

Date: July 9, 2003

Topic: Flex Program Overview

Facilitator: Terry Hill, TASC

Guests: Gary Wingrove, Rochelle Schultz-Spinarski, Eric Shell, Ira Moscovice, Sally Buck, and Forrest Calico

Opening Comments – Terry Hill & Forrest Calico

Topics mentioned at the beginning of the call included:

- The annual Flex conference will be August 19, 2003, as a part of the ORHP All Programs Meeting in Washington D.C.
- Legislative discussion included:
 - There was concern with the division of the \$40M appropriation of Flex and SHIP. Medicare Legislation updates; The Senate conference committee report for the reauthorization of Flex and SHIP is appropriated at \$40M with \$20M for SHIP and \$20M for Flex. Kip Smith, MT, added that Senator Baucus' office didn't know where the 50/50 split had originated. Tami is getting hard copy confirmation and TASC will monitor.
 - House and Senate differences regarding the flexibility of beds: Senate - Swing or acute care beds increased to 25; House - An expansion of five acute care beds for seasonal purposes.
 - The House version moves the cost-based reimbursement to 102% of cost
 - Kip Smith, noted that at least one of the bills includes a fix for on-call ER providers which would allow for mid-levels to cover call as opposed to only physicians.
 - Possible elimination of the 35 mile rule for cost-based reimbursement for ambulance services owned and operated by a CAH. Both bills include provisions for this fix.
 - There was discussion about CMS' ruling that patients must be present at the CAH to receive cost-based reimbursement for labs and how this might affect CAHs.

*** For exact language, see the attached AHA side-by-side comparison of the bills courtesy of John Supplitt.**

The remaining time was dedicated to the panel of experts on the call.

- **Financial Questions**
 - Q: Is the large number of CAHs costing CMS a lot of money?
 - A: *Terry Hill*: The difference between cost-based and PPS is relatively minimal, and CMS' objection may be more philosophical and rooted in a dislike of cost-based reimbursement.
 - A: *Ira Moscovice*: This is a drop in the bucket financially for CMS. He agreed with Terry's interpretation of CMS' hesitation and spoke to the larger issue of whether or not increased access to the program via provisions such as REACH would make CMS nervous and potentially negatively impact the CAH program.
 - A: *Eric Shell*: Addressed the "invisible cap" of cost-based reimbursement. Eric explained that even when costs are raised, the outcome is only the cost-based portion of your payer mix that yields higher reimbursement. Thus creating an "invisible cap" on cost-based reimbursement that, according to Eric, many policy makers don't understand. Ultimately, the way a CAH makes money is by reducing its unit cost, the cost on a "per unit of service" basis. This is the same way a general acute care hospital makes money. The key is to increase volume relative to cost.

- A: *Kim Busch*: Pointed out that reimbursement is always changing and one way the States can assist small rural hospitals is to encourage them to do their own cost reports and increase their skill level and knowledge about different reimbursement programs so they can weigh all of their options.
- Q: Is there a certain amount of revenue hospitals cannot exceed and still remain a CAH?
- A: *Eric Shell*: There is no formula tied to revenue; the only limitation is bed size and length of stay (see CAH Conditions of Participation).
- A: *Terry Hill*: The hospitals that are benefiting are the hospitals that were losing money in the Medicare business; they aren't getting paid more than their costs. Hospitals need to look at how they can serve the needs of the community and provide the services they want. The Tracking Team has found there has been an expansion of services (particularly outpatient) provided by CAHs and their revenue has increased. Hospitals need to work with their communities, build volume, provide more services, and keep folks accessing healthcare in the community.
- *Ira Moscovice*: Instead of the program being about downsizing hospitals, the Tracking Team has seen the contrary where hospitals are embracing the program and using it to expand services and meet the needs of their communities.
- *Beverly Court, WA*: In Washington some hospitals are converting to CAH for better Medicaid reimbursement because it is tied to the Flex program in the state.
- *Pat Schou, IL*: Some Illinois facilities are using a software program six months into the year to make sure they are on track. They are like mini-cost reports to keep them in check.

