

# Introduction

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 important program to America's rural health systems has now completed its fifth year.<sup>1</sup> The purpose of this report is to describe its achievements, as well as to highlight problems and issues remaining to be addressed.

Communities in rural America have long struggled to keep open their hospital doors in the face of accelerating capital and technical requirements, a dwindling population base, lagging economic growth, disproportionate rates of uninsurance and poor insurance, competition for markets from encroaching urban areas, health professional shortages, and changing reimbursement policies. In particular, the reimbursement level afforded under the Prospective Payment System (PPS)--especially for outpatient services--hit many small rural hospitals hard. The Flex Program was designed to relieve some pressure on these hospitals, and in the years leading up to passage of the BBA, there was growing concern about these facilities as reports of their closures and a resulting decline in access to care were prevalent.

The Flex Program, which includes a state grant component and a hospital reimbursement initiative, was designed with five primary goals. These include:

1. Preparing a state rural health plan;
2. Converting eligible and willing hospitals;
3. Improving quality of care;
4. Promoting networking among hospitals; and
5. Improving emergency medical services (EMS).

This report is prepared by the Flex Program's Tracking Team, a consortium of five public universities and a private non-profit rural health research center.<sup>2</sup>

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<sup>1</sup> Although the Flex Program (along with cost-based reimbursement under Medicare) was authorized in the late summer of 1997 and the first official critical access hospitals (CAHs) were designated the following year, appropriations for a grant program to support state and hospital participation in the program did not happen for two more years.

<sup>2</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.

## **The Flex Program Is Both a Grant Program and a Medicare Reimbursement Program**

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The Flex Program has two central components. The first component is a four-year, \$25 million per year grant program that awards up to \$775,000 to each state, to be used as needed to improve rural health systems. This component is administered by the Federal Office of Rural Health Policy (FORHP), and expires at the end of FY 2002, unless renewed by Congress. During the current legislative cycle, Congress will decide whether to extend the grant program through 2007.<sup>3</sup> The efforts of the Tracking Team are financed by the Flex grant program.

The second component of the Flex Program is the critical access hospital (CAH) component, administered by the Centers for Medicare and Medicaid Services (CMS). It allows CAHs<sup>4</sup> to be reimbursed indefinitely by Medicare for both inpatient and outpatient services on the basis of their current Medicare-allowable costs. Since the passage of the Benefits Improvement and Protection Act (BIPA) of 2000, CAH swing beds are paid on a cost basis like inpatient and outpatient services. However, home health and skilled nursing services continue to be paid according to the PPS. In 17 states, Medicaid has followed Medicare's lead and has a more advantageous reimbursement system, as well.<sup>5</sup>

Medicare is the largest purchaser of health services from hospitals, and plays a more prominent role in rural hospitals than for those in urban areas because rural populations are generally older. As such, Medicare has a number of special payment categories for rural hospitals, of which CAH is the newest. The CAH program has the potential to reduce hospital losses by increasing Medicare inpatient reimbursement to allowable cost levels and insulating the hospital from the impact of the Outpatient Prospective Payment System (OPPS). Although most rural hospitals have a "hold harmless" provision on OPPS, that exemption is scheduled to expire January 1, 2004, and is generally not as beneficial as cost-based payments.

This document describes the Flex Program's experience in the 2001-2002 fiscal year (referred to as Year 3 of the grant program). In particular, we have focused on the:

1. Role of state agencies and organizations in designating CAHs.
2. CAH characteristics and financial performance prior to conversion.

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<sup>3</sup> HR 4954 passed the House in June 2002.

<sup>4</sup> There were 620 CAHs as of June 1, 2002, or about 12% of all short-term acute care U.S. hospitals and 28% of all non-metropolitan hospitals.

<sup>5</sup> Seventeen states (40% of the 42 states studied) have created special, enhanced Medicaid inpatient reimbursement policies for CAHs. Forty-eight percent of all CAHs are located in these 17 states. In 11 of the 17 states, the special payment policy is cost-based reimbursement through annual cost settlement.

3. Hospital issues, including networking and scope of services, quality of care, access to capital, staffing patterns, workforce issues (with a focus on international medical graduates), the safety net and a “Balanced Scorecard” analysis of hospital performance.
4. EMS initiatives at state and local levels.
5. State Medicaid payment policies for CAHs.
6. State-based evaluations of the Flex Program.

