§ 52.670 Identification of plan.

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EPA-APPROVED IDAHO NONREGULATORY PROVISIONS AND QUASI-REGULATORY MEASURES

Name of SIP provision	Applicable geographic or nonattainment area	State submittal date	EPA approval date	Comments
*	*	*	*	*
Interstate Transport Requirements for the 2010 Sulfur Dioxide NAAQS.	State-wide	12/24/2015	4/9/2021, [Insert **Federal Register** citation].	This action addresses CAA 110(a)(2)(D)(i)(I).

[FR Doc. 2021–07333 Filed 4–8–21; 8:45 am]

BILLING CODE 6560–50–P

FEDERAL COMMUNICATIONS COMMISSION

47 CFR Chapter I

[WC Docket Nos. 20–89, 18–213; FCC 21–39; FR ID 20341]

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

AGENCY: Federal Communications Commission.

ACTION: Final rule; denial of petition for partial reconsideration.

SUMMARY: In this document, the Federal Communications Commission (Commission) establishes rules and processes to further distribute funding through the COVID–19 Telehealth Program to health care providers, in response to the COVID–19 pandemic, to build on Round 1 of the Program, and implement Congress's direction under the Consolidated Appropriations Act, 2021 (CAA) for additional relief. The CAA funding is distributed through the Program to the health care providers who need it most, as determined by objective metrics.

DATES: Effective April 9, 2021.

FOR FURTHER INFORMATION CONTACT: Stephanie Minnock, Wireline Competition Bureau, (202) 418–7400 or by email at *Stephanie.Minnock@fcc.gov.* We ask that requests for accommodations be made as soon as possible in order to allow the agency to satisfy such requests whenever possible. Send an email to *fcc504@fcc.gov* or call the Consumer and Governmental Affairs Bureau at (202) 418–0530.

SUPPLEMENTARY INFORMATION: This is a synopsis of the Commission's Report and Order (RO) and Order on Reconsideration (Recon) in WC Docket Nos. 20–89 and 18–213; FCC 21–39, adopted March 29, 2021 and released March 30, 2021. 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-21-39A1.pdf.*

I. Introduction

1. The RO, builds upon the success of the Commission's Coronavirus Disease 2019 (COVID–19) Telehealth Program (Program), established pursuant to the Coronavirus Aid, Relief, and Economic Security (CARES) Act. The Commission adopts additional requirements and processes to further fund telehealth and connected care services as required by Congress in the CAA. Over the course of the last year, in response to the COVID–19 pandemic, people across the country have migrated more aspects of their daily lives online, including health care visits and treatment, to slow the spread of the COVID–19 virus. As a result, the use of telehealth has exploded and has become an increasingly vital tool for health care providers, enabling them to minimize the risk of exposure to COVID–19 while still providing patient care.

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

3. Subsequently, in December 2020, as part of the CAA, Congress appropriated $249.95 million in additional funding for the Program. In January 2021, as required by the CAA, the Bureau sought comment on application evaluation metrics to ensure the equitable distribution of these additional funds, including proposing and seeking comment on improvements to the initial application process. Then, in February 2021, the Commission adopted a Report and Order, FCC 21–24, expanding the responsibilities of the Universal Service Administration Company (USAC) to include the administration of the COVID–19 Telehealth Program. The Commission establishes requirements, processes, and procedures for the second round of Program funding appropriated under the CAA (Round 2). The Commission directs USAC to administer the Program and the Bureau and the Office of Managing Director (OMD) to provide oversight over USAC's activities consistent with the RO.

4. Telehealth refers to a ''broad range of health care-related applications that depend upon broadband connectivity,'' and can include, ''telemedicine; exchange of electronic health records; collection of data through Health Information Exchanges and other entities; exchange of large image files (*e.g.,* X-ray, MRIs, and CAT scans); and the use of real-time and delayed video conferencing for a wide range of telemedicine, consultation, training, and other health care purposes.'' This definition does not preclude health care providers from using telecommunications services to provide

telehealth in response to COVID–19, as telecommunications services are eligible for funding for Round 2 of the Program. The Commission has previously observed that health care providers use telehealth to respond to health challenges as varied as diabetes, pediatric heart disease, opioid dependency, strokes, high-risk pregnancies, cancer, and mental health treatment, and to provide such benefits as specialist consultations and ongoing patient monitoring. In addition to improving health outcomes for patients, telehealth technologies have the potential to significantly reduce health care costs. In the *First COVID–19 Report and Order,* FCC 20–44, 85FR70150, November 4, 2020 (C19–RO), the Commission defined ''connected care services'' as a subset of telehealth that ''uses broadband internet access service-enabled technologies to deliver remote medical, diagnostic, patient-centered, and treatment-related services directly to patients outside of traditional brick and mortar medical facilities—including specifically to patients at their mobile location or residence.'' While the use of telehealth and connected care services are not new methods of providing health care, the deployment of these services has accelerated in response to the transmission risks of the coronavirus.

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

6. On December 27, 2020, the CAA was signed into law, providing an additional $249.95 million to the Commission to support the COVID–19 Telehealth Program. This additional funding will allow the Commission to continue its efforts to expand telehealth and connected care services throughout the country and enable patients to access necessary health care services while helping slow the spread of the disease. In addition to appropriating $249.95 million in new funds for the Program, the CAA requires the Commission to consider several changes to the Program and to make several others. First, it directs the Commission to seek comment on the ''metrics the Commission should use to evaluate applications for funding'' and ''how the Commission should treat applications filed during the funding rounds for awards from the [Program] using amounts appropriated under the CARES Act . . . .'' Second, it instructs the Commission, to the extent feasible, to ensure that at least one applicant from all 50 states and the District of Columbia is awarded funds during either of the Program's funding rounds. Third, the CAA directs the Commission to allow applicants from Round 1 the opportunity to update or amend their applications. Fourth, it directs the Commission, to the extent feasible, to provide applicants, upon request, information on the status of their application and a rationale for the final funding decision. And finally, it requires that the Commission ''issue notice to the applicant of the intent of the Commission to deny the application and the grounds for that decision'' and ''provide the applicant with 10 days to submit any supplementary information that the applicant determines relevant,'' which must be taken into account for the final funding decisions.

7. On January 6, 2021, the Bureau released a Public Notice that sought comment, as required by the CAA, on improvements to the Program and lessons learned from Round 1. In the *C19–RO,* the Commission determined that additional notice and comment was not necessary for two independent reasons: Additional notice and comment procedures would be impracticable and contrary to the public interest under the Administrative Procedure Act's ''good cause'' exception, and all or nearly all of the COVID–19 Telehealth Program was a logical outgrowth of the agency's *Connected Care Notice,* FCC 18–112. *See C19–RO,* 35 FCC Rcd at 3383, paras. 35–36 (citing, *inter alia,* 5 U.S.C. 553(b)). The Commission reachs a similar determination here. First, the Commission finds that the decision today is a logical outgrowth of the *Connected Care Notice.* Indeed, the Commission's decision constitutes a second round of the very same program for which the FCC properly proceeded to an Order in April 2020, FCC 20–44. Second, the Commission also finds that the APA's good cause exception to notice and comment is satisfied. In reaching this conclusion, the Commission notes that the CAA specified that the Commission ''shall issue a Public Notice seeking comment within ten days of enactment.'' CAA 903(c)(1)(A). The Commission satisfied this directive when it sought comment through a Bureau-level Public Notice in January 2021, DA 21–14, 86FR8356, February 5, 2021. In any event, the Commission finds that there was good cause to seek comment through a Bureau-level Public Notice because of the unprecedented nature of this pandemic and the need for immediate action, and the fact that issuing a Commission-level Public Notice would have necessitated a delay in committing funds to providers who are addressing the COVID–19 pandemic. Indeed, issuing a Notice of Proposed Rulemaking in these circumstances would be unnecessary and therefore not required under the ''good cause'' exception of U.S.C. 553(b)(B). *See* 5 U.S.C. 553(b)(B) (permitting deviation from formal rulemaking procedures where the agency ''for good cause'' finds that they are ''impracticable, unnecessary, or contrary to the public interest.''). The Bureau first sought comment on which evaluation metrics to use during Round 2, and whether the Commission should continue to target funding to areas that were ''hardest hit'' by COVID–19 and where applicants were working under pre-existing strain. The Bureau also asked whether the Commission should maintain the $1 million cap per applicant on funding awards and proposed establishing an application filing window rather than continuing to accept and evaluate applications on a rolling basis. Next, the Bureau sought comment on how the Commission should treat remaining, unfunded applications from Round 1, and proposed requiring Round 1 applicants to update and resubmit their applications to be considered for Round 2. The Bureau further sought comment on additional improvements to the Program and proposed using USAC to assist in administering the remaining work necessary to complete Round 1, as well as Round 2 application review, invoice review, and outreach. Finally, the Bureau requested comment on how to improve the eligibility review processes for Round 2, both with respect to the eligibility of health care provider applicants and their requests for services and connected devices.

8. On February 2, 2021, the Commission acted on the *Public Notice,* DA 21–14 and decided to use USAC to administer the remainder of Round 1 and to administer all of Round 2 of the Program. On February 4, 2021, the Commission entered into an MOU with USAC in support of the Program. As with its role in administering the Universal Service Fund (USF) Programs, USAC will be limited to program administration and will not have the authority to make policy decisions.

