

## HISTORY OF THE MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

The Medicare Rural Hospital Flexibility Program, or Flex Program, was established by the Balanced Budget Act (BBA) of 1997. Any state with rural hospitals and a state rural health plan may establish a Flex Program and apply for federal funding that provides for the creation of rural health networks, promotes regionalization of rural health services, and improves access to hospitals and other services for rural residents.

The Flex legislation also created critical access hospitals (CAHs) as a Medicare provider type. CAH designation allows a hospital to be reimbursed on a reasonable cost basis for inpatient and outpatient services provided to Medicare patients (including lab and qualifying ambulance services) and, in some states, Medicaid patients.

The design of the CAH designation was based on the experiences of the Medical Assistance Facility (MAF) Demonstration Project, and the Rural Primary Care Hospital (RPCH) Project. MAFs were initially developed through a demonstration project of the Montana Health Research and Education Foundation (MHREF) in 1987 and received Medicare waivers in 1990. CAH designation was designed, in part, to decrease rural hospital closures, strengthen local health care delivery, and improve rural health care access.

The legislation has undergone many changes and updates such as the Balanced Budget Refinement Act (BBRA) of 1999, the Benefits Improvement Protection Act (BIPA) of 2000, the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003, the Medicare Improvements to Patients and Providers Act (MIPA) of 2008, the American Recovery and Reinvestment Act of 2009, and the Patient Protection and Affordable Care Act of 2015.

In 1999, the Technical Assistance and Services Center (TASC) was created by the National Rural Health Resource Center (The Center) through funding from the Federal Office of Rural Health Policy (FORHP) to provide technical assistance and resources to the grantees of the Flex Program. TASC provides a resource network for answers and information regarding the program including best practices, peer learning, and tools. TASC has been so successful that many other Health Resources and Services Administration

(HRSA) programs have used this model to develop technical assistance centers for their programs.

TASC recognized a growing need for a knowledge base in health information technology (HIT) for rural health grantees and rural health providers. Currently, HIT requirements in quality, safety, Health Insurance Portability and Accountability Act (HIPAA), telemedicine, reimbursement, pharmacy, and meeting the three stages of [Promoting Interoperability](#) (formerly known as Meaningful Use) as set forth by the Centers for Medicare and Medicaid Services (CMS) are overwhelming many rural health care providers. TASC has been providing HIT informational resources, education, and technical assistance since 2006. As of late, an increased emphasis is placed on telehealth to support quality of care, access to care, collaboration and information sharing among care providers, patient satisfaction, and safety during the COVID-19 pandemic and beyond.

TASC manages the [National Rural HIT Coalition](#) and ad hoc sub-groups, which is an informal network of rural and HIT leaders from organizations at every level, working together to advance the implementation of HIT across rural America. This is done by enhancing the understanding of rural HIT issues, advocating for HIT applications and solutions relevant to rural facilities, and helping to drive knowledge and information about rural HIT throughout the country. State Flex Programs are welcome and encouraged to participate in the Coalition.

As the US transitions to a health care system that pays for value, there are new programs and projects in the areas of accountable care organizations (ACOs); bundled payments, telehealth and patient centered medical homes; Medicare and Medicaid payment changes and demonstration projects including global budgeting; workforce; long-term care; and public health. Changes are occurring in the health care marketplace and CMS has focused its priorities on better care, smarter spending, and healthier people and communities. In 2015, the [Medicare Access & CHIP Reauthorization Act \(MACRA\)](#) was passed, introducing the [Quality Payment Program \(QPP\)](#), which has two tracks: [Advanced Alternative Payment Models \(APMs\)](#) and the [Merit-based Incentive Payment System \(MIPS\)](#). In short, APMs provide an incentive payment based on a specific clinical condition, care episode, or population where providers assume some of the risk related to their patients' outcomes. MIPS provides a payment adjustment to health care providers built on evidence-based and practice-specific quality data demonstrating

high quality, and efficient care supported by technology such as the electronic health record. Additional models have been introduced, with the most recent introduction of the [Community Health Access and Rural Transformation \(CHART\) Model](#) in September 2020.

