2023 Flex Program Fundamentals

An Introduction to the Medicare Rural Hospital Flexibility Program

Updated Fall 2026

National Rural Health Resource Center

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Executive Summary

The Medicare Rural Hospital Flexibility Program, or Flex Program, was established by the Balanced Budget Act (BBA) of 1997. This bill meant states with eligible rural hospitals and a state rural health plan could establish a Flex Program and apply for federal funding. Forty-five states participate in the Flex Program. The BBA also created the critical access hospital (CAH) designation as a Medicare provider type. CAH designation allows the hospital to be reimbursed on a reasonable cost basis for inpatient and outpatient services, including lab and qualifying ambulance services that are provided to Medicare patients and, in some states, Medicaid patients.

The Flex Program is a cooperative agreement administered through the Federal Office of Rural Health Policy (FORHP) at the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS). This program provides funding to state governments or other designated entities like universities or non-profits to support CAHs and provider-based rural health clinics (RHCs) in quality improvement, quality reporting, performance improvements and benchmarking, financial sustainability, designating facilities as CAHs, population health, and the provision of rural emergency medical services (EMS). Only states with CAHs or hospitals eligible to convert to CAH status and a state rural health plan can participate in the Flex Program. The fiscal year for the Flex program typically starts on September 1 and ends on August 31. The current 5-year cooperative agreement cycle began on September 1, 2024, and runs through August 31, 2029.

Flex funding encourages the development of cooperative systems of care in rural areas by joining together CAHs, providers of EMS services, clinics, and health practitioners to increase efficiency and quality of care. The Flex Program requires states to assess statewide needs and implement community-level outreach and technical assistance to advance the following goals:

- Increase the number of CAHs consistently reporting quality data.
- Improve the quality of care in CAHs.
- Maintain and improve the financial viability of CAHs.
- Build capacity of CAHs to achieve measurable improvements in the health outcomes of their communities.
- Improve the organizational capacity of rural EMS.
- Improve the quality of rural EMS.
- Assist rural hospitals in seeking or maintaining appropriate Medicare participation status to meet community needs.

Federal Office of Rural Health Policy

FORHP coordinates activities related to rural health care within the U.S. and is responsible for analyzing the possible effects of policy on residents of rural communities. Created by Section 711 of the Social Security Act, FORHP advises the Secretary of HHS on health issues within these communities, including the effects of Medicare and Medicaid on rural citizens' access to care, the viability of rural hospitals, and the availability of physicians and other health professionals.

FORHP administers grant and cooperative agreement programs designed to build health care capacity at both the local and state levels. These grants provide funds to many rural health facilities including 50 State Offices of Rural Health (SORHs) to support ongoing improvements in care, and to small rural hospitals through Flex and SHIP grants. Learn more about FORHP in Section 2 of this guide.

Technical Assistance and Services Center

TASC was created in 1999 by the National Rural Health Resource Center (The Center) through funding from FORHP to provide technical assistance and resources to Flex Program grantees. This Flex Program Fundamentals guide was developed as part of TASC's services and is updated annually. The TASC section of the guide includes information on the tools and resources found on the TASC website, Flex Program Workshops, communication tools, technical assistance, and contact information for TASC staff. State Flex Program contact information can also be found within the State Flex Profiles on the TASC website.

TASC's services are essential as the job duties of a Flex Coordinator are broad, far-reaching, and without step-by-step instructions. Because of the varying tasks associated with the Flex Coordinator position, it is essential to remember the following tips:

- The role of the Flex Coordinator is to be the convener and liaison between local, state, and national rural health groups, all the while maintaining a neutral position.
- Partnerships are keys to success.
- Understanding the CAH environment and how to promote financial and operational improvement are vitally important.
- For quality improvement, look at what exists and think creatively about how to improve.
- CAHs need to play a part in a comprehensive system of care.
- Be aware of the resources available to help you be successful.

