



AUGUST 2010

American Hospital
Association

*Dedicated to keeping our small or rural hospitals informed about pertinent issues, this edition of **Small or Rural Update** looks at recent legislative activities following the historic passage of the Patient Protection and Affordable Care Act (PPACA). On the regulatory front, we examine the multiple proposed and final rules from the Centers for Medicare & Medicaid Services (CMS), including regulations for the inpatient and outpatient prospective payment systems (PPS), physician fee schedule (PFS) and the definition of “meaningful use” and certification standards for electronic health records (EHRs). In addition, we review rules that affect small or rural hospitals from the Health Resources and Services Administration (HRSA), Federal Communications Commission (FCC) and Internal Revenue Service (IRS).*

LEGISLATIVE ADVOCACY: MOVING FORWARD

Several provisions of the PPACA that extended critical Medicare policies are scheduled to expire in the next several months. Moving forward, these “extenders” represent advocacy priorities for small or rural hospitals. In addition, there are other advocacy issues that have surfaced as part of rulemaking or that were missed in the PPACA. These issues comprise the AHA advocacy agenda for small or rural hospitals moving forward.

MEDICARE PROGRAM EXTENSIONS

In a May 20 [letter](#) to House and Senate leaders, the AHA, along with 13 related organizations including the National Rural Health Association, requested immediate action to address harmful Medicare policies that will go into effect on January 1, 2011. Many of these policies have been temporarily addressed by Congress in multiple bills over the past decade. However, without congressional action by December 31, these policies will expire and revert back to the detrimental provisions that limit access, beneficiary choice and provider reimbursement.

The groups urged Congress to address the following list of provisions:

- Extend the work geographic index floor and revise the practice expense geographic adjustment under the Medicare physician fee schedule.
- Extend the exceptions process for Medicare therapy caps.
- Extend the provision that allows independent laboratories to bill Medicare directly for certain clinical laboratory.
- Extend the bonus payments made by Medicare for ground and air ambulance services in rural and other areas.
- Extend certain payment rules for long-term care hospital services and of moratorium on the establishment of certain hospitals and facilities.
- Extend the physician fee schedule mental health add-on, which increases the payment rate for psychiatric services delivered by physicians, clinical psychologists and clinical social workers by 5%.
- Extend the existing outpatient hold harmless provision and allow sole community hospitals (SCH) with more than 100 beds also to be eligible for this adjustment.
- Extend the Medicare Modernization Act (MMA) policy that provides reasonable cost reimbursement for laboratory services provided by certain small rural hospitals (expires June 30, 2011).
- Extend reclassifications under section 508 of the MMA. (This provision expires on September 30).

MEDICAID FMAP EXTENSION

The Education Jobs and Medicaid Assistance Act (H.R. 1586) became law earlier this month. This AHA-backed legislation contains a six-month extension through June 2011 of Medicaid's temporary enhanced Federal Medical Assistance Percentage for states. The extension, which was part of the AHA's summer advocacy efforts, is crucial, as many states have included the FMAP funds in their 2010-2011 budgets. The FMAP increase is scaled-back from the original 6.2% for the six months to 3.2% for the first additional quarter (January 2011 through March 2011) and 1.2% for the second quarter (April 2011 through June 2011). States with high unemployment will continue to receive additional percentage points in funding for the six-month extension, as they do under current law.

OTHER LEGISLATIVE PRIORITIES

Other outstanding advocacy issues for the AHA include fixes to physician payment and certified registered nurse anesthetist (CRNA) services.

Physician Payment Fix - A steep payment cut to physicians was scheduled to go into effect on June 1. On June 18, the Senate passed legislation that delays for six months a 21% Medicare pay cut for physicians by providing a 2.2% increase in the Medicare physician fee schedule through November. A permanent fix remains a priority.

CRNA Pass-through and Standby Services - *The Rural Access to Nurse Anesthesia Services Act* (H.R. 3151/S.1585) would permit pass-through payment for reasonable costs of CRNA services in critical access hospitals (CAH) despite the reclassification of such hospitals as urban hospitals, including hospitals located in "Lugar counties," and for on-call and standby costs for such services.