Changes in Medicare and Medicaid payment and delivery systems are anticipated to have the following impact:

- Increased pressure on operating margins caused by payment reductions, both federal and state
- Physician integration will be necessary to support ACOs and other shared savings models
- Capital will be required to implement physician alignment strategies
- Quality will drive reimbursement levels and will be a market differentiator
- Quality reporting will require a more sophisticated infrastructure
- Collaboration and effective alignment with the physician-provider community will be imperative as health care moves from a volume-based system to a value-based system

As CAHs seek to understand their future value, they will need to look at their economic value in a new world consisting of transitioned payments.

Challenges faced by rural hospitals are not insurmountable, and to meet them head on will require a strong commitment to the communities served, as well as the desire to problem solve and work collaboratively. This commitment, along with desire and collaboration are the qualities that define rural hospitals and rural leaders. Because they are the lifelines for the residents they call neighbors, rural hospitals can lead the way in transforming the American health care system. They are smaller, less complex and, therefore, able to change quicker than their urban counterparts. Rural hospitals are also more closely connected to their local communities.

Nationally, there is an important movement toward increased quality of care and patient health care experiences. FORHP created the [Medicare Beneficiary Quality Improvement Project \(MBQIP\)](#) as a Flex Program activity within the program area of quality improvement. The primary goal of this project is for CAHs to implement quality improvement initiatives to improve patient care and operations. Flex Programs focus their work in the required Quality Improvement Program Area specifically on MBQIP. This work provides

support to CAHs with technical assistance and national benchmarks to improve health care outcomes.

Increased usage of and understanding of publicly available quality and patient satisfaction data (from [Hospital Compare and the Hospital Consumer Assessment of Healthcare Providers and Systems \(HCAHPS\)](#) survey) has contributed to increased knowledge and understanding of hospital quality improvement. In the environment of [MACRA](#), pay for performance, bundled payments and Accountable Care Organizations (ACOs), and use of data to improve care, CAHs may soon be compared with their urban counterparts to ensure public confidence in their quality of health services. The MBQIP initiative takes a proactive and visionary approach to ensure CAHs are well-equipped and prepared to meet potential future quality legislation. Additionally, MBQIP fulfills the Flex grant quality improvement objectives regarding Hospital Compare reporting and supporting participation in various multi-hospital quality improvement initiatives. The main emphasis of this project is putting patients first by focusing on improving health care services, processes, and administration. More information can be found on the [MBQIP webpage](#) of the [TASC website](#).

Starting in Fiscal Year (FY) 2015, FORHP required participation in MBQIP as a condition for critical access hospitals (CAH) to participate in Flex-funded activities. CAHs had opportunity to work with their State Flex Program to meet the MBQIP reporting requirements and be able to participate in Flex-funded activities. However, as our nation grapples with the COVID-19 pandemic, FORHP has decided to suspend eligibility requirements for the FY 2020 (September 1, 2020 – August 31, 2021) and FY 2021 (September 1, 2021 – August 31, 2022). In order to support all hospitals in prioritizing their COVID-19 response, FORHP will also allow all Flex states to participate in Flex-funded activities during this period.

Per FORHP policy, CAHs must meet two criteria to be eligible for FY 2020 Flex-funded activities:

1. A signed MOU to submit and share MBQIP data
2. Reported data on at least one MBQIP Core measure, for at least two quarters, in at least three of the four quality domains, within the FY 2020 reporting period. For this policy exception, Flex grantees will not need to submit an MBQIP waiver for FY 2020 and will not be penalized for not meeting minimum reporting requirements for MBQIP.

CAHs that have the ability to report are highly encouraged to continue reporting on as many measures as possible.

As of October 2020, there were 1,351 hospitals in the nation designated as CAHs. The majority of CAH designations in the country are now complete, due to support provided by the state Flex Programs. CAH designation is only one part of the Flex Program. The prevention of CAH closure or assisting CAHs to identify other viable models to serve the health care needs of their rural communities is an important role for state Flex Programs to play in this shifting health care environment. State Flex Programs also use their cooperative agreement dollars to: improve networks, improve population health, and integrate emergency medical services (EMS); work on performance improvement, financial improvement and operational improvement; address quality improvement issues; and explore innovative models of care, all in an effort to enhance and ensure health care access to rural Americans.