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RUPRI Center for Rural Health Policy Analysis

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173)

A Summary of Provisions Important to Rural Health Care Delivery

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The mission of the RUPRI Center is to provide timely analysis to federal and state health policy makers, based on the best available research. The research of the RUPRI Center focuses on rural health care financing/system reform, rural systems building, and meeting the health care needs of special rural populations. Specific objectives include: conducting original research and independent policy analysis that provides policy makers and others with a more complete understanding of the implications of health policy initiatives, and disseminating policy analysis that assures policy makers will consider the needs of rural health care delivery systems in the design and implementation of health policy.

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PURPOSE

The purpose of this *Policy Paper* is to provide a wide audience of rural health policy makers, advocates, and researchers a consolidated summary of legislative provisions contained in P.L. 108-173 (the Act) that have particular meaning to the delivery of services in rural areas. More narrowly focused summaries exist elsewhere, for example, a summary of provider provisions is available from the American Hospital Association (http://www.hospitalconnect.com), and a summary of prescription drug coverage is available from the Kaiser Family Foundation (http://www.kff.org). A summary of rural provisions contained in Title IV of the Act ("Rural Provisions") is available from the National Rural Health Association (http://www.nrharural.org). This document is a review of all 12 titles of the Act that are focused on rural health care delivery (Titles 8, 11, and 12 do not include a specific rural focus, although Titles 8 and 12 have implications for rural beneficiaries and are summarized in the Appendix).

OVERVIEW

P.L. 108-173 affects the Medicare program in many ways beyond creating a benefit that pays for some portion of expenses associated with the purchase of outpatient prescription medications. During the implementation of the Act the provisions not related directly to prescription medications may be more critical to meeting the needs of rural beneficiaries and providers than the benefits included in the first two titles (prescription drug program) of the Act. The text of this *Policy Paper* highlights certain provisions of the Act particularly important to rural interests and provides a more systematic, detailed summary in the Appendix. The sources used to develop this *Policy Paper* were: the text of P.L. 108-173, available through the Government Printing Office, the text of the Conference Committee Report (explanation of the legislation), also available from the Government Printing Office, and *Medicare Prescription Drug, Improvement, and Modernization Act of 2003: Law and Explanation* by CCH Incorporated, available for purchase through http://health.cch.com. Highlights are organized by interest and type: rural beneficiaries, regulations affecting access, provider payment, regulations affecting providers, administration improvements and contracting reform, demonstration projects and grant programs, and studies.

[1] The author wishes to thank those who reviewed and commented on an earlier draft of this paper, including advisors to the RUPRI Center for Rural Health Policy Analysis and staff of the RUPRI Center. The author is solely responsible for the content of this document.

HIGHLIGHTS

Provisions Related to the Needs of Rural Beneficiaries

Note on other sources: For a thorough explanation of the prescription drug benefit, including cost-sharing provisions that affect all beneficiaries, see the summary available from the Kaiser Family Foundation, http://www.kff.org.

- All beneficiaries are entitled to obtain prescription drug coverage, including fee-for-service drug plans (Section 101, new Section 1860D of the Social Security Act)

Note: The legislative references regarding the new prescription drug benefit are to subsections of the new Section 1860D of the Social Security Act – the section identification used in P.L. 108-173.

- Information comparing plans must be provided through special outreach efforts to hard-to-reach populations, including targeted efforts in historically underserved populations (new Section 1860D-1 of the Social Security Act).

- Prescription drug plans may provide coverage beyond that included in the basic Medicare benefit, including filling the "donut hole" (new Section 1860D-2).

- The Secretary shall ensure that there are at least two qualifying plans in all areas of the county, one of which must be a prescription drug plan (not an HMO). If this objective is not met even after the Secretary assumes risk, the Secretary shall provide a fallback prescription drug plan (new Section 1860D-3).

New Regulations Affecting Access to Services

- 70% of rural plan enrollees will have access to a pharmacy within 15 miles of their residences (new Section 1860D-4(b)).

- All plans must permit enrollees to receive benefits through a community pharmacy, including 90-day supplies. Any differential cost is to be paid by enrollees (new Section 1860D-4(b)).

- Prescription drug plan (PDP) regions will be the same as Medicare Advantage (MA) regions, there being no fewer than 10 and no more than 50 in the nation, each to include at least one state and no state to be divided (new Section 1860D-11(a)).

- The Secretary will establish a fund, starting at $10 million, to provide bonus payments to MA plans that enter and stay in areas otherwise unserved (Section 221 (c)).

- There will be a separate process for soliciting bids to offer fallback service in one or more regions. The Secretary will pay actual costs of covered drugs (no risk for the plan). The Secretary can establish a formulary (new Section 1860D-11(g)).

- Cost contracts are allowed to operate indefinitely as MA plans unless two other plans of the same type enter the service area with active enrollment of 1,500 beneficiaries in non-metropolitan areas (Section 234 of the Act).

- Coverage of an initial preventive examination is authorized (Section 611).

- Coverage is authorized for cardiovascular screening blood tests, diabetes screening tests, and mammography services, the latter two not being subject to the outpatient Prospective Payment System (PPS) (Section 612-614).

- The administrator of a federal health program is permitted to waive 5-year exclusions from Medicare if a sole source of services would be excluded (Section 949).

Provisions Affecting Payment to Rural Providers

General Hospital Provisions

- The standardized payment in inpatient PPS is set at the amount used for large urban areas (Section 401).

- The cap on Disproportional Share Hospital (DSH) payment for rural hospitals is increased to 12%. Rural referral centers are exempted from the cap (Section 402).

- The calculation of the labor-related share of the hospital inpatient payment to which a wage index is applied changes from 71% to 62%, when that change results in a higher payment (Section 403).

- Inpatient payments to hospitals with fewer than 800 discharges in a year and located at least 25 miles from another hospital are increased up to 25% (Section 406).

- Rural hospitals with fewer than 101 acute beds (including Sole Community Hospitals (SCHs)) are paid no less for outpatient services than they would have received under reimbursement systems prior to PPS, through December 31, 2005 (Section 411).

- Hospitals under 50 beds in low density population rural areas will receive 100% of cost for lab services provided as outpatient hospital services (Section 416).

- The PPS update for Fiscal Year (FY) 2004 is the full market basket (MB) (Section 501).

- The PPS update for FY 2005 through FY 2007 is the full market basket if a hospital submits data on ten quality indicators listed by the Secretary; otherwise it is market basket minus 0.4 percentage points (Section 501 (c)).

- The adjustment percentage for indirect medical education is increased to 1.47 for FY 2004, 1.42 for FY 2005, 1.37 for FY 2006, 1.32 for FY 2007, and set at 1.35 for FY 2008 (Section 502).

- At least two years of data are required before incorporating a new technology into a permanent group (Section 503).

- Allotments for Medicaid DSH payments for FY 2004 are set at 116% of FY 2003 and not subject to the ceiling capping state's allotments. Subsequent years are set at the FY 2004 amount (Section 1001(a)).

- The temporary floor for treatment as a low DSH state is increased by 16% above current amounts, FY 2004 through FY 2008 (Section 1001(b)).

- Hospitals may appeal their wage index classification during a special one-time only period. Appeals are due by February 15, 2004, with three-year classifications beginning April 1, 2004 (Section 508).

- The Secretary is required to establish a process of payment adjustment that recognizes the outmigration of hospital employees who reside in a county and work in a different area with a higher wage index (Section 505).

Critical Access Hospital Provisions

- Critical Access Hospitals (CAHs) will be reimbursed at 101% of reasonable costs for inpatient, outpatient, and covered swing bed skilled nursing services (Section 405 (a)).

- Reimbursement for on-call providers is extended to include physician assistants, nurse practitioners, and clinical nurse specialists (Section 405 (b)).

- CAHs are eligible for periodic interim payments for inpatient services (Section 405 (c)).

- CAHs will be eligible for payment based on facility costs plus 115% of the physician fee schedule for services provided by those physicians assigning billing to the CAHs, without a requirement that all physicians providing services in a CAH assign their billing rights to the CAH (Section 405 (d)).

Physician Payment

- The work component of the geographic practice index will have a minimum value of 1.0 until January 1, 2007 (Section 412).

- A 5% bonus payment program is created for physicians in areas that have the fewest physicians per Medicare beneficiaries (bottom 20% of beneficiaries) (Section 413).

- The update factor for each of 2004 and 2005 will be at least 1.5% (Section 601).

- Physician services of evaluating need, counseling, and advising beneficiaries regarding advance care planning as part of hospice care shall be reimbursed starting January 1, 2005 (Section 512).

Ambulance Payment

- Payment will be increased by one quarter of the payment per mile rate for trips longer than 50 miles (Section 414 (b)).

- Payment will be based on the ambulance specific amount blended with either the national schedule or a combined national and regional schedule (Section 414(a)).

- There will be a percentage increase in the base rate for ground ambulance services operating in areas with the lowest population densities, totaling 25% of the population in all rural areas (Section 414(c)).

- Payment for air ambulance, using the rate for that service, will be made if the service is reasonable and necessary as determined by a physician or pursuant to a state or regional protocol (Section 415).

Provisions Affecting Other Providers and Organizations

- MA plans will be paid, at a minimum, the fee-for-service rate (total per capita expenditures). The minimum payment increase will be 2% or the national per capita MA increase (Section 211).

- The Secretary can provide payment to an essential hospital if an MA plan certifies it was unable to reach agreement on payment. The MA plan must pay at least the fee-for-service (FFS) equivalent, and the Secretary will pay a differential if the hospital proves its costs exceed Part A payment (the CAH equivalent) (Section 221 (b)).

- Federally Qualified Health Centers (FQHCs) will receive wrap around payment for the reasonable costs of care to Medicare managed care patients (Section 237).

- The Secretary will establish programs for competitive acquisition of durable medical equipment, but will not include rural areas before 2009; and the Secretary can exempt rural areas that are not competitive unless a national market exists (Section 302).

- Payment for home health care services furnished in a rural area is increased 5% from April 1, 2004 through March 31, 2005 (Section 421).

