Medicare Learning Network
MLN Matters®
CMS
Information for Medicare Fee-For-Service Health Care Professionals

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MMA - Medicare Prescription Drug, Improvement and Modernization Act of 2003 Information for Medicare Rural Health Providers, Suppliers, and Physicians

Note: This article was updated on April 9, 2013, to reflect current Web addresses. All other information remains unchanged. .

Provider Types Affected

Medicare rural providers, suppliers, and physicians

Provider Action Needed

This Special Edition summarizes and explains rural health provisions included in the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003.

Hospital Inpatient Prospective Payment System (PPS)

MMA Section 401 – *As of April 1, 2004*
The urban and rural standardized amounts under the Hospital Inpatient PPS will be permanently equalized by establishing a single base payment or standardized amount for hospitals in all areas of the 50 states, the District of Columbia, and Puerto Rico. The Centers for Medicare & Medicaid Services (CMS) has implemented the following:

- Equalized the standard amounts from April 1, 2003 to March 31, 2004;
- Increased the large urban and other area national adjusted amounts for Puerto Rico retroactive to October 1, 2003; and
- Equalized the Puerto Rico-specific urban and other area rates.

Although these changes were not effective in Medicare systems until April 1, 2004, CMS has calculated the payment necessary to make up for the six months that Puerto Rico and other areas did not receive payments equal to Puerto Rico urban rates.

MMA Section 401(d)(2) – *From April 1, 2004 through September 30, 2004*
Puerto Rico-specific other area rates will exceed the Puerto Rico urban rate so that the requirements of the provision can be implemented without reprocessing claims.

MMA Section 402 – *For discharges on or after April 1, 2004*
The Disproportionate Share Hospital (DSH) adjustment for rural hospitals, rural referral centers, Sole Community Hospitals (SCHs), and urban hospitals with fewer than 100 beds will be increased. The cap on the adjustment will be 12 percent, except for hospitals classified as rural referral centers. The formulas to establish a hospital's DSH payment adjustment are based on the following:

- Hospital's location
- Number of beds
- Status as a rural referral center or SCH.

Under §1886(d)(5)(F) of the Social Security Act (SSA), Medicare makes additional DSH payments to acute hospitals that serve a large number of low-income Medicare and Medicaid patients as part of its Inpatient PPS.

The new DSH adjustment is not applicable to Pickle Hospitals, as defined at §1886(d)(5)(F)(i)(II) of the SSA.

Effective April 1, 2001, as specified in §211 of the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Benefits Improvement and Protection Act of 2000, all inpatient PPS hospitals that meet the number of beds requirement are eligible to receive DSH payments when their DSH patient percentage meets or exceeds 15 percent.

MMA Section 504 – *For discharges occurring on April 1, 2004 through September 30, 2004*
The current blend of input into Medicare payments will be changed from 50 percent for national and 50 percent for Puerto Rico to 62.5 percent for national and 37.5 percent for Puerto Rico.

On October 1, 2004, the blend will be further adjusted to 75 percent for national and 25 percent for Puerto Rico.

For discharges occurring on or after April 1, 2004 through September 30, 2004, the new fixed-loss amount used to determine the cost outlier threshold is $30,150.

This fixed-loss amount is part of the equation used to determine inpatient operating and capital-related costs in both the operating PPS and the capital PPS. Because the fixed-loss amount is being changed for discharges during this period, the resultant new capital PPS rates are $413.48 for national and $202.96 for Puerto Rico.

These rates were determined by an updated national Geographic Adjustment Factor/Diagnosis-Related Group (GAF/DRG) adjustment factor of 1.0025 with an outlier adjustment of 0.9508 and a Puerto Rico GAF/DRG adjustment factor of 1.0011 with an outlier of 0.9922.

Hospital Inpatient PPS Wage Index

MMA Section 403(b) – *For discharges occurring on or after October 1, 2004*
The percentage of hospital inpatient PPS payment adjustment based on the area hospital wage index will be decreased from 71.1 percent to 62 percent. These payments are adjusted by the hospital wage index of the area where the hospital is located or the area in which the hospital is classified. The decrease in the

percentage of Hospital Inpatient PPS payment adjustment is applicable only if the hospital would receive higher total payments.