## **Provisions and Goals of the Flex Program**

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CAH designation is available in any state (except Rhode Island and New Jersey, the two states that do not have rural hospitals, and Delaware, whose only rural hospital has chosen not to participate) that elects to set up such a program and provide CMS with the required assurances.

To be designated as a CAH, a facility must be located in a state that has an approved rural health plan, and must be located in a rural area more than a 35-mile drive from any other hospital or CAH (in mountainous terrain or in areas with only secondary roads available, the criterion is 15 miles), or must be certified by the state as being a necessary provider of health care services to residents in the area.

The CAH’s average per-person length of stay must be 96 hours or less annually. CAHs are limited in size to 15 acute-care beds. An additional 10 beds may be set up for skilled nursing facility (SNF)-level care (swing beds). While all 25 beds can be used as swing beds, only 15 of all 25 can be used for acute care at any given time.

Each state must have at least one rural health network. A network is defined as an organization consisting of at least one CAH and at least one hospital, the members of which have entered into certain agreements regarding patient referral and transfer, communications, and patient transportation.

Each CAH that is a network member is required to have an agreement covering these minimum areas of activity. In addition, each CAH in a network must have an agreement for credentialing and quality assurance with at least one hospital that is a member of the network, or with a Peer Review Organization (PRO) or equivalent entity, or with another appropriate and qualified entity identified in the rural health care plan for the state.

As we emphasize throughout this report, the Flex Program is much more than the CAH program. Quality improvement, EMS and networking activities are the key features of the grant portion of the Flex Program.

The FORHP is working in close partnership with state offices of rural health and related state-based entities to ensure the success of the program. Another important partner in program implementation and monitoring is the Flex Program's Technical Assistance and Services Center (TASC), which operates out of the National Rural Health Resource Center in Duluth, Minnesota (see the Web site: <http://www.ruralresource.org/index.asp>). Hospital associations, as well, have played significant roles in many states in the implementation of the Flex Program.

One of the strengths of the Flex Program is that there is federal leadership, backed by significant resources, with implementation provided through partnerships at the state and local levels. As a result, however, there are varying interpretations of the federal vision, and the consequent variety of implementation strategies and policies at state levels. One of the overarching goals of the Tracking Project (described in the next section) is to allow the FORHP to learn from the states about what works well in implementing the Flex Program locally.

## The Tracking Project

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FORHP has contracted with six rural health research centers to track the grant program and document its successes and opportunities for improvement.

The goal of the Flex Program Tracking Project ("Tracking Project") is to maximize the effectiveness of the Flex Program by tracking and reporting implementation successes and barriers. The centers engaged in the Tracking Project are based at the University of North Carolina (UNC), the University of Southern Maine (USM), the University of Minnesota (UM), the Project HOPE Walsh Center for Rural Health Analysis (HOPE), the University of Washington's WWAMI Rural Health Research Center (UW), and the Rural Policy Research Institute (RUPRI) at the University of Nebraska Medical Center. RUPRI is responsible for disseminating research findings (see Appendix A for more about dissemination) and for managing the project Web site (<http://www.rupri.org/rhfp-track/>). The UW provides coordination for the Tracking Team.

*The Tracking Project's objectives are to:*

1. Provide a continuous stream of information on program implementation to the FORHP and the states;
2. Conduct surveillance sufficient to allow early adjustments to optimize program performance;
3. Disseminate good practices, policies and ideas; and
4. Produce an annual report on findings.

## Methods

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### *Survey of CAH Administrators*

One of the primary data sources for this year's report was a telephone survey of the administrators of CAHs certified as of May 1, 2001. There were 406 eligible CAHs, and 388 (96%) responded to the survey fielded by the Survey Research Center, Division of Health Services Research and Policy, University of Minnesota. The survey instrument is available from the University of Minnesota.

The survey was launched in November 2001 and completed by early March 2002. The hospitals included in the survey were initially identified from listings provided by CMS and state Flex Program contacts, maintained by the University of North Carolina Rural Health Research and Policy Analysis Center. The survey questions covered a range of topics including strategies to increase or retain local market share, changes in scope of services, staffing strategies, experience with state and federal agencies involved in the program's implementation, governance relationships, and quality assurance and quality improvement strategies, among others.

The CAHs selected for the phone survey included all CAHs certified by CMS on or before May 1, 2001. This date was selected as the cut off in order to ensure that the facility had been operating as a CAH for a minimum of six months at the time of the survey. This universe of CAHs (406 hospitals) included 236 facilities that participated in the previous year's survey, and 170 new facilities.