TASC provides tools and resources on topics applicable to the Flex Program, including CAH surveys.

Introduction to the Medicare Rural Hospital Flexibility Program

- History of the Medicare Rural Hospital Flexibility Program
- Program Areas of Flex
- Flex Cooperative Agreement Resources
- Core Competencies for State Flex Program Excellence
- Flex Program Frequently Asked Questions

History of the Medicare Rural Hospital Flexibility Program

The Flex Program was established by the 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 BBA also created CAHs as a Medicare provider type. CAH designation allows a hospital to be reimbursed on a reasonable cost basis for inpatient and outpatient services, including lab and qualifying ambulance services, provided to Medicare patients and, in some states, Medicaid patients.

As of July 2026, there are over 1,380 hospitals in the nation designated as CAHs; an up-to-date map of CAHs locations and numbers can be found on the Flex Monitoring Team's website. While most CAH designations in the country are now complete due to support provided by state Flex Programs, there has been additional specification regarding the definition of "primary /secondary roads", which has opened the possibility for additional hospitals across the country to convert (see FAQs of this section for more information). CAH designation is only one part of the Flex Program. The prevention of CAH closure or assisting them in identifying other viable models to serve the health care needs of their rural communities is a vital 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 improve and integrate EMS; work on performance improvement, operational and financial improvement, address quality improvement issues; explore innovative models of care, all to enhance and ensure health care access to rural Americans.

CAHs must comply with Medicare Conditions of Participation (CoP) to receive Medicare/Medicaid payment.

In order to be designated as a CAH [and meet the conditions of participation (CoPs)], hospitals must meet the following criteria:

- Be located in a state that has established a state Flex Program (as of 2025, 45 states have an established program;
- Be located in a rural area or be treated as rural under a special provision that allows qualified hospital providers in urban areas to be treated as rural for purposes of becoming a CAH;
- Furnish 24-hour emergency care services, using either on-site or on-call staff;
- Be located either more than 35 miles from the nearest hospital or CAH or more than 15 miles in areas with mountainous terrain or only secondary roads OR prior to January 1, 2006 were state-certified as a "necessary provider" of health care services to residents in the area;

- Provide no more than 25 inpatient acute care beds that can be used for either inpatient or swing bed services. A swing bed can be used to provide either acute or skilled nursing facility care. A CAH may also operate a distinct part rehabilitation or psychiatric unit, each with up to 10 beds;
- Have an average annual length of stay of 96 hours or less.

A CAH survey is used to determine whether a CAH complies with the CoP set forth at 42 Code of Federal Regulations (CFR) Part 485 Subpart F. Certification of CAH compliance with the CoP is accomplished through observations, interviews, and document/record reviews. The survey focuses on a CAH's performance of organizational and patient-focused functions and processes while assessing compliance with federal health, safety, and quality standards that will ensure the beneficiary receives safe, quality care and services.

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 BBA 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 (ARRA) of 2009, and the Patient Protection and Affordable Care Act (PPACA) of 2015.

In 1999, the Technical Assistance and Services Center (TASC) was created by The National Rural Health Resource (The Center) through funding from FORHP to provide technical assistance and resources to Flex Program grantees. TASC provides a resource network for information regarding the program including best practices, peer learning, and tools. TASC also offers webinars and forums to communicate with other Flex programs.

Through their work with Flex program staff, TASC recognized a growing need for a knowledge base regarding Health Information Technology (HIT) for rural health grantees and providers. Current HIT standards are set forth by the Centers for Medicare & Medicaid Services (CMS) and pertain to quality, safety, Health Insurance Portability & Accountability Act (HIPAA), telemedicine, reimbursement, pharmacy, and Promoting Interoperability (formerly known as Meaningful Use). Necessary levels of adoption to HIT standards and systems can be overwhelming to many rural health care providers. In the recent past, TASC provided HIT informational resources, education, and technical assistance to help ease the HIT transition. As of late, an increased emphasis has been placed on telehealth to support quality of care, access to care, collaboration among care providers, patient satisfaction, and patient safety. For more information about Rural HIT, please visit the TASC HIT webpage.

