A. Application Evaluation Process

1. Application Evaluation Metrics

1. The Consolidated Appropriations Act 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.[1] The Consolidated Appropriations Act also requires the Commission to provide notice to Congress of what metrics we intend to use to evaluate applications.[2]

2. The *January 6th Public Notice* sought comment on how to evaluate and prioritize applications during Round 2;[3] 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;[4] and whether there are "any other metrics we should use to prioritize applications during the evaluation process."[5] It also sought comment on prioritizing applications from providers who treat "specific at-risk populations, such as Tribal, low-income, or rural communities,"[6] and sought comment on defining the populations that each metric represents.[7]

3. In response, stakeholders recommended that the Commission use a variety of factors to evaluate Round 2 applications, including: application quality,[8] treatment of specific types of patients,[9] underserved and at-risk communities,[10] treatment of low-income and impoverished patients (regardless of rural or urban location),[11] mental and behavioral health facilities,[12] large percentage of COVID-19 patients,[13] institutions with telehealth experience,[14] and teaching hospitals.[15] Commenters were generally

[1] Consolidated Appropriations Act, § 903(c)(1)(A)(i)-(ii).

[2] *See* Consolidated Appropriations Act § 903(c)(1)(B) (requiring the Commission to provide, not later than 15 days before first committing Program funds, "notice to the appropriate congressional committees of the metrics the Commission plans to use to evaluate applications for those funds."). We intend to timely fulfill this obligation.

[3] *January 6th Public Notice* at 3-5, paras. 6–17.

[4] *Id.* at 3, para. 7.

[5] *Id.* at 4, para. 11.

[6] *Id.*

[7] *Id.*

[8] *See, e.g.*, AUCH Comments at 3-4; CPCA Comments at 2-3.

[9] *See, e.g.*, Planned Parenthood Comments at 3-5 (recommending prioritizing providers that focus on reproductive health); Alzheimer's Association Comments at 2 (recommending prioritizing funding for long-term care institutions); 19Labs Comments at 2, 4 (recommending, among other things, prioritizing the timeliness of implementation and dollars awarded per population covered); Netsmart Comments at 1 (recommending, among other things, prioritizing mental and behavioral health providers).

[10] *See, e.g.*, CUSOM Comments at 1; OCHIN Comments at 1; WU Physicians Comments at 2; Blessing Corporate Comments at 1; NACRHHS Comments 2-3; CHI Comments at 3 (high risk, low-income, rural providers).

[11] *See, e.g.*, USA Health Comments at 2; Blessing Corporate Comments at 1; Russell Doyle Comments at 3; Wexner Medical Comments at 3.

[12] *See, e.g.*, SHLB Comments at 5-6; Centerstone Comments at 1-2; JFNA Comments at 2-3; Netsmart Comments at 1.

[13] *See, e.g.*, UAB Hospital Comments at 5; Wexner Medical Comments at 3.

[14] *See, e.g.*, Southcoast Health Comments at 2; LCMC Health Comments at 2; Stel Life Comments at 1-2; Trinity Health Comments at 1; MBCHC Comments at 3.

[15] *See, e.g.*, Wexner Medical Comments at 3; SBHA Comments at 2.

supportive of prioritizing applicants who serve at-risk populations.[16] Other commenters stressed that Round 1 funding was disproportionately awarded to urban areas.[17]

4. We agree with commenters who supported using a set of evaluation metrics, and we establish 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, we conclude 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. We acknowledge 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, we select application evaluation metrics that can be verified using publicly available information. To reduce the administrative burden during the review process, we are adopting application evaluation metrics that will be simple to quantify and evaluate. We direct USAC to apply these evaluation metrics during the Round 2 application review process.

2. Round 2 Evaluation Metrics

5. We direct 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. We find that these objective metrics will allow us 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, we provide a list of both the metrics and the prioritization points for those metrics in the table below.

[16] *See*, *e.g.*, Hudson Headwaters Health Comments at 4; SHLB Comments at 5; Blessing Corporate Comments at 1.

[17] *See, e.g.*, Gundersen Health Comments at 2; Hospital Sisters Health Comments at 2-3.

