory categories would limit the amount of Pilot Program funding available to eligible health care providers that clearly fall within the statutory categories under section 254(h)(7)(B). Using the statutory definition of health care provider to determine eligibility to participate in the Pilot Program also appropriately focuses Pilot Program funds on the types of health care providers that are more likely to need additional funding to provide connected care services to the target patient populations for this Pilot Program.[103]

49. Pilot Program support will be available to health care providers located in both rural and non-rural areas and we decline to limit participation to only rural health care providers and expressly

[99] *See, e.g.*, AUA Comments at 6 (recommending that eligible health care providers not be limited in any way at this early stage); CHI Comments at 8-9 (discouraging limiting health care providers to nonprofit or public health care providers, and urging the Commission to adopt the definition of health care provider under section 1171(3) of the Social Security Act); Dr. on Demand Comments at 2 (proposing that the Commission adopt the definition of health care provider under 1171(3) of the Social Security Act); Multistakeholder Comments at 2 (same); UMMC Comments at 3 (same); MUSC Comments at 8 (suggesting not to exclude any particular types of health care providers); myNexus Comments at 12 (urging the Commission not to limit health care providers to public or nonprofit health care providers in the categories under section 254(h)(7)(B)); PATH Comments at 6-7 (recommending that emergency medical service centers and school-based health centers be considered health care providers under section 254(h)(7)(B)); PHIT Comments at 3 (requesting the Commission include pharmacists as eligible health care providers); Open Arms Reply Comments at 1 (requesting the Commission include "faith based organizations" as eligible health care providers).

[100] *See, e.g.*, AHA Comments at 10 (suggesting that for-profit hospitals be considered eligible health care providers under the Pilot Program); FAH Comments at 2 (urging the Commission to permit investor-owned hospitals to participate in the Pilot Program); TORCH Comments at 1 (suggesting the Commission include for-profit rural health clinics as eligible health care providers).

[101] *See, e.g.*, PATH Comments at 6-7 (advocating for providing Pilot Program funding to school clinics, emergency medical service centers, technicians, and emergency medical transport centers); NTCA Reply Comments at 5-6 (advocating for funding emergency medical technicians and schools). Similarly, health kiosks and community locations (e.g., libraries, community centers), retail stores, or other facilities that do not traditionally provide health care services do not fall within the statutory categories of health care providers, so we also decline to provide support to these entities as part of the Pilot Program.

[102] *See Universal Service First Report and Order*, 12 FCC Rcd at 9086, para. 593; *2003 RHC Report and Order*, 18 FCC Rcd at 24555, para. 16.

[103] *See, e.g.*, VTN Comments at 12 (supporting limiting the Pilot Program to nonprofit and public health care providers and stating that these entities "typically lack the resources necessary to facilitate the deployment of connected care services on their own" and that directing support to these "entities will have the greatest impact on access to telehealth services, which otherwise might not be available in certain communities or to certain individuals."); OCHIN Comments at 4 (supporting limiting the Pilot to nonprofit and public health care providers and focusing the Pilot on "[s]afety-net clinics, health departments rural clinics, and consortia that support them" and explaining that these categories "require additional support to gain telehealth capabilities[.]").

allow eligible non-rural health care providers to participate in the Pilot Program.[104] This decision will promote diversity among pilot projects, and will also maximize the potential benefits of and the data collected through the Pilot Program.[105] The Commission has previously concluded that section 254(h)(2)(A) does not limit the provision of universal service support to health care providers in rural areas.[106] Further, commenters assert that underserved communities exist in both rural and non-rural settings, and broadband access is a concern to low-income communities generally, regardless of their non-rural or rural status.[107] We agree that the Pilot Program should target vulnerable and medically underserved patients regardless of whether these patients or their health care providers are located in a rural or non-rural area.

50. In selecting pilot projects, we have a strong preference for health care providers that have either (1) experience with providing telehealth or connected care services to patients (e.g., remote patient monitoring, store-and-forward imaging, or video conferencing) beyond using electronic health records, or (2) a partnership with another health care provider, government agency, or designated telehealth resource center with such experience that will work with the health care provider to implement its proposed pilot project.[108] Our strong preference for these providers is based on our belief that these types of health care

[104] For purposes of the Pilot Program, we use the RHC Program's definition of "rural area" to classify a health care provider as rural or non-rural. *See* 47 CFR § 54.600(e) ("A 'rural area' is 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. For purposes of this rule, 'Core Based Statistical Area,' 'Urban Area,' and 'Place' are as identified by the Census Bureau."). Many health care providers may already be familiar with this definition, and using this definition allows us to leverage existing databases for determining whether a health care provider is rural or non-rural. Health care providers can determine whether they are located in a rural area under this definition by visiting the Eligible Rural Areas Search Tool on USAC's website. *See* USAC, Rural Health Care Program, Healthcare Connect Fund Program, Determine Eligibility of Your Site, Rural Look Up Tool, https://apps.usac.org/rhc/tools/Rural/search/search.asp (last visited Mar. 24, 2020). Our decision to allow eligible non-rural health care providers to participate in the Pilot Program reflects the unique circumstances of the Pilot Program and does not alter health care provider eligibility criteria for the existing RHC Program.

[105] Many commenters advocate for the Commission not to restrict the Pilot Program to specific geographic regions, and to allow eligible non-rural health care providers to participate in the Pilot Program. *See, e.g.*, AAFP Comments at 2; AANP Comments at 3; AHA Comments at 10; AMIA Comments at 2; AEH Comments at 4; CHI Comments at 9; LHN Comments at 12; UMMC Comments at 3; CHIME Reply Comments at 4; PATH Reply Comments at 2; Viraspex Reply Comments at 2.

[106] 47 U.S.C. § 254(h)(2)(A). Recognizing that there can be benefits to rural health care by including eligible non-rural participants, the Healthcare Connect Fund Program provides support for eligible non-rural health care providers participating in a consortium that is comprised of more than 50% rural health care providers. *See Healthcare Connect Fund Order*, 27 FCC Rcd at 16705-07, paras. 59-61; *see also Texas Office of Public Utility Counsel v. FCC*, 183 F.3d 393, 446 (5th Cir. 1999) (finding that "the language in § 254(h)(2)(A) demonstrates Congress's intent to authorize expanding support to 'advanced services,' when possible, for non-rural health [care] providers."). The only statutory limitation on health care providers receiving supported services under Section 254(h)(2)(A) is that health care providers must be public or nonprofit entities and must be within one of the eligible statutory health care provider categories. *See* 47 U.S.C. § 254(h)(2)(A), 254(h)(7)(B).

[107] *See* LHN Comments at 12; VTN Comments at 13; Ochsner Comments at 32 (limiting area designation or patient population could preclude the involvement of specialists in a particular health practice or discipline who may not be located in a health care access area the Commission might designate, which would defeat the purpose of getting underserved populations more care remotely).

[108] Partnering with a service provider (e.g., a vendor of connected care services, or provider of broadband connectivity) is not sufficient to meet this preference. To meet this preference, pilot projects must partner with another health care provider or entity that has experience with telehealth (e.g., a federal health agency, federally-funded Telehealth Resource Centers or state and local health departments or agencies). Various commenters

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providers are more likely to submit pilot projects that can be successfully implemented within the three-year period and better enable the Commission to collect meaningful data on the impact of the Pilot Program. At the same time, this approach also provides a path for eligible health care providers that lack telehealth experience, many of which may serve high percentages of veterans and low-income patient populations, to participate in the Pilot Program.

51. *Targeted Patient Populations*. The Pilot Program we establish today is intended to help defray eligible health care providers' costs of providing connected care services particularly for low-income Americans and veterans. Accordingly, in selecting applications, we have a strong preference for pilot projects that can demonstrate that they will primarily benefit[109] veterans or low-income individuals.[110] Veteran and low-income patients are more likely to have complex, high-cost health care needs,[111] reside in areas with physician shortages,[112] and may not have mobile or residential Internet

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expressed support for requiring health care providers to have telehealth experience or partnering with an organization that has telehealth experience. *See, e.g.*, AAFP Comments at 3; CCHP Comments at 3; HLC Comments at 2; MUSC Comments at 8; myNexus Comments at 13; OCHIN Comments at 4; PHIT Comments at 4; SC CTC Comments at 3; UMMC Comments at 2; VTN Comments at 11-12. Other commenters suggest that the Pilot Program should not be limited to those health care providers with telehealth experience. *See, e.g.*, Netsmart Comments at 5; CPCA Reply Comments at 2; LHN Comments at 1. The approach we take today allows health care providers without telehealth experience to participate in the Pilot Program, while our strong preference for pilot projects from health care providers with telehealth experience, or who partner with an entity with such experience, will help us ensure that the pilot projects we select can actually be implemented.

[109] As an example, we would consider a pilot project to primarily benefit veterans or low-income patients if 75% or more of the participating patients are veterans or low-income patients, based on the criteria identified in this Report and Order.

[110] Commenters generally support targeting the Pilot Program support towards projects serving veterans or low-income patients. *See, e.g.*, VTN Comments at 11; Comcast Reply Comments at 1; NCTA Comments at 1-2; Microsoft Comments at 3.

[111] *See, e.g.,* Carrie M. Farmer, Susan D. Hosek, & David M. Adamson, *Balancing Demand and Supply for Veterans' Health Care*, Rand Health Quarterly (June 20, 2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5158276/ ("Because many veterans have served on overseas missions, including combat, veterans with service-connected health issues are a clinically complex and potentially vulnerable population."); *Veterans Broadband Report* at 2-3 (stating "[a]s of 2014, a total of 3.8 million veterans had a service-connected disability rating, and veterans are twice as likely as the general population to be disabled"); and that "[r]ural veterans are substantially more likely to enroll in the VA's health care system than urban veterans, and rural veterans are on average older than the general population, more often face health problems, and live further from physical medical facilities."); Robin Rudowitz, Rachel Garfield, & Elizabeth Hinton, *10 Things to Know About Medicaid: Setting the Facts Straight*, Kaiser Family Foundation (Mar. 6, 2019), https://www.kff.org/medicaid/issue-brief/10-things-to-know-about-medicaid-setting-the-facts-straight/ (stating that many low-income Americans participating in Medicaid have complex and costly care needs); Dhruv Khullar& Dave A. Chokshi, *Health, Income, & Poverty: Where We Are & What Could Help*, Health Affairs (Oct. 4, 2018), https://www.healthaffairs.org/do/10.1377/hpb20180817.901935/full/ (stating "low-income Americans have higher rates of physical limitation and of heart disease, diabetes, stroke, and other chronic conditions, compared to higher-income Americans"); Medicaid CHIP Payment and Access Commission (MCPAC), *Access in Brief: Rural and Urban Health Care* (Oct. 2018), https://www.macpac.gov/wp-content/uploads/2018/10/Rural-Access-In-Brief.pdf (stating that individuals living in rural areas were more likely to be covered by Medicaid than individuals living in urban areas, and that rural residents are generally older, sicker, and poorer than urban residents).

[112] Fred Jacobs, *U.S. Health Care's Biggest Problem: A Doctor Shortage*, Salon (Sept. 23, 2018), https://www.salon.com/2018/09/23/u-s-health-cares-biggest-problem-a-doctor-shortage/ (stating that the shortfall in primary care doctors in America will hit "low-income minority communities hardest. They already lack access to qualified medical personnel"); Rural Healthcare Workforce, Rural Health Information Hub, https://www.ruralhealthinfo.org/topics/health-care-workforce (last visited Mar. 25, 2020) ("Areas with higher proportions of low-income and minority residents, such as rural areas, tend to suffer most from lower supply of
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access for connected care services.[113] Therefore, emphasizing pilot projects that will primarily benefit low-income patients or veterans[114] is appropriate as it will expand connected care services to individuals who are less likely to have access to these innovative services without universal service support. Participating patients may only participate in one pilot project and cannot participate in multiple pilot projects as part of the Pilot Program.

52. We also conclude that health care providers are in the best position to identify patients for their pilot projects. To the extent a selected pilot project asserts that it will primarily benefit low-income or veteran patients, the pilot project must maintain adequate documentation of the numbers of participating veterans or low-income patients served through that Pilot Project compared to other patients served. For purposes of the Pilot Program, health care providers can determine whether a patient is considered low-income by determining whether (1) the patient is eligible for Medicaid or (2) the patient's household income is at or below 135% of the U.S. Department of Health and Human Services Federal Poverty Guidelines.[115] Many commenters support using Medicaid eligibility as a patient qualifying

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physicians and other health professionals."); *Veterans Broadband Report* at 3 (stating many rural veterans "live further from medical facilities"); Christopher Zara, *This Veteran Population Map Shows VA Healthcare Access is Wildly Unequal Throughout the U.S.*, Fast Company (May 27, 2019), https://www.fastcompany.com/90355253/veteran-population-map-shows-unequal-access-to-va-healthcare (stating "veterans in larger states, particularly in the Western half of the country, often carry a burden of longer-than-average transportation times" and many have drive times of 45 minutes or more to the nearest VA health care facility).

[113] *See* Microsoft Comments at 1 (stating that according to the VA, "[t]here are 2.7 million veterans enrolled in Veterans Affairs (VA) who are living in rural communities, and 42 percent of them do not have internet access at home which could support their use of VA telehealth services"); *Veterans Broadband Report* at 3, 12 (stating that 27% of the nearly 3 million veterans enrolled in the VA's health care system who reside in rural or highly rural areas lack internet access at home, and that 2.2 million veteran households lack fixed or mobile broadband connections at home, with price being one of the barriers to broadband adoption); Victoria L. Elliot, Department of Veterans Affairs (VA): *A Primer on Telehealth*, Congressional Research Service 21 (July 16, 2019), https://fas.org/sgp/crs/misc/R45834.pdf (stating "[v]eteran patients who do not have readily accessible internet connections would likely have difficulty reaching their VA providers" and that "an estimated 20.1% of veterans did not have internet access in 2016"); Monica Anderson & Madhumitha Kumar, *Digital Divide Persists Even as Lower-Income Americans Make Gains in Tech Adoption*, Pew Research (May 7, 2019), https://www.pewresearch.org/fact-tank/2019/05/07/digital-divide-persists-even-as-lower-income-americans-make-gains-in-tech-adoption/ (stating that for Americans with household incomes below $30,000 a year, more than 4 in 10 (44%) do not have home broadband service and roughly 3 in 10 (29%) do not own a smartphone, while these technologies are virtually ubiquitous for adults in households earning $100,000 or more annually).

[114] Certain commenters advocated for allowing a broad range of patients to participate in the Pilot Program, advocated against including veterans, or advocated for excluding patients who reside in areas with access to physicians. *See, e.g.*, AOA Comments at 2 (arguing that patients in areas with access to physicians should not be directed to telehealth care); AUA Comments at 6 (stating that there should be no limits on patients because there are many patients whose financial means deprive them of adequate access to specialists even in metropolitan areas where specialty care is otherwise accessible); MercatusGMU/Rhodes Comments at 2 (including veterans could "confound the results and make the findings less generalizable"). We do not limit the Pilot Program to specific patient populations but intend to target funding towards projects that would primarily benefit low-income or veteran patients. As explained above, there are sound policy reasons for targeting Pilot Program funding to pilot projects that would primarily benefit these two patient populations.

[115] The Federal Poverty Guidelines are updated annually. *See* U.S. Dept. of Health and Human Services, Office of the Assistant Secretary for Planning and Evaluation, Poverty Guidelines (Jan. 15, 2020), https://aspe.hhs.gov/poverty-guidelines. To determine whether a patient qualifies as low-income based on income level, health care providers should confirm the patient income level through the patient's most recent federal, state, or Tribal tax return. Relying on a federal, state or Tribal tax return to verify income will significantly reduce the potential for waste, fraud, and abuse.

criteria for the Pilot Program.[116] We also include income-based criteria to give pilot projects another option for identifying low-income patients outside of Medicaid eligibility.[117] We expect that using these two criteria to identify low-income patients for purposes of the Pilot Program will allow a large number of low-income Americans to participate in the Pilot Program, including many residents of medically underserved rural areas.[118] In addition, using these criteria will facilitate efficient program administration, minimize the potential for waste, fraud, and abuse, while still appropriately targeting the population of patients that we intend to primarily benefit from connected care services through the Pilot Program.

53. Health care providers may determine whether a patient qualifies as a veteran for purposes of the Pilot Program by confirming that the patient qualifies for health care through the VA.[119] We decline to apply an income limit to veterans. While certain veterans who are eligible for health care through the VA undergo means testing when enrolling for VA health care, other veterans (e.g., those with service-connected disabilities) may not be required to undergo means testing.[120] We believe that veterans, regardless of income level, who are eligible for health care through the VA are an important population to include in this Pilot Program. As reported in the Bureau's *Veterans Broadband Report* to Congress, a significant number of veterans suffer from a disability, reside in rural areas, and/or are older than the general population.[121] Specifically, veterans are twice as likely as the general population to be disabled,

[116] A number of commenters supported using Medicaid as an eligibility criteria and some commenters specifically indicated that using Medicaid as a criteria would be easy to administer as many health care providers already have this information and are familiar with Medicaid. *See, e.g.*, VTN Comments at 14; Hathaway-Sycamores Comments at 2; NaLA NOI Comments at 1, 4; UAMS NOI Comments at 3; Medical Home Network NOI Comments at 6; CHF NOI Comments at 1; AT&T NOI Comments at 6.

[117] A household income of 135% of the Federal Poverty Guidelines is in line with the income levels that many states use to determine adult eligibility for Medicaid as of January 1, 2019. *See Where Are States Today? Medicaid and CHIP Eligibility Levels for Children, Pregnant Women, and Adults*, Kaiser Family Foundation Table 3 (Mar. 31, 2019), https://www.kff.org/medicaid/fact-sheet/where-are-states-today-medicaid-and-chip/ (indicating that a household income of 138% of the federal poverty guidelines was the median Medicaid eligibility limit for adults based on state data as of January 1, 2019). In addition, an income at or below 135% of the Federal Poverty Guidelines is an eligibility criterion for the FCC's Lifeline Program which provides low-income consumers with discounts on qualifying communications services. *See* 47 CFR § 54.409(a)(1). A table showing 135% of the 2020 Federal Poverty Guidelines for various household sizes is available at https://www.usac.org/lifeline/eligibility/customer-eligibility/income-eligibility/ (last visited Mar. 22, 2020).

[118] According to the Centers for Medicaid and Medicare Studies, in December 2019, approximately 71 million individuals participated in Medicaid and the Children's Health Insurance Programs (CHIP) in the 51 jurisdictions that provided data to CMS. *See, e.g.*, Medicaid.gov, December 2019 Medicaid and CHIP Enrollment Data Highlights, https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html (last visited Mar. 24, 2020).

[119] Veterans who are eligible for care through the VA typically have a Veteran Health Identification Card, or other documentation demonstrating their eligibility for health care benefits through the VA. *See* U.S. Dept. of Veterans Affairs, Eligibility for VA health care, Get a Veteran Health Identification Card, https://www.va.gov/health-care/get-health-id-card/ (last visited Mar. 24, 2020) (describing Veteran Health Identification Cards); U.S. Dept. of Veterans Affairs, Eligibility for VA health care, After You Apply, https://www.va.gov/health-care/after-you-apply/ (last visited Mar. 24, 2020) (indicating that veterans receive a letter indicating if they are approved for care through the VA).

[120] *See* U.S. Dept. of Veterans Affairs, Eligibility for VA health care, VA Priority Groups, https://www.va.gov/health-care/eligibility/priority-groups/ (last visited Mar. 24, 2020) (describing VA's basic eligibility criteria and the VA's priority groups); U.S. Department of Veterans Affairs, Financial Assessment, https://www.va.gov/opa/publications/benefits_book/Chapter_1_Health_Care_Benefits.asp (last visited Mar. 24, 2020) (describing VA's financial assessment) ;*Veterans Broadband Report* at 2 (stating "[a]s of 2014, a total of 3.8 million veterans had a service-connected disability rating, and veterans are twice as likely as the general population to be disabled.").

[121] *See Veterans Broadband Report* at 1.

and roughly a quarter of all veterans live in areas designated as rural.[122] Of the veterans who live in rural areas, nearly 27% do not have Internet access at home, and many veterans continuously struggle with access to medical care.[123] Given these statistics and the ability of telehealth to connect health care providers to patients in remote and rural locations, we believe that qualifying veterans, regardless of income level, are an appropriate group to include in this Pilot Program and could stand to benefit significantly from connected care services.[124] While we decline to adopt an income criteria for veterans, we expect that pilot projects focused on serving veterans will primarily focus on veteran populations that are more likely to experience issues accessing health care.

54. *Service Providers*. Eligible health care providers that participate in the Pilot Program can receive support for qualifying broadband service from any broadband provider, regardless of whether that provider is designated as an eligible telecommunications carrier (ETC).[125] Section 254(c)(3) makes clear that, in addition to the supported services included in the definition of universal service in section 254(c), "the Commission may designate additional services for such support mechanisms for . . . health care providers for the purposes of subsection (h)."[126] Section 254(h)(2)(A) in turn directs the Commission "to enhance to the extent technically feasible and economically reasonable, access to advanced telecommunications services and information services" for health care providers and does not by its language require that such services be provided by ETCs.[127] The Commission has previously explained that language in section 254(e) limiting universal service reimbursements to ETCs does not apply to services supported under section 254(h)(2)(A).[128] Moreover, based on the record, policy considerations also support not limiting Pilot Program participation to broadband service providers with an ETC designation.[129] Allowing non-ETCs to provide broadband service through the Pilot Program will incent participation among a diverse range of both health care providers and service providers while promoting flexibility, competition, and innovation.

[122] *Id.* at 1.

[123] *Id.* at 2.

[124] *Id*.

[125] 47 U.S.C. § 254(c)(3).

[126] *Id*.

[127] 47 U.S.C. § 254(h)(2)(A). *See also, e.g.*, *Universal Service First Report and Order*, 12 FCC Rcd at 9085-86, paras. 591-92 ("Section 254(h)(2), in conjunction with Section 4(i), authorizes the Commission to establish discounts and funding mechanisms for advanced services provided by non-telecommunications carriers, in addition to the funding mechanisms for telecommunications carriers created pursuant to sections 254(c)(3) and 254(h)(1)(B). . . . section 254(h)(2)(A) does not limit support to telecommunications carriers."); *RHC Pilot Program Order*, 22 FCC Rcd at 20421, para. 119 ("First, funding under the Pilot Program is not limited to telecommunications carriers. As discussed above, the Commission established the Pilot Program under the authority of section 254(h)(2)(A) of the 1996 Act, which does not limit support to only eligible telecommunications carriers.").

[128] *See Universal Service First Report and Order*, 12 FCC Rcd at 9086, para. 593.

[129] Numerous commenters support not limiting the Pilot Program to ETCs or facilities-based ETCs because those limitations would artificially limit participation in the Pilot Program and could also limit the effectiveness of the Pilot Program. *See, e.g.*, ACA Connects Comments at 2; ConnectME Comments at 8; MCN Comments at 6; NCTRC Comments at 1; Ochsner Comments at 11; Colorado Comments at 18-19; VTN Comments at 9; Comcast Reply Comments at 5-6. *But see* NTCA Reply Comments at 7 (supporting limiting the Pilot Program to ETCs, only if funding is distributed directly to service providers, instead of health care providers.); mHealth Reply Comments at 2 (stating that non-ETCs should not be eligible for awards).

3. Eligible Services and Equipment

55. The Pilot Program will provide eligible health care providers funding to defray the costs of providing connected care services through selected pilot projects. Specifically, the Pilot Program will fund 85% of the qualifying costs incurred by eligible health care providers. These costs include: (1) patient broadband Internet access services, (2) health care provider broadband data connections, (3) other connected care information services, and (4) certain network equipment.[130] Our determination as to what are eligible and ineligible services[131] under the Pilot Program reflects our consideration of the record, the Pilot Program budget, the scope of the Commission's statutory authority under section 254(h)(2)(A), and Commission precedent.