- Per diem payment for a skilled nursing facility resident with acquired immune deficiency syndrome (AIDS) is increased by 128% (Section 511).

- The application of payment caps to therapy services is suspended for calendar year (CY) 2005 (Section 624).

- There are no updates to the clinical diagnostic laboratory test fee schedule, 2004 through 2008 (Section 628).

- There is a five-year extension of items and services covered under Medicare Part B when furnished in Indian hospitals and ambulatory care clinics (Section 630).

- Home health payment updates will be the full MB through March 2004, and then minus 0.8 percentage points through 2006 (Section 701).

- $250 million are appropriated for each fiscal year, 2005 through 2008, in additional federal funding for emergency services to undocumented aliens, to be paid directly to providers (Section 1011).

- Services provided by Rural Health Clinics (RHCs) and FQHCs are excluded from Skilled Nursing Facility-PPS if they would have been excluded if furnished by a provider not affiliated with a RHC or FQHC (Section 410).

Regulations Affecting Providers

- A PDP shall permit any pharmacy that meets its terms and conditions to participate (New Section 1860D-4(b)).

- The Secretary will promulgate standards for electronic prescription that provide information to physicians. A pilot project is authorized (New Section 1860D-4(e)).

- The 15 acute care bed limit on CAHs is eliminated, effectively allowing up to 25 acute care beds, effective January 1, 2004 (Section 405(e)).

- A CAH can establish a distinct part unit that meets requirements for such units as part of short-term general hospitals, without those beds counting toward the CAH limit, limited to 10 beds and paid on a prospective payment basis (Section 405(g)).

- State waiver authority, as applied to designating CAHs as necessary providers, is eliminated as of January 1, 2006 (Section 405 (h)).

- A nurse practitioner can be designated as the attending physician in a hospice (Section 408).

- The Secretary is required to pay the 10% Medicare Incentive Payment automatically to physicians providing services in whole-county health professions shortage areas (Section 413(b)).

- Rural hospitals with fewer than 250 acute care beds are exempt from scheduled (in July 2005) reductions in resident positions. The Secretary can increase residents for certain hospitals by reallocation, with first priority being hospitals located in rural areas (Section 422).

- Safe harbor is established within one year of enactment for exchanges between health centers and entities providing goods, items, services, donations, or loans (Section 431).

- The requirement that home health agencies collect OASIS data on private pay patients is suspended until the Secretary reports on the benefit compared to the burden of data collection and use (Section 704).

- Each MA organization is required to have an ongoing quality improvement program (Section 722).

Administrative Improvements and Contracting Reform

Note: To understand the rural implications of administrative improvements and contracting reform, see *"Comments on Regulatory and Contractor Reform Legislation,"* Mueller and Shay, primary authors. Rural Policy Brief PB2002-1. January 2002. Available at http://www.rupri.org/publications/archive/pbriefs/PB2002-1/PB2002-1.pdf.

- The Secretary will establish and publish a regular timeline for publication of final regulations, not longer than three years. Interim final regulations cannot continue beyond that time frame (Section 902).

- Retroactive application of any substantive changes in regulation is banned, and providers and supplier are not subject to penalty or repayment if they reasonably relied on program guidance (Section 903).

- The Secretary is permitted to competitively contract with Medicare Administrative Contractors, with fiscal intermediaries and carriers merged into single authorities (Section 911).

- The Secretary will use specific error rates (by providers) to provide incentives to implement effective education and outreach programs (Section 921 (a)).

- Medicare contractors are required to provide responses to written inquiries that are clear, concise, and accurate within 45 business days (Section 921 (c)).

- Such funds as are necessary are authorized to increase provider education and training (Section 921 (d)).

- If repayment within 30 days would be a hardship, the Secretary will enter into an extended repayment plan of at least six months but less than three years (five years in the case of extreme hardship) (Section 935).

- The Secretary will not require a hospital to ask questions relating to the Medicare secondary payer provisions in the case of reference lab services (Section 943).

- Emergency room services are to be evaluated for Medicare's "reasonable and necessary" requirement on the basis of information available to the physician at the time services were ordered, not the patient's principal diagnosis (Section 944).

Demonstration Projects and Grant Programs

- Physicians will be eligible for grants to upgrade computer hardware and software, purchase or lease new hardware or software, and obtain education and training for staff. Preferences are given to physicians providing services in rural and underserved areas (Section 108).

- A project in up to three hospice care programs in rural areas, for no longer than five years, would provide hospice services to beneficiaries unable to access home-based care, in facilities of 20 or fewer beds (Section 409).

- In rural areas with low population densities, no more than 15 hospitals of fewer than 51 beds will be included in a five-year demonstration of different payment methods that are cost-based for inpatient and extended services (Section 410A).

- The four-year demonstration using high-capacity computer systems and medical informatics to improve primary care and prevent health complications in beneficiaries with diabetes is extended for four additional years (Section 417).

- A SNF will be treated as an originating site in a demonstration project using telehealth services (Section 418).

- A demonstration project will treat frontier extended stay clinics as Medicare providers (Section 434).

- Alternative data sources to current ones used to establish the geographic index for the practice expense component in physician payment will be evaluated in two localities, one of which must be rural (Section 605).

- A three-year demonstration project will test a methodology of bundled payment for dialysis services, including a payment adjustment to account for additional costs incurred by rural facilities (Section 623).

- A five-year program will examine factors which encourage the delivery of improved patient care quality (Section 646).

- At least three projects will be designed to evaluate methods to improve the quality of care provided to beneficiaries with chronic conditions, one of which must be in a rural area (Section 648).

- A three year demonstration project will promote continuity of care, help stabilize medical conditions, prevent or minimize acute exacerbations of chronic conditions and reduce adverse outcomes. Four sites will be designated, with at least one being rural (Section 649).

- A two-year program at four sites (two rural) will evaluate the feasibility and desirability of covering additional chiropractic services (Section 651).

- A two-year project will clarify the definition of homebound, with sites in three states, in three regions, with up to 15,000 beneficiaries in each site (Section 702).

- A three-year project is designed for a home health agency to provide medical adult day care services as a substitute for a portion of home health services, in up to five sites (Section 703).

- A program will be undertaken which randomly assigns beneficiaries with chronic care conditions to a care improvement program (Section 721).

- A program will provide technical assistance to small providers and suppliers in order to improve compliance with Medicare requirements (Section 922).

- A three-year program will have Medicare specialists assigned to at least six local Social Security Offices (two must be rural) to provide assistance to beneficiaries (Section 924).

Studies

- The Secretary will study the variation in prescription drug spending across regions and make recommendations regarding the appropriateness of adjusting the government payment (subsidy) to account for that variation (Section 107 (a)).

- The Institute of Medicine (IOM) will conduct a study of drug safety and quality that includes evaluating approaches to reduce medication errors and providing guidance to stakeholders on strategies to achieve drug safety goals (Section 107 (b)).

- MedPAC will examine the basis for variation in costs between different areas, the appropriate geographic area for payment, and the accuracy of risk adjustment methods (Section 211 (f)).

- The Secretary will submit a report describing the impact of additional financing on the availability of MA plans in different areas and the impact on lowering premiums and increasing benefits (Section 211 (g)).

- The Secretary will contract with the IOM to evaluate leading health care performance measures and options to implement policies that align payment with performance (Section 238).

- The General Accounting Office (GAO) will study payment differences under the physician fee schedule for different geographic regions (Section 413 (c)).

- The GAO will submit a report on cost differences among different types of ambulance providers and the impact of payment reductions on access, supply, and quality (Section 414 (f)).

- MedPAC will conduct a study of the impacts of changes in hospital payment policies, analyzing the effect on total payments, growth in costs, capital spending, and other such payment effects (Section 433).

- The GAO will conduct a study to determine the appropriate level and distribution of payments in relation to costs under PPS for short-term general hospitals (Section 501 (c)).

- The Secretary is to conduct a study to determine if costs incurred by rural hospitals for ambulatory classification groups (outpatient) exceed those incurred by urban hospitals (Section 411).

- The GAO will issue a report on whether the current list of conditions represents a clinical appropriate standard for defining Inpatient Rehabilitation Facility services (Section 501 (c)).

- The GAO will study access to physicians' services through an analysis of claims data (Section 604).

- MedPAC will report on the effects of refinements to the practice expense component of payment for physicians' services (Section 606)

- The GAO is required to identify conditions or diseases that may justify waiving the application of therapy caps (Section 624).

- MedPAC will study the feasibility and advisability of allowing Medicare FFS beneficiaries direct access to physical therapy services (Section 647).

- MedPAC will study the payment margins of home health agencies paid under Medicare PPS (Section 705).

- The Secretary is required to develop a plan to reduce the cost of care for chronically ill Medicare beneficiaries (Section 723).

- MedPAC will examine the budgetary consequences of its recommendations and submit reports that study the need for current data and the sources of current data to determine

the solvency and financial circumstances of hospitals and other providers, and to address investments and access to capital for hospitals (Section 735).

- The GAO will study the feasibility and appropriateness of legally binding advisory opinions on appropriate interpretation and application of Medicare regulations (Section 904).

- The Secretary will develop Evaluation & Management guidelines in collaboration with practicing physicians, conduct pilot projects (at least one of which must be a rural site), and establish and implement an education program (Section 941).

- The GAO will study which external data can be collected in a shorter time to use in calculating payments for inpatient hospital services for new technology, including new clinical diagnostic lab tests (Section 942).

- The GAO will report on the appropriateness of the updates in the conversion factor for physician payment, including the appropriateness of the sustainable growth rate (Section 953).

- $50 million is authorized for FY 2004 for Agency for Healthcare Quality and Research (AHQR) to conduct research to address the scientific information needs and priorities identified by the Medicare, Medicaid, and State Children Health Insurance Programs related to clinical effectiveness and appropriateness (Section 1013).

- $3 million is authorized for each of the fiscal years 2005 and 2006 to establish the "Citizen's Health Care Working Group" which will produce reports regarding expanding coverage options, the cost of health care, innovative state and community strategies to expand coverage or reduce costs, and the role of evidence-based medicine and technology in improving quality and lowering costs (Section 1014).

