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KEY PROVIDER ISSUES IN HEALTH CARE REFORM

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RURAL HEALTH PROVISIONS

Rural health care access, utilization and quality received a great deal of attention throughout the health care reform process. In addition to making payment changes, the bill requires the Medicare Payment Advisory Commission (MedPAC) to study the adequacy of Medicare payments to providers and suppliers in rural areas by January 1, 2011. Below is a summary of major provision that will improve payments to rural health care providers.

- Revising the practice expense geographic adjustment under the Medicare physician fee schedule for 2010 and 2011. The fix will pay providers in low-wage markets at a higher rate against the national average for employee wages and rent (three-quarters for 2010 and one-half for 2011) in an effort to minimize geographic variation. (SEC. 3102)
- Low-volume Medicare hospitals received a temporary improvement to the inpatient hospital payment adjustment for discharges occurring between 2005 and 2010. The definition of low-volume hospital is expanded for fiscal years 2011 and 2012 to include facilities located 15 road miles (rather than 25) from another hospital and those with up to 1,600 discharges. In 2013, the definition of low-volume hospital reverts back to the 2010 criteria. (SEC. 3125)
- Increases the number of residency slots and training grants for graduate medical education (GME) programs in rural and underserved communities by redistributing unused positions from any hospital across the U.S. starting as early as July 2011. CMS must produce a rule and establish an application process to implement this provision. (SEC. 5503)
- Rural home health agencies and ambulance services both received temporary payment add-ons that had been set to expire in 2010. CMS is reprocessing claims back to the start of the year and advising providers on submission guidelines going forward. (SEC. 3105)
- The rural community hospital demonstration program was extended by five years and expanded to include a total of twenty states (from the original ten) and thirty hospitals, as determined by the Secretary. This demo pays CAH-type rates to hospitals with up to 50 beds. (SEC. 3123)

Beyond the statutory changes, the administration also committed to take several actions to immediately address geographic inequities in Medicare's payment systems and direct the Institute of Medicine to make recommendations to better align Medicare's payments to reward providers in low cost markets for quality and efficiency.

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