G. Executive Order 13045: Protection of Children From Environmental Health Risks and Safety Risks

This action is not subject to Executive Order 13045 (62 FR 19885, April 23, 1997), because this is not an economically significant regulatory action as defined under Executive Order 12866, and it does not address environmental health or safety risks disproportionately affecting children.

H. Executive Order 13211: Actions Concerning Regulations That Significantly Affect Energy Supply, Distribution, or Use

This action is not subject to Executive Order 13211 (66 FR 28355, May 22, 2001), because this action is not expected to affect energy supply, distribution, or use and because this action is not a significant regulatory action under Executive Order 12866.

I. National Technology Transfer and Advancement Act (NTTAA)

Since this action does not involve any technical standards, NTTAA section 12(d), 15 U.S.C. 272 note, does not apply to this action.

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

This action does not entail special considerations of environmental justice related issues as delineated by Executive Order 12898 (59 FR 7629, February 16, 1994).

III. Congressional Review Act (CRA)

This action is subject to the CRA, 5 U.S.C. 801 *et seq.,* and EPA will submit a rule report to each House of the Congress and to the Comptroller General of the United States. The CRA allows the issuing agency to make a rule effective sooner than otherwise provided by the CRA if the agency makes a good cause finding that notice and comment rulemaking procedures are impracticable, unnecessary or contrary to the public interest (5 U.S.C. 808(2)). The EPA has made a good cause finding for this rule as discussed in Unit I.C., including the basis for that finding.

List of Subjects in 40 CFR Part 711

Environmental protection, Chemicals, Confidential Business Information (CBI), Hazardous materials, Importer, Manufacturer, Reporting and recordkeeping requirements.

Dated: March 17, 2020.

Alexandra Dapolito Dunn,

Assistant Administrator, Office of Chemical Safety and Pollution Prevention.

Therefore, 40 CFR chapter I is amended as follows:

PART 711—[AMENDED]

■ 1. The authority citation for part 711 continues to read as follows:

Authority: 15 U.S.C. 2607(a).

■ 2. In § 711.20, revise the third sentence to read as follows.

§ 711.20 When to report.

* * * The 2020 CDR submission period is from June 1, 2020, to November 30, 2020. Subsequent recurring submission periods are from June 1 to September 30 at 4-year intervals, beginning in 2024. * * *

[FR Doc. 2020–06074 Filed 4–8–20; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 54

[WC Docket Nos. 18–213 and 20–89; FCC 20–44; FRS 16647]

Promoting Telehealth for Low-Income Consumers; COVID–19 Telehealth Program

AGENCY: Federal Communications Commission.

ACTION: Final order; announcement of effective date.

SUMMARY: In this document, the Federal Communications Commission (Commission) establishes two programs: The COVID–19 Telehealth Program designed to distribute a $200 million appropriation from Congress under the Coronavirus Aid, Relief, and Economic Security (CARES) Act, to help health care providers provide connected care services to patients at their homes or mobile locations in response to the novel Coronavirus 2019 disease (COVID–19) pandemic, and the Connected Care Pilot Program (Pilot Program) designed to make available up to $100 million over three years to examine how the Universal Service Fund can help support the trend towards connected care services to consumers, particularly for low-income Americans and veterans.

DATES: The Report and Order is effective May 11, 2020, except for the information collections requiring Office of Management and Budget (OMB) approval. The Commission received OMB approval of the COVID–19 Telehealth Program information collection requirements on April 6, 2020, and those requirements are effective April 9, 2020. The Pilot Program requirements will not become effective until approved by OMB. The Federal Communications Commission will publish a document in the **Federal Register** announcing the effective date of OMB approval of the Pilot Program requirements.

FOR FURTHER INFORMATION CONTACT: Please email *EmergencyTelehealthSupport@fcc.gov* with questions related to the COVID–19 Telehealth Program, and *ConnCarePltProg@fcc.gov* with questions related to the Pilot Program.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's Promoting Telehealth for Low-Income Consumers; COVID–19 Telehealth Program, Report and Order (R&O), in WC Docket Nos. 18–213 and 20–89; FCC 20–44, adopted March 31, 2020 and released April 2, 2020. Due to the COVID–19 pandemic, the Commission's headquarters will be closed to the general public until further notice. The full text of this document is available at the following internet address: *https://docs.fcc.gov/public/attachments/FCC-20-44A1.pdf.*

I. Introduction

1. The novel Coronavirus disease 2019 (COVID–19) pandemic and associated respiratory illness have spread throughout the United States in recent weeks. In response to this pandemic, many health care providers are expanding existing telehealth services and implementing new telehealth services, and the demand for connected care services provided directly to patients in their homes or their mobile locations is skyrocketing. As a result, many health care providers are facing new challenges in technical infrastructure and experiencing staffing issues. In response to the outbreak, on March 27, 2020, President Trump signed the Coronavirus Aid, Relief, and Economic Security (*CARES*), Act into law, Public Law 116–136, 134 Stat. 281 (2020), providing, among a panoply of other actions, $200 million to the FCC to support health care providers in the fight against the ongoing pandemic.

2. In the R&O, to effectuate Congress' intent in enacting the *CARES* Act, the Commission establishes a $200 million emergency *COVID–19 Telehealth Program* to implement the CARES Act and ensure access to connected care services and devices in response to the ongoing COVID–19 pandemic and surge

in demand for connected care services. The support provided through the *COVID–19 Telehealth Program* will help eligible health care providers purchase telecommunications services, information services, and devices necessary to provide critical connected care services, whether for treatment of coronavirus or other health conditions during the coronavirus pandemic. The *COVID–19 Telehealth Program* is funded through a $200 million appropriation signed into law as part of the CARES Act, and the program will not rely on Universal Service Fund (USF or Fund) support. The Commission also establishes a longer-term Connected Care Pilot Program (*Pilot Program*) within the Universal Service Fund that will make available up to $100 million over three years to examine how the Fund can help support the trend towards connected care services, particularly for low-income Americans and veterans. The *Pilot Program* will help defray eligible health care providers' costs of providing connected care services, with a particular emphasis on supporting these services for eligible low-income Americans and veterans. The Commission expects that the *Pilot Program* will benefit many low-income and veteran patients who are responding to a wide variety of health challenges such as diabetes management, opioid dependency, high-risk pregnancies, pediatric heart disease, mental health conditions, and cancer. The Commission also expects that the *Pilot Program* will provide meaningful data that will help to better understand how universal service funds can support health care provider and patient use of connected care services, and how supporting health care provider and patient use of connected care services can improve health outcomes and reduce health care costs. The Commission anticipates that the data and information collected through the *Pilot Program* could also have the ancillary benefit of aiding policy makers and legislators in the consideration of broader reforms—such as statutory changes or updates to rules administered by other agencies—that could support this trend towards connected care.

II. COVID–19 Telehealth Program

3. The *COVID–19 Telehealth Program* is one piece of a comprehensive approach to reducing barriers to telehealth services for health care providers and their patients throughout the country in response to the COVID–19 pandemic. Working in step with other federal efforts to provide relief related to the COVID–19 pandemic, the *COVID–19 Telehealth Program* will be open to eligible health care providers, whether located in rural or non-rural areas, and will provide eligible health care providers support to purchase telecommunications, information services, and connected devices to provide connected care services in response to the coronavirus pandemic. The *COVID–19 Telehealth Program* will only fund monitoring devices (*e.g.,* pulse-ox, BP monitoring devices), that are themselves connected. The *COVID–19 Telehealth Program* will not fund unconnected devices that patients can use at home and then share the results with their medical professional remotely.

4. The *COVID–19 Telehealth Program* will provide selected applicants full funding for eligible services and devices. The *COVID–19 Telehealth Program* has a congressionally appropriated $200 million budget, and these funds will be available until they are expended or until the current pandemic has ended. In order to ensure as many applicants as possible receive available funding, the Commission does not anticipate awarding more than $1 million to any single applicant. The Commission will award support to eligible applicants based on the estimated costs of the supported services and connected devices they intend to purchase, as described in each health care provider's respective application. However, in order to give each health care provider maximum flexibility to respond to changing circumstances during the pandemic, the Commission does not require applicants to purchase only the services and connected devices identified in their applications. They may rather use awarded support to purchase any necessary eligible services and connected devices. In addition, applicants that have exhausted initially awarded funding may request additional support.