Up until FY 2021, TASC coordinated the National Rural HIT Coalition; this group is now hosted by the National Rural Health Association (NRHA). The National Rural HIT Coalition acts as an informal network of rural and HIT leaders from organizations at every level, working together to drive knowledge and information about rural HIT throughout the country. The current purpose of the group is to enhance understanding of rural HIT issues

and resources, provide a forum for rural health providers/clinics/hospitals to discuss issues, advocate for rurally relevant HIT programs and policy solutions, and to share rural successes, opportunities, and perspectives with federal, national, and state organizations.

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 the U.S. transitions to a health care system that pays for value, CAHs need to look at their economic value in a new world consisting of transitioned payments. Collaboration and effective alignment with the physician-provider community will be imperative as healthcare moves from a volume-based to a value-based system. With focus shifting to value-based care, there are new programs and projects in the areas of accountable care organizations (ACOs); bundled payments, telehealth, and patient-centered medical homes (PCMH); 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 patient 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.

In recent years, additional models have been introduced, including the Achieving Healthcare Efficiency through Accountable Design (AHEAD) Model. Per the CMS website, the AHEAD Model is a total cost of care (TCOC) model designed to collaborate with states to curb healthcare costs growth, improve population health, and promote healthier living while also aiming to increase investment in primary care, provide financial stability for hospitals, and support beneficiary connection to community resources. As of July 2025, the first three cohorts have been selected and are in a pre-implementation period. As CAHs seek to understand their future value, they need to look at their economic value in a new world consisting of transitioned payments.

In response to continuing hospital closures, CMS created a new provider designation, the Rural Emergency Hospital (REH). According to the Rural Health Information Hub's (RHIhub) topic guide, the REH designation is designed to maintain access to critical outpatient hospital services in communities that may not be able to support or sustain a CAH or small rural hospital. REHs are required to provide 24-hour emergency and observation services and can elect to furnish other outpatient services. Facilities designated as an REH will receive enhanced Medicare payments for certain outpatient services and additional monthly payments. REH designations became effective in January 2023. For more information about REH conversion, REH technical assistance services, or for a map of current REHs, visit the Rural Health Redesign Center.

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

Nationally, there is an important movement toward increased quality of care and patient health care experiences. The Flex Program has evolved over the years to adapt to the changing healthcare landscape, which will be seen more in the sections to come.

Program Areas of Flex

There are five program areas, each with their own goals:

- **CAH Quality Improvement (required)**
  - Increase the number of CAHs consistently reporting quality data.
  - Improve the quality of care in CAHs.
- **CAH Financial and Operational Improvement (required)**
  - Maintain and improve the financial viability of CAHs.
- **CAH Population Health Improvement (optional)**
  - Build capacity of CAHs to achieve measurable improvements in the health outcomes of their communities.
- **Rural EMS Improvement (optional)**
  - Improve the organizational capacity of rural EMS.
  - Improve the quality of rural EMS.
- **CAH Designation (required if assistance is requested by rural hospitals)**
  - Assist rural hospitals in seeking or maintaining appropriate Medicare participation status to meet community needs.

The overall goal of the Flex Program is to ensure that high-quality health care is available in rural communities and aligned with community needs. In FY 2024 (September 1, 2024 – August 31, 2025), the Flex Program began a new funding cycle focused on providing training and technical assistance to build capacity, support innovation, and promote sustainable improvement in rural health care systems.

The Flex Program has a five-year project period designed to allow programs to develop, implement, and measure impact and improvement.

I. CAH Quality Improvement

FORHP created the Medicare Beneficiary Quality Improvement Project (MBQIP) as a Flex Program activity within the quality improvement program area. The primary goal of this project is for CAHs to implement quality improvement initiatives to improve their patient care and operations. MBQIP uses Flex funding to support CAHs with technical assistance and national benchmarks to improve health care outcomes. Participating CAHs report a specific set of annual and quarterly measures determined by FORHP and engage in quality improvement projects to benefit patient care.

