

# CAH/FLEX National Tracking Project

## FINDINGS FROM THE FIELD

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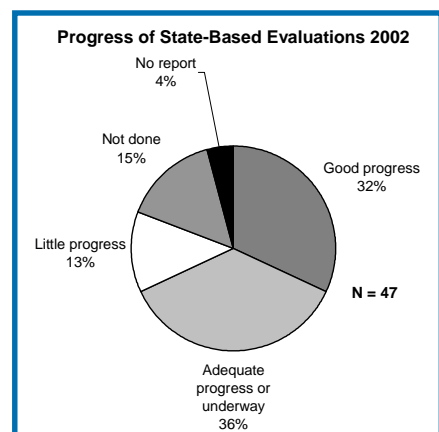
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## State-Based Evaluations of the Flex Program

Most states that have undertaken any evaluation activities have done a creditable job of tracking the progress of the Rural Hospital Flexibility Program (Flex Program) in their states. There remain, however, inconsistencies among the states concerning their approaches to evaluations. Many have completed summative evaluation activities and have learned about where their Flex Programs are succeeding and/or failing. Less commonly, states have taken a formative approach to evaluation, and, in tracking progress of their Flex Program, have identified opportunities to improve their program. This Finding will concentrate on those identified opportunities for improvement.

In response to a request from the Federal Office of Rural Health Policy, states with Flex Program grants sent us reports on their evaluation activities. We reviewed each report and abstracted information concerning methods, linkages to goals of the Flex Program, and findings from the evaluations. State-based evaluation reports were received from 45 of the 47 states participating in the Flex Program.

The figure shows the progress of the evaluations. Two-thirds of the states have made adequate progress on their evaluations, with about half of those states getting high marks for their efforts. States whose evaluations have been the most thorough have carefully designed evaluation methodologies that include a range of approaches to gathering summative and formative information. These states have done a thorough job of tracking their progress toward meeting the objectives of the Flex Program, and they have shared documentation of their efforts with the Flex Program Tracking Team. At the other end of the scale, more than a quarter of the states participating in the Flex Program report little or no progress on their evaluations.



Below are key findings gleaned from written evaluation reports and telephone interviews with state officials. As appropriate, reference is made to specific states. These references may not be comprehensive, and consequently, some states may have been inadvertently excluded.

**Cost-based reimbursement improves bottom lines for CAHs.** There are substantial methodological barriers to assessing the financial impacts of the Flex Program, but several states studied this area. Some states are concentrating on developing good baseline data so that they will be able to test the financial benefits when Critical Access Hospitals (CAHs) have several years of experience (and concomitant cost reports) (AZ, MN, OR, PA). The states that proffered opinions about financial impacts found

positive effects (MT, NE, OK, PA, TX, WA), sometimes at levels even greater than predicted in financial feasibility studies (MI). Evaluations in several states noted that conversion to CAH status saved several hospitals from financial failure (CA, IL, NC, TX, WA). States reported that even though CAHs generally have improved finances via cost-based reimbursement, the new method of payment is usually not sufficient, in and of itself, to bring hospitals starting from loss positions to profitability (MI, MT, WA).

**Virtually all of the states presented information on their progress in the five main areas of activity of the Flex Program (i.e., development of a state rural health plan, designation of CAHs, network development, quality assurance, and emergency medical systems). Most of the states have focused on evaluating processes rather than outcomes. While measuring outcomes may be difficult at this early stage of the program, future evaluations should move in that direction.**

**Improved financial status allows CAHs to make improvements to plants, add services, and increase wages.** Several state evaluations showed that these enhancements had beneficial effects on the overall strength of local health systems (KS, MN, MT, NE, NV, NH). States reported that the ability to make systems improvements afforded by improved overall financial status is probably more important than “saving” financially fragile rural hospitals.

**Benchmarking helps CAHs improve quality.** The states that reported making the best progress on quality improvements were working with benchmarking (MT). While there is substantial enthusiasm about this approach, the usefulness will be tested down the road several years, when the hospitals have more data points.

**Mini-grants remain popular in the states.** While it is no surprise that America’s small hospitals will take any resources that they can get, the mini-grants show that the federal government and the states are making this program as flexible as possible. The grants demonstrate a certain trust that communities know where to best spend additional resources (MT, ND, WV). As funds for mini-grants diminish, hospitals are doing a better job of collaborating with other hospitals and with leveraging mini-grant funds with other grants (MI, ND, WV). Some states helped CAHs leverage their mini-grants by linking projects to other sources of funding. One state provided competitive grant opportunities to work with local health departments (MI), and another directed grant funds from foundations and third party payers to CAHs (ND). Some states are starting to link mini-grants to cooperative activities among several CAHs (CO, TX, WV). Mini-grants were a central feature of several states’ Flex Programs (AK, FL, MD, MI, MN, TN, WA).