II. Discussion

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

10. Through the RO, the Commission takes steps to improve the COVID–19 Telehealth Program in accordance with Congressional guidance while building upon the lessons learned during Round 1. The Commission modifies some Program requirements but keep unchanged many others, including requirements regarding the eligibility of health care providers, funding limitations, procurement, compliance audits, and post-program feedback reports. The Commission cautions applicants to carefully review the Program requirements and guidance. Applicants are ultimately responsible for compliance with Program requirements, including all deadlines and eligibility requirements.

11. *Establishing an Application Filing Window.* To facilitate a more efficient and equitable application review process, the Commission first establishes an application filing window after which USAC, with oversight from the Bureau, will review all applications from eligible applicants based on the pre-defined evaluation metrics the Commission discusses in more detail. The Commission's *C19–RO* established an application process for the first round of the COVID–19 Telehealth Program applicants that permitted applicants to file requests at any time after the start of the Program and required Commission staff to review, approve, and grant funding to applicants ''as rapidly as possible on a *rolling basis* . . . until it ha[d] committed all COVID–19 Telehealth Program funding . . . .''

12. During Round 1 of the Program, applications were submitted starting on April 13, 2020; the Bureau announced that it would no longer accept new applications on June 25, 2020. At the same time, Commission staff reviewed and awarded funding on a rolling basis until all appropriated funding had been committed. While this process allowed funding to be committed immediately after the Program began, applications submitted later in the Program were not reviewed because the available funds had already been committed. There is also a concern that some smaller providers with more limited resources may have faced difficulties quickly completing their applications. In the *Public Notice,* DA 21–14 the Bureau proposed establishing an application filing window and awarding funding based on pre-defined evaluation metrics instead of reviewing applications and awarding funding on a rolling basis. Commenters overwhelmingly supported this approach, and the Commission agrees. Establishing a filing window is consistent with the plain language of the CAA, is more equitable, and will allow USAC to review all applications before selecting the best-qualified applicants.

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

14. The CAA also directs the Commission to ensure that, to the extent feasible, at least one applicant in each state and the District of Columbia receives Program funding. Adopting a filing window and objective evaluation metrics allows the Commission to fulfill this the statutory directive by comparing all applicants against each other, and committing funding to the top-scoring applicant in each state. It would not be possible to follow this statutory directive if the Commission accepted applications on a rolling basis, as the Commission would risk exhausting all funding before an acceptable application from a certain state was received. By adopting a filing window, the Commission is able to ensure that funding will be committed to applicants in each state and territory, as discussed in more detail in the following.

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

16. Commenters overwhelmingly supported a filing window. Commenters argued that accepting applications on a rolling basis disadvantaged smaller providers who lacked the resources to quickly complete applications, and that awarding funding on a ''first-come, first-served'' basis meant that many applications would not be evaluated. While a few commenters supported awarding Round 2 funding on a rolling basis because it would allow for funding to be awarded more quickly, the Commission believes the CAA requires a funding window and also, based on the experience administering Round 1, all applications should be reviewed first, before funding decisions are made, to ensure that funding is awarded to the most deserving applicants. A filing window will therefore enable the Commission to accomplish Congress's objectives. At the same time, and to address in part concerns about the

ability to quickly commit funding, the Commission establishes an abbreviated application filing window of seven calendar days for Round 2 of the Program. Commenters also requested additional guidance, including technical webinars, for Round 2 of the COVID–19 Telehealth Program. *See, e.g.,* Hudson Headwaters Health Comments, WC Docket No. 20–89, at 4. As the Commission discusses in more detail in the following, *see infra* Round 2 Outreach, the Commission instructs USAC to conduct outreach and education for a period of at least three weeks before the filing window opens to prepare potential applicants for the application filing window

17. Given the short duration of the Round 2 application filing window, the Commission directs the Bureau to publicly provide notice of the opening of the Round 2 application filing window at least two weeks before it opens. The Commission believes this two-week notice period, along with outreach associated with the Program, will provide potential applicants enough time to ready applications for filing during the window. The Commission also expects that the Round 2 application filing window will open within 30 days of release of the RO. Accordingly, the Commission directs the Bureau to issue a Public Notice announcing the opening and closing dates for the Round 2 application filing window as soon as possible, consistent with the effective date of this Program.

18. *Application Filing Process.* In the *Public Notice,* DA 21–14 the Bureau sought comment on a number of application-related issues, including whether Round 1 applicants would be required to resubmit their applications for Round 2, whether Round 1 applicants that received funding awards (funding awardees) should be eligible to participate in Round 2, and whether applicants should be required to complete the FCC Form 460. As the Commission discusses in more detail in the following, Round 1 applicants that did not receive funding during the initial round are required to submit a new application for Round 2; Round 1 funding awardees are eligible to apply for Round 2 of the Program, subject to a $1 million cap per applicant for Round 2; and all Round 2 applicants without an approved eligibility determination through the FCC Form 460 process will be required to submit FCC Forms 460.

19. *Round 1 Applicants' Eligibility.* Congress made it clear that at least some applicants who had applied for funding in Round 1 were to be eligible for Round 2 of the Program, and it instructed the Commission to seek comment on how to treat Round 1 applicants during Round 2. To fulfill Congress's directives, the *Public Notice,* DA 21–14 sought comment on specific issues, and proposed requiring Round 1 applicants who wished to participate in Round 2 to update and resubmit their applications to be considered for Round 2 funding. Commenters overwhelmingly supported the Bureau's proposal that Round 1 applicants should be able to update and resubmit their applications to receive Round 2 funding, and the Commission adopts this requirement. Many commenters agreed that applications filed during Round 1 contain stale, outdated information, and therefore require updating. While some commenters suggested that it should be optional for Round 1 applicants to resubmit their applications, and others suggested a more streamlined application or review process for Round 1 applicants, including a priority review process for such applications, the Commission disagrees with these suggestions. By requiring Round 1 applicants to resubmit their applications for Round 2, the Commission can ensure that funding is not awarded based on outdated, incorrect information, and ensure equitable review of all Round 2 applications. Finally, as discussed later, Round 1 applicants that were not awarded funding will also receive an increase in points in Round 2 which are not available to other Round 2 applicants.

20. The *Public Notice,* DA 21–14 also specifically sought comment on whether Round 1 participants that were awarded $1 million in Round 1 should be eligible to participate in Round 2, and whether the Commission should continue the approach of not awarding more than $1 million per applicant. The Commission concludes to maintain the commitment to not award more than $1 million total per applicant in Round 2 to distribute funding to more applicants. While the record was mixed on limiting support to $1 million across both rounds, the Commission concludes that the limitation should only apply to Round 2. Thus, all eligible Round 2 applicants may qualify for the full commitment amount per application. The Commission believes that many applicants, even those receiving Round 1 funding, continue to need program support given the passage of time between last year's commitments and Round 2, and that the application evaluation metrics the Commission adopts will sufficiently ensure equitable, nationwide distribution of funding, and a blanket prohibition on applicants who received $1 million in Round 1 could lead to providers who badly need funding being unable to receive it.

21. *Eligibility and Application Requirements.* Health Care Provider Eligibility. The Commission will also continue to use the Rural Health Care (RHC) program's statutory categories to determine the eligibility of health care providers for Round 2 of the Program, including non-profit and public health care providers, as defined in section 254(h)(7)(B) of the Communications Act. Accordingly, the Commission directs USAC, with oversight from the Bureau and OMD, to only award funding to applications from eligible health care providers. The Commission reminds health care providers interested in applying for Round 2 of the Program that for-profit entities are not eligible for funding. With the limited exception of dedicated emergency departments of rural for-profit hospitals that participate in Medicare, which are also eligible to participate in the RHC program, and were therefore eligible for Round 1 funding. *See Rural Health Care Support Mechanism,* Report and Order, Order on Reconsideration, and Further Notice of Proposed Rulemaking, 18 FCC Rcd 24546, 24553–54, para. 13 (2003), 68 FR 74492, December 24, 2003. The Program remains open to eligible health care providers regardless of whether they are located in a rural or non-rural location. Based on its extensive experience administering the RHC Program, the Commission concluded that instituting the same eligibility criteria for Round 1 would facilitate the administration of the COVID–19 Telehealth Program. The Commission finds that this conclusion was correct.

22. Several commenters recommended expanding the eligibility for Round 2 to include other health care providers, such as physician-office-based practices. The Commission disagrees. As the Commission explains in more detail in the following, Program participation is limited to the providers enumerated in section 254(h)(7)(B) of the Communications Act to maintain consistent eligibility with Round 1 and to provide clarity to program participants. Keeping Program eligibility requirements the same across both Rounds will result in more efficient review of applications. Maintaining the same eligibility rules will also ensure that funding is targeted to health care providers that are likely to need it most to respond to this pandemic while allowing the Commission to ensure that funding is used for its intended purposes. Accordingly, Round 2 funding should only be provided to

non-profit and public eligible health care providers that fall within the categories of health care providers in section 254(h)(7)(B) of the Communications Act. The statutory categories of health care providers include: (1) Post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (2) community health centers or health centers providing health care to migrants; (3) local health departments or agencies; (4) community mental health centers; (5) not-for-profit hospitals; (6) rural health clinics; (7) skilled nursing facilities; or (8) consortia of health care providers consisting of one or more entities falling into the first seven categories. For purposes of the COVID–19 Telehealth Program, which is authorized by the CARES Act, and not the 1996 Telecommunications Act, both rural and non-rural health clinics are eligible to receive funding.

