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MONTANA HOSPITAL ASSOCIATION  
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April 12, 1996

Federal Communications Commission  
Washington D C 20554

DOCKET FILE COM-96-45

**RE: CC DOCKET NO. 96-45**

The Montana Hospital Association represents 59 member facilities statewide. Among our members, three (3) major Telemedicine networks and 5 local sites service two-thirds of the state. A major objective of the networks is to provide quality Telemedicine services and support to rural and frontier practitioners and patients in Montana.

Specifically, MHA members and the Montana Telecommunications Alliance, representing these facilities are concerned with the following issues:

- Availability of quality services
- Reasonable and affordable rates
- Statewide access to advanced services for health care providers
- Cross-network, seamless and transparent connectivity

Availability of Quality Services

In regard to Section 254(a)(1) of the Telecommunications Act: The definition of services supported by Federal universal service support mechanisms should include advanced telecommunications and the availability of digital services for all rural and frontier communities. The commission needs to recognize the more remote a community, the greater need for advanced telecommunications. Bringing advanced services to all regions of Montana will take time. Special emphasis should be placed on implementing services for the legislatively prescribed purposes of health and education.

Section 254(b)(3) of the Act, refers to the definition of rural communities. The FCC and MT PSC must be cognizant that "urban centers" in rural states such as Montana meet Federal criteria as "rural communities". MHA is concerned that telecommunications carriers will point to these "rural" communities as demonstrative of their efforts to bring advanced communications to rural areas. Access must be to all areas and rurality must be defined relative to varied demographics.

Statewide Access to Advanced Services for Health Care Providers

The issue of "access to advanced services", although specifically defined in the Telecommunications Act, is somewhat compromised by the statement in Section

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254(h)(2)(A). This clause could provide carriers with a non-compliance option if they choose to construe a low population density, poor rate of return, rural area as "technically unfeasible and economically unreasonable". This clause does not create much incentive for a carrier to provide universal access to rural locations at a reasonable cost to accommodate Telemedicine video applications.

Referring to Section 254(b)(4), it is the intent of Congress to "accelerate rapidly private sector deployment of advanced services to all Americans". The Telecommunications bill recognizes that local telecommunication providers who provide advanced telecommunications to rural areas may, in some circumstances, draw from without contributing to the universal service pool. Congress has identified an excellent incentive that will encourage a more level playing field and may help create needed access through competition. We urge the recognition of this potential (drawing from the pool without contributing) as intended and thereby encourage local TECO's to participate in bringing advanced telecommunications to small, rural markets.

Unless there is significant financial incentives, the market share in Montana's rural and frontier areas will not drive deployment of service. In recent discussions with a major telecommunications carrier, the Eastern Montana Telemedicine Network (EMTN) was informed about the new and advanced services that would be deployed by that carrier in Montana. The carrier defined Montana as Billings, Great Falls, Helena, Bozeman, and Missoula.

#### Reasonable and Affordable Rates

Under the status quo, a major barrier to providing universal access for the transport of health care data, voice and visual information is the cost of transmission. For Telemedicine applications, the current small rural healthcare facility is faced with T-1 line charges of \$1200 to \$3900 per month (figures based for T-1 facilities from a rural hospital point of presence to the telephone central office, Colorado). Adding to this litany of ludicrousness are charges for T-1 access from the Colorado central office to the long distance carrier (\$450/mo), six channel, 336 Kbps usage fees (\$50 - \$90/hr), bridging fees (\$60 - \$80/hr), and cross-network access fees, i.e. AT&T to Sprint (\$150 - \$200/hr). These are not pricing structures that support a principle of Section 254(b)(1) of the Telecommunications Act for "...just, reasonable and affordable rates...". When cost is a barrier to the development and/or implementation of telecommunications based projects, the rate is not affordable. MHA supports a rate structure that is, in fact, reasonable and affordable. This may require a tiered pricing structure.

MHA supports a mandate for a minimum of T-1 or comparable facilities, with connectivity to a dial-up, T-1 long distance carrier of choice.

#### Cross-network, seamless and transparent connectivity

MHA supports a provision for enhanced telecommunications capabilities to hospitals and

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medical providers based on advances in technology.

MHA supports language that requires a plan and process for seamless and transparent transmission between networks.

There is substantial evidence that Telemedicine applications will continue to grow and be a positive factor in fee for service and managed care environments. The broadband demands of Telemedicine will also allow for planning that may incorporate separate, cost saving data and voice applications over the same pipeline. This would be a substantial benefit to our rural and frontier facilities.

It is expedient that telemedicine for the state of Montana be accessible, affordable, and of provide the quality of service needed to meet the health care requirements of our citizens.

Sincerely,



James F Ahrens  
President