56. *Patient Broadband Internet Access Service*. By creating the Pilot Program, we hope to gain "insight into how universal service funds could better promote the adoption of connected care services among low-income Americans and veterans and their health care providers."[132] Funding health care provider purchases of broadband Internet access service for participating patients to receive connected care services will help expand connected care services to many Americans, particularly low-income and veteran patients.[133] Several commenters indicate that a key barrier to widespread adoption of connected care services is the lack of residential or mobile broadband Internet access service, particularly for low-income Americans and veterans.[134] Many low-income consumers and veterans do not have broadband Internet access service at all, while other low-income consumers and veterans may not have

[130] Pursuant to section 254(h)(3) of the Act, health care providers participating in the Pilot Program are prohibited from selling, reselling, or transferring telecommunications services or network capacity purchased through the Pilot Program. *See* 47 U.S.C. § 254(h)(3) ("Telecommunications services and network capacity provided to a public telecommunications user under this section may not be sold, resold, or transferred by such user in consideration for money or any other thing of value."). To ensure that health care providers participating in the Pilot Program comply with this statutory restriction, we extend section 54.629 (a)-(b) of the Commission's rules to health care providers participating in the Pilot Program. *See* 47 CFR § 54.629 (a)-(b). Section 254(h)(3) only applies to telecommunications services and network capacity, and therefore we clarify that we do not interpret this provision as prohibiting health care providers from providing broadband to patients who sign up to participate in their pilot project. The Commission has interpreted that the resale prohibition was intended to prevent USF program participants from passing off discounts to ineligible entities. *See Universal Service First Report and Order*, 12 FCC Rcd at 9074, para. 544. As such, we believe that it was not intended to bar health care providers from purchasing USF-funded broadband Internet access services for patient use at their homes or mobile locations. The Commission's limited duration E-Rate Deployed Ubiquitously (EDU) 2011 Pilot Program similarly allowed participating schools and school districts to purchase mobile hot spots that students could use in their homes. *See Schools and Libraries Universal Service Support Mechanism, A National Broadband Plan for Our Future*, CC Docket No. 02-6, GN Docket No. 09-51, Sixth Report and Order, 25 FCC Rcd 18762, 18785 paras. 44-46 (2010); *Wireline Competition Bureau Announces Application Deadline for the E-Rate Deployed Ubiquitously (EDU) 2011 Pilot Program*, WC Docket No. 10-2128, Public Notice, 25 FCC Rcd 15834, 15834 (WCB 2010).

[131] We will require selected pilot projects to cost allocate, in a manner consistent with the Commission's Healthcare Connect Fund Program, all ineligible services and/or equipment that are included in bundles, packages, or suites of services that the participating health care providers are using as part of their pilot projects. Therefore, we extend section 54.623(a)(4) of the Commission's Healthcare Connect Fund rules to the Pilot Program. *See* 47 CFR § 54.623(a)(4) (requiring RHC Program applicants to "submit a description of how costs will be allocated for ineligible entities or components, as well as any agreements that memorialize such arrangements with ineligible entities").

[132] *Connected Care Notice*, 34 FCC Rcd at 5626, para. 16.

[133] Health care providers that do not require funding for patient broadband Internet access service may still submit applications and be considered for participation in the Pilot Program to receive funding for eligible health care provider broadband connectivity or network equipment.

[134] *See* AHA Comments at 3; Geisinger Comments at 2; Mercy Virtual Comments at 11-13; MUSC Comments at 2; PATH Comments at 6; UMMC Comments at 1-2; Viraspex Comments at 3-4; VTN Comments at 3. *See also Connected Care Notice*, 34 FCC Rcd 5624-27, para. 13 & nn.23-24.

broadband Internet access service that is sufficient to receive connected care services.[135] Based on the record, aside from the VA's tablet loan program, which serves a limited number of veterans,[136] it appears that no other federal program provides health care providers funding dedicated to purchase patient broadband Internet access service for connected care services.[137] Some health care providers are already addressing this gap by funding patient broadband Internet access service for certain low-income or vulnerable patients who lack broadband service at home.[138]

57. To advance the goals of this Pilot Program and to address one of the barriers to the adoption of connected care services, the Pilot Program will provide funding for participating health care providers to purchase mobile or fixed broadband Internet access service for participating patients who do not already have broadband Internet access service or who lack sufficient broadband Internet access service necessary to participate in the specific pilot project.[139] Insufficient broadband for connected care services could include subscriptions to low-bandwidth connections, low usage allowances, or other inadequate service levels—all of which negatively impact patients' and health care providers' ability to use telehealth services. For the Pilot Program, funding these services will expand health care providers' digital footprints for purposes of providing connected care services, and allow health care providers to serve more patients through the Pilot Program and thus enhance health care providers' access to advanced telecommunications and information services.[140]

58. To ensure that funding for patient broadband Internet access service is targeted appropriately, we will require Pilot Program applicants seeking support for patient broadband Internet access service to identify the estimated number of patient broadband connections that the health care provider intends to purchase for purposes of providing connected care services to patients who lack broadband service or have insufficient broadband services. A health care provider seeking funding for patient broadband Internet access service must also explain in its application how it plans to assess whether a patient lacks broadband service or has insufficient broadband Internet access service for the proposed connected care service based on speed, technology (e.g., fixed or mobile broadband), or other

[135] *See, e.g.*, VTN Comments at 3; MUSC Comments at 2; CHIME Reply Comments at 2; Microsoft Comments at 1. *See also supra* para. 12; *Connected Care Notice*, 34 FCC Rcd at 5624-27, para. 13 & nn.26-27.

[136] Press Release, U.S. Dept. of Veteran Affairs, Office of Public and Intergovernmental Affairs, VA-distributed Video Tablets Deliver Telehealth to Veterans (Sept. 13, 2019), https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5313. "In 2016, VA's Offices of Rural Health and Connected Care initiated an effort to expand video teleconferencing into the home through tablet-enabled secure video technology. The goal of this initiative was to enhance access for Veterans with geographic, clinical, and social barriers to in-person care."); Donna Zulman, et al., *Making Connections: Nationwide Implementation of Video Telehealth Tablets to Address Access Barriers in Veterans*, Jamia Open 324 (2019), https://academic.oup.com/jamiaopen/article/2/3/323/5538629. *See also* Eli Richman, *The VA Tried Out Loaning Thousands of iPads to Veterans for Telehealth. Now They Plan to Double the Program*, Fierce Healthcare (Sept. 19, 2018), https://www.fiercehealthcare.com/tech/va-expects-to-double-tablet-leasing-program-for-at-need-veterans-potentially-distributing-12 (discussing VA's wireless-enabled tablet loan program).

[137] *See* Mercy Virtual Comments at 12 ("Mercy Virtual has limited its growth and number of patients served due to the costs of devices and broadband connectivity acquisition/maintenance. There are no other adequate forms of reimbursement or recovery to address these needs.").

[138] *See, e.g.*, VTN Comments at 3; Mercy Virtual Comments at 11.

[139] While the VA funds mobile broadband connections for a small fraction of its patients, it has limited resources to do so. *See generally supra* note 34; *Connected Care Notice*, 34 FCC Rcd at 5624-28, para. 13 & n.28.

[140] 47 U.S.C. § 254(h)(2)(A) (directing the Commission to establish competitively neutral rules "to enhance to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for all public and nonprofit elementary and secondary school classrooms, health care providers, and libraries[.]").

appropriate service characteristics.[141] It is appropriate under section 254(h)(2)(A) to fund the whole patient broadband connection as long as it is "primarily" used for activities that are integral, immediate, and proximate to the provision of connected care services to participating patients.[142] In contrast to broadband connectivity for a single health care provider facility, it would not be "technically feasible and economically reasonable,"[143] for health care providers to track, monitor, and cost-allocate non-connected care uses of the supported patient broadband connections.[144]

59. *Health Care Provider Broadband Data Connections*. The Pilot Program will also provide support for eligible, participating health care providers to purchase the broadband data connections needed to provide connected care services under the Pilot Program. Although the Healthcare Connect Fund Program already provides support for eligible health care providers to receive broadband data connections,[145] the Pilot Program will disburse funding to health care providers specifically for purposes of providing connected care services directly to their patients. We recognize that while many eligible health care providers may already have the broadband connectivity necessary to participate in the Pilot Program, other eligible health care providers may require new or additional broadband data connections to participate in the Pilot Program.[146] We believe that providing funding for health care provider broadband data connections in this latter situation will incentivize health care provider participation, which, in turn, will aid our ability to collect meaningful data. Moreover, requiring Pilot Program applicants that require broadband data connections in order to provide connected care services to seek support for those connections through the Healthcare Connect Fund would produce duplicative application requirements with minimal benefit to either program. We expect that funding health care provider connectivity under these circumstances will not subsume the budget for the Pilot Program given the broad participation in the existing Healthcare Connect Fund Program which provides funding for health care provider broadband connectivity.

60. To avoid duplicate funding and to stretch limited Pilot Program funds, eligible health care providers participating in the Pilot Program may not request or receive funding for broadband data connections for which they already receive funding through the Healthcare Connect Fund Program or other federal programs, and similarly may not request or receive funding for broadband data connections through the Healthcare Connect Fund Program or other federal programs for which they have already received funding through the Pilot Program. In addition, the Pilot Program will not fund broadband

[141] *Id.*

[142] To the extent that participating patients use the supported broadband Internet access service primarily, but not exclusively, for activities that are integral, immediate, and proximate to the provision of connected care services, selected Pilot Program participants will not be required to cost-allocate the dollar amount of support for non-connected care usage.

[143] *See* 47 U.S.C. § 254(h)(2)(A).

[144] *See, e.g.*, GRTI Comments at 2-3 (stating that requiring cost-allocation of non-connected care uses of supported patient broadband would be incredibly burdensome for health care providers, would require the adoption of new tracking and monitoring tools and would introduce unnecessary complexity given the marginal cost of the additional broadband traffic).

[145] *See* 47 CFR § 54.612.

[146] For example, some eligible health care providers that do not receive funding for broadband through the Commission's existing RHC Program may seek to participate in the Pilot Program. *See, e.g.*, MCN Comments at 2 (stating "every recipient will not also be recipients of the [Healthcare Connect Fund Program] or other programs offered through the Commission"). *But see* LHN Comments at 6 (arguing that the Pilot Program should not fund broadband connectivity for health care providers because virtually all hospitals and clinics already have broadband connectivity); Ochsner Comments at 28 (stating "the Pilot should not duplicate existing healthcare funding").

connections between health care providers[147] as these connections are already eligible for funding through the Healthcare Connect Fund Program, and we do not believe that funding connections between health care providers is necessary for this Pilot Program given the focus on supporting the provision of connected care services to participating patients in their homes or mobile locations.[148]

61. *Other Connected Care Information Services*. The Pilot Program will also provide support for information services other than broadband connectivity that eligible, participating health care providers use for connected care as part of the Pilot Program.[149] Commenters indicate that health care providers use a vast array of services for connected care that capture, transmit (including video visits), and store health care data for connected care.[150] For example, some commenters indicated that health care providers use information services with "store-and-forward" technology or remote patient monitoring capabilities to monitor expecting mothers or to treat mental health conditions.[151] Commenters further indicate that new and innovative services for connected care will continue to evolve with advancements in technology.[152] According to commenters, health care providers incur significant costs to provide connected care services, including, but not limited to, the costs of services (other than broadband) for connected care, and that many of these costs typically are not reimbursable through health care payors, which can present an obstacle to connected care services.[153] Funding information services for health care providers' use for connected care through the Pilot Program, therefore, could enhance health care providers' access to such information services and encourage innovation in the way health care providers provide connected care services to their patients. We also believe funding these information services will

[147] As examples, the Pilot Program will not fund private network connections between health care providers (e.g., Metropolitan Area Networks (MANs), Wide Area Networks (WANs), and Local Area Networks (LANs).

[148] The record also supports not funding broadband connections between health care providers through the Pilot Program. *See, e.g.*, Ochsner Comments at 28 (agreeing that the Pilot Program should not fund Internet connections between health care providers); CTIA Comments at 6 (stating that the Commission correctly noted that the Pilot Program should not fund Internet connections between health care providers).

[149] The supported services discussed in this section are likely "information services" as defined by the Act. *See* 47 U.S.C. § 153(24). Section 254(h)(2)(A) of the Act directs the Commission to "establish competitively neutral rules . . . to enhance, to the extent technically feasible and economically reasonable, access to advanced . . . information services" for all public and nonprofit health care providers. *See* 47 U.S.C. § 254(h)(2)(A). The record supports providing Pilot Program support for information services that qualifying health care providers use to provide connected care services for purposes of the Pilot Program. *See, e.g.*, Ochsner Comments at 19; PATH Comments at 6; CHRISTUS Comments at 3 (urging the Commission to provide "additional coverage options for other essential technologies that enable storage transmission and transmission storage of the vital data that is communicated through broadband, which renders that information useful"); PBTRC Reply Comments at 1 (stating that there are packages of suites of telehealth services that are used for connected care services and that such services are a common requirement necessary for health care providers to make connected care services available); CHI Comments at 6 (strongly encouraging the Commission to fund "turnkey solutions" such as software, remote patient monitoring tools and patient broadband access).

[150] *See, e.g.*, CHI Comments at 6; CHRISTUS Comments at 3, 7; AUA Comments at 4; Ochsner Comments at 19-21; PATH Comments at 6; VTN Comments at 16. Specifically, health care providers may be using suites of technology and services like those offered by Amwell, or remote patient monitoring platforms like those offered by Cloud DX. *See* Amwell, https://business.amwell.com/telemedicine-solution-hospitals/ (last visited Mar. 17, 2020) (describing Amwell's telemedicine platform); Cloud DX, https://www.clouddx.com/#/ (describing Cloud DX's remote patient monitoring platforms) (last visited Mar. 27, 2020).

[151] *See, e.g.*, Mercy Virtual Comments at 3-4; Ochsner Comments at 19-21; PATH Comments at 9.

[152] *See, e.g.*, CHI Comments at 4; Mercy Virtual Comments at 2-3; Ochsner Comments at 4-9; UMMC Comments at 3.

[153] *See, e.g.*, Mercy Virtual Comments at 7 ("The cost to stand up, implement, and utilize telemedicine is extremely high and serves as the primary barrier to adoption.").

encourage broader participation in the Pilot Program, which will allow us to collect meaningful data that will help us understand the potential capabilities of connected care services and whether and how the Universal Service Fund can play a role in promoting the use of connected care services. In funding these information services for connected care, however, we will not fund the costs associated with medical professional review of data or images transmitted or stored through such services, or services which have a primary purpose other than capturing, transmitting and storing data to facilitate connected care. While these latter costs may be part of providing connected care, they fall outside the scope of the Commission's statutory authority under Section 254(h)(2)(A). Mobile applications will only be funded to the extent that they are part of a qualifying information service.

62. While we will provide funding for information services under the Pilot Program, we decline to provide a specific list of services that could be eligible for support as information services through the Pilot Program. Attempting to provide a specific list of these services poses a risk of being underinclusive and unintentionally excluding information services that we have the authority to and want to fund through the Pilot Program to further the goals of the Pilot Program. To facilitate a determination of whether a specific service for a proposed pilot project constitutes a qualifying "information service," eligible health care providers that seek Pilot Program support for an information service should include in their application a thorough description of the service, including a description of the primary function/s of the service, and whether and how it facilitates the capturing, transmission (including video visits), and storage of data for connected care.[154]

63. *Network Equipment*. The Pilot Program will provide funding to eligible, participating health care providers for necessary network equipment for broadband connectivity funded through the Pilot Program for connected care services. The Commission previously concluded that it has authority under section 254(h)(2)(A) to fund network equipment (e.g., routers and servers) necessary to make a supported service functional and for consortium applicants to fund network equipment necessary to manage, control, or maintain a supported broadband service.[155] Several commenters who currently provide connected care services indicate that funding network equipment through the Pilot Program will help offset the high cost associated with providing connected care services, which is also a barrier to widespread adoption of connected care services.[156] We emphasize that this funding can only be used for network equipment that is necessary to make Pilot Program funded broadband services for connected care services functional, or to operate, manage, or control such services, and must not be used for purposes other than providing connected care services under the Pilot Program.

64. Health care providers seeking funding for qualifying network equipment for other health care uses may apply for such funding under the Healthcare Connect Fund Program.[157] Further, to avoid duplicate funding issues, we make clear that eligible health care providers participating in the Pilot Program may not request and receive funding for network equipment for which they already applied or received funding through the Healthcare Connect Fund Program or another federal program, and similarly may not request and receive through the Healthcare Connect Fund Program or another federal program funding for network equipment for which the health care provider receives funding through the Pilot Program. Moreover, consistent with section 54.9 of the Commission's rules, the Pilot Program will prohibit health care providers from using universal service funds to purchase equipment or services for use through the Pilot Program that are produced or provided by a company that the Commission has

[154] *See* 47 U.S.C. § 154(24) (defining "information service" for purposes of the Communications Act).

[155] *See Healthcare Connect Fund Order*, 27 FCC Rcd at 16751, para. 157 & n.435. We apply the list of eligible network equipment in section 54.613 of the Commission's rules to the Pilot Program. *See* 47 CFR § 54.613.

[156] *See* AHA Comments at 19; CCC Comments at 1; CCHP Comments at 2; CHRISTUS Comments at 7; Mercy Virtual Comments at 10; MUSC Comments at 5.

[157] *See* 47 CFR § 54.613.

identified as posing a national security threat to the integrity of communications networks or the communications supply chain.[158]

65. *End-User Devices and Medical Equipment.* Consistent with the Commission's long-standing approach to implementing its universal service programs, the Pilot Program will not fund end-user devices or medical equipment. Various commenters urge the Commission to fund these items through the Pilot Program and argue that not funding these items could prevent certain eligible health care providers from participating in the Pilot Program.[159] However, the record does not provide a sufficient legal basis for departing from Commission precedent and funding these types of items through Universal Service Fund support mechanisms.[160] This long-standing prohibition is derived from section 254's focus on the availability of and access to "services."[161] Thus, the Commission has consistently declined to fund equipment unless it is "necessary" for the transmission function of the service.[162] Additionally, providing limited Pilot Program funding to end-user devices and medical equipment costs may not be economically reasonable because it could significantly reduce the Pilot Program funding available for the costs directly associated with providing connected care services, and would limit the number of pilot projects we can select. The record indicates that some selected pilot projects may be able to obtain grant funding and

[158] *See* 47 CFR § 54.9. *See also generally Protecting Against National Security Threats to the Communications Supply Chain Through FCC Programs*, Report and Order, Further Notice of Proposed Rulemaking, and Order, 34 FCC Rcd 11423 (2019).

[159] *See, e.g.*, AHA Comments at 4; VTN Comments at 7-8; NCTRC Comments at 1; Hathaway-Sycamores Comments at 2; Mercy Virtual Comments at 8-9; Ochsner Comments at 19-22; UMMC Comments at 2.

[160] *See, e.g., Universal Service First Report and Order*, 12 FCC Rcd at 9021-22, para. 460 (denying E-Rate support to finance the purchase of equipment, such as PCs, that do "not provide such a necessary transmission function"); *Lifeline and Link Up Reform and Modernization et al.*, WC Docket No. 12-23, Report and Order and Further Notice of Proposed Rulemaking, 27 FCC Rcd 6656, 6804-05, para. 348-49 (2012) (*2012 Lifeline Order*) (stating that, consistent with the Commission's "historic approach" not to subsidize equipment through the USF, Commission would not subsidize equipment needed by low-income consumers to access the Internet); *Healthcare Connect Fund Order* 27 FCC Rcd at 16751-54, paras. 157 & n.435, 167 (deeming devices ineligible for support because they were not necessary to make the broadband service functional, stating that "the Commission previously has concluded that it lacked statutory authority to support telemedicine equipment").

[161] *See, e.g.*, 47 U.S.C. § 254(c)(1) (defining "universal service" as "an evolving level of telecommunications services"); 47 U.S.C. § 254(d) (mechanisms are "established by the Commission to preserve and advance universal service"). Although we are providing support for some devices through the COVID-19 Telehealth Program, the appropriations language in the CARES Act authorizing us to implement that program specifically allows us to support "devices" as part of the COVID-19 response, but did not modify the language in section 254 that focuses on the availability of and access to services.

[162] *See Lifeline and Link Up Reform and Modernization et al*., WC Docket No. 12-23, Report and Order and Further Notice of Proposed Rulemaking, 27 FCC Rcd 6656, 6805, para. 349 (2012) (2012 Lifeline Order) ("However, in keeping with the Commission's historic approach to using the Fund, we will not subsidize equipment purchases as part of the pilot program."); *Lifeline and Link Up Reform and Modernization et al*., WC Docket Nos. 11-42, 09-197, 10-90, Third Report and Order, Further Report and Order, and Order on Reconsideration, 31 FCC Rcd 3962, 4005-4006, para. 125 (2016) (2016 Lifeline Order) ("Past Commission precedent makes it clear that Lifeline, with the exception of a brief period after Hurricane Katrina, has been used to fund services, and not equipment. At this time, we see no reason to deviate from that approach."); *Healthcare Connect Fund Order*, 27 FCC Rcd at 16754, para. 167 & n.455 ("The Universal Service Fund historically has not supported end user devices."); *id.* at 16754, para. 157 & n.435 ("The Commission previously has concluded that it lacked statutory authority to support telemedicine equipment."); 47 CFR § 54.617 (listing end user devices, telemedicine equipment, applications and software as examples of ineligible expenses); *Modernizing the E-rate Program for Schools and Libraries*, Order, 33 FCC Rcd 11219, 11231, Appendix B, Eligible Service List for Funding Year (WCB 2018) ("Examples of items that are ineligible components of Internet access services include applications . . . and end-user devices and equipment such as computers, laptops, and tablets."). The RHC Pilot Program also did not fund end-user devices, medical equipment or telemedicine applications. *See RHC Pilot Program Selection Order*, 22 FCC Rcd at 20398, para. 75.

other funding for end-user devices or medical equipment where needed to participate in the Pilot Program.[163] We therefore encourage eligible health care providers to explore available grant and other funding opportunities, potential partnerships and other avenues that could help them obtain end-user and medical devices necessary to participate in the Pilot Program.

66. *Administrative Expenses and Other Miscellaneous Expenses.* Consistent with the RHC Program and the RHC Pilot Program, this Pilot Program will not provide funding for health care provider administrative costs associated with participating in the Pilot Program (e.g., costs associated with completing Pilot Program applications and other submissions) or other miscellaneous expenses (e.g., doctor and staff time spent on the Pilot Program and outreach).[164] This is also consistent with the U.S. Department of Agriculture's Distance Learning and Telemedicine grant program.[165] We acknowledge that some commenters advocate for the Pilot Program to support these types of costs.[166] However, we do not find that there is a sound legal or policy basis for departing from the Commission's prior determinations not to use USF support for these types of expenses. Section 254 focuses on the availability of and access to "services."[167] Funding administrative or miscellaneous expenses associated with participating in the Pilot Program would not fulfill this statutory focus. Moreover, other commenters argue that funding these costs would not be an efficient use of Pilot Program funds.[168] We agree that allocating scarce Pilot Program funding to administrative costs would significantly reduce the Pilot Program funding available for the costs directly associated with providing connected care services.

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[163] *See, e.g.*, myNexus Comments at 9 (agreeing that the Pilot Program should not fund end-user devices and stating "[w]e believe providers and entities who are committed to the Pilot's success will self-fund or obtain other resources for end-user devices, medical devices, and mobile applications."); VTN Comments at 7 (stating "[w]here other sources of funding for tablets, peripherals, applications, and similar technologies are already available, the pilot program's limited budget should be allocated elsewhere."); GRTI Comments at 3 (stating "it may very well be the case that states and larger federal entities…are capable of securing funding from other sources for the purchase of these devices…."). *See also* CoBank Comments at 5 (stating that the Pilot should not fund end-user devices).

[164] *See RHC Pilot Program Selection Order*, 22 FCC Rcd at 20398-99, para. 75 (stating that the ineligible expenses for the RHC Pilot Program included: "Personnel costs (including salaries and fringe benefits), except for those personnel directly engaged in designing, engineering, installing, constructing, and managing the dedicated broadband network. Ineligible costs of this category include, for example, personnel to perform program management and coordination, program administration, and marketing."; "Program administration or technical coordination that involves anything other than the design, engineering, operations, installation, or construction of the network."; "Administration and marketing costs (*e.g.*, administrative costs; supplies and materials (except as part of network installation/construction); marketing studies, marketing activities, or outreach efforts; evaluation and feedback studies)."); *Healthcare Connect Fund Order*, 27 FCC Rcd at 16758, para. 175 (declining to fund administrative expenses through the Healthcare Connect Fund Program and stating "[n]either the Telecommunications nor Pilot Programs fund administrative expenses.").

[165] *See, e.g.*, U.S. Dept. of Agriculture, 2018 Distance Learning and Telemedicine Program at 16, 19 (2018), https://www.rd.usda.gov/files/DLT-2018_Webinar.pdf (stating that administrative expenses are ineligible);U.S. Dept. of Agriculture, 2019 Distance Learning and Telemedicine Program- at 13, 16 (2019), https://www.rd.usda.gov/files/Webinar_DLT-2019-Understanding_DLT_Opioid_Treatment.pdf (stating the same).

[166] *See, e.g.*, AHA Comments at 18-19; CCHP Comments at 2; CHRISTUS Comments at 6-8; MUSC Comments at 6; and NCTRC Comments at 2.

[167] *See supra* para. 65.

[168] *See, e.g.*, myNexus Comments at 9 (stating that funding administrative expenses "will reduce the resources available to expanding access to connected care and the remote monitoring and care management it will make possible" and agreeing that health care providers would participate in the Pilot program if these expenses were not funded.); NCTA Comments at 2-3 (stating that not funding administrative or outreach expenses would "ensure that these limited universal service dollars can provide the greatest benefit possible to the greatest number of eligible patients."). *See also* MCN Comments at 2 (supporting not funding administrative expenses through the Pilot Program).