5. *Application, Evaluation, and Selection Process.* Because of the urgency attendant in combating the COVID–19 outbreak, the Commission establishes a streamlined application process for the *COVID–19 Telehealth Program,* separate from the longer application process adopted for the broader *Pilot Program.* The Commission directs the Wireline Competition Bureau (Bureau) to review the applications, in consultation with the FCC's Connect2Health Task Force and its medical and public health experts, and announce selected participants and funding amounts for each selected applicant as rapidly as possible on a rolling basis, and continue reviewing additional applications and selecting participants until it has committed all *COVID–19 Telehealth Program* funding or the current pandemic has ended. In reviewing applications, the Commission has a strong interest in targeting funding towards areas that have been hardest hit by COVID–19. In addition, given the public health emergency and widespread scope of the coronavirus pandemic, unlike the broader *Pilot Program,* the Commission will not target *COVID–19 Telehealth Program* funding toward specific medical conditions, patient populations, or geographic areas. However, the Commission strongly encourages selected applicants to target the funding they receive through the *COVID–19 Telehealth Program* to high-risk and vulnerable patients to the extent practicable. The Commission recognizes that some health care providers may have been under pre-existing strain (*e.g.,* large underserved or low-income patient population; health care provider shortages; rural hospital closures; limited broadband access and/or internet adoption) and encourage applicants to document such factors in their applications. While health care providers may use the *COVID–19 Telehealth Program* to treat patients that have COVID–19, the program is not limited to treating those types of patients as long as program funds are used ''to prevent, prepare for, and respond to coronavirus.'' For instance, treating other types of conditions or patient groups through the Commission's *COVID–19 Telehealth Program* could free up resources, including physical space and equipment in a brick-and-mortar health care facility, allow health care providers to remotely treat patients with other conditions who could risk contracting coronavirus by visiting a health care facility, and could reduce health care professionals' unnecessary exposure to coronavirus. The Commission will also consider as part of a health care provider's application a showing that telemedicine directly aids in the prevention of pandemic spread by facilitating social distancing and similar measures in the community. Connected devices and services like patient-reported outcome platforms funded through the *COVID–19 Telehealth Program* must be integral to patient care.

6. *Eligible Health Care Providers.* Consistent with the 1996 Act and the CARES Act, the Commission limits the program to nonprofit and public eligible health care providers that fall within the categories of health care providers in section 254(h)(7)(B) of the 1996 Act: (1)

Post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (2) community health centers or health centers providing health care to migrants; (3) local health departments or agencies; (4) community mental health centers; (5) not-for-profit hospitals; (6) rural health clinics; (7) skilled nursing facilities; or (8) consortia of health care providers consisting of one or more entities falling into the first seven categories. The Commission has more than two decades of experience administering its RHC Program for these types of health care providers, and limiting the *COVID–19 Telehealth Program* to public and nonprofit health care providers that fall within these statutory categories is in the public interest because it will facilitate the administration of the program and ensure that funding is targeted to health care providers that are likely to be most in need of funding to respond to this pandemic while helping ensure that funding is used for its intended purposes.

7. Interested health care providers that do not already have an eligibility determination can obtain one by filing an FCC Form 460 with the Universal Service Administrative Company (USAC). The Commission directs USAC to review and process eligibility forms for health care providers interested in participating in the *COVID–19 Telehealth Program* as expeditiously as possible. Health care providers that are interested in the *COVID–19 Telehealth Program,* but do not yet have an eligibility determination from USAC, can still submit applications for the *COVID–19 Telehealth Program* while their FCC Form 460 is pending.

8. *Application Process.* To be considered for participation in the *COVID–19 Telehealth Program,* interested eligible health care providers must submit applications that, at a minimum, contain the information detailed in the following.

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

9. Additionally, *COVID–19 Telehealth Program* applicants will also be required, at the time of submission of their application, to certify, among other things, that they will comply with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy and reimbursement laws and regulations, and applicable medical licensing laws and regulations, as waived or modified in connection with the COVID–19 pandemic, as well as all applicable *COVID–19 Telehealth Program* requirements and procedures, including the requirement to retain records to demonstrate compliance with the *COVID–19 Telehealth Program* requirements and procedures for three years following the last date of service, subject to audit. Health care providers that participate in the *COVID–19 Telehealth Program* must also comply with all applicable federal and state laws, including the False Claims Act, the Anti-Kickback Statute, and the Civil Monetary Penalties Law, as waived or modified in connection with the COVID–19 pandemic. Further, applicants will also be required to certify that they are not already receiving or expecting to receive other federal or state funding for the exact same services or devices for which they are requesting support under the *COVID–19 Telehealth Program.*

10. The Wireline Bureau will issue a public notice announcing the date when COVID–19 Telehealth Program applications will be accepted and instructions for filing applications with the Commission. This date will be after April 9, 2020. Applicants will be required to complete each section of the application and make the required certifications at the end of the application. Applicants may request that any materials or information submitted to the Commission in its application be withheld from public inspection pursuant to the procedures set forth in section 0.459 of the Commission's rules.

11. *Instructions for Filing Applications. COVID–19 Telehealth Program* applications must reference WC Docket No. 20–89, and must be filed electronically consistent with the instructions provided in a subsequent public notice. All filings must be addressed to the Commission's Secretary, Office of the Secretary, Federal Communications Commission. Applicants must also send a courtesy copy of their application via email to *EmergencyTelehealthSupport@fcc.gov.*

12. *Evaluation of Applications and Selection Process.* The Bureau, in consultation with the FCC's Connect2Health Task Force, will evaluate the *COVID–19 Telehealth Program* applications and will select participants based on applicants' responses to the criteria listed in the document. The Commission's goal is to select applications that target areas that have been hardest hit by COVID–19 and where the support will have the most impact on addressing the health care needs. In selecting applicants, the Commission directs the Bureau to consider the funding sought by each applicant compared to the total *COVID–19 Telehealth Program* budget. This does not mean that the Bureau will evaluate applications based solely on requested funding, but the Bureau will seek to select as many applicants as reasonably possible within the *COVID–19 Telehealth Program*'s limited budget. Upon selection, the Bureau will provide additional guidance to program participants, as necessary, to facilitate the implementation of the *COVID–19 Telehealth Program.* Applicants who are selected for the *COVID–19 Telehealth*

Program may later submit applications to participate in the broader *Pilot Program* but may not request funding for the same exact services from both programs at the same time.

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

14. The *COVID–19 Telehealth Program* will not provide funding for health care provider administrative costs associated with participating in the *COVID–19 Telehealth Program* (*e.g.,* costs associated with completing *COVID–19 Telehealth Program* applications and other submissions) or other miscellaneous expenses (*e.g.,* doctor and staff time spent on the *COVID–19 Telehealth Program* and outreach). The Commission emphasizes that *COVID–19 Telehealth Program* funds may only be used for services and devices covered under the *CARES* Act. The costs of ineligible items must not be included in the reimbursement requests for the *COVID–19 Telehealth Program.* To guard against potential waste, fraud, and abuse, the Commission makes clear that participating health care providers are prohibited from selling, reselling, or transferring services or devices funded through the *COVID–19 Telehealth Program* in consideration for money or any other thing of value.

15. *Procurement for COVID–19 Telehealth Program-Supported Services and Equipment, and Document Retention.* The *COVID–19 Telehealth Program* is funded through a congressional appropriation and not the USF. Given the immediate need to award and disburse the *COVID–19 Telehealth Program* funding to health care providers, the Commission will not require *COVID–19 Telehealth Program* participants to conduct a competitive bidding process to solicit and select eligible services or devices, or otherwise comply with the competitive bidding requirements that apply to the RHC Program and the broader *Pilot Program.* The Commission finds that, in light of the coronavirus pandemic and ongoing community efforts to slow its spread, requiring *COVID–19 Telehealth Program* participants to seek competitive bids prior to requesting funding would cause unnecessary delays and pose an unreasonable burden on health care providers during this unprecedented time. The Commission also finds that it would not be in the public interest during this national health crisis to prohibit participating health care providers from receiving gifts or things of value from service providers valued at over $20, including, but not limited to devices, equipment, free upgrades or other items.