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[18]	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
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

[18] 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.

6. *Hardest Hit Area*. In response to the *January 6th Public Notice*, several commenters supported using the "hardest hit" factor to prioritize applications during Round 2.[19] We agree, 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,[20] 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,"[21] we find 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, we define "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).[22] 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."[23] Hotspots are defined by HHS as "communities that have reached a threshold of disease activity considered as being of high burden."[24] For Round 2, we direct 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 above, 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." We also find 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, we direct 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."

7. *Low-Income Area.* In response to the *January 6th Public Notice*, many commenters recommended prioritizing applications from health care providers that are located in low-income areas.[25]

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[19] *See, e.g.*, OCHIN Comments at 2 (encouraging FCC to use "hardest hit" at the time of funding decision); WU Physicians Comments at 2 ("FCC should consider the broader COVID-19 infection rate in the U.S. and pandemic-related strains when defining parameters to target Round 2 funding."); Gunderson Health Comments at 2; Marana Health Comments at 1.

[20] *See, e.g.*, NACRHHS Comments at 1 ("the initial award of funds for the program was heavily tilted toward large urban areas … with urban areas being hardest hit"); Hospital Sisters Health Comments at 2-3 ("applying the same first round criteria … may result in funding being awarded predominantly to providers serving urban metropolitan areas.").

[21] *See, e.g.*, Duke Health Comments at 1; CPCA Comments at 4; Ochsner Health Comments at 3-6; MBCHC Comments at 2.

[22] *See* U.S. Department of Health and Human Services, *Community Profile Report*, at 13 (Mar. 11, 2021), https://beta.healthdata.gov/Health/COVID-19-Community-Profile-Report/gqxm-d9w9 (Area of Concern Continuum by County). We direct 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.

[23] *Id.*

[24] *Id*.

[25] *See, e.g.*, USA Health Comments at 2 (stating that prioritization should be given to patients that live at or below the "Federal Poverty Level"); Ethan Whitener Comments 2-3; Blessing Corporate Comments at 1; Wexner Medical Comments at 2 (encouraging FCC to prioritize low-income communities, but not necessarily just rural communities). We find 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 we believe 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. *But see*, Hospital Sisters Health Comments at 3 ("The Commission should

(continued….)

We agree 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, we direct USAC to use Census Bureau data to determine which health care providers are located in low-income areas.[26] We direct 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.[27] 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%.[28] We direct 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.[29] 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), we direct USAC to award the application the higher points available between the two. We direct 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..

8. *Round 1 Unfunded Applicants*. During Round 1, we received thousands of applications from health care providers nationwide. The Commission awarded funding commitments to 539

consider prioritizing Round 2 applications and awards that … [a]re located by address in an economically distressed Opportunity Zone").

[26] *See* U.S. Census Bureau, *Small Area Income and Poverty Estimates*, Interactive Map, https://www.census.gov/data-tools/demo/saipe/#/?map_geoSelector=aa_c (last updated Dec. 2020) (Interactive map and data set reflecting poverty rates for the United States and counties within the United States as of 2019); U.S. Census Bureau, *American Community Survey: Poverty Status in the Past Twelve Months*, https://data.census.gov/cedsci/table?q=poverty&tid=ACSST1Y2019.S1701&hidePreview=false (last visited Mar. 23, 2021). 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.

[27] 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.

[28] The Small Area Income and Poverty Estimates do not include estimates for U.S. territories. For consistency, we exclude 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, we direct USAC to rely on other U.S. Census Bureau data sets or other publicly available information to estimate poverty rates.

[29] We direct 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. We therefore direct USAC to develop a methodology to consider poverty rates in adjacent census tracts in awarding points for this metric.

applications during Round 1, which left a substantial number of Round 1 applications unfunded.[30] In response to the high number of applications that did not receive funding, and the Consolidated Appropriations Act, the *January 6th Public Notice* sought comment on prioritizing the applications of eligible health care providers who applied for, but did not receive, Round 1 funding.[31] The majority of commenters supported prioritizing these applicants.[32] While some commenters did not believe that these applicants should be prioritized,[33] we conclude that it is appropriate to prioritize eligible applicants who applied for but did not receive Round 1 funding. We believe 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 our goal of distributing funding as widely as possible. Accordingly, we direct 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, we also assign 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.