Additionally, if we were to provide direct support for administrative expenses, it would necessitate additional application requirements, guidelines, and other administrative controls to protect such funding from waste, fraud, and abuse.[169] This would increase the administrative burden on USAC and on applicants as well.[170]

4. Application and Evaluation Process

67. *Application Process*. To participate in the Pilot Program, a prospective health care provider must first obtain an eligibility determination from USAC by submitting an FCC Form 460 (Eligibility and Registration Form)[171] along with supporting documentation to USAC to verify its eligibility to participate in the Pilot Program.[172] After confirming its eligibility for the Pilot Program, the applicant must submit its pilot project proposal to the Commission describing its proposed pilot project and providing information that will facilitate the evaluation and eventual selection of high-quality pilot projects in order to participate in the Pilot Program.[173] Specifically, the applicant must show how its proposed pilot project meets the criteria outlined below. We expect each applicant to present a clear research and evaluation strategy for meeting the health care needs of participating patients through the use of connected care services and how the proposed pilot project will accomplish these objectives. We anticipate that successful applicants will be able to demonstrate that they have a viable strategic plan for delivering innovative connected care services directly to patients while leveraging existing resources or telehealth programs within their state or region. In particular, we will give greater consideration to applications that propose to provide connected care services to a significant number of low-income or veteran patients in a given state or region. An application that intends to provide connected care services to only a *de minimis* number of low-income or veteran patients will not be selected.

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[169] *See Healthcare Connect Fund Order*, 27 FCC Rcd at 16757-58, para. 174.

[170] *Id.*

[171] *See* USAC, Rural Health Care Program, Healthcare Connect Fund Program, Determine Eligibility of Your Site, https://www.usac.org/rural-health-care/healthcare-connect-fund-program/step-1-determine-eligibility-of-your-site/ (last visited Mar. 24, 2020) (describing the process for submitting an FCC Form 460 to receive an eligibility determination for a health care provider site). Each separate site or location of a health care provider is considered an individual health care provider site for eligibility determination purposes. *See* 47 CFR § 54.601(a)(2). USAC assigns a health care provider number for each health care providers site it determines to be eligible for support. The FCC Form 460 can be accessed through the Commission's website at https://www.fcc.gov/licensing-databases/forms (last visited Mar. 24, 2020). As detailed above, the Pilot Program is open to eligible health care providers in both rural and non-rural areas—eligible health care providers located in non-rural areas do not need to be part of a consortium to participate in the Pilot Program. For any questions concerning the FCC Form 460, Pilot Program participants should call USAC's RHC Program staff at RHC-Assist@usac.org or by phone at (800) 453-1546.

[172] Those health care providers that have already received an eligibility determination from USAC through participation in the RHC Program do not have to seek another eligibility determination. For purposes of this Pilot Program, the FCC Form 460 contains new or modified information collection requirements subject to the Paperwork Reduction Act of 1995 (PRA), Public Law 104-13, and the FCC Form 460 and attachments will become available for those health care providers that do not already have an eligibility determination from USAC upon approval of the information collection by the Office of Management and Budget (OMB). The Wireline Competition Bureau (Bureau) will announce receipt of OMB approval for the use of the FCC Form 460 for the Pilot Program.

[173] *See Connected Care Notice*, 34 FCC Rcd at 5641, para. 49. In order to facilitate the application review process, pursuant to the Paperwork Reduction Act of 1995 (PRA), the Commission plans to seek OMB approval for a Connected Care Pilot Program Application form for applicants to use when submitting their pilot project proposals to the Commission. As part of the information collection process, parties will have an opportunity to comment on the form.

68. To be eligible for participation in the Pilot Program, interested parties should submit applications that, at a minimum, contain the following required information: [174]

- Names and addresses of all health care providers that will participate in the proposed pilot project and identify the lead health care provider for proposals involving multiple health care providers.
- Contact information for the individual that will be responsible for the management and operation of the proposed pilot project (telephone number, mailing address, and email address).
- Health care provider number(s) and type(s) (e.g., not-for-profit hospital, community mental health center, community health center, rural health clinic), for each health care provider included in proposal.[175]
- Description of each participating health care provider's previous experience with providing telehealth services (other than electronic health records) or experience and name of a partnering health care provider or organization.
- Description of the plan for implementing and operating the pilot project, including how the pilot project intends to recruit patients, estimated amount of ramp-up time necessary for the pilot project (not to exceed six months), plans to obtain any necessary end-user devices (e.g., tablets, smartphones) and medical devices for the connected care services that the pilot project will provide, and to what extent the pilot project can be self-sustaining once established.
- Description of the connected care services the proposed pilot project will provide, the conditions to be treated, the health care provider's experience with treating those conditions, the goals and objectives of the proposed pilot project (including the health care provider's anticipated goals with respect to reaching new or additional patients, and improved patient health outcomes), expected health care benefits to the patients, health care provider, or the health care industry that will result from the proposed pilot project, and how the pilot project will achieve each of the goals of the Pilot Program.
- Documentation of the participating health care provider(s)'s financial health (e.g., recent audited balance sheets and income statements that are no more than two years old).
- Description of the estimated number of patients to be treated.
- Description of any commitments from community partners, including physicians, hospitals, health systems, and home health/community providers to the success of the proposed pilot project.
- Description of the anticipated level of broadband service required for the proposed pilot project, including the necessary speeds, the technologies to be used (e.g., mobile or fixed broadband) and any other relevant service characteristics (e.g., LTE service).
- Description of the estimated number of patient broadband connections that the health care provider intends to purchase for purposes of providing connected care services to patients who lack broadband service or have insufficient broadband services. This description must

[174] We recognize that some applications could contain confidential information. Applicants may request that any materials or information submitted to the Commission in its application be withheld from public inspection pursuant to the procedures set forth in section 0.459 of the Commission's rules. 47 CFR § 0.459.

[175] *See supra* note 171.

include an explanation of how the health care provider plans to assess whether a patient lacks broadband service or has insufficient broadband Internet access service for the indicated connected care service based on speed, technology or data cap limitations.

- If seeking support for an information service used to provide connected care, other than broadband connectivity, used to provide connected care, a description of the service, including a description of the primary function/s of the service, and whether it facilitates the capturing, transmission, and storage of data for connected care.

- Estimated total project costs, including costs eligible for support through the Pilot Program and costs not eligible for Pilot Program support but still necessary to implement the proposed pilot project. This entry must include the total estimated eligible funding (85%) to be requested from the Pilot Program per year over the three-year funding period.

- A list of anticipated sources of financial support for the pilot project costs not covered by the Pilot Program.

- Description of the metrics for the proposed pilot project that are relevant to the Pilot Program goals and how the participating providers will collect those metrics. Examples of the types of metrics the Commission is interested in include: reductions in potential emergency room or urgent care visits; decreases in hospital admissions or readmissions; condition-specific outcomes, such as reductions in premature births or acute incidents among suffers of a chronic illness, and patient satisfaction as to with their overall health status.[176]

- Description of how the health care provider intends to collect, track, and store, the required Pilot Program data.

Further, to facilitate our review in selecting a diverse set of projects and target Pilot Program funds to geographic areas and populations most in need of USF support for connected care, applicants should also provide the following information, as applicable:

- Description of whether the health care provider is located in a rural area,[177] on Tribal lands,[178] or is associated with a Tribe, or part of the Indian Health Service.[179] If the health care

[176] *See Connected Care Notice*, 34 FCC Rcd at 5660, para. 89.

[177] We use the RHC Program's definition of "rural area." *See* 47 CFR § 54.600(e) ("A 'rural area' is 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. For purposes of this rule, 'Core Based Statistical Area,' 'Urban Area,' and 'Place' are as identified by the Census Bureau."). Many health care providers may already be familiar with this definition through their participation in the existing RHC Program, and using the RHC Program definition of rural area will allow us to use existing systems and processes to identify rural and non-rural health care providers for purposes of the Pilot Program. Health care providers can determine whether they are located in a rural area under this definition by visiting the Eligible Rural Areas Search Tool on USAC's website. *See* USAC, Rural Health Care Program, Healthcare Connect Fund Program, Determine Eligibility of Your Site, Rural Look Up Tool, https://apps.usac.org/rhc/tools/Rural/search/search.asp (last visited Mar. 25, 2020).

[178] For purposes of Pilot Program applications, Tribal lands is inclusive of Alaska Native regions established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688) and Hawaiian Homelands (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. *See* 47 CFR 54.400(e).

[179] Considering this information will allow us to identify and target limited Pilot Program funding towards pilot projects that would serve patients in areas where USF funding to support the use of connected care could have the greatest impact. Many commenters support focusing the Pilot Program on or prioritizing projects located in rural or (continued….)

provider is not located in a rural area, include a description of whether the health care provider will primarily serve veterans or low-income patients located in rural areas as defined in the RHC Program rules, and identify those specific rural areas.[180]

- Listing of all Department of Health and Human Services, Health Resources & Services Administration (HRSA) designated Health Professional Shortage Areas (for primary care or mental health care only) or HRSA designated Medically Underserved Areas that will be served by the proposed project.[181]
- Description of whether the pilot project will primarily benefit low-income or veteran patients, and if so, the estimated number or percentage of those patients the project will serve compared to the total number of patients that the pilot project estimates serving.
- Description of whether the primary purpose of the proposed pilot project is to provide

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Tribal areas. *See, e.g.*, ATN Reply Comments at 2; Seneca Nation Comments at 1; CL Reply Comments at 1; AHA Comments at 13-14; APTA Comments at 4; MCN Comments at 6; VTN Comments at 14; Verizon Comments at 4. The health care shortages in rural and Tribal areas are well documented. *See, e.g.*, National Indian Health Board, *Indian Health Care 101* at 2 (July 2014), https://www.nihb.org/docs/01132015/Indian%20Health%20Care%20101.pdf ("Many American Indians and Alaska Natives rely solely upon IHS [Indian Health Service]-funded health care, especially those individuals living in remote rural areas. For many Indians, reasonable access to alternative providers does not exist."); Clemens Scott Kruse, et al., *Telemedicine Use in Rural Native American Communities in the Era of the ACA: a Systematic Literature Review*, J. Med. Sys. (Apr. 27, 2016), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4848328/ ("Native American communities face serious health disparities and, living in rural areas, often lack regular access to healthcare services as compared to other Americans."); U.S. Commission on Civil Rights, Broken Promises: Continuing Federal Funding Shortfall for Native Americans at 61-94 (Dec. 2018), https://www.usccr.gov/pubs/2018/12-20-Broken-Promises.pdf (discussing the poor access to quality health care in Indian Country); Rural Health Information Hub, Rural Tribal Health, https://www.ruralhealthinfo.org/topics/rural-tribal-health (last visited Mar. 25, 2020) ("In fact, health workforce shortages are persistent enough that the Health Resources and Services Administration automatically designates groups of federally recognized Native American tribes as Health Professional Shortage Area population groups."); Brock Slaback, *Fixing the Medical Staff Shortage Problems in Rural Areas* Becker's Hospital Review (June 20, 2018), https://www.beckershospitalreview.com/population-health/fixing-the-medical-staff-shortage-problem-in-rural-areas.html ("Physicians are disappearing from the map of rural America . . . . 60 million people are dealing with the impact of this shortage."); American Hospital Association, Rural Report at 2-3 (2019), https://www.aha.org/system/files/2019-02/rural-report-2019.pdf (stating "[w]hile almost 20 percent of the U.S. population lives in rural areas, less than 10 percent of U.S. physicians practice in these communities" and discussing the increasing closures of rural hospitals); Testimony of Dr. Karen Rheuban Before the Senate Committee on Commerce, Science and Transportation's Subcommittee on Communications, Technology, Innovation and the Internet (June 20, 2017), https://www.commerce.senate.gov/public/_cache/files/6057a97a-dda2-4f6d-9d93-93f60d8c232f/5A5E13FD93156485723F5B2A48F1863E.rheuban-testimony.pdf ("'Core health care services' such as primary care, emergency medical services, long term care, mental health and substance abuse services, oral health and other services are considerably less accessible in rural communities. Lack of access to specialty care services is an even greater challenge.").

[180] Rural area determinations are based on USAC's Eligible Rural Areas Search Tool. *See* USAC, Rural Health Care, Eligible Rural Areas Search, https://apps.usac.org/rhc/tools/Rural/search/search.asp (last visited Mar. 25, 2020).

[181] *See* HRSA, *Health Professional Shortage Areas (HPSAs)*, https://bhw.hrsa.gov/shortage-designation/hpsas (last visited Mar. 25, 2020); HRSA, *Medically Underserved Areas and Populations (MUA/Ps)*, https://bhw.hrsa.gov/shortage-designation/muap (last visited Mar. 25, 2020). The record supports targeting Health Professional Shortage Areas and Medically Underserved Areas/Populations. *See, e.g.*, APTA Comments at 5; CCHP Comments at 3-4; ConnectMe Comments at 10. We decline to adopt suggestions to expand the types of Health Professional Shortage Areas that the Pilot Program will target. The Health Professional Shortage Areas we target are most likely to treat the types of conditions that are the focus of this Pilot Program.

> connected care services to respond to a public health epidemic, or to provide connected care services for opioid dependency, high-risk pregnancy/maternal mortality, mental health conditions (e.g., substance abuse, depression, anxiety disorders, schizophrenia, eating disorders and addictive behavior) or conditions of a chronic or long term nature (including, but not limited to heart diseases, diabetes, cancer, stroke).[182]

69. Additionally, applicants will also be required, at the time of submission of their application, to certify, among other things, that they will comply with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy and reimbursement laws and regulations, and applicable medical licensing laws and regulations, as well as all applicable Pilot Program requirements and procedures, including the requirement to retain records to demonstrate compliance with the Pilot Program rules and requirement for five years, subject to audit.[183] Health care providers that participate in the Pilot Program must also comply with all applicable federal and state laws, including the False Claims Act, the Anti-Kickback Statute, and the Civil Monetary Penalties Law.[184] We understand that health care providers must routinely navigate these laws in other contexts. Thus, health care providers that are

[182] These conditions are associated with high costs for patients and the health care system, high death rates, or are American health crises and could benefit from connected care services. See Connected Care Notice, 34 FCC Rcd at 5648-49, para. 61; *supra* notes 75, 76. See also CDC, National Center for Health Statistics, Leading Causes of Death, https://www.cdc.gov/nchs/fastats/leading-causes-of-death.htm (last visited Mar. 25, 2020) (indicating heart disease, cancer, stroke and diabetes were among the top ten leading causes of death for Americans in 2017); Samantha McGrail, Health Payor Intelligence, Cost of Cancer Care Reaches More Than $150B Nationally (Jan. 15, 2020), https://healthpayerintelligence.com/news/cost-of-cancer-care-reaches-nearly-150b-nationally (discussing the high costs of cancer treatment and stating that the cancer death rate is 20% higher in the poorest counties in the United States). The record supports targeting funding towards pilot projects that treat conditions of a chronic or long-term nature, such as cancer, heart conditions, diabetes, mental health conditions, high risk pregnancy/maternal mortality. See VTN Comments at 13 (supporting prioritizing pilot projects that focus on health conditions that disproportionately impact vulnerable individuals including opioid dependency, heart disease, diabetes, mental health conditions and high-risk pregnancy); UCSD Comments at 1-2 (describing the benefits of connected care for cancer patients and stating that cancer disproportionately impacts rural Americans); PBTRC Reply Comments at 2 (agreeing with the priority designation for treating certain chronic health conditions including high-risk pregnancies, heart disease, diabetes, or mental health conditions (including substance abuse)); CHIME Reply Comments at 8; FACHC Reply Comments at 5; NACHC Reply Comments at 5; VCHA Reply Comments at 3; CHRISTUS Comments at 5 (urging the Commission to include maternal fetal medicine in Pilot to improve maternal health in order to reduce morbidity and mortality).

[183] *See* 47 CFR § 54.631. We emphasize that the Commission is committed to guarding against waste, fraud, and abuse and ensuring that USF funds disbursed through the Pilot Program are used for appropriate purposes. In the event of a violation of Pilot Program rules or requirements, the Commission reserves the right to take appropriate actions, including, but not limited to, seeking recovery of funds.

[184] *See* False Claims Act, 31 U.S.C. §§ 3729-3733; Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b); Civil Monetary Penalties Law, 42 U.S.C. § 1320a-7a. *See* False Claims Act, 31 U.S.C. §§ 3729-3733; Anti-Kickback Statute, 42 U.S.C. § 1320a-7b(b); Civil Monetary Penalties Law, 42 U.S.C. § 1320a-7a. *See* AHA Comments at 20 (noting that anti-kickback statutes prohibit health care providers "from giving or receiving [ ] items of value (such as monitoring equipment), as they could be seen as an inducement"); AH Comments at 4 (recommending that the Commission consider how laws and regulations might affect the distribution of equipment to providers and subsequently to patients at little to no cost, and mentioning the Transportation Safe Harbor to the anti-kickback statute introduced by HHS OIG in 2017); Ochsner Comments at 17 (explaining that "[a]ny form of discount offered to a new telemedicine subscriber may risk exposure under the Civil Monetary Penalties Law and the Anti-Kickback Statute, both of which prohibit offering or paying remuneration to a Medicare or Medicaid beneficiary with the intent of encouraging the patient to continue using healthcare services from a particular provider"); Ochsner Reply Comments at 6 (noting that the Pilot program must "effectively address the provision of connected care services – such as free or discounted access to HCP-funded end-user equipment or devices – from the risk of being considered a prohibited inducement under the Self-Referral or Anti-Kickback Statutes" and calling for a regulatory safe harbor). As explained above, health care providers should consult with their compliance professionals about these issues.

interested in applying for the Pilot Program should speak to their compliance experts prior to submitting an application to participate in the Pilot Program.[185] Further, applicants will also be required to certify that they are not already receiving or expecting to receive other federal funding for the exact same services eligible for support under the Pilot Program.[186] We recognize that we may need to waive certain of the RHC Program rules that we extend to the Pilot Program in order to implement the Pilot Program, and we therefore also request that applicants identify in their application, as applicable, any Commission rules that we extend to the Pilot Program in this Report and Order from which they may need a waiver in order to participate in the Pilot Program, if selected.[187]

70. We have taken into consideration commenters' suggestions regarding the application criteria[188] and have determined that the criteria outlined above will provide us with meaningful information with which we can select pilot projects. We acknowledge that certain commenters suggest other evaluation factors, but we believe that each of the factors listed above best enables us to select high quality projects that will best meet the Pilot Program goals, and also target Pilot Program funding towards specific geographic areas or patient populations where there is the greatest need for USF support for the types of connected care services that will be offered through the Pilot Program. Further, each of these criteria plays an important part in helping us better understand the relationship of affordable patient broadband Internet access service to the impact of connected care on patient health outcomes and to the availability of quality health care in certain areas where there are more widely-recognized health disparities.[189] While we understand the desire by some commenters to keep the initial application as streamlined as possible,[190] in order to evaluate the proposed pilot projects and select well-defined,

[185] The *Connected Care Notice* sought comment on whether providing USF funding to health care providers to provide connected care services to their patients raised issues under the Anti-Kick Back Statute, or the Civil Monetary Penalties Laws. *Connected Care Notice*, 34 FCC Rcd at 5631, para. 27.

[186] In the event that after we select pilot projects, new federal funding sources become available for the services or network equipment that is funded through the Pilot Program, pilot projects cannot receive duplicate funding for those exact same items. If such new federal funding sources become available, pilot projects will need to decide whether to continue receiving funding for the eligible services or equipment through the Pilot Program, or to instead receive the funding for these items through any such new federal sources.

[187] 47 CFR § 1.3 provides that "[a]ny provision of the rules may be waived by the Commission on its own motion or on petition if good cause therefor is shown." Waiver of the Commission's rules is therefore appropriate only if special circumstances warrant a deviation from the general rule, and such deviation will serve the public interest. *Northeast Cellular Telephone Co. v. FCC*, 897 F.2d 1164, 1166 (D.C. Cir. 1990).

[188] *See, e.g.*, Hathaway-Sycamore Comments at 1 (indicating that the use of HRSA designations promotes continuity of standard definitions across federal programs, minimizes confusion, and focuses distribution of funding to the areas in most need); HIMSS Comments at 2 (recommending, among other things, that the Commission require applicants to include plans for long-term sustainability, commitments from community partners, and documentation of commitment from all health care payer(s) and/or insurers who cover the population likely to receive telehealth services of their willingness to reimburse for telehealth services); LHN Comments at 15 (asserting that any application should state how the proposal will further the goals of the Pilot Program); OCHIN Comments at 4 (recommending to look at the ability of the pilot project design to determine how many patients are reached, and what, if any, improvements in patient outcomes are achieved); PATH Comments at 3-4 (generally supporting the Commission's criteria for Pilot Program applications as proposed in the *Connected Care Notice*); UHG Comments at 4 (supporting the proposal that applicants should describe the federal and state privacy standards that will be applied, and that applicants should address how patients will transition to continued care when the program ends).

[189] *See Connected Care Notice*, 34 FCC Rcd at 5621, para. 2; OCHIN Comments at 5 (stating that evaluation of a project should not be based on whether a project would support primarily rural patients, but the goal instead should be maximizing the population health tools to understand where the greatest need remains, and what services require extension into underserved communities that can be served by the Pilot Program).

[190] *See, e.g.*, Mercy Virtual Comments at 15-16 ("The Commission proposes a detailed application process that may deter applicants from participating in the pilot program."); Mercy Virtual Reply Comments at 5-6 (limiting the

(continued….)

sustainable projects, it is incumbent upon us to require certain information at the application stage.[191] Applicants therefore should do their best to provide the requested information in the application, including information on estimated costs. To promote transparency, applications for the Pilot Program must be submitted through the Commission's Electronic Comment Filing System (ECFS) under **WC Docket No. 18-213**. Applications for the Pilot Program will be due 45 days from the effective date of the Pilot Program rules or 120 days from the release of this Report and Order , whichever is later. The Bureau will issue a public notice announcing the effective date of the Pilot Program rules and the deadline for submitting applications. Interested parties may not submit applications for the Pilot Program prior to the effective date of the Pilot Program rules.

71. *Instructions for Filing Applications*. In order to facilitate the application process, we plan to provide an application form titled "Connected Care Pilot Program Application" that applicants must use when submitting their project proposals to the Commission. As indicated above, Pilot Program applications will be due 45 days from the effective date of the Pilot Program rules or 120 days from the release date of this Report and Order, whichever comes later. Applicants will be required to complete each section of the application and make the required certifications at the end of the application. Applicants may request that any materials or information submitted to the Commission in its application be withheld from public inspection pursuant to the procedures set forth in section 0.459 of the Commission's rules.[192] Applications must reference **WC Docket No. 18-213** only, and may be filed using the Commission's Electronic Comment Filing System (ECFS), *see Electronic Filing of Documents in Rulemaking Proceedings*, 63 FR 24121 (1998). Applications may be filed electronically using the Internet by accessing the ECFS: https://www.fcc.gov/ecfs. All filings must be addressed to the Commission's Secretary, Office of the Secretary, Federal Communications Commission. Applicants must also send a courtesy copy of their application via email to ConnCarePltProg@fcc.gov. For questions, please contact (1) Rashann Duvall at (202) 418-1438, Rashann.Duvall@fcc.gov or (2) Hayley Steffen at (202) 418-1586, Hayley.Steffen@fcc.gov.

72. *Evaluation of Proposals and Selection of Pilot Projects*. We plan to evaluate the applications and select pilot project proposals based on applicants' responses to the criteria listed above.[193] We will also consider the cost of the proposed pilot project compared to the total Pilot Program budget. This does not mean we will evaluate proposed pilot projects based solely on a proposed pilot project's total budget, but we will seek to select an array of pilot projects that can all be funded within the Pilot Program's budget.[194]

73. In choosing participants for the Pilot Program, we will also consider whether the applicant has successfully developed, coordinated, or otherwise implemented a telehealth program. While we will consider applicants' responses to all of the application criteria factors listed above when evaluating pilot project proposals, they are not determinative of whether a pilot project will be selected

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administrative costs and burden for potential Pilot Program participants will increase participation in the application stage and maximize the Pilot Program's funding for patient care); AHA Comments at 11-12 (stating that health care providers are less likely to participate in the Pilot Program if the application process is unduly complex or restrictive).

[191] For ease of review, to the extent possible, the Commission will attempt to group applications with similar characteristics together to review against each other. *See* AHA Comments at 13.

[192] *See supra* note 174; 47 CFR § 0.459

[193] *See supra* para. 68.

[194] *See supra* paras. 41-42 (establishing a budget of up to $100 million for the Pilot Program); *Connected Care Notice*, 34 FCC Rcd at 5645-46, para. 56. *See also* APTA Comments at 4 (recommending that the Commission not look merely to the cost of a pilot project and the conditions it treats, but also whether the pilot project will use telehealth in innovative, new ways).

because we recognize that each pilot project proposal will have its own unique strengths and potential challenges. However, our goal is to select pilot projects that present a well-defined plan for meeting the health care needs of participating patients, with a particular emphasis on eligible low-income and veteran patients and the Pilot Program goals.