23. Round 2 Application Requirements. During Round 1, the Commission required any health care provider interested in participating in the Program that did not already have an eligibility determination for the RHC Program to file an FCC Form 460 to receive an eligibility determination and an HCP number for each site included on its application. While the Commission retains the previously adopted eligibility rules for applicants in Round 2, the Commission modifies the previous requirement that applicants obtain an eligibility determination for each site listed on its application by filling out an FCC Form 460 for each site. Instead, the Commission will only require applicants to obtain an approved eligibility determination for the lead health care provider listed on the application. The Commission expects the lead health care provider site listed on each application to ensure that it has an approved eligibility determination from USAC. If it does not already have an approved eligibility determination, the lead health care provider should file an FCC Form 460 with USAC. Applicants requesting funding for multiple eligible health care provider sites in a single application do not need to receive eligibility determinations for every site that will receive funding during Round 2 of the Program, but instead will be required only to certify under penalty of perjury that all other health care sites that would receive Program funding are eligible for Program funding. Additionally, although applicants may still file their applications while their FCC Forms 460 are pending USAC's review, during Round 2 all applicants must have a health care provider number (HCP Number) assigned to them by USAC at the beginning of the FCC Form 460 application process before they can submit their application. Health care providers submitting FCC Forms 460 in anticipation of participation in Round 2 of the Program should indicate on their FCC Forms 460 that they are applying for the COVID–19 Telehealth Program to expedite the review of their FCC Forms 460.

24. While requiring applicants to submit FCC Forms 460 for each site in their applications during Round 1 assisted with funding eligible locations, it also delayed review of many applications, particularly for applications with a large number of sites, each of which required its own eligibility determination. This requirement also imposed a substantial burden on applicants with multiple sites. In the *Public Notice,* DA 21–14 the Commission sought comment on ways to streamline the application process, including directing USAC to include eligibility review as part of the application process and potentially ending the requirement that applicants submit FCC Forms 460. In conjunction with seeking comment on ending the requirement that applicants submit the FCC Form 460, the Commission sought comment on other methods of determining an applicant's eligibility for the Program.

25. After a careful review of the record, the Commission retains the requirement that each new applicant submit an FCC Form 460. The Commission note's that Round 1 applicants who submitted an FCC Form 460 and were deemed eligible do not need to submit a new Form; if any applicant's FCC Form 460 is no longer accurate, however, they must update the Form's information. While some commenters argued that filing an FCC Form 460 is a burdensome and unnecessary process, the Commission concludes that the FCC Form 460 remains a necessary tool that will enable USAC to quickly and efficiently determine an applicant's eligibility, and the Commission strongly encourages prospective applicants that have not already obtained an eligibility determination to file an FCC Form 460 as soon as possible.

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

27. The Commission also concludes that requiring the lead applicant to submit an FCC Form 460 is an important Program safeguard because it allows for reviewers to ensure that only eligible health care providers receive funding. This conclusion is supported by the experience in Round 1 when many ineligible applicants filed the FCC Forms 460 and incorrectly certified their eligibility. Ineligible applicants also contributed to the FCC Forms 460 processing backlog that many commenters noted. The Commission is confident that with more extensive outreach and education before the filing window opens, fewer ineligible applicants will submit the FCC Form 460. While some commenters suggested applicant certifications combined with post-disbursement audits would be sufficient to ensure program integrity, the Commission disagrees. Even if disbursements to ineligible applicants were discovered during audits and the improper payments were recouped, this approach would still thwart Congress's clear intent of quickly distributing funding to the eligible health care providers who need it the most. Such a delay, in the midst of a pandemic, would harm the public interest. The Commission concludes that eligibility reviews must be conducted before funds are awarded to make sure that funds go to those eligible providers who need them the most.

28. The Commission's review of the record also convinces that a better alternative to the FCC Form 460 is not available. Many commenters opined that filing the FCC Form 460 was an unnecessary burden, yet none identified an adequate alternative to verify an applicant's eligibility for purposes of this Program. While some commenters suggested using an applicant's Tax ID number or National Provider Identifier

(NPI) number, the Commission does not believe that either identifier, standing alone, would be sufficient to determine an applicant's eligibility because an NPI number does not provide information needed to determine an applicant's Program eligibility, such as an applicant's non-profit status. Other commenters suggested using an applicant's HCP number. The Commission notes that a health care provider that already has an HCP number and an approved eligibility determination, whether obtained from USAC for this Program or the RHC program after filling out an FCC Form 460, does not need to file an additional FCC Form 460 application. Additionally, the Commission agrees with those commenters who noted that Round 1 applicants are already familiar with the Program's application procedures, and new eligibility determination procedures for Round 2 would lead to confusion for applicants.

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

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

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

- The name, physical address, county, and the HCP number, for the lead health care provider seeking funding from the COVID–19 Telehealth Program application. USAC assigns a health care provider number when an applicant files an FCC Form 460. As discussed in more detail in the following, an HCP number, and approved eligibility determination, is only required for an application's lead health care provider site.
- Contact information for the individual who will be responsible for the application (telephone number, mailing address, and email address), as well as the contact information for the project manager.
- A list of the telecommunications services, information services, or connected ''devices necessary to enable the provision of telehealth services'' requested, the cost for each service or connected device, and the total amount of funding requested.
- Supporting documentation for the costs indicated in the application, such as a vendor or service provider quote, invoice, or similar information.

32. *SAM Registration.* All entities that intend to apply to the Program must also register with the System for Award Management (SAM). SAM is a web-based, government-wide application that collects, validates, stores, and disseminates business information about the federal government's partners in support of federal awards, grants, and electronic payment processes. Registration in SAM provides the Commission with an authoritative source for information necessary to provide funding to applicants and to ensure accurate reporting pursuant to the Federal Funding Accountability and Transparency Act of 2006, as amended by the Digital Accountability and Transparency Act of 2014 (collectively the Transparency Act or FFATA/DATA Act). In August 2020, the Office of Management and Budget updated the rules governing compliance with the Transparency Act as part of wider ranging revisions to title 2 of the Code of Federal Regulations. 85 FR 49506 (published Aug. 13, 2020) (including revisions to 2 CFR parts 25, 170, 183, and 200). OMB explained that the SAM registration requirements were expanded ''beyond grants and cooperative agreements to include other types of financial assistance'' to ensure compliance with FFATA. 85 FR 49506, 49517. Only those entities registered in SAM will be able to receive reimbursement from the Program. Potential applicants that are already registered with SAM do not need to re-register with that system. Active SAM registration, however, is required for an awardee to receive a payment from the Treasury. To register with the system, go to *https://www.sam.gov/SAM/* and provide the requested information. Furthermore, Program awardees may be subject to further FFATA/DATA Act reporting requirements to the extent that awardees subaward the payments they receive from the Program, as defined by FFATA/DATA Act regulations. Awardees may be required to submit data on those subawards.

33. *Do Not Pay.* Pursuant to the requirements of the Payment Integrity

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

34. *Application Evaluation Process.* Application Evaluation Metrics. The CAA directs the Commission to seek public comment on ''the metrics the Commission should use to evaluate applications for funding'' as well as ''how the Commission should treat applications filed during'' Round 1 that did not receive CARES Act funding, should those applicants wish to apply for funding during Round 2. The CAA also requires the Commission to provide notice to Congress of what metrics the Commission intends to use to evaluate applications.

35. The *Public Notice,* DA 21–14 sought comments on how to evaluate and prioritize applications during Round 2; whether the Commission ''should continue to target funding to health care providers in areas 'hardest hit' by COVID–19,'' particularly given the broader infection rate across the nation; and whether there are ''any other metrics [the Commission] should use to prioritize applications during the evaluation process.'' It also sought comment on prioritizing applications from providers who treat ''specific at-risk populations, such as Tribal, low-income, or rural communities,'' and sought comment on defining the populations that each metric represents.

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

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

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

ROUND 2 EVALUATION METRICS

Factor	Information required	Points
Hardest Hit Area	Applicants must provide health care provider county	Up to 15.
Low-Income Area	Applicants must provide health care provider physical address and county	Up to 15.
Round 1 Unfunded Applicant	Applicants must provide unique application number from Round 1. For applicants that applied during Round 1, the application number started with ''GRA'' followed by seven numbers (*e.g.,* GRA0000123). Some applications submitted via e-mail during Round 1 did not receive a GRA number. If the applicant did not receive an application number, USAC may accept proof of an email submission in lieu of the application number.	15.
Tribal Community	Applicants must provide physical address and/or provide supporting documentation to verify Indian Health Service or Tribal affiliation.	15.
Critical Access Hospital	Applicants must provide proof of Critical Access Hospital certification	10.
Federally Qualified Health Center/Federally Qualified Health Center Look-Alike/Disproportionate Share Hospital.	Applicants must (1) provide proof of Federally Qualified Health Center certification, or (2) demonstrate qualification as a Federally Qualified Health Center Look-Alike, or (3) demonstrate qualification as a Disproportionate Share Hospital.	10.

ROUND 2 EVALUATION METRICS—Continued

Factor	Information required	Points
Healthcare Provider Shortage Area	Applicants must provide Healthcare Provider Shortage Area ID number or health care provider county.	Up to 10.
Round 2 New Applicant	Applicants must certify, under penalty of perjury, that the applicant has not previously applied for Program funding.	5.
Rural County	Applicants must provide health care provider county	5.

