

CAH/FLEX National Tracking Project

FINDINGS FROM THE FIELD

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Participation in the Medicare Rural Hospital Flexibility Program: Documenting Trends and Changes

Background

The Medicare Rural Hospital Flexibility Program (Flex Program) Tracking Team, with the cooperation of state Flex Program/ Critical Access Hospital (CAH) coordinators and officials at the Health Care Financing Administration (HCFA), has been documenting trends and changes in the Flex Program in terms of CAH conversions. Program activities, including recent CAH conversions, are reported by these state and federal contacts and cataloged in an electronic tracking system. Additional data are extracted from secondary datasets and linked to the tracking system to form a Monitoring Data Set (MDS). Information contained in the MDS presents a useful picture of the hospitals, communities, and states participating in the Flex Program.

Overview

Participation in the Flex Program has grown rapidly since its inception in October of 1997. As of January 1, 2001, 303 hospitals in 35 states had been certified as CAHs.* In the year 2000, more than half of the currently certified CAHs joined the Flex Program, and State Program Coordinators expect at least 350 more facilities to convert within the next three years.

Forty-eight states have received funds from HCFA since 1999 to support the development of a state rural health plan and most have received additional funding to participate in the Flex Program. A state's health plan must be approved by HCFA in order for its hospitals to be eligible for CAH designation. As of January 1, 2001, 45 states had obtained HCFA approval for their state rural health plans, and two of the remaining states will likely obtain HCFA approval by mid 2001.

* Due to lags in reporting, the assignment of retroactive designation for billing purposes, and continuous CAH conversion, this figure may have changed. For the most current information about CAHs, refer to our website at <http://www.rupri.org/rhfp-track/>

Previous Findings From The Field

Vol. 1, No. 14: From Wisconsin: The Role of the Stakeholder Coalition Model in the Rural Hospital Flexibility Program

Project Website: <http://www.rupri.org/rhfp-track/>

Three states, Maryland, New Jersey, and Rhode Island, will not participate in the Flex Program due to a lack of eligible and/or interested rural hospitals.

What are the Characteristics of Hospitals that Have Become Critical Access Hospitals?

Table 1 summarizes data from HCFA's Hospital Cost Reporting System Minimum Data Set. Although these data describe operating characteristics prior to conversion for many facilities, since the latest fiscal year end included in the file is August 1998, the data provide a picture of general operations for the hospitals.

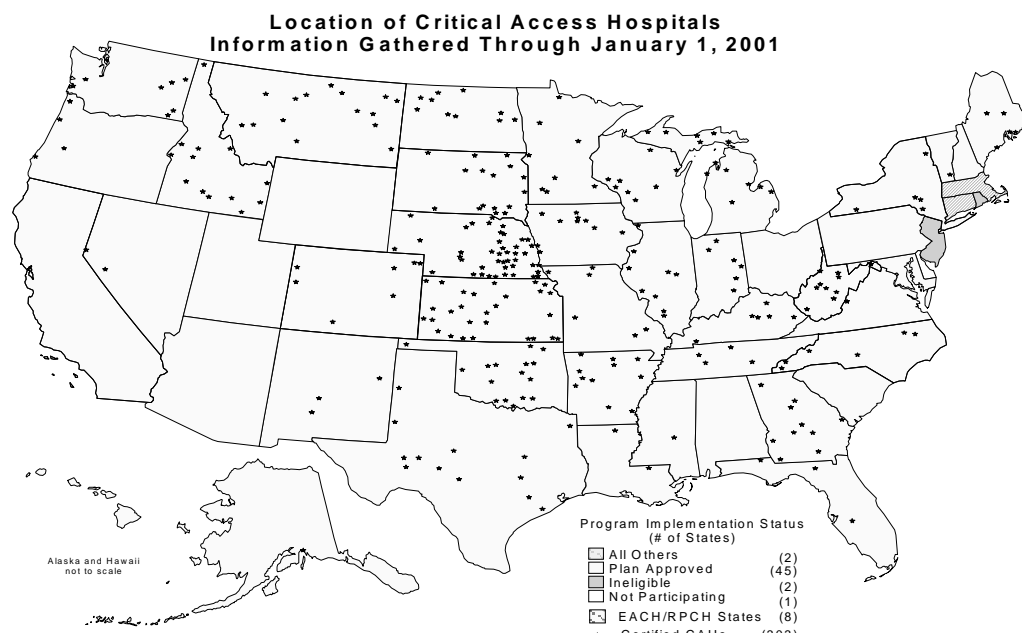
Table 1. Characteristics of CAHs - HCFA Data