The University of Minnesota Rural Health Research Center coordinated the development of the survey instrument with three of the other research centers involved in the Tracking Project. Following approval from the University Institutional Review Board, an interview protocol was developed. A field test involving five previously interviewed administrators and five newly identified administrators was conducted in November 2001, and some of the individual survey questions were also tested separately by some of the participating Tracking Team members. Following minor revisions of the survey protocol, additional training was provided for survey research center staff and the full survey was launched in early December 2001.

The interviews were coordinated with a mailing that introduced the purpose and scope of the project and a fact sheet for administrators to complete prior to their phone interview. Mailings and phone calls were conducted in a staggered fashion from East to West to accommodate the different time zones and maximize the survey research center efforts.

**Table 1. Characteristics of CAHs in Phone Survey Sample (n=388)**

|   | Before-CAH Average | Average in early 2002 |
|---|--------------------|-----------------------|
| Total beds (set up and staffed)           | 24.1               | 19.2                  |
| Length of stay (all inpatients)           | 3.15               | 2.92                  |
| Length of stay (Medicare patients)        | 3.44               | 3.13                  |
| Physicians on staff (MDs and DOs)         | 4.82               | 4.83                  |
| Non-physicians practitioners (mid-levels) | 1.69               | 2.36                  |

*Note: the “before-CAH average” number of physicians and mid-levels comes from last year’s survey. All other numbers are from the survey of CAH administrators that was completed in March 2002.*

### Site Visits

During this year of the Tracking Project, three research centers visited six states and eight CAHs. Visiting teams were from UM, HOPE and UW. Each of the visits was conducted by a research center team using a semi-structured site visit protocol.

**Table 2. Site Visits to Critical Access Hospitals and EMS Systems**

|                           | HOPE | UM | UW |
|---------------------------|------|----|----|
| Minnesota hospitals       |      | 2  |    |
| Minnesota EMS systems     | 2    |    |    |
| Nebraska hospitals        |      | 2  |    |
| Kentucky hospitals        |      |    | 4  |
| North Carolina EMS system | 1    |    |    |
| Kansas EMS system         | 1    |    |    |

### Tracking Hospital and State Activity

Like past years, UNC engaged in continuous monitoring of activities in the states through regular e-mail and telephone contacts. UNC identified a “Flex contact” in each state, typically the Flex/CAH Coordinator. These individuals were e-mailed monthly to provide UNC with their state’s CAH update and verification of the CAH information provided by the CMS contact. The information collected from these state and CMS contacts is continuously added to the database that was created to organize the data. It contains hospital identification numbers, current and previous provider numbers, activity status, certification dates, and contact names. Additional

data are extracted from various sources to provide a more detailed description of the states participating in the Flex Program, the communities in which CAHs operate, and the CAHs themselves. See details in Chapter 2 for an explanation of the data sets that are merged with the CAH data.

In addition to the monthly e-mail updates, UNC conducted 47 telephone interviews of all of the Flex/CAH Coordinators between November 2001 and January 2002. This was the third year that these telephone interviews occurred, during which valuable information was collected on each state's Flex activities, initiatives, and challenges.

### ***Phone Calls to State Grantees***

UW telephoned all 47 states participating in the Flex Program to ask grantees about their evaluation activities, and reached 38 of these (81%). Grant applications were reviewed to identify planned evaluation activities, and when available, evaluation documents were collected and reviewed. Information collected by UNC through the e-mail and telephone surveys (as described above) were also reviewed. This activity will be continued in Year 4 since many states have not yet launched evaluation activities.

USM and UNC telephoned the Medicaid offices in all 47 states to ask about payment policies for CAHs, and reached 42 of these (89%). The interviews with Medicaid officials requested information about the state's reimbursement policies for various kinds of health services, special provisions for CAHs, the state's Disproportionate Share Hospital (DSH) program and any other Medicaid supplemental payment programs, the impact of special payment policies on the Medicaid program, and the Medicaid program's participation in the development and implementation of the Flex Program.

### ***Grant Proposal Reviews***

The UW compiled information from each state's applications for funding for fiscal year 2001-2002, presented in Appendix B. Other centers reviewed the portions of the grant proposals that pertained to their particular area of study, such as UM's review of proposals for networking activity support, and HOPE's review of EMS activity.