74. We direct the Bureau to establish an application schedule consistent with the direction provided in this Report and Order, to review the applications, to consult with the FCC's Office of Economics and Analytics, Office of Managing Director, Office of General Counsel, and the FCC Connect2Health Task Force, as needed, and to recommend pilot project selections to the Commission. To the extent possible in reviewing applications, we also encourage the Bureau to consult with federal agencies with expertise in telehealth or the federally designated Telehealth Resource Centers. After the Commission selects the pilot projects to participate in the Pilot Program, the Bureau will announce the selected pilot projects. After the selection of pilot projects, additional specifics will also be provided concerning the requirements outlined in this Report and Order, including additional instructions and procedural information regarding, requests for funding, invoicing, and the specific data to be reported and reporting format.

5. Administrative Matters

75. *Procurement of Supported Services*. Once selected to participate in the Pilot Program, and prior to requesting funding as described below,[195] health care providers participating in the Pilot Program will be required to conduct a procurement process to solicit and select eligible services and/or equipment. The Commission has traditionally required RHC Program participants to seek competitive bids for the services for which they seek support as a measure to ensure that rural health care providers are aware of cost-effective alternatives, and to ensure that the universal service fund is used wisely and efficiently.[196] However, under the RHC Program, applicants are exempt from seeking competitive bids under certain circumstances.[197] We will adopt, to the extent feasible, the competitive bidding requirements for the Healthcare Connect Fund Program for participants in the Pilot Program.[198] Specifically, health care providers can seek bids for multi-year or single-year contracts during the competitive bidding process. If a health care provider only seeks bids for a single-year contract, it will need to conduct a new competitive bidding process for each year of the Pilot Program. The competitive bidding requirements for the Pilot Program are in addition to and do not supplant any applicable state or local procurement requirements.

76. Similar to the competitive bidding exemptions provided under the Healthcare Connect Fund Program, eligible health care providers participating in the Pilot Program will not be required to seek competitive bids if:

- The eligible health care provider seeks support for services and equipment purchased from Master Services Agreements (MSAs) negotiated by federal, state, Tribal, or local government entities on behalf of such health care providers and others, if such MSAs were awarded pursuant to applicable federal, state, Tribal, or local competitive bidding requirements;[199]

[195] *See infra* para. 77.

[196] *See Universal Service First Report and Order*, 12 FCC Rcd at 9134, para. 688.

[197] *See* 47 CFR § 54.622(i).

[198] *See* 47 CFR § 54.622, § 54.609, § 54.610. A number of commenters support requiring competitive bidding for the Pilot Program. *See, e.g.*, VTN Comments at 10; MUSC Comments at 10-11; ACA Connects Comments at 4-5; MCN Comments at 8. However, other commenters advocated against requiring competitive bidding for the Pilot Program. *See, e.g.*, APTA Comments at 5. As explained above, sound policy supports extending the competitive bidding requirements for the RHC Program to the Pilot Program to the extent feasible.

[199] *See* 47 CFR § 54.622(i)(1).

- The eligible health care provider opts into an existing MSA approved under the Rural Health Care Pilot Program or Healthcare Connect Fund Program and seeks support for services and equipment purchased from the MSA, if the MSA was developed and negotiated in response to an RFP that specifically solicited proposals that included a mechanism for adding additional sites to the MSA;[200]
- The eligible health care provider has a multi-year contract designated as "evergreen" by USAC and seeks to exercise a voluntary option to extend an evergreen contract without undergoing additional competitive bidding;[201]
- The eligible health care provider is in a consortium with participants in the schools and libraries universal service support program (E-Rate program) and a party to the consortium's existing contract, if the contract was approved in the E-Rate program as a master contract;[202]
- The eligible health care provider seeks support for $10,000 or less of total undiscounted eligible expenses for a single year, if the term of the contract is one year or less;[203] or
- The eligible health care provider already has entered into a legally binding agreement with a service provider for services or equipment eligible for support in the Pilot Program and that legally binding agreement itself was the product of competitive bidding.[204]

In the absence of an applicable exemption, applicants will have to seek competitive bids for services and equipment that are eligible for support through the Pilot Program. Applicants will be required to follow the RHC Program's competitive bidding requirements, which include submitting a Request for Services and Request for Proposal (RFP) (as applicable) for USAC to post on its website, seeking bids,[205] waiting 28 days before selecting a service provider,[206] conducting a bid evaluation to select a service provider,[207] and then selecting the most-cost effective service.[208] All potential bidders must have access to the same information and be treated in the same manner during the competitive bidding period to ensure that the process is "fair and open."[209] Gifts from service providers will also be prohibited.[210] We find that adopting these competitive bidding rules and procedures for the Pilot Program will enable health care providers operating under certain existing contracts to be exempt from the competitive bidding

[200] *See* 47 CFR § 54.622(i)(2).

[201] *See* 47 CFR § 54.622(i)(3)(i)-(iii).

[202] See 47 CFR § 54.622(i)(4).

[203] *See* 47 CFR § 54.622(i)(5).

[204] We include this additional exemption because we recognize that many Pilot Program applicants may already have established competitively bid contracts with service providers for broadband Internet access, other information services, or network equipment for the provision of connected care services. *See Wireline Competition Bureau Announces Application Deadline for the E-Rate Deployed Ubiquitously (EDU2011) Pilot Program*, Public Notice, 25 FCC Rcd 15834, 15837-38 (WCB 2010) (waiving the E-rate program competitive bidding requirements, to the extent necessary, for EDU2011 Pilot Program applicants that have already entered into legally-binding agreements with service providers for the off-premises connectivity for portable wireless devices).

[205] 47 CFR § 54.622(e).

[206] 47 CFR § 54.622(g).

[207] 47 CFR § 54.622(d)

[208] 47 CFR § 54.622(c).

[209] 47 CFR § 54.622(b).

[210] 47 CFR § 54.622(h).

requirements, while allowing all participating health care providers the ability to procure services for the Pilot Program by seeking bids. We further find that these rules and procedures ensure that the Commission is acting as a good steward of the USF by using scarce funding wisely and efficiently.

77. *Requesting Funding, Invoicing, Disbursements, and Material Changes.* Once selected, Pilot Program participants will be required to submit a Request for Funding to USAC no later than six months after the selection date with specific pricing and service information for the funding they are requesting through the Pilot Program.[211] Participating health care providers with multi-year contracts may submit a single funding request for the full period covered by the contract. For example, if a participating health care provider enters into a three-year contract for Pilot-Program supported services, that health care provider can submit a single funding request for the full three years of the Pilot Program. However, if a participating health care provider elects to enter into a one-year contract, it will have to submit a new funding request for each subsequent year of Pilot Program funding. USAC will review the funding requests and issue funding commitment letters to the participating health care providers and service providers indicating the amount committed under the Pilot Program for the selected pilot project. Given that Pilot Program funding will be collected over a multiple year period, while participating health care providers with multi-year contracts can submit a single funding request covering the contract period, we anticipate that USAC will issue funding commitments for one year at a time rather than for multiple years.

78. Selected pilot projects will be required to report to the Commission any material change in the participating health care providers' or pilot projects' status (e.g., health care provider site has closed, or pilot project has ceased operations) within 30 days of such material change in status. In instances where a selected Pilot Program participant is unable to participate in the Pilot Program for the three-year period due to extenuating circumstances, a successor may be designated by the Bureau. We expect that pilot projects may experience decreases in the number of participating patients. To facilitate the tracking and monitoring of the Pilot Program budget and guard against potential waste, fraud and abuse, selected pilot projects must notify USAC within 30 days of any decrease of 5% or more in the number of patients participating in their respective pilot project.

79. After providing the eligible services and/or equipment, service providers, in conjunction with the participating health care providers, will be required to make certain certifications and then submit invoicing forms (Request for Disbursement) on a monthly basis[212] and supporting documentation to USAC to receive reimbursement for the cost of the eligible services and/or equipment they have provided to participating health care providers under the Pilot Program. USAC will review the monthly invoicing forms and supporting documentation and issue disbursements to the applicable service providers or vendors,[213] whether a broadband service provider, or other provider.[214] Pilot Program participants will

[211] *See supra* paras. 75-76 (discussing the procurement requirements for Pilot Program participants); 47 CFR § 54.623, § 54.625.

[212] Monthly invoice submissions are an important safeguard that will help the Commission ensure that the selected pilot projects are continuing to proceed and will also allow USAC and the Commission to monitor expenditures in order to ensure compliance with the Pilot Program requirements and prevent waste, fraud, and abuse.

[213] In order to receive disbursements, service providers or vendors providing services or equipment as part of the Pilot Program must obtain a 498 ID (formerly known as the Service Provider Identification Number) from USAC. Additional information on the FCC Form 498 ID and process for obtaining a FCC Form 498 are available on USAC's website at the following links: https://www.usac.org/rural-health-care/service-providers/fcc-form-498/, https://www.usac.org/service-providers/participating-in-a-usf-program/register-for-a-498-id/.

[214] We acknowledge that certain commenters request that disbursements be provided directly to the health care provider rather than to the broadband service provider. *See, e.g.*, VTN Comments at 8; Verizon Comments at 5, ACA Connects Reply Comments at 3; CL Reply Comments at 3. However, we conclude that using the same reimbursement structure as the Healthcare Connect Fund Program for the Pilot Program makes the most administrative sense because it will allow us to use existing invoicing systems, processes, and procedures. Given (continued….)

also be required to make certifications as part of the form submissions to USAC to ensure that Pilot Program funds are used for their intended purpose and to ensure that all participating health care providers and service providers are in compliance with the Commission's rules and procedures.[215]

80. *Data Reporting, Document Retention, and Audits.* We direct the Bureau to issue a report detailing the results of the Pilot Program after it has been completed. To assist with this report, we will require participating health care providers to submit periodically anonymized, aggregated data to the Bureau regarding their pilot project to the Bureau after each year of funding for that pilot project.[216] The *Connected Care Notice* provided examples of the types of metrics that the Commission is contemplating for pilot projects, including: reductions in emergency room or urgent care visits in a particular geographic area or among a certain class of patients; decreases in hospital admissions or re-admissions for a certain patient group; condition-specific outcomes such as reductions in premature births or acute incidents among sufferers of a chronic illness; and patient satisfaction as to health status.[217] However, the scope of the pilot project proposals is unknown at this time, and some metrics may not be applicable to all of the selected pilot projects.

81. Accordingly, we will determine the specific data to be reported by pilot projects and format of the required data after review of the pilot project proposals.[218] Participating health care providers will also be required to submit final reports within six months of the end dates of their pilot projects summarizing the final results, and explaining whether the pilot projects met their stated goals and the goals of the Pilot Program. These data will assist the Commission in determining whether and how universal service funds can efficiently and effectively be used for connected care, and track progress towards meeting the Pilot Program goals. Also, these data will enable the Commission to ensure that universal service funds are being used in a manner consistent with section 254, the Commission's rules and procedures, and the goals of the Pilot Program. The collection of these data is also essential to ensuring that support provided under the Pilot Program is being used for its intended purpose. In accordance with section 54.631 of the Commission's rules, health care providers and selected participants, in addition to maintaining records related to their pilot projects to demonstrate their compliance with the Pilot Program rules and requirements, must also keep supporting documentation for these reports for at least five years after the conclusion of their pilot project and must present that information to the Commission or USAC upon request.[219] Consistent with section 54.631 of the Commission's rules, pilot projects will also be subject to random compliance audits to ensure compliance with the Pilot Program rules and requirements.[220]

82. *USAC Outreach.* After announcement of the selected Pilot Program projects, each selected pilot project will be required to provide to USAC, within 14 calendar days of such announcement, the name, mailing address, e-mail address, and telephone number of the lead project

(Continued from previous page)
the limited duration of the Pilot Program, it would be impractical to expend limited resources developing an entirely new invoicing system, processes and procedures solely for the Pilot Program.

[215] *See generally Connected Care Notice*, 34 FCC Rcd at 5649-56, paras. 63-77. While we provide a general outline of the application, invoicing, and disbursement process and Pilot Program requirements in this Report and Order, once pilot projects have been selected, we will provide more specific details regarding such processes and requirements as part of a subsequent notice or order.

[216] The Commission reserves the right to direct USAC to withhold disbursements if a pilot project fails to submit the required data.

[217] *Connected Care Notice*, 34 FCC Rcd at 5660, para. 89.

[218] The specific data sought and format will be provided in a subsequent order or notice.

[219] *See* 47 CFR § 54.631.

[220] *See id.*

coordinator for its pilot project. Within 30 days of the effective date of the announcement, USAC shall conduct an initial coordination meeting with selected Pilot Program participants. USAC shall will further conduct a targeted outreach program, such as a webinar or similar outreach, to educate and inform selected participants on the Pilot Program administrative process, including various filing requirements and deadlines, in order to minimize the possibility of selected participants making inadvertent errors in completing the required forms. We expect that these outreach and educational efforts will assist selected participants in meeting the Pilot Program's requirements. Further, we believe such an outreach program will increase awareness of the filing rules and procedures and will improve the overall efficacy of the Pilot Program. We also encourage selected participants to contact USAC with any questions prior to filing their forms or supporting documentation. The direction we provide USAC will not lessen or preclude any of its review procedures. We retain our commitment to detecting and deterring potential instances of waste, fraud, and abuse by ensuring that USAC scrutinizes Pilot Program submissions and takes steps to educate selected participants in a manner that fosters appropriate Pilot Program participation.

6. Pilot Program Goals and Metrics

83. We adopt three explicit goals for the Pilot Program to determine how USF support provided to health care providers for the costs associated with providing connected care services can enable them to: (1) improve health outcomes through connected care; (2) reduce health care costs for patients, facilities and the health care system; and (3) support the trend towards connected care everywhere.[221] The goals we adopt for this Pilot Program are sound and measurable goals, and will help advance the Commission's statutory obligation to promote universal service by providing the Commission with information that will help inform it about how to best allocate limited universal service funding.[222]

84. *Goals.* We adopt as our first goal determining how universal service support can help health care providers improve health outcomes through connected care.[223] This goal implements the statutory directive under the Act to "enhance access to advanced telecommunications and information services" for all public and nonprofit health care providers.[224] Broadband connectivity necessary to

[221] The record indicates widespread support for these goals. *See, e.g.*, APTA Comments at 5; CHI Comments at 1, 5; CoBank Comments at 7; ConnectME Comments at 3; LHN Comments at 19; myNexus Comments at 17; Multistakeholders Comments at 1; MUSC Comments at 9-12; Colorado Comments at 8-12; UCSD Comments at 2; VTN Comments at 4-5. While the *Connected Care Notice* proposed a fourth goal, "determining how USF funding can positively impact existing telehealth initiatives," we believe this goal is encompassed by the other three goals and does not need to be a separate goal. *See Connected Care Notice*, 34 FCC Rcd at 5659-60, paras. 86-87.

[222] *See* 47 U.S.C. § 254(h)(2)(A) (directing the Commission to establish rules to enhance access to advanced telecommunications and information services for health care providers); 47 U.S.C. § 254(b)(3) (providing that "[c]onsumers in all regions of the Nation, including low-income consumers and those in rural, insular, and high cost areas, should have access to advanced telecommunications and information services . . . that are reasonably comparable to those services provided in urban areas and that are available at rates that are reasonably comparable to rates charged for similar services in urban areas.").

[223] This goal is supported by the record. *See, e.g.*, VTN Comments at 1 (stating that connected care holds significant promise to improve clinical outcomes for this nation's most vulnerable individuals as well as health care providers that serve them); AAFP Comments at 1 (stating that it "firmly believes that telehealth technologies can enhance patient-physician collaborations, increase access to care, [and] improve health outcomes by enabling timely care interventions"); TruConnect Comments at 11 (stating that the "use of telehealth applications on smartphones and devices helps improve the health and wellness for people who use them[,]" especially "rural patients who typically must travel great distances to obtain care"); ASTHO Comments at 6 (supporting this goal and stating that AANP Comments at 3 (supporting the goal to improve health outcomes through connected care and stating that providing residents of rural and underserved areas with access telehealth may significantly improve health outcomes).

[224] *See* 47 U.S.C. § 254(h)(2)(A).

support telehealth and connected care service is critical to improving the quality of care provided by health care providers and access to necessary medical care by patients in America.[225] Broadband access for telehealth purposes not only increases the likelihood that patients will seek out medical care and follow a prescribed course of treatment,[226] but also can reduce emergency room visits and hospital admissions and readmissions,[227] and lead to increased contact with specialists.[228] Broadband connectivity also enables the efficient exchange of patient and treatment information, reduces geographical barriers to receiving medical care, and provides an avenue for patients who cannot afford or lack sufficient broadband Internet access connectivity to receive the health benefits achieved through connected care services. While the existing RHC Program supports health care providers' access to communications technologies, it is not primarily focused on connected care services delivered directly patients at their homes or mobile locations. We therefore establish this Pilot Program with a primary focus on connected care services to examine how the Universal Service Fund could play a part in increasing access to connected care services so that all Americans can realize the benefits of these services.

85. We adopt as our second goal examining whether and how universal service support can be used to enable eligible health care providers to reduce health care costs for patients, facilities, and

[225] *See supra* paras. 3-4, 10-11. *See also* VTN Comments at 4 (indicating that the University of Virginia Health Systems Connected Care Diabetes Program has improved patient engagement and outcomes for diabetic patients with elevated hemoglobin A1c levels); CoBank Comments at 3-4 (reporting improvements in outcomes for patients with chronic conditions who received connected care services); CHRISTUS Comments at 2-3 (reporting improvements in outcomes for patients with chronic conditions who received connected care services); UMMC Comments at 1 ("A consistently growing body of evidence demonstrates that connected health technologies improve patient care, reduce hospitalizations, help avoid complications, and improve patient engagement, particularly for the chronically ill."); AAFP Comments at 1 ("The AAFP firmly believes that telehealth technologies can enhance patient-physician collaborations, increase access to care, improve health outcomes by enabling timely care interventions, and decrease costs when utilized as a component of, and coordinated with, longitudinal care."); AH Comments at 1 ("[T]he delivery of quality care is increasingly inextricable from internet access . . . ."); AHIP Comments at 1-2 (stating "[t]elehealth has become essential in serving low-income, rural, and underserved communities" and explaining that the improved affordability and access that telehealth brings are not possible without access to broadband.); CHI Comments at 6 ("A well-established (and growing) body of use cases and evidence demonstrate how the wide array of connected health technologies available today improve patient care, reduce hospitalizations, help avoid complications, and improve patient engagement, particularly for the chronically ill.").

[226] OCHIN Comments at 5 (stating that many low-income patients without regular access to primary care may forgo care until it is dire, but "[w]hen these individuals have regular contact with a provider and can utilize telehealth services, they receive more timely care, and can better manage their health."); ASTHO Comments at 6 (explaining that its telehealth efforts in Macon, Georgia "increased access and adherence to care."); MUSC Comments at 12 ("Low income patients that are able to participate in fully supported [telehealth] programs see the most improved health outcomes and are more likely to participate[,]" and "patients seem to test more frequently when they know a provider is looking at their day-to-day results.").

[227] *See, e.g.*, VTN Comments at 4 (stating that VTN's experience confirms the benefits of connected care, including reduced hospital readmission rates); CHRISTUS Comments at 2 (stating that CHRISTUS Health's remote patient monitoring program for patients with chronic heart disease and diabetes reduced hospital readmission rates for the identified patient population by 24%); Mercy Virtual Comments at 5 (stating that Mercy Virtual's vEngagement Program, which provides remote patient monitoring, lowered hospitalizations by 50%); UVAHealth Reply Comments at 3 (stating that UVA's heart failure remote monitoring and care coordination programs for high risk patients "reduced 30 day readmission rates by 82 percent and ER visits by 77 percent").

[228] *See* AUA Comments at 3 ("Telehealth expands the geographic reach of specialists and other providers, efficiently leveraging workforce capacities to connect patients to high-quality care, expand access, and improve population health."); CPCA Reply Comments at 1 (explaining that telehealth services are particularly critical in rural areas "where many residents can face long distances between their home and health care facilities. These distances are greatest for specialized providers including cardiologists, neurologists, and orthopedics.").

health care systems by increasing access to connected care services provided directly to patients at their homes or mobile locations. Based on the record, connected care services greatly reduce travel time for patients, significantly reducing out-of-pocket costs, in addition to reducing the need to miss work or school to see a health care provider.[229] Additionally, the record shows that the reduction in travel times lowers costs for physicians and health care providers.[230] For example, Banner Health's Ambulatory Care Program provides patients with Bluetooth-enabled remote patient monitoring tools along with a tablet for video visits, which resulted in a 34.5 % reduction of overall costs.[231] We also believe that improvements in health outcomes through connected care can yield significant cost savings.[232] Thus, by using USF support for this purpose, we expect that the Pilot Program will collect data that will help identify circumstances in which support for telehealth services could create savings for patients, health care providers and health care systems, including the Medicaid program and the VA.[233]

86. We adopt as our third goal supporting and furthering the trend toward bringing connected care services directly to more consumers.[234] While the RHC Program has played a key role in supporting health care providers' access to communications technologies, there is a trend away from relying on connectivity solely within and between physical health care facilities and towards a "connected care everywhere" model—a trend that has shown promising results for patients, communities, and the health care system.[235] We believe that making Universal Service Fund dollars available to support the broadband connectivity and information service and network equipment costs associated with providing connected care services will promote access to health care services, particularly for low-income and veteran patients, outside of the confines of brick-and-mortar medical facilities. In establishing this Pilot Program, we have the opportunity to support the trend towards greater use of connected care for treating health conditions and evaluate the success of the Pilot Program based in part on how it furthers this trend.[236]

7. Legal Authority

87. We find that section 254(h)(2)(A) of the 1996 Act authorizes us to establish this Pilot Program to help defray health care provider's eligible costs of providing connected care services to low-income or veteran patients.[237] Specifically, section 254(h)(2)(A) directs the Commission to "establish

[229] *See* AEH Comments at 3 (indicating that racial minorities, older adults, rural residents, and those with lower levels of education and income may greatly benefit from improving access to medical care without having to travel or take time off work); AHIP Comments at 1 (indicating that telehealth can save consumers time and money by decreasing travel to and from doctors' appointments and time away from work).

[230] *See, e.g.*, HLC Comments at 1 ("HLC members have seen firsthand the value of innovative connected health technologies, such as telehealth and remote patient monitoring, to reduce healthcare costs and improve health outcomes for various acute and chronic health conditions by making it easier for providers to treat patients and through improved care coordination and continuity of care."); MUSC Comments at 12 (indicating that its remote patient monitoring program resulted in savings in time and effort for both patient and provider); CCHP Comments at 1 ("Many studies show telehealth's utility to improved health outcomes and reduce health care costs . . . .").

[231] *See* AHA Comments at 6.

[232] *See supra* paras. 10-11.

[233] *Id.*

[234] *Connected Care Notice*, 34 FCC Rcd at 5658-59, paras. 84-85; APTA Comments at 5; CHI Comments at 1, 5; LHN Comments at 19; myNEXUS Comments at 17; MUSC Comments at 9; PATH Comments at 1; VTN Comments at 4-5; ConnectME Comments at 3; Colorado Comments at 14-15; CoBank Comments at 7.

[235] *See supra* paras. 10-11; *Connected Care Notice of Inquiry*, 33 FCC Rcd at 7832, para. 21.

[236] *See* ConnectME Comments at 6-7; Colorado Comments at 14; UCSD Comments at 2; VTN Comments at 3-4.

[237] 47 U.S.C. § 254(h)(2)(A). In 2006, the Commission relied on section 254(h)(2)(A) to establish the RHC Pilot Program to support the construction of state or regional broadband networks and services provided over those

(continued….)

competitively neutral rules[ ] to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for all public and nonprofit . . . health care providers."[238] As explained above, the Pilot Program will fund broadband connectivity for participating health care providers and patients, certain network equipment, and other information services that may facilitate the provision of connected care services provided through the Pilot Program. These connected care services may be defined as either telecommunications services or information services.

88. For the Pilot Program, funding patient broadband Internet access services would expand health care providers' digital footprints for purposes of providing connected care services and allow health care providers to serve more eligible low-income patients and veterans through the Pilot Program and, thus, enhance health care providers' access to "advanced telecommunications and information services." Accordingly, funding health care provider purchase of broadband Internet access service for participating patients through this discrete, limited duration Pilot Program falls within the scope of section 254(h)(2)(A) of the Act.[239] Relying on this statutory provision also ensures that the Pilot Program is health care provider-driven and enables participating health care providers to select from the broadest range of broadband Internet access service providers to meet the health care needs of participating patients.[240]

89. First, the Pilot Program will be "competitively neutral," which means that "universal service support mechanisms and rules neither unfairly advantage nor disadvantage one provider over another, and neither unfairly favor nor disfavor one technology over another."[241] The Pilot Program satisfies this requirement because eligible health care providers are free to choose any broadband connectivity technology and broadband connectivity provider, in compliance with the applicable competitive bidding requirements for the Pilot Program-supported services needed to provide connected care services through their respective pilot projects.[242] In addition, participating health care providers are not required to adopt any specific non-broadband information service to provide broadband-enabled connected care services through the Pilot Program. Second, the Pilot Program will be "technically feasible" because the Pilot Program will not require the development of any new technology and gives participating health care providers flexibility to use any available technology to implement their

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networks. *See RHC Pilot Program Order,* 21 FCC Rcd at 11111, 11114-15, paras. 1, 10-12. The record in this proceeding also supports the Commission's reliance on section 254(h)(2)(A) to establish this Pilot Program. *See, e.g.*, VTN Comments at 16; MCN Comments at 10; ConnectME Comments at 13; *see also Connected Care Notice*, 34 FCC Rcd at 5664, para. 106 & n.206 (citing to comments advocating for relying on section 254(h)(2)(A) to establish the Pilot Program).

