

Summary of the Rural Provider Provisions of the Medicare Prescription Drug and Modernization Act.

Rural Hospital Provisions:

- **Equalizing Urban and Rural Standardized Payment Amounts**

Beginning with discharges in FY2004, Medicare will pay hospitals in rural and small urban areas using the standardized amount that would be used to pay hospitals in large urban areas.

- **Enhanced Disproportionate Share Hospital (DSH) Payments**

Starting for discharges after April 1, 2004, a hospital that is not a large urban hospital that qualifies for a DSH adjustment will receive its DSH payments using the current DSH adjustment formula for large urban hospitals, capped at 12%.

- **Revision of the labor-related share of the Inpatient Hospital Wage Index**

For cost reporting periods beginning on or after October 1, 2004, the labor-related share of the wage index will be lowered to 62% of the standardized amount when such change will result in higher total payments to the hospital.

- **More Frequent Update in Weights Used in Hospital Market Basket**

The Secretary is required to revise the market basket weights to reflect the most currently available date and to establish a schedule for revising the cost category weights more often than once every 5 years.

- **Improvements for Critical Access Hospital (CAH) Program**

Inpatient, outpatient, and covered skilled nursing services provided by a CAH will be reimbursed at 101% of reasonable costs, beginning on or after January 1, 2004.

Reimbursement of on-call emergency room providers is expanded to include physician assistants, nurse practitioners, and clinical nurse specialists for the cost associated with covered Medicare services provided on or after January 1, 2005.

For payments made on or after July 1, 2004, and eligible CAH will be able to receive payments made on a periodic basis for its inpatient services.

The Secretary would not be able to require all physicians providing services in a CAH assign their billing rights to the entity in order for the CAH to be able to be paid on the basis of 115% of the fee schedule for the professional services provided by the physician. However, a CAH would not receive payment based on the 115% of the fee schedule for any individual physician who did not assign its billing rights to the CAH.

A CAH would be able to operate up to 25 swing beds or acute care beds, subject to the 96 hour average length of stay for acute care patients.

The Rural Hospital Flexibility Grant Program is reauthorized at \$35 million each year from FY 2005 through FY 2008. A state may not spend more than 15% of the grant amount or the States federally negotiated indirect rate for administrative purposes. Beginning with FY 2005 up to 5% of the total amount appropriated from grants will be available to HRSA for administering these grants.

A CAH can establish a distinct part psychiatric or rehabilitation unit that meets the applicable requirements for such beds established for a short-term, general hospital. Medicare payments for services provided in the distinct part units will equal payments that are made on a prospective payment basis to distinct part units of a short-term general hospital. These beds, which cannot exceed 10, will not count against the CAH bed limit.

The authority to waive the distance requirements for CAH status will be eliminated 2 years after enactment.

- **Inpatient Hospital Payment Adjustment for Low-Volume Hospitals.**

A low volume hospital is a short-term general hospital that is located more than 25 road miles from another such hospital and that has less than 800 discharges. A graduated adjustment to Medicare's inpatient payment rates will be provided to account for the higher unit costs associated with low-volume hospitals starting for discharges occurring in FY 2005. The Secretary shall determine the empirical relationship between the standardized cost per case, the number of discharges, and the additional incremental cost for low-volume hospitals. The percentage payment increase

for these hospitals will be based on this relationship, but will be no greater than 25%.

- **Treatment of Missing Cost Reporting Periods for Sole Community Hospitals.**

A hospital will not be able to be denied treatment as a Sole Community Hospital because data are unavailable for any cost reporting period due to changes in ownership, fiscal intermediaries, or other extraordinary circumstances, so long as data from at least one applicable base cost reporting period is available.

- **Rural Community Hospital Demonstration Program**

The Secretary is required to establish a demonstration program in rural areas to test different payment methods for under 50 bed rural hospitals. The hospitals are paid their costs for inpatient and extended care services for 5 years, subject to a cap.

- **2-Year Extension of Hold Harmless Provisions for Small Rural Hospitals and Sole Community Hospitals.**

The hold harmless provisions governing outpatient department reimbursement for small rural hospitals (under 100 beds) would be extended until January 1, 2006 and would be extended to Sole Community Hospitals located in rural areas for services provided in 2006.

Non-Hospital Rural Provider Provisions:

- **Rural Hospice Demonstration Project**

A 5-year demonstration project will be established for 3 hospice programs to deliver hospice care to Medicare beneficiaries in rural areas. Beneficiaries who lack an appropriate caregiver and are unable to receive home-based hospice care could receive hospice care in a facility of 20 or fewer beds that offers a full range of hospice services within its walls. The limit on the aggregate number of inpatient day provide to Medicare beneficiaries who elect hospice care is waived under the demonstration.

