

Conclusions from Year 3

Tracking Team Members from All Six Collaborating Centers

The Rural Hospital Flexibility Program (Flex Program) is a popular and influential federal program involving several federal agencies, 47 state governments, 620 hospitals, most state emergency medical services (EMS) systems, most state hospital associations, and a variety of other groups such as quality improvement organizations and urban hospitals that have partnered with participating rural hospitals.

Despite this popularity and visibility, the Flex Program faces some challenges, and the pace of implementation varies significantly across the states. Chronic rural hospital problems have not been resolved, although the increased cash flow resulting from cost-based reimbursement has provided considerable relief in some locations. As one hospital administrator told us this year, “The BBA (Balanced Budget Act) knocked us to the ground. The Flex Program extended a hand, helping us to our knees.” In addition to the usual workforce recruitment and retention struggles, rural hospitals increasingly feel the need for capital improvements to aging facilities. More than half of participating hospitals, known as critical access hospitals (or CAHs), are serving a designated Health Professional Shortage Area (HPSA).

The hospitals that converted during the last three to four years generally had, while still under the Prospective Payment System (PPS), very poor financial indicators in their 1999 Medicare cost reports. Eighty-seven percent of them reported operating losses, with half reporting operating losses of greater than 10 percent (compared to 39% of non-converting hospitals that reported losses during the same period). CAHs appear to have access to non-operating funds that sustained them during that period (such as local tax revenues, grants or contributions). Even after accounting for non-operating revenue, however, 57 percent reported total losses. Seven of ten hospitals that converted were paid less than cost for inpatient services under Medicare prospective payment. The average reimbursement per inpatient Medicare day was \$1,056, compared to average costs of \$1,176, for a ratio of .94. Non-converting hospitals had an average ratio of 1.09. We hope next year to have access to newer cost reports that will allow post-conversion financial analyses.

Conclusions are organized here by the five goals of the program. Following these, we present some conclusions about subsidiary issues. Finally, we recap some of the continuing problems CAHs face.

1. Conversion of Hospitals

All 47 states that planned to participate in the Flex Program now have approved state plans that allow them to do so, although there are still four states without any CAHs. Growth in the number of low-volume hospitals that chose to convert to CAH status has continued at a steady pace

during the last year. Nearly one-third of the now more than 600 CAHs were designated during the most recent twelve months. Heavy clustering of CAHs in the Midwestern corridor demonstrates the popularity of the program in this part of the country. Fifty-three percent of all CAH conversions are located in only ten states.¹ Another 800 rural hospitals are thought to be eligible to convert, but have not done so.

Counties where CAHs are located tend to be more sparsely populated than the rural counties where non-converting low-volume hospitals are located. Counties with CAHs do not appear different from comparison counties with respect to health care supply measures. Low-volume hospitals that chose to convert tended to be smaller than eligible hospitals that did not choose to do so, and they were more likely to provide long-term care in addition to their acute services. More than half of CAHs are publicly owned.

2. Rural Health Plans: “Necessary Provider” Criteria

States are required to submit rural health plans to the Centers for Medicare and Medicaid Services (CMS) as a condition of hospital Medicare cost reimbursement. A primary feature of those plans is the formulation of rules to qualify hospitals for CAH eligibility. The “necessary provider” provision of CAH rules allows state officials to recommend certification of hospitals² that are closer than the 35-mile minimum distance from another hospital, but are nonetheless important to the delivery of health care. The distribution of states heavily reliant on “necessary provider” rules (rather than the 35-mile rule) to certify the majority of hospitals shows clear regional patterns. In a number of states in the Midwest, South, and Northeast, the majority, if not all, CAHs were able to convert as a result of their status as “necessary providers.” This pattern suggests that federal mileage requirements may have been more applicable to Western states and those states with fewer, more geographically isolated hospitals.

The flexibility inherent in the program regulations has been used by states to develop criteria specific to their needs. Most use a core set of criteria involving either shortage area designations and/or standards of demographic, economic, or health-related hardship. These criteria are supplemented in many, but not all, cases by criteria specific to a state’s health care infrastructure. For the most part, states have been inclusive in the development of their “necessary provider” criteria to maximize the number of hospitals eligible for conversion.

Concerns have been raised that the relatively inclusive nature of the criteria established by the states allows for the certification of hospitals that are not truly “necessary providers” based on their proximity to other facilities. Whether these concerns are warranted must be viewed in the context of the health care infrastructure in each state, the infrastructure of the communities in

¹ Nebraska (55), Kansas (45), Iowa (34), Minnesota (32), Texas (28), North Dakota (28), South Dakota (27), Montana (24), Georgia (22), and Wisconsin (20).