APPENDIX
DETAILED DESCRIPTION

TITLE I – MEDICARE PRESCRIPTION DRUG BENEFIT

Note: This title contains provisions that affect all beneficiaries, rural and urban. Some of the provisions may affect beneficiaries differently as a function of income. For a summary of the provisions affecting premiums and beneficiary co-payments, see the summary provided by the Kaiser Family Foundation, http://www.kff.org. This table describes provisions that may, as implemented, require different types of activities to be effective in rural areas, or affect access to services in rural areas.

Section 101 of this Title adds a new section, 1860D, to the Social Security Act. All citations within Section 101 are to the new Section numbers, which is how the reader can locate these provisions in P.L. 108-173. That pattern of citations changes after Section 101, to a section of P.L. 108-173 and subsections designated by letter.

Section	Provision	Rural Relevance	Effective	Ends
Section 101 Subpart 1	All beneficiaries are entitled to obtain prescription drug coverage, including through FFS plans.	Enrollment is possible through FFS prescription drug plans.	Jan. 1, 2006	No end date
New Section 1860D-1 to the Social Security Act *Information to beneficiaries*	The Secretary of HHS shall provide information comparing prescription drug and MA plans with regard to benefits provided, monthly premium, quality and performance indicators, beneficiary cost-sharing, and consumer satisfaction.	The information will be particularly important to rural beneficiaries who have no previous experience selecting from multiple plans. As the Conference Agreement explains: "special outreach efforts shall be made for disadvantaged and hard-to-reach populations, including targeted efforts in historically underserved populations." In addition, the Secretary is to work with public, voluntary, and private community organizations serving Medicare beneficiaries.	Upon enactment, and 30 days before the first enrollment period, which begins Nov. 15, 2005	No end date

Section	Provision	Rural Relevance	Effective	Ends
New Section 1860D-2 *Supplemental coverage*	PDPs may provide supplemental prescription drug coverage beyond that offered in the basic Medicare benefit.	This may benefit rural Medicare beneficiaries who would otherwise incur substantial out-of-pocket expenses, *depending on what the plans that operate in rural areas decide to offer.*	Jan. 1, 2006	No end date
New Section 1860D-2 *Demonstrations of different plan designs*	The conference agreement clarifies current Medicare demonstration authority to include allowing private sector plans maximum flexibility to design alternative prescription drug coverage, including capitated payment to MA plans, regional preferred provider organizations (PPOs) or PDPs in lieu of specific reinsurance for prescription drug coverage to increase plan efficiency, and improve quality of services.	These demonstrations may include plans offering benefits in rural areas – such as regional PPOs and PDPs.	Jan. 1, 2006	No end date
New Section 1860D-3 *Assurance of available plan*	The Secretary shall ensure that there are least two qualifying plans in all areas of the country, one of which must be a PDP. If this condition is not met even after the Secretary assumes risk, the Secretary shall provide for a fallback PDP.	Rural areas are the most likely targets of a policy to assure choices, or in the absence of choice a fallback plan. This section, combined with new Section 1860D-11, is the assurance that all rural beneficiaries will have access to plans offering the new prescription drug benefit.	Jan. 1, 2006	No end date
New Section 1860D-4 *Making new plan information available*	Plans are required to make detailed information about the benefit structure available and to make information about changes available on the internet.	The venues for dissemination are not specified in the law or conference agreement. There could be differences across geography, based on the means of communication frequently accessed by beneficiaries.	Upon enactment	No end date
New Section 1860D-4(b) *Any willing pharmacy*	A PDP shall permit any pharmacy that meets its terms and conditions to participate.	This rule applies to PDPs, not MA plans. For PDPs, which will likely be more prevalent in rural areas, this allows for participation by all pharmacies.	Upon enactment	No end date

Section	Provision	Rural Relevance	Effective	Ends
New Section 1860D-4(b) *Access requirement*	All PDP and MA plans are required to provide access to pharmacies in a manner that is no less restrictive than that provided by TRICARE.	The standard in the conference committee report is that 70% of rural plan enrollees will have access to a pharmacy within 15 miles.	Upon enactment	No end date
New Section 1860D-4(b) *Use of community pharmacy*	All PDP and MA plans must permit enrollees to receive benefits through a community pharmacy, including 90-day supplies, rather than through mail order, with any differential paid by enrollees.	Historic patterns of accessing prescription drugs through a local pharmacist can be retained.	Upon enactment	No end date
New Section 1860D-4(c) *Drug utilization and quality assurance programs*	PDP sponsors are required to have a cost-effective drug utilization management program, quality assurance measures, a medication therapy management program, and a program to control waste, fraud, and abuse. Targeted individuals include those with multiple chronic diseases or taking multiple drugs or likely to incur annual costs that exceed a specified level. The programs shall be developed in cooperation with licensed and practicing pharmacists and physicians.	There could be opportunities for programs focused on rural beneficiaries, involving rural practicing pharmacists and physicians.	Upon enactment	No end date
New Section 1860D-4(e) *Electronic transmission of plan and prescription information*	By September 1, 2005, the Secretary shall promulgate standards for electronic prescription that provide for transmitting information to physicians regarding eligibility and benefits, information on the drug being prescribed and others in the patient's medication history, and the availability of lower-cost therapeutically appropriate alternate drugs. A pilot project is authorized.	The standards could affect costs to rural providers, but the legislation includes language stating the standards shall "be designed so that, to the extent practicable, the standards do not impose an undue burden on prescribing health care professionals and dispensing pharmacies and pharmacists." This section includes a safe harbor provision for hospitals with medical staffs, group practices and their members, PDP sponsors and pharmacies, for the purpose of providing hardware, software, information technology, and technical assistance.	Upon enactment, with the initial standards due Sept. 1, 2005	No end date

Section	Provision	Rural Relevance	Effective	Ends
Section 101 Subpart 2; New Section 1860D-11(a) of Social Security Act *PDP regions, service areas*	PDP regions should be the same as MA regions: no fewer than 10 and no more than 50 in the nation. Each PDP region shall include at least one state and no state is to be divided. No multi-state metropolitan area should be divided.	The design of regions will influence the availability of plans in rural service areas. The service area must include the entire region.	Upon enactment. Regions will need to be designated before first enrollment period.	No end date
New Section 1860D-11(f) *Limited Risk Plans*	The Secretary may approve limited risk plans only as needed to meet access requirements in certain regions. The limited risk plan will, in effect, have some level of risk assumed by the Secretary.	Rural areas are likely to dominate regions in which limited risk plans are approved.	Upon enactment, prior to initial enrollment	No end date
New Section 1860D-11(g) *Fallback*	The Secretary will establish a separate process for soliciting bids from eligible entities to offer fallback service in one or more regions. A fallback entity is not a risk-bearing entity and would not submit any bids in competitive regions. The Secretary would pay actual costs of covered drugs, taking into account negotiated price concessions. The Secretary is not allowed to enter into negotiations or establish a particular formulary.	This provision is most likely to apply only to certain rural regions of the country. Contracts are for three years, assuming the area remains a fallback area for all of that time.	Upon enactment, prior to initial enrollment	No end date
Section 107 *(a) Study regarding regional variations in prescription drug spending*	The Secretary shall conduct a study that examines variations in per capita spending for covered drugs among PDP regions and the amount of variation attributable to price variations and per capita utilization. The final report will include analysis of the impact on subsidies in different regions if the subsidies were adjusted to take into account spending variation.	The final report will make recommendations regarding the appropriateness of applying an additional geographic adjustment factor to subsidies that reflects variation in expenditures.	Upon enactment	The report is due Jan. 1, 2009.

Section	Provision	Rural Relevance	Effective	Ends
Section 107 *(c) IOM Study on Drug Safety and Quality*	The Secretary will contract with the IOM for a study of drug safety and quality issues that includes an evaluation of alternative approaches to reducing medication errors in terms of their efficacy, cost-effectiveness, appropriateness in different settings and circumstances, feasibility, institutional barriers to implementation, associated risks, and the quality of evidence supporting the approach. The study will provide guidance to stakeholders on strategies to achieve drug safety goals. The study will assess the opportunities and impediments to broad nationwide implementation of medication error reductions and provide guidance to policy makers and government agencies in promoting a national agenda for medication error reduction.	Identification of medication errors and approaches to reducing them may be a function of the size of the delivery organization, the resources available, and type of medication errors that occur most frequently. Developing research designs that account for differences that occur among rural delivery sites will be challenging. Designing systems to account for differences in scale and resources will also be challenging.	Upon enactment	The study is to be completed within 18 months of enactment
Section 108 *Grants to physicians to implement electronic prescription drug programs*	Grants are authorized to physicians for the purpose of implementing electronic prescription drug programs. Funds can be used for purchasing, leasing, and installing computer software and hardware; making upgrades and other improvements to existing hardware and software; and providing education and training to physician staff. The authorization is for $50 million in FY 2007 and funds as necessary for FYs 2008 and 2009.	Preferences are to be give to physicians who serve a rural or underserved area, and to physicians who serve a disproportionate number of Medicare patients.	Oct. 1, 2006	Sept. 30, 2009

TITLE II – MEDICARE ADVANTAGE

Section	Provision	Rural Relevance	Effective	Ends
Section 211 Immediate Improvements *(a)– (d) Payment*	MA plans will be paid, at a minimum, the FFS rate. No adjustment will be made in 2004 for budget neutrality. The minimum payment increase will be the previous year's payment increased by the minimum percentage increase (2% or the national per capita MA increase).	Changes in payment may affect plan offerings in rural areas.	Upon enactment	No end date
(f) MedPAC study of AAPCC	The Medicare Payment Advisory Commission will examine the basis for variation in costs between different areas, including differences in input prices, utilization, and practice patterns; the appropriate geographic area for payment; and the accuracy of risk adjustment methods.	This study could lead to changes in geographic variation of payment to MA plans.	Upon enactment	Study is due no later than 18 months after enactment
(g) Secretary report on impact of financial assistance to MA Plans	The Secretary is required to submit a report describing the impact of additional financing (including from previous budget legislation) on the availability of MA Plans in different areas and the impact on lowering premiums and increasing benefits.	This report should include the impact of changes in MA Plan payment on availability of such plans in rural areas previously not served by MA plans, and on decisions plans make to remain in rural areas.	Upon enactment	The report is due by Jul. 1, 2006
(h) MedPAC study of MA cost-sharing	MedPAC is to conduct a study to determine the effect of cost sharing requirements on access to services or enrollment of individuals.	MedPAC is to consult with beneficiaries, consumer groups, employers, and organizations offering plans. The requirements may vary in rural areas.	Upon enactment	Recommendations are due by Dec. 31, 2004
(i) Payment in 2004	Within six weeks, the Secretary will announce new rates for 2004. Plans would be given an opportunity to reconsider decisions regarding service areas for 2004.	Plans may reconsider withdrawals from rural counties.	Upon enactment	Mar. 2004

