

SUPPORTING STATEMENT

This submission is being made pursuant to 44 U.S.C. § 3507 of the Paperwork Reduction Act of 1995 (PRA) to obtain the Office of Management and Budget (OMB)'s approval to revise the existing collection 3060-1271 to include information collection requirements for the Connected Care Pilot Program established by the Commission in the Report and Order entitled *In the Matter of Promoting Telehealth for Low-Income Consumers; COVID-19 Telehealth Program* (WC Docket No. 18-213, WC Docket No. 20-89, FCC 20-44, Adopted Mar. 31, 2020).

A. Justification:

1. ***Circumstances that make the collection of information necessary.*** Section 254(h)(1)(A) of the Telecommunications Act of 1996 (1996 Act), 47 U.S.C. § 254(h)(1)(A), mandates that telecommunications carriers provide telecommunications services for health care purposes to eligible rural public or non-profit health care providers at rates that are “reasonably comparable” to rates in urban areas. In addition, section 254(h)(2)(A) of the 1996 Act, 47 U.S.C. § 254(h)(2)(A), directs the Federal Communications Commission (Commission) to establish competitively neutral rules to enhance, to the extent technically feasible and economically reasonable, access to “advanced telecommunications and information services” for public and non-profit health care providers.

Based on this legislative mandate, the Commission established the Rural Health Care (RHC) Program which supports health care providers' access to communications services. However, there are developments in telehealth, including the increased use of connected care services, that the Commission has not yet fully explored.

- In August 2018, the Commission released a Notice of Inquiry (*Connected Care Notice of Inquiry* or *Notice of Inquiry (NOI)*), 33 FCC Rcd 7825, seeking information on how the Commission can help advance and support the movement towards connected care everywhere and improve access to life-saving broadband-enabled telehealth services.
- In July 2019, the Commission adopted a Notice of Proposed Rulemaking (*Connected Care Notice*), 34 FCC Rcd 5620, that proposed and sought comment on a Connected Care Pilot Program that would help defray health care provider costs of providing connected care services to low-income Americans and veterans.

In the Report and Order, the Commission established two programs designed to assist health care providers provide connected care services to consumers—the COVID-19 Telehealth Program and the Connected Care Pilot Program (collectively, Programs), as described below.

Specifically, this information collection, as described in more detail below, is being revised to: (1) update several certifications and the reporting requirements to the existing information collection requirements for the COVID-19 Telehealth Program; and (2) add new information collection requirements for the Connected Care Pilot Program. This information collection is necessary so that the Commission will have sufficient information to evaluate and select applications under both programs and ensure compliance with the Commission's rules and procedures applicable to each program, and the CARES Act.

COVID-19 Telehealth Program

The Commission established the COVID-19 Telehealth Program, funded through a \$200 million Congressional appropriation under the under the Coronavirus Aid, Relief, and

Economic Security (CARES) Act,¹ to immediately support health care providers responding to the novel Coronavirus 2019 disease (COVID-19) pandemic by providing funding for telecommunications services, information services, and devices necessary to provide critical connected care services whether for treatment of COVID-19 disease or other health conditions during the COVID-19 pandemic. The Commission expects that the COVID-19 Telehealth Program will provide immediate assistance to help health care providers provide connected care services in response to the COVID-19 pandemic.

The COVID-19 Telehealth Program is open to eligible health care providers, whether located in rural or non-rural areas. Consistent with the 1996 Act and the CARES Act, the Commission limits the COVID-19 Telehealth Program to nonprofit and public eligible health care providers that fall within the categories of health care providers in section 254(h)(7)(B) of the 1996 Act: (1) post-secondary educational institutions offering health care instruction, teaching hospitals, and medical schools; (2) community health centers or health centers providing health care to migrants; (3) local health departments or agencies; (4) community mental health centers; (5) not-for-profit hospitals; (6) rural health clinics; (7) skilled nursing facilities; or (8) consortia of health care providers consisting of one or more entities falling into the first seven categories. The COVID-19 Telehealth Program will provide selected applicants full funding for eligible services and devices. The COVID-19 Telehealth Program has a Congressionally appropriated \$200 million budget, and these funds will be available until they are expended or until the pandemic ends.

In order to receive funding under the COVID-19 Telehealth Program, applicants must submit an application, which includes certain certifications, to the Commission for review. As noted below, the certifications on the application form have been updated. (See Attachment 1, COVID-19 Telehealth Program Application). The Wireline Competition Bureau (Bureau) will evaluate the COVID-19 Telehealth Program applications and will approve funding under the program. The goal is to select applications that target areas that have been hardest hit by COVID-19 and where the support will have the most impact on addressing the health care needs. In order to receive funding under the COVID-19 Telehealth Program, health care providers that do not already have an eligibility determination from the Universal Service Administrative Company (USAC), the Administrator of the Universal Service Fund (USF or Fund) programs, must obtain one by completing the FCC Form 460, including supporting documentation. The form and instructions are attached to this submission and can be found at <https://www.usac.org/rural-health-care/resources/forms/>. The approval for the information collection associated with the FCC Form 460 can be found in OMB Control No. 3060-0804.

Upon receipt of service and/or connected devices, approved applicants must submit requests for reimbursement that contain required certifications to the Commission, as well as invoices and supporting documentation. As noted below, the certifications on the reimbursement form have been updated. (See Attachment 3, Request for Reimbursement Form). For consortium applicants, funding recipients must include an authorization documentation (e.g., letter) from each participating eligible health care provider that authorizes the funding recipient to receive funding on their behalf and provide such funding to the eligible health care providers to reimburse them for their respective costs incurred under the COVID-19 Telehealth Program. Within six months after the conclusion of the COVID-19 Telehealth Program, COVID-19 Telehealth Program participants should provide a report to the Commission on the effectiveness of the COVID-19 Telehealth Program funding on health outcomes, patient

¹ CARES Act, Pub. L. No 116-136, 134 Stat. 281 (2020). The CARES Act appropriates \$200 million to the Commission “to support efforts of health care providers to address coronavirus by providing telecommunications services, information services, and devices necessary to enable the provision of telehealth services” during the pendency of the COVID-19 pandemic. *Id.*

treatment, health care facility administration, and any other relevant aspects of the pandemic. Additionally, there are reporting requirements under the CARES Act for recipients of COVID-19 Telehealth Program funds who receive more than \$150,000.

Connected Care Pilot Program

The Commission also established a Connected Care Pilot Program, as proposed in the *Connected Care Notice*, within the USF to examine how the Fund can help support the trend towards connected care services, particularly for low-income Americans and veterans. The Connected Care Pilot Program will help defray eligible health care providers' costs of providing connected care services, with a particular emphasis on supporting these services for eligible low-income Americans and veterans. We expect that the Connected Care Pilot Program will benefit many low-income and veteran patients who are responding to a wide variety of health challenges such as diabetes management, opioid dependency, high-risk pregnancies, pediatric heart disease, mental health conditions, and cancer.

Specially, all eligible non-profit and public health care providers that fall within the statutory categories under section 254(h)(7)(B) as listed above, regardless of whether they are non-rural or rural, can apply for the Connected Care Pilot Program. Eligible health care providers can receive support for the qualifying costs of providing connected care services to patients participating in their pilot projects. The Commission intends to target funding towards pilot projects that would primarily benefit low-income or veteran patients. The Connected Care Pilot Program will make available up to \$100 million to be committed over a three-year funding period and will be separate from the budgets of the existing USF programs. The Connected Care Pilot Program will provide funding for selected pilot projects to cover 85% of the eligible costs of broadband connectivity, network equipment, and information services necessary to provide connected care services to the intended patient population.

The Connected Care Pilot Program will help the Commission better understand how the USF can play a role in helping patients stay directly connected to health care providers through telehealth services and improve health outcomes among medically underserved populations that are missing out on these vital technologies. The Commission also expects that the Connected Care Pilot Program will provide meaningful data that will help us better understand how USF funds can support health care provider and patient use of connected care services, and how supporting health care provider and patient use of connected care services can improve health outcomes and reduce health care costs. The data and information collected through this Connected Care Pilot Program could also have the ancillary benefit of aiding policy makers and legislators in the consideration of broader reforms—such as statutory changes or updates to rules administered by other agencies—that could support this trend towards connected care.