[238] 47 U.S.C. § 254(h)(2)(A).

[239] 47 U.S.C. § 254(h)(2)(A) (directing the Commission to establish competitively neutral rules "to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for all public and nonprofit elementary and secondary school classrooms, health care providers, and libraries….").

[240] As explained above, section 254(h)(2)(A) does not limit the provision of USF support to eligible telecommunications carriers (ETCs). *See* 47 U.S.C. § 254(h)(2)(A); *supra* para. 54.

[241] *See RHC Pilot Program Order*, 21 FCC Rcd at 11115, para. 12; *Universal Service First Report and Order*, 12 FCC Rcd at 8801, para. 47.

[242] *See RHC Pilot Program Order,* 21 FCC Rcd at 11114, para. 11 (concluding that the RHC Pilot Program was competitively neutral because "eligible health care providers are free to choose any technology and provider of the broadband connectivity needed to provide telehealth, including telemedicine, services.").

respective pilot projects.[243] Third, the Pilot Program will be "economically reasonable." In discussing economic reasonableness, the Commission has generally focused on the effect that any new rules would have on growth in the universal service support mechanisms.[244] As explained above, we establish a budget separate from the existing universal service programs and limit the Pilot Program budget to at most $100 million, which provides a reasonable cap and will not significantly increase the contributions burden on consumers.[245] Additionally, we have developed measures to promote the fiscally responsible use of Pilot Program funds, including requiring that evaluations of pilot project proposals include a comparison of the estimated costs of each proposed pilot project to the total Pilot Program budget.[246]

90. We recognize that the Commission has not previously relied on section 254(h)(2)(A) of the Act to specifically defray eligible health care provider costs of providing connected care services by supporting broadband connections for patient use or other information services necessary to provide connected care services. The Commission previously concluded, however, that it has "broad discretion regarding how to fulfill this statutory mandate" under section 254(h)(2)(A).[247] We believe establishing this limited Pilot Program for this purpose is consistent with that discretion. Advances in information technologies and services are allowing health care providers to expand their digital footprint by using broadband and broadband enabled devices to provide connected care services to patients in their homes or mobile locations,[248] and there is growing evidence of the benefits of connected care services both for health care providers and their patients.[249] Further, the record indicates that the costs of broadband Internet access service for patient use in their homes or mobile locations, and the costs of other information services necessary to provide connected care services, are an obstacle for certain health care providers and their patients to adopt connected care services.[250] Because of the growing evidence of the benefits of providing connected care services for both health care providers and their patients, and the fact that many health care providers and patients have yet to adopt these services, we believe that it is appropriate for us to establish this Pilot Program to examine whether and how universal service can play a role in helping all Americans access and obtain the benefits of connected care services. We thus believe that the specific services and network equipment funded under this Pilot Program are within the scope of our statutory directive under section 254(h)(2)(A) to enhance eligible health care providers' access to advanced telecommunications and information services.[251]

91. While we rely on our authority under section 254(h)(2)(A) to establish the Pilot Program, the Pilot Program is also consistent with the directive that the Commission base policies for the

[243] *See id.* (concluding that RHC Pilot Program satisfied the "technically feasible" requirement because it did not "require the development of any new technology[, but r]ather, participants [were] free to utilize any currently available technology.").

[244] *Id.*; *Universal Service First Report and Order*, 12 FCC Rcd at 9160, para 748 (finding that "the limits on the number of hours and dollar cap per provider create economically reasonable mechanisms").

[245] *See supra* paras. 41-42.

[246] *See supra* para. 72.

[247] *See Healthcare Connect Fund Order*, 27 FCC Rcd at 16700-701, para. 49.

[248] *See supra* paras. 3-4, 10-11. For example, the Virginia Telehealth Network states that this nation's most vulnerable patient populations—particularly low-income individuals and the elderly, but also veterans and rural communities—often lack access to the broadband connectivity necessary to benefit from such connected care services. VTN Comments at 6. We believe that such funding would provide the health care providers participating in the Pilot Program with the resources necessary to reach more of these patient populations.

[249] *See supra* paras. 3-4, 10-11, note 23.

[250] *See supra* paras. 12, 56-58.

[251] *See* 47 U.S.C. § 254(h)(2)(A).

advancement of universal service on the principles outlined in section 254(b) of the Act.[252] Specifically, section 254(b)(2) provides that "[a]ccess to advanced telecommunications and information services should be provided in all regions of the Nation" and section 254(b)(3) provides that "[c]onsumers in all regions of the Nation, including low-income consumers and those in rural, insular, and high cost areas, should have access to telecommunications and information services, including interexchange services and advanced telecommunications and information services, that are reasonably comparable to those services provided in urban areas and that are available at rates that are reasonably comparable to rates charged for similar services in urban areas."[253] As explained above, the Pilot Program will fund eligible health care provider purchases of broadband Internet access services for participating patients to use for purposes of connected care services.

IV. PROCEDURAL MATTERS

92. *Final Regulatory Flexibility Analysis*. The Regulatory Flexibility Act of 1980, as amended (RFA), requires that an agency prepare a regulatory flexibility analysis for notice and comment rulemakings, unless the agency certifies that "the rule will not, if promulgated, have a significant economic impact on a substantial number of small entities."[254] The Final Regulatory Flexibility Analysis (FRFA) concerning the impact of the requirements contained in the Report and Order is attached as Appendix A.

93. *Paperwork Reduction Act Analysis*. This document contains new information collection requirements subject to the Paperwork Reduction Act of 1995 (PRA), Public Law 104-13. The information collection requirements related to the COVID-19 Telehealth Program will be submitted to the Office of Management and Budget (OMB) for review and emergency processing pursuant to the PRA, 44 U.S.C. § 3507(j). The information collection requirements related to the Pilot Program will also be submitted to OMB for review under Section 3507(d) of the PRA. OMB, the general public, and other federal agencies are invited to comment on the new information collection requirements. Applications for the COVID-19 Telehealth Program will be accepted by the Commission immediately after receipt of OMB approval and publication of this Report and Order in the Federal Register, which will serve as the notice of the effective date of the COVID-19 Telehealth Program rules. Applications to participate in the Pilot Program will be due 45 days from the effective date of the Pilot Program rules or 120 days from the release date of this Report and Order, whichever comes later. In addition, pursuant to the Small Business Paperwork Relief Act of 2002, Public Law 107-198, *see* 44 U.S.C. § 3506(c)(4), we seek specific comment on how we might further reduce the information collection burden for small business concerns with fewer than 25 employees.

94. *Congressional Review Act*. The Commission has determined, and the Administrator of the Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), concurs that the rules implementing the COVID-19 Telehealth Program are "major" and the rules implementing the Connected Care Pilot Program are "non-major" under the Congressional Review Act, 5 U.S.C. § 804(2). Because we find for good cause that notice and public procedure on the rules implementing the COVID-19 Telehealth Program is impracticable, unnecessary, or contrary to the public interest, those portions of the Report and Order related to the COVID-19 Telehealth Program will become effective immediately upon publication in the Federal Register pursuant to 5 U.S.C. § 808(2), except for any

[252] *See generally* 47 U.S.C. § 254(b) ("The Joint Board and the Commission shall base policies for the preservation and advancement of universal service on the following principles…."). In 2012, the Commission previously relied in part on the universal service principles in section 254(b) to establish a limited duration pilot program to explore how USF funding could increase broadband adoption among Lifeline consumers. *See Lifeline Link Up Reform and Modernization*, Report and Order and Further Notice of Proposed Rulemaking, 27 FCC Rcd 6656, 6797, paras. 328-330 (2012).

[253] 47 U.S.C. § 254(b)(1), (b)(3).

[254] 5 U.S.C. §§ 601 *et seq*.

portions containing information collection requirements that have not been approved by OMB. The Commission will send a copy of this Report and Order to Congress and the Government Accountability Office pursuant to 5 U.S.C. § 801(a)(1)(A).

V. ORDERING CLAUSES

95. 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 403, and DIVISION B of the Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No 116-136, 134 Stat. 281, this Report and Order IS ADOPTED and SHALL BECOME EFFECTIVE 30 days after publication of this Report and Order, pursuant to 47 U.S.C. § 408, with the exception of those portions related to the COVID-19 Telehealth Program in the Report and Order which SHALL BECOME EFFECTIVE immediately upon publication in the Federal Register pursuant to 5 U.S.C. § 553(d) and 5 U.S.C. § 808(2) and the portions containing information collection requirements that have not been approved by the Office of Budget and Management (OMB).

96. IT IS FURTHER ORDERED that pursuant to DIVISION B of the Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No 116-136, 134 Stat. 281, and the Paperwork Reduction Act of 1995, 5 CFR § 1320.13, the COVID-19 Telehealth Program information collection requirements SHALL BECOME EFFECTIVE immediately upon publication of this Report and Order and notice of OMB approval of the COVID-19 Telehealth Program rules in the Federal Register.

97. IT IS FURTHER ORDERED that applications to participate in the COVID-19 Telehealth Program SHALL BE FILED after publication of this Report and Order and notice of OMB approval of the COVID-19 Telehealth Program information collection requirements in the Federal Register.

98. IT IS FURTHER ORDERED that, pursuant to the Paperwork Reduction Act of 1995, Section 3507(d), the Connected Care Pilot Program information collection requirements SHALL BECOME EFFECTIVE after announcement in the Federal Register of OMB approval of the Pilot Program rules, and on the effective date announced therein.

99. IT IS FURTHER ORDERED that applications to participate in the Connected Care Pilot Program SHALL BE FILED 45 days from the effective date of the Pilot Program rules or 120 days from the release date of this Report and Order, whichever comes later.

100. IT IS FURTHER ORDERED that the Commission's Consumer and Governmental Affairs Bureau, Reference Information Center, SHALL SEND a copy of this Report and Order, including the Final Regulatory Flexibility Analysis, to the Chief Counsel for Advocacy of the Small Business Administration.

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

FEDERAL COMMUNICATIONS COMMISSION

Marlene H. Dortch
Secretary

APPENDIX A

Final Regulatory Flexibility Analysis

1. As required by the Regulatory Flexibility Act of 1980 (RFA),[1] as amended, the Federal Communications Commission (Commission) included an Initial Regulatory Flexibility Analysis (IRFA) of the possible significant economic impact on a substantial number of small entities by the policies and requirements proposed in the *Promoting Telehealth for Low-Income Consumers Notice* (*Connected Care Notice*) in WC Docket No. 18-213.[2] The Commission sought written public comment on the proposals in the *Connected Care Notice*, including comment on the IRFA. The Commission did not receive any comments in response to the IRFA. This Final Regulatory Flexibility Analysis (FRFA) conforms to the RFA.[3]

A. Need for, and Objectives of, the Report and Order

2. In the Telecommunications Act of 1996 (1996 Act), Congress recognized the value of providing rural health care providers with "an affordable rate for the services necessary for the provision of telemedicine and instruction relating to such services."[4] The 1996 Act mandated that telecommunications carriers provide telecommunications services for health care purposes to rural public or nonprofit health care providers at rates that are "reasonably comparable" to rates in urban areas.[5] The 1996 Act also directed the Commission to establish competitively neutral rules to enhance, to the extent technically feasible and economically reasonable, access to "advanced telecommunications and information services" for public and nonprofit health care providers.[6] Based on this legislative mandate, the Commission established the Rural Health Care (RHC) Program which supports health care providers' access to communications technologies. However, there are developments in telehealth, including increased use of connected care services, that the Commission has not yet fully explored. With remote patient monitoring and mobile health applications that can be accessed on a smartphone or tablet, health care providers now have the technology to deliver quality health care directly to patients, regardless of where they are located. Despite the numerous benefits of connected care services to patients and health care providers alike, patients who cannot afford or who otherwise lack reliable, robust broadband Internet access connectivity, including many low-income Americans and veterans, are not realizing the benefits of these innovative telehealth technologies. Also, the costs necessary to provide connected care services may limit some health care providers' ability to treat low-income Americans and veterans with connected care services.

3. Thus, in August 2018, the Commission released a Notice of Inquiry (*Connected Care Notice of Inquiry* or *Notice of Inquiry* (*NOI*)) seeking information on "how the Commission can help advance and support the movement towards connected care everywhere and improve access to the life-

[1] 5 U.S.C. § 603. The RFA, 5 U.S.C. §§ 601-612, has been amended by the Contract with America Advancement Act of 1996, Public Law No. 104-121, 110 Stat. 847 (1996) (CWAAA). Title II of the CWAAA is the Small Business Regulatory Enforcement Fairness Act of 1996 (SBREFA).

[2] *See Promoting Telehealth for Low-Income Consumers*, WC Docket No. 18-213, Notice of Proposed Rulemaking, 34 FCC Rcd 5620 (2019) (*Connected Care Notice*).

[3] *See* 5 U.S.C. § 604.

[4] Joint Explanatory Statement of the Committee of Conference, 104th Cong., 2d Sess. at 133 (1996). *See also* 47 U.S.C. § 254(b)(3), (h)(1)(A); Telecommunications Act of 1996, Pub. L. No. 104-104, 110 Stat. 56 (1996). The 1996 Act amended the Communications Act of 1934 (Communications Act or Act).

[5] 47 U.S.C. § 254(h)(1)(A).

[6] 47 U.S.C. § 254(h)(2)(A).

saving broadband-enabled telehealth services it makes possible."[7] Subsequently, in July 2019, the Commission adopted a Notice of Proposed Rulemaking (*Connected Care Notice*) that proposed and sought comment on a Pilot Program that would help defray health care provider costs of providing connected care services to low-income Americans and veterans.[8] In the Report and Order, given the benefits of connected care services provided through broadband connections, the Commission takes the important step of establishing a Pilot Program to explore whether and how the Universal Service Fund (USF) can help defray health care providers' qualifying costs of providing connected care services, including low-income Americans and veterans. The ultimate goal of the Pilot Program is to examine how USF support can be used to help health care providers improve health outcomes and reduce health care costs, thereby supporting efforts to advance connected care initiatives. The Commission expects that the Pilot Program will benefit many eligible patients who are responding to a wide variety of health challenges, such as diabetes management, opioid dependency, high-risk pregnancies, pediatric heart disease, mental health conditions, and cancer. The Commission also expects that the Pilot Program will provide meaningful data that will help us better understand how the USF can support health care provider and patient use of connected care services, and how supporting health care provider and patient use of connected care services can improve health outcomes and reduce health care costs. The data and information collected through the Pilot Program could also have the ancillary benefit of aiding policy makers and legislators in the consideration of broader reforms—whether statutory changes or updates to rules administered by other agencies—that could support this trend towards connected care.

4. In the Report and Order, in response to the public health emergency associated with the coronavirus disease (COVID-19), the Commission also establishes a separate, emergency COVID-19 Telehealth Program focused on connected care in response to the ongoing COVID-19 pandemic and surge in demand for connected care services. The Commission expects this additional support will help eligible health care providers purchase broadband connectivity, network equipment and information services to provide critical connected care services whether for treatment of coronavirus or other health conditions during this time.

B. Summary of Significant Issues Raised by Public Comments in Response to the IRFA

5. There were no comments filed that specifically address the rules and policies proposed in the IRFA.

C. Response to Comments by the Chief Counsel for Advocacy of the Small Business Administration

6. Pursuant to the Small Business Jobs Act of 2010,[9] which amended the RFA, the Commission is required to respond to any comments filed by the Chief Counsel of the Small Business Administration (SBA), and to provide a detailed statement of any change made to the proposed rule(s) as a result of those comments.[10] The Chief Counsel did not file any comments in response to the proposed policies and requirements in this proceeding.

D. Description and Estimate of the Number of Small Entities to Which the Rules Will Apply

7. The RFA directs agencies to provide a description of and, where feasible, an estimate of the number of small entities that may be affected by the proposed rules, if adopted.[11] The RFA generally

[7] *Promoting Telehealth for Low-Income Consumers*, WC Docket No. 18-213, Notice of Inquiry, 33 FCC Rcd 7825, 7825-26, paras. 1, 5 & n.15 (2018) (*Connected Care Notice of Inquiry* or *Notice of Inquiry*).

[8] *See generally Connected Care Notice*, 34 FCC Rcd 5620.

[9] 5 U.S.C. § 604(a)(3).

[10] *Id.*

[11] 5 U.S.C. § 603(b)(3).

defines the term "small entity" as having the same meaning as the terms "small business," "small organization," and "small governmental jurisdiction."[12] In addition, the term "small business" has the same meaning as the term "small business concern" under the Small Business Act.[13] A small business concern is one that: (1) is independently owned and operated; (2) is not dominant in its field of operation; and (3) satisfies any additional criteria established by the SBA.[14]

8. *Small Businesses, Small Organizations, Small Governmental Jurisdictions*. Our actions, over time, may affect small entities that are not easily categorized at present. We therefore describe here, at the outset, three broad groups of small entities that could be directly affected herein.[15] First, while there are industry specific size standards for small businesses that are used in the regulatory flexibility analysis, according to data from the SBA's Office of Advocacy, in general a small business is an independent business having fewer than 500 employees.[16] These types of small businesses represent 99.9% of all businesses in the United States, which translates to 30.7 million businesses.[17]

9. Next, the type of small entity described as a "small organization" is generally "any not-for-profit enterprise which is independently owned and operated and is not dominant in its field."[18] The Internal Revenue Service (IRS) uses a revenue benchmark of $50,000 or less to delineate its annual electronic filing requirements for small exempt organizations.[19] Nationwide, for tax year 2018, there were approximately 571,709 small exempt organizations in the U.S. reporting revenues of $50,000 or less according to the registration and tax data for exempt organizations available from the IRS.[20]

10. Finally, the small entity described as a "small governmental jurisdiction" is defined generally as "governments of cities, counties, towns, townships, villages, school districts, or special

[12] 5 U.S.C. § 601(6).

[13] 5 U.S.C. § 601(3) (incorporating by reference the definition of "small business concern" in 15 U.S.C. § 632). Pursuant to the RFA, the statutory definition of a small business applies "unless an agency, after consultation with the Office of Advocacy of the Small Business Administration and after opportunity for public comment, establishes one or more definitions of such term which are appropriate to the activities of the agency and publishes such definition(s) in the Federal Register." *Id*.

[14] *See* 15 U.S.C. § 632.

[15] *See* 5 U.S.C. § 601(3)-(6).

[16] *See* SBA, Office of Advocacy, "What's New With Small Business," https://cdn.advocacy.sba.gov/wp-content/uploads/2019/09/23172859/Whats-New-With-Small-Business-2019.pdf (Sept 2019) (last visited Mar. 19, 2020).

[17] *Id*.

[18] 5 U.S.C. § 601(4).

[19] The IRS benchmark is similar to the population of less than 50,000 benchmark in 5 U.S.C § 601(5) that is used to define a small governmental jurisdiction. Therefore, the IRS benchmark has been used to estimate the number small organizations in this small entity description. S*ee* Annual Electronic Filing Requirement for Small Exempt Organizations — Form 990-N (e-Postcard), "Who must file," https://www.irs.gov/charities-non-profits/annual-electronic-filing-requirement-for-small-exempt-organizations-form-990-n-e-postcard (last visited Mar. 19, 2020). We note that the IRS data does not provide information on whether a small exempt organization is independently owned and operated or dominant in its field.

[20] *See* Exempt Organizations Business Master File Extract (EO BMF), "CSV Files by Region," https://www.irs.gov/charities-non-profits/exempt-organizations-business-master-file-extract-eo-bmf (last visited Mar. 19, 2020). The IRS Exempt Organization Business Master File (EO BMF) Extract provides information on all registered tax-exempt/non-profit organizations. The data utilized for purposes of this description was extracted from the IRS EO BMF data for Region 1-Northeast Area (76,886), Region 2-Mid-Atlantic and Great Lakes Areas (221,121), and Region 3-Gulf Coast and Pacific Coast Areas (273,702) which includes the continental U.S., Alaska, and Hawaii. This data does not include information for Puerto Rico.

districts, with a population of less than fifty thousand."[21] U.S. Census Bureau data from the 2017 Census of Governments[22] indicate that there were 90,075 local governmental jurisdictions consisting of general purpose governments and special purpose governments in the United States.[23] Of this number there were 36,931 general purpose governments (county[24], municipal and town or township[25]) with populations of less than 50,000 and 12,040 special purpose governments - independent school districts[26] with enrollment populations of less than 50,000.[27] Accordingly, based on the 2017 U.S. Census of Governments data, we estimate that at least 48,971 entities fall into the category of "small governmental jurisdictions."[28]

11. Small entities potentially affected by the reforms adopted herein include eligible nonprofit and public health care providers and the eligible service providers offering them services, including telecommunications service providers, Internet Service Providers (ISPs), and service providers of the services and equipment used for dedicated broadband networks.[29]

1. Health Care Providers

12. *Offices of Physicians (except Mental Health Specialists).* This U.S. industry comprises establishments of health practitioners having the degree of M.D. (Doctor of Medicine) or D.O. (Doctor of Osteopathy) primarily engaged in the independent practice of general or specialized medicine (except psychiatry or psychoanalysis) or surgery. These practitioners operate private or group practices in their

[21] 5 U.S.C. § 601(5).

[22] *See* 13 U.S.C. § 161. The Census of Governments survey is conducted every five (5) years compiling data for years ending with "2" and "7." *See also* Census of Governments, https://www.census.gov/programs-surveys/cog/about.html (last visited Mar. 19, 2020).

[23] *See* U.S. Census Bureau, 2017 Census of Governments – Organization Table 2. Local Governments by Type and State: 2017 [CG1700ORG02], https://www.census.gov/data/tables/2017/econ/gus/2017-governments.html (last visited Mar. 19, 2020). Local governmental jurisdictions are made up of general purpose governments (county, municipal and town or township) and special purpose governments (special districts and independent school districts). *See also* Table 2. CG1700ORG02 Table Notes_Local Governments by Type and State_2017.

[24] *See* U.S. Census Bureau, 2017 Census of Governments - Organization, Table 5. County Governments by Population-Size Group and State: 2017 [CG1700ORG05], https://www.census.gov/data/tables/2017/econ/gus/2017-governments.html (last visited Mar. 19, 2020). There were 2,105 county governments with populations less than 50,000. This category does not include subcounty (municipal and township) governments.

[25] *See* U.S. Census Bureau, 2017 Census of Governments - Organization, Table 6. Subcounty General-Purpose Governments by Population-Size Group and State: 2017 [CG1700ORG06], https://www.census.gov/data/tables/2017/econ/gus/2017-governments.html (last visited Mar. 19, 2020). There were 18,729 municipal and 16,097 town and township governments with populations less than 50,000.

[26] *See* U.S. Census Bureau, 2017 Census of Governments - Organization, Table 10. Elementary and Secondary School Systems by Enrollment-Size Group and State: 2017 [CG1700ORG10], https://www.census.gov/data/tables/2017/econ/gus/2017-governments.html (last visited Mar. 19, 2020). There were 12,040 independent school districts with enrollment populations less than 50,000. *See also* Table 4. Special-Purpose Local Governments by State Census Years 1942 to 2017 [CG1700ORG04], CG1700ORG04 Table Notes_Special Purpose Local Governments by State_Census Years 1942 to 2017.

[27] While the special purpose governments category also includes local special district governments, the 2017 Census of Governments data does not provide data aggregated based on population size for the special purpose governments category. Therefore, only data from independent school districts is included in the special purpose governments category.

[28] This total is derived from the sum of the number of general purpose governments (county, municipal and town or township) with populations of less than 50,000 (36,931) and the number of special purpose governments - independent school districts with enrollment populations of less than 50,000 (12,040), from the 2017 Census of Governments - Organizations Tables 5, 6, and 10.

[29] 47 CFR §§ 54.601, 54.608.

own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or health maintenance organization (HMO) medical centers.[30] The SBA has created a size standard for this industry, which is annual receipts of $12 million or less.[31] According to 2012 U.S. Economic Census, 152,468 firms operated throughout the entire year in this industry.[32] Of that number, 147,718 had annual receipts of less than $10 million, while 3,108 firms had annual receipts between $10 million and $24,999,999.[33] Based on these data, we conclude that a majority of firms operating in this industry are small under the applicable size standard.

13. *Offices of Physicians, Mental Health Specialists.* The U.S. industry comprises establishments of health practitioners having the degree of M.D. (Doctor of Medicine) or D.O. (Doctor of Osteopathy) primarily engaged in the independent practice of psychiatry or psychoanalysis. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.[34] The SBA has established a size standard for businesses in this industry, which is annual receipts of $12 million dollars or less.[35] The U.S. Economic Census indicates that 8,809 firms operated throughout the entire year in this industry.[36] Of that number 8,791 had annual receipts of less than $10 million, while 13 firms had annual receipts between $10 million and $24,999,999.[37] Based on these data, we conclude that a majority of firms in this industry are small under the applicable standard.

