

environmental health or safety risks that the EPA has reason to believe may disproportionately affect children, per the definition of “covered regulatory action” in section 2–202 of the Executive Order. This action is not subject to Executive Order 13045 because it does not impose additional requirements beyond those imposed by state law.

I. Executive Order 13211: Actions That Significantly Affect Energy Supply, Distribution, or Use

This action is not subject to Executive Order 13211, because it is not a significant regulatory action under Executive Order 12866.

J. National Technology Transfer and Advancement Act (NTTAA)

Section 12(d) of the NTTAA directs the EPA to use voluntary consensus standards in its regulatory activities unless to do so would be inconsistent with applicable law or otherwise impractical. The EPA believes that this action is not subject to the requirements of section 12(d) of the NTTAA because application of those requirements would be inconsistent with the CAA.

K. Executive Order 12898: Federal Actions To Address Environmental Justice in Minority Populations and Low-Income Population

The EPA lacks the discretionary authority to address environmental justice in this rulemaking.

List of Subjects in 40 CFR Part 62

Environmental protection, Air pollution control, Incorporation by reference, Intergovernmental relations, Landfills, Methane, Ozone, Reporting and recordkeeping requirements, Sulfur oxides, Volatile organic compounds.

Authority: 42 U.S.C. 7401 *et seq.*

Dated: July 23, 2019

Michael B. Stoker,

Regional Administrator, Region IX.

[FR Doc. 2019–16184 Filed 7–29–19; 8:45 am]

BILLING CODE 6560–50–P

ENVIRONMENTAL PROTECTION AGENCY

40 CFR Part 300

[EPA–HQ–SFUND–1998–0006; FRL–9997–19–Region 2]

National Oil and Hazardous Substances Pollution Contingency Plan; National Priorities List: Deletion of the Peter Cooper Superfund Site

AGENCY: Environmental Protection Agency (EPA).

ACTION: Proposed rule; notice of intent.

SUMMARY: The Environmental Protection Agency (EPA) Region 2 is issuing a Notice of Intent to Delete the Peter Cooper Superfund Site (Site) located in the Village of Gowanda, Cattaraugus County, New York, from the National Priorities List (NPL) and requests public comments on this proposed action. The NPL, promulgated pursuant to section 105 of the Comprehensive Environmental Response, Compensation, and Liability Act (CERCLA) of 1980, as amended, is an appendix of the National Oil and Hazardous Substances Pollution Contingency Plan (NCP). The EPA and the State of New York, through the Department of Environmental Conservation (NYSDEC), have determined that all appropriate response actions under CERCLA, other than operation and maintenance, monitoring and five-year reviews, have been completed. However, this deletion does not preclude future actions under Superfund.

DATES: Comments must be received by August 29, 2019.

ADDRESSES: Submit your comments, identified by Docket ID no. EPA–HQ–SFUND–1998–0006, by mail to Sherrel Henry, Remedial Project Manager, U.S. Environmental Protection Agency, Region 2, 290 Broadway, 20th Floor, New York, New York 10007–1866. Comments may also be submitted electronically or through hand delivery/courier by following the detailed instructions in the **ADDRESSES** section of the direct final rule located in the Rules and Regulations section of this issue of the **Federal Register**.

FOR FURTHER INFORMATION CONTACT: Sherrel Henry, Remedial Project Manager, U.S. Environmental Protection Agency, Region 2, 290 Broadway, 20th Floor, New York, New York 10007–1866, (212) 637–4273, email: henry.sherrel@epa.gov.

SUPPLEMENTARY INFORMATION: In the “Rules and Regulations” section of this issue of the **Federal Register**, we are publishing a direct final Notice of Deletion of the Peter Cooper Superfund Site without prior Notice of Intent to Delete because we view this as a noncontroversial revision and anticipate no adverse comment. We have explained our reasons for this deletion in the preamble to the direct final Notice of Deletion, and those reasons are incorporated herein. If we receive no adverse comment(s) on this deletion action, we will not take further action on this Notice of Intent to Delete. If we receive adverse comment(s), we will

withdraw the direct final Notice of Deletion, and it will not take effect. We will, as appropriate, address all public comments in a subsequent final Notice of Deletion based on this Notice of Intent to Delete. We will not institute a second comment period on this Notice of Intent to Delete. Any parties interested in commenting must do so at this time.

For additional information, see the direct final Notice of Deletion which is located in the Rules and Regulations section of this **Federal Register**.

List of Subjects in 40 CFR Part 300

Environmental protection, Air pollution control, Chemicals, Hazardous substances, Hazardous waste, Intergovernmental relations, Penalties, Reporting and recordkeeping requirements, Superfund, Water pollution control, Water supply.

Authority: 33 U.S.C. 1321(d); 42 U.S.C. 9601–9657; E.O. 13626, 77 FR 56749, 3 CFR, 2013 Comp., p. 306; E.O. 12777, 56 FR 54757, 3 CFR, 1991 Comp., p. 351; E.O. 12580, 52 FR 2923, 3 CFR, 1987 Comp., p. 193.

Dated: July 16, 2019.

Peter D. Lopez,

Regional Administrator, Region 2.

[FR Doc. 2019–16063 Filed 7–29–19; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 54

[WC Docket No. 18–213; FCC 19–64]

Promoting Telehealth for Low-Income Consumers

AGENCY: Federal Communications Commission.

ACTION: Proposed rule.

SUMMARY: In this document, the Federal Communications Commission (Commission) seeks to propose a Pilot program within the Universal Service Fund (USF or Fund) to support connected care for low-income Americans and veterans. The Commission specifically seeks to better understand how the Fund can play a role in helping patients stay directly connected to health care providers through telehealth services and improve health outcomes among medically underserved populations that are missing out on vital technologies.

DATES: Comments are due on or before August 29, 2019 and reply comments are due on or before September 30, 2019. If you anticipate that you will be submitting comments but find it

difficult to do so within the period of time allowed by this document, you should advise the contact listed in the following as soon as possible.

ADDRESSES: You may submit comments, identified by WC Docket No. 18–213, by any of the following methods:

- *Federal Communications Commission's Website:* <http://fjallfoss.fcc.gov/ecfs2/>.

- *Electronic Filers:* Comments may be filed electronically using the internet by accessing the ECFS: <http://fjallfoss.fcc.gov/ecfs2/>.

- *Paper Filers:* Parties who choose to file by paper must file an original and one copy of each filing.

- Filings can be sent by hand or messenger delivery, by commercial overnight courier, or by first-class or overnight U.S. Postal Service mail. All filings must be addressed to the Commission's Secretary, Office of the Secretary, Federal Communications Commission.

- All hand-delivered or messenger-delivered paper filings for the Commission's Secretary must be delivered to FCC Headquarters at 445 12th St. SW, Room TW–A325, Washington, DC 20554. The filing hours are 8:00 a.m. to 7:00 p.m. All hand deliveries must be held together with rubber bands or fasteners. Any envelopes and boxes must be disposed of *before* entering the building.

- Commercial overnight mail (other than U.S. Postal Service Express Mail and Priority Mail) must be sent to 9050 Junction Drive, Annapolis Junction, MD 20701.

- U.S. Postal Service first-class, Express, and Priority mail must be addressed to 445 12th St. SW, Washington, DC 20554.

- *Availability of Documents.*

Comments, reply comments, and *ex parte* submissions will be publicly available online via ECFS. These documents will also be available for public inspection during regular business hours in the FCC Reference Information Center, which is located in Room CYA257 at FCC Headquarters, 445 12th Street SW, Washington, DC 20554. The Reference Information Center is open to the public Monday through Thursday from 8:00 a.m. to 4:30 p.m. and Friday from 8:00 a.m. to 11:30 a.m.

- *People with Disabilities.* To request materials in accessible formats for people with disabilities (braille, large print, electronic files, audio format), send an email to fcc504@fcc.gov or call the Consumer & Governmental Affairs Bureau at 202–418–0530 (voice), 202–418–0432 (tty).

For detailed instructions on submitting comments and additional information on the rulemaking process, see the **SUPPLEMENTARY INFORMATION** section of this document.

FOR FURTHER INFORMATION CONTACT:

Jodie Griffin, Wireline Competition Bureau, (202) 418–7550 or TTY: (202) 418–0484.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Notice of Proposed Rulemaking (NPRM) in WC Docket No. 18–213; FCC 19–64, adopted on July 10, 2019 and released on July 11, 2019. The full text of this document is available for public inspection during regular business hours in the FCC Reference Center, Room CY–A257, 445 12th SW, Washington, DC 20554 or at the following internet address: <https://docs.fcc.gov/public/attachments/FCC-19-64A1.pdf>.

I. Introduction

1. Telemedicine has assumed an increasingly critical role in health care delivery as technology and improved broadband connectivity have enabled patients to access health care services even when they cannot access a health care provider's physical location. Advances in telemedicine 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 location. 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 are not enjoying the benefits of these innovative telehealth technologies. The Commission proposes a Pilot program within the USF to support connected care for low-income Americans and veterans. This Pilot program would help the Commission better understand how the Fund can play a role in helping patients stay directly connected to health care providers through telehealth services and improve health outcomes among medically underserved populations that are missing out on these vital technologies.

2. Specifically, in the NPRM, the Commission proposes the creation of a Pilot program that would allow the Commission to obtain valuable data concerning connected care services and also help to better understand the relationship of affordable patient broadband internet access service to the availability of quality health care, the health care cost savings that result from

connected care services, and the role of connected care on patient health outcomes. The Commission's proposal seeks to bring these innovative telemedicine technologies to medically underserved populations, including low-income communities and veterans, by empowering health care providers to connect directly with their patients.

3. As discussed more fully in the following, the Commission proposes that the Connected Care Pilot program will operate as a new program within the USF, which would provide funding to eligible health care providers to defray the qualifying costs of providing connected care services to low-income Americans and veterans.

4. The Commission expects this Pilot could benefit Americans that are responding to a wide breadth of health challenges, including diabetes management, opioid dependency, high-risk pregnancies, pediatric heart disease, mental health conditions, and cancer. Data gathered from the Pilot program will help the Commission understand whether and how USF funds can be used to promote health care provider and consumer adoption and use of connected care services. The data and information collected through this Pilot program might also aid 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.

II. Discussion

5. To the extent that lack of affordable and robust broadband internet access service is an obstacle to the adoption of connected care services by health care providers and patients, the Commission believes universal service support could help address that obstacle. Further, by encouraging more health care providers to make use of connected care technologies, the Commission may help create a model for the nationwide adoption of such technologies, which could lead to improved health outcomes for patients and savings to the country's health care system overall.

6. Thus, the Commission proposes a three-year Connected Care Pilot program (Pilot) with a \$100 million budget that would provide support for eligible health care providers to obtain universal service support to offer connected care technologies to low-income patients and veterans. Through this Pilot program, the Commission seeks to develop a record that will help to understand the benefits that subsidization of broadband service for connected care brings.

7. The Commission seeks to design a cost-effective and efficient Pilot program

that incentivizes participation from a wide range of eligible health care providers and broadband service providers, provides meaningful data about the use of connected care services provided over broadband for low-income Americans and veterans, and provides 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.

