Dear FCC,

"Consistent with section 151's mandate, further utilization of the rural health care universal service support mechanism may benefit the development of a broader and more fully integrated network of health care providers across our nation. In the aftermath of recent national events, the importance of such a network cannot be underestimated."

Avera Health is a regional non-profit healthcare delivery network that operates in over 130 communities in South Dakota, North Dakota, Minnesota, Iowa, Nebraska, and North Dakota. Support from the Universal Service Fund has had a very positive effect on our network and has allowed us to expand and provide many services to our affiliates such as teleradiology, telehealth, distance education, Internet based education and access to clinical and financial data systems. Our private network allows us to communicate when needed and allows us to provide crucial support to rural hospitals, clinics, and nursing homes that were and are struggling financially.

The RHCD support mechanism has driven down the costs of our communications network by over 60% for our RHCD supported hospitals and clinics and provides support to 33 of our locations. We have participated in the program since it's inception in 1998. We are very appreciative of this support and of the modifications to the program over the last five years. Please review our comments below as they relate to the April 19, 2002 "Notice of Proposed Rulemaking", WC Docket No. 02-60.

Page 8 Section 16
It is our position that the term "health care provider" be expanded to include additional non-profit healthcare facilities such as nursing homes and currently non-eligible rural health clinics and emergency service facilities. Organizations such as these provide vital healthcare services and many of these types of organizations, especially long-term care facilities, operate on extremely tight budgets. They will benefit from subsidized telecommunications services and will be able to provide additional services to their patients that they may not be able to otherwise provide such as psychiatric consults and treatments for nursing home residents. These types of consults and treatments can effectively be provided over telehealth (videoconferencing) without having to transport the residents to a hospital or clinic, which in many cases could be over 60 miles away. Add in various weather conditions and seldom-traveled roads and it is obvious in rural areas that transporting residents of long-term care facilities may not be in their best interests and could potentially be hazardous. Another benefit for these facilities is on-line education. With a subsidized Internet connection, these types of facilities can obtain mandatory training for the members of their staff over the Internet and keep employees in the community. The community and residents benefit from this in that the employee does not have to travel to obtain education and is readily available within the facility in the event that that employee's services are needed.

Page 11 Section 22 and 23
It is our position that support for toll charges could be eliminated without harming any rural health providers and that in it's place all Internet Service Provider charges be supported including flat-rate fees. Health providers can all potentially benefit from support for Internet

service. High-speed access to the Internet will allow the providers to access on-line health education for their employees, communicate with other providers and support organizations, and, in the near future, allow them to access telehealth services with high reliability and security. When combined with Virtual Private Networking (VPN), broadband services also provide a cost effective method for outreach sites to connect into a regional network.

Access to on-line health education is very critical to the employees of rural hospitals and clinics. Without this access they have to travel to various cities to obtain mandatory education and continuing education credits in order to maintain the accreditation and licensure need for their professions. Access to health education of this type will reduce health providers travel expenditures, keep the employees at the facility, and provide the hospitals and clinics greater access to education than they could obtain without high speed Internet access.

Although the Schools and Libraries program is unfamiliar to us, if the RHCD implements this discount it would seem that the process from the Schools and Libraries program, if efficient and fair, would be a proper mechanism for providing support for Internet services. We would recommend that the RHCD also provide support for Internet services that are purchased as a consortium and may connect into a network at an urban center. For example, our system purchases Internet services that connect into the network at our urban hospital. The networked rural hospitals and clinics all receive their Internet services from the urban hospital and pay their share for the Internet services, however the urban hospital is not eligible for support and they are billed by the Internet provider. If the RHCD supports this type of network, the rural hospitals and clinics will benefit from the additional RHCD support.

If the RHCD chooses to provide support in the form of a flat-rate percentage discount this would probably be the fairest method to distribute funds. The demand for Internet access support would likely be high, although it is unlikely that it would push the program over the funding limit of $400 million.

