

## CAH/FLEX

National  
Tracking  
Project

## FINDINGS FROM THE FIELD

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# Reauthorizing the Medicare Rural Hospital Flexibility Grant Program: Lessons from the Field

## *Introduction*

Since 1998, the Rural Hospital Flexibility Program Tracking Project (Tracking Team), a collaboration of six rural health research and policy analysis centers, has been studying the implementation and early impact of the Rural Hospital Flexibility Program (Flex Program). In an effort to inform the discussion of the reauthorization of the Flex Program in 2002, the Tracking Team has prepared this summary of the key findings of this project. All of the Tracking Team's products are available at [www.rupri.org/rhfp-track](http://www.rupri.org/rhfp-track).

## *The Program*

The Flex Program has two important components. The first authorizes states to designate Critical Access Hospitals (CAHs) based on a state Rural Health Plan approved by the Secretary of Health and Human Services. Designated facilities are reimbursed by Medicare on the basis of costs. The second component consists of a \$25 million per year grant program to support the following state activities:

- planning and implementing the state rural health plan;
- developing rural health networks;
- designating CAHs;
- developing quality improvement initiatives; and
- establishing or expanding rural emergency medical programs.

## *The CAH Component*

To date, the Flex Program has had far-reaching effects on health care in rural communities across America. With over 550 hospitals and 47 states participating, the Program is highly visible and popular. More than half of the designated CAHs are serving counties dually designated as both a Medically Underserved Area (MUA) and a Health Professional Shortage Area (HPSA). Fewer than one in ten CAHs are located in counties with neither a HPSA nor an MUA designation. On average, counties with CAHs have fewer primary care physicians per 1,000 residents than all rural counties with a hospital and all counties nationwide. After one year, 119 participating CAHs reported a median financial impact of +\$250,000. To the extent that these financial results are attributable to Program

### **Accomplishments of the Flex Grant Program**

Reported by State Flex Coordinators as of  
January 1, 2002

[www.rupri.org/rhfp-track/mrhfgrid.html](http://www.rupri.org/rhfp-track/mrhfgrid.html)

1170	hospitals received some form of assistance (meetings, education, grants, technical assistance)
881	emergency medical services projects received assistance
557	communities received assistance with needs assessment and community development
559	hospitals were certified as Critical Access Hospitals

participation, the Program may be credited with stabilizing many small rural hospitals and thus contributing to access to health care for rural Americans (Medicare Payment Advisory Commission, 2001).

### ***The Grant Component***

The Tracking Team has shown that most states have been highly successful in implementing the Flex Program. State Offices of Rural Health, state hospital associations, and other collaborating organizations have developed successful partnerships that are assisting rural hospitals and communities to implement this Program. Beyond the immediate financial implications of this Program for small rural hospitals, this Program has provided a vehicle for rural stakeholders to address broader community health concerns and has contributed to a growing awareness of rural issues across the states.

The first two years of the Flex Program have largely focused on stabilizing small, vulnerable rural hospitals. This remains a central goal in the Program. As the Flex Program has evolved, we have witnessed an increasing emphasis in state priorities and local activities on strengthening the rural community health infrastructure of which hospitals are a core element.

The reauthorization and continuing implementation of the Flex Program represents an opportunity to further assist states, rural hospitals, and rural communities to continue to develop innovative strategies and technical assistance programs for stabilizing and strengthening rural hospitals and community health systems. Information collected by the Tracking Team over the first three years of the Flex Program suggests a number of key opportunities for building on the successful development and implementation of this Program.

### ***Using the Flex Program to Further Strengthen Rural Health Systems***

#### **Rural Health Planning and Policy Development:**

- Continue to support the role of states in convening and coordinating partnerships with state Hospital Associations and other organizations to engage in collaborative planning for rural health policy development.
- Provide incentives and support for states to develop, expand, and/or maintain data and information collection strategies to track and assess the status of vulnerable rural communities and hospitals and to inform rural health policy development.
- Support and expand the role of (and support for) states and their collaborating partners to facilitate technical assistance for small rural hospitals, rural health networks, and communities.
- Continue to support a forum for the exchange of information among states, hospitals, and other Program participants concerning “best practices,” innovative strategies, and other Program implementation issues.
- Support continued tracking and assessment of Flex Program implementation and impact.

