

# Executive Summary

## Tracking Team Members from All Six Collaborating Centers

In 1997, the U.S. Congress created the Rural Hospital Flexibility Program (Flex Program) as part of the Balanced Budget Act (BBA). This highly visible and popular rural health program, authorized in the late summer of 1997, provides for cost-based reimbursement under Medicare to eligible small, relatively remote hospitals. A companion grant program supports state emergency medical services systems (EMS) and hospital participation in the program. The reimbursement component is the responsibility of the Center for Medicare and Medicaid Services (CMS), while the grant program is the responsibility of the Federal Office of Rural Health Policy (FORHP). Funding to support the monitoring efforts of the Flex Program Tracking Team is provided under the grant program appropriation. The Tracking Team is a consortium of six rural health research centers.<sup>1</sup> The purpose of this report is to describe Flex Program achievements, as well as to highlight problems and issues that need further work.

In the years leading up to the authorization of the BBA, there was growing concern about the plight of our country's small rural hospitals. In particular, the reimbursement level afforded under the Prospective Payment System (PPS) hit many rural hospitals hard, especially after PPS was created for outpatient services. As a result, the Flex Program was designed to relieve some of the pressure experienced by these hospitals.

There are five main national goals for implementation of the grant component of the Flex Program in the states and participating hospitals. These include:

1. Preparing a state rural health plan.
2. Converting eligible and willing hospitals to critical access hospital (CAH) status.
3. Improving quality of care.
4. Promoting networking among hospitals.
5. Improving emergency medical services.

This report relies on the following data-gathering initiatives performed during the last year:

- A survey of 388 administrators at CAHs certified as of May 1, 2001 (conducted by University of Minnesota-UM), with the collaboration of the Tracking Team.

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<sup>1</sup> Project HOPE Walsh Center for Rural Health Analysis, the Rural Policy Research Institute's Center for Rural Health Policy Analysis at the University of Nebraska, the University of Minnesota Rural Health Research Center, the University of North Carolina Rural Health Research and Policy Analysis Center, the University of Southern Maine Rural Health Research Center, and the WWAMI Rural Health Research Center at the University of Washington.

- Continuous monitoring of activities in the states through e-mail and telephone contacts (University of North Carolina-UNC).
- 1999 Medicare cost reports (UNC).
- Data collected through site visits to 12 hospitals or EMS systems.
- A telephone survey of all the state grantees about their evaluation efforts (University of Washington-UW).
- A telephone survey of state Medicaid offices about CAH reimbursement (UNC and University of Southern Maine-USM).
- Compilation of information included in state applications for funding (UW, UM, and Project HOPE Walsh Center for Rural Health Analysis-HOPE).
- Other small data-gathering activities such as e-mail communications and phone calls.

We worked with the Flex Program's Technical Assistance and Service Center (TASC) to understand the issues facing the states and the hospitals as they implement the Flex Program and to provide early feedback based on our tracking work. We produced *Findings from the Field* and a Year 2 monograph, and made many presentations at a variety of forums across the country, including a session in May on Capitol Hill to a group of policy makers and staff.

Over 620 hospitals have converted to CAH status to date, and approximately 800 more could convert during the next few years. Many eligible hospitals will elect not to convert, after considering the benefits and costs. Nearly one-third of CAHs were designated during the most recent twelve months while more than half of all CAHs (53%) are located in only ten states, most in the Midwest.

Despite the limited resources available through the Flex Program, significant changes in the rural health landscape have been identified that are most likely attributable to this initiative. Offices of rural health across the country have been provided with access to new resources and are investing them in the rural infrastructure of their states, forging relationships with other important partners, such as state hospital associations, and strengthening relationships with the hospitals in their states. Program participants' reports of service expansions and improvements in the quality of care available to rural residents were common.

In addition to these initiatives, states and hospitals are using Flex Program grants for EMS improvements to provide training, conduct needs assessments, engage in planning, move systems toward regional collaboration, and improve finances.