Benefits of participating in MBQIP include:

- Engagement in quality improvement initiatives
- Improved patient care across a broad population
- Improved hospital services, administration, and operations
- Creation of clear benchmarking and the identification of CAH best practices
- Receiving technical assistance regarding cutting edge quality improvement tools and models
- Preparing CAHs for the future when they will likely have to report national standardized measures
- Fulfilling the quality improvement portion of the Flex grant

Increased usage of publicly available quality and patient satisfaction data from Care Compare and the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) surveys has contributed to increased knowledge and understanding of hospital quality improvement. In the environment of MACRA, pay for performance, bundled payments and 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 that CAHs are well-equipped and prepared to meet future quality legislation. Additionally, MBQIP fulfills the Flex grant quality improvement objectives regarding Care Compare reporting for hospitals 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.

The MBQIP requirements include:

- CAHs must have a Memorandum of Understanding (MOU).
- CAHs will report all measures, for all four quarters of the year, in the new measure set.

- For CAHs that are unable to report on one or more measures, State Flex Programs will provide that information on a regular basis to FORHP along with a reason why the CAH(s) cannot report a measure(s).

For a more detailed view of the minimum eligibility requirements, visit the Flex Eligibility Criteria webpage.

Currently, MBQIP activities are grouped in five core quality domains measures:

- Global Measures
- Patient Safety
- Patient Experience
- Care Coordination
- Emergency Department

FORHP expects all State Flex Programs to include a minimum of one improvement project focused on the improvement of one of the Core MBQIP domain measures in the CAH Quality Improvement section of each year's work plan. Projects must have outputs and measurable (short, intermediate, and long-term) outcomes. Not all hospitals are required to participate in the project and State Flex Programs may choose to have multiple quality projects. For example, if a state has three CAHs who need to improve their antibiotic stewardship (Patient Safety Measure), these three hospitals make a cohort which can be considered a project.

Additionally, for FY 2024-2028, State Flex Programs should also ensure quality improvement needs assessment is done for their state to lead their quality work, provide quality improvement education, and provide quality improvement reporting support.

Along with the required set of quality improvement activities/project(s), there are additional MBQIP domain measures not considered "core measures" that grantees can also choose to work in based on the needs of the CAHs in their state. These domains do not require participation from all CAHs and can use a cohort approach as mentioned above. It is acceptable to work with an individual hospital, but the need must be clearly justified. While some of the additional activity categories have existing measures, some do not have a standardized measure set or reporting mechanism. These activity categories were included to give states an option to work on these national quality priority areas.

Building and maintaining the participation of all CAHs in MBQIP through quality measurement and reporting activities is required. In year one of the cooperative agreement cycle, it is acceptable to work towards building the capacity for CAHs to participate in these activities and report data if they are not already doing so. For CAHs already engaged in quality reporting, the focus should be quality improvement.

To support the technical assistance needs of state Flex Programs and participating CAHs, FORHP established the Rural Quality Improvement Technical Assistance (RQITA) cooperative agreement. RQITA works closely with TASC, FMT, and FORHP to improve quality and health outcomes in rural communities through technical assistance to beneficiaries of FORHP quality initiatives, including MBQIP and the Small Health Care Provider Quality Improvement (SHCPQI) grantees. To support SHCPQI, RQITA works closely with the Georgia Health Policy Center.

Potential resources related to quality improvement include:

- TASC website
- RQITA website
- EDTC Measure Reporting Data
- Flex Monitoring Team (FMT)

For specific information on program area 1: CAH Quality Improvement goals, activity categories, requirements, and suggested output and outcome measures, please see the Medicare Rural Hospital Flexibility Program Structure for FY 2024 – FY 2028.