Hospital Market Basket Weight Updates

MMA Section 404 – *By October 1, 2005*
The frequency with which CMS revises the category weights, re-evaluates the price priorities for the category weights, and rebases the hospital market basket will be determined. The hospital market basket weights are currently updated once every five years. Annual Hospital Inpatient PPS standardized amount increases are determined in part by the projected increase in the hospital market basket, which is the factor used to estimate the change in price of goods and services used to furnish inpatient hospital care.

Critical Access Hospitals (CAHs)

MMA Section 405(a)
CAHs will be paid under the *Standard Method Payment – Cost-Based Facility Services with Billing of Carrier for Professional Services*, unless they elect to be paid under the Optional (Elective) Payment Method.

For cost reporting periods beginning on or after January 1, 2004:

Outpatient CAH services payments have been increased to the lesser of the following:

- Eighty percent of the 101 percent of reasonable costs for CAH services, which is up from 100 percent of reasonable costs for CAH services; or
- One hundred and one percent of the reasonable cost of the CAH in furnishing CAH services minus the applicable Part B deductible and coinsurance amounts.

As of January 1, 2004:

The Optional Payment Method – Cost-Based Facility Services Plus 115 Percent Fee Schedule Payment for professional services for outpatient CAH services is based on the sum of the following:

- The lesser of 80 percent of 101 percent of the reasonable cost of the CAH in furnishing CAH services or 101 percent of the outpatient services less applicable Part B deductible and coinsurance amounts; and
- One hundred and fifteen percent of the allowable amount, after applicable deductions, under the Medicare Physician Fee Schedule for physician professional services. Payment for non-physician practitioner professional services is 115 percent of 85 percent of the allowable amount under the MPFS.

MMA Section 405(a) – *For cost reporting periods beginning on or after January 1, 2004*
Reimbursement for services furnished will be based on 101 percent of the CAH's reasonable costs, up from 100 percent of reasonable costs.

MMA Section 405(b) – *For services furnished on or after January 1, 2005*
Cost-based reimbursement is extended to on-call emergency room physician's assistants, nurse practitioners, and clinical nurse specialists who are on-call emergency room providers.

MMA Section 405(c) – *For services furnished on or after July 1, 2004*
Periodic interim payments will be paid every two weeks to CAHs that provide inpatient services and meet certain requirements.

MMA Section 405(d) – *For cost reporting periods beginning on and after July 1, 2004*
Physicians or other practitioners providing professional services in the hospital are not required to reassign their Part B benefits to the CAH in order for the CAH to select the Optional Payment Method. The following applies:

- For CAHs that elected the Optional Payment Method before November 1, 2003 for a cost reporting period that began on or after July 1, 2001, the effective date of this rule is retroactive to July 1, 2001.
- For CAHs that elected the Optional Payment Method on or after November 1, 2003, the rule will be effective for cost reporting periods beginning on or after July 1, 2004.

MMA Section 405(e) – *Beginning on January 1, 2004*
Prior to January 1, 2004, a CAH could not operate more than 15 acute care beds or more than 25 beds if it included up to 10 swing beds.

CAHs may operate up to 25 beds for acute (hospital-level) inpatient care, subject to the 96-hour average length of stay for acute care patients. For CAHs with swing bed agreements, any of its beds may be used to furnish either inpatient acute care or swing bed services.

MMA Section 405(f) – *The Medicare Rural Hospital Flexibility Program (FLEX)*
This program has been reauthorized to make grants to all states in the amount of $35 million in each of fiscal years (FY) 2005 through 2008. The FLEX program makes grants for specified purposes to states and eligible small rural hospitals.

MMA Section 405(g) – *For cost reporting periods beginning on or after October 1, 2004*
CAHs may establish psychiatric units and rehabilitation units that are distinct parts (DP) of the hospital. The total number of beds in each CAH DP may not exceed ten. These beds will not count against the CAH inpatient bed limit. The psychiatric and rehabilitation DPs must meet the applicable requirements for such beds in short-term general hospitals, and Medicare payments will equal payments to units of short-term general hospitals for these services.