The Tracking Team's Year 3 report, covering the 2001 federal fiscal year, has several key findings that have been categorized as follows:

- “Necessary provider” criteria for designating CAHs.
- Profiles of CAHs.
- Organizational networks in which CAHs are engaged.
- Quality of care in CAHs.
- Access to capital for CAHs.
- CAH staffing patterns.
- Workforce issues, with a focus on international medical graduates.
- Safety net activities of CAHs.
- A “balanced scorecard” analysis of CAH strategic activities.
- Emergency medical service systems.
- Medicaid reimbursement policies for CAHs.
- State-based Flex Program evaluations.

The findings related to each of these are described below.

## **CAH Designation: Use of “Necessary Provider” Criteria**

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Flex Program regulations require a hospital to be located more than a 35-mile drive (or, in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from another hospital to be eligible for CAH certification. The regulations also provide an exception to these mileage requirements through the creation of a “necessary provider” provision. Certification of a hospital as a “necessary provider” exempts the facility only from the federal mileage requirements—the hospital must still meet all other regulatory requirements of the Flex Program to be certified as a CAH.

Flex Program regulations provide states with the flexibility to define their own criteria by which they will certify “necessary providers.” This provision recognizes that mileage alone is an inadequate measure of access needs. It further recognizes that states are in the best position to develop standards that correspond to their own assessments of the access needs and vulnerability of the health care infrastructure in their states. The “necessary provider” criteria established by each state were reviewed and approved by the regional CMS office as part of each state’s Flex Program application.

The ability to certify “necessary providers” has substantially increased the number of hospitals eligible for participation in the Flex Program. As of June 30, 2002, 65 percent (368) of all CAHs (567) had been certified as “necessary providers” under the terms of their state plans.<sup>2</sup> Without this provision for making an exception to the federal mileage requirements, only 199 hospitals would have been able to convert to CAH status.

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<sup>2</sup> We were unable to obtain data from Louisiana, North Dakota, and South Dakota on the number of hospitals that qualified for CAH conversion as a result of being certified as “necessary providers.”

The most common criteria used by states to certify “necessary providers” require that the hospital be located in an area that:

- Is either a Health Professional Shortage Area (HPSA) or a Medically Underserved Area (MUA) and/or
- Meets some standard of demographic or economic hardship. These typically include location in an area with a higher percentage of elderly, low-income individuals or families, and/or unemployed persons than the rest of the state. All but three states (Alaska, New Mexico, and Utah) use some or all of these criteria.

A number of states have used the flexibility provided under the Flex Program regulations to develop specific criteria to address their own unique geographic, community, and health care infrastructure characteristics. Although our review of each state’s “necessary provider” criteria suggests that states have tended to be more rather than less inclusive in developing their criteria, we are unable to assess the long-term consequences of these decisions on the rural health care infrastructure without further study and analysis.

## Critical Access Hospital Conversion

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The North Carolina Rural Health Research and Policy Analysis Center at the University of North Carolina (UNC) has been tracking the implementation of the Flex Program for three years using a systematic process to examine and detail program activities. Chapter 2 provides a comprehensive overview of the data collected through the tracking activities.

As of March 31, 2002, CMS had certified 596 providers as CAHs. Six of these have closed. The remaining 590 CAHs are located in 43 of the 47 states participating in the Flex Program.<sup>3,4</sup> State Flex Program coordinators estimate that more than 800 other hospitals are eligible for CAH status. However, states define eligibility differently, and this may be a generous estimate. Nearly one-third of 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: Nebraska (55), Kansas (45), Iowa (34), Minnesota (32), Texas (28), North Dakota (28), South Dakota (27), Montana (24), Georgia (22), and Wisconsin (20).

Ninety percent of CAHs are located in rural counties, and 10 percent are located in rural portions of Metropolitan Statistical Area (MSA) counties. Population density in the rural CAH counties

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<sup>3</sup> For the most current information on CAHs, please refer to the Tracking Team’s Web site: <http://www.rupri.org/srhf-eval>.

