

Summary of Rural Provisions
Prescription Drug and Medicare Improvement Act of 2003
(Update with S. 1 and HR 1- 7/17/2003)

Issue	Senate Provision	Effective Date	House Provision	Effective Date
Medicare Base Rate Differential	Eliminates base rate differential between urban and all other hospitals.	October 1, 2003	Eliminates base rate differential between urban and all other hospitals	October 1, 2003
Disproportionate Share Payment (DSH) Cap	Eliminates the DSH payment cap of 5.25% for small rural hospitals and 10% for sole community hospitals	October 1, 2004	Raises the DSH payment cap to 10% for small rural hospitals	October 1, 2003
Low-volume payment adjustment	Institutes a low-volume payment adjustment of up to 25%	October 1, 2004		
Labor-related share of base payment	Reduces the labor-related share of the inpatient Perspective Payment System (PPS) base rate to 62%	October 1, 2004	Reduces the labor-related share of the inpatient Perspective Payment System (PPS) base rate to 62%	October 1, 2003
Outpatient PPS	<ul style="list-style-type: none"> ▪ Extends the outpatient PPS hold-harmless provision for small rural hospitals to apply during 2006 ▪ Increase payment for services performed in small rural hospitals and reimbursed through the outpatient PPS by 5% ▪ Also includes sole community hospitals in the hold harmless provision 	January 1, 2004	<ul style="list-style-type: none"> ▪ Extends the outpatient PPS hold-harmless provision for small rural hospitals until January 1, 2006 ▪ Also includes sole community hospitals in the hold harmless provision Directs the Secretary to study the cost of OPSS for rural providers vs. urban providers and make payment adjustments to rural providers if they have higher costs	January 1, 2004

Issue	Senate Provision	Effective Date	House Provision	Effective Date
Critical Access Hospital (CAH) provisions	<ul style="list-style-type: none"> ▪ Allows CAHs to allocated any number of beds between inpatient and swing beds (October 1, 2004) ▪ Eliminates 35 mile isolation test for cost based ambulance services ▪ Extends cost reimbursement to on-call emergency care providers to physician assistants, nurse practitioners, and clinical nurse specialists ▪ Reinstates periodic interim payments (PIP) for inpatient services ▪ Excludes new CAHs from inpatient PPS wage index calculations (January 1, 2004) ▪ Exclusion of distinct part rehab and psychiatric units from the bed limit 	January 1, 2005 (except where noted)	<ul style="list-style-type: none"> ▪ Increase payments to 102% of reasonable costs (effective October 1, 2003) ▪ Extends cost reimbursement to on-call emergency care providers to physician assistants, nurse practitioners, and clinical nurse specialists ▪ Eliminates 35 mile isolation test for cost based ambulance services provided by the first responder (first cost reporting period after enactment) ▪ Reinstates periodic interim payments (PIP) for inpatient services and requires the Secretary to develop an alternate PIP methodology ▪ Eliminates requirement for all physicians to assign billing rights to a CAH in order for them to receive 115% of fee-schedule payments for physician services for physicians who do assign billing rights (upon enactment and retro active to BBRA) <p>Increases limitations for inpatient and swing beds by 5 beds for hospitals that the have provided justification of “strong seasonal variation” in occupancy. For hospitals not qualifying for seasonal adjustment, permits flexibility in the use of 25 beds as long as no more than 10 are used for non-acute services.</p>	January 1, 2004 (unless otherwise noted)

Issue	Senate Provision	Effective Date	House Provision	Effective Date
Home Health Services	Increases payments for home health services provided in rural areas by 5%	October 1, 2004	Increases payments for home health services provided in rural areas by 5%	January 1, 2004
Ground Ambulance	Increase payments for ground ambulance services in rural areas by 5%	January 1, 2005	Increase payments for ground ambulance services originating in a qualified rural areas by an amount to be determined by the Secretary	January 1, 2004
Exclusions from SNF PPS	Excludes services provided in Skilled Nursing Facilities (SNFs) by providers affiliated with the following types of facilities from the SNF PPS: <ul style="list-style-type: none"> • RHCs • FQHCs • Entities jointly owned by hospitals and CAHs 	January 1, 2005	Excludes services provided by providers affiliated with RHCs or FQHCs from the SNF PPS	January 1, 2004
Medicare Incentive Payment Program (IPP)	Requires the Secretary to: <ul style="list-style-type: none"> ▪ Establish a procedure for determining when IPP payments are applicable ▪ Develop and implement a program to train providers about the IPP 	Upon enactment.	Provides a 5% bonus payment to physicians in primary care or specialty care scarcity areas Requires the Secretary to: <ul style="list-style-type: none"> ▪ Establish a procedure for determining when IPP payments are applicable ▪ Develop and implement a program to train providers about the IPP 	January 1, 2004
Sole Community Hospital Lab Services	Provides cost-based reimbursement for lab services performed in a sole community hospital	January 1, 2005		
Physician Payments	Establishes a floor of .980/1.00 in the practice expense, malpractice, and work geographic indices used to calculate the physician fee schedule	January 1, 2004/January 1, 2005	Establishes a floor of 1.00 in the work geographic indices used to calculate the physician fee schedule	January 1, 2004

