BETTER BENEFITS – MORE CHOICES

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

Investments in Better Care: Hospital Provisions

The Medicare Modernization Act includes several hospital provisions, some of which are described below, to enhance beneficiary access to quality health care services and improve provider payments.

Hospital Provisions:

- ✓ ***Standardized amount.*** Prior to the MMA, Medicare had 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. The **MMA equalizes the urban and rural "standardized amounts"** under Medicare's prospective payment system for inpatient hospital services. 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.**

- ✓ ***Labor-Share:*** The MMA revises the labor-related share of the wage index used in Medicare's prospective payment system for inpatient hospital services. The labor-related share of the wage index is reduced to 62 percent from the current 71.1 percent, unless such revision would result in lower payments. The labor share is an estimate of the national average proportion of hospitals' costs associated with inputs that are directly or indirectly affected by local wage levels. Many rural hospitals argue that a high labor-related share adversely affects them, because their local wage levels are low.

- ✓ ***Disproportionate Share:*** The MMA modifies Medicare's payments for those hospitals that furnish care to a disproportionate share of low-income and uninsured patients. **The MMA increases the rural and small urban disproportionate share hospital adjustment cap from its current level of 5.25 percent to 12 percent**.

- ✓ ***Outpatient PPS:*** Under the MMA, **sole community hospitals and small rural hospitals are held harmless under the outpatient hospital prospective payment system for 2 years.**

- ✓ ***Low Volume Hospitals:*** The MMA establishes **a graduated adjustment/add-on payment for low-volume hospitals.** Hospitals that are located more than 25 miles away from another hospital and have less than 800 discharges in a given year are eligible. The maximum total adjustment is 25 percent of the otherwise applicable prospective payment rate.

- ✓ ***Residencies:*** The MMA redistributes 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.**

- ✓ ***Medicaid DSH:*** The **MMA includes a provision for 16 extremely low Medicaid DSH states (Alaska, Arkansas, Delaware, Idaho, Iowa, Minnesota, Montana, Nebraska, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Wisconsin, and Wyoming).** Each will receive an enhanced allotment under the agreement. Allotments for these 10 states will be increased by 16 percent for each of five years (FY 2004 - FY 2008) at which point allotment levels will be those for the previous year increased by the CPI-U.

- ✓ ***Pass Through Drugs:*** To help ensure access to new treatments in this setting, the MMA requires payments of up to 2 percent of outpatient payments per year to pass through drugs and devices. For 2004, this will result in estimated payments of $300 million.

- ✓ ***Orphan Drugs:*** To help **ensure access to treatments for those with rare diseases**, the MMA requires payments of 88 percent of the average wholesale price for 11 single indication orphan drugs.

- ✓ ***Hospital Quality Data:*** To promote the release of hospital quality data, the MMA increases **the inpatient update factor for hospitals that provide CMS with the information in a timely manner.**