<sup>4</sup> New Jersey, Rhode Island, and Delaware do not participate in the Flex Program. New Jersey and Rhode Island are ineligible for the program because of their metropolitan composition and Delaware has chosen not to participate since its only eligible facility has shown no interest in CAH conversion.

averages only 23 persons per square mile, and one-fourth of these counties are classified as “frontier counties.” Compared to other low-volume hospitals, CAHs tend to be located in “older” counties, where a greater proportion of the population is aged 65 or older.

The hospitals that converted during the last three to four years had, in general, 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, and the average costs were \$1,176, for a reimbursement-to-cost ratio of .94. Non-converting hospitals had an average ratio of 1.09.

## **Organizational Networks and Scope of Services**

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Rural health networks form for a variety of reasons. They can form naturally when there is a clear and compelling need, the interests of potential members are obvious, options for addressing those needs are clear, and strong leadership is present. They can also be dramatically influenced by the presence of external incentives such as grant programs and reimbursement or regulatory advantage. Although participation in a rural health network is not an explicit program requirement for conversion to a CAH, states are encouraging their CAHs to establish linkages with other providers of health care services. Evidence is growing at both the policy and provider levels that network relationships can be helpful in meeting the needs of rural communities. Historically, rural health network development has been heavily dominated by horizontal relationships between similar types of providers (e.g., all hospitals, all nursing homes, or all community health centers). Over the last several years, there has been a growing trend toward a diversification of network memberships to include a wider array of provider types.

In our survey, CAHs reported they receiving a range of benefits from their association with formal network arrangements. Over half of all CAHs identified at least one of the following three areas of benefit: development of existing services, obtaining technical assistance, and improving quality assurance or improvement.

CAHs use both formal and informal network arrangements. Although there was only a very small increase in the number of CAHs that joined health care systems following conversion, one out of six initiated participation with a formal rural health network. Network arrangements were considered formal when they involved the use of resources from more than one existing organization and specified objectives and the methods by which various collaborative functions are achieved. CAHs that participate in formal network arrangements are more likely to participate in service development activities such as specialty clinics, quality assurance and quality improvement than are freestanding CAHs or those only in systems. CAHs that are

members of a health care system are more likely to participate in infrastructure support activities such as financial and clinical information systems than freestanding or formally networked CAHs. CAHs that were members of a formal rural health network and were a member of a health care system shared the characteristics of CAHs involved in either type of arrangement. Freestanding CAHs were the least likely to engage in any service agreement other than those explicitly required by the Flex Program.

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 a large contributor to an increase in services was the existence of network agreements. 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 in a more proactive way.

## **CAH Quality Assurance (QA) and Quality Improvement (QI) Strategies**

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We anticipated that states and CAHs initially would target other components of the Flex Program (e.g., CAH designation, network development, EMS systems) before using their resources to address quality of care issues. Our analysis assesses whether the level of activity related to quality of care issues has increased as the CAHs have matured. We also document the best practices of two states and CAHs that have developed innovative QA/QI programs.

Major findings from our survey of CAH administrators include:

1. The vast majority of CAHs are involved in a broad range of QA/QI activities. These activities have been strengthened over time as the Flex Program and CAHs have matured.
2. The most significant post-CAH activities that contribute to improving quality of care in CAHs are the redefinition of QA/QI processes and improved staffing.
3. Substantial support from affiliated hospitals, quality improvement organizations (QIOs), and state hospital associations enabled CAHs to participate in relevant QA/QI activities.
4. The most salient barriers to addressing QA/QI needs in CAHs relate to the scale of the facility and the limited availability of financial resources to make necessary changes in QA/QI activities.

We reviewed the state Flex Program grant proposals and held discussions with state office of rural health staff to identify states and CAHs that have developed innovative QA/QI programs.

In Minnesota, QI activities were enhanced through comprehensive technical assistance provided by the office of rural health and strong links with the QIO, Stratis Health. The initiatives enabled CAHs to overcome the initial barriers of limited staff QI expertise and limited time and financial resources. The collaboration also expanded the visibility of rural health on the QIO's radar screen and stimulated QI initiatives with other rural hospitals and other rural providers (e.g. nursing homes, home health, ambulance squads) in the state.