14. *Offices of Dentists.* This U.S. industry comprises establishments of health practitioners having the degree of D.M.D. (Doctor of Dental Medicine), D.D.S. (Doctor of Dental Surgery), or D.D.S. (Doctor of Dental Science) primarily engaged in the independent practice of general or specialized dentistry or dental surgery. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers. They can provide either comprehensive preventive, cosmetic, or emergency care, or specialize in a single field of dentistry.[38] The SBA has established a size standard for that industry of annual receipts of $8 million or

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[30] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621111 "Offices of Physicians (except Mental Health Specialists)," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621111&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

[31] 13 CFR § 121.201, NAICS Code 621111.

[32] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States:* 2012, NAICS Code 621111, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621111 (last visited Mar. 4, 2020).

[33] *Id.* The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $12 million or less.

[34] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621112 "Offices of Physicians, Mental Health Specialists," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621112&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

[35] 13 CFR § 121.201; NAICS Code 621112.

[36] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States*: 2012, NAICS Code 621112, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621112 (last visited Mar. 4, 2020).

[37] *Id.* The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $12 million or less.

[38] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621210 "Offices of Dentists," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621210&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

less.[39] The 2012 U.S. Economic Census indicates that 115,268 firms operated in the dental industry throughout the entire year.[40] Of that number 114,417 had annual receipts of less than $5 million, while 651 firms had annual receipts between $5 million and $9,999,999.[41] Based on these data, we conclude that a majority of business in the dental industry are small under the applicable standard.

15. *Offices of Chiropractors.* This U.S. industry comprises establishments of health practitioners having the degree of D.C. (Doctor of Chiropractic) primarily engaged in the independent practice of chiropractic. These practitioners provide diagnostic and therapeutic treatment of neuromusculoskeletal and related disorders through the manipulation and adjustment of the spinal column and extremities, and operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.[42] The SBA has established a size standard for this industry, which is annual receipts of $8 million or less.[43] The 2012 U.S. Economic Census statistics show that in 2012, there were 33,940 firms operated throughout the entire year.[44] Of that number 33,910 operated with annual receipts of less than $5 million per year, while 26 firms had annual receipts between $5 million and $9,999,999.[45] Based on that data, we conclude that a majority of chiropractors are small.

16. *Offices of Optometrists.* This U.S. industry comprises establishments of health practitioners having the degree of O.D. (Doctor of Optometry) primarily engaged in the independent practice of optometry. These practitioners examine, diagnose, treat, and manage diseases and disorders of the visual system, the eye and associated structures as well as diagnose related systemic conditions. Offices of optometrists prescribe and/or provide eyeglasses, contact lenses, low vision aids, and vision therapy. They operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers, and may also provide the same services as opticians, such as selling and fitting prescription eyeglasses and contact lenses.[46] The SBA has established a size standard for businesses operating in this industry, which is annual receipts of $8 million or less.[47] The 2012 Economic Census indicates that 18,050 firms operated the entire year.[48] Of that

[39] 13 CFR § 121.201; NAICS Code 621210.

[40] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States:* 2012, NAICS Code 621210, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621210 (last visited Mar. 4, 2020).

[41] *Id.* The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $8 million or less.

[42] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621310 "Offices of Chiropractors," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621310&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020). *See also* NAICS Code 621310; 13 CFR § 121.201.

[43] 13 CFR § 121.201; NAICS Code 621310.

[44] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States*: 2012, NAICS Code 621310, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621310 (last visited Mar. 4, 2020).

[45] *Id.* The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $8 million or less.

[46] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621320 "Offices of Optometrists," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621320&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

[47] 13 CFR § 121.201; NAICS Code 621320.

number, 17,951 had annual receipts of less than $5 million, while 70 firms had annual receipts between $5 million and $9,999,999.[49] Based on these data, we conclude that a majority of optometrists in this industry are small.

17. *Offices of Mental Health Practitioners* (*except Physicians*). This U.S. industry comprises establishments of independent mental health practitioners (except physicians) primarily engaged in (1) the diagnosis and treatment of mental, emotional, and behavioral disorders and/or (2) the diagnosis and treatment of individual or group social dysfunction brought about by such causes as mental illness, alcohol and substance abuse, physical and emotional trauma, or stress. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.[50] The SBA has created a size standard for this industry, which is annual receipts of $8 million or less. [51] The 2012 U.S. Economic Census indicates that 16,058 firms operated throughout the entire year.[52] Of that number, 15,894 firms received annual receipts of less than $5 million, while 111 firms had annual receipts between $5 million and $9,999,999.[53] Based on these data, we conclude that a majority of mental health practitioners who do not employ physicians are small.

18. *Offices of Physical, Occupational and Speech Therapists and Audiologists.* This U.S. industry comprises establishments of independent health practitioners primarily engaged in one of the following: (1) providing physical therapy services to patients who have impairments, functional limitations, disabilities, or changes in physical functions and health status resulting from injury, disease or other causes, or who require prevention, wellness or fitness services; (2) planning and administering educational, recreational, and social activities designed to help patients or individuals with disabilities, regain physical or mental functioning or to adapt to their disabilities; and (3) diagnosing and treating speech, language, or hearing problems. These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.[54] The SBA has established a size standard for this industry, which is annual receipts of $8 million or less.[55] The 2012 U.S. Economic Census indicates that 20,567 firms in this industry operated throughout the

(Continued from previous page)

[48] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States*: 2012, NAICS Code 621320, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621320 (last visited Mar. 4, 2020).

[49] *Id.* The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $8 million or less.

[50] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621330 "Offices of Mental Health Practitioners (except Physicians)," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621330&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

[51] 13 CFR § 121.201; NAICS Code 621330.

[52] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States*: 2012, NAICS Code 621330, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621330 (last visited Mar. 4, 2020).

[53] *Id.* The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $8 million or less.

[54] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621340 "Offices of Physical, Occupational and Speech Therapists and Audiologists," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621340&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

[55] 13 CFR § 121.201; NAICS Code 621340.

entire year.[56] Of this number, 20,047 had annual receipts of less than $5 million, while 270 firms had annual receipts between $5 million and $9,999,999.[57] Based on these data, we conclude that a majority of businesses in this industry are small.

19. *Offices of Podiatrists.* This U.S. industry comprises establishments of health practitioners having the degree of D.P.M. (Doctor of Podiatric Medicine) primarily engaged in the independent practice of podiatry. These practitioners diagnose and treat diseases and deformities of the foot and operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.[58] The SBA has established a size standard for businesses in this industry, which is annual receipts of $8 million or less.[59] The 2012 U.S. Economic Census indicates that 7,569 podiatry firms operated throughout the entire year.[60] Of that number, 7,545 firms had annual receipts of less than $5 million, while 22 firms had annual receipts between $5 million and $9,999,999.[61] Based on these data, we conclude that a majority of firms in this industry are small.

20. *Offices of All Other Miscellaneous Health Practitioners.* This U.S. industry comprises establishments of independent health practitioners (except physicians; dentists; chiropractors; optometrists; mental health specialists; physical, occupational, and speech therapists; audiologists; and podiatrists). These practitioners operate private or group practices in their own offices (e.g., centers, clinics) or in the facilities of others, such as hospitals or HMO medical centers.[62] The SBA has established a size standard for this industry, which is annual receipts of $8 million or less.[63] The 2012 U.S. Economic Census indicates that 11,460 firms operated throughout the entire year.[64] Of that number, 11,374 firms had annual receipts of less than $5 million, while 48 firms had annual receipts between $5 million and $9,999,999.[65] Based on these data, we conclude the majority of firms in this industry are

[56] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States*: 2012, NAICS Code 621340, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621340 (last visited Mar. 4, 2020).

[57] *Id.* The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $8 million or less.

[58] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621391 "Offices of Podiatrists," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621391&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

[59] 13 CFR § 121.201; NAICS Code 621391.

[60] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States: 2012*, NAICS Code 621391, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621391 (last visited Mar. 4, 2020).

[61] *Id.* The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $8 million or less.

[62] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621399 "Offices of All Other Miscellaneous Health Practitioners," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621399&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

[63] 13 CFR § 121.201; NAICS Code 621399.

[64] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States*: 2012, NAICS Code 621399, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621399 (last visited Mar. 4, 2020).

[65] *Id.* The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $8 million or less.

small.

21. *Family Planning Centers.* This U.S. industry comprises establishments with medical staff primarily engaged in providing a range of family planning services on an outpatient basis, such as contraceptive services, genetic and prenatal counseling, voluntary sterilization, and therapeutic and medically induced termination of pregnancy.[66] The SBA has established a size standard for this industry, which is annual receipts of $12 million or less.[67] The 2012 Economic Census indicates that 1,286 firms in this industry operated throughout the entire year.[68] Of that number 1,237 had annual receipts of less than $10 million, while 36 firms had annual receipts between $10 million and $24,999,999.[69] Based on these data, we conclude that the majority of firms in this industry are small.

22. *Outpatient Mental Health and Substance Abuse Centers*. This U.S. industry comprises establishments with medical staff primarily engaged in providing outpatient services related to the diagnosis and treatment of mental health disorders and alcohol and other substance abuse. These establishments generally treat patients who do not require inpatient treatment. They may provide a counseling staff and information regarding a wide range of mental health and substance abuse issues and/or refer patients to more extensive treatment programs, if necessary.[70] The SBA has established a size standard for this industry, which is $16.5 million or less in annual receipts.[71] The 2012 U.S. Economic Census indicates that 4,446 firms operated throughout the entire year.[72] Of that number, 4,069 had annual receipts of less than $10 million while 286 firms had annual receipts between $10 million and $24,999,999.[73] Based on these data, we conclude that a majority of firms in this industry are small.

23. *HMO Medical Centers.* This U.S. industry comprises establishments with physicians and other medical staff primarily engaged in providing a range of outpatient medical services to the HMO subscribers with a focus generally on primary health care. These establishments are owned by the HMO. Included in this industry are HMO establishments that both provide health care services and underwrite health and medical insurance policies.[74] The SBA has established a size standard for this industry, which

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[66] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621410 "Family Planning Centers," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621410&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

[67] 13 CFR § 121.201; NAICS Code 621410.

[68] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States*: 2012, NAICS Code 621410, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621410 (last visited Mar. 4, 2020).

[69] *Id.* The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $12 million or less.

[70] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621420 "Outpatient Mental Health and Substance Abuse Centers," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621420&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

[71] 13 CFR § 121.201; NAICS Code 621420.

[72] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States*: 2012, NAICS Code 621420, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621420 (last visited Mar. 4, 2020).

[73] *Id.* The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $16.5 million or less.

[74] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621491 "HMO Medical Centers," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621491&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

is $32.5 million or less in annual receipts.[75] The 2012 U.S. Economic Census indicates that 14 firms in this industry operated throughout the entire year.[76] Of that number, 5 firms had annual receipts of less than $25 million, while 1 firm had annual receipts between $25 million and $99,999,999.[77] Based on these data, we conclude that approximately one-third of the firms in this industry are small.

24. *Freestanding Ambulatory Surgical and Emergency Centers.* This U.S. industry comprises establishments with physicians and other medical staff primarily engaged in (1) providing surgical services (e.g., orthoscopic and cataract surgery) on an outpatient basis or (2) providing emergency care services (e.g., setting broken bones, treating lacerations, or tending to patients suffering injuries as a result of accidents, trauma, or medical conditions necessitating immediate medical care) on an outpatient basis. Outpatient surgical establishments have specialized facilities, such as operating and recovery rooms, and specialized equipment, such as anesthetic or X-ray equipment.[78] The SBA has established a size standard for this industry, which is annual receipts of $16.5 million or less.[79] The 2012 U.S. Economic Census indicates that 3,595 firms in this industry operated throughout the entire year.[80] Of that number, 3,222 firms had annual receipts of less than $10 million, while 289 firms had annual receipts between $10 million and $24,999,999.[81] Based on these data, we conclude that a majority of firms in this industry are small.

25. *All Other Outpatient Care Centers.* This U.S. industry comprises establishments with medical staff primarily engaged in providing general or specialized outpatient care (except family planning centers, outpatient mental health and substance abuse centers, HMO medical centers, kidney dialysis centers, and freestanding ambulatory surgical and emergency centers). Centers or clinics of health practitioners with different degrees from more than one industry practicing within the same establishment (i.e., Doctor of Medicine and Doctor of Dental Medicine) are included in this industry.[82] The SBA has established a size standard for this industry, which is annual receipts of $22 million or less.[83] The 2012 U.S. Economic Census indicates that 4,903 firms operated in this industry throughout

[75] 13 CFR § 121.201; NAICS Code 621491.

[76] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States*: 2012, NAICS Code 621491, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621491 (last visited Mar. 4, 2020).

[77] *Id.* The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $35 million or less.

[78] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621493 "Freestanding Ambulatory Surgical and Emergency Centers," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621493&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

[79] 13 CFR § 121.201; NAICS Code 621493.

[80] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States*: 2012, NAICS Code 621493, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621493 (last visited Mar. 4, 2020).

[81] *Id.* The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $16.5 million or less.

[82] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621498 "All Other Outpatient Care Centers," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621498&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

[83] 13 CFR § 121.201; NAICS Code 621498.

the entire year.[84] Of this number, 4,269 firms had annual receipts of less than $10 million, while 389 firms had annual receipts between $10 million and $24,999,999.[85] Based on these data, we conclude that a majority of firms in this industry are small.

26. *Blood and Organ Banks.* This U.S. industry comprises establishments primarily engaged in collecting, storing, and distributing blood and blood products and storing and distributing body organs.[86] The SBA has established a size standard for this industry, which is annual receipts of $35 million or less.[87] The 2012 U.S. Economic Census indicates that 314 firms operated in this industry throughout the entire year.[88] Of that number, 235 operated with annual receipts of less than $25 million, while 41 firms had annual receipts between $25 million and $49,999,999.[89] Based on these data, we conclude that approximately three-quarters of firms that operate in this industry are small.

27. *All Other Miscellaneous Ambulatory Health Care Services.* This U.S. industry comprises establishments primarily engaged in providing ambulatory health care services (except offices of physicians, dentists, and other health practitioners; outpatient care centers; medical and diagnostic laboratories; home health care providers; ambulances; and blood and organ banks).[90] The SBA has established a size standard for this industry, which is annual receipts of $16.5 million or less.[91] The 2012 U.S. Economic Census indicates that 2,429 firms operated in this industry throughout the entire year.[92] Of that number, 2,318 had annual receipts of less than $10 million, while 56 firms had annual receipts between $10 million and $24,999,999.[93] Based on these data, we conclude that a majority of the firms in this industry are small.

28. *Medical Laboratories.* This U.S. industry comprises establishments known as medical laboratories primarily engaged in providing analytic or diagnostic services, including body fluid analysis,

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[84] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States*: 2012, NAICS Code 621498, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621498 (last visited Mar. 4, 2020).

[85] *Id.* The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $22 million or less.

[86] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621991 "Blood and Organ Banks," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621991&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

[87] 13 CFR § 121.201; NAICS Code 621991.

[88] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States*: 2012, NAICS Code 621991, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621991 (last visited Mar. 4, 2020).

[89] *Id.* The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $35 million or less.

[90] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621999 "All Other Miscellaneous Ambulatory Health Care Services," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621999&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

[91] 13 CFR § 121.201; NAICS Code 621999.

[92] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States*: 2012, NAICS Code 621999, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621999 (last visited Mar. 4, 2020).

[93] *Id.* The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $16.5 million or less.

generally to the medical profession or to the patient on referral from a health practitioner.[94] The SBA has established a size standard for this industry, which is annual receipts of $35 million or less.[95] The 2012 U.S. Economic Census indicates that 2,599 firms operated in this industry throughout the entire year.[96] Of this number, 2,465 had annual receipts of less than $25 million, while 60 firms had annual receipts between $25 million and $49,999,999.[97] Based on these data, we conclude that a majority of firms that operate in this industry are small.

29. *Diagnostic Imaging Centers.* This U.S. industry comprises establishments known as diagnostic imaging centers primarily engaged in producing images of the patient generally on referral from a health practitioner.[98] The SBA has established size standard for this industry, which is annual receipts of $16.5 million or less.[99] The 2012 U.S. Economic Census indicates that 4,209 firms operated in this industry throughout the entire year.[100] Of that number, 3,876 firms had annual receipts of less than $10 million, while 228 firms had annual receipts between $10 million and $24,999,999.[101] Based on these data, we conclude that a majority of firms that operate in this industry are small.

30. *Home Health Care Services.* This U.S. industry comprises establishments primarily engaged in providing skilled nursing services in the home, along with a range of the following: personal care services; homemaker and companion services; physical therapy; medical social services; medications; medical equipment and supplies; counseling; 24-hour home care; occupation and vocational therapy; dietary and nutritional services; speech therapy; audiology; and high-tech care, such as intravenous therapy.[102] The SBA has established a size standard for this industry, which is annual receipts of $16.5 million or less.[103] The 2012 U.S. Economic Census indicates that 17,770 firms operated in this industry throughout the entire year.[104] Of that number, 16,822 had annual receipts of less than $10

[94] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621511 "Medical Laboratories," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621511&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

[95] 13 CFR § 121.201; NAICS Code 621511.

[96] U.S. Census Bureau, *2012 Economic Census of the United States,* Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States*: 2012, NAICS Code 621511, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621511 (last visited Mar. 4, 2020).

[97] *Id.* The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $35 million or less.

[98] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621512 "Diagnostic Imaging Centers," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621512&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

[99] 13 CFR § 121.201; NAICS Code 621512.

[100] U.S. Census Bureau, *2012 Economic Census of the United States,* Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States*: 2012, NAICS Code 621512, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621512 (last visited Mar. 4, 2020).

[101] *Id.* The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $16.5 million or less.

[102] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621610 "Home Health Care Services," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621610&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

[103] 13 CFR § 121.201; NAICS Code 621610.

[104] U.S. Census Bureau, *2012 Economic Census of the United States,* Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States*: 2012,

(continued….)

million, while 590 firms had annual receipts between $10 million and $24,999,999.[105] Based on these data, we conclude that a majority of firms that operate in this industry are small.

31. *Ambulance Services.* This U.S. industry comprises establishments primarily engaged in providing transportation of patients by ground or air, along with medical care. These services are often provided during a medical emergency but are not restricted to emergencies. The vehicles are equipped with lifesaving equipment operated by medically trained personnel.[106] The SBA has established a size standard for this industry, which is annual receipts of $16.5 million or less.[107] The 2012 U.S. Economic Census indicates that 2,984 firms operated in this industry throughout the entire year.[108] Of that number, 2,926 had annual receipts of less than $15 million, while 133 firms had annual receipts between $10 million and $24,999,999.[109] Based on these data, we conclude that a majority of firms in this industry are small.

32. *Kidney Dialysis Centers.* This U.S. industry comprises establishments with medical staff primarily engaged in providing outpatient kidney or renal dialysis services.[110] The SBA has established assize standard for this industry, which is annual receipts of $41.5 million or less.[111] The 2012 U.S. Economic Census indicates that 396 firms operated in this industry throughout the entire year.[112] Of that number, 379 had annual receipts of less than $25 million, while 7 firms had annual receipts between $25 million and $49,999,999.[113] Based on these data, we conclude that a majority of firms in this industry are small.

33. *General Medical and Surgical Hospitals.* This U.S. industry comprises establishments known and licensed as general medical and surgical hospitals primarily engaged in providing diagnostic and medical treatment (both surgical and nonsurgical) to inpatients with any of a wide variety of medical conditions. These establishments maintain inpatient beds and provide patients with food services that

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NAICS Code 621610, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621610 (last visited Mar. 4, 2020).

[105] *Id*. The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $16.5 million or less.

[106] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621910 "Ambulance Services," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621910&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

[107] 13 CFR § 121.201; NAICS Code 621910.

[108] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States*: 2012, NAICS Code 621910, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621910 (last visited Mar. 4, 2020).

[109] *Id*. The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $16.5 million or less.

[110] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 621492 "Kidney Dialysis Centers," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=621492&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

[111] 13 CFR § 121.201; NAICS Code 621492.

[112] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States*: 2012, NAICS Code 621492, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~621492 (last visited Mar. 4, 2020).

[113] *Id*. The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $41.5 million or less.

meet their nutritional requirements. These hospitals have an organized staff of physicians and other medical staff to provide patient care services. These establishments usually provide other services, such as outpatient services, anatomical pathology services, diagnostic X-ray services, clinical laboratory services, operating room services for a variety of procedures, and pharmacy services.[114] The SBA has established a size standard for this industry, which is annual receipts of $41.5 million or less.[115] The 2012 U.S. Economic Census indicates that 2,800 firms operated in this industry throughout the entire year.[116] Of that number, 877 has annual receipts of less than $25 million, while 400 firms had annual receipts between $25 million and $49,999,999.[117] Based on these data, we conclude that approximately one-quarter of firms in this industry are small.

34. *Psychiatric and Substance Abuse Hospitals.* This U.S. industry comprises establishments known and licensed as psychiatric and substance abuse hospitals primarily engaged in providing diagnostic, medical treatment, and monitoring services for inpatients who suffer from mental illness or substance abuse disorders. The treatment often requires an extended stay in the hospital. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements. They have an organized staff of physicians and other medical staff to provide patient care services. Psychiatric, psychological, and social work services are available at the facility. These hospitals usually provide other services, such as outpatient services, clinical laboratory services, diagnostic X-ray services, and electroencephalograph services.[118] The SBA has established a size standard for this industry, which is annual receipts of $41.5 million or less.[119] The 2012 U.S. Economic Census indicates that 404 firms operated in this industry throughout the entire year.[120] Of that number, 185 had annual receipts of less than $25 million, while 107 firms had annual receipts between $25 million and $49,999,999.[121] Based on these data, we conclude that more than one-half of the firms in this industry are small.

35. *Specialty (Except Psychiatric and Substance Abuse) Hospitals.* This U.S. industry consists of establishments known and licensed as specialty hospitals primarily engaged in providing diagnostic, and medical treatment to inpatients with a specific type of disease or medical condition (except psychiatric or substance abuse). Hospitals providing long-term care for the chronically ill and hospitals providing rehabilitation, restorative, and adjustive services to physically challenged or disabled

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[114] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 622110 "General Medical and Surgical Hospitals," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=622110&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

[115] 13 CFR § 121.201; NAICS Code 622110.

[116] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States*: 2012, NAICS Code 622110, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~622110 (last visited Mar. 4, 2020).

[117] *Id.* The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $41.5 million or less.

[118] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 622210 "Psychiatric and Substance Abuse Hospitals," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=622210&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

[119] 13 CFR § 121.201; NAICS Code 622210.

[120] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States*: 2012, NAICS Code 622210, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~622210 (last visited Mar. 4, 2020).

[121] *Id*. The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $41.5 million or less.

people are included in this industry. These establishments maintain inpatient beds and provide patients with food services that meet their nutritional requirements. They have an organized staff of physicians and other medical staff to provide patient care services. These hospitals may provide other services, such as outpatient services, diagnostic X-ray services, clinical laboratory services, operating room services, physical therapy services, educational and vocational services, and psychological and social work services.[122] The SBA has established a size standard for this industry, which is annual receipts of $41.5 million or less.[123] The 2012 U.S. Economic Census indicates that 346 firms operated in this industry throughout the entire year.[124] Of that number, 146 firms had annual receipts of less than $25 million, while 79 firms had annual receipts between $25 million and $49,999,999.[125] Based on these data, we conclude that more than one-half of the firms in this industry are small.

36. *Emergency and Other Relief Services.* This industry comprises establishments primarily engaged in providing food, shelter, clothing, medical relief, resettlement, and counseling to victims of domestic or international disasters or conflicts (e.g., wars).[126] The SBA has established a size standard for this industry, which is annual receipts of $32.5 million or less.[127] The 2012 U.S. Economic Census indicates that 541 firms operated in this industry throughout the entire year.[128] Of that number, 509 had annual receipts of less than $25 million, while 7 firms had annual receipts between $25 million and $49,999,999.[129] Based on these data, we conclude that a majority of firms in this industry are small

2. Providers of Telecommunications and Other Services

a. Telecommunications Service Providers

37. *Incumbent Local Exchange Carriers* (*LECs*). Neither the Commission nor the SBA has developed a small business size standard specifically for incumbent local exchange services. The closest applicable NAICS Code category is Wired Telecommunications Carriers.[130] Under the applicable SBA size standard, such a business is small if it has 1,500 or fewer employees.[131] U.S. Census Bureau data for

[122] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 622310 "Specialty (Except Psychiatric and Substance Abuse) Hospitals," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=622310&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

[123] 13 CFR § 121.201; NAICS Code 622310.

[124] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States*: 2012, NAICS Code 622310, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~622310 (last visited Mar. 4, 2020).

