Before the
Federal Communications Commission
Washington, D.C. 20554

CONTENTS

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In the Matter of	)	
	)	
Promoting Telehealth for Low-Income Consumers	)	WC Docket No. 18-213
	)	

COMMENTS OF GILA RIVER TELECOMMUNICATIONS INC.

I. Introduction

Gila River Telecommunications, Inc. (GRTI) hereby submits these comments in the above captioned proceedings before the Federal Communication Commission ("Commission" or "FCC").[1] As an eligible telecommunications carrier (ETC) providing service to a predominately low-income community in Indian country, we file these comments in support of the Commission's proposed "Connected Care Pilot Program" and offer suggestions regarding some of the questions raised by the Commission in its Notice of Inquiry (NOI). GRTI urges the Commission to move forward as soon as practicable in establishing this program and looks forward to working with the Commission as it develops the framework.

As GRTI sets forth in its comments below, the Commission should adopt as goals the six categories it sets forth in the NOI as they reflect not only the potential benefits that a telehealth pilot program could promote, but also reflect the Commission charge under the statute in

[1] In the Matter of Promoting Telehealth for Low-Income Consumers, *Notice of Inquiry*, WC Docket No. 18-213, FCC 18-112 (rel. Aug. 3, 2018) (*Connected Care NOI* or *NOI*).

promoting healthcare opportunities via communication services. In structuring the program, GRTI agrees that partnering with an existing eligible telecommunications carrier would serve the goal of promoting broadband deployment and will assist the Commission and health care providers in getting the Connected Care Pilot Program underway expeditiously. Similarly, the Commission should rely on Medicaid and Veterans Affairs (VA) criteria for determining eligible low-income participants. GRTI supports the Commission's goal to designate at least one program for Tribal lands, but would urge the Commission to consider the demographics of living on Tribal lands, which demonstrate that low-income and health challenges are higher than in the Nation generally and connectivity lags the rest of the Nation. As such, the Commission should strive to select as many tribally-focused programs as possible. The Commission may be able to afford greater opportunities if it were to consider increasing the funding available for the pilot program. Regarding supported services, broadband connectivity, equipment and applications provided by health care providers are all critical components of measuring the potential opportunities by increased access to telehealth for low-income families. The Commission's proposed $100 million is one-quarter of the funding made available in the previous Rural Health Care Pilot Program in 2006, which provided $418 million for 50 projects in 38 states.[2] GRTI urges the Commission to consider increased funding levels to better realize the full potential this pilot program presents to help better manage chronic diseases, such as diabetes, in Tribal and rural communities.

[2] Wireline Competition Bureau Evaluation of Rural Health Care Pilot Program, *Staff Report*, WC Docket No. 02-60, 27 FCC Rcd 9387 (2012) (*2012 RHC Pilot Program Staff Report*).

GRTI believes that the changes urged in these comments can improve upon the proposal put forward by the Commission.

II. Background

GRTI: GRTI was founded in 1988 and is wholly-owned by the Community. When the Gila River Indian Community ("Community") first purchased the exchange from Mountain Bell, later known as Qwest, only 10 percent of residents in the Community had access to basic phone service and for those looking to get connected, they were asked to pay an "aid to construction" deposit in the tens of thousands of dollars before Mountain Bell would install a party line connection (a "chat room" on the old telephone network). Today, through much hard work and the combined dedication of the staff at GRTI and the efforts of the Community to make connectivity a reality, GRTI offers phone service to 100 percent of residents and 84 percent subscribe. GRTI also offers broadband service to its residential customers at 6/1 Mbps and 10/3 Mbps.

The Community: The Community is located in south central Arizona and is comprised of two tribes, the Akimel O'odham (also called Pima) and the Pee Posh (also called Maricopa). The reservation is approximately 372,500 acres and there are over 20,000 people enrolled as members of the Community. Almost 12,000 people live on the reservation, meaning it has a population density of approximately 20 persons per square mile. Over 75 percent of the residents are under age 44, with 40 percent younger than 19. The median income is $24,771 and approximately 48 percent of the persons living on the reservation live below the poverty level.

The Community is striving to change these circumstances by driving economic development through diversifying our industrial, agricultural, business, retail and recreational sectors. It has over 35,000 acres of the reservation land under cultivation, with plans to add at least 20,000 acres. In addition to GRTI, the Community has also established entities to provide the reservation with electricity, water and sewer.