#### **Expand Rural Network Development:**

- Encourage and support the development of partnerships among rural hospitals and their partners, community organizations, and rural health networks to address critical rural community health infrastructure needs.

- Expand training and networking opportunities for CAH administrators, chief financial officers, rural health network managers, and medical directors to expand their understanding of the role of the small rural hospital in community health systems development.

**Expand Quality Improvement:**

- Encourage states, hospitals, and communities to include quality improvement initiatives as a core component in their network development, EMS, and other Program initiatives.

**Strengthen Rural EMS:**

- Encourage the development of rural EMS services as a critical component of hospital care through expanded partnerships of EMS provider organizations (or other EMS representatives) with other providers (e.g., hospitals) and inclusion of EMS in rural health network development.

**Expand Hospital Technical Assistance:**

- Continue to encourage and support the development of rural hospital performance improvement initiatives that expand and improve management and fiscal capacity, including strategic planning, practice management assistance, peer assistance programs for CAH administrators, and other activities.

There has been remarkable progress in the Flex Program to date. Conversion to CAH status seems to have helped over 550 hospitals improve financial performance, address quality issues, and network with other hospitals. States are also making progress on improvements to their rural EMS systems. However, America's small rural hospitals still face many significant challenges to their survival, and continued support would help to ensure that the progress to date is sustained.

**References**

Medicare Payment Advisory Commission. (June 2001). *Report to Congress: Medicare in Rural America*. Washington, DC: Medicare Payment Advisory Commission.

**Characteristics of CAHs Compared to Other Rural Hospitals,  
as of December 31, 2001, for 489 CAHs**

	<b>CAHs*</b> (N=489)	<b>Small Rural Hospitals (ADC &lt;=15)</b> (N=759)	<b>Other Rural Hospitals</b> (N=988)
Percentage of Facilities with Swing Beds	86%**	60%	39%
Median Daily Census (Acute Only)	3.5	6.7	29
Average Proportion of Discharges Paid for by Medicare	61.5%	54.1%	47.5%
Average Operating Margin	-15.3%	-9.2%	-0.7%

These Data were produced by the North Carolina Rural Health Research and Policy Analysis Center, Sheps Center for Health Services Research, University of North Carolina - Chapel Hill.

Source: Hospital Cost Report Information System Minimum Data Set, PPS 15, Health Care Financing Administration, 1997-1998

\*Reported data describe characteristics prior to conversion to CAH status for 79% of the 489 hospitals.

\*\*Swing bed license data were obtained from the Centers for Medicare and Medicaid Services for CAHs and characterize the hospitals post conversion.

## Previous Findings From The Field and Tracking Project Reports

Report:	Rural Hospital Flexibility Program Tracking Project Year Two
Vol. 2, No. 3:	Administration in Critical Access Hospitals
Vol. 2, No. 2:	Regionalization of Emergency Medical Services: The Experience of Michigan's Upper Peninsula
Vol. 2, No. 1:	Impact of the Rural Hospital Flexibility Program on Rural Emergency Medical Services: Evidence From the First Two Years
Vol. 1, No. 11:	From Sixteen Critical Access Hospitals: Strategic Planning and the Balanced Scorecard
Vol. 1, No. 9:	From Kansas and Idaho: Supporting Quality Assurance/Improvement in Critical Access Hospitals: A Role for Networks and State Agencies
Vol. 1, No. 3:	From North Carolina and Wisconsin: The RHFP as a Vehicle for State Policy
Project Website:	<a href="http://www.rupri.org/rhfp-track/">http://www.rupri.org/rhfp-track/</a>

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