39. *Hardest Hit Area.* In response to the *Public Notice,* DA 21–14 several commenters supported using the ''hardest hit'' factor to prioritize applications during Round 2. The Commission agrees, as this metric ensures that Program funding is prioritized to health care providers responding directly to the COVID–19 pandemic. While some commenters expressed concern that prioritizing applications based on areas that are ''hardest hit'' may favor large, urban institutions, and others argued that ''hardest hit'' is no longer a useful metric because the virus has spread exponentially since last April and most locations could be considered ''hardest hit,'' the Commission finds it appropriate to continue to prioritize funding to eligible health care providers located in areas that are most-impacted by the COVID–19 pandemic. To limit support only to those areas most affected by the COVID–19 pandemic, the Commission defines ''hardest hit'' as areas designated as either a ''sustained hotspot,'' or a ''hotspot,'' on the COVID–19 Community Profile Report, Area of Concern Continuum by County dataset provided by the U.S. Department of Health and Human Services (HHS). The Commission directs USAC to use the county tab of the report generated on the date of the close of the application filing window for this prioritization factor. A ''sustained hotspot'' is defined by HHS as a community that has ''a high sustained case burden and may be higher risk for experiencing health care limitations.'' Hotspots are defined by HHS as ''communities that have reached a threshold of disease activity considered as being of high burden.'' For Round 2, the Commission directs USAC to rely on publicly available COVID–19 infection rates from the day the application filing window closes, specifically using the U.S. Department of Health and Human Services dataset identified in the preceding, which breaks down different levels of community spread of COVID–19, and award prioritization points to applications in which an eligible health care provider is located in a county defined as a ''sustained hotspot'' or a ''hotspot.'' The Commission also finds that this factor warrants a generous point assignment because it is the only metric directly linked to the geographic area of the applicant as it relates to the spread of the virus. Accordingly, the Commission directs USAC to award seven (7) points to applications that demonstrate that an eligible health care provider is located in a ''hotspot'' and 15 points to applications that demonstrate that an eligible health care provider is located in a ''sustained hotspot.''

40. *Low-Income Area.* In response to the *Public Notice*, DA 21–14 many commenters recommended prioritizing applications from health care providers that are located in low-income areas. The Commission finds using this evaluation metric is sufficient to target funding to low-income areas, and decline to also use Qualified Opportunity Zones as an additional evaluation metric to target funding to low-income areas because the Commission believes that the U.S. Census Bureau, Small Area Income and Poverty Estimates dataset more accurately represents a location's economic reality, and using both low-income areas and Qualified Opportunity Zones as evaluation metrics would be redundant. The Commission agrees that health care providers located in low-income areas should be prioritized because such areas contain underserved and at-risk populations. Poverty rates serve as useful benchmarks to identify these low-income areas. Accordingly, the Commission directs USAC to use Census Bureau data to determine which health care providers are located in low-income areas. County-level median and 75th percentile poverty rates are calculated from the Small Area Income and Poverty Estimates data, and census tract rates are calculated from the American Community Survey data. These resulting levels vary because the Small Area Income and Poverty Estimates include additional information related to participation in the Supplemental Nutrition Assistance Program and individual income tax return data, and because the distributions of rates among each geographic area are different. The Commission directs USAC to use both county and census tract poverty data because county data alone may not sufficiently capture highly concentrated low-income communities in urban areas or the poverty level of communities within counties where there are large income gaps. An average poverty rate in a county may fail to reveal substantially higher poverty rates in smaller geographic areas within a county. For example, Cook County, Illinois has a county-level poverty rate of 13%; however, over 53% of the census tracts within the county have poverty rates greater than the tract-level nationwide median rate of 11.5% and approximately 31% of the tracts have tract-level poverty rates greater than the 75th percentile rate of 19.8%. If only county-level poverty data were used, eligible health care providers in those low-income census tracts would be ineligible for any low-income prioritization points. Similar differences in county and census tract poverty rates occur in other counties across the United States, *e.g.,* Los Angeles County, California; Allegheny County, Pennsylvania; Mecklenburg County, North Carolina; Erie County, New York. In such areas, considering both county and census tract poverty rates provides greater flexibility and will identify low-income communities that may otherwise be obscured in county-level data. The median poverty rate for a county is 13.4%, and the 75th percentile poverty rate for a county is 17.5%. For census tracts, the median poverty rate is 11.5%, and the 75th percentile poverty rate is 19.8%. The Small Area Income and Poverty Estimates do not include estimates for U.S. territories. For consistency, the Commission excludes Puerto Rico from the American Community Survey census tract poverty rates. To the extent information for U.S. territories and protectorates is not available in these datasets, the Commission directs USAC to rely on other U.S. Census Bureau data sets or other publicly available information to estimate poverty rates. The Commission directs USAC to determine the poverty rate of both the county and the census tract for the eligible health care provider site the applicant has designated for this metric. The Commission also directs

USAC to determine the relevant census tract for a health care provider by geocoding the applicant-submitted physical address using standard Geographic Information Systems processes. The census tract where an eligible health care provider is located is geographically limited and may not reflect the provider's complete service area. The Commission therefore directs USAC to develop a methodology to consider poverty rates in adjacent census tracts in awarding points for this metric. If an application would be eligible for more points using the census tract poverty rate than using the county-level poverty rate (or vice versa), the Commission directs USAC to award the application the higher points available between the two. The Commission further directs USAC to award 7 points to applications that demonstrate that an eligible health care provider is located in a county or census tract where the poverty rate is equal to or greater than the median poverty rate and less than the 75th percentile for poverty for that geographic area, and 15 points to applications that demonstrate that an eligible health care provider is located in a county or census tract where the poverty rate is in the 75th percentile or greater for that geographic area.

41. *Round 1 Unfunded Applicants.* During Round 1, the Commission received thousands of applications from health care providers nationwide. The Commission awarded funding commitments to 539 applications during Round 1, which left a substantial number of Round 1 applications unfunded. Notably, only about 2,500 of these are from institutions that may be eligible for Program funding. Many applications were received from for-profit or otherwise ineligible providers. In response to the high number of applications that did not receive funding, and the CAA, the *Public Notice*, DA 21–14 sought comment on prioritizing the applications of eligible health care providers who applied for, but did not receive, Round 1 funding. The majority of commenters supported prioritizing these applicants. While some commenters did not believe that these applicants should be prioritized, the Commission concludes that it is appropriate to prioritize eligible applicants who applied for but did not receive Round 1 funding. The Commission believes that equitable distribution of Program funds is essential, and thus find that prioritizing eligible health care providers that did not receive funding during Round 1 over eligible health care providers that did receive Round 1 funding is consistent with the goal of distributing funding as widely as possible. Accordingly, the Commission directs USAC to prioritize eligible health care providers that applied for Round 1 funding but did not receive it, and award 15 points to applications that demonstrate they applied for, but did not receive, Round 1 funding. Furthermore, the Commission also assigns a sizable points allocation to this metric to reflect the importance of encouraging unfunded Round 1 applicants to file in Round 2 and the statutory requirement that Round 1 applicants are able to file in Round 2.

42. *Tribal Community.* The Commission next prioritizes applications to serve sites located in Tribal areas because those areas are generally most in need of support to enhance broadband connectivity. While broadband in urban areas is nearly ubiquitous, as of the end of 2019, ''approximately 17% of Americans in rural areas and 21% of Americans in Tribal lands lack coverage from fixed terrestrial 25/3 broadband.'' The absence of broadband availability in these areas also makes it more difficult for telehealth to be provided, and the Commission concludes that prioritizing these factors will help to address this discrepancy. Additionally, the Commission has previously recognized that ''there are significant health care shortages in rural areas and Tribal lands,'' and seek to address this issue by prioritizing Tribal participation in this Program. Accordingly, the Commission's decisions to prioritize applicants located on Tribal lands is rooted in both commenters' support and the ''significant obstacles to broadband deployment'' that Tribal lands still face. While broadband deployment is nearly ubiquitous in urban areas, broadband deployment ''on certain Tribal lands, particularly rural Tribal lands, lags behind deployment in other, non-Tribal areas.'' Additionally, Tribal populations face a significantly higher risk from the COVID–19 pandemic, and facilitating a more robust telehealth infrastructure could help to address this disparity. For Round 2, the Commission adopts the definition of Tribal lands provided in the Commission's Lifeline program rules, and direct Program applicants to use USAC's Tribal PDF map or the reference shapefile to determine whether they are located on Tribal lands. The Commission also includes the Eastern Navajo Agency lands that have previously been designated as eligible for Lifeline and are included in the shapefile and map posted on USAC's website. Consistent with the eligibility determinations made using the FCC Form 460, the Commission directs USAC to award 15 points to applications that demonstrate that an eligible health care provider site is either located on Tribal lands or is operated by the Indian Health Service or is otherwise affiliated with a Tribe. The Commission directs applicants that are otherwise affiliated with a Tribe to provide supporting documentation sufficient to verify their Tribal affiliation. Finally, in recognition of the importance of funding applicants on Tribal lands, the Commission assigns the largest point allocation to these applications.