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

17. *Outreach for COVID–19 Telehealth Program.* Upon release of the R&O, in order to ensure that health care providers are aware of available funding under the *COVID–19 Telehealth Program,* the Commission will, to the extent possible, coordinate with other federal agencies to distribute information about the program to the health care community. The Commission also directs the Bureau to coordinate with the FCC's Connect2Health Task Force and USAC as necessary to promote and announce the *COVID–19 Telehealth Program* to interested stakeholders including service providers and health care providers. The Commission is committed to addressing the needs of health care providers as demand for connected care services increases to address the coronavirus pandemic. Such coordination and outreach will improve the overall efficacy of the *COVID–19 Telehealth Program.*

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

III. Connected Care Pilot Program

19. The *Pilot Program* will make available up to $100 million over a three-year funding period, separate from the budgets of the existing universal service programs, to cover 85% of the eligible costs of broadband connectivity, network equipment, and information services necessary to provide connected care services to the intended patient

population. All eligible nonprofit and public health care providers that fall within the statutory categories under section 254(h)(7)(B), regardless of whether they are non-rural or rural, can apply for the *Pilot Program.* Eligible health care providers must first submit applications to the Commission, and after review, the Commission will announce the selected projects and provide further information on additional requirements for the *Pilot Program.*

20. For purposes of the *Pilot Program,* the Commission considers ''connected care'' as a subset of telehealth that uses broadband internet access service-enabled technologies to deliver directly to patients' remote medical, diagnostic, and treatment-related services outside of traditional brick and mortar medical facilities—specifically to patients at their mobile location or residence. For purposes of the *Pilot Program,* the Commission also defines ''telehealth'' as the broad range of health care-related applications that depend upon broadband connectivity, including telemedicine; exchange of electronic health records; collection of data through Health Information Exchanges and other entities; exchange of large image files (*e.g.,* X-ray, MRIs, and CAT scans); and the use of real-time and delayed video conferencing for a wide range of telemedicine, consultation, training, and other health care purposes. Connected care services can be provided by doctors, nurses, or other health care professionals. Health care providers will have the flexibility to identify the medical conditions to be treated through their proposed pilot projects, and whether to treat a single medical condition or multiple medical conditions. For purposes of the *Pilot Program,* the Commission uses the U.S. Department of Health and Human Services' definition of ''medical condition'' to identify the types of health conditions that can be treated through the Pilot—''any condition, whether physical or mental, including but not limited to any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation.''

21. In reviewing applications, the Commission is interested in targeting limited *Pilot Program* funding towards pilot projects that are primarily focused on treating public health epidemics, opioid dependency, mental health conditions, high-risk pregnancy, or chronic or recurring conditions that typically require at least several months to treat, including, but not limited to, diabetes, cancer, kidney disease, heart disease, and stroke recovery. Focusing *Pilot Program* funding on these conditions identified best ensures that limited *Pilot Program* resources are targeted to populations that are most in need. Moreover, targeting these types of health conditions, which impact large segments of the population, and often require several months or more of treatment, or are public health crises will provide more meaningful data to track progress towards the *Pilot Program* goals of helping health care providers to improve health outcomes and reduce costs, and will also promote the efficient, fiscally responsible use of universal service funds.

22. *Budget Number of Pilot Projects and Support Amount Per Project, Funding Duration, and Discount Level.* The *Pilot Program* will make available up to $100 million over three years for selected pilot projects. Targeting this amount of funding for qualifying eligible services and equipment under the *Pilot Program* is sufficient to obtain meaningful data and ensure significant interest from a wide range of participants. Funding the *Pilot Program* in this manner will not significantly increase the contributions burden on consumers and will not impact the budgets of, or disbursements for, the other existing universal service programs.

23. To secure the funds for the *Pilot Program,* the Commission directs USAC to separately collect funds for the *Pilot Program* each quarter beginning with the demand filing for the fourth quarter of 2020. USAC should collect necessary funds up to the amount of the budget over the entire three-year period in order to minimize any impact on the contribution factor. The Commission anticipates the collection schedule would increase the quarterly contribution factor by approximately 0.11%. Moreover, by starting the collection before selecting the pilot projects, USAC will have funding on hand as soon as the pilot projects begin to seek support. Requests for funding may vary year to year and therefore *Pilot Program* funding may not be distributed evenly each year. While anticipating significant participation in the *Pilot Program,* total amount disbursed will depend upon those funds ultimately committed by USAC, invoiced, and disbursed. Unused collected *Pilot Program* funds will be carried forward to subsequent quarters over the duration of the *Pilot Program* for use by pilot projects and need not be returned to offset future collections. Any unused funds that remain at the end of the *Pilot Program* will be used to reduce collections for the ongoing universal service programs.

24. *Discount Level.* The *Pilot Program* will provide universal service support for 85% of the cost of eligible services and equipment. This support amount will allow for funding of a sufficient number of pilot projects to provide meaningful data and provide substantial financial incentive for health care providers to participate in the *Pilot Program.* Consistent with the Commission's existing rules for the Healthcare Connect Fund Program, health care providers must contribute their portion of the eligible costs from eligible sources (*e.g.,* the applicant, eligible health care provider, participating patients, or state, federal, or Tribal funding or grants) and cannot use ineligible sources (*e.g.,* direct payments from vendors or service providers) to pay their share of the requested services.

25. *Number of Pilot Projects and Support Amount Per Project.* Based on the record, the Commission declines to set a limit on the number of pilot projects selected for the *Pilot Program* or the amount of support requested per pilot project. Setting a fixed number of pilot projects or a fixed amount per-project will artificially limit the number of pilot projects to be funded even before pilot project proposals are submitted and evaluated, and will not provide enough flexibility to select a diverse group of pilot projects. The Commission does not anticipate allocating all of the *Pilot Program* funds on one or two large projects. In reviewing pilot project applications, the Commission will be mindful of the reasonableness of the estimated total support amount indicated in each application, looking specifically at the proportion to the total *Pilot Program* budget and individual project size, to provide sufficient funding to enough projects to generate meaningful data.

26. *Duration.* The *Pilot Program* will provide selected pilot projects support for a three-year funding period with separate transition periods of up to six months before and after the three-year funding period. Specifically, selected pilot participants will have up to six months from the date of their initial funding commitment letter from USAC to organize and start their pilot projects (including, but not limited to procuring eligible services or network equipment), and up to six months after the funding end date on their final funding commitment letters to wind down their pilot projects and complete any necessary administrative tasks. Providing a ramp up period of up to six months will allow sufficient time for health care providers to implement pilot project plans and begin offering

connected care services. Extending the *Pilot Program* for too long risks stale data, and therefore providing selected pilot projects up to six months to ramp and up to six months to wind down to ensure a reasonable timeframe to obtain meaningful, current data. There may be unforeseen circumstances that arise when implementing or operating the pilot projects, and therefore the Bureau is delegated authority to grant limited extensions of deadlines in order to ensure the successful operation of the *Pilot Program.*

27. *Eligible Health Care Providers, Patients, and Service Providers.* The Commission establishes the *Pilot Program* pursuant to the legal authority under section 254(h)(2)(A), which directs the Commission to establish competitively neutral rules to enhance, to the extent technically feasible and economically reasonable, access to ''advanced telecommunications and information services'' for public and nonprofit health care providers. Accordingly, for purposes of the *Pilot Program,* the Commission limits participation to the statutorily-enumerated categories of ''health care provider.'' Eligible nonprofit or public health care providers include: (1) Post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (2) community health centers or health centers providing health care to migrants; (3) local health departments or agencies; (4) community mental health centers; (5) not-for-profit hospitals; (6) rural health clinics; (7) skilled nursing facilities; or (8) consortia of health care providers consisting of one or more entities falling into the first seven categories.