Also, the Community operates three medical facilities as part of its Gila River Health Care (GRHC) group. These facilities were established to provide each patient with the care they need, offering a full range of services from pediatrics to long-term care, and with a provider they trust because it is part of their Community.[3]

Perhaps the most important statistic for these comments, however, is that the Gila River Indian Community suffers from one of the highest rate of diabetes in the world.[4] In fact, based on a more than 40-year study, it has been found that one-half of the adults have diabetes and 95 percent of those with diabetes are overweight.[5] The National Institute of Health and others have worked with the Community to advance the treatment of this chronic disease not only for the Community but for the world. While GRHC and its facilities are helping to tackle this chronic

[3] More information on Gila River Health Care is available at http://grhc.org/.

[4] *See* Leslie O. Schulz, Ph.D. & Lisa S. Chaudhari, Ph.D., High-Risk Populations: The Pimas of Arizona and Mexico. Curr. Obes. Rep. 4:92–98, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4418458/, (2015) (*Schulz Chaudhari Report*); *see also* Smith-Morris, Carolyn, *Diabetes Among the Pima: Stories of Survival* (Univ. of Ariz. Press 2008) (*Diabetes Among the Pima*).

[5] *Id*. *See also* The Pima Indians Pathfinders for Health, National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) (2014).

disease in the Community, there is still much to be done and advancement in remote monitoring and better connectivity for patients holds great promise.[6]

It is against this backdrop that GRTI provides these comments to the Commission regarding its support of the proposed Connected Care Pilot Program.

III. Discussion

A. Goals of the Pilot Program

In the *Connected Care NOI*, the Commission seeks comment on goals for the Connected Care Pilot Program.[7] Specifically, the Commission seeks comment on how such a program could: 1) improve health outcomes through broadband access; 2) support the trend toward ubiquitous care; 3) reduce costs for patients, facilities, and health care systems; 3) bridge gaps in the federal government's initiatives building on prior successes with regards to improving health care outcomes; 5) increased broadband deployment; and 6) increase broadband adoption among low-income households.

Improving Health Outcomes: In the *NOI*, the Commission seeks comment on how the pilot program can improve health outcomes by focusing on particular demographics or geographical areas and how USF funds can best support the goal of increased access to telehealth services and thereby improve health outcomes among participating low-income patients.[8]

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[6] *Schulz Chaudhari Report* ("The challenge for the twenty-first century will be to identify and implement mechanisms for modernization throughout the developing world that take place in a manner that promotes health rather than impairs it and thereby protects the next generation from the inevitability of increased chronic disease.").

[7] *Connected Care NOI* at paras. 16-27.

[8] *Id*. at paras. 17, 19.

As noted above, the rate of diabetes amongst members of the Gila River Indian Community is among the highest in the world. Research conducted by Smith-Morris on how best to assist patients in managing this chronic disease found that addressing certain key obstacles to care was essential. Among those obstacles were: transportation, confidentiality, wait times for appointments, and knowing when to go in for a meeting with a doctor.[9] As Smith-Morris notes, a "personal sense of being knowledgeable and competent to manage (adjust, decline) their medication to all of life's circumstances" was important to the Pima patients.[10] Engaging patients in the treatment of their chronic disease is one critical element to better management of the disease and greater access to telehealth can aid in overcoming that obstacle.

Moreover, removing the transportation barrier for patients to receive care is essential, particularly in places like the Gila River Indian Community where extreme desert heat make walking an impossible alternative.[11] Again, monitoring through telehealth applications can remove this obstacle. In fact, when you look at the obstacles identified by Smith-Morris, each one could benefit from telehealth. The Commission's proposed Connected Care Pilot Program can be used to help quantify just what impact removing these obstacles has on health outcomes and thus this should be a key goal of the pilot program.

Supporting Connected Care Everywhere: In the *NOI*, the Commission seeks comment on costs and benefits of supporting the trend towards direct-to-consumer health care.[12] The benefits of connected care are improved health outcomes for patients, which can result in a reduction of the

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[9] *Diabetes Among the Pima* at 40-48.

[10] *Id*. at 47

[11] *Id*. at 40.