In order to be selected to participate in the Connected Care Pilot Program, applicants must submit an application to the Commission for review and selection. A prospective health care provider must first obtain an eligibility determination from USAC by submitting an FCC Form 460 (*see link above*), including supporting documentation, to verify its eligibility to participate in the Connected Care Pilot Program. The Commission anticipates that successful applicants will be able to demonstrate that they have a viable strategic plan for delivering innovative connected care services directly to patients while leveraging existing resources or telehealth programs within their state or region.

Once selected to participate in the Connected Care Pilot Program, and prior to requesting funding, health care providers will be required to conduct a procurement process to solicit and select eligible services and/or equipment. Connected Care Pilot Program participants will also be required to submit a funding request to USAC with specific pricing and service

information for the funding they are requesting through the Connected Care Pilot Program. USAC will review the funding requests and issue funding commitment letters to the participating health care providers and service providers indicating the amount committed under the Connected Care Pilot Program for the selected pilot project. After providing the eligible services and/or equipment, service providers, in conjunction with the participating health care providers, will be required to make certain certifications and then submit invoicing forms on a monthly basis, along with supporting documentation, to USAC to receive reimbursement for the cost of the eligible services and/or equipment they have provided to participating health care providers under the Connected Care Pilot Program.

Additionally, there are reporting and record retention requirements under the Connected Care Pilot Program as well as certification requirements that eligible health care providers and service providers must comply and attest to in order to receive funding under the Connected Care Pilot Program.

To the extent possible, the Commission anticipates using the Healthcare Connect Fund Program forms for the Connected Care Pilot Program to ease program administration of the Connected Care Pilot Program. Thus, as part of this information collection, the Commission is also revising the Healthcare Connect Fund Program FCC Forms 460, 461, 462, and 463, to the extent necessary, to apply to the Connected Care Pilot Program consistent with the rules and requirements adopted for the Connected Care Pilot Program in the Report and Order. The Commission may use supplements or slightly modified versions of each FCC Form in order to simplify the process for the Connected Care Pilot Program and eliminate any confusion as to the applicable requirements for the Connected Care Pilot Program. Any supplements or revisions to the existing forms will only apply to Connected Care Pilot Program participants to capture information specific to the Connected Care Pilot Program and will not be extended to participants in the Health Care Connect Fund. The information on the FCC Form templates is a representative description of the information to be collected via an online portal and is not intended to be a visual representation of what each applicant or service provider will see, the order in which they will see information, or the exact wording or directions used to collect the information. Where possible, information already provided by applicants that currently participate in the Healthcare Connect Fund Program will be carried forward and auto-generated into the form to simplify the information collection for applicants.

Privacy Act: This information collection does not affect individuals or households. Therefore, there is no impact under the Privacy Act.

Statutory authority for this collection of information is contained in sections 1-4, 201-205, 214, 254, 303(r), and 403 of the Communications Act of 1934, as amended, 47 U.S.C. §§ 151-154, 201-205, 214, 254, 303(r), and 403, and DIVISION B of the Coronavirus Aid, Relief, and Economic Security Act, Pub. L. No 116-136, 134 Stat. 281.

COVID-19 TELEHEALTH PROGRAM

Revision of currently approved requirements in this information collection:

Minor revisions were made to the certifications on the application and reimbursement forms; everything else remains unchanged.

- a. COVID-19 Telehealth Program Application and Request for Funding. In order to receive funding under the COVID-19 Telehealth Program, eligible health care providers must submit an application to the Bureau electronically (See Attachment 1, COVID-19 Telehealth Program Application; Attachment 2, COVID-19 Telehealth Program Application Filing

Instructions) with sufficient information that will allow the Bureau to make selections and funding amount determinations. Specifically, to be considered for participation in the COVID-19 Telehealth Program, interested eligible health care providers must submit complete applications along with supporting documentation and required certifications. Additionally, applicants will also be required, at the time of submission of their applications, to make various certifications to ensure program integrity and compliance with all applicable COVID-19 Telehealth Program rules, requirements, and procedures, the CARES Act, and all applicable federal and state laws. These certifications must be made/signed by the authorized person (primary contact for the application) who is making the certifications.

This information collection requirement is being revised to update one certification to read (added words emphasized): “I certify under penalty of perjury that the health care provider(s) listed in the application, to the best of my knowledge, is not already receiving or expecting to receive other funding (*from any source, private, state, or federal*) for the exact same services or devices eligible for support under the COVID-19 Telehealth Program.”

- b. COVID-19 Telehealth Program Request for Reimbursement. This serves as the request to the Commission for disbursement of funding under the COVID-19 Telehealth Program for the eligible services and/or connected devices set forth by an applicant that received a funding commitment notification (funding recipient). Service providers or vendors will bill eligible health care providers directly for services and/or connected devices that they have provided participating eligible health care providers under the COVID-19 Telehealth Program. Under the COVID-19 Telehealth Program, disbursements will be issued directly to participating health care providers rather than to the service providers or vendors. Any funding received by a consortium applicant on behalf of the eligible health care provider(s) shall be provided to such health care provider(s) to reimburse them for their respective costs incurred under the COVID-19 Telehealth Program. Following the eligible health care provider’s receipt of eligible services and/or connected devices, and payment for the services and/or devices provided, in order to receive a reimbursement, funding recipients must on a monthly basis:
- Invoice the Commission for services and/or connected devices eligible for COVID-19 Telehealth Program funding through the U.S. Department of the Treasury’s Bureau of the Fiscal Service Invoice Processing Platform (IPP) <https://www.ipp.gov/>; and
 - Upload the following documents as “Attachments” to their invoice submission in the IPP: (a) a completed COVID-19 Telehealth Program Request for Reimbursement Form (*See Attachment 3, Request for Reimbursement Form, Attachment 4, Request for Reimbursement Form Instructions*); and (b) supporting documents that identify the eligible services and/or connected devices purchased and received, and price paid (e.g., invoices, vendor and service provider quotes identifying the costs, or other similar information and actual documentation of payment). Consortium funding recipients must include documentation (e.g., letter) from participating eligible health care providers that authorizes the funding recipient to receive funding on their behalf and provide this funding to the health care providers to reimburse them for their respective costs incurred under the COVID-19 Telehealth Program (*See Attachment 5, Sample Letter of Authorization*).

Both steps must be completed in order for eligible health care providers to receive reimbursement for expenses incurred under the COVID-19 Telehealth Program.

This information collection requirement is being revised to update several certifications to add the words “under penalty of perjury;” to update one certification to read (added words emphasized) “I certify under penalty of perjury that the health care provider(s) listed in the

application, to the best of my knowledge, is not already receiving or expecting to receive other funding (*from any source, private, state, or federal*) for the exact same services or devices eligible for support under the COVID-19 Telehealth Program.”; and to revise one certification to read (added words emphasized) “I certify under penalty of perjury *that I have read the instructions relating to reimbursements and* that the above costs were incurred and paid for in accordance with COVID-19 Telehealth Program rules and procedures, and I have attached the relevant supporting documents.”

This information collection is being revised with a non-substantive change to clarify that recipients may be required to report the status of their invoice submissions for the COVID-19 Telehealth Program, including, but not limited to, reason(s) why invoices have not been submitted to the Commission for the COVID-19 Telehealth Program, and an estimated timeframe for submission of reimbursement requests to the Commission for eligible items. This clarification does not increase funding recipients’ burden hours associated with this information collection.

- c. COVID-19 Telehealth Program Recordkeeping, Reporting, and Audits. All health care providers in the COVID-19 Telehealth Program must maintain required documentation for at least three years from the last date of delivery of the supported services and produce these records upon request of the Commission, any auditor appointed by the Commission, or of any other state or federal agency with jurisdiction. Within six months after the conclusion of the COVID-19 Telehealth Program, COVID-19 Telehealth Program participants should provide a report to the Commission on the effectiveness of the COVID-19 Telehealth Program funding on health outcomes, patient treatment, health care facility administration, and any other relevant aspects of the pandemic. Such information could include feedback on the application and invoicing processes, ways funding was helpful in providing or expending telehealth services, including anonymized patient accounts, how funding promoted innovation and improved health outcomes, and other areas for improvement. Funding recipients may provide metrics that they tracked in connection with their use of COVID-19 Telehealth Program funds.

This information collection is being revised to reflect the fact that recipients of COVID-19 Telehealth Program payments do not need to submit separate quarterly reports to the FCC or the Pandemic Response Accountability Committee. The FCC is working with the Department of Treasury to reflect the status of all COVID-19 Telehealth Program awards and payments on [USAspending.gov](https://www.usaspending.gov). Posting the data to [USAspending.gov](https://www.usaspending.gov) meets the reporting requirements of the CARES Act per guidance from the Office of Management and Budget. (See [Appendix A of OMB Memo M-20-21](#), Implementation Guidance for Supplemental Funding Provided in Response to the Coronavirus Disease 2019 (COVID-19)).