28. To promote diversity among pilot projects, and to maximize the data collected, *Pilot Program* support will be available to health care providers located in both rural and non-rural areas. Section 254(h)(2)(A) does not limit the provision of universal service support to health care providers in rural areas. Consistent with the record, the Commission believes that the *Pilot Program* should target vulnerable and medically underserved patients regardless of whether these patients or their health care providers are located in a rural or non-rural area.

29. In selecting pilot projects, the Commission has a strong preference for health care providers that have either (1) experience with providing telehealth or connected care services to patients (*e.g.,* remote patient monitoring, store-and-forward imaging, or video conferencing) beyond using electronic health records, or (2) a partnership with another health care provider, government agency, or designated telehealth resource center with such experience that will work with the health care provider to implement its proposed pilot project. These types of health care providers are more likely to submit pilot projects that can be successfully implemented within the three-year period and better enable the Commission to collect meaningful data on the impact of the *Pilot Program.* At the same time, this approach also provides a path for eligible health care providers that lack telehealth experience, many of which may serve high percentages of veterans and low-income patient populations, to participate in the *Pilot Program.*

30. *Targeted Patient Populations.* The Commission has a strong preference for pilot projects that can demonstrate that they will primarily benefit veterans or low-income individuals. Veteran and low-income patients are more likely to have complex, high-cost health care needs, reside in areas with physician shortages, and may not have mobile or residential internet access for connected care services. Therefore, emphasizing pilot projects that will primarily benefit low-income patients or veterans is appropriate as it will expand connected care services to individuals who are less likely to have access to these innovative services without universal service support. Participating patients may only participate in one pilot project and cannot participate in multiple pilot projects as part of the *Pilot Program.*

31. The Commission also concludes that health care providers are in the best position to identify patients for their pilot projects. To the extent a selected pilot project asserts that it will primarily benefit low-income or veteran patients, the pilot project must maintain adequate documentation of the numbers of participating veterans or low-income patients served through that pilot project compared to other patients served. For purposes of the *Pilot Program,* health care providers can determine whether a patient is considered low-income by determining whether (1) the patient is eligible for Medicaid or (2) the patient's household income is at or below 135% of the U.S. Department of Health and Human Services Federal Poverty Guidelines. Using these two criteria to identify low-income patients for purposes of the *Pilot Program* will allow a large number of low-income Americans to participate in the *Pilot Program,* including many residents of medically underserved rural areas. In addition, using these criteria will facilitate efficient program administration, minimize the potential for waste, fraud, and abuse, while still appropriately targeting the population of patients that the Commission intends to primarily benefit from connected care services through the *Pilot Program.*

32. Health care providers may determine whether a patient qualifies as a veteran for purposes of the *Pilot Program* by confirming that the patient qualifies for health care through the VA. The Commission declines to apply an income limit to veterans. While certain veterans who are eligible for health care through the VA undergo means testing when enrolling for VA health care, other veterans (*e.g.,* those with service-connected disabilities) may not be required to undergo means testing. The Commission believes that veterans, regardless of income level, who are eligible for health care through the VA are an important population to include in the *Pilot Program.* As reported in the Bureau's *Veterans Broadband Report* to Congress (May 1, 2019), a significant number of veterans suffer from a disability, reside in rural areas, and/or are older than the general population, and therefore would stand to benefit from connected care services. While the Commission declines to adopt an income criterion for veterans, the expectation is that pilot projects focused on serving veterans will primarily focus on veteran populations that are more likely to experience issues accessing health care.

33. *Service Providers.* Eligible health care providers that participate in the *Pilot Program* can receive support for qualifying broadband service from any broadband provider, regardless of whether that provider is designated as an eligible telecommunications carrier (ETC). 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).'' Section 254(h)(2)(A) in turn directs the Commission ''to enhance to the extent technically feasible and economically reasonable, access to advanced telecommunications services and information services'' for health care providers and does not by its language require that such services be provided by ETCs. The Commission has previously explained that language in section 254(e) limiting universal service reimbursements to ETCs does not apply to services supported under section 254(h)(2)(A). Moreover, allowing non-ETCs to provide broadband service through the *Pilot Program* will incent participation among a diverse range of both health care providers and service

providers while promoting flexibility, competition, and innovation.

34. *Eligible Services and Equipment.* The *Pilot Program* will fund 85% of the qualifying costs incurred by eligible health care providers. These costs include: (1) Patient broadband internet access services, (2) health care provider broadband data connections, (3) other connected care information services, and (4) certain network equipment.

35. *Patient Broadband internet Access Service.* Funding health care provider purchases of broadband internet access service for participating patients to receive connected care services will help expand connected care services to many Americans, particularly low-income and veteran patients. Many low-income consumers and veterans do not have broadband internet access service at all, while other low-income consumers and veterans may not have broadband internet access service that is sufficient to receive connected care services. Aside from the VA's tablet loan program, which serves a limited number of veterans, it appears that no other federal program provides health care providers funding dedicated to purchase patient broadband internet access service for connected care services. Some health care providers are already addressing this gap by funding patient broadband internet access service for certain low-income or vulnerable patients who lack broadband service at home.

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

37. To ensure that funding for patient broadband internet access service is targeted appropriately, the Commission will require *Pilot Program* applicants seeking support for patient broadband internet access service to identify the estimated number of patient broadband connections that the health care provider intends to purchase for purposes of providing connected care services to patients who lack broadband service or have insufficient broadband services. A health care provider seeking funding for patient broadband internet access service must also explain in its application how it plans to assess whether a patient lacks broadband service or has insufficient broadband internet access service for the proposed connected care service based on speed, technology (*e.g.,* fixed or mobile broadband), or other appropriate service characteristics. It is appropriate under section 254(h)(2)(A) to fund the whole patient broadband connection as long as it is ''primarily'' used for activities that are integral, immediate, and proximate to the provision of connected care services to participating patients. In contrast to broadband connectivity for a single health care provider facility, it would not be ''technically feasible and economically reasonable,'' for health care providers to track, monitor, and cost-allocate non-connected care uses of the supported patient broadband connections.

38. *Health Care Provider Broadband Data Connections.* The *Pilot Program* will also provide support for eligible, participating health care providers to purchase the broadband data connections needed to provide connected care services under the *Pilot Program.* While many eligible health care providers may already have the broadband connectivity necessary to participate in the *Pilot Program,* other eligible health care providers may require new or additional broadband data connections to participate in the *Pilot Program.* Providing funding for health care provider broadband data connections in this latter situation will incentivize health care provider participation, which, in turn, will aid in the ability to collect meaningful data. Moreover, requiring *Pilot Program* applicants that require broadband data connections in order to provide connected care services to seek support for those connections through the Healthcare Connect Fund would produce duplicative application requirements with minimal benefit to either program. The Commission expects that funding health care provider connectivity under these circumstances will not subsume the budget for the *Pilot Program* given the broad participation in the existing Healthcare Connect Fund Program which provides funding for health care provider broadband connectivity.

39. To avoid duplicate funding and to stretch limited *Pilot Program* funds, eligible health care providers participating in the *Pilot Program* may not request or receive funding for broadband data connections for which they already receive funding through the Healthcare Connect Fund Program or other federal programs, and similarly may not request or receive funding for broadband data connections through the Healthcare Connect Fund Program or other federal programs for which they have already received funding through the *Pilot Program.* In addition, the *Pilot Program* will not fund broadband connections between health care providers as these connections are already eligible for funding through the Healthcare Connect Fund Program, and the Commission does not believe that funding connections between health care providers is necessary for the *Pilot Program* given the focus on supporting the provision of connected care services to participating patients in their homes or mobile locations.