8. The Commission proposes implementing a flexible Pilot program that will give health care providers some latitude to determine specific health conditions and geographic areas that will be the focus of the proposed projects. Under this proposal, the Pilot program would provide funding to selected Pilot project health care providers to defray the costs of purchasing broadband internet access service necessary for providing connected care services directly to qualifying patients. The Commission seeks comment on this proposal. The Commission believes its proposed approach will increase the variety of projects without discouraging or prejudging any applicants considering whether to participate. Nevertheless, the Commission proposes limiting the Pilot program to projects that primarily focus on health conditions that typically require at least several months or more to treat—such as behavioral health, opioid dependency, chronic health conditions (e.g., diabetes, kidney disease, heart disease, stroke recovery), mental health conditions, and high-risk pregnancies. The Commission believes that collecting data across at least several months would provide more meaningful, statistically significant data to track health outcomes and cost savings—health conditions that do not require at least several months of treatment, therefore, may not provide the type of meaningful data the Commission seeks to collect through the Pilot program.

9. The *Notice of Inquiry* (FCC 18–112) sought comment on whether the Pilot program should focus on certain health conditions or geographic regions. Many commenters asserted that the Pilot program should not be limited to projects that treat specific health conditions. In addition, the record identifies numerous health conditions that can benefit from connected care services. To ensure that Pilot program funding is used for legitimate medical conditions and to guard against potential waste, fraud, and abuse, should the Commission adopt a specific definition of “health condition” for purposes of the Pilot program? If so, is

there a generally accepted authority that provides a definition of “health condition” that would be appropriate to adopt for the Pilot program? The Commission also seeks information from commenters regarding the marketplace for connected care services, specifically whether health care providers typically purchase complete packages or suites of services that include patient broadband internet access service and other functionality necessary to provide connected care services, or whether health care providers typically purchase broadband internet access service connections for connected care as a stand-alone product. Additionally, the Commission seeks comment on the costs health care providers incur to purchase such services.

10. *Supported Services*. The *Notice of Inquiry* sought comment on providing funding for the costs of: (1) The broadband connectivity that eligible low-income patients of participating hospitals and clinics would use to receive connected care services; and (2) the broadband connectivity that a participating hospital or clinic would need to conduct its proposed connected care pilot project. The record demonstrates that many patients lack home broadband service or lack sufficient broadband service to receive connected care services, and evidences widespread support for funding broadband internet access connections for connected care through the Pilot program. Many commenters also expressed support for funding both fixed and mobile broadband for connected care. The record indicates that the VA’s tablet program, which provides patient broadband connections for a small fraction of veterans who receive care through the VA, is the only federal agency program that currently funds patient broadband connections specifically for connected care.

11. The record indicates that health care providers typically purchase broadband internet access service that enables connected care through a broadband carrier or a connected care company (for example, a remote patient monitoring company). The health care provider then provides a connected care service, including the broadband internet access service underlying that connected care service, to the patient directly. To what extent are health care providers already funding patient broadband connections for connected care services and what are the costs associated with funding those connections? To what degree would providing universal service funding to offset these costs enable health care

providers to extend service to additional patients or treat additional health conditions? Several health care providers asserted that the Pilot program should not fund internet connections between health care providers. The Commission agrees, as doing so would be duplicative with the existing Rural Health Care (RHC) programs and propose to exclude such connections from the Pilot program.

12. The Commission considers “telehealth” for the purposes of this proceeding to 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. The Commission also defines the term “telemedicine” as using broadband internet access service-enabled technologies to support the delivery of medical, diagnostic, and treatment-related services, usually by doctors. The Commission seeks comment on these definitions and their applicability to the Connected Care Pilot program. In addition, the Commission also proposes to define the term “connected care” as a subset of telehealth that is focused on delivering remote medical, diagnostic, and treatment-related services directly to patients outside of traditional brick and mortar facilities. The Commission seeks comment on this proposed definition of connected care. Should the Commission place any additional qualifiers on this definition to ensure that the Pilot program is focused on medical services delivered directly to patients outside of traditional medical facilities through broadband-enabled technologies?

13. The Commission seeks comment on common existing uses of connected care technologies, such as remote patient monitoring devices. The record indicates that such devices are generally single-purpose, meaning that they cannot be used to access the public internet or for uses outside of the health care context. Are there other circumstances where health care providers are providing patient connectivity that enables them to access the internet for non-health care purposes? Are there any barriers to receiving connected care services for low-income patients and veterans, and, if so, what are those barriers? Would this Pilot enable additional connectivity not currently available to low-income patients and veterans?

14. The Commission also seeks comment on whether there are packages or suites of services that health care providers use to provide connected care services (such as a turnkey solution that includes software, remote patient

monitoring and remote monitoring devices, and patient broadband internet access) that are not currently funded under the existing RHC support programs that could be funded through the Pilot program as information services. What types of services would be considered information services, as well as any applicable precedents and should be funded through the Pilot program? How do service providers currently fund these types of services and what are the typical costs? Are specific types of health care providers or provider locations more likely to be unable to purchase these types of information services? Are there any federal or other grant programs or other funding sources that provide health care providers support for purchasing these types of services? Should the Commission provide support for internal connections for eligible health care providers through the Pilot program? Is such support needed for connected care services?

15. *Network Equipment.* The *Notice of Inquiry* sought comment on whether the Pilot program should fund “network equipment necessary to make a broadband service functional” and for consortia applicants “equipment necessary to manage, control or maintain an eligible service or a dedicated health care broadband network” as is done in the Healthcare Connect Fund program. At least one commenter supported funding this type of network equipment through the Pilot. Because the Commission currently funds the types of network equipment that are eligible for support through the Healthcare Connect Fund program, the Commission believes it has the authority to provide funding for similar equipment here, to the degree it is necessary to enable connectivity for the purposes of connected care. However, the Commission proposes not to permit duplication of funding for this equipment and equipment funded through the Healthcare Connect Fund program. The Commission seeks comment on this interpretation and approach. Would such network equipment be necessary to providing the broadband service underlying connected care, or part of a health care provider’s purchase of a telehealth information service? Would health care providers still be interested in and be able to participate in the Pilot program if the Pilot program did not fund the types of health care provider network equipment that is eligible for support under the Healthcare Connect Fund program? If the Commission were to fund this type of equipment, how could

the Commission ensure that the health care provider actually needs this equipment for the Pilot program and would not have needed or purchased this equipment but for participating in the Pilot program?

16. The Commission also acknowledged that a few commenters stated that the Pilot program should support health care provider administrative and outreach costs associated with participating in the Pilot program (such as personnel costs, and program management costs). Consistent with the existing RHC support programs and the RHC Pilot program, however, the Commission does not propose funding these expenses as part of the Pilot. As the Commission has previously explained, past experience in the RHC support programs and RHC Pilot program demonstrates that “[health care providers] will participate even without the program funding administrative expenses.” The Commission seeks comment on this approach.

17. *End-User Devices, Medical Equipment, Mobile Applications, and Health Care Provider Administrative Expenses.* The *Notice of Inquiry* also sought comment on whether the Pilot program should fund end-user equipment, medical devices, or mobile applications for connected care. Many commenters supported funding such items. That said, traditionally, the Commission has declined to fund these items through the Universal Service Fund because of section 254’s focus on the availability of and access to services. As such, the Commission proposes to make end-user devices, medical devices, or mobile applications (excepting those applications that may be part of a service that could be considered an information service) ineligible for support in the Pilot program. Based on the record and other sources, some health care providers may be able to self-fund or obtain outside funding for end-user devices, medical devices, and connected care applications needed for their connected care pilot projects. The Commission seeks comment on the extent to which health care providers participating in the Pilot program may be able to obtain outside funding for end-user devices, medical devices, or mobile applications necessary to provide connected care services. Would health care providers still be interested in and be able to participate in the Pilot program if the Pilot program does not fund end-user devices, connected care medical devices, or connected care mobile applications?

18. *Other Program Structure Considerations.* The Commission seeks comment on whether there are any

medical licensing laws or regulations, or medical reimbursement laws or regulations that would have a bearing on how the Commission structures the Pilot program. If so, how would those specific laws or regulations impact the Pilot program, and how should the Commission design the structure of the Pilot program in light of those impacts? For example, commenters in the record identify reimbursement as a major barrier to telehealth adoption. They urge the Commission to coordinate with the Centers for Medicare and Medicaid Services (CMS)—whether through a Memorandum of Understanding or other means—to implement reforms to reimbursement policies for telehealth. How should the Commission structure the Pilot to best ensure coordination between the Commission and other federal agencies, such as CMS? How can the Commission most easily obtain data through the Pilot that would be informative on issues such as reimbursement and licensure? Additionally, the Commission seeks comment on whether the provision of USF support to health care providers to provide connected care to low-income patients (or any other Pilot program funded item used by individual patients as part of the Pilot program) raises any issues under the Medicare and Medicaid Anti-Kick Back Statute, the Civil Monetary Penalties Act, or any other federal statutes.

19. *Budget.* The *Notice of Inquiry* sought comment on a potential \$100 million budget for the Pilot program. Based on the broad support in the record, the Commission believes that targeting this amount of funding for the broadband underlying connected care technologies is substantial and sufficient to allow it to obtain meaningful data and ensure significant interest from a wide range of participants. The Commission therefore proposes to adopt that budget for the Pilot program. As discussed in the following, the Commission also proposes a three-year funding period for the Pilot program, during which selected projects would receive funding. The Commission seeks comment on these proposals. How should the total Pilot program budget be distributed over the three-year funding period? Should each selected project’s funding commitment be divided evenly across the Pilot program duration? For example, if a selected project requests and receives a \$9 million funding commitment and the funding period is three years, should the project receive \$3 million for each year?

20. Several commenters expressed concern that the budget for the Pilot

program could be debited against the existing budgets for the Lifeline or Rural Health Care programs. However, the proposed Pilot program would not divert resources from the existing universal service support programs. Instead, the Commission proposes requiring the Universal Service Administrative Company (USAC) to separately collect on a quarterly basis the funds needed for the duration of the Pilot program. The Commission expects that funding the Pilot program in this manner would not significantly increase the contributions burden on consumers. This approach also would not impact the budgets or disbursements for the other universal service programs. The Commission seeks comment on this approach. Should the collection be based on the quarterly demand for the Pilot program? The Commission also proposes to have excess collected contributions for a particular quarter carried forward to the following quarter to reduce collections. Under this approach, the Commission also proposes to return to the Fund any funds that remain at the end of the Pilot program. Are there other approaches the Commission should consider for funding the Pilot program?

21. *Number of Pilot Projects and Amount of Funding per Project.* The *Notice of Inquiry* sought comment on funding up to 20 projects with awards of \$5 million each. First, the Commission proposes to provide a uniform percentage of eligible services or equipment to be funded, rather than fully funding any Pilot projects, consistent with the Healthcare Connect Fund program and the RHC Pilot program. Several commenters similarly suggest that the Pilot program should not fund 100% of the eligible costs for each project. Based on the Commission's experience with the E-Rate and Rural Health Care programs, there are significant advantages to providing a set discount percentage that requires participants to contribute a portion of the costs, including being administratively simple, predictable, and equitable, and incentivizing participants to choose the most cost-effective services and equipment and refrain from purchasing a higher level of service or equipment than needed. In addition, the Commission believes that funding less than 100% of the costs minimizes the risk of non-usage of the supported services. The Commission seeks comment on this approach.