BEYOND HEALTH CARE REFORM: REGULATORY POLICY

Several rules recently have been promulgated by CMS, HRSA and the IRS that have implications for small or rural hospitals. We highlight key provisions of three major rules for IPPS, OPSS proposed, and PFS proposed rule. Other regulations affecting small or rural hospitals also are reviewed including final

rules for health information technology. Details about the specific rural provisions of the IPPS final rule including implementation of the provisions in the PPACA will be discussed in a future *Update*. A more detailed analysis of CMS' regulations is discussed in the AHA's [Regulatory Advisories](http://www.aha.org), available at www.aha.org.

FY 2011 IPPS Final Rule

On July 30 CMS issued its hospital inpatient and long-term care prospective payment system (PPS) final rule for fiscal year (FY) 2011. Ignoring concerns expressed by America's hospitals and a majority of both houses of Congress, the rule finalizes a 2.9% cut to IPPS payments to eliminate what CMS claims is the effect of coding or classification changes the agency says do not reflect real changes in case-mix.

Operating Payment Update - The rule includes a mandated market basket update of 2.6%, as well as a 0.25 percentage point reduction to the FY 2011 marketbasket mandated by the PPACA. Thus, the marketbasket update for those hospitals that publicly report data on 45 quality measures is 2.35%. Hospitals not submitting data will receive a 0.35% update.

The final standardized amounts for FY 2011 are as follows:

Area Wage Index Greater Than 1.0			
Full Update (2.35%)		Reduced Update (0.35%)	
Labor-related	Non-labor-related	Labor-related	Non-labor-related
\$3,522.91	\$1,611.20	\$3,483.49	\$1,579.62

Area Wage Index Less Than 1.0			
Full Update (2.35%)		Reduced Update (0.35%)	
Labor-related	Non-labor-related	Labor-related	Non-labor-related
\$3,201.75	\$1,962.36	\$3,139.19	\$1,924.02

Documentation and Coding Offset – As stated earlier, the rule finalizes CMS' proposed cut of 2.9% to eliminate what it claims is the effect of coding or classification changes due to implementation of Medicare Severity Diagnosis-related Groups (MS-DRGs) that the agency says do not reflect real changes in case-mix.

In total, this proposal cuts \$3.7 billion for FY 2011. Although CMS has the authority to apply a prospective cut to permanently remove the remaining increased payments from the system, the agency stated that it will not do so at this time. Unlike in previous IPPS rules, CMS will apply the coding offset to SCHs, Medicare-dependent hospitals (MDHs) and Puerto Rico hospitals.

Capital Payment Update - CMS also will apply a 2.9% documentation and coding adjustment to the capital federal rate on a prospective basis, which will permanently remove these increased payments from the system. When coupled with the capital input price index update of 1.5%, hospitals will see their capital payments decrease by an average of 0.5%, or \$21 million total, in FY 2011 compared to FY 2010.

Outliers - The rule decreases the outlier fixed-loss threshold from its current level of \$23,140 to \$23,075.

Quality Reporting - CMS finalized several new measures for the Reporting Hospital Quality Data for the Annual Payment Update program. These new measures expand the data reporting requirements from 45 measures in FY 2011 to 60 measures in FY 2014. In addition, CMS will require hospitals to use additional mechanisms for the submission of data in certain instances. CMS did **not** finalize two proposals – collection of all-payer volume data and mandatory reporting into a clinical registry database.