² Only the Centers for Medicare and Medicaid Services can certify CAHs, but they rely on states to conduct inspections and make recommendations for licensure by Medicare.

which these hospitals are located, the services they provide, the populations they serve, and the traditional health care utilization patterns of the local residents. These concerns must also be considered in light of the intent of the Flex Program to support the transition of small hospitals from their traditional inpatient orientations to new service roles better suited to the needs of rural communities.

3. Organization Relationships (Networks)

Our observations and analyses suggest that CAHs that form interdependent relationships with other providers of rural health care services are taking a very important step toward stabilizing operations. One-third of all CAHs experiencing significant changes in their scope of services credited the assistance from their support or affiliate hospital for this accomplishment. Networking remains an important and viable strategic tool for CAHs.

Contrary to some expectations, participation in the Flex Program did not result in a general decrease in available services, but rather in an increase that was quite marked for some services. While many scope of services changes are probably attributable to background industry trends, administrators told us the existence of network agreements contributed greatly when there was an increase in services. Five services are the most likely to expand after CAH conversion: specialty clinics, swing beds, outpatient rehabilitation, radiological services, and rural health clinics. Three services are most likely to be reduced or eliminated following conversion: home health, obstetrics and inpatient general surgery. A hospital's decision to participate in the Flex Program may improve its chances of making these and other changes.

4. Quality Improvement

All CAHs are required by CMS to have credentialing and quality improvement agreements with another organization such as a hospital or professional review organization. CAH quality improvement activities have significantly matured over the last year or two, as the Flex Program has moved beyond the initial focus on conversion to the true mission of the program – network development, strengthening EMS, and quality improvement. States with “best practices” for quality improvement are data-driven and based on extensive technical assistance from a variety of sources. Rural and urban hospital quality issues are different, resulting from differences in organizational size and complexity. We found the CAH environment to be an excellent laboratory for examining rural quality issues.

We now need to better understand how organizational learning to improve quality can be supported in the rural CAH environment. CAHs need to be part of the emerging national strategy for public reporting by hospitals. We believe the systematic collection of data from CAHs can lead to quality improvement and challenge existing myths about the quality of care provided in small rural hospitals.

5. Emergency Medical Services

This year's review of states' EMS activities has revealed that there is increasing emphasis on the goal of EMS improvements as the Flex Program matures. States are proposing to spend larger proportions of their overall Flex budgets on EMS activities, and are implementing more specific projects that appear to be well targeted to local needs. Although a wide range of EMS projects is being carried out, activities in most states target the most pressing rural EMS problems, namely problems of inadequate financial resources, difficulties in recruiting and retaining EMS providers, and the need to improve collaboration and cooperation among small, independent EMS providers.

We are seeing evidence of continued collaboration between state rural health officials and state EMS officials. This collaboration is often attributed to the state's Flex Program administrative process and the opportunities presented by the program for these offices to work together. Collaboration appears to be a good predictor of states' progress in defining and accomplishing EMS goals under the Flex Program, with more successful states tending to have stronger links between their state rural health and EMS offices.

As was noted in prior years of the Tracking Project, we cannot overemphasize the importance of having strong EMS leaders with vision and effective management skills, and a team of committed people to assist with project implementation. This factor has been cited as key in virtually every successful EMS project we have visited over the past three years.

6. Other Conclusions

Access to Capital

Two major federal programs represent lenders of last resort for small rural hospitals unable to borrow from private markets. The U.S. Department of Housing and Urban Development (HUD) and the U.S. Department of Agriculture (USDA) have each made capital available to rural hospitals for the past thirty years through special programs. However, only a quarter of the more than 2,000 rural hospitals in operation today have taken advantage of either program.

In our survey of CAH administrators this year, we sought to determine whether they were aware of these programs or had tried to use them to finance capital projects. Three-fifths of the administrators were not familiar with either the HUD 242 Hospital Mortgage Insurance Program or the USDA's Community Facilities Program. In addition, only one-fourth of the hospitals surveyed were aware of the special CAH-related process that had been developed for the HUD 242 Program.

Thirty-seven percent of CAHs surveyed in 2001 had successfully obtained a capital loan to maintain code compliance, renovate, and modernize or replace needed equipment. The average loan amount for initial loans was \$1.7 million, with a median of \$400,000, and the average size

for second loan was \$676,000, with a median of \$100,000. More than half of the initial loans and almost two-thirds of the secondary loans were underwritten by local lenders.

Workforce Issues

Clinical staffing has been a longstanding problem for many rural communities in the U.S. Nursing retention and recruitment just for current levels of service is a “major problem” for 56 percent of hospital administrators, and physician recruitment is a major problem for 42 percent. Only 20 percent felt nursing retention and recruitment was a major strength for ongoing operations, and only 27 percent said the same for physician recruitment.