22. For services supported under this structure, the Commission proposes a discount level of 85%—the discount amount participants received in the Rural Health Care Pilot Program—and

seeks comment on whether this amount would strike the right balance between requiring a health care provider contribution for such services and encouraging a wide range of eligible health care providers to participate in the Pilot program. Are there other grant or support programs or data that the Commission could look to in order to determine an appropriate discount level for these types of services that could be funded under this structure? For example, in the E-Rate program, the lowest discount level is 20% and ranges up to 90%. In contrast, the discount level for the Healthcare Connect Fund is 65%. To further ensure the cost-effective use of Pilot funds, in addition to adopting a flat, uniform discount percentage, should the Commission cap the monthly amount of support that can be paid for broadband internet access service to a health care provider for each participating patient? If so, what would be an appropriate cap, and what data and specific information would support this cap amount?

23. For the Healthcare Connect Fund program, the health care provider is required to pay the non-discounted share of the eligible costs from eligible sources (e.g., the applicant, eligible health care provider, or state, federal, or Tribal funding or grants), and is prohibited from paying the non-discounted share of eligible costs from ineligible sources (e.g., direct payments from vendors or service providers). The Commission seeks comment on whether it should apply this same limitation to health care providers participating in the Pilot program. If so, should participating patients also be considered an eligible source of the non-discounted share for services funded under the Pilot? Should the Commission limit the portion of the non-discounted costs that health care providers can require participating patients to pay for the supported broadband internet access service? If so, what would be an appropriate limit on the patient share of the costs? For purposes of the Pilot program, should the Commission place any limitation at all on the source of funding for the non-discounted share of the costs? Are there any other approaches the Commission should consider for limiting the source of funding that are not tied to the Healthcare Connect Fund program rules?

24. Next, the Commission addresses the number of projects and the per-project budget cap. Some commenters agreed that the Commission should fund up to 20 projects with awards of \$5 million per project. Other commenters argued for the selection of fewer projects

with larger funding amounts, or for the selection of a larger number of projects with varied or smaller funding amounts. On further consideration of the record, the Commission proposes not to expressly limit the number of funded Pilot projects, and to permit flexible and varied funding for each selected Pilot project. The Commission believes setting a fixed number of funded projects would not serve the goals of the Pilot program because it would artificially limit the number of funded projects before any proposals are even submitted. In addition, not setting a fixed number of projects to be funded will allow the Commission to better focus on selecting quality projects that can provide meaningful data rather than selecting a pre-determined number of projects. The Commission seeks comment on this view. The record likewise indicates that a uniform \$5 million funding amount per project could artificially limit the scope of potential pilot projects and the data collected. While the Commission proposes allowing varied funding amounts for selected projects, the Commission does not anticipate spending all of the Pilot program funds on one or two large projects. Should the Commission establish a ceiling on the amount of the total budget that can be allocated to a single project and, if so, what would be an appropriate maximum funding amount for a single project?

25. *Cost Allocation.* The Commission also seeks comment on whether cost allocation should be required for services or other items supported through the Pilot program that are used for non-health care purposes or include ineligible components. For example, if a Pilot project permits patients to use the supported broadband service for non-health care purposes, should the Commission require cost allocation of the non-health care usage? If so, how should the cost allocation work? For supported patient broadband internet access service, should the cost allocations be based solely on the percentage of the service that is used for health care purposes? Should the cost allocations instead take into account the health care providers' savings associated with the use of the supported patient broadband internet access for health care purposes? If a health care provider contracts with a remote patient monitoring solution provider for a package that includes end-user devices and other items that are not broadband internet access service, how should cost allocation work for those devices or items? Should cost allocations for all

Pilot-supported costs follow the cost allocation rules and processes for the Healthcare Connect Fund? Which entity or entities (e.g., the health care provider or service provider) should be responsible for providing the cost allocation and supporting documentation? What type of documentation should the Commission require to support the cost allocation?

26. *Duration.* The *Notice of Inquiry* sought comment on whether the Pilot program should have a two- or three-year funding duration and six-month ramp-up and wind-down periods. Many commenters asserted that a three-year duration is appropriate and would allow the Commission to obtain sufficient, meaningful data from the selected projects. A few commenters argued that more than three years would be necessary if broadband deployment was a Pilot program goal, or that the Pilot program duration should be as long as four or five years. USTelecom cautioned 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” Other commenters separately assert that a six-month ramp-up and six-month wind-down period should be part of the funding period.

27. Based on the record and the proposed Pilot program goals (which do not include broadband deployment), the Commission proposes a three-year funding period and separate ramp-up and wind-down periods of up to six months in order to give projects time to complete set up and other administrative matters related to the Pilot program. The Commission seeks comment on these proposals. When should the ramp-up period begin? Should the clock for the ramp-up period start after the selected project has been notified of its selection, or is there another event that should trigger the start of the ramp-up period? Should there be a uniform start date for funding under the Pilot program, and if so, how should the Commission determine that start date? Should the proposed three-year funding period for the Pilot program use a funding-year approach, with a fixed start date and end date for each Pilot program funding year, as is done in the E-Rate and Rural Health Care programs? If so, how would the ramp-up and wind-down periods work with a funding-year approach (e.g., would the ramp-up period precede the start of the funding year)? Should funding disbursements begin during the ramp-up period, and if so how should funding be split between the ramp-up period and the Pilot project term? The

Commission proposes setting a fixed end date for the Pilot program, with the possibility of extensions where circumstances warrant. The Commission seeks comment on this proposal.

28. *Eligible Health Care Providers.* The Commission proposes to limit health care provider participation in the Pilot program to non-profit or public health care providers within section 254(h)(7)(B): (i) Post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (ii) community health centers or health centers providing health care to migrants; (iii) local health departments or agencies; (iv) community mental health centers; (v) not-for-profit hospitals; (vi) rural health clinics; (vii) skilled nursing facilities; (viii) and consortia of health care providers consisting of one or more entities described in clauses (i) through (vii).

29. The Commission seeks comment on whether section 254 requires it to limit health care provider participation to these categories of providers. And if not, the Commission believes that applying this limitation to the Pilot program would provide significant benefits: Leveraging the statutory definition of health care provider used for the Rural Health Care program would focus Pilot program funding on health care providers most in need of additional funding to reach eligible patients through connected care services, and would also realize administrative efficiencies by using existing definitions and application processes that parties are already familiar with through the Rural Health Care program. In addition, having a single uniform definition of “health care provider” would provide clarity for potential participants and facilitate the administration of the Pilot program.

30. While the statutory definition of “health care provider” may exclude certain health care providers, the Commission believes that it would still allow for a wide range of health care providers to participate in the Pilot program. For example, the Healthcare Connect Fund program is subject to this definition and over 8,600 distinct health care providers received funding commitments in the Healthcare Connect Fund program for funding year 2018. Additionally, the statutory definition encompasses many facilities serving medically underserved communities, including VA health administration facilities and facilities run by the Indian Health Service. The Commission seeks comment on this interpretation. Is there an interpretation of section 254(h)(7)(B)

that would allow the Commission to provide funding to Emergency Medical Technicians, health kiosks, and school clinics through the Pilot program, as commenters request? Would the definition of “health care provider” under section 254(h)(7)(B) preclude sites like the VA’s Virtual Living Room sites, community center or similar sites that provide dedicated rooms in convenient locations with broadband connections for patients to engage with technology and connect with the professionals providing them with medical care? The Commission seeks comment on whether limitations on eligible entities could limit the effectiveness of the Pilot program and the ability to obtain meaningful data on connected care services. Finally, are the proposed eligible health care providers sufficiently well versed in medical research methods to be able to properly evaluate the health outcomes linked to the provision of connected care?

31. In the event that the Commission limits Pilot program participants to the statutory definition of “health care provider” under section 254, the Commission proposes requiring interested health care providers to indicate their respective category(ies) for eligibility by submitting FCC Form 460, which USAC uses to determine the eligibility of health care providers in the Healthcare Connect Fund Program. The Commission proposes requiring eligible health care providers to have prior experience with telehealth and long-term patient care.

32. The Commission also proposes to borrow additional administrative procedures from the RHC programs in implementing the Pilot program. For example, the Commission proposes to have consortia applicants file FCC Form 460 identifying all sites that would participate in the Pilot program, including off-site data centers and administrative offices, and propose permitting consortia applicants to file FCC Form 460 on behalf of any site in the consortium that would participate in the Pilot program to determine that site’s eligibility. Consistent with the Healthcare Connect Fund program, the Commission proposes requiring consortia applicants to have in place a Letter of Agency, which provides a consortium leader with authority to act on behalf of the participating health care providers. Additionally, the Commission proposes permitting third parties to “submit forms and other documentation on behalf of the applicant” if USAC receives written authorization from an “officer, director, or other authorized employee stating that the [health care provider] or

Consortium Leader accepts all potential liability from any errors, omissions, or misrepresentations on the forms and/or documents being submitted by the third party.” The Commission proposes that consortium applicants must update their FCC Form 460s if any information on their FCC Form 460 changes. Similarly, the Commission proposes that an eligible health care provider participating in the Pilot program, including those participating in consortia, submit an updated FCC Form 460 within 30 days of a material change. The Commission seeks comment on these proposals.

33. The Commission also proposes that the Pilot program be open to both urban and rural eligible health care providers. Several commenters assert that the Pilot should not be limited to projects serving only rural areas. To the extent that section 254(h)(2)(A) applies to the Pilot program, it does not limit universal service support to rural health care providers, and the Commission believes the Pilot program should not be limited to rural health care providers. The Fifth Circuit has found “the language in section 254(h)(2)(A) demonstrates Congress’s intent to authorize expanding support of ‘advanced services,’ when possible, for non-rural health [care] providers.” Likewise, section 254(h)(2)(A) authorizes the Commission “to enhance public and non-profit health care providers’ access” to broadband services. The Commission seeks comment on this proposal.

34. To promote geographic diversity, the Commission seeks comment on limiting participation in the Pilot program to health care providers that are located in or serve an area that has received the Health Resources and Services Administration’s Health Professional Shortage Areas designation or Medically Underserved Areas designation, which correlate with professional shortages and lower-income areas, respectively, within a defined geographic area. What are the benefits and drawbacks of limiting participation by using these designations? Should the Commission also, or alternatively, consider limiting participation in the Pilot program only to eligible health care providers that currently provide care to at least a certain percentage of uninsured and underinsured patients, or to a certain percentage of Medicaid patients? The Commission seeks comment on these ideas. Would these types of limitations impact the interest and participation of health care providers in the Pilot program?

35. As connected care services continue to grow, health care providers that only offer connected care have entered the marketplace. These new market entrants may bring innovative new services and inject competition that benefits patients, but it is not clear whether they would qualify as eligible health care providers under section 254(h)(7)(B). The Commission seeks comment on this question. Additionally, the record indicates that these types of providers may not be involved in long-term patient treatment. What steps should the Commission take to ensure that participating health care providers have significant experience with providing long-term patient care, in order to guard against waste, fraud, and abuse in the Pilot program? The Commission also seeks comment on determining criteria that would demonstrate health care providers’ experience with long-term care for patients. Are there types of connected care only companies that could demonstrate the level of experience with long-term patient care needed for the Pilot?

36. To ensure projects meet the goals of the Pilot program, should the Commission require participating health care providers to have experience integrating remote monitoring and telehealth services? Specifically, should the Commission limit eligibility in the Pilot program to health care providers that are federally designated as Telehealth Resource Centers or as Telehealth Centers of Excellence, or to otherwise demonstrate their experience providing telehealth services? Should the Commission exclude health care providers that have no prior connected care experience? Should participating health care providers have experience, or be required to partner with research bodies or firms with experience, conducting clinical trials in order to ensure statistically sound evaluation of patient outcomes?