72-hour Rule (Three-day Payment Window) - CMS modifies Medicare's policy for payment of outpatient non-diagnostic services provided on either the day of or during the three days prior to a Medicare beneficiary's inpatient admission – generally known as the "72-hour rule" or the "three-day payment window." For PPS hospitals, for outpatient services furnished on or after June 25, 2010, all nondiagnostic services (other than ambulance and maintenance renal dialysis services) provided by the hospital on the date of a beneficiary's inpatient admission are deemed related to the admission and, therefore, must be billed with the inpatient stay. For PPS hospitals, for outpatient services furnished on or after June 25, 2010, all nondiagnostic services (other than ambulance and maintenance renal dialysis services) provided by the hospital on the first, second and third calendar days preceding the date of a beneficiary's inpatient admission are deemed related to the admission and, therefore, must be billed with the inpatient stay, *unless the hospital attests that the nondiagnostic service is unrelated to the hospital stay.*

CMS is making similar changes for non-PPS or CAH hospitals, but only for services provided on the date of admission and on the first calendar day preceding the date of admission.

CMS states that it intends to establish a process for hospitals to attest that a non-diagnostic service is unrelated to the hospital stay, which will involve a condition code, modifier or other indicator on the claim. As part of the process, hospitals would be required to maintain documentation in the beneficiary's medical record to support their claim.

Area Wage Index - The rule makes several changes to the hospital area wage index mandated by the PPACA. Specifically, the rule:

- Decreases the thresholds necessary for a hospital to reclassify to another wage area, setting them at the levels that were in effect in FY 2008. This change will remain in effect through FY 2013. As a result, 22 additional hospitals qualify for reclassification to their primary area for FY 2011.
- Applies the rural floor budget-neutrality adjustment on a national basis, rather than at the state level.

CY 2011 OPPTS AND AMBULATORY SURGICAL CENTERS PROPOSED RULE

On July 2, CMS released the OPPTS and the ambulatory surgical center (ASC) payment system proposed rule for calendar year (CY) 2011. The proposed rule also implements several provisions enacted by the PPACA, including rural provisions such as a wage index floor for frontier states, physician supervision, a hold-harmless payment and adjustment for SCHs, and a "rural provider" exception in the physician self-referral prohibition. The final rule is expected to be issued by November 1.

Outpatient PPS Update - The rule includes a mandated 0.25%age point reduction to the CY 2011 marketbasket update of 2.4%. The resulting marketbasket update for CY 2011 will be 2.15%. For 2011 payment update purposes, hospitals must continue to report on the 11 existing outpatient quality measures. The update in 2011 for hospitals that do not meet quality reporting requirements would be

0.15%. CMS proposes a 2011 OPPTS conversion factor for hospitals meeting quality data reporting requirements of \$68.267. Hospitals that do not report the quality data will receive a reduced conversion factor of \$66.930.

Wage Index Floor for Frontier States - The PPACA required CMS to establish a wage index floor of 1.0 for Medicare inpatient and outpatient PPS payments to hospitals in frontier states. Therefore, CMS proposes to adjust the FY 2011 wage index to 1.00, as adopted on a calendar year basis for the OPPTS, for all hospitals paid under the OPPTS located in a frontier state in instances where their assigned FY 2011 wage index is less than 1.00. CMS used Census Bureau data to propose the following states as eligible: Montana, Nevada, North Dakota, South Dakota and Wyoming.

Physician Supervision - In response to concerns raised by the AHA, rural, CAH and other hospital and rural health groups, CMS proposes to permit a modified level of physician supervision for a few specified hospital outpatient therapeutic services, beginning in 2011. CMS identifies a set of 16 "nonsurgical extended duration therapeutic services" - these are procedures with a significant monitoring component that can extend for a sizable period of time, are not surgical, and typically have a low risk of complication. The list of services to which this revised policy applies includes observation services, various intravenous and subcutaneous infusions and various therapeutic, prophylactic or diagnostic injections. CMS proposes that these services require direct supervision only for the initiation of the service followed by general supervision for the remainder of the service. CMS would adopt the same definition of "general supervision" currently used for certain diagnostic services.

Physician Self-Referral - CMS proposes to implement AHA-supported changes enacted in PPACA to the "whole hospital" and "rural provider" exceptions in the physician self-referral law that will prohibit their use by new physician-owned hospitals and limit the ability of existing physician-owned hospitals to expand their capacity.