- **Tracking Team Questions**

- *Ira Moscovice*: The Tracking Team is finishing up the current cooperative agreement with the Office of Rural Health Policy and writing an overall synthesis of the last four years of the program tentatively entitled *Strengthening the Rural Health Infrastructure: Lessons Learned from the Medicare Rural Hospital Flexibility Program*. It will be a document to share with people within and beyond the Flex program.
- Online and printed copies of the *Third Year Findings* are available from TASC. E-mail Heather (hhartung@ruralcenter.org) with your requests.

- **EMS Questions**

- *Gary Wingrove*: The “35 mile elimination rule” went through both sides of Congress in the Medicare Prescription Drug Bill.

- **TASC**

- Heather Hartung, TASC Program Coordinator, put together the “Flex Coordinator Manual” with the assistance of Rochelle Schultz-Spinarski to assist state Flex coordinators with the program
- The manual contains different venues of the Flex program and will be updated annually.

The meeting was adjourned at 3:35 p.m. CST. The next TASC 90 conference call is yet to be determined.

For further information, please contact TASC at 218-727-9390 or tasc@ruralresource.com

Side-by-Side Comparison of House and Senate Medicare and Medicaid Rural Provisions in Medicare Rx Drug Bill
 Updated July 14, 2003

ISSUES	HOUSE COMMITTEE H.R. 1	SENATE FINANCE COMMITTEE S. 1	10-YEAR BUDGET IMPACT (Preliminary CBO Estimates House – 06-17-03 Senate – 06-11-03)
Inpatient PPS Update	Provides an update of market basket minus 0.4 percentage points for three years from FY 2004 to FY 2006.	No provision (maintains full market-basket update).	<u>Ways and Means:</u> Cuts of \$12 billion
Standardized Amount	Equalizes the standardized amount for rural and small urban hospitals immediately beginning in FY 2004.	Equalizes the standardized amount for rural and small urban hospitals, including those in Puerto Rico beginning FY 2004.	<u>Finance:</u> \$7.8 billion <u>Ways and Means:</u> \$7.9 billion
Wage Index/Labor Share	<ul style="list-style-type: none"> a. Lowers the labor-related share to 62% of the standardized amount for those hospitals that would benefit beginning in FY 2004. b. Provides a provision to update the hospital market basket, including the labor share, more frequently than once every 5 years. 	<ul style="list-style-type: none"> a. Same as House, but beginning FY 2005. b. No provision 	<u>Finance:</u> \$5.4 billion <u>Ways and Means:</u> \$5.6 billion
Low-Volume Adjustment	No provision.	Beginning in FY 2005, hospitals with less than 2,000 inpatient discharges would be eligible for up to a 25% increase in Medicare inpatient PPS payments if they are at least 15 miles from a similar hospital.	<u>Finance:</u> \$1.9 billion
Medicare Disproportionate Share Payments (DSH)	<ul style="list-style-type: none"> a. Enhances Medicare DSH payments for small urban and rural hospitals by increasing payment cap to 10% (from 5.25%) effective in FY 2004. b. No provision. c. No provision. 	<ul style="list-style-type: none"> a. Equalizes Medicare DSH payments by eliminating the 5.25% payment cap for small urban and rural hospitals, effective in FY 2005. b. Increases the disproportionate share adjustment percentage from 35 percent to 40 percent beginning in FY 2004 for certain ("Pickle") hospitals c. Calls for a MedPAC study within one year to determine whether DSH payments should be made in the same manner as payments for GME and Medicaid DSH, and whether uncompensated care costs should be added to the DSH formula 	<u>Finance:</u> \$3.2 billion <u>Ways and Means:</u> \$2.1 billion