The average number of physicians reported to be practicing in each town was 4.8, and more than half the hospitals (58%) employ physicians using a payroll mechanism. The average CAH reported 2.4 nurse practitioners practicing in its towns, with a median of two. One in four physicians admitting to CAHs (24%) are graduates of non-U.S. medical schools, and they are present in 44 percent of CAHs.

We speculated that relaxed staffing requirements under the Flex Program could create opportunities for lowered costs, and so we looked for examples of cross-training and staff reduction among CAHs. We found a majority of respondents to the administrators’ survey (53%) are using cross-training, although many reported barriers to this approach, including limited clinical capacity of staff to work in multiple areas. Legal barriers such as state regulations or labor agreements were also mentioned by a few respondents, but were much less common. It would appear that increased clinical capacity is needed--through expanded training efforts--if more CAHs are to optimize the use of cross-training.

Nearly half of the CAHs surveyed were involved in workforce training of one sort or another, primarily with licensed practical nurses (LPNs) and certified nurse aides (CNAs). The most common strategies employed by CAHs to recruit new healthcare workers were health career promotions (39%) and on-site training programs (32%).

Safety Net Activities

CAHs are serving an important safety net role by serving vulnerable populations (e.g., Medicaid, State Child Health Insurance Program (SCHIP), uninsured, and underinsured patients) in rural, isolated areas and/or by their certification as “necessary providers” under criteria developed by the states. They are also providing an important array of safety net services such as free and reduced cost care to low-income patients, well child care and immunizations, outreach and screening services, and assisting patients to enroll in public and private assistance programs for which they may be eligible. In addition, over 50 percent of the CAHs surveyed own or are involved with rural health clinics (RHCs) to serve their communities.

Slightly over 48 percent of CAHs receive no outside funding to support these activities. According to their administrators, the safety net efforts of CAHs are most commonly supplemented by local public health agencies (68%) in their communities and less commonly by

rural health clinics (9.5%), community health centers, (7.6%), free clinics (5%), and a variety of other providers (9.3%).

Balanced Scorecard

The Balanced Scorecard was designed to provide a framework for viewing an organization's strengths, problems and initiatives. Over two-thirds of the strengths cited by CAH administrators fall into the infrastructure and services areas of the Balanced Scorecard. Respondents overwhelmingly feel the quality of their services and staff and the way they are governed (the board and management team) are particularly strong. In addition, a large portion feel the community is quite supportive.

CAH administrators most frequently say they are only undertaking initiatives in a single area of the Balanced Scorecard: infrastructure (e.g., modernizing facilities and equipment). This is puzzling, since relatively few major initiatives are listed in the areas of recruiting and retaining staff—areas that administrators say are more likely to be major problems. It is uncertain whether CAH administrators can achieve their strategic goals without overcoming their major problems related to access to capital and their ability to attract and retain physicians and non-clinical staff.

Medicaid

While Medicaid revenue represents a comparatively small share of CAHs' overall business (10.2% of gross revenues, on average), it is important to rural hospitals, and Medicaid reimbursement policies are a significant factor for some hospitals in the decision to convert to CAH status. Enhanced Medicaid inpatient reimbursement policies for CAHs exist in 17 states (40% of the 42 states studied), and cover 48 percent of all CAHs. In 11 of the 17 states, the special payment policy is cost-based reimbursement through annual cost settlement. Enhanced payment policies usually do not apply to hospitals that participate in Medicaid managed care plan networks.

Many states without special payment policies have been involved in efforts to create an enhanced CAH payment policy. Budget constraints have been the most common obstacle to implementing such changes. Medicaid officials engaged in enhanced payment arrangements for CAHs were, however, nearly unanimous in their opinion that the impact of cost-based payment for CAHs on Medicaid expenditures is likely to be minimal.

Evaluation

To date, only modest progress has been made by the states in evaluating their Flex Programs. Some states have had thoughtful and thorough evaluation processes in place since the beginning of the Flex Program. These states have used a variety of methodologies including mail surveys, site visits, and focus groups. However, many states have done very little on this front. These states cite several reasons for not making progress: insufficient experience with the program to be able to track changes, lack of knowledge about how to conduct evaluations or what the

FORHP expects in terms of evaluations, and competing needs for resources. The states that have made little progress expressed interest in knowing what the expectations are from the FORHP.

7. Continuing Issues

As has been described in several of the chapters in this and previous years' reports, America's small rural hospitals have largely benefited from the Flex Program, whether they converted to CAH status or not. Many of the troublesome issues identified in last year's Tracking Team report have been addressed, or hospitals have adjusted in response to the challenges.