37. *Eligible Service Providers.* In the RHC Program, the statute permits non-eligible telecommunications carriers (ETCs) to receive support; 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).” Further, section 254(h)(2)(A) 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, thus, allows support

for non-ETCs. The Commission has previously explained that the ETC limitation in section 254(e) applies to the section 254(c) supported services, but not to additional supported services under section 254(h)(2)(A).

38. The *Notice of Inquiry* sought comment on whether the Pilot should be limited to ETCs, including facilities-based ETCs. Numerous parties opposed limiting the Pilot program to ETCs or facilities-based ETCs and explained that such a limitation would artificially limit participation in the Pilot program and could also limit the effectiveness of the Pilot program. The Commission proposes not to limit Pilot program funding to only ETCs. The Commission anticipates that it would provide funding to eligible health care providers to purchase broadband internet access service that would be provided to the patient through a connected care offering, or that the health care provider would use USF funding to purchase telehealth services that qualify as information services. As such, the Commission does not believe that health care providers should be restricted to purchasing broadband internet access service from only ETCs.

39. The Commission hopes that this will help incent participation in the program by a diverse range of both health care providers and service providers. The Commission seeks comment on this approach. What impact would this approach have on service provider and health care provider interest in participating in the Pilot program? If, instead, the Commission were to conclude that only ETCs would be able to receive support for providing broadband internet access service to patients participating in the Pilot, what impact would this approach have on service provider and health care provider participation in the Pilot program? As a practical matter, how could the Commission ensure that the Pilot program still leverages and supports the expertise of the health care provider as the main driver of each Pilot project, even if the monetary support must be paid to an ETC?

40. *Application Process.* The *Notice of Inquiry* requested comment on the application process for the Pilot program and proposed several categories of information that should be contained in the application. The Commission proposes that interested health care providers first submit an application describing the proposed pilot project and providing information that will facilitate the selection of high-quality projects that will best further the goals of the Pilot program. At the time of the application, should the

Commission require participating health care providers to have already identified specific broadband providers from which the health care provider will receive service? If the Commission requires broadband providers to be ETCs, should the Commission require all designations to be obtained prior to the application process? Or should the Commission require that if the project is selected, the service provider would obtain the necessary ETC designations before the project commences?

41. Based on the Commission's review of the record and prior experience with Pilot programs, it proposes that applications contain, at a minimum, the following information:

- Names and addresses of all health care providers that would participate in the proposed project and the lead health care provider for proposals involving multiple health care providers.
- Contact information for the individual(s) that would run the proposed pilot project (telephone and email).
- Health care provider number(s) and type(s) (e.g., non-profit hospital, community mental health center, community health center, rural health clinic, community mental health center), for each health care provider included in proposal.
- Description of each participating health care provider's experience with providing connected care services and conducting clinical trials or the experience of a partnering health care provider.
- Description of the connected care services the proposed 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 project (including the health care provider's anticipated goals with respect to reaching new or additional patients, improved patient health outcomes, or cost savings), and how the project will achieve the goals of the Pilot program.
- Description of the clinical trial design intended to measure the effect of the connected care pilot on health outcomes.
- Description of the estimated number of eligible low-income patients to be served.
- Description of the plan for implementing and operating the project, including how the project intends to recruit eligible patients, plans to obtain the end-user and medical devices for the connected care services that the project would provide, and transition plans for participating patients after Pilot program funding ends.

- List of all Department of Health and Human Services, Health Resources and Services Administration (HRSA) designated Health Care 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.

- Description of whether the health care provider will primarily serve veterans or patients located in a rural area, or the provider is located in a rural area, on Tribal lands, or is associated with a Tribe, or part of the Indian Health Service.
 - Description of the anticipated level of broadband service required for the proposed project, including the necessary speeds/technologies and relevant service characteristics (e.g., 10/1 Mbps, or 4G).
 - Detailed estimated break-down of the total estimated costs for the broadband internet access services and any other eligible costs.
 - Estimated total ineligible costs and description of the anticipated sources of financial support for the project's ineligible costs.
 - Description of how the participating health care provider will ensure compliance 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, and how it will safeguard the collected patient information against data security breaches.
 - Description of the health outcome metrics that the proposed project will measure and report on, and how those metrics will demonstrate whether the supported connected care services have improved health outcomes.
 - Description of how the health care provider intends to collect and track the required Pilot program data.
42. Is there any additional information that the Commission should require health care providers to submit in the application? What types of information or documentation should the Commission require health care providers to include in their applications to demonstrate that the supported services would enhance the health care provider's access to advanced telecommunications and information services? Is there a minimum number of patients that a project must serve to provide statistically significant data? Is the proposed application information sufficient to determine whether projects have processes in place to ensure compliance with the applicable medical

licensing laws and regulations, HIPAA and any other applicable privacy laws, and guard against data security breaches? Is there anything in HIPAA or privacy laws and regulations that would limit the Commission's ability to structure the Pilot program or collect data needed to evaluate the Pilot's success?

43. Should the Commission require health care providers to submit a self-certification regarding their patient care and telehealth qualifications with their applications? Moreover, should the Commission require applicants to certify that they are financially qualified? If so, what information should the Commission rely on to make that determination? Is there any supporting documentation the Commission should require to demonstrate that applicants are financially qualified? Likewise, should the Commission require health care providers to submit a self-certification that specifies that they will be able to meet patients' long-term care needs as well as provide the appropriate technology to help meet those needs? Should the Commission require applicants to certify that they have the capacity to conduct a valid clinical trial? If so, are there specific criteria the Commission should rely on to make such a showing? Should the Commission require applicants to certify that all information in their application is true and accurate?

44. The Commission intends to establish a deadline for submitting applications for the Pilot program. If the Commission ultimately issues an order establishing the proposed Pilot program, would requiring that applications be submitted within 120 days from the release of such an order give health care providers sufficient time to develop and submit a meaningful application for the Pilot program?

45. The Commission proposes to direct the Wireline Competition Bureau (Bureau) to review applications in coordination with the FCC's Office of Economics and Analytics, Office of Managing Director, Office of General Counsel, and the Connect2Health Task Force. The Commission proposes that it will then make any final selection decisions. To facilitate the review and selection of proposals, should the Commission also seek advice from other expert health care entities with telehealth expertise? For example, should the Commission consult with the federally designated Telehealth Resource Centers or Telehealth Centers of Excellence? Are there other organizations with whom the

Commission should consult during the application and selection process?

46. *Evaluation of Proposals and Selection of Projects.* The Commission seeks comment on the factors to evaluate the applications and select Pilot program projects. At a minimum, the Commission proposes considering whether each project would serve the Pilot program goals and whether the applicant is able to successfully implement, operate, and evaluate the outcomes of the project. The Commission also proposes considering the cost of the proposed project compared to the total Pilot program budget. What other objective factors should be used to evaluate the proposals and what should be the relative importance of each objective evaluation factor? For example, should a project's ability to further the goals of the Pilot program be more important than the estimated cost of the project compared to the total Pilot program budget? Should the Commission decline to consider proposals that do not have a plan for how participating patients will obtain the necessary connected care medical devices, end user devices (e.g., smartphones or tablets), or connected care applications? Should the Commission decline to consider projects that cannot provide statistically sound evaluations of their proposed interventions?

47. To promote the selection of a diverse range of projects, the Commission proposes awarding additional points to proposed projects that would serve geographic areas or populations where there are well-documented health care disparities (Tribal lands, rural areas, or veteran populations) or that treat certain health crises or chronic conditions that significantly impact many Americans and are documented to benefit from connected care, such as opioid dependency, diabetes, heart disease, mental health conditions, and high-risk pregnancy. For all of the additional point factors the Commission proposes in the following, to seek comment on the relative importance of these factors compared to each other and compared to the other standard objective evaluation factors. Are there any other factors for which additional points should be awarded to a particular project?

48. It is well documented that there are significant health care shortages in rural areas and Tribal lands. In addition, the Department of Health and Human Services' Health Resources and Services Administration (HRSA) designates areas that are Healthcare Provider Shortage Areas (HPSA) or are Medically

Underserved Areas (MUA)—these areas can be urban or rural. Given the significant health care disparities in these areas and potential benefits of increasing the adoption of connected care in these areas, the Commission proposes awarding extra points during the evaluation process to proposals that satisfy the following factors: (a) The health care provider is located in a rural area; (b) the project would primarily serve patients who reside in rural areas; (c) the project would serve patients located in five or more Health Professional Shortage areas (for primary care or mental health care only) or Medically Underserved Areas as designated by HRSA by geography; (d) the health care provider is located on Tribal lands, is affiliated with a Tribe, or is part of the Indian Health Service; or (e) the health care provider would primarily serve patients who are veterans. How should the relative importance of these additional factors be compared to each other and to the other proposed standard objective factors for evaluating proposals? Should projects receive additional points for each factor that they satisfy? What criteria should determine whether a health care provider is located in a rural area for purposes of these additional points? Would the definition of "rural area" in section 54.600 of the Rural Health Care program rules or the definition of "urban area" in section 54.505(b)(3)(i) of the E-Rate rules be appropriate for determining whether a project qualifies for additional points based on rurality? Is there another definition of "rural area" that the Commission should consider and, if so, what geographic level (e.g., Census block, Census tract, Census block group) should the Commission use to determine eligibility for extra points based on rurality? How should this proposal apply to consortia?

49. The Commission also seeks comment on the criteria that should be used to determine whether a project would primarily serve patients who reside in rural areas. The Commission believes that relying on individual patient addresses for this purpose would be too complex to administer because of the potential volume of individual patient addresses. Are there other, non-patient address measures that could be used instead? For example, should the Commission use a metric that estimates average patient travel distance to the health care provider's facility?

50. The Commission proposes relying on the health care provider's certification that it is located on Tribal lands, affiliated with a Tribe or is part

of the Indian Health Service. The Commission seeks comment on this proposal. For purposes of the additional points, should the Commission apply the definition of Tribal lands in section 54.400(e) of the Lifeline rules? Is there another definition that the Commission should consider? To receive the extra Tribal points, should the Commission require that the health care provider be located in a rural area as defined for the Pilot program? If so, how should rurality be defined? Should the Commission use the same definition for "rural" areas as that found in section 54.505(b)(3)(i) of the Commission's rules, or instead use a population density measure for a given geographic unit?

51. Similarly, the Commission seeks comment on the criteria that should be used to determine whether a project would primarily serve veterans. What threshold would be appropriate? For example, the Commission seeks comment on whether a project "primarily serves" veterans if more than 50% of its patient base are veterans. What documentation, if any, is appropriate to define a veteran population? Many veterans receive disability compensation from the VA, for instance, or cost-free health care based on certain factors. Would receipt of these benefits be sufficient to identify veteran status for purposes of the application?