In Nebraska, participation in the Flex Program has regenerated an interest in and awareness of quality-related activities in small rural hospitals. In conjunction with other key stakeholders (such as the hospital association and QIO), the office of rural health has fostered a non-threatening playing field for QA/QI discussions where providers listen to other stakeholders and jointly attempt to develop new initiatives. The states used network development and clinical information systems to stimulate the transformation of the QI organizational culture in CAHs. The challenge ahead is to enact these activities in a manner relevant to the scale of the CAH environment.

The next step is 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 objective assessment of the quality of care provided in small rural hospitals.

## **Access to Capital for Critical Access Hospitals**

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Health care is a capital-intensive enterprise--consumers and practitioners insist on the latest technologies and amenities--while the ability of small rural hospitals to obtain capital to improve and modernize operations is limited.<sup>5</sup> Bond sales, the most popular source of debt financing, have become more difficult to obtain over the last several years for all but those hospitals with the highest credit rating.

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, recent analyses of the program portfolios of these two initiatives (Gregg et al., 2001) have revealed that only a quarter of the more than 2,000 rural hospitals in operation today have taken advantage of either program.

Recently HUD, through its 242 Program, has developed a specific mortgage insurance process that recognizes the special circumstances of CAHs. While the same bottom-line performance

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<sup>5</sup> National Advisory Committee on Rural Health, Fiscal Year 2000 Recommendation. Available on the World Wide Web at [www.nal.usda.gov/policy/nac.htm](http://www.nal.usda.gov/policy/nac.htm).

measures are required to calculate mortgage insurance eligibility, the 242 Program uses the more advantageous assumptions of the CAH cost-based reimbursement methodology rather than the prospective payment methodology used for other hospitals. Through its Community Facilities Program, the USDA also makes capital financing available to CAHs.

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 a 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.

## **Critical Access Hospital Staffing Patterns**

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Rural hospitals face a bitter irony with regard to staffing. When volumes are low, cost-conscious administrators would like to furlough excess staff to avoid unneeded labor costs; on the other hand, they face workforce shortage problems, especially among nurses and technicians, who are the very staff that would be furloughed on low-census days. A policy of furloughing staff does not lead to success with recruitment or retention, especially if there are alternative employers in another town within commuting distance.

Despite this conundrum, 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. Of 388 CAHs responding to our survey, 217 (or 56 %) identified difficulties recruiting and retaining nursing staff. Site visits also found that administrators had a particular problem recruiting radiation technologists.

We calculated an efficiency ratio of "outpatient-adjusted FTE per occupied bed." Due to extremely low census in some hospitals, values for this ratio varied widely (one-fourth of hospitals had a ratio of less than 13—most efficient—and one-fourth had more than 78—least efficient).

If a hospital had a greater number of labor-intensive services, it could theoretically afford more opportunities for cross-training. We examined the relationship between an index of the number of these services and our measure of efficiency. We found, however, no inherent efficiency in having a greater array of such services. Nevertheless, those hospitals that do have a more varied array of services were found to be more apt to offer their own training programs ( $p < .005$ ).

Despite the fact that a majority of respondents (53%) are using cross-training, many reported barriers to instituting this approach. The most common barrier was the limited clinical capacity of staff to work in multiple areas (39%). 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, achieved 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%). State policy, statewide area health education centers (AHECs), and health professions educators may be of help in addressing the continuing education needed to facilitate more cross-training, but hospitals and their communities must also take the initiative in recruiting students into health careers if they wish to have a high-quality, stable workforce in the future.

## **Workforce Patterns and the Use of International Medical Graduates in CAHs**

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Clinical staffing has been a longstanding problem for many rural communities in the U.S. Nurse retention and recruitment to maintain current levels of service is a “major problem” for 56 percent of hospital administrators. Recruitment and retention of physicians is a “major problem” for 42 percent of hospitals. For those who might wish to expand into new services, 47 percent reported recruitment of physicians to fill those needs would be a major problem. Only 27 percent indicated that physician retention and recruitment was a major strength for ongoing operations.