43. *Critical Access Hospital.* Critical Access Hospitals are located in states that have established a State Medicare Rural Hospital Flexibility Program. Applicants should review their state's department of health websites for additional information, and must include some identifier or proof of CAH certification in their application. In response to the *Public Notice*, DA 21–14 several commenters suggested considering whether an applicant is a Critical Access Hospital (CAH). A CAH designation is given to eligible rural hospitals in participating states by the Centers for Medicare and Medicaid Services. As defined by statute, a CAH is a hospital that is located in a rural area and that: (1) Has 25 or fewer acute care inpatient beds; (2) is located more than 35 miles from another hospital (although exceptions to this requirement apply); (3) maintains an annual average length of stay of 96 hours or less for acute care patients; and (4) provides 24/7 emergency care services. Small health care providers like CAHs frequently struggle to access the resources and capacity to set up their own telehealth infrastructure. The Commission finds that these characteristics place CAHs among the health care providers that need funding from the Program, as they would benefit from telehealth and are frequently the only health care institutions in their nearby vicinities. Accordingly, the Commission directs USAC to award 10 points to applications that demonstrate an eligible health care provider qualifies as a Critical Access Hospital. The Commission awards these entities points to reflect the importance of these facilities, but the Commission assigns a modest allocation of points because the Commission anticipates that this metric will overlap with other metrics.

44. *Federally Qualified Health Center, Federally Qualified Health Center Look-Alike, or Disproportionate Share Hospital.* Applicants shall verify whether they qualify for this metric by

providing either their Federally Qualified Health Center ID number or BHCMISID/UDS numbers. In response to the *Public Notice,* DA 21–14 commenters recommended prioritizing applications that include health care providers that qualify as a Federally Qualified Health Center (FQHC), a FQHC Look-Alike, or a Disproportionate Share Hospital (DSH). Applicants can verify their eligibility as a Look-Alike on the Health Resources and Services Administration website. A Federally Qualified Health Center is a community-based health care provider that receives funds from the Health Resources and Services Administration (HRSA) Health Center Program to provide primary care services in underserved areas. They are also referred to as the ''backbone of the nation's health care safety net.'' These entities must: (1) Offer services to all, regardless of the person's ability to pay; (2) establish a sliding fee discount program; (3) be a nonprofit or public organization; (4) be community-based, with the majority of its governing board of directors composed of patients; (5) serve a Medically Underserved Area or Population; (6) provide comprehensive primary care services; and (7) have an ongoing quality assurance program. Federally Qualified Health Centers provide health care services to at-risk and vulnerable patients supporting low-income and underserved communities in both urban and rural areas. FQHC Look-Alikes meet the same HRSA Health Center Program qualifications required of FQHCs, and they provide primary care services in underserved areas (like traditional FQHCs), provide care on a sliding fee scale based on ability to pay, and operate under a governing board that includes patients. A DSH must serve a significantly disproportionate number of low-income patients and receive payments from the Centers for Medicaid and Medicare Services to cover the costs of providing care to uninsured patients. After careful review of the record, the Commission finds that directing Program funding to FQHCs, FQHC Look-Alikes, and DSHs will meet the preceding stated objectives of directing Program funding to entities that target funding to at-risk and low-income communities and would most benefit from telehealth services. Accordingly, the Commission directs USAC to award 10 points to applications that demonstrate that an eligible health care provider qualifies as (1) an FQHC, (2) an FQHC Look-Alike, or (3) a DSH.

45. *Healthcare Provider Shortage Area.* Applicants should use the HPSA score for primary care, which is publicly available on the Health Resources and Services Administration website. In response to the *Public Notice*, DA 21–14 some commenters suggested prioritizing health care providers located in a Healthcare Provider Shortage Area (HPSA). HPSAs do not have enough health care providers to adequately serve their community. Support for telehealth and connected care services is especially needed in these areas to help health care providers serve more patients at a greater distance. The Commission directs applicants and USAC to the Health Resources and Services Administration (HRSA), which is an agency that provides health care to people who are geographically isolated, and economically or medically vulnerable. HRSA uses a health care provider's geographic area and the medical services it provides to award an HPSA score that ranges from 1 to 25. Applicants should use the HRSA website to find their HPSA score under the ''primary care'' category, and to provide on their application either the county information or the HPSA ID number for the eligible health care provider site for this prioritization factor. The Commission directs USAC to award 5 points to applications that include this information on their application and qualify for this factor with an HPSA score of 1–12; and to award 10 prioritization points to applications that include this information on their application and qualify for this factor with an HPSA score of 13–25.

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

47. *Rural County.* The Commission also prioritizes applicants that are located in rural areas, as defined by the Rural Healthcare Program. Although other application evaluation metrics, such as whether an applicant is a Critical Access Hospital, already take into consideration the rurality of health care providers for Round 2 funding, the Commission directs USAC to consider this evaluation metric independently as well to ensure that applications representing health care providers in rural areas are prioritized. Given that multiple other evaluation metrics also target funding to rural areas, however, the Commission attaches fewer prioritization points to the Rural Area metric to account for the expected overlap between evaluation metrics. Applicants should use USAC's Eligible Rural Areas Search tool to determine if an eligible health care provider is located in a rural area, and provide the physical address of the qualifying health care provider in their application. To the extent information for U.S. territories and protectorates is not available in this dataset, the Commission directs USAC to rely on other publicly available information, *e.g.,* urbanization codes, to confirm that the health care provider is located in a rural area. The Commission directs USAC to award 5 points to applications that demonstrate that an eligible health care provider site is located in a rural area.

48. *Ensuring Equitable Nationwide Distribution of COVID–19 Telehealth Program Funding.* The CAA directs the Commission, to the extent feasible, to ensure ''that not less than 1 applicant in each of the 50 States and the District of Columbia has received funding'' from the Program since the Program's inception, ''unless there is no such applicant eligible for assistance in a State or in the District of Columbia.'' The *Public Notice,* DA 21–14 sought comment on different ways to accomplish this directive, and proposed adopting an application filing window, which would allow for applications from states, the District of Columbia, or territories where a lead applicant did not receive Round 1 funding to be prioritized. The Commission also sought comments on ways to ensure that lead applicants from each state and the District of Columbia would receive Round 2 funding. The Commission now adopts these proposals and seeks to ensure that at least two applications with lead health care providers from every state, territory, and the District of Columbia receive Program funding, if such applications exist. After applications are scored, the Commission directs USAC, with Bureau and OMD oversight, to first commit funding to the

top-scoring Round 2 application with an eligible lead health care provider located in a state or territory that did not have a lead health care provider receive funding during Round 1, if feasible. Those states are Alaska, Hawaii, and Montana, and the territories are American Samoa, the Northern Mariana Islands, Puerto Rico, and the U.S. Virgin Islands. The Commission then directs USAC, with Bureau and OMD oversight, to commit funding to the top-scoring Round 2 application in the states and territories where an application with a lead health care provider was awarded Round 1 funding, and to award funding to the second-ranked application in the states where no lead health care provider received Round 1 funding. If there is more than one application with the same highest or second-highest total score in a location, then the application with the highest score for only the four most valuable metrics, each of which is worth 15 points, will receive the equitable distribution commitment. Those metrics are Hardest Hit, Low-Income Area, Round 1 Unfunded Applicant, and Tribal Area. Applications may have a maximum of 60 points across those four metrics, and the tiebreaker between applications is which application scores higher considering only those four metrics. Making this the first tiebreaker reflects the Commission's view that the most important factors should determine the commitment in the event of identical scores for applications in the same geographic location. If two or more applications remain tied after considering only the four most valuable metrics, then the application with the highest score only for the next most valuable metrics, each worth 10 points: Critical Access Hospital; Federally Qualified Health Center, Federally Qualified Health Center Look-Alike, or Disproportionate Share Hospital; and Healthcare Provider Shortage Area, will receive the equitable distribution commitment. Applications may get a total of 30 points from those three metrics, and the next tiebreaker between applications is which application scores higher among those three metrics. This will result in funding for at least two applications with lead health care providers in each state, territory, or the District of Columbia across both rounds of the Program, if such applications exist.

49. The Commission believes that committing funding to the top-scoring application in states and territories where a lead health care provider was not awarded Round 1 funding is dictated by the statute's unambiguous language. Because the Commission has already committed to using an application filing window, it is feasible to ensure that the highest-scoring applicant with a lead health care provider in the states and territories where a lead health care provider was not awarded Round 1 funding will receive funding in Round 2. The Commission also believes that guaranteeing each state, territory, and the District of Columbia Round 2 funding is consistent with the statutory goal of nationwide equitable distribution of Program funding. The Commission declines to adopt SHLB's proposal to use a ''proportional allocation of funds based on state and territory population.'' SHLB Comments, WC Docket No. 20–89, at 4. The application process adopted in the RO provides a simpler solution, and satisfies the CAA requirement. The Commission also declines to adopt UAB Hospital's suggestion that the Commission set aside $250,000 for each state. UAB Hospital Comments, WC Docket No. 20–89, at 2–3. Establishing an application filing window will allow USAC to commit funds to applicants of each state without the Commission separately setting aside funds for this purpose. Finally, the Commission declines to adopt Northern Light Health's proposal that the Commission commits a minimum of three awards to applicants in each state where an applicant did not receive funding during Round 1. Northern Light Health Comments, WC Docket No. 20–89, at 2. While this decision could result in some lower-scoring applications receiving funding commitments at the outset of the Program, the Commission notes that applications with lead health care providers in 47 states, the District of Columbia, and Guam received Round 1 funding without separate prioritization, and the Commission anticipates a similar geographic distribution of Round 2 applications.