Transitional Corridor "Hold-Harmless" Payments - As required by the PPACA, CMS proposes to end the transitional outpatient payments (TOPs), also known as the "hold-harmless" payments, for rural hospitals with 100 or fewer beds and for SCHs with 100 or fewer beds as of December 31. Thus, in the absence of an extension of this policy in law, no hold-harmless payments are expected to be made for these hospitals in 2011.

Rural Adjustment for SCHs - CMS proposes to continue increasing payments to SCHs, including essential access community hospitals, by 7.1% for all services paid under the OPPTS, with the exception of drugs, biologicals, services paid under the pass-through policy, and items paid at charges reduced to costs. The adjustment is budget neutral to the OPPTS and applied before calculating outliers and coinsurance.

Cardiac and Pulmonary Rehab Services - In the proposed rule, CMS clarifies that a CAH outpatient department is considered a covered setting for cardiac, pulmonary and intensive cardiac rehabilitation programs, provided that the program meets all of the regulatory requirements including direct supervision of all services by a physician.

CY 2011 PHYSICIAN FEE SCHEDULE PROPOSED RULE

On June 25, CMS released the Medicare PFS [proposed rule](#) for CY 2011. The rule makes annual payment updates mandated by law and implements certain provisions of the PPACA. A final rule is expected by November 1 and will take effect January 1, 2011

Geographic Practice Cost Indices - CMS proposes to implement a number of statutory changes to the practice expense GPCIs in accordance with the new health reform law. This includes extending the 1.0 work GPCI floor for services furnished through December 31; revising the methodology for calculating

the practice expense GPCIs for CY 2010-2011 to reflect one-half of the relative cost differences for each locality compared to the national average; and establishing a 1.0 practice expense GPCI floor for physicians' services delivered in frontier states.

Bonus for Primary Care Services and General Surgery Services - The PPACA provides for a 10% primary care incentive payment (PCIP) for certain primary care services delivered by a primary care practitioner for five years, beginning January 1, 2011. In the rule, CMS proposes to use CY 2009 PFS claims data to determine those practitioners who are eligible for the PCIP in CY 2011. In order for Nurse Practitioners, Clinical Nurse Specialists and Physician Assistants to be eligible, they must be billing for their services under their own National Provider Identifier (NPI) and not furnishing services incident to physicians' services.

Also, the PPACA provides a 10% health professional shortage area (HPSA) surgical incentive payment (HSIP) for certain major procedure codes delivered by general surgeons in a HPSA for five years, beginning January 1, 2011. For the HSIP program, CMS proposes to define major surgical procedures as those for which a 10-day or 90-day global period is used for payment under the PFS. In addition, CMS indicates that the procedure must be in a location that was defined by the HHS Secretary as of December 31 of the prior year as a geographic HPSA.

The PCIP and HSIP will be made quarterly. For those CAHs paid under the Optional Method, in which they bill on behalf of practitioners for their professional services, CMS will make quarterly payments directly to the CAH.

CAH Method 2 Payment Policies - Under Section 5501 of the PPACA and as referenced in the PFS proposed rule, an eligible primary care physician in HPSAs may receive both a 10% HPSA bonus and PCIP. Also CAHs that use Method 2 or the Optional Method would receive their 101% facility payment (as of the PPACA) plus 115% for physician payments plus 10% for the new PCIP or HSIP bonus.

PCIP/HSIP for CAHs under the Optional Method - Payment is made to the eligible primary care practitioner or, where the physician has reassigned his or her benefits to a CAH paid under the Optional Method, to the CAH based on an institutional claim. HPSA surgical incentive payment is made to the surgeon or, where the surgeon has reassigned his or her benefits to a CAH paid under the Optional Method, to the CAH based on an institutional claim.