**According to information gathered by the states, the Flex Program is succeeding. There is near unanimity that cost-based reimbursement benefits CAHs. The states that have examined their own performance in administering the Flex Program see evidence that their constituents appreciate what the states have done to facilitate the decision to convert to CAH status and appreciate support for rural health systems improvements the state has made through technical assistance and mini-grants.**

**Network development fosters the growth of rural health systems.** Network development activity is increasing. Of the states that looked at networking in their evaluation reports, 25 of the 30 (83%) found substantial progress in network formation. The networking movement started as a rather minor CAH requirement (only one per state was actually required), but is now being embraced as a strategy for strengthening and expanding rural health systems. Substantial Flex Program funds are aimed at creating new networks and supporting existing ones (AK, FL, MD, MT). Networks are becoming the key feature of the Flex Program in some states (KS, OH, PA, WA). Some states found that networking is as valuable as cost-based reimbursement because it puts the rural hospitals more in control of their futures (MI, ND, WA).

**Preparing state rural health plans improves rural health organization.** The act of organizing the Flex Program has encouraged thinking and action around creating more organized rural health systems (KS, ND, SC, WA, WI). Clearly, the intent of requiring states to prepare state rural health plans was to improve rural health coordination in the states, and the state evaluations are showing progress in that arena.

**The quality of a state's Flex Program administration affects program activities.** Many states found that hospitals gave high ratings to state-based grantees on the administration of the Flex Program (MN, OH, OR, PA, WA, WI). While this may be partially related to that fact that the state-based grantees were giving out mini-grants and facilitating improved reimbursement, there is evidence that the offices of rural health and state hospital associations are doing a good job of helping with conversions and other aspects of the Flex Program.

**Allocating substantial resources for technical assistance pays off, according to evidence from some states (AK, AZ, CA, CO, ID, IL, MT, SC, TX).** Examples of technical assistance include financial feasibility studies, training in quality assurance, and facilitation of emergency medical systems planning.

**Involving communities in the CAH conversion process reduces opposition to conversion.** Communities and medical staffs have either been supportive of conversion or indifferent to it (MN, MT). A concern, early in the development of the Flex Program, was that communities or physicians would object to limitations placed on hospitals converting to CAH status. States that have engaged communities in the conversion process have found little opposition to conversion.

**Improvements to state Flex Programs arise directly from evaluation findings.** Our telephone interviews with selected states showed evidence of improvements to state programs that arose directly from evaluation findings. Examples include strengthening and improving the survey and licensure process (CA), developing a case-management approach to conversions (IL), recognizing the need for and/or providing training for communities in quality assurance and emergency medical systems (CO, MI, SC, TX), and helping CAHs deal with fiscal intermediaries that are new to the cost-based reimbursement process (CO).

The states listed below have made good progress on their evaluations. These states have tracked the progress of their Flex Program, tested the effects of various aspects of their programs, and produced substantial documentation of their evaluation efforts. States seeking assistance with evaluation or looking for good examples of how to conduct a thorough state evaluation should contact these states:

California (Michele Yepes, 916-449-5757)  
Colorado (Lou Ann Wilroy, 303-832-7493)  
Idaho (Idaho Office of Rural Health and Primary Care, 208-332-7212)  
Illinois (Pat Schou, 217-786-6992)  
Kansas (Chris Tilden, 785-296-7439)  
Michigan (John Barnas, 517-432-1066)  
Minnesota (Estelle Brouwer, 651-282-6348)

Montana (Pamela Sourbeer, 406-444-9519)  
Nebraska (David Palm, 402-471-0146)  
Ohio (Heather Reed, 614-752-8935)  
Oklahoma (Rod Hargrave, 405-271-8750)  
Pennsylvania (Larry Barroner, 814-863-8214)  
Texas (Quang Ngo, 512-936-6729)  
Washington (Beverly Court, 360-455-6439)

***Where can I get more information?***

**About this report:** Peter J. House, MHA, Department of Family Medicine, School of Medicine, Department of Health Services, School of Public Health, University of Washington, 206-616-4985, 206-685-3676, or peter\_house@fammed.washington.edu

**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.

## **Previous Findings From The Field and Tracking Project Reports**

Report: Rural Hospital Flexibility Program Tracking Project Year Three  
Vol. 3, No. 3: Medicare Reimbursement for Ambulance Transports and the Critical Access Hospital Community  
Vol. 3, No. 2: A Case Study of Six Critical Access Hospitals  
Vol. 3, No. 1: The Role of International Medical Graduates in America's Small Rural "Critical Access" Hospitals  
Vol. 2, No. 8: State Medicaid Payment Policies for Critical Access Hospitals  
Vol. 2, No. 7: State Flex Programs--Perspectives of the Flex Coordinators  
Vol. 2, No. 6: A Critical Access Hospital Update, September 2002  
Vol. 2, No. 5: Reauthorizing the Medicare Rural Hospital Flexibility Grant Program: Lessons from the Field  
Vol. 2, No. 4: Critical Access Hospitals and Community Development  
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

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RUPRI Center  
for Rural Health Policy Analysis  
University of Nebraska Medical Center  
984350 Nebraska Medical Center  
Omaha, NE 68198-4350

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