Committee on Ways and Means

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

How the Medicare Bill Immediately Helps Hospitals

The Conference Report corrects existing inequities by infusing billions of dollars over the next decade into hospitals everywhere. It includes the following provisions that benefit hospitals:

- **Standardized Amount.** Permanently maintains the increase in the standardized amount (or base payment rate) for rural hospitals and hospitals in cities under 1 million by 1.6%, up to the large urban payment rate.
- **Labor Share.** The labor share of the usage index used for hospital reimbursement drops from 71% to 62% for low wage rural, small urban and large urban cities in FY 2005. All other areas held harmless.
- **Inpatient Technology.** Increases payments for new technology for inpatient hospital services.
- **Indirect Medical Education.** Increases payments for teaching hospitals over the next three years.
- **Disproportionate Share (DSH**). Increases DSH payments as of April, 2004 for small rural and urban hospitals in all areas by more than doubling the amount of allowed payments (5.7 to 12% of total Medicare inpatient payments).
- **Wage Index.** Reforms wage index reclassification by allowing another option based on commuting rather than arbitrary distance criteria.
- **Hospital Outpatient**. Targets additional funds at high cost drugs.
- **Low Volume.** Targets additional payments at hospitals with less than 800 discharges in a year. The hospital must be 25 miles from another similar hospital.
- **Critical Access Hospitals (CAH)**.
    - Pays costs plus 1% to ensure that these hospitals can improve access and services;
    - Reinstates special cash flow provision (Periodic Interim Payments) and asks the Secretary to tailor these payments to small hospitals;
    - Fixes special physician payment adjustment so that local physicians and visiting specialists receive a 15% bonus for hospital outpatient services;
    - Creates flexibility in the bed size requirement for current and future CAHs;
    - Extends coverage of costs to retain emergency on-call providers to physician assistants, nurse practitioners and clinical nurse specialists;
    - Allows for hospitals with psychiatric or rehabilitation units of 10 beds or less to be eligible for CAH status.
    - Maintains $35 million in FLEX grants per year, which is targeted at providing services to CAH providers.
- **Graduate Medical Education (GME).** Allows hospitals in rural areas and small cities that provide graduate medical education to receive additional direct medical education and indirect teaching hospital funds by moving unused residency slots to these hospitals.
- **Sole Community Hospitals.** Allows hospitals to qualify as sole community hospitals that are missing some of the qualifying data.

- **Hospital Outpatient**. Extends by two-years stability in funding for hospital outpatient services provided by small rural and sole community hospitals.
- **Independent Pathology.** Grandfathers existing relationships that are common for rural hospitals and urban hospitals for separate payment and billing for pathology.
- **Regulatory Reform.** Hospitals benefit from policies related to overpayments, disallowing the application of local coverage policies to emergency services, limitation on collection of information for Medicare Secondary Payer for reference lab tests, and requiring the secretary to arrange for the data needed for the calculation of Medicare DSH.
- **Illegal Immigrants.** Almost $1 billion in funding for services provided to illegal immigrants.
- **Medicaid DSH**. First year increase of 16% increase in Medicaid DSH payments.