	Mean	Median
Average Daily Census (ADC)	24.1	10.0
Average Daily Census (ADC) excluding swing beds	4.3	3.0
Average Length of Stay (ALOS) excluding swing beds	3.4	3.3
Operating Margin (Net Income From Patient Services/Net Patient Revenues)	15.5 %	-9.9 %
Total Margin [(Net Income or Loss for Period) / (Net Patient Revenues + Total Other Income)]	-1.9 %	-0.3 %
Medicare Utilization-Days (Medicare Hospital Days/ Total Patient Days)	61.7 %	63.3 %
Medicare Utilization-Discharges (Medicare Discharges Excluding Swing/Total Discharges Excluding Swing)	61.9 %	66.9 %
Distance from CAH to closest hospital (calculated using ZIP code centroids)	20.4 mi	18.2 mi

What are the Characteristics of the Counties in Which CAHs are located?

CAHs are important sources of health care in the counties where they operate. These facilities tend to be located in areas designated by the U.S. Bureau of Primary Health Care as underserved. Ninety-one percent of CAHs are located in geographic areas designated as Health Professional Shortage Areas or Medically Underserved Areas. Analysis also shows that 65% of CAHs are the only hospital in their county. Finally, nearly 83% of CAHs are located in counties where the population of persons aged 65 or older is higher than the average in the hospitals' state. A map of the CAH locations is shown below.

Figure 1



Sources: HCFA Regional & Central Offices, ORHP, and State Offices coordinating w/ MRHFP, 2001.

Produced By: North Carolina Rural Health Research Program, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill.

Essential Access Community Hospitals (EACHs), Rural Primary Care Hospitals (RPCHs), and Medical Assistance Facilities (MAFs)

Overall, the implementation of the Flex Program has been much more rapid in states that participated in the EACH/RPCH and MAF demonstration programs. These states were among the first to have hospitals certified as CAHs, and approximately 29% of all CAHs are located in these states. All but 2 of the 53 hospitals that participated in these demonstrations have since become CAHs; one of the non-converting facilities became a long-term care facility and the other closed.

Similarities and Differences in State Programs

The administrative structure of the Flex Program varies from state to state, but the State Office of Rural Health is most often the lead agency on the project. In a few states, the State Hospital Association leads the project and the State Office of Rural Health is a contributing partner. In all states, multiple agencies collaborate to plan and implement Flex Program activities including emergency medical services improvements, rural network development, community development, and CAH certification.

Many states have arranged for, or are considering, enhanced Medicaid reimbursement, often cost-based, for inpatient and/or outpatient services at CAHs. Though rural hospitals generally serve a limited Medicaid population and are less affected by changes in Medicaid payments than by Medicare changes, the financial stability of some hospitals eligible for CAH status has been greatly improved by increases in Medicaid reimbursement. To date, more than half of the current population of CAHs in 17 states benefit from some form of enhanced Medicaid reimbursement.

The Consolidated Appropriations Act, P.L. 106-554, signed into law on December 21, 2000, has brought resolution to issues that had been stalling CAH designation in several states. The addition of lab and ambulance services to the cost-based reimbursement method is a change that is expected to stimulate new, and re-ignite deferred, interest in CAH conversion. However, a limited number of states continue to report that their financially fragile hospitals cannot benefit from the CAH program due to the unresolved issues regarding psychiatric and/or rehabilitation distinct-part units and bed size limits. Financial evaluations have shown that these facilities would lose more money than they would generate under cost-based Medicare reimbursement if they were to abolish their geriatric psychiatric services and/or reduce their bed capacity in order to meet the requirements for CAH status. Consequently, states affected by these unresolved issues have not moved ahead in designating CAHs.

Where Can I Get More Information?

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About this project: Check our website: <http://www.rupri.org/rhfp-track/>

BACKGROUND

The Rural Hospital Flexibility Program is a federal initiative to strengthen rural health. The Program:

1. Allows small hospitals the flexibility to reconfigure operations and be licensed as Critical Access Hospitals (CAHs).
2. Offers cost-based reimbursement for Medicare acute inpatient and outpatient services.
3. Encourages the development of rural-centric health networks.
4. Offers grants to states to help implement a CAH program in the context of broader initiatives to strengthen the rural health care infrastructure.

CAH/FLEX
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