9. *Tribal Community.* We next prioritize 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."[34] The absence of broadband availability in these areas also makes it more difficult for telehealth to be provided, and we conclude that prioritizing these factors will help to address this discrepancy. Additionally, we have previously recognized that "there are significant health care shortages in rural areas and Tribal lands,"[35] and seek to address this issue by prioritizing Tribal participation in this Program. Accordingly, our decision 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.[36] 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."[37] Additionally, Tribal populations face a significantly higher risk from the COVID-19 pandemic,[38] and facilitating a more robust telehealth infrastructure could help to address this disparity. For Round 2, we adopt the definition of Tribal lands provided in the Commission's Lifeline program rules,[39] and direct

[30] 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.

[31] *January 6th Public Notice* at 5, para. 17.

[32] *See, e.g.*, Children's Wis. Comments at 2; Savoy Medical Comments at 2.

[33] *See, e.g.*, Mount Sinai Comments at 4.

[34] *Inquiry Concerning Deployment of Advanced Telecommunications Capability to All Americans in a Reasonable and Timely Fashion*, GN Docket No. 20-269, Fourteenth Broadband Deployment Report, FCC 21-18, at 19-20, para. 33 (Jan. 19, 2021) (*Fourteenth Broadband Deployment Report*).

[35] *Promoting Telehealth for Low-Income Consumers*, Notice of Proposed Rulemaking, 34 FCC Rcd 5620, 5646, para. 57 (2019).

[36] *Fourteenth Broadband Deployment Report* at 11-12, para. 20.

[37] *Id*.

[38] *See* Centers for Disease Control and Prevention, *CDC Data Shows Disproportionate COVID-19 Impact on American Indian/Alaskan Native Populations*, https://www.cdc.gov/media/releases/2020/p0819-covid-19-impact-american-indian-alaska-native.html (updated Aug. 19, 2020).

[39] 47 CFR § 54.400(e) (defining Tribal lands as "any federally recognized Indian tribe's reservation, pueblo, or colony, including former reservations in Oklahoma; Alaska Native regions established pursuant to the Alaska Native (continued….)

Program applicants to use USAC's Tribal PDF map or the reference shapefile to determine whether they are located on Tribal lands.[40] Consistent with the eligibility determinations made using the FCC Form 460, we direct 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.[41] We direct 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, we assign the largest point allocation to these applications.

10. *Critical Access Hospital*.[42] In response to the *January 6th Public Notice*, several commenters suggested considering whether an applicant is a Critical Access Hospital (CAH).[43] A CAH designation is given to eligible rural hospitals in participating states by the Centers for Medicare and Medicaid Services.[44] 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.[45] Small health care providers like CAHs frequently struggle to access the resources and capacity to set up their own telehealth infrastructure.[46] We find that these characteristics place CAHs among the health care providers that need funding from this Program, as they would benefit from telehealth and are frequently the only health care institutions in their nearby vicinities. Accordingly, we direct USAC to award 10 points to applications that demonstrate an eligible health care provider qualifies as a Critical Access Hospital. We award these entities points to reflect the importance of these facilities, but we assign a modest allocation of points because we anticipate that this metric will overlap with other metrics.

11. *Federally Qualified Health Center, Federally Qualified Health Center Look-Alike, or*

Claims Settlement Act (85 Stat. 688); Indian allotments; Hawaiian Home Lands—areas held in trust for Native Hawaiians by the state of Hawaii, pursuant to the Hawaiian Homes Commission Act, 1920 July 9, 1921, 42 Stat. 108, *et. seq.*, as amended"). We also include 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. *See Federal-State Joint Board on Universal Service, Smith Bagley, Inc., Petition for Waiver of Section 54.400(e) of the Commission's Rules*, Memorandum Opinion and Order, 20 FCC Rcd 7701 (2005) and *Sacred Wind Communication*, Order, 21 FCC Rcd 9227 (WCB 2006).