Medicare Telehealth - CMS maintains a specific list of services that can be billed as telemedicine services for patients presenting to an eligible provider in a designated rural area. The "originating site," where the patient presents, may bill Medicare for a facility fee, while the physician providing the service through telecommunications from a "distant site" is paid the amount allowed by the Medicare fee schedule. In the rule, CMS reviews requests to expand the list. For inpatients, CMS proposes to add subsequent hospital care services to the list of approved telemedicine services, with the limitation of one telehealth visit every three days. For post-acute settings, to add subsequent nursing facility care services that are not federally mandated, with the limitation of one telehealth visit every 30 days.

Exceptions Process for Medicare Therapy Caps – The rule extends the exceptions process for therapy caps through December 31, 2010.

Payment for Technical Component of Certain Physician Pathology Services – The rule continues payment to independent laboratories for the therapy component of physician pathology services for fee-for-service Medicare beneficiaries who are inpatients or outpatients of a covered hospital through CY 2010.

Ambulance Add-On - The rule implements the PPACA's extension to the existing add-on payment for ground ambulance services – a 3% add-on for rural areas and a 2% add-on for urban areas – through December 31. It also extends through December 31 the “super rural” ambulance add-on. These provisions are retroactive to January 1, 2010.

Medicare Reasonable Costs Payments for Certain Clinical Diagnostic Lab Tests - The rule reinstates reasonable cost payment for clinical diagnostic laboratory tests performed by hospitals with fewer than 50 beds that are located in qualified rural areas as part of their outpatient services for cost reporting periods beginning on or after July 1, 2010 through June 30, 2011.

Extension of the Work Geographic Index Floor - The law extends the 1.0 work GPCI floor for services furnished through December 31. Absent further statutory extension of the policy, however, as of January 1, 2011, this provision will expire. Second, for CYs 2010 and 2011, the PPACA implements a geographic adjustment factor to the physician practice expense (PE) portion of the GPCI. Third, this section of the law requires the HHS Secretary to analyze the current methods and data sources it uses to determine the PE component of the PFS, specifically the relative cost differences in employee wages and office rent compared to the national average, and to make appropriate adjustments to the PE GPCI by no later than January 1, 2012. Finally, effective January 1, 2011, the law establishes a 1.0 PE GPCI floor for PFS services furnished in frontier states, defined by CMS as Montana, Wyoming, Nevada, North Dakota and South Dakota.

FINAL RULES ON “MEANINGFUL USE” AND CERTIFICATION CRITERIA

On July 13, CMS released its final rule defining "meaningful use" of EHRs. At the same time, the Office of the National Coordinator (ONC) for Health Information Technology (IT) issued a final rule that sets certification criteria, standards and implementation specifications for EHR technology. Taken together, these regulations set EHR adoption requirements that hospitals and physicians must meet under the *American Recovery and Reinvestment Act of 2009* (ARRA) to qualify for additional Medicare and Medicaid incentive payments beginning in 2011 and to avoid significant payment penalties in 2015 and later years.

CMS Meaningful Use – In the final rule, CMS rightly recognized the special role that CAHs play in their communities by providing needed access to Medicaid funding under this rule. CMS also removed some unnecessary administrative burdens that would have been time consuming and costly for hospitals, without improving patient care. However, the AHA is concerned that this rule may adversely impact rural hospitals and the patients they serve and exacerbate the digital divide in health care.

The rule requires that hospitals adopt and meaningfully use certified EHRs to meet 14 "core," or mandatory, objectives and an additional five objectives chosen from a "menu set" of 10 options, of which at least one must address public health objectives. The finalized measures draw from those in the proposed rule. In response to comments, including those from the AHA, many of the objectives were narrowed in scope and clarified.

The ARRA also requires that hospitals including CAHs submit to the Secretary information on clinical quality measures through EHRs as determined by the Secretary. CMS has finalized 15 clinical quality measures that hospitals must report to meet the meaningful use criteria. To report on the quality measures, for FY 2011, hospitals must attest to the use of a certified EHR system to capture and calculate the results for the clinical quality measures. Hospitals also must submit the numerators, denominators and patient exclusions for each clinical quality measure and attest to the accuracy and completeness of the information submitted. Beginning in FY 2012, an eligible hospital using a certified EHR technology would be required to submit information on clinical quality measures electronically in order to be a meaningful EHR user.