[125] *Id.* The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $41.5 million or less.

[126] *See* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 624230 "Emergency and Other Relief Services", https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=624230&search=2012+NAICS+Search&search=2012 (last visited Mar. 4, 2020).

[127] 13 CFR § 121.201; NAICS Code 624230.

[128] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1262SSSZ4, *Healthcare and Social Assistance: Subject Series - Estab and Firm Size: Receipts/Revenue Size of Firms for the United States*: 2012, NAICS Code 624230, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/62SSSZ4//naics~624230 (last visited Mar. 4, 2020).

[129] *Id.* The available U.S. Census data do not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $35 million or less.

[130] *See*, U.S. Census Bureau, *2017 NAICS Definition, NAICS Code 517311 "Wired Telecommunications Carriers,"*, https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517311&search=2017 (last visited Mar. 19, 2020).

[131] *See* 13 CFR § 121.201, NAICS Code 517311 (previously 517110).

2012 indicate that 3,117 firms operated the entire year.[132] Of this total, 3,083 operated with fewer than 1,000 employees.[133] Consequently, the Commission estimates that most providers of incumbent local exchange service are small businesses that may be affected by our actions. According to Commission data, one thousand three hundred and seven (1,307) Incumbent Local Exchange Carriers reported that they were incumbent local exchange service providers.[134] Of this total, an estimated 1,006 have 1,500 or fewer employees.[135] Thus, using the SBA's size standard the majority of incumbent LECs can be considered small entities.

38. *Interexchange Carriers (IXCs)*. Neither the Commission nor the SBA has developed a small business size standard specifically for Interexchange Carriers. The closest applicable NAICS Code category is Wired Telecommunications Carriers.[136] The applicable size standard under SBA rules is that such a business is small if it has 1,500 or fewer employees.[137] U.S. Census Bureau data for 2012 indicate that 3,117 firms operated for the entire year.[138] Of that number, 3,083 operated with fewer than 1,000 employees.[139] According to internally developed Commission data, 359 companies reported that their primary telecommunications service activity was the provision of interexchange services.[140] Of this total, an estimated 317 have 1,500 or fewer employees.[141] Consequently, the Commission estimates that the majority of interexchange service providers are small entities.

39. *Competitive Access Providers*. Neither the Commission nor the SBA has developed a definition of small entities specifically applicable to competitive access services providers (CAPs). The closest applicable definition under the SBA rules is Wired Telecommunications Carriers and under the size standard, such a business is small if it has 1,500 or fewer employees.[142] U.S. Census Bureau data for

[132] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table No. EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms: 2012* (517110 Wired Telecommunications Carriers). https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5//naics~517110 (last visited Mar. 19, 2020).

[133] *Id.*

[134] *See Trends in Telephone Service*, Federal Communications Commission, Wireline Competition Bureau, Industry Analysis and Technology Division at Table 5.3 (Sept. 2010) (*Trends in Telephone Service*).

[135] *Id*.

[136] *See*, U.S. Census Bureau, *2017 NAICS Definition, NAICS Code 517311 "Wired Telecommunications Carriers,"* https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517311&search=2017 (last visited Mar. 19, 2020).

[137] *See* 13 CFR § 120.201, NAICS Code 517311 (previously 517110).

[138] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table No. EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms: 2012* (517110 Wired Telecommunications Carriers). https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5//naics~517110 (last visited Mar. 19, 2020).

[139] *Id*. The largest category provided by the census data is "1000 employees or more" and a more precise estimate for firms with fewer than 1,500 employees is not provided.

[140] *See Trends in Telephone Service*, Federal Communications Commission, Wireline Competition Bureau, Industry Analysis and Technology Division at Table 5.3 (Sept. 2010) (*Trends in Telephone Service*). https://apps.fcc.gov/edocs_public/attachmatch/DOC-301823A1.pdf (last visited Mar. 19, 2020).

[141] *Id*.

[142] *See* 13 CFR § 121.201. The Wired Telecommunications Carrier category formerly used the NAICS Code of 517110. As of 2017, the U.S. Census Bureau definition shows the NAICS Code as 517311 for Wired Telecommunications Carriers. *See* U.S. Census Bureau, *2017 NAICS Definition*, 517311 Wired Telecommunications Carriers, https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517311&search=2017 (last visited Mar. 4, 2020).

2012 indicate that 3,117 firms operated during that year.[143] Of that number, 3,083 operated with fewer than 1,000 employees.[144] Consequently, the Commission estimates that most competitive access providers are small businesses that may be affected by our actions. According to Commission data the *2010 Trends in Telephone Report*, 1,442 CAPs and competitive local exchange carriers (competitive LECs) reported that they were engaged in the provision of competitive local exchange services.[145] Of these 1,442 CAPs and competitive LECs, an estimated 1,256 have 1,500 or few employees and 186 have more than 1,500 employees.[146] Consequently, the Commission estimates that most providers of competitive exchange services are small businesses.

40. *Wired Telecommunications Carriers.* The U.S. Census Bureau defines this industry as "establishments primarily engaged in operating and/or providing access to transmission facilities and infrastructure that they own and/or lease for the transmission of voice, data, text, sound, and video using wired communications networks. Transmission facilities may be based on a single technology or a combination of technologies. Establishments in this industry use the wired telecommunications network facilities that they operate to provide a variety of services, such as wired telephony services, including VoIP services, wired (cable) audio and video programming distribution, and wired broadband internet services. By exception, establishments providing satellite television distribution services using facilities and infrastructure that they operate are included in this industry."[147] The SBA has developed a small business size standard for Wired Telecommunications Carriers, which consists of all such companies having 1,500 or fewer employees.[148] U.S. Census Bureau data for 2012 show that there were 3,117 firms that operated that year.[149] Of this total, 3,083 operated with fewer than 1,000 employees.[150] Thus, under this size standard, the majority of firms in this industry can be considered small.

41. *Wireless Telecommunications Carriers* (*except Satellite*). This industry comprises establishments engaged in operating and maintaining switching and transmission facilities to provide communications via the airwaves. Establishments in this industry have spectrum licenses and provide services using that spectrum, such as cellular services, paging services, wireless internet access, and wireless video services.[151] The appropriate size standard under SBA rules is that such a business is small if it has 1,500 or fewer employees.[152] For this industry, U.S. Census Bureau data for 2012 show that there

[143] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table No. EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms:* 2012, NAICS Code 517110, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5//naics~517110 (last visited Mar. 4, 2020).

[144] *Id*.

[145] *See Trends in Telephone Service*, at Table 5.3, page 5.5.

[146] *Id.*

[147] *See* U.S. Census Bureau, *2017 NAICS Definition, NAICS Code 517311 "Wired Telecommunications Carriers,"*, https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517311&search=2017 (last visited Mar. 19, 2020).

[148] *See* 13 CFR § 120.201, NAICS Code 517311 (previously 517110).

[149] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table No. EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms: 2012.* NAICS Code 517110. https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5//naics~517110 (last visited Mar. 19, 2020).

[150] *Id.* The largest category provided by the census data is "1000 employees or more" and a more precise estimate for firms with fewer than 1,500 employees is not provided.

[151] U.S. Census Bureau, *2017 NAICS Definitions, "517312 Wireless Telecommunications Carriers* (Except Satellite)," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517312&search=2017%20NAICS%20Search (last visited Mar. 19, 2020).

[152] 13 CFR § 121.201, NAICS Code 517312 (previously 517210).

were 967 firms that operated for the entire year.[153] Of this total, 955 firms employed fewer than 1,000 employees and 12 firms employed of 1000 employees or more.[154] Thus under this category and the associated size standard, the Commission estimates that the majority of wireless telecommunications carriers (except satellite) are small entities.

42. The Commission's own data—available in its Universal Licensing System—indicate that, as of August 31, 2018 there are 265 Cellular licensees that will be affected by our actions.[155] The Commission does not know how many of these licensees are small, as the Commission does not collect that information for these types of entities. Similarly, according to internally developed Commission data, 413 carriers reported that they were engaged in the provision of wireless telephony, including cellular service, Personal Communications Service (PCS), and Specialized Mobile Radio (SMR) Telephony services.[156] Of this total, an estimated 261 have 1,500 or fewer employees, and 152 have more than 1,500 employees.[157] Thus, using available data, we estimate that the majority of wireless firms can be considered small.

43. *Wireless Telephony*. Wireless telephony includes cellular, personal communications services, and specialized mobile radio telephony carriers. The closest applicable SBA category is Wireless Telecommunications Carriers (except Satellite).[158] Under the SBA small business size standard, a business is small if it has 1,500 or fewer employees.[159] For this industry, U.S. Census Bureau data for 2012 show that there were 967 firms that operated for the entire year.[160] Of this total, 955 firms had fewer than 1,000 employees and 12 firms had 1000 employees or more.[161] Thus under this category and the associated size standard, the Commission estimates that a majority of these entities can be considered small. According to Commission data, 413 carriers reported that they were engaged in wireless

[153] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1251SSSZ5, Information: Subject Series: Estab and Firm Size: Employment Size of Firms for the U.S.: 2012, NAICS Code 517210. https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5//naics~517210 (last visited Mar. 19, 2020).

[154] *Id*. Available census data does not provide a more precise estimate of the number of firms that have employment of 1,500 or fewer employees; the largest category provided is for firms with "1000 employees or more."

[155] *See* http://wireless.fcc.gov/uls. For the purposes of this FRFA, consistent with Commission practice for wireless services, the Commission estimates the number of licensees based on the number of unique FCC Registration Numbers.

[156] *See* Federal Communications Commission, Wireline Competition Bureau, Industry Analysis and Technology Division, Trends in Telephone Service at Table 5.3 (Sept. 2010) (*Trends in Telephone Service*), https://apps.fcc.gov/edocs_public/attachmatch/DOC-301823A1.pdf (last visited Mar. 19, 2020).

[157] *See id*.

[158] U.S. Census Bureau, 2017 NAICS Definitions, "517210 Wireless Telecommunications Carriers (Except Satellite)," *See* https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517312&search=2017%20NAICS%20Search (last visited Mar. 19, 2020).

[159] 13 CFR § 121.201, NAICS Code 517312 (previously 517210).

[160] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1251SSSZ5, Information: Subject Series: Estab and Firm Size: Employment Size of Firms for the U.S.: 2012 NAICS Code 517210. https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5//naics~517210.

[161] *Id*. Available census data do not provide a more precise estimate of the number of firms that have employment of 1,500 or fewer employees; the largest category provided is for firms with "1000 employees or more."

telephony.[162] Of these, an estimated 261 have 1,500 or fewer employees and 152 have more than 1,500 employees.[163] Therefore, more than half of these entities can be considered small.

44. *Satellite Telecommunications.* This category comprises firms "primarily engaged in providing telecommunications services to other establishments in the telecommunications and broadcasting industries by forwarding and receiving communications signals via a system of satellites or reselling satellite telecommunications."[164] Satellite telecommunications service providers include satellite and earth station operators. The category has a small business size standard of $35 million or less in average annual receipts, under SBA rules.[165] For this category, U.S. Census Bureau data for 2012 show that there were a total of 333 firms that operated for the entire year.[166] Of this total, 299 firms had annual receipts of less than $25 million.[167] Consequently, we estimate that the majority of satellite telecommunications providers are small entities.

45. *All Other Telecommunications*. The **"**All Other Telecommunications" category is comprised of establishments primarily engaged in providing specialized telecommunications services, such as satellite tracking, communications telemetry, and radar station operation.[168] This industry also includes establishments primarily engaged in providing satellite terminal stations and associated facilities connected with one or more terrestrial systems and capable of transmitting telecommunications to, and receiving telecommunications from, satellite systems.[169] Establishments providing Internet services or voice over Internet protocol (VoIP) services via client-supplied telecommunications connections are also included in this industry.[170] The SBA has developed a small business size standard for All Other Telecommunications, which consists of all such firms with annual receipts of $35 million or less.[171] For this category, U.S. Census Bureau data for 2012 show that there were 1,442 firms that operated for the entire year.[172] Of those firms, a total of 1,400 had annual receipts less than $25 million and 15 firms had

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[162] *See* Federal Communications Commission, Wireline Competition Bureau, Industry Analysis and Technology Division, Trends in Telephone Service at Table 5.3 (Sept. 2010) (*Trends in Telephone Service*), https://apps.fcc.gov/edocs_public/attachmatch/DOC-301823A1.pdf (last visited Mar. 19, 2020).

[163] *Id*.

[164] U.S. Census Bureau, *2017 NAICS Definitions, "517410 Satellite Telecommunications";* https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=517410&search=2017+NAICS+Search&search=2017 (last visited Mar. 19, 2020).

[165] 13 CFR § 121.201, NAICS code 517410.

[166] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1251SSSZ4, Information: Subject Series - Estab and Firm Size: Receipts Size of Firms for the United States: 2012, NAICS Code 517410, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ4//naics~517410 (last visited Mar. 19, 2020).

[167] *Id*. The available U.S. Census Bureau data does not provide a more precise estimate of the number of firms that meet the SBA size standard of annual receipts of $35 million or less.

[168] *See* U.S. Census Bureau, 2017 NAICS Definitions, NAICS Code "517919 All Other Telecommunications", https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=517919&search=2017+NAICS+Search&search=2017 (last visited Mar. 19, 2020).

[169] *Id*.

[170] *Id*.

[171] *See* 13 CFR § 121.201, NAICS code 517919.

[172] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1251SSSZ4, Information: Subject Series - Estab and Firm Size: Receipts Size of Firms for the United States: 2012, NAICS code 517919, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ4//naics~517919 (last visited Mar. 19, 2020).

annual receipts of $25 million to $49, 999,999.[173] Thus, the Commission estimates that the majority of "All Other Telecommunications" firms potentially affected by our action can be considered small.

b. Internet Service Providers

46. *Internet Service Providers* (*Broadband*). Broadband Internet service providers include wired (e.g., cable, DSL) and VoIP service providers using their own operated wired telecommunications infrastructure fall in the category of Wired Telecommunication Carriers.[174] Wired Telecommunications Carriers are comprised of establishments primarily engaged in operating and/or providing access to transmission facilities and infrastructure that they own and/or lease for the transmission of voice, data, text, sound, and video using wired telecommunications networks. Transmission facilities may be based on a single technology or a combination of technologies.[175] The SBA size standard for this category classifies a business as small if it has 1,500 or fewer employees.[176] U.S. Census Bureau data for 2012 show that there were 3,117 firms that operated that year. Of this total, 3,083 operated with fewer than 1,000 employees.[177] Consequently, under this size standard, the majority of firms in this industry can be considered small.

47. *Internet Service Providers* (*Non-Broadband*). Internet access service providers such as Dial-up Internet service providers, VoIP service providers using client-supplied telecommunications connections and Internet service providers using client-supplied telecommunications connections (e.g., dial-up ISPs) fall in the category of All Other Telecommunications. The SBA has developed a small business size standard for All Other Telecommunications, which consists of all such firms with gross annual receipts of $35 million or less.[178] For this category, U.S. Census Bureau data for 2012 show that there were 1,442 firms that operated for the entire year. Of these firms, a total of 1,400 had gross annual receipts of less than $25 million.[179] Consequently, under this size standard, a majority of firms in this industry can be considered small.

c. Vendors and Equipment Manufacturers

48. *Vendors of Infrastructure Development or "Network Buildout."* The Commission has not developed a small business size standard specifically directed toward manufacturers of network facilities. There are two applicable SBA categories in which manufacturers of network facilities could fall and each have different size standards under the SBA rules. The SBA categories are "Radio and Television Broadcasting and Wireless Communications Equipment" with a size standard of 1,250 employees or less[180] and "Other Communications Equipment Manufacturing" with a size standard of 750

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[173] *Id.*

[174] *See* 13 CFR § 121.201. The Wired Telecommunications Carrier category formerly used the NAICS Code of 517110. As of 2017 the U.S. Census Bureau definition show the NAICS Code as 517311. *See* U.S. Census Bureau, *2017 NAICS Definition*, 517311 Wired Telecommunications Carriers, https://www.census.gov/cgi-bin/sssd/naics/naicsrch?code=517311&search=2017 (last visited Mar. 4, 2020) (2017 NAICS Definition, 517311 Wired Telecommunications Carriers).

[175] 2017 NAICS Definition, 517311 Wired Telecommunications Carriers.

[176] *Id.*

[177] *See* U.S. Census Bureau, *2012 Economic Census of the United States*, Table No. EC1251SSSZ5, *Information: Subject Series - Estab & Firm Size: Employment Size of Firms:* 2012, NAICS Code 517110, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/51SSSZ5//naics~517110 (last visited Mar. 4, 2020).

[178] 13 CFR § 121.201; NAICS Code 517919.

[179] U.S. Census Bureau, *2012 Economic Census Table*, Table EC1251SSSZ4, *Information: Subject Series - Estab & Firm Size: Receipts Size of Firms for the U.S.*: 2012, NAIC Code 517919, https://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?src=bkmk (last visited Mar. 4, 2020).

[180] 13 CFR § 121.201; NAICS Code 334220.

employees or less."[181] U.S. Census Bureau data for 2012 show that for Radio and Television Broadcasting and Wireless Communications Equipment firms 841 establishments operated for the entire year.[182] Of that number, 828 establishments operated with fewer than 1,000 employees, 7 establishments operated with between 1,000 and 2,499 employees and 6 establishments operated with 2,500 or more employees.[183] For Other Communications Equipment Manufacturing, U.S. Census Bureau data for 2012 show that 383 establishments operated for the year.[184] Of that number, 379 firms operated with fewer than 500 employees and 4 had 500 to 999 employees. Based on these data, we conclude that the majority of Vendors of Infrastructure Development or "Network Buildout" are small.

49. *Telephone Apparatus Manufacturing*. This industry comprises establishments primarily engaged in manufacturing wire telephone and data communications equipment. These products may be standalone or board-level components of a larger system. Examples of products made by these establishments are central office switching equipment, cordless telephones (except cellular), PBX equipment, telephones, telephone answering machines, LAN modems, multi-user modems, and other data communications equipment, such as bridges, routers, and gateways."[185] The SBA size standard for Telephone Apparatus Manufacturing is all such firms having 1,250 or fewer employees.[186] According to U.S. Census Bureau data for 2012, there were a total of 266 establishments in this category that operated for the entire year.[187] Of this total, 262 had employment of under 1,000, and an additional 4 had employment of 1,000 to 2,499.[188] Thus, under this size standard, the majority of firms can be considered small.

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[181] 13 CFR § 121.201; NAICS Code 334290.

[182] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size*: 2012, NAICS Code 334220, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2//naics~334220 (last visited Mar. 4, 2020).

[183] *Id*.

[184] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size*: 2012, NAICS Code 334290, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2//naics~334290 (last visited Mar. 4, 2020).

[185] U.S. Census Bureau, *2012 NAICS Definition and Comparability*, "2012 NAICS: 334210 - Telephone apparatus manufacturing," https://www.census.gov/econ/isp/sampler.php?naicscode=334210&naicslevel=6# (last visited Mar. 4, 2020).

[186] 13 CFR § 121.201; NAICS Code 334210.

[187] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size*: 2012, NAICS Code 334210, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2//naics~334210 (last visited Mar. 4, 2020). The number of "establishments" is a less helpful indicator of small business prevalence in this context than would be the number of "firms" or "companies," because the latter take into account the concept of common ownership or control. Any single physical location for an entity is an establishment, even though that location may be owned by a different establishment. Thus, the numbers given may reflect inflated numbers of businesses in this category, including the numbers of small businesses. In this category, the Census data for firms or companies only gives the total number of such entities for 2012, which was 250. *See also* U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG1, *Manufacturing: Summary Series: General Summary: Detailed Statistics by Subsectors and Industries*: 2012, NAICS Code 334210 https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG1//naics~334210 (last visited Mar. 4, 2020).

[188] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size*: 2012, NAICS Code 334210, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2//naics~334210 (last visited Mar. 4, 2020). An additional 4 establishments had employment of 2,500 or more.

50. *Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing.* This industry comprises establishments primarily engaged in manufacturing radio and television broadcast and wireless communications equipment.[189] Examples of products made by these establishments are: transmitting and receiving antennas, cable television equipment, GPS equipment, pagers, cellular phones, mobile communications equipment, and radio and television studio and broadcasting equipment.[190] The SBA has established a small business size standard for this industry of 1,250 employees or less.[191] U.S. Census Bureau data for 2012 show that 841 establishments operated in this industry in that year.[192] Of that number, 828 establishments operated with fewer than 1,000 employees, 7 establishments operated with between 1,000 and 2,499 employees and 6 establishments operated with 2,500 or more employees.[193] Based on these data, we conclude that a majority of manufacturers in this industry are small.

51. *Other Communications Equipment Manufacturing.* This industry comprises establishments primarily engaged in manufacturing communications equipment (except telephone apparatus, and radio and television broadcast, and wireless communications equipment).[194] Examples of such manufacturing include fire detection and alarm systems manufacturing, Intercom systems and equipment manufacturing, and signals (e.g., highway, pedestrian, railway, traffic) manufacturing.[195] The SBA has established a size for this industry as all such firms having 750 or fewer employees.[196] U.S. Census Bureau data for 2012 show that 383 establishments operated in that year.[197] Of that number, 379 operated with fewer than 500 employees and 4 had 500 to 999 employees.[198] Based on these data, we conclude that the majority of Other Communications Equipment Manufacturers are small.

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[189] The NAICS Code for this service is 334220. 13 CFR § 121.201. *See also* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 334220 "Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing," https://factfinder.census.gov/faces/affhelp/jsf/pages/metadata.xhtml?lang=en&type=ib&id=ib.en./ECN.NAICS2012.334220# (last visited Mar. 4, 2020).

[190] *See also* U.S. Census Bureau, *2012 NAICS Definitions*, NAICS Code 334220 "Radio and Television Broadcasting and Wireless Communications Equipment Manufacturing," https://factfinder.census.gov/faces/affhelp/jsf/pages/metadata.xhtml?lang=en&type=ib&id=ib.en./ECN.NAICS2012.334220# (last visited Mar. 4, 2020).

[191] 13 CFR § 121.201; NAICS Code 334220.

[192] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size*: 2012, NAICS Code 334220, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2//naics~334220 (last visited Mar. 4, 2020).

[193] *Id*.

[194] U.S. Census Bureau, *2017 NAICS Definition*, NAICS Code "334290 Other Communications Equipment Manufacturing," https://www.census.gov/cgi-bin/sssd/naics/naicsrch?input=334290&search=2017+NAICS+Search&search=2017 (last visited Mar. 4, 2020).

[195] *Id.*

[196] 13 CFR § 121.201, NAICS Code 334290.

[197] U.S. Census Bureau, *2012 Economic Census of the United States*, Table EC1231SG2, *Manufacturing: Summary Series: General Summary: Industry Statistics for Subsectors and Industries by Employment Size*: 2012, NAICS Code 334290, https://factfinder.census.gov/bkmk/table/1.0/en/ECN/2012_US/31SG2//naics~334290 (last visited Mar. 4, 2020).

[198] *Id.*

E. Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements for Small Entities

52. In the Report and Order, the Commission establishes a Pilot Program within the USF that will make available up to $100 million over three years to help defray eligible health care providers' costs of providing connected care services primarily to low-income or veteran patients for purposes of connected care. The Commission also establishes an COVID-19 Telehealth Program funded through a $200 million congressional appropriation under the Coronavirus Aid, Relief, and Economic Security (CARES) Act,[199] for COVID-19 relief to help eligible health care providers meet the health care needs of their patients during the COVID-19 pandemic. The Pilot Program is structured to target funding to eligible health care providers serving patients that are most likely to need USF support for connected care services, and to ensure that the Pilot Program provides meaningful, measurable data. To participate in the Pilot Program, health care providers must satisfy the definition of an eligible health care provider under section 254(h)(7)(B) of the Act and receive an eligibility determination from the Universal Service Administrative Company (USAC), the administrator of the USF programs. Applicants must then submit an application to the Commission regarding their pilot projects by the application deadline ultimately established for the Pilot Program. While the COVID-19 Telehealth Program is structured a bit differently than the Pilot Program, applicants for both programs will be required to certify that they will comply with all applicable requirements and procedures. Applicants among other things, will also be required to comply with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy and reimbursement laws and regulations, and applicable medical licensing laws and regulations, including document retention requirements, subject to audit.[200]

53. As part of Pilot Program, the Commission seeks a diverse set of pilot projects from a wide variety of eligible health care providers and eligible service providers, including small entities. The Commission seeks to strike a balance between requiring applicants to submit enough information that allows us to select high-quality, cost-effective pilot projects that would best further the goals of the Pilot Program, but also minimizing the administrative burdens on entities that seek to apply. The Report and Order provides specific information that health care providers are required to submit in their applications for each pilot project proposal, including, but not limited to, information on the participating health care provider(s), description of the pilot project and how it would further the goals of the Pilot Program, estimated pilot project budget, patient populations and the geographic areas to be served and health conditions to be treated. The Report and Order also establishes a streamlined application process for the COVID-19 Telehealth Program in order to more expeditiously address the needs of health care providers affected by the coronavirus epidemic.