[40] USAC, *Enhanced Tribal Benefit*, *Eligible Tribal Lands Maps and Shapefile*, https://www.usac.org/lifeline/get-started/enhanced-tribal-benefit/#Eligible (last updated Jan. 22, 2021) (providing link to eligible Tribal lands map and shapefile for reference purposes).

[41] *See First COVID-19 Report and Order*, 35 FCC Rcd at 3406, para. 68 (establishing the same criteria for "Tribal" for the Connected Care Pilot Program).

[42] 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. Centers for Medicare and Medicaid Services, *Critical Access Hospitals*, https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/CAHs (last updated Apr. 9, 2013); Flex Monitoring Team, *Critical Access Hospitals Locations List*, https://www.flexmonitoring.org/critical-access-hospital-locations-list (last updated Aug. 1, 2020) (The Flex Monitoring Team consists of researchers from the Universities of Minnesota, North Carolina, and Southern Maine and is funded by the Federal Office of Rural Health Policy).

[43] *See, e.g.*, NACRHHS Comments at 2-3, Rush Health Comments (Express).

[44] Rural Health Information Hub, *Critical Access Hospitals*, https://www.ruralhealthinfo.org/topics/critical-access-hospitals (last updated Aug. 20, 2019) (defining and discussing Critical Access Hospitals).

[45] 42 U.S.C. § 1395i-4(c)(2)(B)(i)-(iv).

[46] *See, e.g.*, Letter from Joe Manchin III *et al.*, Senators, U.S. Senate, to Jessica Rosenworcel, Chairwoman, FCC, WCB Docket No. 20-89, at 2 (Jan. 25, 2021) (Senator Manchin Letter).

Disproportionate Share Hospital.[47] In response to the *January 6th Public Notice*, commenters recommended prioritizing applications that include health care providers that qualify as a Federally Qualified Health Center (FQHC),[48] a FQHC Look-Alike,[49] or a Disproportionate Share Hospital (DSH).[50] 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.[51] They are also referred to as the "backbone of the nation's health care safety net."[52] 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.[53] 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,[54] 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.[55] 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.[56] After careful review of the record, we find that directing Program funding to

[47] Applicants shall verify whether they qualify for this metric by providing either their Federally Qualified Health Center ID number or BHCMISID/UDS numbers. *See* Health Resources and Services Administration, *About the Health Center Program*, https://bphc.hrsa.gov/about/index.html (last visited Mar. 24, 2021).

[48] *See, e.g.*, OCHIN Comments at 2 (stating that many FQHCs and CHCs did not receive funding from Round 1, which went to larger institutions, because the first come first serve process disadvantaged smaller health care centers that were already under strain and burden from providing health care to services to the most vulnerable patients); WU Physicians Comments at 2; Gunderson Health Comments at 2; Marana Health Comments at 1; NACRHHS Comments at 2-3; Butler Healthcare Comments at 2; True Health Comments at 1; CHI Comments at 3; AUCH Comments at 4-5; CPCA Comments at 4; CHAD Comments at 4.

[49] 42 U.S.C. § 1396d(l)(2)(B); *see* OCHIN Comments at 1. Applicants can verify their eligibility as a Look-Alike on the Health Resources and Services Administration website. *See* Health Resources and Services Administration, *FQHCs and LALs by State: Federally Qualified Health Centers and Look-Alikes*, https://data.hrsa.gov/data/reports/datagrid?gridName=FQHCs (last visited Mar. 24, 2021).

[50] *See* Southcoast Health Comments at 2; Letter from Kali P. Chaudhuri, MD, Founder & Chairman, KPC Health, and Peter Baronoff, Chief Executive Officer, KPC Health, to FCC Commissioners, WC Docket No. 20-89, at 2 (filed Jan. 22, 2021).

[51] Health Resources and Services Administration, *Federally Qualified Health Centers*, https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc/index.html (last visited Mar. 12, 2021) (defining Federally Qualified Health Centers).

[52] CHAD Comments at 2; CCHN Comments at 1.