Pursuant to the CARES Act, not later than 10 days after the end of each calendar quarter, each entity recipient that receives COVID-19 Telehealth Program funds of more than \$150,000 must submit to the FCC and the Pandemic Response Accountability Committee (Committee) a report that contains—(A) the total amount of large covered funds received from the agency; (B) the amount of large covered funds received that were expended or obligated for each project or activity; (C) a detailed list of all projects or activities for which large covered funds were expended or obligated, including—(i) the name of the project or activity; (ii) a description of the project or activity; and (iii) the estimated number of jobs created or retained by the project or activity, where applicable; and (D) detailed information on any level of subcontracts or subgrants awarded by the covered recipient or its subcontractors or subgrantees, to include the data elements required to comply with the

Federal Funding Accountability and Transparency Act of 2006² (31 U.S.C. 6101 note) allowing aggregate reporting on awards below \$50,000 or to individuals, as prescribed by the Director of the Office of Management and Budget. (3) Not later than 30 days after the end of each calendar quarter, the Committee, in consultation with the agency that made large covered funds available to any covered recipient shall make the information in reports submitted under paragraph (2) publicly available by posting the information on the website established under section 15010(g).

For a consortium, the Consortium Leader is responsible for compliance with the recordkeeping requirements. Health care providers may also be subject to compliance audits to ensure that participants are complying with the COVID-19 Telehealth Program certification requirements.

This information collection requirement is being revised to include the requirement, pursuant to the *Report and Order*, that COVID-19 Telehealth Program participants should provide a report to the Commission on the effectiveness of the COVID-19 Telehealth Program funding on health outcomes, patient treatment, health care facility administration, and any other relevant aspects of the pandemic within six months after the conclusion of the COVID-19 Telehealth Program.

CONNECTED CARE PILOT PROGRAM

New information collection requirements:

The following are proposed new information collection requirements associated with the Connected Care Pilot Program:

- a. Connected Care Pilot Program Application. To participate in the Connected Care Pilot Program, an eligible health care provider must submit an application to the Commission electronically describing, among other things, its proposed pilot project and how the pilot project will use connected care services to serve the health care needs of participating patients. As part of the application submission process, applicants may be required to create and use a username and password to submit the application. The below descriptions are a representative description of the information to be collected on the application and are not intended to be a visual representation of what each applicant will see, the order in which they will see information, or the exact wording or directions used to collect the information.

Interested parties seeking to participate in the Connected Care Pilot Program must submit applications that, at a minimum, contain the following required information:

- Applicant Name
- Applicant Login (e.g., FCC Registration Number)
- Applicant National Provider Identifier (NPI) (unique health care provider identifier)
- Description of whether the health care provider is applying as an individual entity or applying as a consortium (on behalf of multiple sites). If applying as a consortium, description of whether consortium is a health system, and if so, name and address of health system main corporate location.

² Federal Funding Accountability and Transparency Act of 2006 (FFATA), Pub. L. No 109-282, 120 Stat. 1186-1190 (2006), as amended by the Digital Accountability and Transparency Act of 2014 (DATA Act), Pub. L. No. 113-101, 128 Stat. 1146 (2014).

- Characteristics about health care provider (e.g., size, number of employees)
- Names and addresses of all health care providers sites that will participate in the proposed pilot project and the lead entity or lead health care provider for proposals involving multiple health care providers.
- Contact information for the individual submitting the application and the individual that will be responsible for the management and operation of the proposed pilot project (name, organization and position, telephone number, mailing address, and email address).
- Health Care Provider Nos., eligibility type(s) (e.g., not-for-profit hospital, community mental health center, community health center, rural health clinic), and National Provider Identifier, for each participating health care provider site and description of whether the FCC Form 460 has been filed and an eligibility determination made for each participating site, including the lead entity or lead health care provider for applications involving multiple health care providers.
- Service Location (name of state(s) where connected care services will be provided)
- Description of each participating health care provider's previous experience with providing telehealth services (other than electronic health records) or experience and name of a partnering health care provider or organization.
- Description of the plan for implementing and operating the pilot project, including how the pilot project intends to recruit patients, number of health care provider sites that will be involved in treating patients with program funding, estimated amount of ramp-up time necessary to implement the proposed pilot project (not to exceed six months), plans to obtain any necessary end-user devices (e.g., tablets, smartphones) and medical devices for the connected care services that the pilot project will provide, and to what extent the pilot project can be self-sustaining once established.
- Description of the connected care services the proposed pilot project will provide, the conditions to be treated, the health care provider's experience with treating those conditions, the goals and objectives of the proposed pilot project (including the health care provider's anticipated goals with respect to reaching new or additional patients, and improved patient health outcomes), expected health care benefits to the patients, health care provider, or the health care industry that will result from the proposed pilot project, and how the pilot project will achieve each of the goals of the Connected Care Pilot Program.
- Documentation of the participating health care provider(s)'s financial health (e.g., recent audited balance sheets and income statements that are no more than two years old).
- Description of whether the health care provider site is in a rural or non-rural area.
- Description of whether the health care provider(s) will primarily serve patients in rural areas, and if so, the counties where patients will be served.
- Description of the total patient population for all health care provider sites included in the application.
- Description of the estimated number of patients to be treated.
- Description of any commitments from community partners, including physicians, hospitals, health systems, and home health/community providers to the success of the proposed pilot project.

- Description of the anticipated level of broadband service required for patients participating in the proposed pilot project, including the necessary speeds, the technologies to be used (e.g., mobile or fixed broadband) and any other relevant service characteristics (e.g., LTE service).
- Description of the estimated number of patient broadband connections that the health care provider intends to purchase for purposes of providing connected care services to patients who lack broadband service or have insufficient broadband services, and, if known, estimated percentage of patients that lack level of broadband service required for telehealth services. This description must include an explanation of how the health care provider plans to assess whether a patient lacks broadband service or has insufficient broadband Internet access service for the indicated connected care service based on speed, technology, or data cap limitations. This description must also include a description of the measures or mechanisms the health care provider will use to verify that participating patients are using the supported broadband service primarily for activities that are integral, immediate, and proximate to the provision of connected care services.
- If seeking support for an information service used to provide connected care, other than broadband connectivity, a description of the service, including a description of the primary function/s of the service, and whether it facilitates the capturing, transmission, and storage of data for connected care, and how it is integral to the pilot project.
- Estimated total project costs, including costs eligible for support through the Connected Care Pilot Program and costs not eligible for Connected Care Pilot Program support but still necessary to implement the proposed pilot project. This entry must provide sufficient detail to identify the costs for each eligible service or network equipment for which funding would be requested through the Connected Care Pilot Program, description of expense, quantity, unit cost, recurring costs, and must include the total estimated eligible funding (85%) to be requested from the Connected Care Pilot Program per year over the three-year funding period.
- A list of anticipated sources of financial support for the pilot project costs not covered by the Connected Care Pilot Program, including the applicant's share of eligible costs.
- Description of the metrics for the proposed pilot project that are relevant to the Connected Care Pilot Program goals and how the participating providers will collect those metrics. Examples of the types of metrics include: number of participating patients, number of patient encounters through telehealth, reductions in potential emergency room or urgent care visits; reductions in hospital admissions or readmissions; condition-specific outcomes, such as reductions in premature births or acute incidents among sufferers of a chronic illness. Selected pilot projects may be asked to track and report additional metrics relevant to the performance and outcomes of each project. Illustrative examples of these additional metrics include number of patients treated using Pilot Program funding, number of telehealth encounters using Pilot Program funding, number of patients retained in treatment at 30, 60, and 90 days and at one year, patient travel miles saved, patient compliance with care plan, increase in patient knowledge of care, patient comfort with telehealth applications and procedures, patient satisfaction with their overall health status, provider comfort with telehealth application and procedures, and provider satisfaction with delivery method.

