Medicare: Today's Issue
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BETTER BENEFITS – MORE CHOICES

Good News about the Medicare Prescription Drug, Improvement and Modernization Act of 2003!

Rural Providers Receive Needed Relief

The Medicare Modernization Act (MMA) **includes several provisions to enhance beneficiary access to quality health care services and improve provider payments in rural areas, providing much needed relief to providers**. Some of these provisions are highlighted below.

HOSPITALS:

- **Standardized amount:** The MMA equalizes the urban and rural "standardized amounts" under Medicare's prospective payment system for inpatient hospital services. Currently, Medicare has two different operating base payments for inpatient hospital services—one for hospitals located in large urban areas and another, smaller payment for hospitals located in rural and small urban areas. **This provision establishes a single base payment, or standardized amount, for hospitals in all areas in the 50 states, the District of Columbia, and Puerto Rico, starting in FY 2004**.

- **Disproportionate Share:** The MMA modifies Medicare's payments for those hospitals that furnish care to a disproportionate share of low-income and uninsured patients. Currently, the disproportionate share hospital adjustment paid to rural and small urban hospitals is capped at 5.25 percent. **The Act increases the rural and small urban cap to 12 percent.**

- **Residencies**. The MMA allows the Secretary to redistribute resident positions from hospitals that have not met their resident cap over a defined period of time. **Hospitals located in rural areas are given top priority for receiving these redistributed resident positions.**

- **Low Volume Hospitals**. The MMA establishes a graduated adjustment/add-on payment for low-volume hospitals. Eligible hospitals are those that are located more than 25 miles away from another hospital and have fewer than 800 discharges in a given year. The adjustment is to be determined by the Secretary based on the relationship between cost-per-case and discharges in low-volume hospitals. The total adjustment may not exceed 25 percent of the otherwise applicable prospective payment rate.

PHYSICIANS:

- **Bonus Payments**. The MMA modifies the Medicare Incentive Payment Program, **which provides 10 percent bonus payments to physicians in Health Professional Shortage Areas.** The Act builds upon this existing program, and **adds a new program for physicians serving beneficiaries in physician scarcity counties.** Under this new program, physicians would receive a 5 percent bonus payment for providing services in newly defined scarcity areas.

- **Geographic Adjustment.** The MMA modifies the geographic adjustment for physician payments. The geographic adjustment is in place to reflect the regional differences in the costs of the various inputs necessary to furnish a physician service. These inputs are physician work, practice expense, and malpractice. The Act establishes a floor on one of the three geographic adjustments—the work component. In so doing, **it increases payments to physicians in rural areas by raising their adjustment to the newly established floor.**

CRITICAL ACCESS HOSPITALS:

- **Status**. The MMA **removes barriers for hospitals that are seeking critical access hospital status,** while easing some of the requirements that are in place for existing critical access hospitals. The Act

allows critical access hospitals to use up to 25 beds for acute care (currently, it is limited to 15 beds). This **allows greater flexibility to critical access hospitals.** The Act also authorizes periodic interim payments, allowing critical access hospitals to receive payments every 2 weeks, as is currently the case for eligible hospitals, skilled nursing facilities, and hospices. The Act **allows critical access hospitals to establish psychiatric and rehabilitation distinct part units** with up to 10 beds each. In addition, the Act limits the state waiver of the 35-mile rule, the facilities designated as critical access hospitals before January 1, 2006 are grandfathered in.

- **Payment.** The MMA modifies the Critical Access Hospital Program in several ways. This program, created by Congress in the Balanced Budget Act of 1997, is designed to support limited-service hospitals located in rural areas. Medicare pays critical access hospitals on the basis of their current Medicare-allowable costs. **The Act increases critical access hospital payments to 101 percent of reasonable costs and extends cost-based reimbursement to additional on-call emergency care providers, providing additional dollars to these rural hospitals.** The Act also **reauthorizes the Medicare Hospital Flexibility (FLEX) Program, expanding this important source of grant funding for small rural hospitals.**

OTHER PROVISIONS:

- **Home Health**. The Act **increases payments to home health agencies by 5 percent for services furnished in rural areas.**

- **Rural Community Hospitals**. The MMA establishes a 5-year demonstration to test the advisability and feasibility of establishing rural community hospitals (RCHs).

- **Frontier Extended Stay Clinics**. The MMA authorizes a new demonstration project under which frontier extended stay clinics in isolated rural areas are treated as providers of items and services under the Medicare program.

- **Office of Rural Health Policy Improvements**. The **MMA expands the list of explicit responsibilities** of the Office to **include administering grants, cooperative agreements, and contracts to provide technical assistance** and other activities as necessary to support activities **related to improving health care in rural areas**.

- **Ambulance**. The **MMA increases payment to ambulance providers and suppliers furnishing services in rural areas,** directing the Secretary to **increase payments for ambulance trips that originate in rural areas with a particularly low population density.** The Act also increases payments by 2 percent for rural ground ambulance services and 1 percent for non-rural ground ambulance services. In addition, the Act establishes an alternate fee schedule phase-in formula for some providers based on a blend of the national fee schedule and a regional fee schedule, to ease the current transition to the national fee schedule. The Act **also increases payment for ground ambulance trips that are longer than 50 miles. The Act also establishes a presumption of medical necessity for certain rural air ambulance services.**