50. *Pre-Existing Strain.* In the *Public Notice,* DA 21–14 the Commission sought comments on whether to prioritize health care providers that are experiencing pre-existing strain, which, the Commission said, could include ''providing care for a large underserved or low-income patient population, facing health care provider shortages, or dealing with rural hospital closures.'' While some commenters supported using the metric, most disagreed, and pointed out that the COVID–19 pandemic has placed many health care providers under significant strain. After careful consideration of the record, the Commission declines to use pre-existing strain as an application evaluation metric because that factor, as described in the C19–RO, is difficult to verify. Instead, the Commission adopts metrics that the Commission previously identified as factors that contribute to pre-existing strain, *e.g.,* areas with low-income patient population and health care provider shortages to target the communities where funding is most needed.

51. Applicants are required to use the publicly available resources specified in the 'Round 2 Evaluation Metrics' table to determine whether they qualify for points in any of the application evaluation metrics, and should also include any information that is necessary to verify these factors on their applications. Applicants must also certify, under penalty of perjury, to the accuracy of their applications, and the Commission directs USAC to verify these qualifications during the application review process using the same publicly available datasets. The Commission anticipates that, just as in Round 1, many applications will include multiple health care provider sites, and an eligible health care provider may only appear on one application. Applications may only receive the associated prioritization points once for each factor. In instances in which the application requests funding for multiple eligible health care provider sites, and the health care provider site that qualifies for one or more factors is not the lead health care provider on the application, the applicant must provide the information of the qualifying health care provider site, in addition to the lead health care provider's information, to receive points for that evaluation metric. The Commission directs USAC not to award points to applicants that do not include sufficient information on their application.

52. Confirming Eligibility of Requested Services and Devices. Consistent with the review process established in Round 1, the Commission directs USAC to conduct an eligibility review of the services and devices applicants request on their applications. This review is an important safeguard and allows the Commission to ensure that funding awards are based on the cost of eligible services and devices, which in turn ensures funding is available to as many health care providers as possible. Moreover, as supported by the record, the Commission continues to allow applicants who are awarded funds the flexibility to purchase, in the course of implementing their telehealth and connected care programs, any necessary

eligible services and connected devices, and do not limit them to receiving funding for only the eligible services and connected devices listed in their applications. Finally, to provide applicants with additional clarity regarding the eligibility of various products and services, and to enhance the transparency of the application review process, the Commission provides applicants with a list of eligible and ineligible services, attached as Appendix B in the RO.

53. *Maintaining Flexibility.* In the *Public Notice,* DA 21–14 the Bureau sought comments on whether the Commission should continue providing applicants that receive funding commitments the flexibility to respond to changing circumstances by not limiting them to the vendors, eligible services, and eligible devices identified in their applications, as long as the total amount sought for reimbursement does not exceed the commitment amount. Commenters unanimously supported the Bureau's suggestion. Many commenters noted that this flexibility provided significant help to funding recipients in Round 1. Other commenters explained that this policy was still necessary because the COVID–19 pandemic continued to present a rapidly changing and evolving situation for health care providers to manage, and still other commenters specified that they expect to continue facing equipment shortages. The Commission maintains this policy from Round 1 because the Commission believes that providing funding recipients this flexibility will allow them to best provide care for their patients in response to the COVID–19 pandemic. However, consistent with the Commission's process in Round 1, the Commission directs USAC, subject to Bureau oversight, to review the eligibility of each service or connected device that a funding awardee proposes to substitute at the reimbursement request stage to ensure that Program funds are used only for authorized purposes. As part of this review, the Commission permits USAC to request a brief explanation from a funding awardee about the reason for the substitution and/or an explanation on how the substituted items are eligible.

54. *Funding Request Review.* The Bureau also sought comment in the *Public Notice,* DA 21–14 on whether, if the Commission maintained this flexibility for applicants, the Commission should also streamline the application process by eliminating the requirement that applicants submit supporting documentation on the eligibility of connected devices and services in their applications. During the Round 1 application process, applicants were required to answer several questions about the anticipated uses and eligibility of their requested services and devices, and they were required to submit documentation supporting the estimated costs for their funding requests. As a result of this process, efforts by Commission staff to review each application to determine the eligibility of the services and devices requested were often hampered by the lack of adequate information in the application. Because applicants commonly did not include enough information on their applications about each of their requested services and connected devices, reviewers conducted substantial outreach to determine what items were being requested and whether those items were eligible for funding. Commission staff also completed a second eligibility review after Round 1 funding awardees filed their reimbursement requests.

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

56. *Eligible Services List.* In the *Public Notice,* DA 21–14 the Bureau also sought comments on whether the Commission should ''publish a list of eligible and ineligible equipment and services to provide applicants with specific guidance on what may be requested for reimbursement.'' Commenters largely supported this idea. The Commission agrees, because an eligible services list will help address the concerns of commenters that advocated for the Commission to develop ''guidance on eligible expenses'' more generally, and will help applicants prepare better applications with this knowledge, which in turn will facilitate USAC's application review. Commenters that opposed the Commission publishing an eligible services list argued that it may unintentionally exclude services or connected devices, that COVID–19 still presents too rapidly evolving of a situation for there to be a fixed list of eligible and ineligible services, and finally that the Commission should only publish an ineligible services list to provide applicants needed flexibility in their applications.

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

58. The Commission makes no additional changes to the types of services and connected devices eligible under the Program. A number of commenters requested the Commission make additional services or devices eligible for funds, such as administrative costs or indirect costs. The Commission notes that the CARES Act directs Program funding to ''telecommunications services, information services, and devices necessary to enable the provision of telehealth services'' during the pendency of the COVID–19 pandemic, and, thus, the Commission is prohibited from expanding the services and equipment that are eligible for Program funding during Round 2.

59. The Commission directs USAC, subject to Bureau oversight, to review the services and equipment listed on each application, and award only as much funding as is supported by the application and associated documentation. The CAA appropriated additional funding to the Program, but is silent regarding the eligibility of services and devices eligible for the additional funding. Under the CARES Act, the Program awards funds to eligible health care providers to support the purchase of ''telecommunications services, information services, and devices necessary'' to provide telehealth and connected care in response to the COVID–19 pandemic. Because the Program is a ''Federal subsidy made available through a program administered by the Commission,'' program funding may not be used to ''purchase, rent, lease, or otherwise obtain any communications equipment or service . . . identified and published on the Covered List.'' *See Protecting Against National Security Threats to the Communications Supply Chain Through FCC Programs,* WC Docket No. 18–89, Second Report and Order, 35 FCC Rcd 14284, 14326, paras. 94–95 (2020); *see also* 47 CFR 54.10; *Public Safety and Homeland Security Bureau Announces Publication of the List of Equipment and Services Covered by Section 2 of the Secure Networks Act,* WC Docket No. 18–89, Public Notice, DA 21–309 (PSHSB Mar. 12, 2021, 86 FR 2904, January 13, 2021). Consistent with Round 1, the Commission interprets this language to include only connected devices (*e.g.,* Bluetooth-enabled pulse-oximeters or remote blood pressure monitoring devices). Personnel costs, marketing costs, administrative expenses, or training costs continue to be ineligible for Program funding. Program funding may be used to support connected care services and devices, but may not be used to support the development of new websites, systems, or platforms. Applicants may apply to receive retroactive funding for eligible services and devices purchased on or after March 13, 2020, so long as they did not receive Round 1 funding for those eligible services and devices. Any services must have been purchased in response to the COVID–19 pandemic, but can include pandemic-related upgrades to existing services.

60. The Commission next addresses how long applicants may receive funding for eligible recurring services. During Round 1, having uncertainty as to how long the pandemic would last, the Commission allowed applicants to request reimbursement for up to six months of eligible recurring services, but allowed applicants to request reimbursement for annual license agreements because of the one-time, up-front nature of those costs. The Commission now anticipates that health care providers will likely continue to rely on telehealth and connected care services as a critical means of addressing the COVID–19 pandemic through at least a good portion of 2022. Accordingly, for Round 2, applicants may receive Program funding to support up to 12 months of eligible recurring services as well as eligible annual license agreements (only one one-year term will be funded). This change will also provide more certainty to applicants and reduce confusion about the funding period.

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

62. *Initial Commitments.* The Commission directs USAC, subject to Bureau and OMD oversight, to award at least $150 million during the initial commitment phase. After the application filing window closes, USAC will score each application using the metrics the Commission adopts in the preceding. After the applications are scored, USAC will rank all of the applications in descending order by the score assigned to each application. The initial funding commitments will then be made in two steps: The first equitable distribution step, as required by the CAA, will ensure that applications with lead health care providers in every state, territory, and the District of Columbia are awarded funding commitments. The second step will award funding to the highest-scoring applications regardless of geographic location of the lead health care provider.

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

64. *Highest-Scoring Applications.* After ensuring that funding is committed across all states, territories, and the District of Columbia, USAC, with oversight from the Bureau and OMD, will then begin to commit funding to the highest-scoring applications, in descending order, until at least $150 million has been committed in the initial commitment window. As an example, if $10 million was awarded during the equitable distribution step of the initial commitment window, when funding commitments are awarded in each state, territory, and the District of Columbia, there would be at least $140 million available for the highest-scoring applications. Once $150 million in funding has been committed, any applications with the same score as the last application to receive a funding commitment will also receive a funding commitment, and the remaining appropriated funds will be rolled over into the final commitment window. Once the initial commitment awardees have been determined, the Commission directs the Bureau to issue a Public Notice announcing those awardees, the amount of their awards, and the remaining funding available for the final commitment window.