In the final rule, CMS clarified that the clinical quality measures adopted for the Medicare EHR Incentive Program also will apply to the Medicaid EHR Incentive Program and did not finalize any separate quality measures for Medicaid. CMS has included CAHs as eligible for Medicaid EHR incentive payments, if they meet the volume thresholds and other Medicaid requirements. In general, hospitals must have 10% Medicaid patient volume (less for children's hospitals). Medicaid payments to CAHs will follow the same formula as for other acute-care hospital, which is based on the Medicare payment formula for subsection (d) hospitals.

ONC Certification - In a separate rule, ONC finalized a definition of certified EHRs and an initial set of certification criteria, standards and implementation specifications for EHRs. The certification criteria follow the Stage 1 meaningful use objectives laid out by CMS and also require specific steps to protect the privacy and security of health information. The certification criteria apply to EHR products, not providers.

Hospitals and physicians must use certified EHRs to qualify for the Medicare and Medicaid payments. ONC provides a multi-stage definition of "certified EHR technology." In essence, providers must use either a "complete EHR," or a combination of EHR modules, which can be "any service, component, or combination thereof that can meet the requirements of at least one" of the certification criteria adopted by the Secretary. Providers who choose to combine multiple EHR modules are responsible for ensuring that the modules work together and that, together, they meet all of the certification criteria.

OTHER REGULATORY PRIORITIES

CAH Conditions of Participation (CoP): Credentialing and Privileging of Telemedicine Physicians and Practitioners - The current Medicare CoP require the governing body of a hospital to make all privileging decisions based on the recommendation of the hospital's medical staff after the medical staff has thoroughly reviewed the credentials of practitioners applying for privileges. Similarly, each CAH is required to have its privileging decisions made by its governing body or the individual responsible for the CAH. This requirement is applied regardless of whether the services are to be provided onsite at the hospital or through a telecommunications system.

CMS proposes revising the credentialing and privileging requirements around the provision of telemedicine services. The proposed change would allow the hospital receiving the telemedicine services to rely upon credentialing and privileging information from the hospital providing the telemedicine services as long as certain conditions are met, including that

- 1) the hospital providing the telemedicine services is a Medicare-participating hospital,
- 2) the practitioner providing the telemedicine services is privileged at the hospital providing the telemedicine services,
- 3) the practitioner is licensed to practice in the state where the receiving hospital is located, and
- 4) the hospital receiving the telemedicine services has evidence of an internal review of the practitioner's performance, including at a minimum information on adverse events and complaints.

In addition, the proposed CoP would require the governing body of the hospital receiving the telemedicine services to ensure that the governing body of the hospital providing the telemedicine services meets the existing medical staff CoP provisions. Similar changes are proposed for the CAH CoP.

The AHA generally support CMS' proposed changes to the credentialing and privileging requirements for telemedicine services and believe these changes will allow hospitals to provide and receive telemedicine services that are vital in many communities to ensuring patients' access to services. However, the proposed CoPs do not address how hospitals might more easily credential and privilege these practitioners in a way that ensures the safe provision of telemedicine services. We urge CMS to

develop a process whereby hospitals can use the credentialing and privileging information from practitioners who fulfill the Medicare Conditions of Coverage.

Additional Requirements for Tax-Exempt Hospitals - Schedule H of IRS Form 990 is required to be completed by an organization that operates at least one facility that is, or is required to be, licensed, registered or similarly recognized by a state as a hospital. The PPACA applies several new requirements to section 501(c)(3) hospital organizations in addition the requirements otherwise applicable for tax exemption. The IRS has requested comments on four new requirements it imposes on hospitals seeking to qualify for and maintain tax-exempt status and that, if the hospital organization operates more than one hospital facility, each of those facilities also must comply with the new requirements. The requirements are for a health needs assessment, a financial assistance policy, a limitation on charges, and billing and collections. Although the community health needs assessment requirement is effective for tax years beginning after March 23, 2012, the remaining three requirements are effective immediately.