Learn more about the MBQIP Core Measure Set and MBQIP Fundamentals Guide on RQITA's website.

II. CAH Financial and Operational Improvement

This program area, sometimes referred to as FOI, focuses on improving and sustaining the financial and operational wellness of CAHs. FORHP requires all grantees to complete a FOI needs assessment (statewide or individual), provide FOI education, and support one or more improvement projects in this program area as determined by the state's needs assessment and program capacity. FORHP encourages states to identify new or existing successful financial and operational improvement programs and leverage those to meet the collective needs of CAHs in each state to maximize the impact of limited Flex funds. Work within this program area must focus on CAHs. However, state Flex Programs may assist CAH-owned provider-based RHCs.

For specific information on the program area 2: CAH Operational and Financial Improvement goal, activity categories, requirements, and suggested output and outcome measures, please see the Medicare Rural Hospital Flexibility Program Structure for FY 2024- FY 2028.

III. CAH Population Health Improvement

This optional program area focuses on helping to build capacity of CAHs to achieve measurable improvements in the health outcomes of their communities.

There are a variety of activities which Flex programs may choose to implement to address the health needs ranging from community-based interventions to shifting clinical care focus to value-based initiatives. While Flex funds cannot be used to pay for the completion of community health needs assessments (CHNAs), Flex programs and CAHs can utilize findings from CHNAs which have already been completed to assess common needs and challenges; this ensures population health initiatives are built to be relevant to the communities they reach.

While there are not required activity categories for this program area, the focus of projects should be to understand health improvement needs, develop strategies to address needs, and engage with community stakeholders to find effective ways to engage with the community. Population health encourages CAHs to look outside of the walls of their clinical care facilities and see how they can support better health outcomes across their communities. For Flex programs who would like assistance with starting a population health initiative, TASC provides a population health toolkit as well as a population health readiness assessment to aid in guiding these

efforts.

For specific information on program area 3: CAH Population Health Improvement, activity categories, requirements, and suggested output and outcome measures, please see the Medicare Rural Hospital Flexibility Program Structure for FY 2024- FY 2028.

IV. Rural Emergency Medical Services (EMS) Improvement

This optional program area focuses on work to improve rural EMS as it is a vital link to emergency health care for rural residents. The Flex Program supports establishing and expanding programs that support the provision of rural EMS. Goals of this program area include improving organizational capacity of EMS providers and improving the quality of rural EMS. Projects within this program area are intended to focus primarily on out-of-hospital emergency medical services. Projects including both EMS and CAH emergency departments (ED) are encouraged, but projects that focus solely on the CAH ED should be part of Program Area 2: Financial and Operational Improvement.

If the Rural EMS Improvement program area is chosen, it is required to do at least one needs assessment throughout the five-year cycle. Needs assessment can be done at the statewide level or at an individual agency/community level. A needs assessment should be completed prior to any implementation of EMS interventions as interventions should be guided by assessment findings. While there is not a required template for the needs assessment, it is recommended to at least assess the following items regarding EMS agencies:

- Ownership: CAH-based, public, non-profit, for profit
- Compensation: volunteer, paid, mixed, full-time, part-time
- Call volume per year
- Patient transport volume per year
- If agencies bill insurance including Medicare and Medicaid
- Funding streams

For specific information on the Program Area 4: Rural EMS Improvement goal, activity categories, requirements, and suggested output and outcome measures, please see the Medicare Rural Hospital Flexibility Program Structure for FY 2024-2028.

V. Flex Program EMS Supplements

With declining numbers of volunteers to staff ambulances, declining financial support from local governments, and increased educational standards for emergency medical technicians and paramedics, access to emergency care is at risk in many rural communities. Flex Program stakeholders have identified addressing the needs of struggling ambulance agencies as a key issue to maintaining access to emergency care in rural communities. To help address some of the issues, FORHP has supported several multi-year supplemental projects.