The average number of physicians reported to be practicing in each town was 4.8, while the median number was four. One in four towns had one or more physician who did not admit to the hospital. Another one-third of towns have at least one physician who works part time (13% overall have more than one part-time physician). The range of physicians per CAH town was 0 through 35. More than half the hospitals (58%) employ physicians using a payroll mechanism. Of those that do, 34 percent employ just one physician and another 32 percent have two physicians.

The average CAH reported 2.4 nurse practitioners practicing in their towns, with a median of two. We do not know how many of them are part time.

Half the hospitals responded that they used their own physician employees to cover the emergency room (ER) at least part of the time, and half contract with local physicians to cover their ERs at least part of the time. About 43 percent use non-physician clinicians to cover ERs at least some of the time.

One in four physicians admitting to U.S. CAHs (24%) are graduates of non-U.S. medical schools. They are present in 44 percent of CAHs responding to our survey. Hospitals east of the Mississippi River are more heavily reliant on international medical graduates (IMGs) than hospitals in the west. The majority of IMGs are internists (59%), and the majority (61%) come from the three countries that supply most of the U.S.'s IMGs: India, Philippines, and Pakistan. CAH administrators rate the clinical skills of their IMGs highly (50% said excellent on a 5-point scale), and their interpersonal skills only slightly lower (41% said excellent). The role of IMGs seems to be increasing, as almost half of CAH administrators responded that their communities received their first IMGs in or later than 1994.

Physicians who completed their medical school education in a country other than the U.S. play a significant role in staffing CAHs. Communities under stress (i.e., those in persistent poverty counties, those with recruitment problems, those with fewer physicians) are more likely to have IMGs than other communities, after controlling for geographic region and size of medical staff.

## **Safety Net Activities of Critical Access Hospitals**

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As they are often the sole hospital in their communities, CAHs are the major source of care for many rural Medicaid recipients, uninsured individuals, and other vulnerable populations, thereby qualifying them as “safety net” providers. 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%).

Most administrators (85%) reported that their hospital strategic plan commits the hospital to developing and/or delivering services to populations without an ability to pay. One in five CAHs offers a free clinic, and more than half (55%) offer such typical public health services as immunizations or well child care. Thirty-seven percent provide free or reduced cost medications. About 39 percent reported that the level of free and reduced cost care had increased after conversion to CAH status. Hospitals in the southeastern states reported more free and reduced care write-offs than those in other regions.

Slightly more than half of CAHs own federally-designated Rural Health Clinics (RHCs). Ten percent added RHCs after conversion while another 6.5 percent expanded their RHC services post-conversion. RHC ownership could be a mechanism to allow CAHs to strengthen the local safety net infrastructure.

Medicare and Medicaid account for slightly more than 64 percent of total charges of the average CAH. Uncompensated care (charity care and bad debt) accounts for another 6.3 percent. Given the often-tenuous financial positions and payer mixes of these facilities, however, CAHs are rarely able to shift the costs associated with uncompensated care to other payers. Almost half of CAHs (48%) receive no supplemental funding for their safety net activities.

## **The Major Strengths, Problems, and Initiatives of CAHs — A Balanced Scorecard Perspective**

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The Balanced Scorecard is designed to look beyond financial success to other areas ultimately affecting hospital viability: services, staffing infrastructure and community. Over two-thirds of the strengths identified by CAH administrators fall into the infrastructure and services area portions 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. Other areas of perceived strength include network affiliations/support, outpatient services, physician/hospital relations and the community.

The major problem areas are staffing and finances. Respondents report major staffing problems in recruiting and retaining physicians and non-physician clinical staff, and financial problems in regard to both Medicaid and other non-Medicare revenue sources. Additional major problems include modernizing facilities and access to capital.