Small hospitals face some chronic problems and some problems that are new as a result of unintended regulatory or market consequences. Some problems are unique to CAHs, others are generic to rural status, while still other problems are a fallout of how U.S. hospitals are reimbursed generally. The Flex Program was not designed to solve all rural health problems, nor should it be expected to. Nonetheless, some of the problems related to the Medicare reimbursement component of the program should be mentioned. These include:

All-Inclusive Payment Option: Section 202 of the Year 2000 Benefits Improvement and Protection Act (BIPA) allowed CAHs to elect to be paid an all-inclusive rate that incorporates the cost-based facility payment *and* a professional fee based on 115 percent of the Medicare physician fee schedule on a single claim. This provision was mandated to become effective for cost reporting periods beginning on or after July 1, 2001. However, CMS announced that its computer system could not handle this payment provision until October 2001, and, in fact, the physician fee schedule would not be loaded in the fiscal intermediary claims payment computer data systems until at least January 1, 2002. This program has still not come on line. Hospitals and their advocacy organizations have strongly urged the reimbursements, when they finally are made, be paid at the more advantageous level retroactive to July 2001. There have been no assurances that CMS can or will do this. Once the system is in place, hospitals will need to do retroactive billing, but probably cannot recoup beneficiary co-pays. The hospitals involved in this problem are generally those with the smallest and least sophisticated billing capacities.

Periodic Interim Payments: Hospitals can even out their cash flow from Medicare by being on a "periodic interim payment" (or PIP) plan with their Medicare fiscal intermediaries. PIP, authorized under the Social Security Act,³ provides cost-reimbursed providers with estimated payments during the cost reporting year pending submission and subsequent settlement of a Medicare cost report. CAHs were informed, however, that they are not eligible for PIP because they are no longer "hospitals" in the strict legal definition of the Tax Equity and Fiscal Responsibility Act (TEFRA). As such, CAHs are to receive their interim payments for cost-based reimbursement on the basis of submitted bills rather than on the more even flow of a PIP system.

³ Social Security Act Sec. 1815. [42 CFR 413.64]; See section 1815(e)(1).

Cost Report Settlement Delays: Rural hospitals have always struggled to get timely settlements on Medicare cost reports, but there are new consequences for these delays. Hospitals considering conversion need cost-report data to responsibly evaluate the effects of that decision, but cannot get the necessary data from fiscal intermediaries to file their 2000 or 2001 cost reports. This has its own cash flow consequences, but also leaves them unable to make a decision about conversion.

Distinct Part Units: A significant barrier to conversion—especially in the southern states, but not exclusively—is the requirement that special inpatient care service unit beds be counted as part of the facility’s total bed count. Those units, usually geriatric, psychiatric, or rehabilitation programs, often disqualify otherwise eligible small rural hospitals from CAH program participation because their bed counts and—more importantly—lengths of stay are too high. Some hospitals are exploring ways to separate those units legally or organizationally from their other operations, but this reduces efficiency and increases costs. BIPA legislation mandated a study of this issue by the federal General Accounting Office, due in December of 2001, with a recommended course of action. This report has yet to be published.

Ambulance Rules: Cost-based reimbursement for ambulance systems owned and operated by CAHs is available only if they are 35 miles from another ambulance system. This rule may need to be refined to account for special circumstances such as travel conditions and types of services being provided by competing ambulance providers. Hospital-owned ambulance systems that cannot meet the mileage requirement may be at risk of financial failure. This provision may also be a deterrent to CAH acquisition of local ambulance services, since any new entrant could jeopardize cost-based reimbursement. Exceptions to the mileage requirement, however, would need to be tightly crafted to create the intended policy effects.

Seasonal Fluctuations: Some hospitals that would like to participate in the Flex Program cannot do so because they experience significant seasonal fluctuations in occupancy that would occasionally exceed 15 acute care beds. The Medicare Modernization and Prescription Drug Act of 2002, passed by the House in June 2002, would allow an increase of five beds for such hospitals, under rules to be developed by the Secretary of Health and Human Services.

Varying Interpretations of Federal Conditions of Participation: States are responsible for the certification surveys that allow CAHs to be certified. We have found that states can have significantly different interpretations of the same federal regulations. For example, there is a requirement that CAHs engage in “networking with another hospital, PRO [Peer Review Organization] or entity as defined by the state for agreements regarding credentialing and peer review,” that is varying interpreted.

Beneficiary Outpatient Co-Insurance: CMS has announced plans to change the CAH payment system by limiting beneficiary outpatient co-insurance. This new policy was a correction by CMS after it had been handled incorrectly over the course of the program. The average financial impact has been estimated by the American Hospital Association to be \$100,000 to \$150,000 per CAH. CMS’ new approach is not felt to be inconsistent with legislation, but there are still political pressures to get the agency to change its mind.