[12] *Connected Care NOI* at para. 21.

need for more expensive treatments as a result of poor management of chronic conditions. In addition, there is the potential to reduce the cost of care by health care providers (HCP) that results from missed appointments and scheduling of more frequent appointments in order to ensure close monitoring of the patient's condition. GRTI is certain there are other concrete benefits that HCP commenters will discuss, but it seems clear that the Commission has an opportunity to support the trend toward greater use of connected care and the benefits of such a policy will inure to patients and HCPs alike. As such, the Commission should evaluate the success of its pilot program based in part on how it furthers this trend.

Reduce Costs for Patients, Facilities, and Health Care Systems: In the *NOI*, the Commission seeks comment on how the pilot program can improve health care affordability for low-income Americans and counteract the burdens of increasing out-of-pocket expenses, including transportation costs for rural and remote patients.[13] In the Smith-Morris research, she notes that transportation is a major obstacle to care. Telehealth has the potential to reduce the need for more frequent visits and thus reduce the cost burden of transportation for low-income families seeking care. Moreover, the reduction in missed appointments that telehealth can provide is significant for HCPs because it will not only help reduce the economic cost missed appointments impose on a hospitals/clinics bottom line, but it will help reduce the cost imposed on the health care system by patients not following a course of treatment.[14]

Increased Broadband Deployment: In the *NOI*, the Commission seeks comment on using the pilot program to promote broadband deployment, noting the lag of deployment in rural and Tribal

[13] *Id*. at para. 22.

[14] *Diabetes Among the Pima* at 48.

areas.[15] Given the proposed, limited amount of funding for the pilot program (approximately $5 million per project), GRTI suggests that while this should be a goal of the program, it should not be a primary goal. As the Commission is aware, the high-cost of deployment in rural and Tribal areas means that significant resources are needed to promote broadband deployment. The Commission's high-cost program is the primary source of funding for deployment and additional support through that mechanism is critical to addressing the broadband gap in rural and Tribal communities. Consistent with its comments in the Lifeline reform proceeding of 2016, GRTI asserts that while funding in the pilot program can enhance deployment, it should not be viewed as a key component of promoting deployment, at least not at the modest funding levels proposed in the *NOI*. Should the Commission increase the funding for the pilot program, it may be that this could be a key goal.

Increasing Broadband Adoption for Low-Income Households: In the *NOI*, the Commission also seeks comment on whether the pilot program should have as a goal increasing adoption of broadband in low-income households, noting that adoption rates among low-income households across the country remain low.[16] GRTI is generally supportive of including this as a goal, and as a participant in the Commission's Lifeline Pilot Program, has some experience in trying to increase adoption for low-income families. The key barrier for adoption by low-income households, as GRTI explained to the Commission in its report as part of the Lifeline pilot program, is affordability.[17] Just as the high-cost program is the primary mechanism by which the Commission promotes broadband deployment, the Lifeline program is the primary mechanism for ensuring the

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[15] *Connected Care NOI* at para. 25.

[16] *Id*. at para. 26.

[17] See Gila River Telecommunications, Inc. ex parte filing, WC Docket No. 12-23, 11-42, and 10-90, available at http://apps.fcc.gov/ecfs/comment/view?id=6017606960.

affordability of broadband for low-income families. As GRTI has stated in that docket, additional per-household funding for broadband should be provided for Lifeline support of broadband.[18] To the extent, however, that the Connected Care Pilot Program can help defray some of the cost of connectivity for low-income families, GRTI is supportive of it being included as a goal of the pilot program.

B. Structure of the Program

In the *2018 Telehealth NOI*, the Commission seeks comment on a number of structural aspects of the program. GRTI provides comment on the following structural components: budget, partnering with facilities-based ETCs, eligibility of low-income consumers, types of projects, supported services, and duration. In these comments, GRTI cites to certain lessons learned as a result of its participation in the Lifeline Pilot program, so it does not address those issues separately.

Budget: In the *NOI*, the Commission seeks comment on whether $100 million in funding is adequate for the pilot program, noting that increases in USF expenditures are borne by ratepayers through increased contributions.[19]

GRTI would urge the Commission to consider increasing the funding level for this effort to expand the opportunities for greater participation by HCPs and low-income patients. As currently proposed, the reach of the pilot project would potentially include only 20 participants at

[18] *See* GRTI Comments, WC Docket No. 11-42, filed Aug. 31, 2015, at 11 ("GRTI believes that in order for the program to be most effective, an increase in the amount of per month support to cover the higher cost of broadband is needed.").