Page 13 Section 27

Providing support for Internet access will have a positive effect on the RHCD program in that it will help rural hospital obtain high-speed access to the Internet and to on-line education and healthcare related services. All entities and consortiums that are eligible for support for "standard" telecommunication services, T1, ISDN, etc, should be eligible for Internet access support without restriction. We anticipate that the applicants will be able to specify a level of bandwidth they require for Internet access and that that level of bandwidth will vary by entity thus the RHCD would best serve the rural healthcare providers by providing a discount at a flat rate for Internet services. There should be no restriction on the connection type for Internet services as those services can be provided over any number of telecommunication lines and the applicant will be able to determine the most appropriate method for the telecommunication providers to provide those services.

There will be potentially a high level of competition between providers of Internet service, which will range from national providers such as AOL and MSN to small local providers each with a variety of methods to provide their service. We do not anticipate that this program will have an impact on the build-out of broadband services in small rural communities. Most rural telcos in our services area already have some method to provide Internet and this program will only provide one customer to them which is not enough of a return on their investment on new services. Rural Utility

Services (RUS) grants will provide a better incentive for rural telcos to deploy broadband.

Page 14 Section 29
In regards to this section, we feel that the term "significant amount of non-health related activities" needs definition. Does significant mean over 50%, over 20%?

Page 16 Section 36 and 37
The most effective and fair method to compare functionality between or among different types of telecommunication services is to simplify how the services are approached. Our position is that bandwidth is bandwidth. First, 1.544mbps from a T1 is the same as 1.544mbps from a Cable Modem is the same as 1.544mbps from a DSL line is the same as 1.544mbps from Wireless Access, with the following caveats. The services should be segmented into private network (dedicated T1, T3, not services that require VPN for secure access) and public network (xDSL, Cable, Frame Relay, ATM, services that require VPN for secure access) for comparison purposes. A private network is more secure, has lower latency and travels a defined route whereas a public network is far less secure, has the potential for high latency and can travel an infinite number of paths. Second, bandwidth is bandwidth and for comparison purposes services should be examined across like configurations. For example, ASDL with 1.544mbps download and 512kbps upload is different than a Frame Relay T1 with 1.544mbps download and 1.544mbps upload in that they differ in the upload speed. Similar bandwidths should be compared for support purposes and the difference between the lowest urban comparable bandwidth and the selected rural bandwidth should be used as the basis for support.
Broadband services such as cable and xDSL should not be viewed as Internet services only but as access methods. When combined with VPN, they can provide a cost effective method for outreach sites to access the main network as opposed to installing high cost private lines that would likely be underutilized.

Page 18 Section 45
We support the elimination of the MAD. This will only affect two of our locations at this point and would provide approximately an additional $1,000 in funding annually to those hospitals. If the RHCD seeks to eliminate a time and labor intensive processes, it could simply institute a MAD that is fixed for everyone and could be set at the current longest MAD if there needs to be some form of restriction in place at all. In addition, this section makes reference to the SUD. We feel that this process should also be examined. We currently have a hospital and two clinics that are over our SUD of 11 miles but are within an RHCD designated "Urban" county. However, these facilities are rural as there is no "metro" area within the county. These locations are approximately 20 to 25 miles from the edge of the designated urban city and would benefit if the entire county were not classified as urban. In addition, on the comment regarding supporting circuits shorter than the SUD, if the rural site can prove that, although the circuit is shorter than the SUD, the cost of the circuit is greater than what its urban counterparts pay then the circuit should be supported.

Page 20 Section 51
The current application process has not been an issue for our system nor has it been a barrier to seeking support. One of the best projects undertaken by the RHCD was to accept electronic signatures and to allow applicants to file the forms on-line. Although not all of the forms are

on-line, the process has been greatly enhanced. We would like to be able to file the Form 466 and 468's online if the RHCD can derive a process for this such as once the telecommunications provider files the 468 online the application may file the 466 online, but not before.

Page 21 Section 52

We cannot suggest an easy method to eliminate delays due to lack of response from eligible telecommunications providers. Does the FCC have the authority to impose fines or some other penalty due to lack of response? An example process could be; 1. The application request either verbally or in writing, either by e-mail, fax, or letter, that the circuit provider provides the requested information or form. 2. After no response, the application sends a formal request on letterhead to the provider that refers to the date of the original request, provides a deadline, and also cc's the RHCD. 3. After no response the application notifies the RHCD of the lack of action by the provider and the RHCD contacts the provider. 4. After lack of response the RHCD notifies the FCC which in turn contacts the provider and informs them of potential penalties. 5. After lack of action the FCC imposes the penalties that should be severe enough to provide adequate funding to support the applications circuit.