[53] 42 U.S.C. § 254b; *see* Rural Health Information Hub, *Federally Qualified Health Centers and Health Center Program*, https://www.ruralhealthinfo.org/topics/federally-qualified-health-centers (last visited Mar. 12, 2021).

[54] *See* Health Resources and Services Administration, *Federally Qualified Health Center Look-Alike Eligibility*, https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc-look-alikes/index.html (last visited Mar. 12, 2021).

[55] *See* Health Resources and Services Administration, *Federally Qualified Health Center Look-Alike Eligibility*, https://www.hrsa.gov/opa/eligibility-and-registration/health-centers/fqhc-look-alikes/index.html (last visited Mar. 12, 2021); Health Resources and Services Administration, *Health Center Program Look-Alikes*, https://bphc.hrsa.gov/programopportunities/lookalike/index.html (last visited Mar. 12, 2021).

[56] 42 U.S.C. § 1395ww(d)(1)(B); *see* Health Resources and Services Administration, *Disproportionate Share Hospitals*, https://www.hrsa.gov/opa/eligibility-and-registration/hospitals/disproportionate-share-hospitals/index.html (last visited Mar. 12, 2021).

FQHCs, FQHC Look-Alikes, and DSHs will meet our above-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.[57] Accordingly, we direct 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.

12. *Healthcare Provider Shortage Area*.[58] In response to the *January 6th Public Notice*, some commenters suggested prioritizing health care providers located in a Healthcare Provider Shortage Area (HPSA).[59] 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. We direct 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.[60] 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. We direct 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.

13. *Round 2 New Applicants*. Because we conclude that equitable and widespread distribution of Program funds is essential, we also direct 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.[61] 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,"[62] and will help distribute funding to as many providers as possible. Accordingly, we direct USAC to award 5 points to applicants who did not apply for Round 1 funding.

14. *Rural County*. We also prioritize applicants that are located in rural areas, as defined by the Rural Healthcare Program.[63] Although other application evaluation metrics, such as whether an

[57] *See, e.g.*, Senator Manchin Letter; OCHIN Comments at 1 ("HRSA-funded health centers serve 1 in 3 people who are experiencing poverty in the United States. In 2019, more than 91% of FQHC patients and 89% of LAL patients had incomes at or below 200% of the Federal Poverty line.").

[58] Applicants should use the HPSA score for primary care, which is publicly available on the Health Resources and Services Administration website. Health Resources and Services Administration, *Find Shortage Area*, https://data.hrsa.gov/tools/shortage-area (last visited March 12, 2021).

[59] *See, e.g.*, NACRHHS Comments at 2; Hospital Sisters Health Comments at 3, 7.

[60] Health Provider Shortage Area, *HPSA Acumen*, *Frequently Asked Questions*, https://hpsa.us/faqs/ (last visited Mar. 12, 2021) ("HPSA Scores are developed for use by the National Health Services Corps (NHSC) and Health Resources and Services Administration (HRSA) to prioritize the need of designations. Based on the severity of a health professional shortage, scores range from 1 to 25 for primary care …. The higher the score, the greater the need for additional medical services, which increases an area's priority for placement of new practitioners.").

[61] *See, e.g.*, CUSOM Comments at 2.

[62] *Id.* at 1-2.

[63] 47 CFR § 54.600(e) (defining a rural area as "an area that is entirely outside of a Core Based Statistical Area; is within a Core Based Statistical Area that does not have any Urban Area with a population of 25,000 or greater; or is in a Core Based Statistical Area that contains an Urban Area with a population of 25,000 or greater, but is within a (continued….)

applicant is a Critical Access Hospital, already take into consideration the rurality of health care providers for Round 2 funding, we direct 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, we attach 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.[64] We direct USAC to award 5 points to applications that demonstrate that an eligible health care provider site is located in a rural area.

specific census tract that itself does not contain any part of a Place or Urban Area with a population of greater than 25,000.").

[64] USAC, *Eligible Rural Areas Search*, https://apps.usac.org/rhc/tools/Rural/search/search.asp (last visited Mar. 12, 2021). To the extent information for U.S. territories and protectorates is not available in this dataset, we direct 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.