52. The Commission seeks comment on awarding additional points for projects that are primarily focused on treating certain chronic health conditions or conditions that are considered health crises, such as opioid dependency, high-risk pregnancies, heart disease, diabetes, or mental health conditions. Opioid dependency is a well-documented epidemic in America and has had a particularly devastating impact in rural America where there are fewer opioid treatment centers. The *Notice of Inquiry* explains that connected care services have been frequently used to treat opioid dependency; thus, the Commission believes that it would be appropriate to award extra points for proposals that seek to use connected care to treat opioid dependency. Maternal mortality is also a crisis in America—the maternal mortality rate in the U.S. is higher than most other high-income countries and has increased over the last few decades. This crisis impacts both rural and urban areas and is particularly acute in rural areas where there is a significant shortage of hospitals and health care providers offering obstetric care, and also disproportionately impacts low-income, African-American women. In December 2018, Congress took action to

address the maternal mortality crises by passing the Preventing Maternal Deaths Act to create a federal infrastructure and resources for collecting and analyzing data on every maternal death in the United States. Accordingly, the Commission believes that it would be appropriate to award additional points for projects focused on treating high-risk pregnancy. Connected care has been used to treat heart disease and diabetes—two of the leading causes of death in America that are also associated with very high costs for patients and the health care system. Therefore, the Commission believes that it would also be appropriate to award additional points to proposals that seek to treat these conditions. Some organizations also have indicated that there is a mental health crisis in America—many Americans need mental health care but lack access or the ability to find it, particularly Americans who are low-income or reside in rural areas. Therefore, the Commission also believes that it would be appropriate to award additional points to proposals that seek to treat mental health conditions. The Commission seeks comment on these proposals. Are there any other health conditions that would warrant awarding additional points to specific project proposals during the selection process? Should the Commission expressly limit eligible health conditions in advance of receiving applications for Pilot projects?

53. Are there any other criteria the Commission should consider in the evaluation and selection of pilot projects? For example, the Commission seeks comment on whether to permit a project to serve a patient population that is primarily, but not entirely low-income? If so, should the Commission require health care providers to conduct a project where more than 50% of the patients are low-income? Or 75%? Similarly, how would the Commission evaluate whether a project includes low-income individuals? Should the Commission, for example, rely on the health care provider to identify patients for their project who are enrolled in Medicaid, receive cost-free health care from the VA, or who are uninsured or underinsured?

54. Consistent with the Commission's other universal service support programs, it is critical that the Commission ensures that the Pilot program funds are spent wisely and appropriately and that the Commission guards the Pilot program from waste, fraud, and abuse. At the same time, the Commission seeks to minimize the administrative burdens on service providers and health care providers participating in the Pilot program. In

this section, the Commission proposes and seeks comment on potential requirements for Pilot program participants, including requirements for the vendor selection for Pilot-eligible costs, requesting funding, and requesting disbursements. For the Healthcare Connect Fund program, the Commission has developed robust rules and processes that are designed to minimize waste, fraud, and abuse. To promote the efficient and cost-effective use of Pilot program funds and guard against waste, fraud, and abuse, the Commission proposes extending many of these rules and processes to the proposed Pilot program.

55. *Selecting Service Providers.* The Commission proposes that participating health care providers, and not the participating patients, procure the services and equipment that could be funded through the Pilot program. The Commission believes that having participating health care providers select the service provider would be a better approach because health care providers are in the best position to know the specific service and performance requirements necessary to provide the specific connected care services supported by their particular Pilot project. In addition, aggregating eligible subscribers and streamlining benefit payments may lead to cost efficiencies and/or better service arrangements. The Commission seeks comment on this approach.

56. Consistent with the Commission's other universal service support programs, it is important that the Commission ensures the cost-effective, efficient use of Pilot program funds. To appropriately tailor the vendor selection requirements to the marketplace, the Commission requests additional information on how health care providers typically purchase broadband internet access service connections for connected care efforts. Do health care providers typically select and contract directly with a broadband service provider for patient broadband internet access service, or is the broadband service provider typically determined by a connected care service vendor, such as a remote patient monitoring service provider? Is the broadband internet access service for connected care, whether purchased as a stand-alone product or as part of a package, a commercially available product that is purchased at publicly-available rates? Are these rates typically negotiable? What is the typical contract term (e.g., month-to-month, annual contract or multi-year contract) for these services? Are the health care provider costs for connectivity services for connected care

determined on a per patient basis? Where health care providers purchase services for connected care as part of a complete package or suite of services, can the costs for the individual components be broken out separately? For example, for such a package or suite of services, is it possible to isolate the costs for the included software, or the broadband internet access service?

57. For all of the costs that could potentially be supported through the Pilot program, the Commission proposes requiring the participating health care providers to conduct a competitive bidding process, and select the most cost-effective service, as is required by the Healthcare Connect Fund program. For the E-Rate and Rural Health Care support programs, the Commission has traditionally required schools and libraries and health care providers to competitively bid for the supported services and equipment, with limited exemptions. These competitive bidding requirements are designed to ensure that applicants select the most cost-effective method of providing the requested service, ensure that service providers have sufficient information to submit a responsive proposal, seek the most cost-effective pricing for eligible services, and guard against waste, fraud, and abuse.

58. If the Commission requires health care providers to competitively bid any services and equipment that could be funded through the Pilot program, should the Commission use the existing Request for Services Form (Form 461) for the Healthcare Connect Fund program and, if so, what modifications would the Commission need to make to that form for purposes of the Pilot program? The Commission also proposes requiring the lead health care provider for projects involving multiple health care providers to secure a Letter of Agency from all participating providers before submitting a request for services. The Commission seeks comment on these proposals. Should the Commission allow exemptions from competitive bidding rules, as done in other USF programs? For example, should the Commission allow an exemption in the Pilot program if the health care provider is requesting commercially available services purchased at publicly-available rates and/or the total cost of the eligible services or equipment is below a specific monetary threshold (e.g., total annual cost under \$10,000 or monthly per-patient cost of \$50 or below)? The Commission seeks comment on whether the other exemptions to the competitive bidding requirements for the Healthcare Connect Fund program should also be

extended to the Pilot program. Are there any other competitive bidding exemptions or alternatives to competitive bidding that the Commission should consider applying to the Pilot program?

59. Where an exemption to competitive bidding applies, are there public resources or entities that could help health care providers identify potential vendors or service providers? Should the Commission require ETCs to indicate their interest in participating in the Pilot program and their service areas, and make this information publicly available before the application deadline for the Pilot program? How can the Commission share similar interests to participate in the Pilot program from telecommunications providers that are not ETCs?

60. The Commission also proposes prohibiting gifts from participating service providers to participating health care providers. Are there any aspects of the competitive bidding requirements for the Healthcare Connect Fund program that would not work for the Pilot program and, if so, why not? If the Commission requires competitive bidding for the Pilot program, the Commission proposes requiring participating health care providers to submit the same competitive bidding information, make the same certifications, and use the same processes that are required for the Healthcare Connect Fund program, including any changes that may be made as a result of the *2017 Promoting Telehealth Order and Notice (FCC 17-164)*.

61. *Requesting Funding.* The Commission further seeks comment on the most efficient methods for Pilot program participants to request funding. Should the Commission require selected Pilot projects to request funding under the Pilot program using the same forms and processes and making the same certifications that are required for the Healthcare Connect Fund program, including any changes that may be made as a result of the *2017 Promoting Telehealth Order and Notice*? Requiring health care providers to submit funding requests for the Pilot program would allow USAC to ensure that the Pilot projects only request funding for eligible services and that the health care providers requesting funding are in fact eligible. What modifications to the Healthcare Connect Fund funding request form, if any, are necessary to use for the Pilot program? Are there other HCF certifications or processes to import to the Pilot program as well? And how should the Commission modify these requirements, if at all?

Would these modifications vary depending on the legal authority on which the Pilot program is based? If competitive bidding is required for the Pilot program, the Commission proposes requiring selected projects to submit a copy of their contract and supporting competitive bidding documentation with their funding request, as is currently required for the Healthcare Connect Fund program.

62. For purposes of administrative efficiency and to ensure that Pilot projects are not unreasonably delayed, the Commission proposes requiring Pilot program applicants who are selected to submit funding requests within six months of the date of their respective selection notices for the Pilot program. The Commission anticipates that USAC would promptly review funding requests of selected Pilot program health care providers on a rolling basis, irrespective of when they submit their funding requests within the six-month window. Would this proposed deadline for submitting the initial funding request give participating health care providers sufficient time to select a vendor and submit a funding request? Should the Commission require participating health care providers to submit a new funding request for each year of the Pilot program?

63. The Commission also proposes requiring selected projects to certify that the provided funding will only be used for the eligible Pilot program purposes for which the support is intended. Should the Commission also require participating health care providers to certify that the supported services and equipment will only be used for purposes reasonably related to the provision of health care services or instruction that the health care provider is legally authorized to provide under law? Additionally, the Commission proposes requiring projects involving multiple health care providers to identify the name and contact information for the organization that will be legally and financially responsible for the activities supported through the Pilot (e.g., submitting funding requests, submitting invoicing and disbursement forms, submitting competitive bidding forms (if required)), as is required for consortia participating in the Healthcare Connect Fund program. This requirement would identify the responsible party if disbursements must be recovered for violations of program rules or requirements. The Commission seeks comment on these proposals.

64. *Disbursements.* The *Notice of Inquiry* sought comment on how disbursements should be issued for the

Pilot program. Few commenters specifically addressed the issue of how often disbursements should be issued and which entity should receive disbursements through the Pilot program. One commenter supported monthly disbursements. Another commenter asserted that disbursements should be issued to service providers to minimize health care providers' administrative burdens, while two other commenters asserted that the disbursements should be issued directly to health care providers. Another commenter recommended issuing disbursements in the form of vouchers directly to participating patients, but other commenters argued that this approach would complicate the administration of the Pilot program, create unnecessary consumer burdens, and raise potential program integrity concerns.

65. The Commission proposes issuing disbursements to the service provider, as is the current practice for the RHC programs, for the purchase of connectivity or other eligible items pursuant to its legal authority. In practice, this would equate to monthly discounts paid towards the cost of service or eligible equipment purchased by the health care provider. The Commission seeks comment on this proposal and any alternatives that commenters may provide. The Commission also proposes requiring that all reimbursement requests for any health care provider-purchased services funded through the Pilot program be submitted within six months of the date of receipt of the eligible service or network equipment, and allow for extensions to this deadline where good cause exists. Based on the Commission's experience with the existing RHC programs, establishing deadlines for submitting invoices would facilitate effective administration of the Pilot program.

66. For all services supported through the Pilot program, should the project's compliance with the data reporting requirements discussed in the following be a requirement for issuing each disbursement to the service provider? Since the purpose of Pilot program is to collect data and test the efficacy of a connected universal service support mechanism, would delay or failure to comply with data reporting requirements create sufficient reason to hold disbursements until the error is corrected? The Commission seeks comment on the best methods to ensure participants are regularly reporting useful and required program data including whether and how to tie the data submission requirement to the

reimbursement of Pilot program support.

67. *Ensuring Effective and Responsible Use of Funds.* Consistent with the other existing universal service support programs, to ensure the fiscally responsible use of Pilot program funds and guard against waste, fraud, and abuse, the Commission proposes adopting document retention and production requirements for health care providers and service providers participating in the Pilot program, and also proposes making individual projects subject to random compliance audits. Specifically, the Commission proposes applying to the Pilot program (1) section 54.648(a) of the Healthcare Connect Fund program rules, which makes participating health care providers and service providers subject to random compliance audits, and (2) section 54.648(b)(1)–(3) of the Healthcare Connect Fund program rules, which require participating health care providers and service providers to retain documentation sufficient to establish compliance with the rules and requirements for the Pilot program for at least five years and produce such documents to the Commission, any auditor appointed by the Administrator or the Commission, or any other state or federal agency with jurisdiction. Are there any other rules or requirements for the RHC support programs, the E-Rate program, or the Lifeline program not specifically mentioned in the NPRM that the Commission should apply to the Pilot program?