Page 21 Sections 54 and 55

Although it is highly unlikely that, even with all the proposed changes such as the removal of the MAD and support for all Internet access, the funding cap of $400 million will be reached, the pro-rata distribution is the most fair method of distributing the funds in the event that the cap is reached.

Page 21 Section 56, 57, and 58

We feel that the current process for competitive bidding is sufficient. We find that the process is not hindered by this requirement and that the RHCD provides ample time for applicants to submit the required form well in advance of the start of the funding year. The main hindrance, however, is the lack of timely response, or in some cases lack of any response, from the telecommunication providers.

Page 22 Section 59

The current process is probably not adequate to ensure that the applicants select the most cost effective services. However, the rules currently state that the applicant may select the service not only on cost, but also on reliability, quality and whatever other factors the application deems relevant. Therefore, the RHCD must rely on the applicant's judgment that the selected service is appropriate for it's intended purpose. If the RHCD feels so inclined as to put in place a better method to track bids it could utilize a web-based form that the applicant fills out with pertinent information such as intended use of the circuit and what type of circuit and bandwidth is required. The telecommunication providers can then search these forms and post their bids on-line for the applicants to view under the applicant login section.

Page 23 Section 60

The partnerships between schools and libraries and clinics should be encouraged and the RHCD and SLD should collaborate to determine what portion of the circuit each will fund. For example, the school has lines that are utilized by both the school and clinic so both divisions should support their share of the usage. If the lines are used by the clinic exclusively, such as for telemedicine, then the RHCD should fund the lines. These

partnerships should not be forced however as clinical data and transmissions need to remain highly secure and confidential. If the clinic or hospital chooses to install separate lines and not share them with another entity that is supportable by the USAC, the clinic or hospital should be free to do so with security and privacy as the only reasons provided.

Page 23 Section 61

The current process is adequate to ensure the appropriate use of funds. So long as supported entities maintain proper paperwork and are able to demonstrate to the auditor that the circuits are being used for the intended supportable purpose, that should satisfy the RHCD.

Page 24 Section 63

The suggestions in this document should adequately spur demand for expanded services and support, although we do not expect that the $400 million cap will be reached.

These comments represent the following organizations that are members of Avera Health.

Eureka Community Health Services/Avera Health Eureka, SD
Marshall County Healthcare Center/Avera Health Britton, SD
Platte Community Memorial Hospital/Avera Health Platte, SD
Hand County Memorial Hospital/Avera Health
Miller, SD
Hegg Memorial Health Center/Avera Health Rock
Valley, IA
Sioux Center Community Hospital & Health Center/Avera Health Sioux
Center, IA
Pipestone County Medical Center/Avera Health Pipestone,
MN
Avera St. Luke's
Aberdeen, SD
Avera Sacred Heart Hospital
Yankton, SD
Avera Queen of Peace Hospital Mitchell, SD
Avera St. Anthony's Hospital
O'Neill, NE
Floyd Valley Hospital/Avera Health
LeMars, IA
Avera St. Benedict Health Center
Parkston, SD
Mobridge Family Practice/Avera Health Mobridge, SD
Milbank Medical Clinic/Avera Health
Milbank, SD
Flandreau Municipal Hospital/Avera Health
Flandreau, SD
Worthington Specialty Clinic/Avera Health
Worthington, MN
Olson Medical Clinic/Avera Health
Windom, MN
Spirit Lake Medical Center/Avera Health
Spirit Lake, IA
Avera Holy Family Health
Estherville, IA

Osceola Community Hospital/Avera Health
Sibley, IA
Marshall County Medical Clinic/Avera Health
Britton, SD
Avera United Clinic
Ellendale, ND
Pipestone County Medical Group/Avera Health Pipestone, MN
Tyler Healthcare Center/ Avera Health
Tyler, MN
Larchwood Medical Clinic/ Avera Health Larchwood, IA
Avera Weskota Memorial Medical Center Wessington Springs, SD
Divine Providence Health Center/ Avera Health Ivanhoe, MN
Fulda Clinic/Avera Health
Fulda, MN
Hegg Medical Clinic/ Avera Health Rock Valley, IA
Health Care Today Clinic / Avera Health
Slayton, MN