In January 2024, FORHP issued a competitive funding opportunity available only to state Flex Programs. This five-year supplement focuses on encouraging rural EMS agencies to establish or expand programs for the provision of rural EMS by strengthening the EMS workforce in rural areas through recruitment, retention, and

financial and operational strategies. Another program goal was to increase the percentage of runs/transports that are submitted for billing by rural EMS agencies to increase financial stability. These supplements will serve as examples to other EMS agencies interested in replicating these projects in their communities. TASC provides technical assistance and support to the additional Flex EMS Supplement projects.

Please note the EMS supplement is an additional funding stream to the above Flex Programs. States who did not apply for and/or receive the EMS Supplement for FY 2024-2028 can still do EMS work within their communities under the Flex Program Area IV Rural EMS Improvement.

The State Flex Programs awarded the Flex EMS Supplement funding up to $250,000 (per year for five years) for FY 2024 – FY 2028 are:

Arizona
Maine
Michigan
Montana
Nevada
Ohio
Oregon
Washington

VI. CAH Designation

In accordance with program authorizing authority, state Flex Programs must facilitate, when requested, appropriate conversion of small rural hospitals to CAH status. Flex Programs must assist hospitals in evaluating the effects of conversion to CAH status.

This may include assisting with financial feasibility studies for hospitals considering conversion to CAH status, as well as feasibility studies for reopening closed rural hospitals or converting CAHs to other types of facilities.

For specific information on the program area 5 CAH Designation, activity categories, requirements, and suggested output and outcome measures, please see the Medicare Rural Hospital Flexibility Program Structure for FY 2024 – FY 2028.

Data Collection Platform (DCP)

The HRSA Data Collection Platform (DCP) is a grant support and performance management application that allows FORHP to collect and review Flex program reporting data from grant recipients. DCP supports data submission tracking, and analysis to assess program performance and outcomes. DCP allows FORHP to gather standardized performance data from recipients to track common measures that focus on CAH performance improvement. A critical part of a successful and effective Flex Program is assessing and documenting program outcomes to show continuous program improvement. Assessments can examine short- and long-term outcomes of the Program, which is important for the Program's success, sustainability, and continued funding. TASC is available to assist in sorting through various tools and resources available to state Flex Programs to find an evaluation model that will work for them. The Flex Program Performance Management/Program Evaluation Guide and the Flex Monitoring Team Outcomes Toolkit are an excellent starting place to help states in establishing or reviewing their current evaluation model.

Flex Cooperative Agreement Resources

The Flex cooperative agreement guidance for each funding cycle can be found on the TASC website. The current cooperative agreement cycle runs from FY 2024-2028. Each program year is September 1-August 31. The

current cycle is non-competitive but the funding for FY24 was competitive. The competitive application for the Flex cooperative agreement occurs electronically through the grants.gov website.

For an easy-to-use manual on writing Federal grant applications, with tips on grant management, please review the Grants Learning Center.

For more information on applying for a federal grant, please visit the HRSA Apply for a Grant webpage. For Federal Funding Accountability and Transparency Act (FFATA) implementation requirements, please visit the HRSA website. For technical assistance resources from HRSA's Grants Management, please visit the Manage Your Grant Workshop webpage. Consider becoming a HRSA grant reviewer. For more information, please visit the HRSA Grant Reviewers webpage.

Core Competencies for State Flex Program Excellence

One role of the state Flex Program is to be a convener and liaison between local, state, and national rural health groups while supporting and promoting improvements in CAHs, population health, and the integration of health services through training and technical assistance.

The responsibilities of state Flex Programs are broad and far-reaching, with no step-by-step instructions for the work. The advantage and difficulty of managing the Flex Program is the flexibility of the assignment. Each state Flex Program needs to identify the strengths and challenges faced by their state's rural health care providers and set goals to build state and local capacity. However, the methods used will vary by state and region.