68. With respect to audits, the Office of the Managing Director and the Bureau would have the authority to direct USAC to conduct targeted audits as necessary to ensure Pilot program funds are being used consistent with the program. The Commission believes that a five-year document retention period after the final disbursement is made would provide sufficient time to conduct audits and any other investigations related to the Pilot program. The Commission seeks comment on this proposal.

69. The *Notice of Inquiry* sought comment on several potential goals for the Pilot program. In addition, the *Notice of Inquiry* proposed several metrics and methodologies for gathering data and measuring progress towards the proposed goals. The Commission proposes to focus on four primary program goals and seeks comment on this approach: (1) Improving health outcomes through connected care; (2) reducing health care costs for patients, facilities, and the health care system; (3) supporting the trend towards connected care everywhere; and (4) determining

how USF funding can positively impact existing telehealth initiatives. Further, the Commission seeks comment on appropriate metrics and methodologies to measure Pilot projects' progress towards these goals.

70. The Commission believes these constitute sound goals for the Pilot program and they are consistent with our statutory obligation to promote universal service. Section 254(c)(1), for example, directs the Commission to keep in mind when establishing the definition of services supported by USF “the extent to which such telecommunications services are essential to education, public health, or public safety.” Moreover, section 254(h)(2)(A) directs the Commission to establish rules to enhance access to advanced telecommunications and information services for health care providers. Additionally, 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 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.” The Commission believes the proposed goals will help advance these principles, and seeks comment on that conclusion.

71. *Proposed Program Goals.* First, the Commission intends that the Pilot will help improve health outcomes through connected care. Several comments in the record expressed support for including this as a program goal. For example, Hughes stated that the “provision of telehealth services expands access to high-level care and closes geographic barriers experienced by patients.” TruConnect stated that the “use of telemedicine applications on smartphones and devices benefits those who use them and will especially help rural patients who must travel great distances to health care providers.” According to the American Heart Association, a “strong and growing body of evidence identifies telehealth and remote patient monitoring as cornerstones of advanced healthcare systems.”

72. Commenters also identified several specific ways in which broadband access can improve health outcomes. For example, the Medical University of South Carolina (MUSC) and Gila River Telecommunications, Inc. (GRTI) both note that greater access to telehealth can enable health care providers to more easily engage their

patients in the daily management of chronic conditions. Commenters also note that broadband access for telehealth purposes increases the likelihood that patients will seek out medical care, and also increases the likelihood that patients will follow a prescribed course of treatment. Commenters stated that telehealth can reduce emergency room visits and hospital admissions and readmissions, and can lead to increased contact with specialists. The Commission agrees with these assessments and therefore proposes to include improvement of health outcomes through connected care as a goal of the Pilot program.

73. The Commission also believes the Pilot program can ultimately help reduce health care costs for patients, facilities, and the health care system, and proposes to adopt that program goal. The Commission seeks comment on this proposal. In the *Notice of Inquiry*, the Commission asked how the Pilot program could help identify effective means of improving health care affordability for patients, including by reducing the burden of out-of-pocket expenses like transportation costs for rural and remote patients. Similarly, the Commission stated that the Pilot program could help identify the circumstances in which support for telehealth services could create savings for health care providers and the Medicaid program.

74. Many commenters noted the potential for the Pilot program to greatly reduce travel time for rural and remote patients, significantly reducing out-of-pocket costs for patients, in addition to reducing the need to miss work or school to see a health care provider. Commenters also noted that reduction in travel times could lower costs for physicians and health care providers. The University of Arkansas for Medical Sciences stated that insurers will “witness cost savings when fewer beneficiaries experience long-term, costly morbidities.” The Medical Home Network described the ability of telemedicine to increase communication between a primary care physician and a specialist, “expediting wait times for patient appointments, and reducing unnecessary referrals and emergency room visits.” In particular, Hughes, citing to videoconferencing capabilities at the University of California, Davis, found that “patients avoided nearly 5 million miles of travel and \$3 million in travel expenses by being able to videoconference the treatment center in Sacramento.” CHRISTUS Health provided data on a remote monitoring pilot in partnership with a carrier and vendor in Texas, and found that after

one year of study, the pilot program reduced the cost of care by an estimated \$236,000 per year for congestive heart failure patients enrolled in the pilot. Thus, based on the record, the Commission believes the program could help reduce health care costs for patients, facilities, and the health care system overall and seeks comment on this program goal.

75. Next, the Commission proposes to establish a goal of supporting the trend toward bringing health care directly to the consumer. The *Notice of Inquiry* observed that there is a trend away from relying on connectivity solely within and between physical health care centers and towards a “connected care everywhere” model—a trend that has shown promising results for patients, communities, and the health care system. The *Notice of Inquiry* sought comment on using the Pilot program to support the current movement towards direct-to-consumer health care to ensure that low-income Americans can realize the benefits of this trend.

76. Commenters broadly support making this a program goal for the Pilot. GRTI, for example, noted that the Commission “has an opportunity to support the trend towards greater use of connected care and the benefits of such a policy,” and supports the goal of evaluating success of the Pilot program based in part on how it furthers this trend. The American Heart Association, commenting on the benefits and costs of the move towards ubiquitous connected care, noted the ability of telehealth to provide “instant healthcare at a fraction of the cost regardless of the patient’s health care status or geographic location,” but also noted potential ethical issues, including questions of trust, confidentiality, privacy, and informed consent. MUSC stated that as part of the movement towards connected care everywhere, the Pilot program should support the participation of rural and underserved consumers in the direct-to-consumer health care market. The Commission seeks comment on adopting this program goal. The Commission encourages commenters to specifically address how making USF dollars available to support the connectivity that enables telehealth applications can promote access to health care services for patients outside of the confines of brick-and-mortar medical facilities.

77. Finally, the Commission anticipates that the Pilot will help to determine how USF funding can positively impact existing telehealth initiatives, and the Commission proposes to include this as a goal of the Pilot program. In the *Notice of Inquiry*,

the Commission stated that it sought “to ensure that the pilot program enhances existing telehealth initiatives by the Commission and other federal agencies.” The Commission observed that it currently has several initiatives to assist with the expansion of health care connectivity in rural and underserved areas including through the Rural Health Care programs and the Connect2Health Task Force. In addition, the Commission noted various other telehealth programs established by other federal agencies, for example, the VA’s Home Telehealth Program and several initiatives run by the Department of Health and Human Services (HHS).

78. Numerous commenters assert that the Commission should consider working with HHS, in particular CMS, the National Coordinator for Health Information Technology (ONC), the Health Resources and Services Administration (HRSA), and the Indian Health Service. The Virginia Telehealth Network similarly proposed that the Commission consider collaborating with private sector entities that are providing broadband internet access service to vulnerable populations that might benefit from connected care services.

79. The Commission seeks comment on this proposed goal. How can the funding of connectivity for telehealth through the Connected Care Pilot complement other Commission initiatives, such as the Rural Health Care Program and the Connect2Health Task Force? How can the Pilot program complement other Commission programs to provide connectivity to low-income consumers, like the Lifeline Program, and rural and remote consumers, like the High Cost Fund? Other than the VA’s Home Telehealth program, what existing federal programs, if any, specifically fund connectivity for patients to enable the provision of telehealth? How can the Commission best collaborate with other federal agencies pursuing this goal?

80. *Metrics.* The Commission seeks comment on the best metrics and methodologies for measuring progress towards its proposed program goals. For example, are there specific ways in which broadband-enabled telehealth applications can improve health outcomes that could be demonstrated through the Pilot program? In the *Notice of Inquiry*, the Commission proposed several metrics: 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. Are there other metrics for measuring this goal? For example, commenters suggested measuring adherence to medication and care plans as a possible metric, because of the correlation with reducing morbidity and mortality. How can the Commission best measure whether and to what extent telehealth can promote adherence to medication and care plans? Similarly, how can the Commission measure patient satisfaction as to health status?

81. The Commission also encourages commenters to explain the specific ways it measures how universal service support for connectivity will improve health outcomes through telehealth. Do low-income consumers face budget constraints that are not adequately addressed by existing programs that prevent them from adopting connected care services via broadband internet access service? In such cases, what alternatives do those consumers use to obtain medical care, and do those alternatives result in poorer health outcomes? Do health care providers face budgetary shortfalls with respect to funding broadband internet access connections for connected care services, or other information services or equipment that health care providers need to provide connected care services such that the Fund can help serve a crucial funding need? In what other ways will universal service funding for connectivity promote improved health outcomes through telehealth?

82. The Commission also asks commenters to provide, where available, data and other information to help evaluate the potential for cost savings through telehealth. In addition to the specific areas of cost savings discussed in this document, in what other ways can the provision of telehealth produce cost savings for patients, facilities, and the health care system? The Commission further asks commenters to provide information on the specific way in which universal service support for connectivity to enable telehealth will produce cost savings. And the Commission seeks comment on the best metrics to evaluate progress towards this goal. How can the Commission best measure the savings from, for example, reduction in travel miles and travel time for patients and physicians? How can the Commission measure the effect of healthier patients on costs faced by health care providers and insurers? To what extent do these measures depend on accurate metrics on the health outcomes of the patients of pilot programs? What metrics exist to determine the cost savings from a

reduction in hospital admissions or re-admissions, or a reduction in emergency room visits?

83. How can the Commission measure its progress in supporting the trend toward bringing health care directly to the consumer? Will that funding enable access for patients and providers that would not otherwise have access to telehealth, perhaps by bringing telehealth into new geographic areas or attracting new funding for existing telehealth services? Will funding connected care pilots draw attention to, and increase the effectiveness of, future connected care applications, thereby promoting the development of connected care? Would it help incent more health care providers to purchase broadband, in order to bring connected care services to more patients? The Commission also seeks comment on any potential costs of ubiquitous connected care, including the ethical issues raised by the American Heart Association. How should these issues impact whether the Commission sets increased use of connected care as a goal of the Pilot program?

84. Finally, the Commission seeks comment on how it can determine whether the Pilot program supports existing Commission and federal efforts to promote telehealth. How can the Commission avoid duplicating existing efforts or otherwise overlap with programs that promote connectivity for telehealth? The Commission proposes to require Pilot program proposals to identify non-USF sources of funding or support, and to also require reporting from Pilot program participants to help the Commission identify how USF support for connected care broadband connectivity can leverage existing or new efforts to support other components of successful telehealth services. The Commission seeks comment on this approach.

85. For the Commission to evaluate the success of the Pilot program, it is critical to establish tools and procedures to gather data from the Pilot program participants on progress toward achieving the stated Pilot program goals. In addition, this information will allow the Commission to evaluate the progress of each project and ensure that Pilot program funds are being used efficiently and effectively. Ultimately, this data will determine the success of the Pilot program and will help inform the Commission about the long-term viability of a connected care program.

86. *Reporting Intervals.* The Commission proposes requiring participating health care providers to submit regular reports with anonymized, aggregated data that will

enable the Commission to monitor the progress of each project and ultimately evaluate the Pilot program, as a condition of receiving the proposed support. The Commission seeks comment on the required reporting intervals (*e.g.*, quarterly, annually) and the information that should be included in the reports. For example, TeleHealthCare America proposed quarterly reports, and the Commission seeks comment on whether quarterly intervals would be sufficient. Is there a shorter or longer reporting interval that would be more appropriate when analyzing outcomes from clinical trials? Do clinical trials commonly report interim results before completion of the trial? What types of information are reported on an interim basis and would such results provide reliable information? Or should the Commission delay reporting of health outcomes until the study is completed? What is the standard practice in medical research? Could such reports create difficulties for blinding protocols?