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<p>Critical Access Hospitals (CAHs)</p>	<p>Provides CAHs Medicare inpatient and outpatient reimbursement at 102% of cost, effective FY 2004.</p> <p>Expands cost-based reimbursement of on-call emergency room physicians to physician assistants, nurse practitioners and clinical nurse specialists beginning CY 2004.</p> <p>Allows CAHs to receive periodic interim payments (PIP) for inpatient services beginning CY 2004.</p> <p>Modifies the isolation test for cost-based CAH ambulances services if the ambulance is a first responder to emergencies (as determined by the Secretary).</p> <p>Effective CY 2004, allows CAHs with strong seasonal census fluctuations (as determined by the Secretary) to increase total acute care beds by 5, or from 15 to 20. The CAH may operate an additional 5 (not 10) swing beds, such that total beds do not exceed 25.</p> <p>Eliminates requirement that physicians providing services in CAHs must accept assignment (retroactive to 2001).</p> <p>g – i. No provision.</p>	<ul style="list-style-type: none"> a. No provision. b. Same as House, but beginning CY 2005. c. Same as House, but beginning CY 2005. d. Eliminates the requirement that a CAH be the only ambulance provider within 35 miles to receive cost-based reimbursement, effective FY 2005. a. Permits CAHs to operate up to 25 swing beds or acute care beds by removing the requirement that only 15 of 25 beds be used for acute care at any one time, effective FY 2005. b. No provision. c. Requires CMS to exclude new CAHs from the calculation of the hospital PPS wage index for cost reporting periods beginning Jan. 1, 2004. d. Allows CAHs to operate psychiatric or rehabilitation distinct part units with less than 25 beds e. Creates a 5-year demonstration program beginning no later than Jan.1, 2005 in four demonstration areas (two would include Kansas and Nebraska) where CAHs would receive reasonable cost based reimbursement plus a return on equity for home health, SNF, psychiatric and rehabilitation services. This provision would be budget neutral. 	<p><u>Finance:</u> \$1.0 billion</p> <p><u>Ways and Means:</u> \$400 million</p>

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“Essential Rural Hospital” payment classification	Effective FY 2005, creates a new payment classification of “Essential Rural Hospital” for hospitals with more than 25 beds in rural areas whose closure would have a significant adverse impact on the community and also meet certain criteria such as the percentage of Medicare beneficiaries served. Payment for Medicare inpatient and outpatient services is 102% of costs.	No provision.	<u>Ways and Means:</u> \$400 million
Rural Community Hospital Demonstration Program	No provision.	Creates a 5-year demonstration program beginning no later than Jan. 1, 2005 in four areas (two would include Kansas and Nebraska) where certain rural hospitals with less than 51 acute care beds would receive either PPS payment or reasonable costs plus a return on equity for inpatient, outpatient, and if elected, home health services. These facilities would be exempt from a potential 30 percent reduction in reimbursement for bad debt. The provision would be budget neutral. CAHs could qualify.	
Outpatient	<ul style="list-style-type: none"> a. Extends the hold harmless provision to rural hospitals with less than 100 beds and Sole Community Hospitals (SCHs) in rural areas for 2 years, in CY 2004 and CY 2005. b. Requests a study by the Secretary to determine if rural providers experience higher costs under outpatient PPS than urban providers. c. No provision 	<ul style="list-style-type: none"> a. Applies the current hold harmless provision to rural hospitals with less than 100 beds and SCHs in rural areas for 1 year, in CY 2006 only. b. No provision. c. Provides a 5% add-on for clinic and emergency room visits in rural hospitals with less than 100 beds and SCHs for CY 2005-CY 2007. 	<u>Finance:</u> Hold harmless \$200 million Rural increase \$100 million <u>Ways and Means:</u> Hold harmless \$300 million
Geographic Reclassification	Requires Secretary to establish a process by which qualifying hospitals with certain wages and commuting patterns could receive a blended increase in their wage index.	Requests within 2 years a GAO study on the appropriateness of payments under the inpatient PPS and the need for geographic adjustments to reflect differences in hospital costs.	No impact

