Committee on Ways and Means

Medicare Prescription Drug, Improvement, and Modernization Act of 2003

How the Medicare Bill Immediately Helps Sustain Access In Rural Areas and Small Cities

The Medicare bill corrects existing inequities by infusing billions of dollars over the next decade into rural and small towns as well as small hospitals everywhere. It includes the following provisions that benefit providers in rural areas and small cities:

- **Standardized Amount.** Permanently extends 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 areas. All other areas held harmless.
- **Disproportionate Share (DSH**). Immediately increases DSH payments for small rural and urban hospitals by more than doubling the amount of allowed payments (5.7% to 12% of total Medicare inpatient payments.)
- **Low Volume Hospitals.** Increases payments for hospitals with a low (800) number of discharges, if the hospital is more than 25 miles away from a 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 hospitals with small psychiatric and rehabilitation units to qualify as critical access hospitals; and,
    - Reauthorizes rural flexibility grants.
- **Wage Index.** Reforms wage index reclassification by allowing another option based on commuting rather than arbitrary distance criteria.
- **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 the outpatient financial protections for small rural hospitals and sole community hospitals.
- **Hospital Outpatient**. Targets additional funds at high cost drugs.

- **Physicians.** Adds a 5% bonus payment for primary care and specialty care physicians providing care in physician scarcity areas from 2005 to 2007.
- **Physician Geographic Adjustor.** Establishes a floor on the work component of the physician geographic adjustor from 2004 to 2006; raises payments in low cost of living areas.
- **Clinics.** Pays separately for the professional services of rural health care clinics and federally qualified health centers to treat skilled nursing patients.
- **Low Volume Rural Ambulance**. Targets higher payments for ambulances in counties with a lower Medicare population and adds a 2% across the board increase.
- **Home Health.** Adds a 5% increase for all rural home health agencies for one year.
- **Nurse Practitioners.** Allows nurse practitioners to continue acting as independent practitioners for hospice patients.
- **Community Health Centers.** Provides safe harbor for community health center activities around donations and other remunerations to be used in providing services to medically underserved areas. Provides for additional payment when private Medicare Advantage plans reimburse a federally qualified health center less than its costs of providing care.
- **Practitioners.** Allows practitioners employed by rural health clinics and community health centers to bill separately for services provided to skilled nursing residents. $0.1 billion.
- **Independent Pathology.** Grandfathers existing relationships that are common for rural hospitals for separate payment and billing for pathology.