87. *Clinical Trials.* The Commission seeks comment on the appropriate methods for measuring the health effects of the connected care Pilot projects. Should all projects be required to conduct randomized controlled trials to determine the effect of the treatments on patients' health? Are there alternative, less costly methods that are statistically sound and can accurately measure the effect of the treatment? Are these alternative methods generally accepted in the scientific and medical communities? If the proposed treatment in a Pilot project has already been extensively studied and the health benefits are generally accepted by the medical community, and the pilot's purpose is to uncover other effects, such as the impact on the costs of providing health care or the broader impacts of subsidized access to broadband internet access services for connected care, is there any need to require the reporting of health outcomes?

88. Would different clinical trials be better served by different reporting requirements and, if so, could these be judged as part of the proposed project methods? Should the Commission require participants to file a detailed annual report, and shorter reports on a quarterly basis? The Commission is mindful of the burden that reporting can create for participants, particularly those that do not regularly report information to the Commission and seek to minimize this burden while still providing a mechanism for participants to provide valuable information. The Commission encourages commenters to

discuss the burdens and the best methods to alleviate them.

89. *Data Fields.* The Commission proposes that the regular reports from each participating project include information on a number of data fields that will enable the Commission to monitor the progress of each project towards the overall goals of the Pilot program. The Commission seeks comment on the data Pilot program participants should provide in regular reports to enable measuring progress towards these goals. The Commission proposes several data fields that should be part of regular reporting from Pilot participants. These fields include: The number of patients participating in the pilot project each month; the number of patients participating in the pilot project being treated for specific health conditions; the types of connected care services provided for each condition; average frequency of patient use of each type of connected care service; health outcomes for patients; and average cost-savings per patient. The Commission seeks comment on the proposed use of these data fields. Are there other types of information the Commission should require Pilot program participants to report on a regular basis? Should the Commission require pilot beneficiaries to submit raw health data on study participants or is it sufficient for beneficiaries to provide estimates of the effect of the treatment? Should the Commission require any type of certification as to the accuracy of the information provided?

90. To obtain information regarding patient experience, the Commission proposes requiring health care providers to conduct regular surveys of participating patients. The purpose of these surveys is to collect information regarding data such as patient cost savings, saved travel miles, patient satisfaction and comfort with the provided connected care services. Given the additional time and expense in administering patient surveys, reviewing data, and reporting it to the Commission, should health care providers conduct these surveys on a quarterly basis, or on a longer timeframe, such as after the completion of the clinical trial?

91. The Commission also proposes collecting additional information from Pilot program patient participants at the time of enrollment to better understand the impact of the Pilot program on the goals identified in this document, including whether the patient already has a mobile and/or home broadband connection, the speed, technology and broadband data usage for any broadband connection the patient already has, and

what devices the patient uses to connect to the internet. What other information might be important to know at the time of enrollment to help establish a baseline for measuring the impact of the Pilot program? Which party would be in the best position to collect this information from participants?

92. As noted in this document, the Commission proposes that all data provided by Pilot program participants should be anonymized and aggregated, and if that is impossible, for example, because there are so few participants within a reporting area their data could be used to identify individuals, then masked. Should the regular reports from each pilot project be made publicly available? If so, is the Commission's website, or USAC's website, the best place to host this information? Should the Commission allow project participants to request delay of publication until the project is completed if publication might impact the experiment? The Commission anticipates that these reports would not raise any HIPAA or other privacy concerns because the proposed required data would be submitted on an aggregated, anonymized basis. The Commission seeks comment on this conclusion. Further, are there other privacy or security measures that the Commission and USAC should take to ensure proper receipt, storage, and use of the data? The Commission is acutely aware of the data protections and sensitivities surrounding health data and seeks comment on the best ways to ensure proper handling of this information.

93. The Commission also proposes that Pilot program participants provide information regarding their experience with the Pilot program. For example, the Commission is interested in measuring the costs that Pilot program participants experience in designing their programs, submitting applications to the Commission, and ensuring ongoing compliance with the Pilot's rules and procedures. The Commission proposes to ask on a regular basis for these types of cost and time estimates to evaluate whether the Pilot program is an administratively feasible method of distributing funding for connected care services. This information will be critical if, following the Pilot, the Commission chooses to make a connected care program permanent, and seeks to minimize applicant burdens in so doing.

94. *Forms.* In addition, the Commission seeks comment on the forms that participants will use to provide this information. Are there existing Commission forms from other

USF programs, in particular the Rural Health Care program, that can be used to report data for the Pilot program? Should the Commission establish new forms for the purposes of the Pilot program?

95. The Commission's stewardship of the universal service support mechanisms and determinations concerning the services that are eligible for universal service funding are bound by section 254 of the Act, as amended by the 1996 Act. The *Notice of Inquiry* sought comment on the Commission's legal authority to establish the Pilot program. In the following, the Commission proposes and seeks comment on its sources of legal authority for the Pilot program. The Commission seeks comment on the potential impact of its legal authority on the structure, administrability, and effectiveness and efficiency of the Pilot program. Are there any additional potential sources of legal authority that the Commission should consider?

96. Based on review of the record and reading of the statute, the Commission believes that the Commission's rural health care legal authority in section 254(h)(2)(A) of the Act supports the proposed Pilot program. Section 254(h)(2)(A) directs the Commission to "establish competitively neutral rules, (A) to enhance, to the extent technically feasible and economically reasonable, access to advanced telecommunications and information services for all public and non-profit . . . health care providers. . . ." The Commission has previously explained that it has "broad discretion regarding how to fulfill this statutory mandate." The Commission seeks comment on whether to rely on the rural health care legal authority in section 254(h)(2)(A) as its authority to create the proposed Pilot program, and how relying on this legal authority would impact the structure of the Pilot program.

97. Several commenters argued that section 254(h)(2)(A) provides the Commission with legal authority to establish the proposed Pilot program. The Commission previously relied on this statutory provision as its legal authority for the RHC Pilot program and the Healthcare Connect Fund program, which were designed to develop dedicated health care provider networks and fund broadband internet access services used directly by health care providers, and network equipment necessary to make the supported services functional. The Commission has not previously relied on this statutory provision to provide support for connectivity between patients and health care providers, however. The

Commission believes the most feasible way to structure the Pilot program would be to have the health care provider purchase the broadband internet access service needed by the patient to access connected care services from a broadband carrier or a connected care company (e.g., a remote patient monitoring company) and then provide the telehealth service, including the underlying internet broadband access service, to the patient directly. The Commission therefore seeks comment on whether and how section 254(h)(2)(A) could be interpreted to authorize the creation of a Pilot program that would support patient broadband internet access service connections for connected care.

98. The Commission requests information on how providing health care providers support for patient-centered connected care enhances health care provider "access to advanced telecommunications and information services" consistent with section 254(h)(2)(A). Is there an argument that patient broadband internet access service falls within section 254(h)(2)(A) when it is purchased by a health care provider and used for medical purposes? Is the legal argument for supporting connectivity underlying technologies such as remote patient monitoring under section 254(h)(2)(A) stronger where the health care provider purchases the residential broadband internet access service as part of a complete solution or package and provides the connected care services to the patient? Does the fact that a health care provider cannot serve a patient at the patient's location through connected care unless the patient has a broadband internet access connection provide a basis for relying on the rural health care authority in section 254(h)(2)(A)? Is there an argument that individual patient broadband connections for connected care services fall within the scope of section 254(h)(2)(A) because they extend the health care provider's network by allowing the health care provider to send and receive communications to its patients wherever the patients are located, and thus would enhance access to advanced service "for" the health care provider, as required by section 254(h)(2)(A)?

99. The Commission also seeks comment on whether section 254(h)(2)(A) would also authorize the Commission to provide funding under the Pilot program for health care provider purchases of services—other than patient connectivity—that are used to provide connected care services but that are not already eligible for support

through the Healthcare Connect Fund program. For example, companies may offer cloud-based solutions, finished service packages, or complete suites of services that allow health care providers to provide telehealth, including connected care. Are these services “information services” under section 254(h)(2)(A), for which the Commission is required to develop competitively neutral rules to enhance access for health care providers? Are there other types of services that qualify as “information services” under section 254(h)(2)(A)? The Commission seeks additional information about, and examples of, these services and the components of these services, including any network equipment required to make these services functional. The Commission also seeks specific information and data that would help it to determine whether these types of services could qualify as supportable information services under section 254(h)(2)(A). Finally, the Commission seeks information on how these types of services help health care providers provide connected care services, and whether health care providers have difficulty affording these types of services without USF support.

100. The Commission believes that the universal service principles in sections 254(b)(1) and (b)(3) of the Act, and section 254(j) of the Act provide additional statutory support for a Pilot program that would provide USF support to enable health care providers to provide connected care technologies to eligible low-income consumers. Sections 254(b)(1) and (b)(3), provide, respectively, that the Commission’s universal service policies must be based on the principles that “[q]uality services should be available at just, reasonable, and affordable rates” and “[c]onsumers in all regions of the Nation, including low-income consumers . . . should have access to 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 those services provided in urban areas.” Section 254(j) ensures the continuation of the Lifeline program through any subsequent changes to the Universal Service Fund. In addition, section 154(i) also authorizes the Commission to “perform any and all acts, make such rules and regulations, and issue such orders, not inconsistent with this chapter, as may be necessary in the execution of its functions.”

101. The Commission believes that using a discrete, time-limited Pilot program to obtain additional data about the benefits of broadband-enabled

connected care services, and how universal service funds could better support the adoption of broadband-enabled connected care services, as well as broadband internet access service more generally, is consistent with these statutory provisions. The Commission notes that it has previously relied on sections 254(b)(1) and (b)(3) and 154(i) to establish the limited Lifeline Broadband Pilot program, which provided participating low-income consumers support for bundled broadband service or stand-alone broadband service to test the impact of Lifeline support on broadband adoption. The Commission seeks comment on relying in part on the low-income legal authority for the proposed Pilot program and how relying on the low-income legal authority would impact the structure of the Pilot program. For example, would relying on the low income legal authority require the Commission to limit Pilot projects to those serving exclusively low-income individuals?

102. The Commission also seeks comment on whether it should rely on its low-income legal authority to provide support for broadband internet access connections for connected care services through the Pilot program, and rely on its rural health care legal authority to provide support for information services not already funded through the Healthcare Connect Fund program that health care providers use to provide connected care services. How would this approach impact the structure and administrability of the Pilot program? Would it result in a Pilot program structure that incentivizes participation from eligible health care providers, service providers, and patients better than under the other proposed legal authorities?

103. For example, if a health care provider contracts with a remote patient monitoring solution provider for a package that includes broadband connectivity for patients, patient remote monitoring equipment, and software for the health care provider to process data received by the patient’s remote monitoring equipment, could the Commission fund some parts of that overall package via its Rural Health Care legal authority and other parts through its low-income legal authority? If the health care provider needed additional broadband capacity to its location to support that remote monitoring service, could the Commission also support that additional capacity through this Pilot program?

104. Are there other services the Commission should consider supporting consistent with its legal authority? For

example, in the Commission’s Rural Health Care Pilot Program, participants were permitted to purchase equipment integral to running their broadband networks, such as servers, routers, firewalls, and switches, or to upgrade their existing equipment and increase bandwidth. The Commission seeks comment on its legal authority to fund such services here.