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Ambulance	<p>a. Increases the mileage base rate (as determined by the Secretary) for ground ambulance services originating in a rural area with a low population density.</p> <p>b. Provides payment at the greater of either the national fee schedule or a blended rate of the national fee schedule and a regional fee schedule.</p> <p>The new regional fee schedule will be determined by the Secretary for each of the 9 Census divisions using a methodology that includes calculating a regional conversion factor and a regional mileage payment rate.</p> <p>The blended rate is: <u>For FY 2004:</u> 20% of the national fee schedule, and 80% of a regional fee schedule <u>For FY 2005:</u> 40% national, 60% regional <u>For FY 2006:</u> 60% national, 40% regional <u>For FY 2007-FY2009:</u> 80% national, 20% regional <u>For FY 2010 and thereafter:</u> 100% current</p> <p>c. Provides a 25% increase in the per-mile rate for trips over 50 miles (regardless of whether they originate in an urban or rural setting) for five years beginning in CY 2004</p> <p>d. Initial GAO report on ambulance cost and access by CY 2006, with a final report by CY 2008.</p> <p>e. No provision.</p> <p>f. No provision.</p>	<p>a. No provision.</p> <p>b. No provision.</p> <p>c. No provision.</p> <p>d. No provision.</p> <p>e. Provides a 5% add-on for ground ambulance services originating in a rural area for three years from CY 2005-CY2007.</p> <p>f. Clarifies and expands definition of medically necessary air ambulance services beginning in CY 2005.</p>	<p><u>Finance:</u> Rural increase \$100 million</p> <p>Ambulance \$200 million</p> <p><u>Ways and Means:</u> \$400 million</p>

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<p>Niche Hospitals</p>	<p>a. Requires MedPAC study comparing specialty hospitals with similar general acute care hospitals under Medicare that examines:</p> <ul style="list-style-type: none"> – Whether there are excessive self-referrals; – Quality of care furnished; – Impact of specialty hospitals on general hospitals; and – Differences in scope of services, Medicaid utilization, and uncompensated care. <p>b. Requires HHS Secretary to submit report on MedPAC study, including legislative and administrative changes deemed appropriate no later than one year after enactment.</p>	<p>Clarifies “whole hospital” and “rural” exceptions to the prohibitions on physician self-referrals to entities in which they have an ownership interest. Specifically:</p> <p>a. Excludes specialty hospitals from the whole hospital exception.</p> <ul style="list-style-type: none"> – Defines specialty hospital as being primarily or exclusively engaged in the care/treatment of cardiac conditions, orthopedic conditions, patients receiving a surgical procedure, or any other specialized category designated by HHS as inconsistent with the purpose of the statute. – Grandfathers specialty hospitals: <ol style="list-style-type: none"> (1) in operation or under development by June 12, 2003; (2) for which the number of beds and of physician investors is no greater than the numbers on June 12, 2003; and (3) meets other requirements set by HHS. <p>Directs HHS to consider several factors in defining “under development” regarding architectural plans, funding, zoning, regulatory approvals, etc.</p> <p>b. Adds a third criterion for the rural exception. In addition to operating in a rural area and substantially serving rural residents of the area, limits the exception to designated services that would not be available in the rural area but for the physician ownership or investment.</p>	<p><u>Finance:</u> Not Available</p> <p><u>Ways and Means:</u> No score</p>