- Description of how the health care provider intends to collect, track, and store, the required Connected Care Pilot Program data.
- Description of whether any health care providers that would participate in the proposed pilot project applied for and were awarded funding through any other FCC Program including the FCC's COVID-19 Telehealth Program, and if so, a description of how the other FCC Program funding was used, and how the request for funding through the Connected Care Pilot Program is different.
- Further, applicants are asked to provide the following information, as applicable: Description of whether the pilot project will primarily benefit low-income or veteran patients, and if so, the estimated number or percentage of those patients the project will serve compared to the total number of patients that the pilot project estimates serving.
- Description of whether each health care provider site listed in the application is located in a rural area, on Tribal lands, is associated with a Tribe, or part of the Indian Health Service. If the health care provider site is not located in a rural area, include a description of whether the health care provider will primarily serve veterans or low-income patients located in rural areas as defined in the RHC Program rules, and identify those specific rural areas.
- Listing of all Department of Health and Human Services, Health Resources & Services Administration (HRSA) designated Health Professional Shortage Areas (for primary care or mental health care only) or HRSA designated Medically Underserved Areas that will be served by the proposed project.
- Description of whether the primary purpose of the proposed pilot project is to provide connected care services to respond to a public health epidemic, including infectious diseases, or to provide connected care services for opioid dependency, high-risk pregnancy/maternal mortality, mental health conditions (e.g., substance abuse, depression, anxiety disorders, schizophrenia, eating disorders, and addictive behavior), or conditions of a chronic or long term nature (including, but not limited to heart diseases, diabetes, cancer, stroke).

Applicants may also provide additional information relevant to the consideration of their application, including, but not limited to, information on existing strains on the submitting health care providers' resources, healthcare shortages in the areas the proposed project would serve, the need for funding, or whether the project may need a waiver of any applicable FCC rules in order to participate in the Pilot Program.

Additionally, applicants will also be required, at the time of submission of their applications, to make various certifications to ensure program integrity and compliance with all applicable Connected Care Pilot Program rules, requirements, and procedures, and all applicable federal and state laws. Selected applicants will be required to make these certifications in connection with submitting the FCC Forms 461, 462, and 463, to the extent not already included on the required program forms applicable to the Connected Care Pilot Program identified in this Supporting Statement. These certifications must be made/signed by the authorized person (primary contact for the application) who is making the certifications. These certifications include:

- Certification under penalty of perjury of authorization to submit this application on behalf of the health care provider(s) listed in the application.

- Certification under penalty of perjury to the best of the person's knowledge, information, and belief, all information contained in this application, and in any attachments, is true and correct.
 - Certification of acknowledgement and under penalty of perjury that, if selected, the health care provider(s) in the application must comply with all applicable Connected Care Pilot Program rules, requirements and procedures, including the requirement to pay 15% of the costs for supported items from eligible sources, and all applicable federal and state laws, including the Americans with Disabilities Act, the Rehabilitation Act, the False Claims Act, the Anti-Kickback Statute, and the Civil Monetary Penalties Law.
 - Certification of acknowledgement and under penalty of perjury that, if selected, the health care providers in the application will comply with the applicable Health Insurance Portability and Accountability Act (HIPAA) requirements and other applicable privacy and reimbursement laws and regulations, and applicable medical licensing laws.
 - Certification of acknowledgement and under penalty of perjury that if selected, all documentation associated with this application must be retained for a period of at least five years after the conclusion of the participating pilot project to demonstrate compliance with the Connected Care Pilot Program rules, requirements and procedures, subject to audit.
 - Certification under penalty of perjury that the health care provider(s) listed in the application, to the best of the person's knowledge, is not already receiving or expecting to receive other funding (from any source, private, state, or federal) for the exact same services and/or equipment eligible for support under the Connected Care Pilot Program.
 - Certification of acknowledgement and under penalty of perjury that all requested equipment and services funded under the Connected Care Pilot Program must be used for their intended purposes.
- b. FCC Form 460 Attachment – State/Non-Profit Entities that Want to Serve as Both Vendor and Consortium Leader/Consultant (Consortia Only). In general, an entity may not simultaneously: (1) provide consulting assistance to a consortium and (2) participate as a potential vendor during the competitive bidding process. State organizations, public sector entities, or non-profit entities who wish to obtain an exemption from this prohibition may make a showing to USAC that they have set up an organizational and functional separation. The exemption must be obtained before the consortium begins preparing its FCC Form 461 and associated documents.
- c. Agreement Regarding Legal/Financial Responsibility for Consortium Activities (Consortia Only). Consortia may allocate legal and financial responsibility for supported program activities as they see fit, except for certain responsibilities specified in the *Healthcare Connect Fund Order* (FCC 12-150) provided that this allocation is memorialized in a formal written agreement between the affected parties (i.e., the Consortium Leader, and the consortium as a whole and/or its individual members). The written agreement must be submitted to USAC for approval with or prior to the submission of the FCC Form 461. The agreement should clearly identify the party(ies) responsible for repayment if USAC is

required, later, to recover disbursements to the consortium due to violations of RHC Program rules.

- d. FCC Form 461 – Request for Services (Competitive Bidding). All health care providers selected to participate in the Pilot Program, unless their funding request is subject to a competitive bidding exemption, must submit a request for services (See Attachment 6, FCC Form 461 – Request for Services) and associated documents for posting by USAC, wait at least 28 days before selecting a service provider, and select the most cost-effective bid. On the FCC Form 461, applicants must provide sufficient information to enable bidders to reasonably determine the needs of the applicant, such as information regarding the health care provider(s) (including contact information for potential bidders), a list of the services and/or equipment for which the site is requesting bids (e.g., Internet access, network equipment), competitively neutral requirements for the services for which bids are sought (e.g., bandwidth), and evaluation criteria for bids. Applicants should be able to demonstrate that price of the eligible services and/or equipment is a primary factor in their service provider selection process.

Selected participants are also required to submit a number of certifications as reflected on the FCC Form 461 (See Attachment 6, FCC Form 461 – Request for Services) demonstrating compliance with the Commission’s rules and procedures. For the Connected Care Pilot Program, however, there is no requirement that the health care provider be located in a rural area or a member of a consortium which satisfies the majority-rural composition requirements. Further, applicants under the Connected Care Pilot Program must certify that the requested Connected Care Pilot Program support will be used for its intended purposes under the Connected Care Pilot Program rules. Additionally, if applicable, applicants must submit a declaration of assistance identifying each and every consultant, vendor, or other outside expert, whether paid or unpaid, who aided in the preparation of their applications and describe the nature of their relationship with the consultant, vendor, or other outside expert providing the assistance. Also, there is no funding year requirement for the Connected Care Pilot Program and certifications that are only specific to the RHC Program rules do not apply to the Connected Care Pilot Program. In submitting the FCC Form 461, Pilot Program participants may be required to indicate that they are participating in the Pilot Program and may be required to submit a supplement identifying the pilot project and providing information on the Pilot Program eligible items being requested (e.g., category of item for which funding is sought, cost, location, requested service period (maximum of three years)).

- e. FCC Form 461 Attachment – Request for Proposals (RFP). Submission of a separate RFP document with the FCC Form 461 is required for: (1) applicants who are required to issue an RFP under applicable state, Tribal, or local procurement rules or regulations; (2) consortium applications that seek more than \$100,000 in program support per year; and (3) consortium applications that seek support for services. In addition, all applicants who utilize an RFP in conjunction with their competitive bidding process must submit the RFP to USAC for posting. An applicant must specify on its bid evaluation worksheet and/or scoring matrix the requested services and/or equipment for which it seeks bids, the information provided to bidders to allow bidders to reasonably determine the needs of the applicant and provide responsive bids, what the applicant’s minimum requirements are for each specified criteria, and also record on the bid evaluation worksheet or matrix each service provider’s proposed service levels for the established criteria. The applicant must also specify its disqualification factors, if any, that the applicant will use to remove bids or bidders from further consideration. Applicants shall also provide full details of any arrangement involving the

purchasing of service/s and/or equipment as part of an aggregated purchase with other entities or individuals.

FCC Form 462 – Request for Funding. Within six months of being notified of selection to participate in the Pilot Program, selected applicants must submit an FCC Form 462 (See Attachment 7, FCC Form 462 – Request for Funding) and supporting documentation to provide information about the services and/or equipment and service providers or vendors selected, and certify, among other certifications, that the services and/or equipment was the most cost-effective offers received (including documentation to support its certification that it has selected the most cost-effective option). The FCC Form 462 is the means by which an applicant identifies the location(s), service(s), rates, service provider(s), and date(s) of service provider selection. Information requested on the FCC Form 462 related to a funding year, circuit ID, fiber leases or similar agreements is not applicable to the Connected Care Pilot Program as well as potentially requested information regarding circuits, and certifications that are specific to the RHC Program. Also, there is no Funding Year requirement for the Connected Care Pilot Program. In submitting the FCC Form 462, selected participants may be required to indicate that they are participating in the Pilot Program and may be required to submit a supplement identifying the pilot project and providing information on the specific items for which Pilot Program funding is requested (e.g., category of item for which funding is sought, cost, location, requested service period (maximum of three years)).