The overwhelming majority of initiatives listed were in the infrastructure area. In fact, over 40 percent of the respondents listed at least one initiative relating to modernization of facilities and equipment. Interestingly, relatively few major initiatives are listed in the areas of recruiting and retaining physicians and non-clinical staff—areas that administrators say are more likely to be problems.

An exploration of strategic positioning indicates that a relatively large number of CAH administrators are being aggressive. They see their strengths in their governance and quality, and feel that in order to be competitive, they must augment these strengths by developing their infrastructure through modernizing plant and equipment. It is uncertain whether they can achieve these goals without overcoming problems in access to capital and attracting and retaining physicians and non-clinical staff.

## **Emergency Medical Service Systems**

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As the Flex Program matures, there is an increasing emphasis on improving EMS systems. In Year 3, states proposed to spend roughly \$4.3 million on EMS activities, or approximately 17 percent of their total request of \$24.8 million. Proposed EMS spending increased nearly two and a half fold in the first three years of the program. The Flex Program continues to foster increased collaboration between EMS entities and other interests at both the state and local levels.

The majority of states are using a “mini-grant” approach to allow hospitals, EMS providers, trauma system organizations, county governments, and other applicants to submit proposals for EMS improvements. In general, these grants are small and might best be viewed as “seed money.” State EMS activities typically include training programs, EMS needs assessments, data collection systems improvements, computerized billing systems, and equipment purchases. As

in Year 2, it appears that training programs were the most popular activity. These programs include initial and continuing education for front-line providers, instruction in medical direction and dispatch, trauma training for hospital emergency department personnel, paramedic-to-RN “bridge programs,” and courses to assist leaders of EMS squads with billing and trauma data collection systems.

For this year of the report, we sought to highlight selected state initiatives designed to address at least one of three areas that have long been challenges for rural EMS systems: 1) EMS system financing, 2) recruitment and retention of EMS personnel, and 3) the need for improved networking and coordination between EMS providers.

Regarding EMS system financing, at least one-third of grant recipients proposed to spend some of their grant money to enhance revenue collection among EMS providers. Grant recipients proposed a wide array of activities, ranging from hosting idea-sharing meetings to providing seed money to facilitate the consolidation of billing functions across several squads. A case study in North Carolina illustrates that improving billing systems may help to alleviate some financing problems, but it is unlikely to be a panacea. Despite a major investment, this EMS agency, which received Flex money in Year 1, has found it difficult to increase its collection rate by using internal billing staff. Serving a small community, it has been hard to be as aggressive as necessary with collections when the billing staff personally know the patients involved. For this organization, using a third-party billing agency may be more economical in the long run. Changes in federal regulations have also altered the relative costs and benefits of doing internal billing, shifting the advantage toward outside firms with more expertise in these areas.

The majority of rural EMS systems continue to depend on volunteer staff, and most are experiencing increasing difficulty recruiting and retaining these volunteers. If volunteer staffing is to continue to be the model used by most rural EMS providers, creative approaches to recruitment and retention are becoming critical. Attracting younger volunteers and staff who are available for daytime shifts are top priorities. Minnesota has supported several projects specifically designed to improve EMS recruitment and retention. One of these grants went to a county public health department, which was working with local EMS providers and a large area hospital, to implement a number of recruitment and retention strategies. These strategies included enhanced training sessions that were open to all area EMS providers (encouraging networking between individual squads), subsidies to enable volunteer personnel to attend professional conferences, public recognition of the services provided by volunteers, and a countywide recruitment campaign consisting of ads in local newspapers and mentoring from existing volunteers. Their most recent classes for new emergency medical technicians (EMTs) and first responders were filled for the first time in memory, and will produce enough graduates to round out the rosters in two ambulance companies that had been in dire need of staff. These grant recipients were also exploring the feasibility of implementing shared staffing between individual ambulance companies, and of using an incentive fund to compensate employers who permit their employees to leave work for emergency runs.