Issue	Senate Provision	Effective Date	House Provision	Effective Date
Durable Medical Equipment (DME) and Orthotics and Prosthetics	Freezes payments for DME and orthotics and prosthetics until 2011	January 1, 2004		
Cost sharing for clinical laboratory tests	Applies deductible and co-insurance to all lab tests except those preformed by an independent laboratory	January 1, 2004		
Outpatient Drugs	Reduces payments for covered outpatient drugs to 85% of the Average Wholesale Price (AWP) in 2004 and to the AWP from June of the previous year adjusted by the CPI for payments in 2005 and subsequent years.	January 1, 2004		
Medicare Hospital Flexibility Program (FLEX)	Reauthorizes FLEX with \$40 million in appropriations for FY 2004-FY2008 with \$25 million per year authorized for the Small Rural Hospital Improvement Program	Upon enactment	Reauthorizes FLEX at \$25 million per year for FY 2004-2008	Upon enactment
GAO Studies	<p>Requires the GAO to conduct the following studies:</p> <ul style="list-style-type: none"> ▪ Appropriateness and need to rebase under the prospective payment system for inpatient hospital services ▪ Conduct a study to determine if IPP payments increase access to care for beneficiaries living in Health Professional Shortage Areas (HPSAs) ▪ Geographic differences in payments for physician services 		Requires the GAO to conduct a study on the geographic differences in payments for physician services	

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Rural Health Clinics (RHC)	RHC upper payment is increased to \$80.00 for calendar year 2005	January 1, 2005		
New Rural Hospital Designations	<p>Establishes 4 Rural Community Hospital (RCH) Demonstrations (including Kansas and Nebraska) that provide:</p> <ul style="list-style-type: none"> • Cost based reimbursement or PPS payments for inpatient, outpatient, home health • Consolidated billing • Exemption from 30% reduction in bad debt payments • Return on equity capital of 150% <p>Eligible hospitals must be:</p> <ul style="list-style-type: none"> • Less than 51 acute care beds • Have 24 hour emergency care • Be in a rural area 	October 1, 2004	<p>Creates a new classification of hospitals based on the following requirements:</p> <ul style="list-style-type: none"> ▪ Located in a rural area ▪ More than 25 acute care beds ▪ Secretary's determination that closure would reduce access to care for Medicare beneficiaries ▪ A high percentage of Medicare beneficiaries in the area receive inpatient care at the hospital ▪ If more than 200 beds, a high percentage of Medicare beneficiaries receive specialized surgical inpatient care at the hospital <p>Hospital has a quality of care score above the median</p>	October 1, 2004
Hospital Market Basket			Hospital market basket weights and the labor share will be updated more frequently than once every 5 years	October 1, 2004
Unused Resident Positions			Identifies hospitals with residency slots and reallocates those residency slots to hospitals with full residency programs with a priority places on rural and small urban area hospitals and residency training programs	Upon enactment

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Safe Harbors			Creates safe harbors for certain collaborative efforts involving health centers that benefit medically underserved populations	180 days after enactment
Sole Community Hospital Designation			Sole Community Hospital treatment and payment will not be denied due to missing cost report data	January 1, 2004
Telemedicine Demonstration Projects			Extends telemedicine demonstration projects by 4 years with funding of \$60 million	Upon enactment
Rural Hospice Demonstration Project			Creates a demonstration project to study hospice care in rural facilities of 20 or fewer beds	Upon enactment
MedPAC Study on DSH Payments	Directs MedPAC to study the GME and DSH payment formulas with respect to the role of uncompensated care costs	Upon enactment		
CAH Improvement Demonstration Project	Establishes 4 demonstration projects (including Kansas and Nebraska) to evaluate the following changes to the CAH program: <ul style="list-style-type: none"> • Exclusion of distinct part rehab and psychiatric units from the bed limit • Exclusion from home health PPS • Exemption from SNF PPS • Establishes consolidated billing • Permits Return on Equity payments 			