In the spring of 2015, a group of experienced State Office of Rural Health (SORH) directors, Flex Program coordinators, and staff from FORHP, FMT, and TASC gathered for a Flex Program Leadership Summit to develop a framework of Flex Program core competencies and recommendations to achieve excellence in state Flex Programs. In 2021, a second summit was held to update the framework, and the guide receives annual updates. As a result of those meetings, the Core Competencies for State Program Excellence Guide was developed.

The Guide provides a framework for assessing state Flex Program strengths as well identifying opportunities for improvements and skill development. The Guide also provides suggestions for developing and/or strengthening performances in each competency area while providing resources for each competency area. For more information, please review the Core Competencies for State Flex Program Excellence Guide.

A Core Competencies Self-Assessment is available to assist users in identifying and prioritizing opportunities for enhancing competency within their state Flex Program at the organization-level, not the individual-level. Based on the results, resources can be identified for those areas in which the program self-identifies an opportunity for improvement. FORHP strongly suggests that state Flex Programs complete this assessment at least annually. Results of the assessment will not be used by FORHP to determine future funding levels. Assessment results can be used to establish a baseline, create benchmarks, and aid in strategic planning and evaluation.

Flex Program Frequently Asked Questions

Flex Program Operations

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

The Medicare Rural Hospital Flexibility (Flex) Program is a federally funded program established in 1997 to strengthen rural health care systems by preserving access to essential services, improving quality, addressing community health needs, and supporting the sustainability of rural hospitals, including Critical Access Hospitals (CAHs). The program is administered at the state level through State Office of Rural Health (SORHs) or other state-designated organizations that receive funding from HRSA's Federal Office of Rural Health Policy (FORHP).

National technical assistance, evaluation, and program support are provided through organizations such as the Technical Assistance and Services Center (TASC), the Rural Quality Improvement Technical Assistance (RQITA) program, and the Flex Monitoring Team (FMT). Additional information about the history, structure, and policy foundations of the Flex Program is provided throughout this guide and in the Understanding Policies and Regulations section of the Core Competencies for State Flex Program Excellence Guide.

For more policy/legislative information, please visit the Understanding Policies and Regulations section of the Core Competencies for State Flex Program Excellence Guide.

What are the primary components of the Flex Program?

(See Program Areas of Flex for a description of each program area)

- Program Area 1: CAH Quality Improvement (required)
- Program Area 2: CAH Financial and Operational Improvement (required)
- Program Area 3: CAH Population Health Improvement (optional)
- Program Area 4: Rural EMS Improvement (optional)
- Program Area 5: CAH Designation (required if requested)

Reporting outcomes of the Flex Program are becoming increasingly important to quantify the benefits of the program. States must have a way to gather data and review the successes of their program and incorporate any needed improvements; needs assessments can be utilized to view the impact of Flex Program work

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

Flex Program Coordinators and other designated Flex Program personnel receive emails regarding program and CAH changes as information is made available. Information also comes directly from TASC, FORHP, RQITA, FMT, state hospital associations, and is reported in the Federal Register. Additionally, changes may be posted on the TASC website, reported through links to other websites, and/or may be posted to the Flex Forum. To join the TASC listservs or the Flex Forum, reach out to tasc@ruralcenter.org.

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, regularly scheduled events such as webinars, new and updated guides and toolkits, and information for in-person events. Information is also shared via the Flex Program Forum (login required), TASC, RQITA, and FMT websites, other stakeholder websites, conferences, and workshops throughout the year.

How do I apply for federal Flex Program funding?

Each state interested in acquiring federal Flex Program funding must submit an annual progress report, the Non-Competing Continuation (NCC) or competitive 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: Application submission
- August: Notice of Award (NOA) announcements
- September 1: The federal Flex Program year begins

Note: This schedule may change, especially during the competitive application year. Contact FORHP for current year schedule.

Who should I contact if I have questions regarding the Flex Program?

