

FLEX PROGRAM FREQUENTLY ASKED QUESTIONS

Flex Program Operations

1. What is the Medicare Rural Hospital Flexibility (Flex) Program?

The Flex Program was created by the Balanced Budget Act (BBA) in 1997. Revisions occurred through the Balanced Budget Refinement Act (BBRA); the Medicare, Medicaid and State Children’s Hospital Insurance Program (SCHIP) Benefits Improvement and Protection Act (BIPA); the Medicare Prescription Drug, Improvement and Modernization Act (MMA); and the Medicare Improvements to Patients and Providers Act (MIPA). The Flex Program is intended to preserve access to primary and emergency health care services, improve the quality of rural health services, provide services that meet community needs, and foster a health delivery system that is both efficient and effective. In addition, the Flex Program supports designation of a type of rural hospital: critical access hospital (CAH).

To accomplish the intent of the Flex Program, federal resources have been made available to:

- State Offices of Rural Health (those who implement state Flex programs)
- The Technical Assistance Service Center (TASC), a program of the National Rural Health Resource Center (The Center) and Rural Quality Improvement Technical Assistance (RQITA), a technical assistance provider to support Medicare Beneficiary Quality Improvement Project (MBQIP) data reporting and quality improvement
- Rural Health Research Centers and the Flex Monitoring Team (FMT) (those who are monitoring the Flex program nationally)

States administer the Flex Program and can apply to the Health Resources and Services Administration (HRSA), Federal Office of Rural Health Policy (FORHP), for federal Flex Program funding.

For more policy/legislative information, please visit the [Core Competencies for State Flex Program Excellence Guide](#).

2. What are the primary components of the Flex Program? (See Section 1 for a description of each program area)

- Program Area 1: Quality Improvement (required)
- Program Area 2: Operational and Financial Improvement (required)
- Program Area 3: Population Health Improvement (optional)

- Program Area 4: Rural Emergency Medical Services (EMS) Improvement (optional)
- Program Area 5: Rural Innovative Model Development (optional)
- Program Area 6: CAH Designation (required if requested)
- Other key areas of the Flex Program include the following
 - Network Development
 - State Rural Health Plan*
 - State Flex Program Evaluation

*Note: Each state participating in the Flex Program was required to develop a state rural health plan. This rural health plan was submitted to the Centers for Medicare and Medicaid Services (CMS) for approval. Reporting outcomes of the Flex Program is becoming increasingly important in order to quantify the benefits of the program. Through continuous assessment, states must have a way to gather data and review the successes of their program and incorporate any needed improvements.

3. How are states made aware of the Flex Program and CAH changes?

TASC sends emails regarding Flex Program changes (including CAH changes) to Flex Program Coordinators and other applicable Flex Program personnel as information is made available. Information also comes directly from FORHP, RQITA, FMT, and state hospital associations and is reported in the Federal Register. Additionally, changes are posted on the TASC website or are reported through links to other websites.

4. Can I expect other updates and information from TASC and others?

Yes. TASC and its partners stay abreast of rural health policy and program changes. Updates are provided via the Flex Program email lists, monthly *Rural Route* newsletter, regularly scheduled conference calls, and webinars such as TASC 90 and Virtual Knowledge Group (VKG) webinars. Information is also shared via the Flex Program Forum, TASC and FMT websites, other stakeholder websites, conferences, and workshops throughout the year.

5. How do I apply for federal Flex Program funding?

Each state interested in acquiring federal Flex Program funding must submit an annual grant application to FORHP. The state designated entity, appointed by the governor, is solely allowed to apply for the funding. The approximate timeline* for applications and awards is below:

- January/February: FORHP sends application guidelines to states
- March - May: Grant submission
- August: Grant award announcements

- September 1: The federal grant program year begins

*Note: This schedule may change; contact FORHP for current year grant schedule.

6. Who should I contact if I have questions regarding the Flex Program? TASC is available to answer your questions, see Section 3.