Section	Provision	Rural Relevance	Effective	Ends
Section 221: Establishment of MA Regional Plans *(a) – (b)*	The Secretary will establish between 10 and 50 regions. Plans must serve entire regions. The Secretary will conduct a market study to determine regions that maximize plan participation. There is a two-year moratorium on new local PPOs. Medical Savings Accounts (MSAs) and private FFS plans are defined as local and can be offered by county.	The Conference Committee report states an intent that regions will bring together urban and rural areas, bringing greater choices to areas previously not served by M+C plans. The moratorium on local PPOs is to encourage them to operate at the regional level. MSAs and private FFSs are allowed to function as regional plans.	Upon enactment	No end date
(c) Risk corridors	If expenses exceed 103% of the target amount, monthly payment to plans will be adjusted by 50% of the difference up to 108%, and 80% of the difference above 108%, plus 2.5% of the target amount. Reductions in payment will occur if actual expenses are lower than the target.	The intent is to provide incentives to MA plans to enter and stay in regions they might otherwise avoid.	Jan. 1, 2006	Dec. 31, 2007
(c) *Regional plan stabilization fund*	The Secretary shall establish a fund to provide incentives for plan entry and plan retention. The fund shall start with $10 million from the Trust Funds, with additional funds allocated from savings attributable to MA plans.	Bonus payments may be equal to 3% of the regional benchmark and can be available for multiple years. Increases for retention can be 3% or an amount that results in a payment equal to the benchmark for all regions divided by the AAPCC for the U.S.	Jan. 1, 2007	Initial fund period is through Dec. 31, 2013
(h) *Assuring network adequacy*	The Secretary can provide payment to an essential hospital if the MA plan certifies that the plan was unable to reach agreement on payment. The plan must pay at least the equivalent of Part A FFS payment. The Secretary will pay an additional amount if the hospital can prove its costs exceed Part A payment.	$25 million is to be available in 2006, and annually increased by the growth in the market basket percentage. Essential hospitals must be necessary for plans to meet network adequacy requirements. The payment amount is based on what an essential hospital demonstrates are costs exceeding CAH payment amounts.	Jan. 1, 2006	No end date
Section 234: Extension of Reasonable Cost Contracts	Cost contracts are allowed to operate indefinitely unless two other plans of the same type (two local or two regional plans) enter the cost contract's service area and achieve enrollment of 1,500 in non-metropolitan areas.	Cost contracts in rural areas will continue indefinitely or until that area includes two or more competing plans.	Jan. 1, 2006	No end date

Section	Provision	Rural Relevance	Effective	Ends
Section 237: Reimbursement of FQHCs Under MA Plans	FQHCs will receive wrap-around payment for the reasonable costs of care to Medicare managed care patients. The combined MA payment and cost-sharing payments from beneficiaries will equal 100% of the reasonable costs. Safe harbor provisions are extended to include remuneration between an FQHC and an MA organization.	This will include FQHCs in rural areas.	Jan. 1, 2006	No end date
Section 238: Study of Performance-Based Payment System	The Secretary will contract with the IOM to evaluate leading health care performance measure and options to implement policies that align payment with performance.	Any action based on this report will affect payment to rural MA plans.	Upon enactment	Report is due within 18 months

TITLE III – COMBATTING WASTE, FRAUD, AND ABUSE

Section	Provision	Rural Relevance	Effective	Ends
Section 302: Payment for Durable Medical Equipment *Competitive acquisition*	The Secretary shall establish and implement programs for competitive acquisition in areas throughout the U.S.	Non-metropolitan areas will not be included before 2009, and the Secretary has the authority to exempt rural areas and areas with low population density that are not competitive unless a national market exists.	2007 in 10 of the largest metropolitan areas	No end date
Section 302 *Payment updates for durable medical equipment*	For durable medical equipment, prosthetic devices, prosthetics and orthotics, the update is one point in each year 2004 through 2008, and the CPI afterwards. Payment for oxygen and oxygen equipment, wheelchairs, nebulizers, diabetic lancets and testing strips, hospital beds, and air mattresses will be reduced.	This includes equipment purchased in rural areas.	Upon enactment	No end date
Section 307 *Pilot program for background checks on direct patient access employees of long-term care facilities or providers*	The Secretary shall enter into agreements with no more than 10 states to conduct criminal history background checks for workers employed by Medicare and Medicaid long-term care providers. States can permit providers to provisionally employ workers during the time checks are conducted.	Evaluation of the program includes determining the extent to which conducting the background checks leads to unintended consequences, including a reduction in the available workforce. In determining what constitutes appropriate supervision of provisional employees, a state shall take into account the cost or other burdens that would be imposed on small rural providers.	Upon enactment	Funds are appropriated for fiscal years 2004 through 2007

TITLE IV – RURAL PROVISIONS

Note: The format of the table summarizing Title IV differs from what is used in other tables. All of the provisions of Title IV are relevant to rural health care delivery for obvious reasons, as evident in the name of the title, *"Rural Provisions."* Therefore, the "rural relevance" column is not used. Instead, a column is inserted with summaries of the law prior to P.L. 108-173, enabling the reader to see clearly the improvement intended by Congress in enacting that particular provision.

Section	Prior Law	New Law	Start Date	Expires
Subtitle A: Relating to Part A only **Section 401** *Equalizing standardized payment*	The standardized payment, which is the basis for calculating inpatient PPS, is 1.6% more for large urban areas than for other urban and rural areas.	The standardized payment for all hospitals will be the amount used for large urban areas.	Upon enactment for discharges in FY 2004 (Oct. 1, 2003)	No end date
Section 402 *Disproportionate share payment*	The amount a small urban or rural hospital can receive is limited to 5.25%. Large urban hospitals and large rural hospitals (500 beds and more) are eligible for higher amounts.	The cap on DSH payment for small urban and rural hospitals is increased to 12% and rural referral centers are exempted from the cap.	Apr. 1, 2004	No end date
Section 403 *Revising the labor-related share to calculate the wage index*	71% of the standardized payment amount for each hospital is adjusted by the area wage index.	The adjustment will apply to 62% of the standardized payment <u>when that change results in higher payment</u>. Budget neutrality requirements are waived.	Oct. 1, 2004.	No end date
Section 404 *More frequent updates of hospital MB*	The weights and estimates of the components of the MB (price of goods and services hospitals purchase) are updated every five years.	The Secretary is required to revise the weights and establish a schedule for revising the cost category weights more often than every five years. The reasons for and options considered in a new schedule will be published in a final PPS payment rule.	Publish in the final rule for FY 2006 payments	No end date

Section	Prior Law	New Law	Start Date	Expires
Section 405 Improvements in the CAH Program *(a) Increased payment*	CAHs are reimbursed for reasonable cost for care rendered to Medicare beneficiaries for inpatient, outpatient, and covered skilled nursing facility services.	CAHs will be reimbursed at 101% of reasonable costs for inpatient, outpatient, and covered swing bed skilled nursing services provided to Medicare beneficiaries.	Jan. 1, 2004	No end date
(b) Coverage of costs for on-call emergency room (ER) providers	Costs of compensation of on-call (ER) physicians are included in determining reasonable costs of outpatient CAH services.	Reimbursement for on-call providers is extended to include physician assistants, nurse practitioners, and clinical nurse specialists.	Jan. 1, 2005	No end date
(c) Authorization of periodic interim payment (PIP)	CAHs are not eligible for PIP, payments every two weeks based on estimated annual costs.	CAHs are eligible for PIP for inpatient services. The Secretary is required to develop alternative methods for timing of PIPs to CAHs.	Jul. 1, 2004	No end date
(d) application of special professional service payment	In order for CAHs to be paid both a facility fee and 115% of the fees schedule for professional services, all physicians providing services would need to assign billing rights to the hospital.	The Secretary cannot require that all physicians or practitioners providing services in a CAH assign their billing right to the CAH before the CAH can bill Medicare for combined payment that includes the facility fee and 115% of the fee schedule for those physicians who do elect to assign billing to the hospital.	Jul. 1, 2003 for CAHs that have elected the 115% prior to the law; Jul. 1, 2004 otherwise	No end date
(e) Revision of bed limitation	CAHs cannot have more than 15 acute care beds, plus 10 designated swing beds for skilled nursing facility care.	All CAHs would be permitted to operate up to 25 beds, eliminating the 15 acute care bed limit.	Jan. 1, 2004	No end date