MMA Section 405(h) – *Until January 1, 2006*
States can continue to certify facilities as necessary providers in order for them to be designated as CAHs.

Low Volume Hospitals

MMA Section 406 – *Effective October 1, 2004*
Low volume hospitals can receive an additional percentage increase, capped at 25 percent, based on the relationship between the cost-per-case and the number of discharges for acute inpatient hospitals. A low volume hospital is a hospital that has fewer than 800 discharges during the fiscal year and is located more than 25 road miles from another acute care hospital.

Hospice

MMA Section 408 – *Effective December 8, 2003*
Nurse practitioners can serve as the attending physician for a patient who elects the hospice benefit. Nurse practitioners acting as the attending physician are prohibited from certifying the terminal diagnosis.

MMA Section 409 – *Demonstration project*
A demonstration project will be conducted for five years to test delivery of hospice care in rural areas, under which Medicare eligible individuals without a caregiver at home may receive care in a facility of 20 or fewer beds. This facility will not have to offer hospice services in the community or comply with the 20 percent limit on inpatient days.

MMA Section 512 – *Effective on or after January 1, 2005*
MMA provides for coverage of certain physician's services for certain terminally ill patients. Beneficiaries entitled to these services are those who have not yet elected the hospice benefit and have not previously received these services. The covered services include evaluating the patient's need for pain and symptom management, including the need for hospice care, counseling the beneficiary on end-of-life issues and care options, and advising the beneficiary regarding advanced care planning. The covered services are those furnished by a physician who is the medical director or employee of a hospice program.

Federally Qualified Health Centers (FQHCs)

MMA Section 410 – *For services furnished on or after January 1, 2005*
Professional services provided by physicians, physician's assistants, nurse practitioners, and clinical psychologists who are affiliated with FQHCs are excluded from the Skilled Nursing Facility (SNF) PPS in the same manner such services would be excluded if provided by individuals not affiliated with FQHCs.

MMA Section 431 – *Safe harbor*
A final rule will be published that contains standards for a new safe harbor to the anti-kickback statute. Under this safe harbor, prohibitions against kickbacks will not apply to remuneration under a contract, lease, grant, loan, or other agreement between certain FQHCs and any individual or entity that provides items, services, donations, or loans to the FQHC. The arrangement must contribute to the FQHC's ability to maintain or increase the availability or quality of services provided to a medically underserved population. These standards will determine whether the arrangement:

- Results in savings of federal grant funds or increased funds to the FQHC;
- Expands or limits a patient's freedom of choice; and
- Protects a health care professional's independent judgment regarding the provision of medically appropriate treatment.

Rural Health Clinics (RHCs)

MMA Section 410 – *For services furnished on or after January 1, 2005*
Professional services provided by physicians, physician's assistants, nurse practitioners, and clinical psychologists who are affiliated with RHCs are excluded from the SNF PPS, in the same manner as such services would be excluded if provided by individuals not affiliated with RHCs.

Rural Community Hospitals (RCHs)

MMA Section 410(A) – *Not before October 1, 2004 or later than January 1, 2005*
A five-year demonstration program will be conducted to test the advisability and feasibility of establishing RCHs to provide Medicare covered inpatient hospital services in rural areas. A RCH is a hospital located in a rural area, or reclassified as such, with fewer than 51 acute care beds that is not currently designated or eligible for designation as a CAH and makes 24-hour emergency care services available.

DP psychiatric and rehabilitation beds do not count toward the bed limit. Not more than 15 hospitals in states with low population densities will be selected to participate in the demonstration. Medicare payment to the hospitals will be on the basis of reasonable costs or a "target amount" of prior year reasonable costs plus the increase in the inpatient hospital update factor.

Hold Harmless Reimbursement Provisions

MMA Section 411 – *Beginning with cost reporting periods on and after January 1, 2004*
Hold harmless reimbursement provisions for hospital Outpatient Department (OPD) services performed at small rural hospitals and SCHs will be extended for two years. Under the hold harmless reimbursement provisions, small rural hospitals and SCHs with no more than 100 beds are paid no less under the Hospital OPD PPS than they would have been paid under the prior reimbursement system for covered OPD services provided before January 1, 2004.