There are several other excellent resources, a sample of those to consider include:

- CAH Licensing and Certifications (including accrediting bodies) – contact your state hospital licensing bureau, your CMS regional office, or TASC.
- Federal Flex Program – contact the Flex Project Officer at FORHP (FORHP Flex Program Project Officers in Section 2).
- [CAH Conditions of Participation](#) (State Operations Manual, Appendix W – Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals and Swing-Beds)
- Changes in federal laws and rules governing the Flex Program – contact your state hospital association, CMS or visit the [Federal Register website](#) and the [Rural Policy Research Institute \(RUPRI\)](#) website.
- [Rural Health Value](#) operates as the Rural Health System Analysis and Technical Assistance (RHSATA) cooperative agreement between FORHP, the RUPRI Center and Stratis Health. The Rural Health Value Team analyzes rural implications of changes in the organization, finance, and delivery of health care services and assists rural communities and providers transition to a high-performance rural health system.
- The [American Hospital Association \(AHA\) Section for Small or Rural Hospitals](#) — The AHA ensures the unique needs of this segment of its membership are a national priority. Working side by side with state and regional associations and with counsel from its governing council, the AHA Section for Small or Rural Hospitals monitors the issues and concerns facing its constituents, develops policy and identifies solutions to their most pressing problems.
- Annual Flex Program Reverse Site Visit – contact TASC

7. If I want information from other states, e.g. asking questions or determining whether they are working on similar issues, how do I access this information?

There are several ways to access state Flex Program information, including:

- Contact information (email addresses, phone numbers and websites) are available through the [State Flex Profiles](#) on the TASC website.
- TASC hosts regularly scheduled TASC 90 webinars. These webinars address issues and topics of interest to state Flex Program Coordinators and CAHs. TASC 90 recordings are made publicly available on the TASC website. TASC hosts Virtual Knowledge Group (VKG) webinars, which are peer discussions for state Flex Coordinators to share best practices and lessons learned. VKG recordings are only shared on the Flex Program Forum.
- The [Flex Program Forum](#) is a secure web-based message forum for use by the state Flex Programs. Forum content focuses on the Flex Program and rural health care. State Flex personnel are able to share messages, pose questions, post documents and web links and comment on each other's posts. This Forum is a method for state Flex Programs to continue to connect and share information, ideas, lessons learned and best practices.

8. Where can I find ideas that may assist me in building my state Flex Program?

There are several resources designed for state Flex Program development, including:

- Staff at The Center working on the TASC program, TASC 90 webinars, other topical webinars, VKG webinars, Flex Program Reverse Site Visit, TASC website, Flex Program Forum, and *Rural Route* e-newsletter (all coordinated by TASC).
- Other state Flex Programs and their websites, which can be found within the [State Flex Profiles](#)
- Publications and the [FMT website](#)
- Health Resources and Services Administration ([HRSA](#)) [FORHP](#)
- [National Rural Health Association \(NRHA\)](#) Annual Conference and Annual CAH Conference
- [National Organization of State Offices of Rural Health \(NOSORH\)](#) Annual Meeting
- The TASC [Core Competencies for State Flex Program Excellence](#), which defines nine Flex Program competencies and provides a guide to state Flex Programs for improving capacity in each of the nine areas.

Critical Access Hospitals

1. What is a CAH?

A CAH is a small rural hospital that has 25 beds (inpatient and/or swing beds) or fewer. CAHs have unique operating requirements and receive cost-based plus one percent reimbursement (101% of allowable costs) for providing inpatient and outpatient services and certain other services to Medicare* beneficiaries.

*Note - some states also provide cost-based reimbursement for inpatient and/or outpatient services for Medicaid services. This varies by state.