40. *Other Connected Care Information Services.* The *Pilot Program* will also provide support for information services other than broadband connectivity that eligible, participating health care providers use for connected care as part of the *Pilot Program.* Health care providers incur significant costs to provide connected care services, including, but not limited to, the costs of services (other than broadband) for connected care, and that many of these costs typically are not reimbursable through health care payors, which can present an obstacle to connected care services. Funding information services for health care providers' use for connected care through the *Pilot Program,* therefore, could enhance health care providers' access to such information services and encourage innovation in the way health care providers provide connected care services to their patients. The Commission also believes funding these information services will encourage broader participation in the *Pilot Program.* The Commission, however, will not fund the costs associated with medical professional review of data or images transmitted or stored through such services, or services which have a primary purpose other than capturing, transmitting and storing data to facilitate connected care. These costs fall outside the scope of the Commission's statutory authority under Section 254(h)(2)(A). Mobile applications will only be funded to the extent that they are part of a qualifying

information service. Eligible health care providers that seek *Pilot Program* support for an information service should include in their application a thorough description of the service, including a description of the primary function/s of the service, and whether and how it facilitates the capturing, transmission (including video visits), and storage of data for connected care.

41. *Network Equipment. The Pilot Program* will provide funding to eligible, participating health care providers for necessary network equipment for broadband connectivity funded through the *Pilot Program* for connected care services. This funding can only be used for network equipment that is necessary to make *Pilot Program* funded broadband services for connected care services functional, or to operate, manage, or control such services, and must not be used for purposes other than providing connected care services under the *Pilot Program.* Health care providers seeking funding for qualifying network equipment for other health care uses may apply for such funding under the Healthcare Connect Fund Program. Further, to avoid duplicate funding issues, eligible health care providers participating in the *Pilot Program* may not request and receive funding for network equipment for which they already applied or received funding through the Healthcare Connect Fund Program or another federal program, and similarly may not request and receive through the Healthcare Connect Fund Program or another federal program funding for network equipment for which the health care provider receives funding through the *Pilot Program.* Moreover, consistent with § 54.9 of the Commission's rules, the *Pilot Program* will prohibit health care providers from using universal service funds to purchase equipment or services for use through the *Pilot Program* that are produced or provided by a company that the Commission has identified as posing a national security threat to the integrity of communications networks or the communications supply chain.

42. *End-User Devices and Medical Equipment.* Consistent with the Commission's long-standing approach to implementing its universal service programs, the *Pilot Program* will not fund end-user devices or medical equipment. The Commission has consistently declined to fund equipment unless it is ''necessary'' for the transmission function of the service. Additionally, providing limited *Pilot Program* funding to end-user devices and medical equipment costs may not be economically reasonable because it could significantly reduce the *Pilot Program* funding available for the costs directly associated with providing connected care services, and would limit the number of pilot projects the Commission can select. The record indicates that some selected pilot projects may be able to obtain grant funding and other funding for end-user devices or medical equipment where needed to participate in the *Pilot Program.* The Commission therefore encourages eligible health care providers to explore available grant and other funding opportunities, potential partnerships and other avenues that could help them obtain end-user and medical devices necessary to participate in the *Pilot Program.*

43. *Administrative Expenses and Other Miscellaneous Expenses.* Consistent with the RHC Program and the RHC Pilot Program, the *Pilot Program* will not provide funding for health care provider administrative costs associated with participating in the *Pilot Program* (*e.g.,* costs associated with completing *Pilot Program* applications and other submissions) or other miscellaneous expenses (*e.g.,* doctor and staff time spent on the *Pilot Program* and outreach). This is also consistent with the U.S. Department of Agriculture's Distance Learning and Telemedicine grant program. Section 254 focuses on the availability of and access to ''services.'' Funding administrative or miscellaneous expenses associated with participating in the *Pilot Program* would not fulfill this statutory focus. Allocating scarce *Pilot Program* funding to administrative costs would significantly reduce the *Pilot Program* funding available for the costs directly associated with providing connected care services. Additionally, if the Commission was to provide direct support for administrative expenses, it would necessitate additional application requirements, guidelines, and other administrative controls to protect such funding from waste, fraud, and abuse. This would increase the administrative burden on USAC and on applicants as well.

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

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

- Names and addresses of all health care providers that will participate in the proposed pilot project and the lead health care provider for proposals involving multiple health care providers.
- Contact information for the individual that will be responsible for the management and operation of the proposed pilot project (telephone number, mailing address, and email address).
- Health care provider number(s) and type(s) (*e.g.,* not-for-profit hospital, community mental health center, community health center, rural health clinic), for each health care provider included in proposal.
- Description of each participating health care provider's previous experience with providing telehealth services (other than electronic health records) or experience and name of a partnering health care provider or organization.
- Description of the plan for implementing and operating the pilot project, including how the pilot project intends to recruit patients, estimated amount of ramp-up time necessary for the pilot project (not to exceed six months), plans to obtain any necessary end-user devices (*e.g.,* tablets, smartphones) and medical devices for

the connected care services that the pilot project will provide, and to what extent the pilot project can be self-sustaining once established.

- Description of the connected care services the proposed pilot project will provide, the conditions to be treated, the health care provider's experience with treating those conditions, the goals and objectives of the proposed pilot project (including the health care provider's anticipated goals with respect to reaching new or additional patients, and improved patient health outcomes), expected health care benefits to the patients, health care provider, or the health care industry that will result from the proposed pilot project, and how the pilot project will achieve each of the goals of the *Pilot Program.*
- Documentation of the participating health care provider(s)'s financial health (*e.g.,* recent audited balance sheets and income statements that are no more than two years old).
- Description of the estimated number of patients to be treated.
- Description of any commitments from community partners, including physicians, hospitals, health systems, and home health/community providers to the success of the proposed pilot project.
- Description of the anticipated level of broadband service required for the proposed pilot project, including the necessary speeds, the technologies to be used (*e.g.,* mobile or fixed broadband) and any other relevant service characteristics (*e.g.,* LTE service).
- Description of the estimated number of patient broadband connections that the health care provider intends to purchase for purposes of providing connected care services to patients who lack broadband service or have insufficient broadband services. This description must include an explanation of how the health care provider plans to assess whether a patient lacks broadband service or has insufficient broadband internet access service for the indicated connected care service based on speed, technology or data cap limitations.
- If seeking support for an information service used to provide connected care, other than broadband connectivity, used to provide connected care, a description of the service, including a description of the primary function/s of the service, and whether it facilitates the capturing, transmission, and storage of data for connected care.
- Estimated total project costs, including costs eligible for support through the *Pilot Program* and costs not eligible for *Pilot Program* support but still necessary to implement the proposed pilot project. This entry must include the total estimated eligible funding (85%) to be requested from the *Pilot Program* per year over the three-year funding period.
- A list of anticipated sources of financial support for the pilot project costs not covered by the *Pilot Program.*
- Description of the metrics for the proposed pilot project that are relevant to the *Pilot Program* goals and how the participating providers will collect those metrics. Examples of the types of metrics the Commission is interested in include: reductions in potential emergency room or urgent care visits; decreases in hospital admissions or readmissions; condition-specific outcomes, such as reductions in premature births or acute incidents among suffers of a chronic illness, and patient satisfaction as to with their overall health status.
- Description of how the health care provider intends to collect, track, and store, the required *Pilot Program* data.

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

- Description of whether the health care provider is located in a rural area, on Tribal lands, or is associated with a Tribe, or part of the Indian Health Service. If the health care provider is not located in a rural area, include a description of whether the health care provider will primarily serve veterans or low-income patients located in rural areas as defined in the RHC Program rules, and identify those specific rural areas.
- Listing of all Department of Health and Human Services, Health Resources & Services Administration (HRSA) designated Health Professional Shortage Areas (for primary care or mental health care only) or HRSA designated Medically Underserved Areas that will be served by the proposed project.
- Description of whether the pilot project will primarily benefit low-income or veteran patients, and if so, the estimated number or percentage of those patients the project will serve compared to the total number of patients that the pilot project estimates serving.
- Description of whether the primary purpose of the proposed pilot project is to provide connected care services to respond to a public health epidemic, or to provide connected care services for opioid dependency, high-risk pregnancy/maternal mortality, mental health conditions (*e.g.,* substance abuse, depression, anxiety disorders, schizophrenia, eating disorders and addictive behavior) or conditions of a chronic or long term nature (including, but not limited to heart diseases, diabetes, cancer, stroke).