65. *Notifications of Intent to Deny and Opportunity to Supplement.* Upon the Bureau's release of the Public Notice identifying the eligible health care providers awarded funding during the initial commitment phase, the Commission directs USAC, with oversight from the Bureau, to issue notices of intent to deny to all Round 2 applications that did not receive funding awards during the initial commitment phase. In the CAA, Congress directs the Commission to

''issue notice to the applicant of the intent of the Commission to deny the application and the grounds for that decision'' for any application the Commission chooses to deny and to ''provide the applicant with 10 days to submit any supplementary information that the applicant determines relevant,'' which must be taken into account for the final funding decisions. Accordingly, each notice will include a denial justification so that the applicant may know why its application was not funded during the initial commitment phase. The Commission notes, that while required by statute to send every applicant that does not receive funding during the initial window a notice of the Commission's intent to deny their application, some of those applicants will ultimately receive funding. The Commission directs the Bureau to provide guidance on how applicants may supplement their applications in the Public Notice announcing the winners from the initial commitment phase. As provided in the statute, applicants will have ten days from the date that this Public Notice is issued to supplement their applications. The Commission directs USAC to consider the supplemental information before issuing the remaining funding awards.

66. The Commission stresses, however, that it is important for applicants to accurately fill out their applications at the time of initial submission, before they have an opportunity to supplement them. If an applicant supplements its application and receives a score that would have qualified it for funding during the initial funding window, the initial funding commitments will not change and that application will only be eligible to receive funding during the final commitment window to the extent there are remaining funds. If an applicant determines that they made an error on their application and this has resulted in an incorrectly high prioritization score, however, they are responsible for notifying the Commission as soon as they discover the error, and the funding that was awarded to that applicant may be made available during the final commitment phase, or at a later point.

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

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

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

70. *Round 2 Outreach.* The Commission remains committed to helping health care providers address the COVID–19 pandemic as demand for telehealth and connected care services increases, and the Commission believes that coordination and outreach with health care providers before the application filing window opens will improve the overall efficacy of Round 2 of the Program. Upon release of the RO, to ensure that health care providers are aware of the available funding under the Round 2 of the Program, the Commission directs USAC to coordinate with the FCC's Connect2Health Task Force, as necessary, to promote and announce Round 2 to interested stakeholders, including service providers and health care providers. The Commission directs USAC to respond to any questions from health care providers regarding Round 2, including, but not limited to, questions about the eligibility and application processes, application status, funding awards, and request for reimbursement process.

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

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

73. *Round 2 Invoicing and Dibursements.* Invoicing and Disbursements. The Commission directs USAC, with Bureau and OMD oversight, to use the same reimbursement structure for Round 2 as was used for Round 1. The Commission concludes that using the same reimbursement structure will allow the use of the existing invoicing systems, processes, and procedures already in use for Round 1. The current system is effective, and it would be impractical to expend limited resources to develop an entirely new invoicing system, processes, and procedures solely for Round 2. Accordingly, Round 2 funding recipients must submit their requests for reimbursement, and any necessary subsequent filings (to include any information necessary to satisfy the Commission's oversight responsibilities and/or agency-specific/government-

wide reporting obligations associated with the appropriation by Congress) through the Invoice Processing Platform (IPP), which is part of the U.S. Department of the Treasury's Bureau of Fiscal Services. Funding recipients must first pay the vendor or service provider for the costs of the eligible services and/or connected devices received before requesting reimbursement for those costs from the COVID–19 Telehealth Program. The Commission declines to adopt the suggestion that the Commission allows applicants to access committed funds prior to first purchasing the eligible services and connected devices and request reimbursement. See Elite Program Comments, WC Docket No. 20–89, at 4; Mount Sinai Comments, WC Docket No. 20–89, at 4; SHLB Comments, WC Docket No. 20–89, at 9. The Commission also declines to adopt the suggestion to use ''a two-phased approach, wherein a smaller amount of initial seed funding is provided with continued support predicated on meeting performance goals or other milestones.'' Hudson Headwaters Health Comments, WC Docket No. 20–89, at 4. The Commission is mindful of the responsibility to prevent waste, fraud, and abuse of Program funding, and the Commission believes that verifying each applicant's purchase of eligible services and connected devices prior to reimbursement is an important part of this responsibility. The COVID–19 Telehealth Program will not directly pay a health care provider's service providers or vendors.

74. Upon receipt of services and/or connected devices and subsequent payment by the health care provider(s) of the costs of the eligible services and/or connected devices to the service provider or vendor, a funding recipient shall submit its requests for reimbursement and supporting documentation to receive reimbursement for the cost of the eligible services and/or devices they have received from their applicable service providers or vendors under the Program. Applicants that distribute Program funding to other health care provider sites must submit Letter(s) of Authorization with their request for reimbursement form to demonstrate that the lead health care provider has been given permission to distribute the requested funding to the other health care provider sites listed on its application. The Commission emphasizes that Program funds shall only be used for services and devices eligible under the CARES Act. The cost of ineligible items must not be included in the reimbursement requests for the Program. To guard against potential waste, fraud, and abuse, the Commission reiterates that participating health care providers are prohibited from selling, reselling, or transferring services or devices funded through the Program in consideration for money or any other things of value. Moreover, the Commission reminds applicants that they shall not use Program funding to pay for the non-discount share of services purchased under the Rural Healthcare Program. Finally, the Commission reminds applicants that they must certify, under penalty of perjury, that they have not received and may not receive duplicative funding for the same services from state, local, or federal sources twice. For example, applicants may not receive funding from both the Program and the Connected Care Pilot Program for the same services or connected devices. Applicants must agree to withdraw their Round 2 application if they receive duplicative funding from another source.

75. In reviewing requests for reimbursement, USAC shall ensure that funding is only awarded after receiving documentation that demonstrates the eligibility of the requested items and substantiates the cost of those items. USAC will review the request for reimbursement forms along with all supporting documentation, and approve requests for reimbursement for eligible items that are supported by invoice documentation. The Commission directs USAC not to accept requests for reimbursement that do not contain the required certifications as part of the Request for Reimbursement Form to ensure that Program funds are used for their intended purpose. The Commission delegates to the Bureau, in coordination with OMD, the authority to make changes to the Request for Reimbursement Form that was used in COVID–19 Telehealth Program Round 1 to facilitate Program administration and to better track expenditures under the COVID–19 Telehealth Program. Pursuant to section 903(e) of the CAA, the collection of information sponsored or conducted under the regulations promulgated in the RO is deemed not to constitute a collection of information for the purposes of the Paperwork Reduction Act, 44 U.S.C. 3501–3521. Accordingly, any changes made to the Request for Reimbursement Form for Round 2 do not require PRA approval.

76. *Red Light Rule.* Additionally, the Commission finds that it remains in the public interest, and good cause still exists, to waive the Commission's ''red light'' rule with respect to applications to the Program. As part of the collection and disbursement rules associated with the Debt Collection Improvement Act, the Commission may withhold action on applications and requests made by any entity found to be delinquent in its debt to the Commission until full payment or resolution of such debt. This is commonly referred to as the Commission's ''red light'' rule. For Round 1 of the Program, OMD and the Bureau found that it was in the public interest and good cause existed to waive the ''red light'' rule because of the extremely unusual circumstances the COVID–19 pandemic presented for health care providers. The Commission finds that this reasoning remains true today; therefore, the Commission continues the waiver of the Commission's ''red light'' rule for Round 2 applicants. As with Round 1, the Commission do not expect there to be a large number of applicants to the Program that are delinquent in their debt to the Commission, and the Commission reiterates that this waiver is limited to COVID–19 Telehealth Program applicants. This waiver does not affect the Commission's right or obligation to collect any debt owed by an applicant by any other means available to the Commission, including by referral to the U.S. Treasury for collection.

77. *Post-Program Reporting and Feedback.* Throughout the RO, the Commission reviewed stakeholder comments as guideposts for the decisions related to the telecommunications services, information services, and connected devices needs of eligible health care providers and their ability to obtain those services to assist their patients throughout this pandemic. The Commission adopts reporting obligations for USAC and for COVID–19 Telehealth Program Round 2 participants that will enable the Commission to measure the funding impact. While the Commission identifies specific reporting obligations, the Commission delegates authority to the Bureau, in coordination with OMD, to finalize the format of those reporting obligations. In doing so, OMD and the Bureau will ensure that such reporting satisfies the CARES Act oversight provisions incorporated by Congress by reference in the CAA.

78. The Commission further directs USAC to collect, within six months after the conclusion of the COVID–19 Telehealth Program Round 2, feedback on the Program from Round 2 funding awardees. This deadline will be calculated from the invoice filing deadline for Round 2. The Commission directs the Bureau to issue a Public

Notice announcing the post-program feedback report deadline and to provide a reporting template and instructions on how to submit the final reports for Round 2 funding. After collecting this feedback, USAC shall provide a report to the Commission in a format to be approved by the Bureau on the effectiveness of the COVID–19 Telehealth Program funding on health outcomes, patient treatment, health care facility administration, benefits from services and connected devices on patients treatments and outcomes, administration, and health care providers overall expanded telehealth programs, and any other relevant aspects of the COVID–19 pandemic. Such information could include: Feedback on the application and invoicing processes; a description of how funding was helpful in providing or expanding telehealth services, including anonymized patient accounts; a description of how funding promoted innovation and improved health outcomes; and other areas for improvement. The Commission delegates authority to the Bureau to update the Post-Program Feedback Report Template based on its experience with Round 1 Post-Program Feedback Reports. The Commission directs the Bureau to provide specific information about how to provide feedback, and associated deadlines, to Round 2 funding recipients. This information will assist Commission efforts to respond to pandemics and other national emergencies in the future. Pursuant to section 903(e) of the CAA, the collection of information sponsored or conducted under the regulations promulgated in the RO is deemed not to constitute a collection of information for the purposes of the Paperwork Reduction Act, 44 U.S.C. 3501–3521. Accordingly, any changes made to the Post-Program Feedback Report for Round 2 do not require PRA approval.