- f. FCC Form 462 Attachment – Competitive Bidding Documents. Connected Care Pilot Program applicants must submit documentation to support their certifications that they have selected the most cost-effective option. Relevant documentation includes a copy of each bid received (winning, losing, and disqualified), the bid evaluation criteria, and any other related documents, such as bid evaluation sheets; a list of people who evaluated bids (along with their title/role/relationship to the applicant organization); memos, board minutes, or similar documents related to the service provider or vendor selection/award; copies of notices to winners; and any correspondence with service providers or vendors during the bidding/evaluation/award phase of the process.

If the application is exempt from competitive bidding, the applicant should submit sufficient documentation to allow USAC to verify that the applicant is eligible for the exemption. In addition to the exemptions provided to applicants under the Healthcare Connect Fund Program, Connected Care Pilot Program applicants are also exempt from the competitive bidding requirements if the eligible health care provider has already entered into a legally binding agreement with a service provider and/or vendor for the services or equipment eligible for support in the Connected Care Pilot Program and that legally binding agreement itself was the product of competitive bidding. Thus, for the Connected Care Pilot Program only, health care providers that claim a competitive bidding exemption for an existing contract will need to submit a copy of that contract and documentation concerning the competitive bidding process underlying the contract.

- g. FCC Form 462 Attachment – Contracts or Similar Documentation. Applicants must submit a contract or other documentation that clearly identifies: (1) the vendor(s) or service provider(s) selected and the health care provider(s) who will receive the services and/or equipment; (2) the service and/or equipment, bandwidth, and costs for which support is being requested; and (3) the term of the service agreement(s) if applicable (i.e., if services are not being provided on a month-to-month basis).
- h. FCC Form 462 Attachment – Cost Allocation Method for Ineligible Components. Applicants who seek to obtain support for services and/or equipment that include both eligible and

ineligible components, should submit a written description of their allocation method(s) to USAC with their funding requests.

- i. FCC Form 462 Attachment – Evidence of Viable Source for 15 Percent Contribution. All consortium applicants must submit, with their funding requests, evidence of a viable source for their 15% contribution (unlike for funding requests in the Healthcare Connect Fund Program, which requires a 35% contribution).
- j. Authorization for Third Parties to Submit FCC Forms on Behalf of HCP/Consortium. Third parties (for example, consultants) may submit FCC Forms and other documentation on behalf of eligible health care providers if USAC receives, prior to submission of the FCC forms or documentation, a written, dated, and signed authorization from the relevant officer, director, or other authorized employee stating that the health care provider or Consortium Leader accepts all potential liability from any errors, omissions, or misrepresentations on the forms and/or documents being submitted by the third party. Applicants must also submit a declaration of assistance with their request for services and/or equipment (FCC Form 461) and request for funding (FCC Form 462) identifying each and every consultant, vendor, or other outside expert, whether paid or unpaid, who aided in the preparation of their applications and, as part of this declaration, applicants must describe the nature of their relationship with the consultant, vendor, or other outside expert providing the assistance. Additionally, an individual who has been identified as the applicant's consultant or other outside expert must provide to USAC, as part of the consultant registration process, his or her name and contact information, the name and contact information of the consulting firm or company that employs him or her, and a brief description of the role he or she will undertake in assisting the applicant. Once this information is provided, USAC will issue a unique registration number to the consultant or outside expert and that number will be linked to the applicant's organization.
- k. FCC Form 463 – Invoicing. Service providers and vendors bill health care providers directly for services and/or equipment that they have provided. Upon receipt of a service provider's or vendors' bill, the health care provider must create and approve an invoice for USAC on the FCC Form 463 (See Attachment 8, Description of Request for Funding Disbursement), on a monthly basis, for the services and/or equipment it has received along with supporting documentation. For the Connected Care Pilot Program, on the invoice, the health care provider or Consortium Leader must certify to USAC that it has paid its 15% contribution directly to the service provider and the health care provider and service provider must certify that they have reviewed the invoice and that it is accurate. USAC will review the monthly invoicing forms and supporting documentation and issue disbursements to the applicable service providers or vendors based on the invoice.

For consortia, the Consortium Leader is responsible for the invoicing process, including certifying that the participant contribution has been paid and that the invoice is accurate. Connected Care Pilot Program participants will also be required to make certifications as part of the form submissions to USAC to ensure that Connected Care Pilot Program funds are used for their intended purpose and to ensure that all participating health care providers and service providers are in compliance with the Commission's rules and procedures for the Pilot Program. In addition, Connected Care Pilot Program participants may be required to indicate that they are participating in the Pilot Program and submit a supplemental cost sheet providing information on the expenses specifically related to the Connected Care Pilot Program.

- l. Site and Service Substitutions. A consortium leader or health care provider may request a site and service substitution using the Post-Commitment Request Form (*See Attachment 11, Post-Commitment Request Form*) if: (1) the substitution is provided for in the contract, within the change clause, or constitutes a minor modification; (2) the site is an eligible health care provider and the service is an eligible service under the Connected Care Pilot Program; (3) the substitution does not violate any contract provision or state, Tribal or local procurement laws; and (4) the requested change is within the scope of the controlling request for services and/or equipment, including any applicable RFP used in the competitive bidding process. Additionally, support is restricted to qualifying site and service substitutions that do not increase the total amount of support under the applicable funding commitment. Health care providers are required to file requests for site and service substitutions with USAC by no later than the applicable service and/or equipment delivery deadline. Health care providers must provide a narrative and any relevant documents to support its request.
- m. Service Provider Identification Number (SPIN) Changes. A SPIN is a unique number that USAC assigns to an eligible service provider seeking to participate in the universal service support mechanisms. When requesting funding under the Connected Care Pilot Program, an applicant must use the SPIN to identify its chosen service provider when filing an FCC Form 462. An applicant may change the SPIN on its FCC Form 462 by filing the Post-Commitment Request Form. *See Attachment 11 (Post-Commitment Request Form)*. A SPIN change may either be classified as a “corrective” SPIN change or an “operational” SPIN change. A “corrective” SPIN change is any “amendment to the SPIN associated with a Funding Request Number that does not involve a change to the service provider associated with that Funding Request Number.” An applicant may request a “corrective” SPIN change if the applicant is: (1) correcting data entry errors (e.g., fixing clerical errors such as naming the correct service provider in the funding request but providing the incorrect SPIN); (2) updating a service provider’s SPIN that has changed due to the merger of companies or the acquisition of one company by another; or (3) effectuating a change that was not initiated by the applicant. An “operational” SPIN change is “any change to the service provider associated with a specific Funding Request Number.” An applicant may request an “operational” SPIN change in situations where: (1) the applicant has a legitimate reason to change providers (e.g., breach of contract or the service provider is unable to perform); and (2) the applicant’s newly selected service provider received the next highest point value in the original bid evaluation, assuming there were multiple bidders. Applicants must file requests for either a “corrective” or “operational” SPIN change by no later than the service delivery deadline. Applicants must provide a narrative and any documents to support its request.
- n. Connected Care Pilot Program Audits and Recordkeeping. All health care providers participating in the Connected Care Pilot Program must maintain required documentation for at least five years after the conclusion of their respective pilot projects and produce these records upon request of the Commission, any auditor appointed by USAC or the Commission, or of any other state or federal agency with jurisdiction. For a consortium, the Consortium Leader is responsible for compliance with the Commission’s recordkeeping requirements. Service providers are also required to retain documentation related to the delivery of discounted services and/or equipment for at least five years after the conclusion of its pilot project. . Service providers must also retain any other document that demonstrates compliance with the statutory or regulatory requirements for the rural health care mechanism. Consistent with section 47 CFR 54.631 of the Commission’s rules, pilot projects will also be subject to random compliance audits to ensure compliance with the Connected Care Pilot Program rules and requirements.

- o. Connected Care Pilot Program Reporting Requirement. All health care providers in the Connected Care Pilot Program are required to submit periodically anonymized, aggregated data to the Bureau regarding their pilot project after each year of funding. Participating health care providers will also be required to submit final reports within six months of the end dates of their pilot projects summarizing the final results and explaining whether the pilot projects met their stated goals and the goals of the Connected Care Pilot Program.