Section	Prior Law	New Law	Start Date	Expires
(f) Revisions to Flex Grants	The Medicare Hospital Flexibility (Flex) Program awards grants to states for rural health care planning and implementation activities, rural network development and implementation, to establish or expand rural emergency medical services, and for CAH designation. The Secretary may also award grants to small rural hospitals to assist in implementing data systems required under BBA 1997.	The authorization to award Flex grants is established at $35 million each year from FY 2005 through FY 2008. States are required to consult with the hospital association and rural hospitals on the most appropriate use of the funds. Not more than 15% of the award can be used for indirect rates for administrative purposes. Up to 5% of the total amount will be available to HRSA for administering these grants.	Oct. 1, 2004	Sept. 30, 2008
(g) Exclusion of certain beds from the bed count	Beds in distinct part psychiatric or rehabilitation units operated by an entity seeking CAH designation have either counted toward bed limits or have been ineligible for payment after designation.	A CAH can establish a distinct part unit (e.g., psychiatric or rehabilitation) that meets requirements for such beds as established for a short-term, general hospital. Medicare payment for services in those units will be on a prospective payment basis. Those beds will not count toward the CAH bed limit, and the total number in the distinct part units cannot exceed 10.	Oct. 1, 2004	No end date
(h) State waiver authority	Mileage standards (35 miles or 15 miles in areas with mountainous terrain or where only secondary roads are available) can be waived if hospital is designated by the state as a necessary provider.	The authority is eliminated as of January 1, 2006.	Jan. 1, 2006	No end date
Section 406 *Inpatient hospital payment adjustment for low volume*	Current payments are without adjustment, except that SCH and Medicare Dependent Hospitals can apply for adjustment if discharges decline more than 5%.	There will be a graduated adjustment to Medicare's inpatient payment rate based on the relationship between the number of discharges and the hospital's incremental costs. The adjustment cannot exceed 25%. A low volume hospital must be at least 25 miles from another hospital and have fewer than 800 discharges during the year.	Oct. 1, 2004	No end date

Section	Prior Law	New Law	Start Date	Expires
Section 407 *Treatment of missing cost reports for SCHs*	SCH payment is either the national PPS rate or based on hospital-specific per discharge costs from either FY 1982, FY 1987, or FY 1966 updated by whichever amount provides the highest reimbursement.	A hospital will not be denied SCH designation or payment as an SCH because data are unavailable for extraordinary circumstances for any cost reporting period, so long as data are available from at least one of the base cost reporting periods.	Jan. 1, 2004	No end date
Section 408 *Recognizing nurse practitioners as attending physicians in hospices*	A beneficiary must be certified as eligible for hospice care by an attending physician and the medical director at the hospice. An attending physician is identified by the patient as having the most significant role in the delivery of the patient's care.	A nurse practitioner can be designated as the attending physician in a hospice. The nurse practitioner cannot certify a beneficiary as terminally ill for the purpose of receiving the hospice benefit.	Upon enactment	No end date
Section 409 *Rural hospice demonstration project*	The days of facility-based hospice care coverage for any beneficiary are limited in any 12-month period to 20% of the total number of days of hospice coverage provided.	A demonstration project in up to three hospice care programs will be established in rural areas, for no longer than five years. Beneficiaries lacking appropriate caregivers and unable to receive home-based care could receive care in a facility of 20 or fewer beds, which would not be required to offer services outside of the home. The limit on the number of inpatient days is waived.	Upon enactment	Five years after the demonstration begins
Section 410 *Exclusion of RHCs and FQHCs from PPS for SNFs*	No provision.	Services provided by these facilities are excluded from SNF-PPS if they would have been excluded if furnished by a provider not affiliated with an RHC or FQHC.	Jan. 1, 2005	No end date

Section	Prior Law	New Law	Start Date	Expires
Section 410A *Rural community hospital demonstration program*	No provision.	The Secretary will establish a demonstration in rural areas with low population densities. No more than 15 hospitals (fewer than 51 beds) that apply will be included for a five-year period. Different payment methods will be tested and hospitals will be paid their costs for inpatient and extended services, subject to a cap. The hospitals cannot be eligible for the CAH program. Budget neutrality applies.	Oct. 1, 2004, but no later than Jan. 1, 2005	Five years after beginning
Subtitle B - Provisions related to Part B only				
Section 411 *Hold harmless for outpatient PPS*	Rural hospitals with no more than 100 beds are paid no less under outpatient PPS than they would have received under prior reimbursement systems, until January 1, 2004.	The hold harmless provision is extended to January 1, 2006, for rural hospitals with fewer than 101 beds, and is extended to larger SCHs in rural areas for cost reporting periods beginning on or after January 1, 2004. The Secretary is required to conduct a study to determine costs, if any, by Ambulatory Payment Classification groups that exceed those incurred by urban providers and if appropriate provide for a payment adjustment as of January 1, 2006.	Upon enactment	Dec. 31, 2005
Section 412 *Floor payment on work geographic adjustment*	The work component, one of three used to calculate geographic practice indices, currently varies around an index value of 1.0 across 89 payment areas.	The Secretary is required to increase the value of any work geographic index that is below 1.0 to 1.0.	Jan. 1, 2004	Jan. 1, 2007

Section	Prior Law	New Law	Start Date	Expires
Section 413 Medicare Payment Incentive Program Improvements *(a) Additional incentive payment for certain physician scarcity areas*	Physicians providing services in Health Professional Shortage Areas (HPSAs) are entitled to bonus payment of 10%. Physicians are responsible for indicating their eligibility for this bonus on their billing forms.	A new 5% payment program is established to reward both primary care and specialist care physicians furnishing services in areas that have the fewest physicians to serve beneficiaries. The payment is made in counties (or subcounties based on the Goldsmith modification in metropolitan counties) accounting for 20% of Medicare beneficiaries affected by the lowest ratios of physicians (primary care and specialty care calculated separately) to beneficiaries. The payment is added after accounting for beneficiary cost sharing.	Jan. 1, 2005	Jan. 1, 2008
(b) Improvement to the Medicare incentive payment program	Same as above.	The Secretary is required to pay the 10% incentive payment automatically to physicians providing services in whole county shortage areas. The Secretary will develop a user-friendly web site through which physicians may obtain information on partial county HPSAs. A physician can receive both the 10% HPSA bonus and the 5% scarcity bonus.	Jan. 1, 2005	No end date
(c) GAO Study of geographic difference in payment for physician services	No provision.	The GAO will study payment difference under the fee schedule for different geographic regions, including (1) assessment of the validity of the geographic adjustment factors for each component of the schedule, (2) evaluation of the measures for each adjustment including the frequency of revisions, (3) evaluation of the method used to determine professional liability costs, and (4) evaluation of the effect of the work component on physician location and retention.	Upon enactment	Report due within one year of enactment date

Section	Prior Law	New Law	Start Date	Expires
Section 414: Payment for Rural and Urban Ambulance Services *(a) Phase-in providing floor using blend of fee schedule and regional schedules*	A national fee schedule became effective April 1, 2002, with full implementation by January 2006.	Payments will be based on the ambulance-specific amount blended with either the national schedule or a combined national and regional schedule, whichever results in the larger payment. The blend will begin with 20% national and 80% regional and phase to 100% national in 2010.	Jul. 1, 2004	2010
(b) Adjustment for certain long trips	Additional mileage payments are made in rural areas for distances greater than 17 miles and up to 50 miles for services provided before January 1, 2004. The amount was at least one-half of the payment per mile for the first 17 miles.	Payment will be increased by one quarter of the payment per mile rate for trips longer than 50 miles, regardless of where the trip originates.	Jul. 1, 2004	Jan. 1, 2009
(c) Improvement in payments to retain emergency capacity for ambulance services in rural areas	See above.	The Secretary will provide a percentage increase in the base rate of the fee schedule for ground ambulance services originating in a qualified rural area. These are rural areas with the lowest population densities, totaling 25% of the population in all rural areas.	Jul. 1, 2004	Jan. 1, 2010
(d) Temporary increase for ground ambulance services	See above.	Payments for ground ambulance services originating in a rural area or rural census tract will be increased by 2% (after other increases are applied). The fee schedule in other areas will increase by 1%.	Jul. 1, 2004	Dec. 31, 2007

Section	Prior Law	New Law	Start Date	Expires
(f) GAO report	No provision.	The GAO is required to submit a report on cost differences among different types of ambulance providers, and on the impact of payment reductions on access, supply, and quality.	Upon enactment	Report due Dec. 31, 2007
Section 415 *Providing coverage of rural air ambulance services*	Medicare pays for ground ambulance services. Payment for other methods of transportation is made only if indicated by the patient's medical condition and in accordance with regulations.	Payment for air ambulance, using the rate for that service, will be made if the air ambulance service is reasonable and necessary based on the condition of the patient and the air service complies with equipment and crew requirements. The service is considered reasonable and necessary when so determined by a physician or the service is furnished pursuant to a protocol under which its use is recommended by a state or regional service.	Jan. 1, 2005	No end date
Section 416 *Treatment of certain clinical diagnostic lab tests*	Hospitals that provide clinical diagnostic lab tests are reimbursed using a fee schedule. SCHs that provide some clinical diagnostic tests 24 hours a day qualify for a 2% increase, with no beneficiary copayments imposed.	Hospitals under 50 beds in low density population rural areas established by Section 414 (c) will receive 100% reasonable cost reimbursement for lab services provided as outpatient hospital services.	Jul. 1, 2004	Jun. 30, 2006
Section 417 *Extension of the telemedicine demonstration project*	BBA 1997 established a single four-year demonstration project to use high-capacity computer systems and medical informatics to improve primary care and prevent health complications in Medicare beneficiaries with diabetes mellitus. This expires in February 2004.	The demonstration is extended for four years and total funding increased from $30 million to $60 million.	Upon enactment	Four years after enactment

Section	Prior Law	New Law	Start Date	Expires
Section 418 *Report on demonstration project permitting SNFs to be originating telehealth sites*	Medicare pays for certain telehealth services. With certain exceptions, beneficiaries are eligible for telehealth services only if they are presented from an originating site located in a HPSA or in a county not in an MSA. Originating sites are defined as physician or practitioner office, hospital, CAH, or FQHC.	The Secretary will evaluate a demonstration project under which a SNF is treated as an originating site. The evaluation is to be delegated to HRSA in consultation with CMS. If the Secretary determines it is advisable to permit an SNF to be an originating site, an SNF may be deemed to be an originating site.	Upon enactment The designation of originating sites based on the evaluation begins Jan. 1, 2006.	The report is due Jun. 1, 2005
Subtitle C – Provisions Related to Parts A and B				
Section 421 *One year increase fort home health services furnished in a rural area*	The Benefits Improvement and Protection Act of 2000 (BIPA) increased home health PPS payments furnished in the home of beneficiaries in rural areas by 10% from April 1, 2001, through March 31, 2003.	There is a one-year, 5% additional payment for home health care services furnished in a rural area without regard to budget neutrality requirements.	Apr. 1, 2004	Mar. 31, 2005
Section 422 *Redistribution of unused resident positions*	Effective October 1, 1997, a hospital may count residents in non-hospital sites for the purposes of Indirect Medical Education payment. The total number of residents is capped. Some exceptions exist, for new programs established before August 5, 1997, and hospitals in rural areas.	Rural hospitals with fewer than 250 acute care beds are exempt from reductions scheduled to start July 1, 2005. The Secretary is authorized to increase resident limits for hospitals for portions of cost reporting periods by an aggregate number that does not exceed the overall reduction in such limits. The priorities for redistribution are first to hospitals located in rural areas, second to hospitals located in urban areas that are not large, and third to hospitals in a state if the program involved is in a specialty for which there are not other programs in the state.	Jul. 1, 2005	No end date