2. Which hospitals are eligible for a CAH designation? **

A Medicare-participating hospital can become certified and remain certified as a CAH by meeting the following regulatory requirements (this list is not all-inclusive but indicates some of the basic criteria):

- Located in a state that established a rural health plan for MRHFPs (as of 2018, only Connecticut, Delaware, Maryland, New Jersey, and Rhode Island have not established MRHFP State Rural Plans).
- Located in a rural area or an area treated as rural under a special provision that allows treating qualified hospital providers in urban areas as rural (refer to [42 CFR 412.103](#) regulations).
- Furnishes 24-hour emergency services, 7 days a week, using either on-site or on-call staff, with specific on-site, on call staff response times.
- Does not exceed 25 inpatient beds also used to swing bed services. It may operate a distinct part rehabilitation and/or psychiatric unit, each with up to 10 beds.
- Report an annual average acute care inpatient length of stay (LOS) of 96 hour or less (excluding swing bed services and DPU beds). Medicare does not assess this requirement on initial certification and only applies after CAH certification.
- A CAH that has not been designated by a state as a necessary provider prior to December 31, 2005 must 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 any other CAH or hospital.

3. Can a CAH convert back from CAH designation to Prospective Payment System (PPS)?

Yes, a CAH can convert back to be a PPS hospital. Contact TASC for examples of hospitals that have converted back to PPS status.

4. Can a CAH have distinct-part units (DPUs) (e.g., psych units)?

Yes. As part of the MMA (2003), a CAH may operate a distinct part rehabilitation or psychiatric unit, each with up to 10 beds (e.g., one psychiatric DPU up to 10 beds and one rehabilitation DPU up to 10 beds).

5. What does “make available 24-hour emergency medical services” mean?

A CAH that does not have inpatients may close (e.g., be unstaffed) provided there is an emergency medical response system in place to address the needs of patients that present at the hospital. This emergency medical response system must ensure that a practitioner with training and experience in emergency care (doctor of medicine or osteopathy, physician assistant or nurse practitioner) is on-call and available by telephone or radio 24 hours a day and available on-site at the CAH within 30 minutes.

6. Are CAH licensure surveys announced or unannounced?

CAH licensure surveys are unannounced. CAHs have an initial survey and then a follow-up survey approximately one year later. Subsequent survey schedules vary by state.

Examples of mock surveys from state offices of rural health (SORH) can be found in the resources on the [TASC website](#).

7. Will the CAH be given a new provider number upon conversion to CAH?

Yes, a new provider number will be assigned.

8. What bed count will be used to determine whether a hospital qualifies as a CAH?

A CAH can have up to 25 Medicare certified beds, including swing beds. Some states allow CAHs to have a larger number (above 25) of state licensed beds; however, they staff by the hospital as it will place them over the 25-bed count.

9. Are observation beds or recovery lounges counted towards the 25 acute care bed limit?

Beds used solely for patients receiving observation services are not included in the 25 acute care bed limit. There are some observation services that are not appropriate and can be referenced in [Appendix W](#). Recovery lounges used in surgery do not count if the patient in the bed meets the criteria for use in the CMS Interpretive Guidelines. Remember, it does not matter the kind of bed (gurney, lounge, etc.), it is the status of the patient in the bed.

10. What happens if emergency situations require greater in-patient capacity than 25 beds?

CAHs can exceed the 25 acute care bed limit in emergency situations, e.g. a disease epidemic, but must document the circumstances to the satisfaction of federal and state officials.

11. Can a CAH build a new hospital and still be a CAH?

Yes, but certain requirements must be maintained or met anew. For hospitals that require a state necessary provider waiver to be a CAH, refer to the [Medicare Conditions of Participation for CAHs](#), section §485.610(d) Standard: Relocation of CAHs With a Necessary Provider Designation Interpretive Guidelines §485.610(d).

For CAHs that are not designated as necessary providers, please see the [Medicare Conditions of Participation for CAHs](#), section §485.610(c) Standard: Location Relative to Other Facilities or Necessary Provider Certification Interpretive Guidelines.

12. Are CAHs issues the same across all states?

No. All states have unique rules and regulations that may affect CAH operations in the state. Therefore, in many instances, states must refer to state licensing and other regulatory experts for information and guidance.