REQUIREMENTS APPLICABLE TO BOTH THE COVID-19 TELEHEALTH PROGRAM AND CONNECTED CARE PILOT PROGRAM

Currently approved requirements (no revisions):

- p. FCC Form 460 – Eligibility Determination and Consortium Information. Program applicants that do not already have an eligibility determination from USAC are required to file an FCC Form 460 (See Attachment 9, FCC Form 460 – Description of Eligibility and Registration) and Letter of Agency (LOA) which is currently used to determine eligibility under the Healthcare Connect Fund Program, with USAC in order to certify that they are eligible to receive funding through the COVID-19 Telehealth Program.³ Applicants are required to provide basic information about the individual health care provider (such as address and contact information, etc.), the eligible health care provider type, and a brief explanation as to why the health care provider is eligible under the Act. Applicants who seek an eligibility determination as a community mental health center must use the Community Mental Health Center (CMHC) Checklist to verify eligibility under this health care provider category. See Attachment 10, CMHC Checklist. The FCC Form 460 also requires applicants to make various certifications under penalty of perjury to the accuracy of the information provided on the FCC Form 460. These certifications also apply to both the COVID-19 Telehealth Program and the Connected Care Pilot Program except that applicants under the COVID-19 Telehealth Program are only required to maintain documentation for a period of three years and there is no requirement under both Programs that the health care provider be located in a rural area or be a member of a consortium if located in a non-rural area.

Applicants may also be required to provide a unique health care provider identifying number, such as a National Provider Identifier code and/or taxonomy code. Consortium applicants may file an FCC Form 460 on behalf of member health care providers if they have a LOA (discussed below). The FCC Form 460 is also used to provide certain basic information about consortia to USAC: (1) the lead entity (“Consortium Leader”); (2) the individual contact person within the lead entity (the “Project Coordinator”); and (3) health care provider sites that will participate in a consortium. Applicants that are interested in the COVID-19 Telehealth Program but do not yet have an eligibility determination can still file their applications with the Commission for the COVID-19 Telehealth Program while their FCC Form 460 is pending with USAC.

- q. FCC Form 460 Attachment – Letters of Agency (LOA) (Consortia Only). Each Consortium Leader must obtain a LOA from each health care provider participant that is independent of the Consortium Leader (*i.e.* health care provider sites that are not owned or otherwise

³ The Commission received OMB approval of the FCC Form 460 as part of the Rural Health Care Program information collection requirements under OMB 3060-0804. Any OMB approved revisions to FCC Form 460 also apply to the Pilot Program because selected Pilot Program participants are subject to the eligibility requirements of the Healthcare Connect Fund Program, except the certification requirement as outlined above. Therefore, in this information collection, we are extending the FCC Form 460 information collection requirements approved under OMB 3060-0804 to the Pilot Program under this information collection, OMB 3060-1271.

controlled by the Consortium Leader). The LOA is submitted as an attachment to the FCC Form 460. The purpose of the LOA is to provide authority for the Consortium Leader to submit the FCC Form 460 and request for funding on behalf of the health care provider. Consortium leaders are required to obtain supporting information and/or documents to support eligibility for each health care provider when they collect the LOA, and may be asked for this information during an audit or investigation.

2. **Use of information.** The information collected herein is necessary in order to facilitate the Commission's and USAC's administration of the Programs, and to determine if entities are complying with the Commission's rules, and to prevent waste, fraud, and abuse. The information also will allow the Commission to evaluate the extent to which the Programs are complying with the applicable rules and procedures for each program. The Name, Address, DUNS Number and Business Type will be disclosed in accordance with the FFATA/DATA Act reporting requirements as part of the COVID-19 Telehealth Program, and awards and disbursement amounts under the COVID-19 Telehealth Program and the Connected Care Pilot Program will be publicly available.
3. **Use of automated, electronic, mechanical, or other technological collection techniques or other forms of information technology.** In an effort to reduce any burden created by these information collection requirements, respondents will be required to submit their applications electronically. The filing process for the COVID-19 Telehealth Program can be found at <https://www.fcc.gov/document/guidance-covid-19-telehealth-program-application-process>, and the application process for the Connected Care Pilot Program will be announced in a public notice.
4. **Efforts to identify duplication.** There will be no duplication of information. The information sought is unique to each respondent and similar information is not already available. The Commission does not otherwise collect this information from health care providers.
5. **Impact on small businesses or other small entities.** Entities directly subject to the requirements of this information collection are eligible health care providers and consortia comprised of eligible health care providers. This information collection is designed to impose the least possible burden on the respondents while ensuring that the Commission has the information necessary to select applicants to ultimately receive funding under the Programs. Specifically, the Commission has limited the information requirements to those necessary for the purposes for which the information will be used.
6. **Consequence if information is not collected.** Failing to collect the information would prevent the Commission from implementing the Programs and prevent eligible health care providers from receiving support under the Programs. Specifically, these requirements are also necessary to ensure that the public funds intended to provide relief from the COVID-19 pandemic are used in compliance with the CARES Act and other applicable requirements, and that Universal Service Fund dollars for the Connected Care Pilot Program are used in compliance with the applicable FCC rules and requirements. Without the requested information, the Commission and USAC will not be able to assess the applicant eligibility and the extent to which funds are properly used. These requirements are also necessary to ensure that funding is being used in compliance with each program's rules and procedures, and other applicable requirements.
7. **Special circumstances.** There are no special circumstances associated with this information collection.
8. **Federal Register notice; efforts to consult with persons outside the Commission.** The Commission published a notice pursuant to 5 CFR § 1320.8(d), in the Federal Register on June

16, 2020 to solicit public comment on the revised collection, 85 FR 36406, June 16, 2020. No comments were received.

9. **Payments or gifts to respondents.** The Commission does not anticipate providing any payment or gifts to respondents.
10. **Assurances of confidentiality.** The Name, Address, DUNS Number and Business Type will be disclosed in accordance with the FFATA/DATA Act reporting requirements as part of the COVID-19 Telehealth Program. Also, the COVID-19 Telehealth Program award and disbursement amounts will be made public. We intend to keep other information submitted under the COVID-19 Telehealth Program confidential to the extent permitted by law. There is no assurance of confidentiality provided to respondents as part of the Connected Care Pilot Program, the selected applicants and estimated funding will be made public. Respondents under both programs may request materials or information submitted to the Commission to be withheld from public inspection under 47 CFR § 0.459 of the Commission's rules.
11. **Questions of a sensitive nature.** This information collection does not address any private matters of a sensitive nature.
12. **Estimates of the hour burden of collection to respondents.** The following represents the hour burden on the collection of information:

COVID-19 TELEHEALTH PROGRAM

a. COVID-19 Telehealth Program Application and Request for Funding

Number of Respondents: Approximately 7,300 applicants.

Frequency of Response: Occasional requirement.

Total Number of Responses Annually: 7,300.

Total Annual Hourly Burden: 109,500 hours. The Commission estimates that this requirement will take approximately 15 hours per submission. 7,300 submissions x 15 hours = 109,500 hours.

Total Estimate of In-House Cost to the Respondents: \$4,380,000 = 109,500 hours x \$40/hour. The Commission estimates that respondents will use a staff person compensated at approximately \$40 per hour.

b. COVID-19 Telehealth Program Request for Reimbursement

Number of Respondents: Approximately 6,158 respondents.

Frequency of Response: Occasional requirement.

Total Number of Responses Annually: 6,158.

Total Annual Hourly Burden: 6,158 hours. The Commission estimates that this requirement will take, on average, approximately 1 hour for applicants per submission. The number of burden hours will vary based on the number of line items included in a funding request. 6,158 submission x 1 hour = 6,158 hours.

Total Estimate of In-House Cost to the Respondents: \$246,320 = 6,158 hours x \$40/hour. The Commission estimates that respondents will use a staff person compensated at approximately \$40 per hour.

c. COVID-19 Telehealth Program Recordkeeping, Reporting, and Audits

Number of Respondents: Approximately 6,158 respondents.

Frequency of Response: Occasional and one-time requirement.

Total Number of Responses Annually: 6,158.

Total Annual Hourly Burden: 49,264 hours. The Commission estimates that this requirement will take approximately 8 hours annually per submission. 6,158 submissions x 8 hours = 49,264 hours.

Total Estimate of In-House Cost to the Respondents: \$1,970,560 = 49,264 hours x \$40/hour. The Commission estimates that respondents will use a staff person compensated at approximately \$40 per hour.