A second grant recipient in Minnesota—a hospital-based ambulance service—planned to tap into a ready pool of students taking EMT courses at local community colleges. Flex funds were used

to create nice crew quarters, complete with internet access, that would be available to these students in exchange for weekend coverage. This hospital was also instituting a program to cross-train paramedics for jobs within the hospital system, such as in the emergency department. Unlike other states, licensing regulations in Minnesota do not restrict the scope of practice for EMS personnel. Because cross-trained staff are paid, this approach can be a huge aid to recruitment and retention. Cross-trained staff also have more opportunities to practice their skills, which can help improve the quality of pre-hospital care and make the transition between the pre-hospital and hospital care more seamless.

Integrating EMS into rural health networks may be an effective way to stabilize pre-hospital emergency care. While closer affiliation between EMS providers, the CAH and its support hospital has been encouraged under the Flex Program, horizontal networks comprised only of EMS providers are rare. Kansas has a long history of working with rural health networks and has established at least one mini-grant to support the formation of a network of rural EMS providers. Under this grant, five independent squads formed a network with the goals of sharing specific resources and improving the level and quality of pre-hospital response, while maintaining their autonomy. Although this network is still in its infancy, sharing of some services has begun. These services include training, recruitment and retention activities, data collection, purchasing, and monitoring changes in government regulatory policies. Volunteerism has served both as an impetus for collaboration, as well as a roadblock. Because the responsibilities for a well-functioning network are particularly great for the network director, a highly committed individual – or perhaps the creation of a paid network director position – is an essential component. The Kansas case study shows that cooperation can occur across multiple governmental jurisdictions if there is an understanding of mutual gains. Overall, the importance of a strong leader with vision and effective management skills and a team of committed people to assist with project implementation has been key in virtually every successful EMS project we have visited over the past three years.

As the Flex Program moves into its fourth year, states need to begin documenting their EMS activities more comprehensively and conducting more extensive assessments of whether these activities have the intended consequences. While many innovative approaches are being tried, their impact is seldom known or reported.

## **Medicaid Payments for Critical Access Hospitals**

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CAHs are exempt from the Medicare's Prospective Payment System (PPS) and instead are entitled to receive cost-based reimbursement for all inpatient Medicare claims. However, CAHs have no such guarantee of cost recovery for services provided to Medicaid recipients. Although Medicaid revenue represents a comparatively small share of most CAHs' overall business (10.2% of gross revenues<sup>6</sup>), Medicaid revenues are important to rural hospitals and Medicaid

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<sup>6</sup> Data obtained from the Year 3 Survey of CAH Administrators conducted by the Tracking Team.

reimbursement policies are said to be a significant factor for hospitals in the decision to convert to CAH status.

In 23 of the 42 states interviewed, CAHs are entitled to an enhanced methodology of reimbursement for inpatient services. In 17 of those states, Medicaid created a special inpatient payment policy specifically for CAHs; 11 provide cost-based reimbursement through annual cost settlement. In six of the 42 states studied, CAHs qualify for a differential inpatient payment methodology that applies to all small and/or rural hospitals.

Medicaid outpatient payments are also an issue of great concern to CAHs because outpatient revenues can represent a significant portion of business for a small rural hospital. In 13 of the 42 states studied, Medicaid agencies have created a special payment policy for CAHs. Approximately 45 percent of all CAHs are located in these 13 states. The most common alternative for outpatient care is cost-based reimbursement through annual settlement; nine states use this methodology for outpatient reimbursement to CAHs. The other four states provide an enhancement to CAH outpatient rates, but do not guarantee 100 percent cost settlement.

Enhanced payment policies usually do not apply to hospitals that participate in Medicaid managed care plan networks. In states with risk-based Medicaid health plans, state Medicaid agencies explained that they do not interfere in the rate-setting process between the health plans and the hospitals. Only two of 22 states with risk-based Medicaid managed care--Oregon and Washington--have systems to ensure that CAHs in HMO networks receive payments on par with other CAHs.