[19] *Connected Care NOI* at paras. 29-30.

$5 million per year. By comparison, the last Rural Health Care Pilot Program allotted $418 million in funding for more than 50 projects in 38 states.[20] It was successful in connecting more than 2,100 HCPs to broadband and thereby providing them with the capability of delivering telehealth and telemedicine.[21] The Commission should be equally ambitious here as developing increased access to telehealth, particularly for low-income families and veterans, has the potential to substantially improve health outcomes and reduce costs for HCPs, many of whom in rural and Tribal areas operate on extremely tight budgets.

Partnering with a Facilities-Based ETC: In the *NOI*, the Commission seeks comment on whether participating broadband service providers should be facilities-based ETCs.[22]

GRTI agrees with the Commission's proposal to limit support to facilities-based ETCs. Funding under the proposed pilot program will support the provisioning of broadband services to low-income families in conjunction with the HCP that applied to participate in the program. While GRTI notes above that the goal of deployment should be seen as a secondary goal, it is nonetheless the case that deployment of broadband will be a component of this program. As such, the Commission rightly notes that facilities-based ETCs can help advance that goal. Moreover, limiting participation to facilities-based ETCs is consistent with the Commission practice in the Lifeline program.

Application Process and Types of Projects: In the *NOI*, the Commission seeks comment on whether there are specific patient groups among low-income Americans that proposed projects

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[20] *2012 RHC Pilot Program Staff Report* at 2

[21] *Id.*

[22] *Connected Care NOI* at para. 37.

should serve, such as veterans, residents of Tribal lands, pregnant women, the elderly, or disabled Americans.[23]

GRTI believes the Commission should cast a wide net in terms of what patient groups to consider. In the Gila River Community, there are representatives of each of the groups enumerated by the Commission and each could benefit from connected care opportunities. A wide net will afford the Commission a better opportunity to assess how well the efforts of the various projects ultimately approved by the Commission achieved the goals the Commission adopted.

Eligible Low-Income Subscribers: In the *NOI*, the Commission seeks comment on the eligibility criteria it should adopt for participation by low-income households and veterans.[24]

For administrative ease and clarity, GRTI believes the Commission should tie eligibility criteria to Medicaid-eligible patients and veterans that qualify for health care benefits without having to make a co-pay. These are criteria that HCPs are familiar with and thus tying participation to them would minimize the need to standup separate systems to monitor participation. Given the proposed duration of the program, this would seem to promote administrative efficiency for participating HCPs.

Tribal Project: In the *NOI*, the Commission seeks comment on whether the pilot program should include at least one partnership involving clinics or hospitals located on Tribal lands.[25]

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[23] *Id*. at para. 33.

[24] *Id*. at paras. 39-41.

[25] *Id*. at para. 36.

GRTI agrees that there should be an opportunity for at least one Tribal project, and urges the Commission to try to expand the pilot program to include as many Tribal projects as possible. According to the Indian Health Service (IHS), the age-adjusted death rate for American Indian and Alaska Native adults exceeds that of the general population by almost 40%. The drivers of these deaths include chronic diseases, such as diabetes, liver disease, heart disease, which are the types of medical conditions that can benefit from the types of telehealth services the Commission seeks to promote through this program.[26] Therefore, GRTI urges the Commission to provide funding opportunities for projects that can advance telehealth access on Tribal lands where the potential to positively affect health outcomes is most needed.

Supported Services: In the *NOI*, the Commission seeks comment on whether the pilot program should support connectivity for both fixed and mobile services; whether it should provide support for equipment necessary for the use of the broadband service as well as end-user equipment; and whether the funds should support mobile health applications.

Regarding connectivity, GRTI would urge the Commission to encourage access by fixed and mobile providers. Both modalities will be useful to HCPs as they seek to tailor their telehealth program to promote access and engagement with their patients. Moreover, some telehealth services, such as remote consultations, may best be performed over a fixed connection, whereas mobile connections may be better for data transmission for Internet-of-Things (IoT) devices associated with monitoring health. As the American Hospital Association recently observed,

[26] *See* Michelle Sarche & Paul Spicer, *Poverty and Health Disparities for American Indian and Alaska Native Children: Current Knowledge and Future Prospects*, Annals of the New York Academy of Sciences, 1136, 126–136, available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2567901/ (2008).