CONNECTED CARE PILOT PROGRAM

d. Connected Care Pilot Program Application

Number of Respondents: Approximately 200 applicants. We estimate that the number of respondents under the Connected Care Pilot Program will be a subset of the number of unique respondents under the COVID-19 Telehealth Program. Although there may be applicants who apply to the Connected Care Pilot Program that did not participate in the COVID-19 Telehealth Program, we likewise expect that there will be respondents who applied for the COVID-19 but do not apply for the Connected Care Program. Therefore, we estimate that the number of respondents will not exceed the previously estimated number of unique respondents.

Frequency of Response: Occasional requirement.

Total Number of Responses Annually: 200.

Total Annual Hourly Burden: 5,000 hours. The Commission estimates that this requirement will take approximately 25 hours per submission. 200 submissions x 25 hours = 5,000 hours.

Total Estimate of In-House Cost to the Respondents: \$200,000 = 5,000 hours x \$40/hour. The Commission estimates that respondents will use a staff person compensated at approximately \$40 per hour.

e. FCC Form 460 Attachment – State/Non-Profit Entities that Want to Serve as Both Vendor and Consortium Leader/Consultant (Consortia Only)

Number of Respondents: Approximately 37 state government or non-profit entities.

Frequency of Response: One-time reporting requirement.

Total Number of Responses Annually: 5. The Commission estimates that of the possible respondents, approximately 5 may make this submission annually.

Total Annual Hourly Burden: 10 hours. The Commission estimates that this requirement will take approximately 2 hours per submission. 5 submissions x 2 hours = 10 hours.

Total Estimate of In-House Cost to the Respondents: \$400 = 10 hours x \$40/hour. The Commission estimates that respondents will use a staff person compensated at approximately \$40 per hour.

f. Agreement Regarding Legal/ Financial Responsibility for Consortium Activities (Consortia Only)

Number of Respondents: Approximately 3 consortia of health care providers.

Frequency of Response: One-time reporting requirement.

Total Number of Responses Annually: 3.

Total Annual Hourly Burden: 30. The Commission estimates that this requirement will take approximately 10 hours per submission. 3 submissions x 10 hours = 30 hours.

Total Estimate of In-House Cost to the Respondents Costs: \$2,340. The Commission anticipates that consortia may engage in-house counsel (attorneys) to prepare this agreement comparable in pay to the Federal government at a GS-15, Step 5, at \$78 per hour (rounded up). We acknowledge the possibility that some respondents may engage outside counsel, but do not include an estimate for use of such counsel given that we are unable to determine this information with certainty 30 hours x \$78/hour = \$2,340.

g. FCC Form 461 – Request for Services (Competitive Bidding)

Number of Respondents: Approximately 200 individual and consortium applicants.

Frequency of Response: Annual requirement.

Total Number of Responses Annually: 120. Applicants who can utilize a competitive bidding exemption do not need to submit an FCC Form 461 to receive support. The Commission estimates that approximately 40% of applicants on average will utilize a competitive bidding exemption, so only 60% of applicants will need to submit an FCC Form 461. 60% of 200 applicants = 120 responses.

Total Annual Hourly Burden: 240 hours. The Commission estimates that this requirement will take approximately 2 hours per submission. 120 submissions x 2 hours = 240 hours.

Total Estimate of In-House Cost to the Respondents: \$9,600 = 240 hours x \$40/hour. The Commission estimates that respondents will use a staff person compensated at approximately \$40 per hour.

h. FCC Form 461 Attachment – Request for Proposals (RFP)

Number of Respondents: Approximately 180 individual and consortium applicants.

Frequency of Response: Annual requirement.

Total Number of Responses Annually: 180. Not all applicants are required to submit an RFP. The Commission estimates that responses will come from 180 out of the 200 individual and consortium applicants.

Total Annual Hourly Burden: 3,060 hours. Approximately 180 respondents. The Commission estimates that this requirement will take, on average, approximately 17 hours for applicants. The number of burden hours will vary depending upon the detail provided by the applicant in the RFP. 180 submissions x 17 hours = 3,060 hours.

Total Estimate of In-House Cost to the Respondents: \$122,400 = 3,060 hours x \$40/hour. The Commission estimates that respondents will use a staff person compensated at approximately \$40 per hour.

i. FCC Form 462 – Request for Funding

Number of Respondents: Approximately 200 individual and consortium applicants.

Frequency of Response: Annual requirement.

Total Number of Responses Annually: 200.

Total Annual Hourly Burden: 400 hours. The Commission estimates that this requirement will take approximately 2 hours per submission. 200 submissions x 2 hours = 400 hours.

Total Estimate of In-House Cost to the Respondents: \$16,000 = 400 hours x \$40/hour. The Commission estimates that respondents will use a staff person compensated at approximately \$40 per hour.

j. FCC Form 462 Attachment – Competitive Bidding Documents

Number of Respondents: Approximately 200 individual and consortium applicants.

Frequency of Response: Annual requirement.

Total Number of Responses Annually: 200.

Total Annual Hourly Burden: 3,000 hours. The Commission estimates that this requirement will take, on average, approximately 15 hours for applicants. The number of burden hours will vary depending upon the size of the funding request and the competitive bidding documentation provided. 200 submissions x 15 hours = 3,000 hours.

Total Estimate of In-House Cost to the Respondents: \$120,000 = 3,000 hours x \$40/hour. The Commission estimates that respondents will use a staff person compensated at approximately \$40 per hour.

k. FCC Form 462 Attachment – Contracts or Similar Documentation

Number of Respondents: Approximately 200 individual and consortium applicants.

Frequency of Response: Annual requirement.

Total Number of Responses Annually: 200.

Total Annual Hourly Burden: 200 hours. The Commission estimates that this requirement will take approximately 1 hour per submission. 200 submissions x 1 hour = 200 hours.

Total Estimate of In-House Cost to the Respondents: \$8,000 = 200 hours x \$40/hour. The Commission estimates that respondents will use a staff person compensated at approximately \$40 per hour.

l. FCC Form 462 Attachment – Cost Allocation Method for Ineligible Components

Number of Respondents: Approximately 75 applicants.

Frequency of Response: Annual requirement.

Total Number of Responses Annually: 75.

Total Annual Hourly Burden: 75 hours. The Commission estimates that this requirement will take approximately 1 hour per submission. 75 submissions x 1 hour = 75 hours.

Total Estimate of In-House Cost to the Respondents: \$3,000 = 75 hours x \$40/hour. The Commission estimates that respondents will use a staff person compensated at approximately \$40 per hour.

m. FCC Form 462 Attachment – Evidence of Viable Source for 15 Percent Contribution

Number of Respondents: Approximately 50 consortium applicants. This requirement applies to consortia only.

Frequency of Response: Annual requirement.

Total Number of Responses Annually: 50.

Total Annual Hourly Burden: 50 hours. The Commission estimates that this requirement will take approximately 1 hour per submission. 50 submissions x 1 hour = 50 hours.

Total Estimate of In-House Cost to the Respondents: \$2,000 = 50 hours x \$40/hour. The Commission estimates that respondents will use a staff person compensated at approximately \$40 per hour.

n. Authorization for Third Parties to Submit FCC Forms on Behalf of HCP/Consortium

Number of Respondents: Approximately 150 individual health care providers or consortia of health care providers.

Frequency of Response: One-time reporting requirement. Once submitted, this authorization need not be re-submitted unless there is a change in the information previously provided.

Total Number of Responses Annually: 150.

Total Annual Hourly Burden: 150 hours. The Commission estimates that this requirement will take approximately 1 hour per submission. 150 submissions x 1 hour = 150 hours.

Total Estimate of In-House Cost to the Respondents: \$6,000 = 150 hours x \$40/hour. The Commission estimates that respondents will use a staff person compensated at approximately \$40 per hour.

o. FCC Form 463 - Invoicing

Number of Respondents: Approximately 200 respondents. The FCC Form 463 is completed jointly by the applicant and service provider or vendor.

Frequency of Response: Monthly requirement.

Total Number of Responses Annually: 4,800.

Total Annual Hourly Burden: 9,600 hours. The Commission estimates that this requirement will take, on average, approximately 2 hours combined for applicants and vendors or service providers. The number of burden hours will vary based on the number of line items included in a funding request. 4,800 submissions x 2 hours = 9,600 hours.

Total Estimate of In-House Cost to the Respondents: \$384,000 = 9,600 hours x \$40/hour. The Commission estimates that respondents will use a staff person compensated at approximately \$40 per hour.

p. Site and Service Substitutions

Number of Respondents: 10.