In a July 22 comment letter, the AHA urged the IRS to seek formal legislative action to establish a “reasonable cure” period for any failure to meet the new requirements, such as the later of 90 days or the end of the fiscal year in which the failure is discovered.

The 340B Drug Pricing Program - Under the 340B drug program, drug manufacturers are required to provide outpatient drugs at a reduced price. The 340B price defined in the statute is a ceiling price, meaning it is the highest price a covered entity would have to pay for a given outpatient drug. Entities can negotiate below ceiling prices with manufacturers. As a result, 340B prices have been found to be roughly 50% of the Average Wholesale Price. Effective August 2, the HRSA Office of Pharmacy Affairs will start enrolling new-covered entities eligible for the 340B drug pricing program as a result of the PPACA. There will be a rolling admission process for these new entities which include CAHs, rural referral centers (RRCs), and SCHs as well as free-standing children’s and cancer hospitals. Rolling admission process for new covered entities will close on September 30. Entities wishing to enroll after that date must wait for the next enrollment period.

The new-covered entities eligible for 340B are:

- Free-standing children’s hospitals with a disproportionate share hospital (DSH) adjustment > 11.75%;
- Free-standing cancer hospitals with a DSH adjustment > 11.75%;
- SCHs and RRCs with DSH adjustment ≥ 8%; and
- CAHs.

All of the new-covered entities must either be publicly owned or be a private, nonprofit hospital with a contract with state or local government to provide health care services to low-income populations not eligible for Medicaid or Medicare. Eligible CAHs, RRCs and SCHs also may be members of GPOs. The [new enrollment forms](#) are available from HRSA.

FCC National Broadband Plan - Recently the FCC issued a proposed rule on reforms to the universal service support programs for rural health care providers. The agency proposes to make the following broad categories of changes:

- Create a “Health Infrastructure Program” that will largely codify the existing Rural Health Care Pilot Program. It will fund up to 85% of the costs of new and upgraded infrastructure for rural health care institutions and providers to connect to medical institutions in more urbanized areas.
- Replace the current Internet Access Fund in the RHC program with a “Broadband Services Program.” This will fund up to 50% of the monthly recurring cost of dedicated broadband connections for health care providers.

- Expand eligibility for the Rural Health Care programs to include administrative offices and data centers that support eligible health care providers, skilled nursing facilities and dialysis centers.
- Establish annual caps and priority rules, in light of the expanded support programs proposed in the item.
- Eliminate the “mandatory offset rule,” which currently requires telecommunications service providers in the rural health care program to take their reimbursements as credits against their required USF contributions rather than direct payments.
- Implement performance measures in the Rural Health Care support programs, including “meaningful use criteria,” and data gathering and analysis programs.

The AHA will be submitting a comment letter to the FCC on its proposed rule.

Rulemaking on Designation of MUPs/HPSAs - The PPACA mandates negotiated rule-making for the definition of Medically Underserved Populations (MUPs) and primary care Health Professions Shortage Areas (HPSAs). Revisions to the criteria or process for designating MUPs/HPSAs will affect the providers, programs and communities in rural and urban areas that depend on these designations for federal funding. More than 34 federal programs use these shortage designations for eligibility and funding criteria..

HHS Secretary Sebelius recently announced the appointment of a committee comprised of 28 members who represent programs that are most affected by these designations. Those programs include:

- Community Health Centers,
- Rural health clinics and health care practitioners,
- Special populations with unique health care needs, and
- Technical experts in the area of research in health care access and statistical methods.

The AHA’s John Supplitt, senior director of the Section for Small or Rural Hospitals, was appointed as a committee member.

Visit the Section for Small or Rural Hospitals Web site at <http://www.aha.org/smallrural>

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