46. Additionally, applicants will also be required, at the time of submission of their application, to certify, among other things, that they will comply with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy and reimbursement laws and regulations, and applicable medical licensing laws and regulations, as well as all applicable *Pilot Program* requirements and procedures, including the requirement to retain records to demonstrate compliance with the *Pilot Program* rules and requirement for five years, subject to audit. Health care providers that participate in the *Pilot Program* must also comply with all applicable federal and state laws, including the False Claims Act, the Anti-Kickback Statute, and the Civil Monetary Penalties Law. The Commission understands that health care providers must routinely navigate these laws in other contexts. Thus, health care providers that are interested in applying for the *Pilot Program* should speak to their compliance experts prior to submitting an application to participate in the *Pilot Program.* Further, applicants will also be required to certify that they are not already receiving or expecting to receive other federal funding for the exact same services eligible for support under the *Pilot Program.* The Commission recognizes the need to possibly waive certain of the RHC Program rules that extend to *the Pilot Program* in order to implement the *Pilot Program,* and therefore also request that applicants identify in their application, as applicable, any Commission rules that extend to the *Pilot Program* in the R&O from which they may need a waiver in order to participate in the *Pilot Program,* if selected.

47. *Instructions for Filing Applications.* The Bureau will issue a public notice announcing the deadline for submitting *Pilot Program* applications and instructions for filing applications with the Commission. Pilot Program applications will be due the later of 45 days from the effective date of the Pilot Program rules or July 31, 2020. Applicants will be required to complete each section of the application and make the required certifications at the end of the application. Applicants may request that any materials or information submitted to the Commission in its application be withheld from public inspection

pursuant to the procedures set forth in § 0.459 of the Commission's rules. Applications must reference WC Docket No. 18–213 only, and will be required to file electronically consistent with the instructions provided in a subsequent public notice. All filings must be addressed to the Commission's Secretary, Office of the Secretary, Federal Communications Commission. Applicants must also send a courtesy copy of their application via email to *ConnCarePltProg@fcc.gov.*

48. *Evaluation of Proposals and Selection of Pilot Projects.* The Commission plans to evaluate the applications and select pilot project proposals based on applicants' responses to the criteria. The Commission will also consider the cost of the proposed pilot project compared to the total *Pilot Program* budget. This does not mean the Commission will evaluate proposed pilot projects based solely on a proposed pilot project's total budget but will seek to select an array of pilot projects that can all be funded within the Pilot Program's budget.

49. In choosing participants for the *Pilot Program,* the Commission will also consider whether the applicant has successfully developed, coordinated, or otherwise implemented a telehealth program. While the Commission will consider applicants' responses to all of the application criteria factors listed in the document when evaluating pilot project proposals, they are not determinative of whether a pilot project will be selected because recognition that each pilot project proposal will have its own unique strengths and potential challenges. However, the Commission's goal is to select pilot projects that present a well-defined plan for meeting the health care needs of participating patients, with a particular emphasis on eligible low-income and veteran patients and the *Pilot Program* goals.

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

51. *Procurement of Supported Services.* The Commission is adopting, to the extent feasible, the competitive bidding requirements for the Healthcare Connect Fund Program for participants in the *Pilot Program.* Specifically, health care providers can seek bids for multi-year or single-year contracts during the competitive bidding process. If a health care provider only seeks bids for a single-year contract, it will need to conduct a new competitive bidding process for each year of the *Pilot Program.* The competitive bidding requirements for the *Pilot Program* are in addition to and do not supplant any applicable state or local procurement requirements.

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

- The eligible health care provider seeks support for services and equipment purchased from Master Services Agreements (MSAs) negotiated by federal, state, Tribal, or local government entities on behalf of such health care providers and others, if such MSAs were awarded pursuant to applicable federal, state, Tribal, or local competitive bidding requirements;
- The eligible health care provider opts into an existing MSA approved under the Rural Health Care Pilot Program or Healthcare Connect Fund Program and seeks support for services and equipment purchased from the MSA, if the MSA was developed and negotiated in response to an RFP that specifically solicited proposals that included a mechanism for adding additional sites to the MSA;
- The eligible health care provider has a multi-year contract designated as ''evergreen'' by USAC and seeks to exercise a voluntary option to extend an evergreen contract without undergoing additional competitive bidding;
- The eligible health care provider is in a consortium with participants in the schools and libraries universal service support program (E-Rate program) and a party to the consortium's existing contract, if the contract was approved in the E-Rate program as a master contract;
- The eligible health care provider seeks support for $10,000 or less of total undiscounted eligible expenses for a single year, if the term of the contract is one year or less; or
- The eligible health care provider already has entered into a legally binding agreement with a service provider for services or equipment eligible for support in the *Pilot Program* and that legally binding agreement itself was the product of competitive bidding.

In the absence of an applicable exemption, applicants will have to seek competitive bids for services and equipment that are eligible for support through the *Pilot Program.* Applicants will be required to follow the RHC Program's competitive bidding requirements, which include submitting a Request for Services and Request for Proposal (RFP) (as applicable) for USAC to post on its website, seeking bids, waiting 28 days before selecting a service provider, conducting a bid evaluation to select a service provider, and then selecting the most-cost effective service. All potential bidders must have access to the same information and be treated in the same manner during the competitive bidding period to ensure that the process is ''fair and open.'' Gifts from service providers will also be prohibited.

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

54. Selected pilot projects will be required to report to the Commission

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

55. After providing the eligible services and/or equipment, service providers will be required to make certain certifications and then submit invoicing forms on a monthly basis and supporting documentation to USAC to receive reimbursement for the cost of the eligible services and/or equipment they have provided to participating health care providers under the *Pilot Program.* USAC will review the monthly invoicing forms and supporting documentation and issue disbursements to the applicable service providers or vendors, whether a broadband service provider, or other provider. *Pilot Program* participants will also be required to make certifications as part of the form submissions to USAC to ensure that *Pilot Program* funds are used for their intended purpose and to ensure that all participating health care providers and service providers are in compliance with the Commission's rules and procedures.

56. *Data Reporting, Document Retention, and Audits.* The Commission directs the Bureau to issue a report detailing the results of the *Pilot Program* after it has been completed. To assist with the report, the Commission will require participating health care providers to submit periodically anonymized, aggregated data, such as 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 to the Bureau regarding their pilot project to the Bureau after each year of funding for that pilot project. However, the scope of the pilot project proposals is unknown at this time, and some metrics may not be applicable to all of the selected pilot projects.

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

58. *USAC Outreach.* After announcement of the selected *Pilot Program* projects, each selected pilot project will be required to provide to USAC, within 14 calendar days of such announcement, the name, mailing address, email address, and telephone number of the lead project coordinator for its pilot project. Within 30 days of the date announcing the selected *Pilot Program* projects, USAC shall conduct an initial coordination meeting with selected *Pilot Program* participants. USAC shall further conduct a targeted outreach program, such as a webinar or similar outreach, to educate and inform selected participants on the *Pilot Program* administrative process, including various filing requirements and deadlines, in order to minimize the possibility of selected participants making inadvertent errors in completing the required forms. The Commission expects that the outreach and educational efforts will assist selected participants in meeting the *Pilot Program's* requirements. Further, such an outreach program will increase awareness of the filing rules and procedures and will improve the overall efficacy of the *Pilot Program.* The Commission also encourages selected participants to contact USAC with any questions prior to filing their forms or supporting documentation. The direction the Commission provides to USAC will not lessen or preclude any of its review procedures. The Commission retains the commitment to detecting and deterring potential instances of waste, fraud, and abuse by ensuring that USAC scrutinizes *Pilot Program* submissions and takes steps to educate selected participants in a manner that fosters appropriate *Pilot Program* participation.