Effective January 1, 2006, payments to small rural hospitals and SCHs may be increased if a study finds that rural costs of providing outpatient services is greater than urban costs of providing outpatient services.

Work Geographic Adjustment

MMA Section 412 – *Work geographic index*
The work geographic index will be raised to 1.0 in any physician payment locality where the index is less than 1.0 during 2004, 2005, and 2006. The work geographic index reflects the geographic variation in average professional compensation in one area compared to the national average.

Medicare Incentive Payment Programs for Physician Scarcity Areas (PSAs) and Health Professional Shortage Areas (HPSAs)

MMA Section 413 – *For services furnished on or after January 1, 2005 and before January 1, 2008*
For services furnished on or after January 1, 2005 and before January 1, 2008, a new PSA incentive payment of five percent will be available to primary care and specialty physicians in areas that have few physicians available. Counties will be identified based separately on the ratio of primary care physicians to Medicare eligible individuals residing in the county and on the ratio of specialist care physicians to Medicare eligible individuals residing in the county. To the extent that it is feasible, a rural census tract of a metropolitan statistical area, commonly known as the Goldsmith Modification area, will be counted as a scarcity area.

Effective January 1, 2005, the HPSA incentive payment will be paid automatically for services furnished in full county primary care geographic area HPSAs and mental health HPSAs rather than having the physician identify that the services are furnished in such areas. Services provided in areas other than full county HPSAs will still require the submission of a modifier to receive the bonus payment.

CMS will develop a user-friendly web site that contains HPSA and PSA information, and before the beginning of the calendar year, a list of the HPSAs for which the incentive payments will automatically be made for the year.

Ambulance Services

MMA Section 414 – *Effective July 1, 2004*
An alternate fee schedule phase-in formula will be established for certain providers and suppliers based on a specified blend of the national fee schedule and a regional fee schedule based on census division. This provision is designed to ease the transition to the national fee schedule. If the alternate phase-in formula for a census division results in higher payment, all providers and suppliers in that region will be paid under that formula and their phase-in will last through 2010. Mileage payment increases are as follows:

- Through 2008, mileage payments for ground ambulance trips that are longer than 50 miles will be increased by one-quarter of the payment per mile otherwise applicable to the trip.
- Through 2009, the base payment rate for ambulance trips that originate in rural areas with a population density in the lowest quartile of all rural county populations will be increased by 22.6 percent. This increase is based on the estimated average cost per trip in the lowest quartile as compared to the average cost in the highest quartile of all rural county populations.
- Through 2006, payments will be increased by two percent for rural ground ambulance services and by one percent for non-rural ground ambulance services.

MMA Section 415 – *Effective January 1, 2005*
Rural air ambulance services will be reimbursed at the air ambulance rate if the services:

- Are reasonable and necessary based on the patient's condition at or immediately prior to transport; and
- Meet equipment and crew requirements.

Rural air ambulance services are deemed medically necessary when they are requested by:

- A physician or other qualified person who reasonably determines that land transport would threaten the patient's survival or health; or
- Recognized state or regional Emergency Medical Services personnel.

In most cases, the presumption of medical necessity does not apply if:

- There is a financial or employment relationship between the person requesting the air ambulance or his/her immediate family and the entity furnishing the service; or
- The entity requesting the service owns the entity furnishing the service.

Outpatient Hospital Clinical Diagnostic Laboratory Tests

MMA Section 416 – *For cost reporting periods beginning July 1, 2004 through June 30, 2006*
Part B covered outpatient hospital clinical diagnostic laboratory tests furnished by rural hospitals with fewer than 50 beds located in rural areas with a population density in the lowest quartile of all rural county populations will be reimbursed on a reasonable cost basis.

Telemedicine

MMA Section 417 – *Telemedicine demonstration*
This section extends the telemedicine demonstration four additional years and authorizes an additional $30 million in funding. This demonstration uses high-capacity computer systems and medical informatics to improve primary care and prevent health complications in Medicare eligible individuals with diabetes mellitus who live in isolated rural and inner city areas.