Section	Prior Law	New Law	Start Date	Expires
Subtitle D – other provisions				
Section 431 *Providing safe harbor for certain collaborative efforts*	People who offer a pay or kickback, a bribe, or rebate to induce referrals or provision of services may be subject to financial penalties and imprisonment. Certain exceptions or safe harbors have been established.	Any remuneration between a health center entity and an individual or entity providing goods, items, services, donations, loans, or a combination to the center pursuant to a contract, lease, grant, loan, or other agreement that contributes to serving a medically underserved population is considered a safe harbor.	The Secretary is required to publish a final regulation within one year of enactment	No end date
Section 432 *Office of rural health improvement*	The Office advices the Secretary on the effects of current policies and proposed changes on rural health care delivery. The Office has responsibilities including coordinating the activities within HHS that relate to rural health care.	The functions of the Office are expanded; it is authorized to administer grants, cooperative agreements, and contracts to provide technical assistance and other necessary activities to support activities related to improving rural health care.	Upon enactment	No end date
Section 433 *MedPAC study on rural hospital payment adjustments*	No provision.	MedPAC will conduct a study of the impacts of Sections 401 through 406, 411, 416, and 505. It will analyze the effect on total payments, growth in costs, capital spending, and other such payment effects.	An interim report with respect to changes to the CAH provisions under section 405 is due within 18 months.	Final report is due no later than three years after enactment
Section 434 *Frontier extended-stay clinic demonstration project*	No provision.	The Secretary is to conduct a demonstration project that would treat frontier extended-stay clinics as Medicare providers. This is a clinic located in a community where the closest acute care hospital or CAH is at least 75 miles away or is inaccessible by public road, and is designated to address the needs of seriously or critically ill or injured persons who cannot be transferred quickly to acute care referral centers or patients who need monitoring and observation for a limited period of time.	Upon enactment	No end date

TITLE V – PROVISIONS RELATED TO PART A

Section	Provision	Rural Relevance	Starts	Ends
Section 501 *Revision of acute hospital payment update*	The update for FY 2004 is the full MB. The update FY 2005 through FY2007 will be the MB if the hospital submits data on 10 quality indicators listed by the Secretary. A hospital not submitting those indicators will receive MB minus 0.4 percentage points.	Rural hospitals (not CAHs) are affected by this update.	Upon enactment	Sept. 30, 2007
(c) *GAO study on PPS payment for inpatient hospital services*	The GAO will conduct a study to determine the appropriate level and distribution of payments in relation to costs under PPS for short-term general hospitals. This will include whether there is a need to adjust payment to reflect differences in costs across different geographic areas, kinds of hospitals, and types of cases.	The GAO report could affect future consideration of differential payment based on geographic area.	Upon enactment	Study is due within 24 months of enactment
Committee instructions regarding Inpatient Rehabilitation Facility (IRF) payment	The Conference Committee report directs the GAO to issue a report on whether the current list of conditions represents a clinically appropriate standard for defining IRF services and, if not, which additional conditions should be added. The Committee urges the Secretary to delay implementation of the rule classifying IRFs until the report is available.	This affects IRFs serving rural beneficiaries.	Upon enactment	Not specified
Section 502 *Revision of the Indirect Medical Education (IME) adjustment percentage*	From April 1, 2004 until September 30, 2004, the IME multiplier is 1.47; during FY 2005, 1.42; during FY 2006, 1.37; during FY 2007, 1.32; and starting October 1, 2007, 1.35.	The law increases the multiplier from its current 1.35 through FY 2007, affecting payment to rural hospitals receiving the IME adjustment.	Upon enactment	No end date

Section	Provision	Rural Relevance	Starts	Ends
Section 503 *Recognition of new technologies under PPS*	The Secretary should collect at least two years of data before incorporating a new technology into a permanent group. The Secretary is required to accept comments and recommendations from the public regarding whether the technology represents a substantial improvement.	This provision will apply to rural hospitals adopting new technologies that will increase costs substantially.	Upon enactment, for new technology determinations beginning in FY 2005	No end date
Section 505 *Wage index adjustment reclassification reform*	The Secretary is required to establish a process and payment adjustment to apply when a hospital's employees who reside in one county work in a different area with a higher wage index. A hospital receiving this commuting wage adjustment is not eligible for reclassification.	This provision could benefit rural hospitals not otherwise seeking reclassification.	Oct. 1, 2004	No end date
Section 508 *Calculation of wage indices for hospitals*	The Secretary will establish a one-time process for hospitals to appeal their wage index classification. Hospitals doing so successfully are not eligible for classification based on distance and/or commuting. Reclassifications are limited to a total fiscal impact of $900 million.	The secretary may specify criteria such as quality by instruction or otherwise. *Note: The procedures announced on December 31, 2003, would give priority to rural hospitals that have submitted quality data under Medicare's National Voluntary Hospital Reporting Quality Initiative.*	Appeals must be filed by Feb. 15, 2004.	Reclassification is for a three-year period beginning Apr. 1, 2004.
Section 511 *Payment for covered SNF services*	The per diem payment for an SNF resident with AIDS is increased by 128%. This applies until the Secretary certifies that the SNF case-mix adjustment adequately compensates SNFs.	Rural SNFs with qualifying residents will receive increased payment.	Oct. 1, 2004	No specific end date
Section 512 *Coverage of hospice consultation services*	This provides coverage of certain physician services: evaluating the beneficiary's need for pain and symptom management, counseling the beneficiary, and advising the beneficiary regarding advanced care planning.	Rural physicians will be paid for these services. Rural beneficiaries <u>may</u> have improved access to services.	Jan. 1, 2005	No end date

TITLE VI – PROVISIONS RELATED TO PART B

Section	Provision	Rural Relevance	Starts	Ends
Subtitle A: Physicians' Services				
Section 601 *Revision of updates*	The update for each of 2004 and 2005 will be at least 1.5%. The formula for calculating the sustainable growth rate will be a 10-year rolling average.	Rural physicians will be paid more in 2004 and 2005 than would have otherwise been true.	Upon enactment The new calculation of the growth rate applies starting in 2003.	Dec. 31, 2005 No end date to the new calculation.
Section 604 *GAO study on access to physicians' services*	A GAO study on access to physicians' services will include an assessment of use of physician services through an analysis of claims data. It will examine the extent to which physicians are not accepting new Medicare beneficiaries as patients.	The report will determine if access problems are indicated in certain geographic areas.	Upon enactment	The report is due within 18 months of enactment.
Section 605 *Collaborative demonstration-based review of physician practice expense geographic adjustment data*	The Secretary is required to review and consider alternative data sources to current ones used to establish the geographic index for the practice expense component. The Secretary will collaborate with state and other appropriate organizations representing physicians, and other appropriate persons. Two localities will be selected for the evaluation.	One of the areas selected for evaluation must be rural.	Upon enactment	The review and consideration of alternatives must be completed by Jan. 1, 2005. The evaluation report is due Jan. 1, 2006.
Section 606 *MedPAC report on payment for physicians' services*	MedPAC is required to report on the effects of refinements to the practice expense component of payments for physicians' services in 2002.	MedPAC will examine the appropriateness of the amount of compensation and the effect on access to care by beneficiaries.	Upon enactment	The report is due within one year of enactment.

Section	Provision	Rural Relevance	Starts	Ends
Subtitle B: Preventive Services				
Section 611 *Coverage of an initial preventive physical examination*	Coverage of an initial preventive examination is authorized subject to deductible and cost sharing.	Rural beneficiaries will have access to this new benefit.	Jan. 1, 2005	No end date
Sections 612 – 614 *Payment for screening services*	Coverage is authorized for cardiovascular screening blood tests, diabetes screening tests, and mammography services.	Screening mammography and diagnostic mammography are excluded from outpatient PPS.	Jan. 1, 2005	No end date
Subtitle C: Other Provisions				
Section 623 *(e) Demonstration of bundled case-mix adjusted payment system for ESRD services*	The Secretary shall establish a demonstration project of a fully case-mix adjusted payment system that bundles payment for drugs and biologicals, and clinical lab tests. During the three-year demonstration, the Secretary shall increase payment rates.	The Secretary shall ensure that rural providers and facilities are included in the demonstration.	Oct. 1, 2005	Dec. 31, 2008
(f) Report on a bundled prospective payment system for ESRD services	The Secretary shall submit a report detailing the element and features for the design and implementation of a bundled PPS for services including bundling of drugs, clinical lab tests, and other items billed by ESRD facilities.	The report shall include a recommendation on the appropriateness of establishing a specific payment adjustment to account for additional costs incurred by rural facilities.	Upon enactment	Oct. 1, 2005

Section	Provision	Rural Relevance	Starts	Ends
Section 624 *Moratorium on therapy caps*	Application of therapy caps is suspended through CY 2005. The Secretary is required to submit reports related to alternatives to a single annual dollar cap on outpatient therapy and utilization patterns for outpatient therapy. The GAO is required to identify conditions or diseases that may justify waiving the application of the therapy caps.	Any changes to the payment system, such as classification of individuals by diagnostic category and prior use of services, may have different effects in rural areas.	Upon enactment	Secretary report is due Mar. 31, 2004. The GAO report is due Oct. 1, 2004
Section 628 *Payment for clinical diagnostic laboratory tests*	The conference agreement does not provide for any updates to the clinical diagnostic laboratory test fee schedule for 2004 through 2008.	The freeze on updates affects all providers.	Upon enactment	Dec. 31, 2008
Section 630 *Five-year reimbursement for Indian hospitals and clinics*	This provision is a five-year extension of the items and services covered under Medicare Part B when furnished in Indian hospitals and ambulatory care clinics.	This will include Indian facilities in rural areas.	Jan. 1, 2005	Dec. 31, 2009