59. Pilot Program Goals and Metrics. The Commission adopts three explicit goals for the *Pilot Program* to determine how USF support provided to health care providers for the costs associated with providing connected care services can enable them to: (1) Improve health outcomes through connected care; (2) reduce health care costs for patients, facilities and the health care system; and (3) support the trend towards connected care everywhere. The goals adopted for the *Pilot Program* are sound and measurable goals, and will help advance the Commission's statutory obligation to promote universal service by providing the Commission with information that will help inform about how to best allocate limited universal service funding.

60. *Legal Authority.* The Commission found that section 254(h)(2)(A) of the 1996 Act authorizes establishing the *Pilot Program* to help defray health care provider's eligible costs of providing connected care services to low-income or veteran patients. Specifically, section 254(h)(2)(A) directs the Commission to ''establish competitively neutral rule[s] 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 *Pilot Program* will fund broadband connectivity for participating health care providers and patients, certain network equipment, and other information services that may facilitate the provision of connected care services provided through the *Pilot Program.* These connected care services may be defined as either telecommunications services or information services.

61. For the *Pilot Program,* funding patient broadband internet access services would expand health care providers' digital footprints for purposes of providing connected care services and allow health care providers to serve more eligible low-income patients and veterans through the *Pilot Program* and, thus, enhance health care providers'

access to ''advanced telecommunications and information services.'' Accordingly, funding health care provider purchase of broadband internet access service for participating patients through this discrete, limited duration *Pilot Program* falls within the scope of section 254(h)(2)(A) of the Act. Relying on this statutory provision also ensures that the *Pilot Program* is health care provider-driven and enables participating health care providers to select from the broadest range of broadband internet access service providers to meet the health care needs of participating patients.

62. First, the *Pilot Program* will be ''competitively neutral,'' which means that ''universal service support mechanisms and rules neither unfairly advantage nor disadvantage one provider over another, and neither unfairly favor nor disfavor one technology over another.'' The *Pilot Program* satisfies this requirement because eligible health care providers are free to choose any broadband connectivity technology and broadband connectivity provider, in compliance with the applicable competitive bidding requirements for the *Pilot Program*-supported services needed to provide connected care services through their respective pilot projects. In addition, participating health care providers are not required to adopt any specific non-broadband information service to provide broadband-enabled connected care services through the *Pilot Program.* Second, the *Pilot Program* will be ''technically feasible'' because the *Pilot Program* will not require the development of any new technology and gives participating health care providers flexibility to use any available technology to implement their respective pilot projects. Third, the *Pilot Program* will be ''economically reasonable.'' In discussing economic reasonableness, the Commission has generally focused on the effect that any new rules would have on growth in the universal service support mechanisms. The Commission establishes a budget separate from the existing universal service programs and limit the *Pilot Program* budget to at most $100 million, which provides a reasonable cap and will not significantly increase the contributions burden on consumers. Additionally, the Commission has developed measures to promote the fiscally responsible use of *Pilot Program* funds, including requiring that evaluations of pilot project proposals include a comparison of the estimated costs of each proposed pilot project to the total *Pilot Program* budget.

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

64. While the Commission relies on authority under section 254(h)(2)(A) to establish the *Pilot Program,* the *Pilot Program* is also consistent with the directive that the Commission base policies for the advancement of universal service on the principles outlined in section 254(b) of the Act. Specifically, section 254(b)(2) provides that ''[a]ccess to advanced telecommunications and information services should be provided in all regions of the Nation'' and section 254(b)(3) provides that ''[c]onsumers in all regions of the Nation, including low-income consumers and those in rural, insular, and high cost areas, should have access to telecommunications and information services, including interexchange services and advanced telecommunications and information services, that are reasonably comparable to those services provided in urban areas and that are available at rates that are reasonably comparable to rates charged for similar services in urban areas.'' As explained in the document, the *Pilot Program* will fund eligible health care provider purchases of broadband internet access services for participating patients to use for purposes of connected care services.

IV. Procedural Matters

A. Paperwork Reduction Act Analysis

65. This document contains new information collection requirements subject to the Paperwork Reduction Act of 1995 (PRA), Public Law 104–13. The information collection requirements related to the *COVID–19 Telehealth Program* were approved on April 6, 2020 by the Office of Management and Budget (OMB) pursuant to the PRA, 44 U.S.C. 3507(j). The information collection requirements related to the *Pilot Program* will also be submitted to OMB for review under Section 3507(d) of the PRA. OMB, the general public, and other federal agencies will be invited to comment on the new information collection requirements. Applications for the *COVID–19 Telehealth Program* will be accepted by the Commission after the Bureau releases a public notice providing instructions for filing applications with the Commission. Applications to participate in the *Pilot Program* will be due 45 days from the effective date of the *Pilot Program* rules or July 31, 2020, whichever comes later. The Bureau will issue a public notice announcing the deadline for submitting *Pilot Program* applications and instructions for filing applications with the Commission. 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 sought specific comment on how it might further reduce the information collection burden for small business concerns with fewer than 25 employees. In the Report and Order, the Commission has assessed the effects of the information collection on small businesses, and find that the benefits of providing support to help defray eligible health care providers costs to provide connected care services to their patients

and COVID–19 relief to help eligible health care providers meet the health care needs of their patients during the COVID–19 pandemic outweigh any significant economic impact on small entities.

B. Congressional Review Act

66. The Commission has determined, and the Administrator of the Office of Information and Regulatory Affairs, Office of Management and Budget (OMB), concurs that the rules implementing the COVID–19 Telehealth Program are ''major'' and the rules implementing the *Pilot Program* are ''non-major'' under the Congressional Review Act, 5 U.S.C. 804(2). The Commission will send a copy of the R&O, including this FRFA, to Congress and the Government Accountability Office pursuant to 5 U.S.C. 801(a)(1)(A). In addition, the Commission will send a copy of the R&O, including the FRFA, to the Chief Counsel for Advocacy of the Small Business Administration.

C. Final Regulatory Flexibility Analysis

67. As required by the Regulatory Flexibility Act of 1980 (RFA), as amended, the Federal Communications Commission (Commission) included an Initial Regulatory Flexibility Analysis (IRFA) of the possible significant economic impact on a substantial number of small entities by the policies and requirements proposed in the *NPRM* in WC Docket No. 18–213. The Commission sought written public comment on the proposals in the *NPRM,* including comment on the IRFA. The Commission did not receive any comments in response to the IRFA. This Final Regulatory Flexibility Analysis (FRFA) conforms to the RFA.

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

69. Thus, in August 2018, the Commission released the Connected Care Notice of Inquiry, FCC 18–112 *(NOI)* seeking information on ''how the Commission can help advance and support the movement towards connected care everywhere and improve access to the life-saving broadband-enabled telehealth services it makes possible.'' Subsequently, in July 2019, the Commission adopted the *NPRM* that proposed and sought comment on a *Pilot Program* that would help defray health care provider costs of providing connected care services to low-income Americans and veterans. In the R&O, given the benefits of connected care services provided through broadband connections, the Commission takes the important step of establishing a *Pilot Program* to explore whether and how the Universal Service Fund (USF) can help defray health care providers' qualifying costs of providing connected care services, including low-income Americans and veterans. The ultimate goal of the *Pilot Program* is to examine how USF support can be used to help health care providers improve health outcomes and reduce health care costs, thereby supporting efforts to advance connected care initiatives. The Commission expects that the *Pilot Program* will benefit many eligible patients who are responding to a wide variety of health challenges, such as diabetes management, opioid dependency, high-risk pregnancies, pediatric heart disease, mental health conditions, and cancer. The Commission also expects that the *Pilot Program* will provide meaningful data that will help better understand how the USF can support health care provider and patient use of connected care services, and how supporting health care provider and patient use of connected care services can improve health outcomes and reduce health care costs. The data and information collected through the *Pilot Program* could also have the ancillary benefit of aiding policy makers and legislators in the consideration of broader reforms—whether statutory changes or updates to rules administered by other agencies—that could support this trend towards connected care.