Originating Telehealth Sites

MMA Section 418 – *For Telehealth service beginning on January 1, 2006*
The Health Resources & Services Administration (HRSA), in consultation with CMS, will evaluate the feasibility of including SNFs in the list of permissible originating sites for telehealth services beginning on January 1, 2006.

Home Health (HH) Agencies

MMA Section 421 – *For Medicare Part A and Part B episodes and visits beginning on April 1, 2004 and before April 1, 2005*
There will be a payment increase of five percent to HH agencies for services furnished in rural areas.

MMA Section 701(a) and 701(b) – *HH Payment Update*
These sections provide for holding the HH payment update at the current rate of the HH market basket percentage increase for the last calendar quarter of 2003 and the first calendar quarter of 2004.

Beginning with the last three calendar quarters of 2004 and continuing through calendar years 2005 and 2006, the HH update will be based on the HH market basket percentage increase minus 0.8 percent. Beginning in 2005, the annual HH PPS update will be effective in January of each year rather than in October.

Unused Resident Positions

MMA Section 422 – *Effective July 1, 2005*
Resident positions from hospitals that have not met their resident full-time equivalent (FTE) cap for the most recently settled or submitted (subject to audit) cost reporting period will be redistributed.

Redistribution of these positions is based on the difference between the hospital's otherwise applicable FTE cap or "otherwise applicable resident limit" and the number of resident slots filled in the most recently settled/submitted cost reporting period or the "reference resident level."

There are some exceptions regarding the expansion of existing programs or previously approved new residency programs that may apply to the calculation of the "reference resident level." Unused residency positions are limited to no more than 25 FTEs. They will be redistributed based on location, with priority given in the following order:

1) Rural hospitals
2) Small urban hospitals

3) Hospitals that are the only ones with a particular residency program in the state. Whether the hospital will be likely to fill such positions within the first three cost periods after the determination is made will be taken into account.

Expanded Responsibilities of Office of Rural Health Policy

MMA Section 432 – *Effective December 8, 2003*
The HRSA Office of Health Policy's responsibilities will be expanded to include the administration of grants, cooperative agreements, contracts, and other activities that will improve health care in rural areas.

Medicare Payment Advisory Commission (MedPAC) Study

MMA Section 433
The MedPAC will analyze how certain rural sections in the MMA affect total payments, growth in costs, capital spending, and other payments.

Frontier Extended Stay Clinics (FESCs)

MMA Section 434(a) – *Demonstration Project*
A demonstration project will be conducted for three years under which FESCs located in isolated rural areas are treated as Medicare providers. The clinics must be located at least 75 miles from the nearest acute care hospital or be inaccessible by public road. The clinics also must be designed to address the needs of seriously ill, critically ill, or injured patients who, because of adverse weather conditions or for other reasons, need monitoring and observation for a limited period of time.

Indirect Medical Education (IME) Adjustment

MMA Section 502
For discharges occurring between April 1, 2004 and October 1, 2004, the IME add-on percentage will be 5.98 percent; during FY 2005, 5.79 percent; during FY 2006, 5.58 percent; during FY 2007, 5.38 percent; and during FY 2008 and future years, 5.5 percent.

Graduate Medical Education

MMA Section 711
For cost reporting periods beginning on or after October 1, 2004 through September 30, 2013, the freeze on updates to the hospital per resident amounts that exceed 140 percent of the geographically adjusted national average will be reinstated.

MMA Section 712
For cost reporting periods beginning on or after October 1, 2003, regardless of the reduction in the initial period of board eligibility by relevant medical boards, the geriatric exception to allow up to two years of additional training in a geriatrics program is considered part of the initial residency period.

MMA Section 713
For a one-year period beginning on January 1, 2004, hospitals will be allowed to count residents who are training at non-hospital sites in osteopathic and allopathic family programs that have been in existence as

of January 1, 2002, regardless of the financial arrangement between the hospital and the supervisory teaching physician.