Section	Provision	Rural Relevance	Starts	Ends
Subtitle D: Additional Demonstrations, Studies, Other				
Section 646 *Medicare health care quality demonstration program*	The Secretary is required to establish a five-year demonstration program to examine factors which encourage the delivery of improved patient care quality, including incentives to improve the safety of care; appropriate use of best practice guidelines; reduction of scientific uncertainty; encouraging shared decision making between providers and patients; providing incentives to improve safety, quality, and efficiency; appropriate use of culturally and technically sensitive care; and related financial effects.	To qualify for the demonstration, health care groups must meet Secretary-established quality standards; implement quality improvement mechanisms that integrate community-based support, primary care, and referral care; and encourage patient participation in decisions, among other requirements. The Secretary may direct agencies within HHS, including AHRQ and CMS, to evaluate, analyze, support, and assist in the demonstration project.	Upon enactment	Five years after the demonstration begins
Section 647 *MedPAC study on direct access to physical therapy services*	MedPAC is directed to study the feasibility and advisability of allowing Medicare FFS beneficiaries direct access to physical therapy services furnished as outpatient or comprehensive rehabilitation facility services.	This may affect access to services for rural beneficiaries.	Upon enactment	The study with recommendations must be submitted by Jan. 1, 2005
Section 648 *Demonstration project for consumer-directed chronic outpatient services*	The Secretary will establish at least three demonstration projects to evaluate methods to improve the quality of care provided to beneficiaries with chronic conditions and to reduce expenditures. The Secretary is required to evaluate practices that permit patients to self-direct the provision of personal care services and determine the scope of personal care services that apply.	Demonstrations must include a rural area, an urban area, and an area that has a Medicare population with a diabetes rate that significantly exceeds the national average rate.	Upon enactment	The demonstrations must be established within two years of enactment, after which biannual reports are required.

Section	Provision	Rural Relevance	Starts	Ends
Section 649 *Medicare care management performance demonstration*	The Secretary is required to establish a three-year demonstration to promote continuity of care, help stabilize medical conditions, prevent or minimize acute exacerbations of chronic conditions, and reduce adverse health outcomes. The conferees encourage AHRQ to provide grants to physicians in carrying out the health information technology aspect of the demonstration.	Four sites will be designated for the demonstration with at least two in urban areas and one in a rural area. One of the demonstrations would be in a state with a medical school with a geriatrics department that manages rural outreach sites and is capable of managing patients with multiple conditions, one of which is dementia. Funds are authorized from the Medical Insurance Trust Fund.	Upon enactment	Report is due 12 months after the demonstration is completed.
Section 651 *Demonstration of coverage of chiropractic services*	The Secretary will establish a two-year demonstration program at four sites to evaluate the feasibility and desirability of covering additional chiropractic services under Medicare.	The four sites will be evenly divided among rural and urban sites. At least one site will be in a health professional shortage area.	Oct. 1, 2004	A report is due to Congress no later than one year after the demonstration is completed.

TITLE VII – PROVISIONS RELATED TO PARTS A AND B

Section	Provision	Rural Relevance	Start Date	End Date
Subtitle A: Home Health Services				
Section 701 *Update in home health services*	The time frame for the update is changed from federal FY to CY effective in 2004. The update is full MB for the final quarter of FY 2003 and the first quarter of CY 2004, then MB minus 0.8 percentage points through 2006. The outlier pool may not exceed 3% of total payments beginning January 1, 2004.	This provision applies as a base payment to rural home health services, which are then adjusted per provisions in Title IV.	Upon enactment	No end date to the FY to CY change; payment set through Dec. 31, 2006.
Section 702 *Demonstration project to clarify the definition of homebound*	The Secretary is required to conduct a two-year demonstration project wherein beneficiaries with specified chronic conditions would be deemed to be homebound and eligible for home health services.	Sites will be three states in the northeast, midwest, and western regions of the U.S. and include up to 15,000 beneficiaries.	Upon enactment, to begin within six months	Two years after the demonstrations begin
Section 703 *Demonstration project for medical adult day care services*	This three-year demonstration project is for a home health agency to provide medical adult day care services as a substitute for a portion of home health services.	Up to five sites will be selected in states that license or certify providers of medical adult care services.	Upon enactment	Report to Congress due within six months of the completion of the demonstration
Section 704 *Temporary suspension of OASIS requirement on non-Medicare and non-Medicaid patients*	The requirement that home health agencies must collect OASIS data on private pay patients is suspended until the Secretary reports to Congress on the benefit of such data compared to the burden of data collection and the use of data and publishes final regulations.	The administrative burden to small agencies is part of what the Secretary must include in the analysis and the report to Congress.	Upon enactment	The report is due no later than 18 months after enactment

Section	Provision	Rural Relevance	Starts	Ends
Section 705 *MedPAC study of Medicare margins of home health agencies*	MedPAC is required to study payment margins of home health agencies paid under Medicare PPS, using cost reports filed by the agencies.	The study is required to examine where systematic differences occur, related to case mix.	Upon enactment	The report is due within two years of enactment.
Subtitle C: Chronic Care Improvement				
Section 721 *Voluntary chronic care improvement under FFS*	The Secretary is required to establish programs targeted to beneficiaries not in Part C with certain health conditions. In Phase I of this program, three-year contracts with chronic care improvement programs will use randomized controlled trials in areas with at least 10% of Medicare beneficiaries. If successful, Phase II will be a national expansion.	Phase I requirements include a minimum number for each chronic care improvement program – at least 10,000 targeted beneficiaries and a sufficient number in a control group.	Oct. 1, 2003	An interim report is due within two years after implementation. An update is due three and one-half years after implementation, and then biennial reports.
Section 722 *MA quality improvement programs*	Each MA organization is required to have an ongoing quality improvement program.	This requirement includes regional PPOs.	Jan. 1, 2006	No end date
Section 723 *Chronically ill Medicare beneficiary research, data, demonstration strategy*	The Secretary is required to develop a plan to improve the quality of care and reduce the cost of care for chronically ill Medicare beneficiaries. This requirement includes integrating data sets, identifying new data needs and methodology, and developing a research agenda.	This provision would apply to all Medicare beneficiaries. The Secretary is required to consult with appropriate experts and enter into contracts with appropriate entities.	Within six months of enactment	A plan will be developed no later than two years after enactment.

Section	Provision	Rural Relevance	Starts	Ends
Subtitle B: Other Provisions				
Section 735 *Modifications to MedPAC*	MedPAC is required to examine the budgetary consequences of recommendations. MedPAC is required to submit two additional reports by June 1, 2004, to study the need for current data and the sources of current data available, to determine the solvency and financial circumstances of hospitals and other providers, and to address investments and capital financing of hospitals and access to capital financing for hospitals.	The required studies should include all hospitals and providers, including those in rural areas.	Upon enactment	Studies are due Jun. 1, 2004. Other requirements regarding examining budget consequence and including experts in pharmaco-economics are ongoing.

Title VIII: COST CONTAINMENT

The provisions in this Title apply to all beneficiaries and providers, regardless of geographic location.

In the event that the general fund share of Medicare funding exceeds 45% in any consecutive period of two reporting years, a process is triggered whereby the President submits legislation to Congress in response to a warning that outlays have exceeded that target. There are no specifics required in the legislation, so the President could be suggesting any appropriate combination of reductions in spending and shifts in sources of funding.

An income-related reduction in Part B premium subsidy is the equivalent of increasing the monthly premium for beneficiaries. Beneficiaries with incomes greater than $80,000 (individual) or $160,000 (couple) will pay up to 80% of the monthly premium expense, scaled to be 25% at $80,000, 35% between $80,000 and $100,000 and 80% above $200,000.

TITLE IX – ADMINISTRATIVE IMPROVEMENTS, REGULATORY REDUCTION, AND CONTRACTING REFORM

Note: To understand the rural implications of administrative improvements and contracting reform, see *"Comments on Regulatory and Contractor Reform Legislation,"* Mueller and Shay, primary authors. Rural Policy Brief PB2002-1. January 2002. Available at http://www.rupri.org/publications/archive/pbriefs/PB2002-1/PB2002-1.pdf.

Section	Provision	Rural Relevance	Start Date	End Date
Section 902 *Issuance of regulations*	The Secretary is directed to establish and publish a regular timeline for publication of final regulations based on the previous publication of a proposed rule or interim final regulation. The time-frame must not be longer than three years. Interim final regulations cannot continue beyond that time frame. A measure in a final regulation that is not a logical outgrowth of the proposed regulation is treated as a proposed regulation.	The consistency in time lines and treatment of new measures will apply to all regulations, including those of special interest to rural providers.	Upon enactment	No end date
Section 903 *Compliance with changes in regulation and policies*	The legislation bars retroactive application of any substantive changes in regulation, manual instructions, interpretative rules, statements of policy, or guidelines unless the Secretary determines it is needed to comply with the statute or is in the public interest. A provider or supplier is not subject to any penalty or interest or a repayment plan if the entity reasonably relied on program guidance.	This provision will apply to rural providers and contractors.	Applies to any sanction imposed with respect to guidance provided on or after Jul. 24, 2003	No end date
Section 904 *Reports and studies relating to regulatory reform*	The GAO is required to study the feasibility and appropriateness of legally binding advisory opinions on appropriate interpretation and application of Medicare regulations. The Secretary is required to report to Congress on areas of inconsistency or conflict among various provisions under law and regulation.	These reports affect all Medicare providers.	Upon enactment	The GAO report is due one year after enactment. The Secretary is required to report in two years and every three years thereafter.