79. *Audits.* While the Commission seeks to ease the burdens upon applicants and service providers, the Commission is mindful of the commitment to ensure the Program's integrity by protecting against waste, fraud, and abuse. The Commission believes that proper documentation is crucial for demonstrating health care providers' compliance with the COVID–19 Telehealth Program rules, and for uncovering waste, fraud, and abuse in the Program, whether through compliance audits or investigations. The Commission's Office of Inspector General was allocated Program funds to provide oversight, and the Commission will provide further guidance about audit procedures at a later date. In addition, the Section 903 appropriation, like all other Division N appropriations, is subject to the same oversight provisions included in the CARES Act, Consolidated Appropriations Act, 2021, H.R. 133, div. O, tit. VIII—Pandemic Response Accountability Committee Amendments Section 801, Amendment to the Pandemic Response Accountability Committee (2020). OMB guidance on such provisions also continues to apply. In this regard, the Commission notes that in Round 1 the Commission leveraged audits conducted under the Single Audit Act to oversee the program.

80. To that end, the Commission delegates authority to OMD to develop and implement an audit process of participating health care providers that complies with the requirements and procedures of the COVID–19 Telehealth Program. OMD may obtain the assistance of third parties, including but not limited to USAC, in carrying out this effort. Consistent with the experience with the Universal Service Fund, the Commission finds that audits are the most effective way to ensure compliance with the rule requirements. Funding recipients are required to maintain documentation sufficient to demonstrate their compliance with program rules for six years after the last date of delivery of services or connected devices supported through the COVID–19 Telehealth Program. Upon request, COVID–19 Telehealth Program participants must submit documents sufficient to demonstrate compliance with Program rules, including, at a minimum, applications, contracts, communications related to Program services, invoices, delivery records, and purchase and receipt records. Additionally, certain health care providers participating in the COVID–19 Telehealth Program that meet the thresholds for being audited under the Single Audit Act are subject to a single audit that contains the FCC compliance supplement for the COVID–19 Telehealth Program. For health care providers subject to a single audit, the CFDA number for the COVID–19 Telehealth Program is 32.006. The Single Audit Act is codified, as amended, at 31 U.S.C. 7501–06, and implementing Office of Management and Budget (OMB) guidance is reprinted in 2 CFR part 200 (2020). Federal award recipients that expend $750,000 or more in federal awards in a fiscal year are required to undergo a single audit, which is an audit of an entity's financial statements and federal awards, or a program-specific audit, for the fiscal year. 31 U.S.C. 7502; 31 CFR 200.501 (2020).

81. *Administrative Procedure Act Exception.* The Administrative Procedure Act (APA) provides that with a showing of ''good cause,'' an agency is permitted to make rules effective before 30 days after publication in the **Federal Register**. ''In determining whether good cause exists, an agency should 'balance the necessity for immediate implementation against principles of fundamental fairness which require that all affected persons be afforded a reasonable amount of time to prepare for the effective date of its ruling.' '' As a general matter, the Commission believes that the APA requirements are an essential component of the rulemaking process. In this case, however, because of the unprecedented nature of this pandemic and the need for immediate action, the Commission finds there is good cause to make the Program rules effective April 9, 2021. In light of the continued spread of COVID–19 and the increasing need to address this public health crisis, any further delay in the use of these funds to assist health care providers in meeting the health care needs of their patients could impede efforts to mitigate the spread of the disease. Waiting an additional 30 days to make this relief available ''would undermine the public interest by delaying'' much needed expansion of telemedicine resources.

III. Order on Reconsideration

82. On April 9, 2020, the American Hospital Association (AHA) filed a Petition for Partial Reconsideration of the Commission's C19–RO. AHA's petition was limited to the Commission's decision to limit eligibility in the Program to the statutorily enumerated providers who are eligible for the Rural Health Care Program. More specifically, AHA's petition sought to extend Program eligibility to ''all types of hospitals and other direct patient care facilities regardless of their size, location or for-profit or not-for-profit status.'' Several commenters filed responses in support of the petition.

83. The Commission concludes that granting the petition for reconsideration would be contrary to the public interest and that the decision here is consistent with Congressional intent. Accordingly, the Commission denies the petition. In the CARES Act, Congress gave the Commission the authority to rely on its already-existing rules to administer Round 1 of the Program, and, consistent with that authority, the Commission adopted the definition of ''health care provider'' as set out in the

Communications Act and the Commission's rules. The Commission reached this conclusion because it was consistent with both the Communications Act and the CARES Act, and because it would help to ''ensure that funding is targeted to health care providers that are likely to be most in need of funding to respond to this pandemic while helping us ensure that funding is used for its intended purposes.'' The Commission reaches the same conclusion, and conclude that directing Program funding away from non-profit providers would be contrary to the public interest.

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

85. This conclusion is bolstered by recent Congressional action through the CAA, when Congress appropriated additional funding for a second round of the Program. By directing these funds to ''the COVID–19 Telehealth Program established by the Commission'' under the authority of the CARES Act, without modifying the eligibility requirements, Congress indicated that it saw no need to change these requirements, especially in light of the fact that Congress chose to mandate a number of other changes to the Program.

86. AHA argues that the COVID–19 pandemic has financially impacted all health care providers, and that many smaller hospitals operate as part of a larger health care system, which could also render these hospitals ineligible for the Program. Additionally, AHA argues that because the Commission has previously ''determined that emergency departments of for-profit hospitals that participate in Medicare should be deemed 'public' health care providers within the meaning of section 254(h)(7)(B) of the Communications Act,'' it has previously acknowledged the importance of for-profit hospitals, and that those providers are ''public'' by nature of their obligation to treat all emergency patients. The Commission finds these arguments unpersuasive. The Commission's previous conclusion that emergency departments of for-profit hospitals that participate in Medicare can participate in the Rural Health Care Program reflected a careful balance of multiple considerations, and those same emergency departments remain eligible for the Program as well. Similarly, while the Commission acknowledges the important role played by smaller hospitals who operate as part of a larger health care system, the Commission notes that by definition these smaller hospitals have available to them the resources of a larger, for-profit health care system. Finally, Congress has had occasion as recently as 2016 to revisit the health care providers who should be eligible for the Rural Health Care program, and to date it has not included for-profit hospitals as eligible. While the Commission does not dispute that all health care providers have been impacted by the COVID–19 pandemic, that does not alter the conclusion that limited funding is best directed towards those entities listed by Congress in section 254(h)(7)(B) of the Communications Act of 1934 as amended.

IV. Procedural Matters

A. Paperwork Reduction Act Analysis

87. Pursuant to section 903(e) of the Consolidated Appropriations Act, the collection of information sponsored or conducted under the regulations promulgated in this Report and Order is deemed not to constitute a collection of information for the purposes of the Paperwork Reduction Act, 44 U.S.C. 3501–3521.

B. Congressional Review Act

88. The Commission has determined, and the Administrator of the Office of Information and Regulatory Affairs, Office of Management Budget (OMB), concurs that the rules implementing the COVID–19 Telehealth Program are ''major'' under the Congressional Review Act, 5 U.S.C. 804(2). Because the Commission finds good cause that compliance with the notice and public procedure requirements of the Administrative Procedure Act on the rules adopted herein is impracticable, unnecessary, or contrary to the public interest, the Report and Order and Order on Reconsideration will become effective April 9, 2021 pursuant to 5 U.S.C. 808(2). The Commission will send a copy of the the Report and Order and Order on Reconsideration to Congress and the Government Accountability Office pursuant to 801(a)(1)(A).

V. Ordering Clauses

89. Accordingly, *it is ordered* that, pursuant to the authority contained in sections 201, 254, 303(r), and 403 of the Communications Act of 1934, as amended, 47 U.S.C. 201, 254, 303(r), and 403, DIVISION B of the Coronavirus Aid, Relief, and Economic Security Act, Public Law 116–136, 134 Stat. 281, and DIVISION N of the Consolidated Appropriations Act, 2021, Public Law 116–260, 134 Stat. 1182, the Report and Order and Order on Reconsideration *is adopted*.

90. *It is further ordered* that, pursuant to the authority contained in section 808(2) of the Congressional Review Act, 5 U.S.C. 808(2), and 5 U.S.C. 553(d), the Report and Order and Order on Reconsideration *shall become effective* April 9, 2021.

91. *It is further ordered* that the Commission *shall send* a copy of the Report and Order to the appropriate Congressional Committees identified in the Consolidation Appropriations Act to provide notice of the application evaluation metrics.

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

93. *It is further ordered* that, pursuant to sections 4(i) and 405 of the Communications Act of 1934, as amended, 47 U.S.C. 154(i), 405, and § 1.429 of the Commission's rules, 47 CFR 1.429, the Petition for Partial Reconsideration filed by the American Hospital Association is *denied*.

Federal Communications Commission.

Marlene Dortch,

Secretary.

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