54. After evaluation of the Pilot Program applications, the Bureau will announce the selected pilot projects and provide further information on the specific requirements for the Pilot Program. Selected Pilot Program participants will be required to conduct a competitive bidding process (unless a competitive bidding exemption applies), including submitting the required competitive bidding forms, for the eligible equipment and services that are supported through the Pilot Program. Participating health care providers will then be required to submit a request for funding with USAC with specific pricing and service information, and will also be required to submit invoicing forms and supporting documentation on a monthly basis for the supported equipment and services. Participating health care providers will also be required to periodically submit data to the Bureau concerning their pilot project after each year of funding during the three-year period of the pilot project, and will also be required to submit a final report concerning their pilot projects. For the COVID-19 Telehealth Program, within six months after the

[199] CARES Act, Pub. L. No 116-136, 134 Stat. 281 (2020). The CARES Act appropriates $200 million to 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 pendency of the COVID-19 pandemic. *Id*.

[200] *See* 47 CFR § 54.631.

conclusion of the COVID-19 Telehealth Program, participants should provide a report to the Commission on the effectiveness of the program. While some of the requirements of the Pilot Program and the COVID-19 Telehealth Program will result in additional recordkeeping and compliance requirements for small entities, we have determined that the benefits of establishing these programs outweighs the burden of any increased recordkeeping and compliance requirements for those small entities that choose to participate in the Pilot Program and the COVID-19 Telehealth Program. Additionally, the requirements are intended to ensure universal service funds are used for their intended purpose and designed so that the Commission can obtain meaningful data to evaluate the Pilot Program and inform our policy decisions.

F. Steps Taken to Minimize the Significant Economic Impact on Small Entities, and Significant Alternatives Considered

55. The RFA requires an agency to describe any significant alternatives that it has considered in reaching its proposed approach, which may include (among others) the following four alternatives: (1) the establishment of differing compliance or reporting requirements or timetables that take into account the resources available to small entities; (2) the clarification, consolidation, or simplification of compliance or reporting requirements under the rule for small entities; (3) the use of performance, rather than design, standards; and (4) an exemption from coverage of the rule, or any part thereof, for small entities.[201]

56. The Pilot Program is for a discrete, limited period of time. The Commission expects to apply the Commission's rules applicable to the Healthcare Connect Fund Program to the Pilot Program, which some entities may already be familiar with if they currently participate in the Healthcare Connect Fund Program. We also do not expect small entities to be disproportionately impacted. In evaluating the applications, the Commission seeks to select a diverse set of pilot projects and will consider whether the proposed pilot projects promotes entrepreneurs and other small businesses in the provision and ownership of telecommunications and information services, including those that may be socially and economically disadvantaged businesses. All eligible health care providers that participate in the Pilot Program will be required to collect and submit data to the Commission at designated intervals during the Pilot Program. We have not yet established metrics to measure the Pilot Program goals and seek information from applicants on the metrics they plan to use and how they plan collect those metrics in order to minimize any impact on small entities when establishing metrics for the Pilot Program. The collection of this information, however, is necessary to evaluate the impact of the Pilot Program, including whether the Pilot Program achieves its goals. Thus, the benefits of collecting this information outweigh any significant economic impact on small entities. Moreover, the Commission sought comment on the IRFA and did not receive any comments in response to the IRFA. Further, in order to minimize the economic impact on small entities, the Commission establishes an emergency COVID-19 Telehealth Program, which is one piece of a comprehensive approach to reducing barriers to telehealth services for patients and health care facilities throughout the country to provide relief related to the COVID-19 pandemic. We therefore believe that the requirements of the Report and Order will not have a significant economic impact on a substantial number of small entities.

G. Report to Congress:

57. The Commission will send a copy of the Report and Order, including this FRFA, in a report to be sent to Congress and the Government Accountability Office pursuant to the Small Business Regulatory Enforcement Fairness Act of 1996.[202] In addition, the Commission will send a copy of the Report and Order, including the FRFA, to the Chief Counsel for Advocacy of the Small Business

[201] 5 U.S.C. § 603(c).

[202] 5 U.S.C. § 801(a)(1)(A).

Administration. A copy of the Report and Order and FRFA (or summaries thereof) will also be published in the Federal Register.[203]

[203] *See id*. § 604(b).

APPENDIX B

Promoting Telehealth for Low-Income Consumers
(*Connected Care Notice*)

Comments and Reply Comments

FCC 19-64

Comments

Commenter	*Abbreviation*	*Date Filed*
AdventHealth	AH	Aug. 29, 2019
American College of Emergency Physicians	ACEP	Aug. 27, 2019
America's Communications Association	ACA Connects	Aug. 29, 2019
America's Essential Hospitals	AEH	Aug. 29, 2019
America's Health Insurance Plans	AHIP	Aug. 28, 2019
American Academy of Family Physicians	AAFP	Aug. 28, 2019
American Association of Nurse Practitioners	AANP	Aug. 29, 2019
American Hospital Association	AHA	Aug. 29, 2019
American Medical Informatics Association	AMIA	Aug. 29, 2019
American Optometric Association	AOA	Aug. 29, 2019
American Physical Therapy Association	APTA	Aug. 19, 2019
American Urological Association	AUA	Aug. 29, 2019
Augusta University	AU	Aug. 12, 2019
Association of State and Territorial Health Officials	ASTHO	Aug. 29, 2019
Blue Cross Blue Shield Association	BCBSA	Aug. 29, 2019
CHRISTUS Health	CHRISTUS	Aug. 29, 2019
CTIA	CTIA	Aug. 29, 2019
Cascade Comprehensive Care, Inc.	CCC	Aug. 8, 2019
Center for Connected Health Policy	CCHP	Aug. 22, 2019
The Center for the Advancement of mHealth	mHealth	Aug. 15, 2019
Children's Hospital of Wisconsin	Children's	Aug. 29, 2019
CoBank, ACB	CoBank	Aug. 27, 2019
Connected Health Initiative	CHI	Aug. 29, 2019
ConnectME Authority	ConnectME	Aug. 29, 2019
Doctor on Demand, Inc.	Dr. on Demand	Aug. 29, 2019
Federation of American Hospitals	FAH	Aug. 29, 2019
Federation of State Medical Boards	FSMB	Aug. 29, 2019
Geisinger Health System	Geisinger	Aug. 26, 2019
Gila River Telecommunications, Inc.	GRTI	Aug. 29, 2019
HNC Virtual Solutions	HNC	Aug. 29, 2019
Hathaway-Sycamores Child and Family Services	Hathaway-Sycamores	July 26, 2019
Healthcare Information and Management Systems Society & Personal Connected Health Alliance	HIMSS PCH Alliance	Aug. 28, 2019
Healthcare Leadership Council	HLC	Aug. 29, 2019
Hodei Technology	Hodei	Aug. 29, 2019
Hughes Network Systems, LLC	Hughes	Aug. 29, 2019
Legacy Community Health	Legacy	Aug. 29, 2019
Lifeguard Health Networks, Inc.	LHN	Aug. 29, 2019
MaineHealth	MH	Aug. 29, 2019
Medical University of South Carolina, et al.	MUSC	Aug. 29, 2019
Mercatus Center at George Mason University (Jared Rhoads)	MercatusGMU/Rhoads	Aug. 27, 2019
Mercatus Center at George Mason University (Darcy Bryan)	MercatusGMU/Bryan	Aug. 27, 2019

Mercy Virtual	Mercy Virtual	Aug. 29, 2019
MetroHealth System	MetroHealth	Aug. 29, 2019
Microsoft	Microsoft	Aug. 29, 2019
Multistakeholder Digital Health Group	Multistakerholder	Aug. 29, 2019
The Muscogee (Creek) Nation	MCN	Aug. 29, 2019
myNEXUS, Inc.	myNexus	Aug. 29, 2019
NCTA - The Internet & Television Association	NCTA	Aug. 29, 2019
National Consortium of Telehealth Resource Centers	NCTRC	Aug. 29, 2019
Netsmart	Netsmart	Aug. 29, 2019
OCHIN	OCHIN	Aug. 28, 2019
Ochsner Health System	Ochsner	Aug. 29, 2019
Partners HealthCare System, Inc.	PHS	Aug. 28, 2019
The Partnership for Artificial Intelligence Telemedicine, and Robotics in Healthcare	PATH	Aug. 29, 2019
Pharmacy Health Information Technology Collaborative	PHIT	Aug. 29, 2019
Sage Telecom Communications, LLC	TruConnect	Aug. 29, 2019
Seneca Nation of Indians	Seneca Nation	Aug. 29, 2019
South Carolina Children's Telehealth Collaborative	SC CTC	Aug. 29, 2019
The State of Colorado	Colorado	Aug. 29, 2019
StationMD	StationMD	Aug. 28, 2019
Susan Conaty-Buck	Conaty-Buck	Aug. 29, 2019
Telecommunications Association of Maine	TAM	Aug. 29, 2019
Telemedicine Centers USA	Telemedicine	Aug. 28, 2019
Texas Organization of Rural & Community Hospitals	TORCH	Aug. 27, 2019
United Health Group	UHG	Aug. 29, 2019
University of California San Diego	UCSD	Aug. 29, 2019
USTelecom – The Broadband Association	USTelecom	Aug. 29, 2019
University of Mississippi Medical Center	UMMC	Aug. 29, 2019
Verizon	Verizon	Aug. 29, 2019
Viraspex	Viraspex	Aug. 29, 2019
Virginia Telehealth Network	VTN	Aug. 29, 2019

Reply Comments

Commenter	***Abbreviation***	***Date Filed***
Adeline Costello		Sept. 30, 2019
ATN International, Inc.	ATN	Sept. 30, 2019
Aerospace and Flight Test Radio Coordinating Council, Inc.	AFTRCC	Sept. 13, 2019
America's Communications Association	ACA Connects	Sept. 30, 2019
CHRISTUS Health	CHRISTUS	Sept. 30, 2019
California Primary Care Association	CPCA	Aug. 30, 2019
The Center for the Advancement of mHealth	mHealth	Sept. 30, 2019
CenturyLink	CL	Sept. 30, 2019
College of Healthcare Information Management Executive & Association for Executives in Healthcare Information Technology	CHIME AEHIT	Sept. 30, 2019
Comcast Corporation	Comcast	Sept. 30, 2019
Florida Association of Community Health Centers, Inc.	FACHC	Sept. 30, 2019
HNC Virtual Solutions	HNC	Sept. 26, 2019
Lifeguard Health Networks, Inc.	LHN	Sept. 30, 2019
Mercy Virtual	Mercy	Sept. 30, 2019
Molly Davis	Davis	Sept. 26, 2019

NCTA - The Internet & Television Association	NCTA	Sept. 30, 2019
National Association of Community Health Centers	NACHC	Sept. 30, 2019
Nykole Sourivong	Sourivong	Sept. 30, 2019
Ochsner Health System	Ochsner	Sept. 30, 2019
Open Arms Assisted Living	Open Arms	Sept. 24, 2019
The Pacific Basin Telehealth Resource Center	PBTRC	Sept. 27, 2019
The Partnership for Artificial Intelligence Telemedicine, and Robotics in Healthcare	PATH	Sept. 30, 2019
RemoteMD Medical Services	RemoteMD	Sept. 27, 2019
Swinomish Indian Tribal Community	Swinomish Tribe	Sept. 13, 2019
UPMC	UPMC	Aug. 30, 2019
UVA Health	UVAHealth	Sept. 19, 2019
Viraspex – The Virtual Vascular Specialists	Viraspex	Sept. 30, 2019
Virginia Community Healthcare Association	VCHA	Sept. 30, 2019

STATEMENT OF
CHAIRMAN AJIT PAI

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

Almost two years ago, former FCC Chairman Newt Minow and I advocated for telemedicine as "a critical tool for making Americans healthier," and called for forward-thinking policies that could "bring[] our health care system more fully into the digital age."[1] Now, in the midst of the national emergency caused by the coronavirus pandemic, our call has taken on serious urgency. Connected care can help us treat coronavirus patients, enable patients with other conditions to get care while maintaining social distancing, and protect health care professionals from greater exposure.

The FCC has an important role to play in achieving that result. Indeed, I'm hard-pressed these days to think of any better use case for the agency's mission of advancing connectivity than telemedicine. And here, we take perhaps the most important step in fulfilling that role by establishing the COVID-19 Telehealth Program. This $200 million program will enable health care providers to deliver cutting-edge care to patients outside the context of a bricks-and-mortar health care facility.

Thank you to President Trump for signing the CARES Act, which among other things provided the FCC with $200 million in funding for the COVID-19 Telehealth Program. Thank you to the bipartisan coalition in Congress (particularly Senators John Kennedy, Chris Coons, and Roger Wicker, and Congressman Greg Walden) that included this funding in the law, as I had requested weeks ago.

Thank you to my FCC colleagues for voting to approve my plan with dispatch. Thank you to Commission Carr for leading on our telehealth efforts, including the Connected Care Pilot Program that we also approve today.

And thank you to the incredible staff of the FCC. We may be in the midst of the most substantial disruption to our day-to-day operations in recent memory, but our dedicated team has delivered—and at one of the most important times in modern history. For all they have done, I want to express my deep gratitude to Allison Baker, Regina Brown, Rashann Duvall, Darren Fernandez, Trent Harkrader, Kris Monteith, Ryan Palmer, Joseph Schlingbaum, and Hayley Steffen from the Wireline Competition Bureau; Deena Shetler and Cara Voth from the Office of the Managing Director; Malena Barzilai, Michael Carlson, Thomas Johnson, Andrea Kelly, Richard Mallen, and Linda Oliver from the Office of General Counsel; Octavian Carare, Stacey Jordan, Giulia McHenry, Eric Ralph, Steven Rosenberg, Emily Talaga, and Tracy Waldon from the Office of Economics and Analytics; and Dr. David Ahern, Ben Bartolome, Michele Ellison, Dr. Chris Gibbons, and Karen Onyeije from the Connect2HealthFCC Task Force.

[1] Newton N. Minow and Ajit Pai, "In rural America, digital divide slows a vital path for telemedicine," *The Boston Globe* (May 21, 2018), *available at* https://www.bostonglobe.com/opinion/2018/05/20/rural-america-digital-divide-slows-vital-path-for-telemedicine/t8n4ncsfFcUASdf7XLH38J/story.html.

STATEMENT OF
COMMISSIONER MICHAEL O'RIELLY
APPROVING IN PART, DISSENTING IN PART

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

Without reservation, I support the first part of this item, which establishes the emergency COVID-19 Telehealth Program pursuant to clear authority provided by Congress under the CARES Act. As our nation engages in a heroic fight against COVID-19, our lawmakers are trying to do everything they can to ensure health care providers have what they need to deliver critical telehealth services to patients. While the $200 million COVID-19 Telehealth Program provides considerable discretion to staff and is short on details, this framework is arguably appropriate given our current emergency situation and has been blessed by Congress.

In contrast, the second part of the item—based on the very limited time I have had to review it—seems to have been half-cooked and rushed out the door to take advantage of the current crisis, even though there's barely anything about it that's expedited or related to COVID-19—other than the means of its adoption. It would be one thing to excuse the Connected Care Pilot Program's extremely weak legal footing—which Congress could have supplied but either wasn't asked for or specifically chose not to provide—or its scant details and total lack of economic analysis if the program were truly going to help fight COVID-19. And, while it is indeed being spun as targeting the awful pandemic causing devastation to people around the world, it seems hard to imagine how any of its funding could be distributed anytime soon, based on the timelines in the item.

I did not want my serious reservations over the Pilot to jeopardize the timely adoption of the urgent COVID-19 Telehealth Program and therefore requested that Commissioners be allowed to vote for the two items separately. Doing so would allow Commissioners to adopt the COVID-19 funding infusion in an expeditious manner, while enabling us to properly vet and thoroughly consider the Pilot Program. For specious reasons, that request didn't carry the day and Commissioners were asked to register our votes for the combined item on a hurried basis, which eliminated the opportunity to suggest edits, let alone properly digest the item. This was not a prudent or effective policymaking process, in my opinion.

Caught in a difficult position, I have been left with no choice other than to dissent with respect to the Pilot. While it's possible that with some tweaks and revisions, the program could have been modified to earn my approval or a concurrence, the current version needs more work. Perhaps it never would have satisfied my principles of fiscal conservatism, but I would have at least been willing to make a good faith effort to get to yes.

For one, I am certainly troubled by an across-the-board 85 percent discount rate, which seems to make no sense for a program designed to fund both urban and rural applicants and has no relationship to applicants' means. Further, that rate appears to have been picked either randomly, or for no other reason than having been used in the 2007 Rural Health Care Pilot Program, which, unlike this Pilot, was created to fund network deployment. This lack of rigor is beneath the Commission's standard.

Moreover, it's bad enough when the federal government runs a "beauty contest" to distribute funding, but the lack of even a points system here is completely unacceptable. Who are we to criticize other agencies for skewed evaluation frameworks or technology bias, when we ourselves are about to run a $100 million program with zero objective criteria for how applications will be evaluated? This dearth of transparency and accountability appears very problematic, and certainly sets a bad precedent.

And, that's apart from the legal problems this item faces. First, the draft plays incredibly fast and loose with section 254(h)(2)(a), stretching the meaning of "competitively neutral rules" beyond recognition and inventing an interpretation of "health care providers" that would never fly with this Commission in the schools and libraries context. I also disagree with past Commission interpretations that claimed we had the authority to cover urban providers or even run a pilot program at all. Again, we

could have worked with Congress to address existing limitations, if lawmakers were on board; for example, consider that the Commission was only able to expand the Rural Health Care program to cover skilled nursing facilities through Congressional action. But, endorsing past mistakes without such a blessing is not something I can condone. Working with Congressional representatives—even if results may take longer than desired—is a privilege, not a penalty, and would have provided a much more appropriate foundation for such a program.

Further, as raised by commenters, as well as the Department of Health and Human Services (HHS), the program would blatantly violate the federal Anti-Kickback Statute. While the item apparently recognizes this problem, its only response is that applicants should "speak to their compliance experts," which doesn't seem quite adequate.

Finally, I strongly object to the program's "neither here nor there" funding source. Presumably to avoid taking money away from any of the four existing USF programs, or at least the optics of doing so, the item would fund the program via "general" USF funding, thus necessitating a higher contribution factor and increased burdens for ratepayers. But that sets an incredibly fiscally reckless precedent; now, the FCC can simply obfuscate the USF sub-caps whenever these constraints turn out to be inconvenient. It also completely belies the claim made by many in response to the USF cap proceeding, that as long as all four USF programs had individual caps, there was no need for an overall USF budget. If we can take ratepayer money to establish a new program outside of the four existing ones, then there aren't any real constraints on USF spending after all, and this item unwittingly makes the case for an overall USF cap.

In the end, while I applaud Chairman Pai and the FCC for moving forward with the COVID-19 program expeditiously, I cannot endorse the decision to rush the Connected Care Pilot out the door in its current state. Therefore, I have voted to approve in part and dissent in part.

STATEMENT OF
COMMISSIONER BRENDAN CARR

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

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

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

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

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

When I was in Laurel Fork, Virginia, which sits near the heart of Appalachia, I met a woman named Cathleen who told me that she struggled for years with uncontrolled diabetes. She had been diagnosed five years before, and receiving treatment meant a two-hour round trip drive to see a doctor. Finding transportation and getting to the clinic wasn't easy, so, like many others dealing with chronic conditions, Cathleen stopped going in for treatment for a few years. When she went back to the doctor, her A1C levels—the blood glucose levels used to indicate diabetes—had skyrocketed to 15.5. Levels that high are considered critical and are commonly followed by strokes and heart attacks. So, her doctor signed her up for remote patient monitoring technologies similar to the ones that had been used by Miss Annie. Through those connected devices, Cathleen's vitals were monitored daily and checked by a team of endocrinologists and specialists at the Laurel Fork community health center and the University of Virginia. After six months her A1C dropped to 7.5, and she has enough energy to run and play with her three grandkids.

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

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

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

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

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

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

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

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

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

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

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

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

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

STATEMENT OF
COMMISSIONER JESSICA ROSENWORCEL,
APPROVING IN PART, CONCURRING IN PART

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

This is a perilous time. The coronavirus pandemic has crashed our economy, filled our hospitals, emptied our public spaces, and tested our communications like nothing before. The news is dizzying. The numbers are harrowing. This virus does not discriminate and in some way, shape, or form it will change us all.

But if there's a source of optimism in this moment, it comes from watching communities come together to respond to this pandemic. There are heroes all around us. If you want to look for them, start with the doctors, nurses, and people working in our nation's healthcare facilities. They are on the front lines in this battle, and they deserve our thoughts, prayers, and boundless gratitude.

They also deserve every possible resource we can give them in this fight.

Congress saw fit to do just that in the Coronavirus Aid Relief and Economic Security Act, when it charged the Federal Communications Commission with the authority to distribute $200 million in special funding to healthcare providers using telemedicine to help provide care in this crisis. This effort is smart and comes not a moment too soon. The toll this pandemic is taking on our healthcare system is clear. It also presents new challenges for patients seeking care for other ailments. To the extent that connectivity solutions can provide immediate assistance with remote care and monitoring, we should use them. There is already evidence across the country that this works. Take, for instance, one hospital in Washington state that is already sending some patients home with a thermometer and pulse oximeter so that doctors can remotely monitor their condition. This is smart because it frees up hundreds of beds and reduces exposure for healthcare workers and patients.

With this new $200 million program authorized by Congress, the FCC has the opportunity to put these kind of tools to use across the country. To this end, in today's decision the FCC commits to fund a range of new healthcare devices and services that depend on connectivity.

We need to get this right. As the text of this decision makes clear, we intend to deploy the $200 million provided in this program to those areas hardest hit by the coronavirus. I hope we do so in a manner that is fast and fair, without playing favorites. It would be shameful for the FCC to do otherwise—as I fear we are seeing elsewhere in the national response.

In the end, I believe this effort to deploy the new $200 million in funding provided by Congress is both necessary and timely. It has my full support.

While we launch this immediate effort to counteract the pandemic, the FCC separately kicks off its own three-year program to explore connected care. This $100 million effort is not undertaken at the explicit direction of Congress. Instead, it is crafted by the FCC alone. It is designed to demonstrate the possibilities of improved care by facilitating direct patient and provider connections through funding the purchase of network equipment and services. It is specifically focused on veterans and low-income individuals.

This is a well-intended effort, but it lacks clear performance metrics. That means it will disburse funds without a system for measuring outcomes or a plan for what comes after this pilot program reaches its end. Moreover, it does not focus on a specific problem in healthcare. So I hope as this effort moves forward, we heed the words of Congressman G.K. Butterfield and 27 other Members of Congress who implored us to focus our attention with this program on the country's maternal mortality crisis. They also urged us to fund such a project in every state. That makes sense because we need to ensure the benefits of this program are available all across the country. Again, it's not time to play favorites. Because the guardrails here are so limited, I can only concur.

Finally, it is important to note that our legal analysis here pursuant to Section 254 of the Communications Act allows for the delivery of services to patients beyond the traditional four corners of the hospital building or healthcare facility. The very same analysis supports delivering connectivity to students struggling at home during this crisis with the Homework Gap. Millions of kids have found that their schools have closed and classes have migrated online. But so many of them lack the internet access they need to continue their education. It's time for the FCC to step up to the plate and use the powers it displays such willingness to use here in service of our nation's students. If we do, we can solve the Homework Gap and make a meaningful difference in the lives of millions of students. We should.

STATEMENT OF
COMMISSIONER GEOFFREY STARKS

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

As more and more Americans are being asked to stay home, the already urgent need for expanded telehealth resources has become even more critical. Unless in-person care is required for a medical reason, experts agree that getting care from a distance helps protect the entire community. Coming from a family of doctors, I have already heard numerous stories from my father and brothers of how caregivers on the front lines are using telehealth to address the challenges of COVID-19. I appreciate that Congress recognized this need in the CARES Act, and that the Commission has acted quickly to start the process of getting that money into the field. Thank you to the many members of the Commission's staff who worked quickly under challenging conditions to make this possible.

Looking ahead, I believe that long-term investments in telehealth will improve healthcare when this crisis has passed and help us prepare for future public health emergencies. We know that many places across the country face shortages of doctors and other public health providers. In my travels around the country, people in both small towns and big cities have told me about the challenges of in-person visits because of medical resources that are too far away, health conditions that make travel difficult, or simply a lack of qualified providers. As I have noted previously, this situation is particularly acute when it comes to access to mental health services. According to the Health Resources & Services Administration, 112 million Americans live in areas with shortages of such caregivers. I am pleased, therefore, to see that the pilot program we adopt today includes mental health services.

I am also glad that the pilot program focuses on meeting the needs of low-income people and veterans. As the coronavirus pandemic continues, more and more Americans face unprecedented economic challenges. Just last week, a record 3.3 million American applied for unemployment benefits. More hardships are ahead. I am hopeful that this pilot program will both provide targeted assistance to communities in need as soon as possible and pave the way for a broader commitment to improving health care and connectivity for low-income people.