Section	Provision	Rural Relevance	Start Date	End Date
Subtitle B: Contracting Reform				
Section 911 *Increased flexibility in Medicare administration*	The Secretary is permitted to competitively contract with eligible entities to serve as Medicare Administrative Contractors (MACs). Authorities for fiscal intermediaries and carriers are merged into a single authority. Contracts are renewable for up to five years.	The Secretary is required to develop contract performance requirements. The Secretary is required to consult with beneficiary and provider organizations, and organizations and agencies performing other Medicare functions. Provider and beneficiary satisfaction must be one of the performance requirements.	Report of plans to implement by Oct. 1, 2004. GAO will evaluate within six months. Competitive bidding begins Oct. 1, 2005	No end date
Subtitle C: Education and Outreach				
Section 921 Provider Education and Technical Assistance *(b) Incentives*	The Secretary will use specific claims error rates (or similar methodology) to provide incentives to implement effective education and outreach programs.	This may reduce error rates over time.	Upon enactment	The Secretary is to report on how this will be done by Oct. 1, 2004
(c) Provision of access to and prompt responses from MACs	MACs are required to provide responses to written inquiries that are clear, concise, and accurate within 45 business days. MACs must have toll-free telephone numbers to obtain Medicare information, maintain a system for identifying the person supplying information, and monitor accuracy, consistency and timeliness of the information.	The Secretary is required to establish and make public standards to monitor the accuracy, consistency, and timeliness of the information provided, and evaluate the contractors against these standards.	Upon enactment	No end date
(d) Improved provider education and training	The legislation authorizes such funds as necessary to increase education and training activities for providers and suppliers.	MACs are required to tailor education and training activities to meet the special needs of small providers and suppliers.	Oct. 1, 2004	No end date

Section	Provision	Rural Relevance	Start Date	End Date
Section 922 *Small provider technical assistance demonstration program*	The Secretary is required to establish a demonstration program to provide technical assistance to small providers and suppliers upon request, in order to improve compliance with Medicare requirements.	Providers are expected to pay 25% of the cost. The GAO is required to evaluate the demonstration no later than two years after it begins. Small providers employ fewer than 25 full time equivalents, suppliers fewer than 10.	Upon enactment	Not specified
Section 924 *Beneficiary outreach demonstration program*	The Secretary will conduct a three-year demonstration program wherein Medicare specialists will provide assistance to beneficiaries in at least six local Social Security Offices.	Two of the sites must be located in rural areas.	Upon enactment	The Secretary is required to evaluate the demonstrations and report to Congress.
Subtitle D: Appeals and Recovery				
Section 932 *Process for expedited access to review*	The Secretary is to establish a process whereby there is access to judicial review when a review entity determines, within 60 days of a request, that it does not have authority to decide the question.	This provision applies to all enquiries.	Oct. 1, 2004	No end date
Section 935 *Recovery of overpayments*	In situations where repayment within 30 days would be a hardship, the Secretary is required to enter into an extended repayment plan of at least six months but less than three years (or five years in the case of extreme hardship).	This provision will apply to rural providers, including those with small margins and therefore difficulty meeting repayment within 30 days.	Upon enactment	No end date

Section	Provision	Rural Relevance	Start Date	End Date
Subtitle E: Miscellaneous				
Section 941 *Policy development regarding evaluation and management (E&M) documentation*	To develop new E&M guidelines, the Secretary must develop the guidelines in collaboration with practicing physicians (both generalists and specialists), establish a plan containing specific goals and schedule, conduct pilot projects, find that the guidelines meet objectives, and establish and implement an education program.	The Secretary is required to study developing a simpler system for documenting claims for E&M services and to alternate systems. The Secretary is required to consult with practicing physicians in carrying out this study. At least one pilot project shall be conducted in a rural area.	Upon enactment	Ongoing. The report of the study is due to Congress by Oct. 1, 2005
Section 942 *Improvement in oversight of technology and coverage*	The Secretary is required to establish procedures for determining the basis for and amount of payments for new clinical diagnostic laboratory tests. The GAO is required to study which external data can be collected in a shorter time to use in calculating payments for inpatient hospital services.	This provision will affect payment to rural providers. The data used and time-frame achieved will affect payment.	Jan. 1, 2005 Upon enactment	No end date. Report is due Oct. 1, 2004
Section 943 *Treatment of hospitals for certain services under secondary payer provisions*	The Secretary is prohibited from requiring a hospital to ask questions or obtain information relating to the Medicare secondary payer provisions in the case of reference lab services.	This provision applies to CAHs as well as general acute care hospitals.	Upon enactment	No end date

Section	Provision	Rural Relevance	Start Date	End Date
Section 944 *EMTALA improvements*	Emergency room services are to be evaluated for Medicare's "reasonable and necessary" requirement on the basis of information available to the physician or practitioner at the time the services were ordered, not the patient's principal diagnosis. The Secretary is required to notify hospitals and physicians when an EMTALA investigation is closed. The Secretary is also required to request a PRO review before terminating a hospital's participation because of EMTALA violations.	This provision will affect rural physicians and hospitals.	Jan. 1, 2004	No end date
Section 949 *Conforming authority to waive a program exclusion*	The administrator of a federal health program is permitted to waive certain five-year exclusions from Medicare if the exclusion of a sole community physician or source of specialized services in a community will impose a hardship.	This provision may sustain access in otherwise unserved rural communities.	Upon enactment	No end date
Section 953 *Other provisions*	The GAO is required to report on the appropriateness of the updates in the conversion factor including the appropriateness of the sustainable growth rate formula for 2002 and subsequent years in the physician payment formula.	The report is also to include a review of alternatives for the physician fee schedule.	Upon enactment	The report is due six months from enactment.

TITLE X – MEDICAID MISCELLANEOUS PROVISIONS

Section	Provision	Rural Relevance	Start Date	End date
Section 1001 Medicaid DSH Payments *(a) Temporary increase*	Allotments for FY 2004 are to be set at 116% of FY 2003 allotments and not subject to the ceiling capping states' allotments at 12% of medical assistance payments. Allotments for subsequent years will be the FY 2004 amount.	This provision will provide additional revenues to DSH providers.	Oct. 1, 2003	No end date
(b) Increase in floor for treatment as a low DSH state	The temporary floor for FYs 2004 through 2008 is increased by 16% above current amounts.	This will increase payment in some states.	Oct. 1, 2003	Sept. 30, 2008
Section 1011 *Federal reimbursement of emergency health services furnished to undocumented aliens*	For each of the FYs 2005 through 2008, Congress appropriates $250 million in additional federal funding for emergency services to undocumented aliens. For each of those years, the Secretary must distribute $83 million to the six states with the highest number of undocumented alien apprehensions.	Eligible providers are paid directly.	Oct. 1, 2004	Sept. 30, 2008
Section 1013 *Research on outcomes of health care items and services*	Congress authorizes $50 million for FY 2004 for AHRQ to conduct research to address the scientific information needs and priorities identified by the Medicare, Medicaid, and State Children's Health Insurance Programs. The priorities will relate to clinical effectiveness and appropriateness of specified health services and treatments.	The Secretary is required to improve information sharing regarding outcomes and quality of care, adopt innovative quality improvement strategies, and support federal and state initiatives to improve quality.	Upon enactment	The Secretary must establish initial priorities within six months. Evaluation and synthesis of scientific evidence must be completed 18 months later.

Section	Provision	Rural Relevance	Start Date	End Date
Section 1014 *Health care that works for all Americans: Citizens' Health Care Working Group*	$3 million each year for FYs 2005 and 2006 is authorized for the Secretary, acting through AHRQ, to establish a group, "Citizens' Health Care Working Group." The group will produce reports regarding expanding coverage options, the cost of health care, innovative state and community strategies to expand coverage or reduce costs, and the role of evidence-based medicine and technology in improving quality and lowering costs.	Appointments to the 15-member group will include consumers of health services representing individuals who have not had insurance within two years of appointment, who have had chronic illnesses, and who receive coverage through Medicare and Medicaid; individuals with expertise in financing and payment for benefits and access to care; business and labor; and providers of health care. "The membership shall reflect a broad geographic representation and a balance between urban and rural representatives."	Upon enactment. Authorized funding begins Oct. 1, 2004.	Sept. 30, 2006

Title XII
TAX INCENTIVES FOR HEALTH AND RETIREMENT SECURITY

The provisions of this Title affect all Medicare beneficiaries. The definition of a high-deductible health plan applicable to HSAs is modified by eliminating the limitation on the maximum amount of the deductible and increasing the limit on out-of-pocket expenses. A high-deductible plan has a deductible of at least $1,000 for self-only coverage or $2,000 for family coverage and an out-of-pocket expense limit that is no more than $5,000 in the case of self-only and $10,000 in the case of family coverage. The maximum aggregate annual contribution that can be made to an HSA is the lesser of (1) 100% of the annual deductible under the high-deductible health plan, or (2) the maximum deductible permitted under an Archer MSA high-deductible health plan under present law (in 2004, the amount is estimated to be $2,600 for self-only coverage and $5,150 for family coverage).

The annual contribution limits for individuals who have attained age 55 by the end of the taxable year are increased by $500 in 2004, $600 in 2005, $700 in 2006, $800 in 2007, $900 in 2008, and $1,000 in 2009 and thereafter. Qualified medical expenses are expanded to include health insurance premiums for individuals eligible for Medicare, other than premiums for Medigap policies.

The following recent publications from the RUPRI Center for Rural Health Policy Analysis may be downloaded at www.rupri.org/healthpolicy:

Care Across the Continuum: Access to Health Care Services in Rural America. December 2003 (P2003-10)

Availability and Use of Health Plan Choices in Rural America: Medicare+Choice, Commercial HMO, and Federal Employees Health Benefit Program Plans. October 2003. (P2003-7)

Medicare Physician Payment: Practice Expense. October 2003. (PB2003-9)

Enrollment in FEHBP Plans in Rural America: What Are the Implications for Medicare Reform? June 2003. (PB2003-8)

Rural Hospital HIPAA Readiness and Resource Needs. May 2003. (PB2003-6)

An Analysis of Availability of Medicare+Choice, Commercial HMO, and FEHBP Plans in Rural Areas: Implications for Medicare Reform. March 2003. (PB2003-5)

Medicare Physician Payment. January 2003. (PB2003-2)