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Home Health	<ul style="list-style-type: none"> a. Provides an inflation update of market basket minus 0.4 percentage points for FY 2004-FY 2006. b. Increases payments by 5% for rural providers for FY 2004 and FY 2005. c. Demonstration project to clarify homebound criteria. d. Changes payment cycle from fiscal year to calendar year starting in 2004. e. Establishes a per episode copay (\$40 for FY 2004) with a copay exemption for low-income beneficiaries. f. Requires MedPAC study on home health payment margins under PPS. g. Temporarily suspends OASIS patient assessment for non-Medicaid/Medicare patients. 	<ul style="list-style-type: none"> a. Includes three duplicative sections regarding increased payments for rural providers for FY 2004 and FY 2005: Sec. 451- 5%; Sec. 459- 10%; Sec. 463- 10% (seeking clarification). b. Limits PPS wage adjustment (may not be more than 3% less than the previous year for FY 2005 and FY 2006). 	<p><u>Finance:</u> Rural add-on \$300 million</p> <p><u>Ways and Means:</u> Rural \$200 million</p> <p><u>Energy and Commerce:</u> Not Available</p>
Skilled Nursing Facilities (SNF)	<ul style="list-style-type: none"> a. Adds new consolidated billing exemptions for rural health clinics and federally qualified health centers. b. Increases per diem payment by 128% for residents with AIDS. 	<ul style="list-style-type: none"> a. Same as House. b. No provision. 	<p><u>Finance:</u> \$300 million</p> <p><u>Ways and Means:</u> \$100 million</p> <p><u>Energy and Commerce:</u> Not Available</p>
Clinical Diagnostic Laboratory	<ul style="list-style-type: none"> a. No provision. b. No provision. 	<ul style="list-style-type: none"> a. Expands beneficiary cost sharing to diagnostic laboratory tests effective CY 2004. b. Provides cost reimbursement for diagnostic laboratory tests performed by SCH under Part B for two years from CY 2005-CY 2006 with no beneficiary cost sharing. 	<p><u>Finance:</u> SCH \$300 million</p>
Rural Health Clinics	No provision.	Increases the per visit payment limit to \$80 in CY 2005.	<p><u>Finance:</u> \$1.8 billion</p>

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<p>Key Medicare Physician Provisions</p>	<p>a. Physician Payment Update – The physician fee schedule payment update factor for 2004 and 2005 shall be not less than 1.5% and will be exempt from budget neutrality adjustment of –0.2% in 2004 and 0.8% in 2005. The sustainable growth rate formula is modified.</p> <p>b. Medicare Incentive Payment (MIP) Program (Bonus Payment) – Physicians will be paid a new 5% bonus payment for certain underserved counties. Counties will be defined based on the number of primary care and specialty care physicians. The Secretary is required to establish procedures to determine when a physician can be paid a Medicare (MIP) bonus payment when providing services in health professional shortage areas (HPSA).</p> <p>c. Studies on Access to Physician Services – GAO must conduct a study on access of Medicare beneficiaries to physician services, supply of physicians, and payment for inhalation therapy. MEDPAC is instructed to conduct a study on physician practice expense.</p> <p>d. Work Index Floor – For localities with a work index of less than 1.00, the index is increased to 1.00 for services furnished in 2005-2007.</p>	<p>a. Establishment of Floor for Geographic Payment Adjustment – Several changes are made to component parts of the Medicare physician fee schedule. The work index will be increased for any locality for which the geographic index is less than the work index. This change applies to services furnished between 01/01/04 and 01/01/08. The work index is increased to 0.980 for services furnished in 2004 and increases to 1.00 for services furnished in 2005-2007. The practice expense and malpractice geographic indices, in low value areas, are increased to 1.00 for services furnished in 2005-2007.</p> <p>b. Medicare Incentive Payment (MIP) Program (Bonus Payment) – The Secretary is required to establish procedures to determine when a physician can be paid a Medicare (MIP) bonus payment when providing services in health professional shortage areas (HPSA). The Secretary is also required to establish ongoing physician education about the program, conduct a study to determine if beneficiary access is improved and submit annual reports regarding the program. GAO is also required to conduct a study of the MIP program.</p> <p>c. No provision</p> <p>d. Similar to the House.</p>	<p><u>Ways and Means:</u></p> <p>a. Update + \$200 million over 10 yr (2004–07 + \$2.8B) (2008-13 - \$3.1B)</p> <p>b. MIP approximately \$5B</p> <p><u>Finance:</u></p> <p>a. Wage Index \$6.5 billion</p> <p>b. MIP \$200 million</p>

In addition to the above there are numerous provisions on regulatory relief that are important to all hospitals including small or rural hospitals.