"[e]lectronic health records, technology-based patient engagement strategies, health information sharing for coordinated care, and remote-monitoring technologies all require robust broadband connections…[and] tens of millions of Americans still lack access to adequate broadband, and rural communities are more likely to be in need."[27] Only by providing opportunities for robust fixed and mobile service will the Commission be able to gauge the potential of telehealth in achieving its enumerated goals.

Based on its experience with the Lifeline Pilot Program, GRTI would urge the Commission to not only ensure that fixed and mobile connectivity are supported, but to provide support for equipment, including end-user devices, through the pilot program. As GRTI explained in its report to the Commission on its experience with the Lifeline Pilot Program, the cost of service and equipment are key factors in determining whether a low-income Tribal resident adopts broadband service. In particular, broadband adoption is more likely when low-income tribal subscribers are offered significant discounts on both broadband service and equipment.[28] GRTI, therefore, would urge the Commission to give serious consideration to supporting equipment, including end-user devices, to ensure this is not a barrier to participation in the pilot program.

In terms of support for applications, GRTI defers to HCPs on whether they should receive support for mobile health applications as GRTI does not have specific knowledge of the cost associated with them. GRTI would note, however, that in order for the pilot programs to

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[27] Healthcare IT News, *Rural Hospitals Need More Funding for Broadband, Telehealth, AHA Says*, available at https://www.healthcareitnews.com/news/rural-hospitals-need-more-funding-broadband-telehealth-aha-says. (visited Sept. 9, 2018).

[28] Letter from Gregory W. Guice, Counsel for Gila River Telecommunications, Inc., to Marlene Dortch, Secretary, Federal Communications Commission, WC Docket Nos. 12-23, 11-42, and 10-90, filed March 13, 2014, available at https://ecfsapi.fcc.gov/file/7521092204.pdf.

measure success, each part of the chain for delivering telehealth may require support. Consistent with its position that the Commission should provide support for equipment, GRTI would urge the Commission to consider inclusion of applications as supported services should non-support be demonstrated to be a hindrance to participation by HCPs.

Duration: In the NOI, the Commission seeks comment on how long funding should be made available for program participants, suggesting either a two-or three-year program.[29]

GRTI would suggest that to the extent the Commission seeks to promote broadband deployment, a longer timeframe should be adopted. As GRTI has noted in the context of the high-cost program, infrastructure deployment on Tribal lands can take a significant amount of time due to regulatory barriers associated with obtaining permits to build.[30] Based on GRTI's experience in navigating these barriers, GRTI would urge the Commission to adopt, at a minimum, a three-year timeframe and if possible extend it to five years. GRTI believes that a pilot program that provides multiple years of funding will allow providers like GRTI to assist HCPs in deploying the infrastructure needed for telehealth and will encourage greater participation by potential HCPs.

IV. Conclusion

GRTI appreciated this opportunity to provide the Commission its perspective based on its experience in delivering broadband to a rural, Tribal community. As stated herein, the

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[29] *Connected Care NOI* at para. 51.

[30] Letter from Gregory W. Guice, Counsel for Gila River Telecommunications, Inc. to Marlene Dortch, Secretary, Federal Communications Commission, filed June 16, 2017, available at https://ecfsapi.fcc.gov/file/10617198743901/GRTI%20Ex%20Parte%20Meeting%20with%20Chairman%20Pai%20OPEX%20Limits.pdf; Comments of Gila River Telecommunications, Inc., filed May 12, 2016, available at https://ecfsapi.fcc.gov/file/60001841634.pdf.

Community GRTI serves has one of the highest rates of diabetes in the world and GRTI sees the tremendous opportunity that telehealth represents for helping those Community members better manage their care. As the provider responsible for bringing broadband to the Community, we also understand our role in making these telehealth opportunities a reality, which is why GRTI supports the Commission's effort to establish the Connected Care Pilot Program, consistent with these comments. GRTI looks forward to engaging further with the Commission as it seeks to refine this proposal, providing any insight it can to help structure this program to ensure its success.

Respectfully Submitted,

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