Frequency of Response: On occasion reporting requirement. This obligation will only arise where a health care provider seeks a site or service substitution.

Total Number of Responses Annually: 10.

Total Annual Hourly Burden: 3 hours. The Commission estimates that this requirement will take approximately 0.30 hours per submission. 10 submissions x 0.30 hours = 3 hours.

Total Estimate of In-House Cost to the Respondents: \$120 = 3 hours x \$40/hour. The Commission estimates that respondents will use a staff person compensated at approximately \$40 per hour.

q. Service Provider Identification Number (SPIN) Changes

Number of Respondents: 10.

Frequency of Response: On occasion reporting requirement. This obligation will only arise where a health care provider seeks a SPIN change.

Total Number of Responses Annually: 10

Total Annual Hourly Burden: 3 hours. The Commission estimates that this requirement will take approximately 0.30 hours per submission. 10 submissions x 0.30 hours = 3 hours.

Total Estimate of In-House Cost to the Respondents: \$120 = 3 hours x \$40/hour. The Commission estimates that respondents will use a staff person compensated at approximately \$40 per hour.

r. Connected Care Pilot Program Audits and Recordkeeping

Number of Respondents: Approximately 200 respondents.

Frequency of Response: Occasional requirement.

Total Number of Responses Annually: 200.

Total Annual Hourly Burden: 1,600 hours. The Commission estimates that this requirement will take approximately 8 hours annually per submission. 200 submissions x 8 hours = 1,600 hours.

Total Estimate of In-House Cost to the Respondents: \$64,000 = 1,600 hours x \$40/hour. The Commission estimates that respondents will use a staff person compensated at approximately \$40 per hour.

s. Connected Care Pilot Program Reporting Requirement

Number of Respondents: Approximately 200 respondents.

Frequency of Response: Occasional requirement.

Total Number of Responses Annually: 200

Total Annual Hourly Burden: 1,600 hours. The Commission estimates that this requirement will take approximately 8 hours annually per submission. 200 submissions x 8 hours = 1,600 hours.

Total Estimate of In-House Cost to the Respondents: \$64,000 = 1,600 hours x \$40/hour. The Commission estimates that respondents will use a staff person compensated at approximately \$40 per hour.

REQUIREMENTS APPLICABLE TO BOTH THE COVID-19 TELEHEALTH PROGRAM AND CONNECTED CARE PILOT PROGRAM

t. FCC Form 460 – Eligibility Determination and Consortium Information

Number of Respondents: Approximately 4,100 individual health care provider sites and consortia of health care providers.

Frequency of Response: One-time reporting requirement, as necessary.

Total Number of Responses Annually: 4,100.

Total Annual Hourly Burden: 4,100 hours. The Commission estimates that this requirement will take approximately 1 hour per submission. 4,100 submissions x 1 hour = 4,100 hours.

Total Estimate of In-House Cost to the Respondents: \$164,000 = 4,100 hours x \$40/hour. The Commission estimates that respondents will use a staff person compensated at approximately \$40 per hour.

u. FCC Form 460 Attachment – Letters of Agency (LOA) (Consortia Only)

Number of Respondents: Approximately 4,304 health care providers.

Frequency of Response: One-time reporting requirement, as necessary.

Total Number of Responses Annually: 4,304.

Total Annual Hourly Burden: 4,304 hours. This requirement applies to consortium applicants only. 4,304 submissions x 1 hour = 4,304 hours.

Total Estimate of In-House Cost to the Respondents: \$172,160 = 4,304 hours x \$40/hour. The Commission estimates that respondents will use a staff person compensated at approximately \$40 per hour.

The estimated respondents, responses, and burden hours are listed below:

Information Collection Requirements	Number of Respondents	Total Number of Responses Annually	Total Annual Hourly Burden	Total In-House Cost to the Respondents
a. COVID-19 Telehealth Program Application and Request for Funding	7,300	7,300	109,500	\$4,380,000
b. COVID-19 Telehealth Program Request for Reimbursement	6,158	6,158	6,158	\$246,320
c. COVID-19 Telehealth Recordkeeping, Reporting, and Audits	6,158	6,158	49,264	\$1,970,560
d. Connected Care Pilot Program Application	200	200	5,000	\$200,000

Information Collection Requirements	Number of Respondents	Total Number of Responses Annually	Total Annual Hourly Burden	Total In-House Cost to the Respondents
e. FCC Form 460 Attachment – State/Non-Profit Entities that Want to Serve as Both Vendor and Consortium Leader/Consultant (Consortia Only)	37	5	10	\$40
f. Agreement Regarding Legal/ Financial Responsibility for Consortium Activities (Consortia Only)	3	3	30	\$2,340
g. FCC Form 461 – Request for Services (Competitive Bidding)	200	120	240	\$9,600
h. FCC Form 461 Attachment – Request for Proposals (RFP)	180	180	3,060	\$122,400
i. FCC Form 462 – Request for Funding	200	200	400	\$16,000
j. FCC Form 462 Attachment – Competitive Bidding Documents	200	200	3,000	\$120,000
k. FCC Form 462 Attachment – Contracts or Similar Documentation	200	200	200	\$8,000
l. FCC Form 462 Attachment – Cost Allocation Method for Ineligible Components	75	75	75	\$3,000
m. FCC Form 462 Attachment – Evidence of Viable Source for 15 Percent Contribution	50	50	50	\$2,000
n. Authorization for Third Parties to Submit FCC Forms on Behalf of HCP/Consortium	150	150	150	\$6,000
o. FCC Form 463 – Invoicing	200	4,800	9,600	\$384,000
p. Site and Service Substitutions	10	10	3	\$120
q. Service Provider Identification Number (SPIN) Changes	10	10	3	\$120
r. Connected Care Pilot Program Audits and Recordkeeping	200	200	1,600	\$64,000
s. Connected Care Pilot Program Reporting Requirement	200	200	1,600	\$64,000
t. FCC Form 460 – Eligibility Determination and Consortium Information	4,100	4,100	4,100	\$164,000
u. FCC Form 460 Attachment –	4,304	4,304	4,304	\$172,160

Information Collection Requirements	Number of Respondents	Total Number of Responses Annually	Total Annual Hourly Burden	Total In-House Cost to the Respondents
Letters of Agency (LOA) (Consortia Only)				
GRAND TOTAL	7,300 unique respondents	34,623	198,347	\$7, 934,660

Total Number of Respondents: 7,300 unique respondents

Total Number of Responses Annually: 34,623

Total Annual Hourly Burden: 198,347

Total Estimate of Annualized Cost: \$7,934, 660

13. **Estimates for cost burden of the collection to respondents.** There are no outside contracting costs for this information collection. See the last column in the chart in Item 12 above for the Total In-House Cost to the Respondents.
14. **Estimate of the cost burden to the Commission.** There will be few, if any, costs to the Commission because reviewing requests and handling financial obligations are already part of Commission duties. Also, ensuring proper use of universal service support is already part of the Commission’s duties. Further, administration of universal service funds is handled by a third-party Administrator.
15. **Program changes or adjustments.** The Commission is reporting program changes/increases to this information collection. These program changes are a result of revising this collection to include the information collection requirements for the Connected Care Pilot Program, pursuant to the *Report and Order*. These program changes increase the total annual responses from 28,020 to 34,623 (+6,603) and total annual burden hours of 173,326 to 198,347 (+25,021). The number of unique respondents does not change. We conclude that the number of respondents under the Connected Care Pilot Program will be a subset of the number of unique respondents under the COVID-19 Telehealth Program. Although there may be applicants who apply to the Connected Care Pilot Program that did not participate in the COVID-19 Telehealth Program, we likewise expect that there will be respondents who applied for the COVID-19 but do not apply for the Connected Care Program. Therefore, we estimate that the number of respondents will not exceed the previously estimated number of unique respondents.
16. **Collections of information whose results will be published.** The Commission has no plans at this time to publish other data collected for statistical use or other reports. However, the Commission may publish such data in the future, to the extent that the data’s confidentiality is not protected under law, in the course of carrying out the Commission’s policymaking responsibilities.
17. **Display the expiration date for OMB approval of the information collection.** The Commission seeks approval to not display the expiration date for OMB approval of this information collection. The Commission publishes a list of all OMB-approved information collections in 47 CFR § 0.408 of the Commission’s rules.
18. **Exception to the certification statement for Paperwork Reduction Act submissions.** There are no exceptions to the Certification Statement.

B. Collections of Information Employing Statistical Methods:

The Commission does not anticipate that the collection of information will employ statistical methods.