- **Recognition of Attending Nurse Practitioners as Attending Physicians to Serve Hospice Patients.**

The definition of attending physician in hospice is expanded to include a nurse practitioner. A nurse practitioner is not permitted

to certify a beneficiary as terminally ill for the purpose of receiving the hospice benefit.

- **Establishment of Floor on Work Geographic Adjustment**

The value of any work geographic index that is below 1.0 will be increased to 1.0 for services furnished on or after January 1, 2004 and before January 1, 2007.

- **Medicare Incentive Payment Program Improvements for Physician Scarcity**

A new 5 percent incentive payment program is established for primary care and specialist care physicians furnishing services in the areas that have the fewest physicians available to serve beneficiaries.

- **Improvement to Medicare Incentive Payment Program**

The current law 10 percent Health Professional Shortage Area (HPSA) incentive payment for services furnished in full county primary care geographic areas HPSAs will be paid automatically rather than having the physicians identify they services were furnished in such an area.

- **Improvement in Payments to Retain Emergency Capacity for Ambulance Services in Rural Areas.**

The Secretary will provide a percentage increase in the base rate of the fee schedule for ground ambulance services furnished on or after July 1, 2004 and before January 1, 2010 that originate in a qualified rural area. The payment increase is estimated using the average cost per trip for the base rate in the lowest quartile as compared to the average cost for the base rate in the highest quartile of all rural counties.

- **Temporary Increase for Ground Ambulance Services**

Payments for ground ambulance services originating in a rural area or a rural census tract will be increased by 2% for services provided on or after July 1, 2004 through December 31, 2007. The fee schedule for ambulances in other areas will increase by 1%.

- **Providing Appropriate Coverage of Rural Air Ambulance Services**

The regulations governing the use of ambulance services will provide that to the extent that any ambulance service may be covered, a rural air ambulance service will be at the air ambulance rate if the air ambulance services is reasonable and necessary base on the health condition of the patient being transported at or immediately prior to the time of the transport service and if the air ambulance service complies with the equipment and crew requirements established by the Secretary.

- **Treatment of Certain Clinical Diagnostic Laboratory Tests Furnished to Hospital Outpatients in Certain Rural Areas.**

Hospitals with under 50 beds in qualified rural areas will receive 100% reasonable cost reimbursement for clinical diagnostic laboratory tests covered under Part B that are provided as outpatient hospitals services. The provision will apply to services furnished during a cost reporting period beginning during the 2-year period starting July 1, 2004.

- **Extension of the Telemedicine Demonstration Project**

The demonstration project is extended for 4 years and total funding authorization will be increased from \$30 million to \$60 million.

- **Exclusion of Certain Rural Health Clinic and Federally Qualified Health Center Services from the Prospective Payment System for Skilled Nursing Facilities**

Services provided by a rural health clinic and a federally qualified health center after January 1, 2005 would be excluded from the Skilled Nursing Facility Prospective Payment System if such services would have been otherwise excluded if furnished by a physician or practitioner who was not affiliated with a RHC or FQHC.

- **Frontier Extended Stay Clinic Demonstration Project**

A demonstration project would be established that would treat frontier extended stay clinics as a Medicare provider. A frontier extended stay clinic is one that is located in a community where the closest acute care hospital or critical access hospital is at least 75 miles away or is inaccessible by public road and is designed to address the needs of seriously or critically ill patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or patients who need monitoring and observation for a limited period of time.

- **Temporary Increase for Home Health Services Furnished in a Rural Area**

A 1-year, 5% additional payment is established for home health care services furnished in a rural area. The temporary increase begins for episodes and visits ending on or after April 1, 2004 and before April 1, 2005.

- **Providing Safe Harbor for Certain Collaborative Efforts that Benefit Medically Underserved Populations**

Remuneration on the form of a contract, lease, grant, loan, or other agreement between a public or non-profit private health center and an individual or entity providing goods or services to the health center would not be a violation of the anti-kickback statute if such an agreement would contribute to the ability of the health center to maintain or increase the availability or quality of services provided to a medically underserved area.

- **Office of Rural Health Policy Improvement**

The functions of the Office of Rural Health Policy will be expanded to include authorization to administer grants, cooperative agreements, and contracts to provide technical assistance and other necessary activities to support activities related to improving rural health care.

- **MedPAC Study on Rural Payment Adjustments**

MedPAC will study the effect on specified rural provisions in this legislation including total payments, growth in costs, capital spending and other payment factors. An interim report on changes to the critical access hospital program is due to Congress no later than 18 months from the date of enactment. MedPAC's final report on all topics is due to Congress no later than 3 years from the date of enactment.