III. Procedural Matters

A. Initial Paperwork Reduction Act Analysis

105. This document contains proposed information collection requirements. The Commission, as part of its continuing effort to reduce paperwork burdens, invites the general public and the OMB to comment on the information collection requirements contained in this document, as required by the Paperwork Reduction Act of 1995, Public Law 104–13. In addition, pursuant to the Small Business Paperwork Relief Act of 2002, Public Law 107–198, *see* 44 U.S.C. 3506(c)(4), the Commission seeks specific comment on how to further reduce the information collection burden for small business concerns with fewer than 25 employees.

106. *Ex Parte Rules—Permit-But-Disclose.* The proceeding the NPRM initiates shall be treated as a “permit-but-disclose” proceeding in accordance with the Commission’s *ex parte* rules. Persons making *ex parte* presentations must file a copy of any written presentation or a memorandum summarizing any oral presentation within two business days after the presentation (unless a different deadline applicable to the Sunshine period applies). Persons making oral *ex parte* presentations are reminded that memoranda summarizing the presentation must (1) list all persons attending or otherwise participating in the meeting at which the *ex parte* presentation was made, and (2) summarize all data presented and arguments made during the presentation. If the presentation consisted in whole or in part of the presentation of data or arguments already reflected in the presenter’s written comments, memoranda, or other filings in the proceeding, the presenter may provide citations to such data or arguments in his or her prior comments, memoranda, or other filings (specifying the relevant page and/or paragraph numbers where such data or arguments can be found) in lieu of summarizing them in the memorandum. Documents shown or given to Commission staff during *ex parte* meetings are deemed to

be written *ex parte* presentations and must be filed consistent with rule 1.1206(b). In proceedings governed by rule 1.49(f) or for which the Commission has made available a method of electronic filing, written *ex parte* presentations and memoranda summarizing oral *ex parte* presentations, and all attachments thereto, must be filed through the electronic comment filing system available for that proceeding, and must be filed in their native format (e.g., .doc, .xml, .ppt, searchable .pdf). Participants in this proceeding should familiarize themselves with the Commission's *ex parte* rules.

107. *Initial Regulatory Flexibility Analysis.* As required by the Regulatory Flexibility Act of 1980, as amended, the Commission has prepared an Initial Regulatory Flexibility Analysis (IRFA) for the NRPM, of the possible significant economic impact on a substantial number of small entities by the policies and rules proposed in the NPRM. Written public comments are requested on this IRFA. Comments must be identified as responses to the IRFA and must be filed by the deadlines for comments on the NPRM. The Commission will send a copy of the NPRM, including this IRFA, to the Chief Counsel for Advocacy of the Small Business Administration. In addition, the NPRM and IRFA (or summaries thereof) will be published in the **Federal Register**.

108. *Need for, and Objectives of, the Proposed Rules.* The Commission is required by section 254 of the Communications Act of 1934, as amended, to promulgate rules to implement the universal service provisions of section 254 and “to establish competitively neutral rules— (A) 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 . . .” The Commission is also required to base policies for the preservation and advancement of universal services on principles including “[q]uality rates should be available at just, reasonable, and affordable rates” and “[c]onsumers in all regions of the Nation, including low-income consumers . . . should have access to telecommunications service 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.” In the NPRM, the Commission proposes a Connected Care Pilot program (Pilot) that will assist

in satisfying these requirements by providing support for eligible health care providers to provide connected care to low-income patients, including veterans and those in medically underserved communities. The Commission seeks comment on whether the Pilot program should fund broadband internet access services or other information services used by health care providers to provide connected care services and network equipment necessary to make the supported services functional. The Commission expects that the data gathered from the Pilot program will help to understand how and whether USF funds could be used to promote health care provider and low-income patient adoption and use of connected care services.

109. The Commission proposes four goals for the proposed Pilot program and also propose a three-year duration and budget of \$100 million for the Pilot program. The Commission also proposes and seeks comment on the application process and the objective criteria for selecting projects among the applications the Commission receives for the Pilot program, and proposes and seeks comment on awarding additional points during the evaluation process for proposed projects that would primarily serve veterans or rural or Tribal areas or populations or primarily treat diabetes, heart disease, opioid addiction, mental health conditions, or high-risk pregnancy. The Commission should be able to fund a range of diverse projects throughout the country. The Commission proposes the specific requirements for health care providers, including vendor selection requirements, requirements for requesting funding and reimbursements, and audit and document retention requirements, and data reporting requirements. Finally, the Commission proposes specific requirements for participating service providers including indicating interest in participating in the Pilot program, requesting disbursements, and document retention and audit requirements. Participating consumers may also be required to complete consumer surveys.

110. *Legal Basis.* The legal basis for the Notice of Proposed Rulemaking is contained in sections 1 through 4, 201, 254, and 403 of the Communications Act of 1934, as amended by the Telecommunications Act of 1996, 47 U.S.C. 151 through 154, 201, 254, and 403.

111. *Description and Estimate of the Number of Small Entities to Which the Proposed Rules Will Apply.* 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. The RFA generally defines the term “small entity” as having the same meaning as the terms “small business,” “small organization,” and “small governmental jurisdiction.” In addition, the term “small business” has the same meaning as the term “small business concern” under the Small Business Act. 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 Small Business Administration (SBA). Nationwide, there are a total of approximately 29.6 million small businesses, according to the SBA. A “small organization” is generally “any not-for-profit enterprise which is independently owned and operated and is not dominant in its field.”

112. *Small Businesses, Small Organizations, Small Governmental Jurisdictions.* The Commission's actions, over time, may affect small entities that are not easily categorized at present. The Commission therefore describes here, at the outset, three broad groups of small entities that could be directly affected herein. 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. These types of small businesses represent 99.9% of all businesses in the United States which translates to 29.6 million businesses.

113. 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.” Nationwide, as of August 2016, there were approximately 356,494 small organizations based on registration and tax data filed by nonprofits with the Internal Revenue Service (IRS).

114. 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 districts, with a population of less than fifty thousand.” U.S. Census Bureau data from the 2012 Census of Governments indicates that there were 90,056 local governmental jurisdictions consisting of general purpose governments and special purpose governments in the United States. Of this number there were 37,132 general purpose governments (county,

municipal and town or township) with populations of less than 50,000 and 12,184 special purpose governments (independent school districts and special districts) with populations of less than 50,000. The 2012 U.S. Census Bureau data for most types of governments in the local government category show that the majority of these governments have populations of less than 50,000. Based on this data the Commission estimates that at least 49,316 local government jurisdictions fall in the category of “small governmental jurisdictions.”

115. Small entities potentially affected by the proposals herein include eligible non-profit and public health care providers and the service providers offering them services, including telecommunications service providers, internet Service Providers (ISPs), and vendors of the eligible services and equipment that would be supported by the Pilot program.

116. *Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements for Small Entities.* In the NPRM, the Commission seeks comment on a proposed Connected Care Pilot program with a \$100 million budget and three-year duration, that would provide support for eligible low-income patients to receive discounts on residential broadband service for purposes of connected care.

117. To participate in the Pilot program, the Commission proposes that health care providers satisfy the definition of an eligible health care provider under section 254(h)(7)(B) of the Act and submit an application by the application deadline that the Commission ultimately adopts for the Pilot program. The NPRM proposes specific information that health care providers would be required to submit in an application for each pilot project proposal, including, but not limited to, information on the participating health care provider(s), description of the project and how it would further the goals of the Pilot program, estimated project budget, patient populations and the geographic areas to be served and health conditions to be treated. The NPRM also proposes that the applications be made publicly available.

118. The NPRM proposes requirements for participating health care providers to select service providers for the supported services and other potential Pilot-program supported items, including the possibility of requiring health care providers to competitively bid the supported services. In addition, the NPRM proposes requiring health care providers

for participating projects to submit funding requests and invoices for services and other items that are eligible for support through the Pilot program, and reports at regular intervals that would allow the Commission to monitor the status of each project and how each project is using the funding and seeks comment on the appropriate interval and contents of those reports. Participating service providers may also have requirements related to requesting disbursements. The NPRM also proposes that participating health care providers and service providers be subject to random compliance audits, and a three or five-year document retention period.

119. *Steps Taken to Minimize the Significant Economic Impact on Small Entities, and Significant Alternatives Considered.* The RFA requires an agency to describe any significant, specifically small business, alternatives that it has considered in reaching its proposed approach, which may include the following four alternatives (among others): “(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 and reporting requirements under the rule for such 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 such small entities.”

120. The Commission does not expect the requirements for the Pilot program to have a significant economic impact on eligible service providers or eligible health care providers because service providers and health care providers have a choice of participating. The Commission also does not expect small entities to be disproportionately impacted. The Bureau will consider whether the proposed projects will promote entrepreneurs and other small businesses in the provision and ownership of telecommunications and information services, consistent with section 257 of the Communications Act, including those that may be socially and economically disadvantaged businesses. All eligible health care providers that choose to participate may be required to collect and submit data at regular intervals during the Pilot program and at the end of the Pilot program to USAC and the Commission, as described in section III(E) of the NPRM. The collection of this information is necessary to evaluate the impact of the Pilot program, including whether the Pilot program achieves its goals. The

benefits of collecting this information outweigh any costs.

121. The NPRM proposes an application process that would encourage a wide variety of eligible health care providers and eligible service providers to participate, including small entities. The Commission seeks to strike a balance between requiring applicants to submit enough information that would allow the selection of high-quality, cost-effective projects that would best further the goals of the Pilot program, but also minimizing the administrative burdens on entities that seek to apply.

122. The Commission proposes awarding additional points during the application process for projects that are located in a rural area, would primarily serve rural patients or veterans, would serve five or more Medically Underserved Areas and Healthcare Provider Shortage Areas, as designated by the Health Resources and Services Administration by geography, or are located on Tribal lands, associated with a Tribe, or part of the Indian Health Service. This recognizes the disparities in health care in rural areas and Tribal areas, and areas that are designated as Medically Underserved Areas and Healthcare Provider Shortage Areas and is aimed at increasing the likelihood projects serving these areas will be selected.

123. The reporting requirements, compliance audit requirements, and document retention requirements the Commission proposes are tailored to ensure that Pilot program funding is used for its intended purposes and so that the Commission can obtain meaningful data to evaluate the Pilot program and inform its policy decisions. The proposed compliance audit and document retention requirements the Commission proposes are the same measures that apply to health care providers and service providers that participate in the Healthcare Connect Fund program. The proposed reporting requirements are tailored to ensure that the Commission receive regular, meaningful data about each project. The Commission finds that ensuring that participating health care providers and service providers, including small entities, are accountable in the use of Pilot program funds and that participating health care providers submit regular, meaningful information about their projects outweighs the burdens associated with these requirements.

IV. Ordering Clauses

124. *It is ordered* that, pursuant to the authority contained in sections 1

through 4, 201, 254, and 403 of the Communications Act of 1934, as amended by the Telecommunications Act of 1996, 47 U.S.C. 151 through 154, 201, 254, and 403 the Notice of Proposed Rulemaking *is adopted*.

125. *It is further ordered* that, pursuant to applicable procedures set forth in sections 1.415 and 1.419 of the Commission's rules, 47 CFR 1.415, 1.419, interested parties may file comments on the NPRM on or before

August 29, 2019, and reply comments September 30, 2019.

Federal Communications Commission.

Marlene Dortch,
Secretary.

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