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

71. *Summary of Significant Issues Raised by Public Comments in Response to the IRFA.* There were no comments filed that specifically address the rules and policies proposed in the IRFA.

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

73. *Description and Estimate of the Number of Small Entities to Which the 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. 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 SBA.

74. *Small Businesses, Small Organizations, Small Governmental Jurisdictions.* The Commission actions, over time, may affect small entities that are not easily categorized at present. Therefore, 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 30.7 million businesses.

75. 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.'' The Internal Revenue Service (IRS) uses a revenue benchmark of $50,000 or less to delineate its annual electronic filing requirements for small exempt organizations. Nationwide, for tax year 2018, there were approximately 571,709 small exempt organizations in the U.S. reporting revenues of $50,000 or less according to the registration and tax data for exempt organizations available from the IRS.

76. 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 2017 Census of Governments indicate that there were 90,075 local governmental jurisdictions consisting of general purpose governments and special purpose governments in the United States. Of this number there were 36,931 general purpose governments (county, municipal and town or township) with populations of less than 50,000 and 12,040 special purpose governments—independent school districts with enrollment populations of less than 50,000. Accordingly, based on the 2017 U.S. Census of Governments data, the Commission estimates that at least 48,971 entities fall into the category of ''small governmental jurisdictions.''

77. The small entities that may be affected by the reforms include eligible nonprofit and public health care providers and the eligible service providers offering them services, including telecommunications service providers, internet Service Providers, and service providers of the services and equipment used for dedicated broadband networks.

78. *Description of Projected Reporting, Recordkeeping, and Other Compliance Requirements for Small Entities.* In the R&O, the Commission establishes a *Pilot Program* within the USF that will make available up to $100 million over three years to help defray eligible health care providers' costs of providing connected care services primarily to low-income or veteran patients for purposes of connected care. The Commission also establishes an *COVID–19 Telehealth Program* funded through a $200 million Congressional appropriation under the Coronavirus Aid, Relief, and Economic Security (CARES) Act, Public Law 116–136, 134 Stat. 281, for COVID–19 relief to help eligible health care providers meet the health care needs of their patients during the COVID–19 pandemic. The *Pilot Program* is structured to target funding to eligible health care providers serving patients that are most likely to need USF support for connected care services, and to ensure that the *Pilot Program* provides meaningful, measurable data. To participate in the *Pilot Program,* health care providers must satisfy the definition of an eligible health care provider under section 254(h)(7)(B) of the Act and receive an eligibility determination from the Universal Service Administrative Company (USAC), the administrator of the USF programs. Applicants must then submit an application to the Commission regarding their pilot projects by the application deadline ultimately established for the *Pilot Program.* While the *COVID–19 Telehealth Program* is structured a bit differently than the *Pilot Program,* applicants for both programs will be required to certify that they will comply with all applicable *Pilot Program* requirements and procedures. Applicants among other things, will also be required to comply with the Health Insurance Portability and Accountability Act (HIPAA) and other applicable privacy and reimbursement laws and regulations, and applicable medical licensing laws and regulations, as well as all applicable *Pilot Program* requirements and procedures, including document retention requirements, subject to audit.

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

80. After evaluation of the pilot program applications, the Bureau will announce the selected pilot projects and provide further information on the specific requirements for the *Pilot Program.* Selected pilot program participants will be required to conduct a competitive bidding process (unless a competitive bidding exemption applies), including submitting the required competitive bidding forms, for the eligible equipment and services that are supported through the *Pilot Program.* Participating health care providers will then be required to submit a request for funding with USAC with specific pricing and service information, and will also be required to submit invoicing forms and supporting documentation on a monthly basis for the supported equipment and services. Participating health care providers will also be required to periodically submit data to the Bureau concerning their pilot project after each year of funding during the three-year period of the pilot project, and will also be required to submit a final report concerning their pilot projects. For the *COVID–19 Telehealth Program,* within six months after the conclusion of the *COVID–19 Telehealth Program,* participants should provide a report to the Commission on the effectiveness of the program. While some of the requirements of the *Pilot Program* and the *COVID–19 Telehealth Program* will result in additional recordkeeping and compliance requirements for small entities, the Commission has determined that the benefits of establishing these programs outweighs the burden of any increased recordkeeping and compliance

requirements for those small entities that choose to participate in the *Pilot Program* and the *COVID–19 Telehealth Program.* Additionally, the requirements are intended to ensure universal service funds are used for their intended purpose and designed so that the Commission can obtain meaningful data to evaluate the *Pilot Program* and inform the policy decisions.

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

82. The *Pilot Program* is for a discrete, limited period of time. The Commission expects to apply the Commission's rules applicable to the Healthcare Connect Fund Program to the *Pilot Program,* which some entities may already be familiar with if they currently participate in the Healthcare Connect Fund Program. With no expectation of the small entities to be disproportionately impacted. In evaluating the applications, the Commission seeks to select a diverse set of pilot projects and will consider whether the proposed pilot projects promotes entrepreneurs and other small businesses in the provision and ownership of telecommunications and information services, including those that may be socially and economically disadvantaged businesses. All eligible health care providers that participate in the *Pilot Program* will be required to collect and submit data to the Commission at designated intervals during the *Pilot Program.* The Commission has yet established metrics to measure the *Pilot Program* goals and seek information from applicants on the metrics plans to use and how plans to collect those metrics in order to minimize any impact on small entities when establishing metrics for the *Pilot Program.* The collection of this information, however, is necessary to evaluate the impact of the *Pilot Program,* including whether the *Pilot Program* achieves its goals. Thus, the benefits of collecting this information outweigh any significant economic impact on small entities. Moreover, the Commission sought comment on the IRFA and did not receive any comments in response to the IRFA. Further, in order to minimize the economic impact on small entities, the Commission establishes an emergency *COVID–19 Telehealth Program,* which is one piece of a comprehensive approach to reducing barriers to telehealth services for patients and health care facilities throughout the country to provide relief related to the COVID–19 pandemic. The Commission therefore believes that the requirements of the R&O will not have a significant economic impact on a substantial number of small entities.

V. Ordering Clauses

83. Accordingly, *it is ordered* that, pursuant to the authority contained in sections 201, 254, 303(r), and 403 of the Communications Act of 1934, as amended, 47 U.S.C. 201, 254, 303(r), and 403, and DIVISION B of the Coronavirus Aid, Relief, and Economic Security Act, Public Law 116–136, 134 Stat. 281, the Report and Order *is adopted* and *shall become* effective May 11, 2020, pursuant to 47 U.S.C. 408, with the exception of those portions related to the COVID–19 Telehealth Program in the Report and Order which *shall become* effective April 9, 2020 pursuant to 5 U.S.C. 553(d) and 5 U.S.C. 808(2) and the portions containing information collection requirements that have not been approved by the Office of Budget and Management (OMB).

84. *It is further ordered* that applications to participate in the COVID–19 Telehealth Program *shall be filed* after the Wireline Competition Bureau issues a public notice announcing the date when applications will be accepted and instructions for filing applications with the Commission. This date will be after April 9, 2020.

85. *It is further ordered* that, pursuant to the Paperwork Reduction Act of 1995, Section 3507(d), the Connected Care Pilot Program information collection requirements *shall become effective* after announcement in the **Federal Register** of Office of Management and Budget approval of the rules, and on the effective date announced therein.

86. *It is further ordered* that applications to participate in the Connected Care Pilot Program *shall be filed* 45 days after the effective date of the Connected Care Pilot Program rules or July 31, 2020, whichever comes later.

87. *It is further ordered* that the Commission's Consumer and Governmental Affairs Bureau, Reference Information Center, *shall send* a copy of the R&O, including the Final Regulatory Flexibility Analysis, to the Chief Counsel for Advocacy of the Small Business Administration.

88. *It is further ordered* that the Commission *shall send* a copy of the R&O to the Congress and the Government Accountability Office pursuant to the Congressional Review Act, *see* 5 U.S.C. 801(a)(1)(A).

Federal Communications Commission.

Cecilia Sigmund,

Federal Register Liaison Officer.

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