Medicaid officials were nearly unanimous in their opinion that the impact of cost-based payment for CAHs on total state Medicaid expenditures is minimal. This assessment was usually premised on the fact that Medicaid volume and expenditures in CAHs account for a very small portion of statewide Medicaid volume and expenditures.

Some states without special payment policies have attempted to create a differential CAH payment policy. However, budget constraints have thwarted these efforts and remain an obstacle to implementing such changes.

Most states do not have special disproportionate share payment provisions for CAHs and/or other small rural acute care hospitals. In most states, large public hospitals located in urban areas tend to be the major sources of care for Medicaid recipients and the uninsured and thus receive the largest share of Medicaid Disproportionate Share (DSH) payments. In general, CAHs receive comparatively little Medicaid DSH funding under the formulas states use to distribute DSH funds.

While the reported impact of enhanced CAH reimbursement on state Medicaid budgets has been minimal, budgetary pressures created by rising Medicaid expenditures have hampered the efforts of some, but not all, states to implement enhanced CAH reimbursement. Cost-based reimbursement is the most common, but not the only, form of enhanced CAH reimbursement developed by state Medicaid programs. States interested in supporting CAHs through enhanced

reimbursement should evaluate the administrative and political choices inherent in cost-based reimbursement against alternative methodologies. They should also investigate and learn from the experiences of those states that have been successful in implementing enhanced CAH reimbursement methodologies.

## State-Based Flex Program Evaluations

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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. The reasons for this include: too little experience with the program to be able to track changes, lack of knowledge about how to perform evaluations or of what the FORHP expects in terms of these evaluations, and competing needs for resources for other aspects of the program that could have been devoted to evaluation.

Only ten states have progressed to the point where they were able to share a written report with us. Another two states have completed evaluations but have not yet produced written reports. Fourteen states have evaluation activities in progress and therefore have some information to share on the progress of the Flex Program in their states. Sixteen states have plans for an evaluation. Four states do not have any plans to conduct an evaluation. Such scant progress on state-based evaluations is a problem for a program that depends on continued legislative support.

The states that have made little progress expressed interest in knowing what the expectations are from the FORHP. We recommend that the FORHP require the states to submit written results of in-state evaluations by the end of calendar year 2002. Evaluations have always been a requirement of the program, and there has now been sufficient time under the Flex Program for each of the state grantees to report their progress with implementation. Besides offering the opportunity for summative findings, evaluations provide formative information that will help the states improve their Flex Programs. This chapter, in addition to the TASC Web site (<http://www.ruralresource.org/eval.shtml>), offers ideas and resources to guide the states in completing their contractual obligation to prepare and complete program evaluations.

In states where evaluations have been performed, the most common approach is the “do-it-yourself” model with the staff from the Flex grantee (most typically the state office of rural health) conducting the evaluation. Several states have used academicians to lead the evaluation while others have employed private consultants, hospital associations, other state agencies, and the state peer review organization (PRO). Some states used a Request for Proposal (RFP) approach to find consultants to do the evaluations while others contracted directly with other external organizations.

Consultants have most typically used surveys of CAH-eligible hospitals to assess the impacts of the Flex Program on hospitals and to ascertain the levels of satisfaction with the services and

activities of the Flex grantees. Other techniques include site visits, telephone interviews, analysis of secondary data, and, in a few cases, focus groups. In addition, many states sponsor meetings of their CAHs and take this opportunity to get feedback on the strengths and weaknesses of the program.

Evaluations should assess the progress states have made in implementing their Flex Program goals and objectives. To start, the goals, activities and accomplishments should be summarized. An evaluation should also assess the effects on CAHs and their communities in the areas of financial impact, quality assurance systems, emergency medical systems, and network development. Site visits and/or telephone interviews work well in this part of the evaluation. Finally, the best evaluations include suggestions from the evaluator for program improvements.

## Continuing Issues

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As is 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,<sup>7</sup> 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.

***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.

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<sup>7</sup> Social Security Act Sec. 1815. [42 CFR 413.64]; See section 1815(e)(1).

***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 varyingly 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.

## Reference

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