There is no "wrong door" to reach out to in the Flex program; if you have any questions related to Flex, you can reach out to tasc@ruralcenter.org and we will help you connect to the right person. As there are three TA providers for Flex as well as FORHP project officers (POs), the below list should help you determine the right contact.

- FORHP: questions about your budget, workplan changes, and grant management systems
- TASC: questions about your workplan, evaluating data, creating projects and activities, any other general Flex grant management support
    - TASC and FORHP will often do TA calls together as all workplan changes must be approved by your PO
- FMT: MBQIP and CAHMPAS questions
- RQITA: Any Quality Improvement questions

In addition to TASC, the following resources may be helpful for individuals navigating the Flex Program:

- For information about CAH licensing and certifications including accrediting bodies, contact your state hospital licensing bureau, your CMS regional office, or review CAH CoP (State Operations Manual, Appendix W – Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals and Swing-Beds)

- For changes in federal laws and policies 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) Rural Health Services — 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 advice from its member council, the section tracks, develops policies, and identifies solutions to their most pressing problems.
- Annual Flex Program Reverse Site Visit – contact TASC for more information.

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/SHIP Profiles on the TASC website.
- The Flex Program Forum is a secure web-based message forum for use by the state Flex Programs. State Flex personnel can share messages, pose questions, post documents, web links, and comment on each other's posts. The Forum is a method for state Flex Programs to continue to connect and share information, ideas, lessons learned, and best practices.
- TASC hosts three types of recurring webinars for Flex program staff: TASC 90, Flex VKG, and EMS Supplements.
    - TASC 90 Webinars are 90 minutes and address issues and topics of interest to state Flex Program Coordinators and CAHs.
    - Flex VKG webinars are an hour and work as peer discussions for state Flex Coordinators to share best practices and lessons learned.
    - EMS Supplmental webinars are 45-minute webinars designed for states receiving the EMS supplement but are open to any Flex program staff to attend.

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

State Flex Programs benefit from engaging in ongoing learning and collaboration with peers and national partners. Technical assistance, webinars, conferences, publications, peer networking opportunities, and educational resources can provide ideas for addressing state priorities and strengthening program impact. Coordinators are encouraged to take advantage of resources such as TASC program staff, webinars, the Flex Program Reverse Site Visit, The Flex Program Forum, the Flex Workshop, the Rural Route e-newsletter, the TASC Website, as well as the forthcoming Flex Learning Module Center which will provide continuing education.

Learning from other state Flex Programs through the State Flex/SHIP Profiles can also provide practical examples, promising practices, and innovative approaches. In addition, resources available through FORHP, FMT , National Rural Health Association (NRHA), National Organization of State Offices of Rural Health (NOSORH), and Rural Health Information Hub (RHIhub), as well as examples from other state Flex Programs, can help identify promising practices and innovative approaches that align with your state's needs. Additional resources can be found in the Useful Organizations section of the Guide.

Critical Access Hospitals

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 and in some states for Medicaid beneficiaries.

Which hospitals are eligible for a CAH designation?

A Medicare-participating hospital can become 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 has established a Medicare Rural Hospital Flexibility Program.
- Designated by the state as a CAH.
- 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 which can also be used for swing bed services.
    - CAHs may operate a distinct part rehabilitation and/or psychiatric unit (DPU), each up to 10 beds.
- Maintain an annual average acute care inpatient length of stay (LOS) of 96 hours or less (excluding swing bed services and distinct part unit (DPU) beds). Medicare does not assess this requirement on initial designation, and it only applies after CAH designation.
- A CAH that has not been designated as a necessary provider (a state designation that ended 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.

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.

Can a CAH have DPUs (e.g., psych units)?

Yes. As part of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), a CAH may operate a distinct part rehabilitation and/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).

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.

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 requested from TASC.

Will the CAH be given a new CMS Certification Number (CCN)upon conversion?

Yes, a new CCN will be assigned upon conversion.

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 cannot be staffed by the hospital as it will place them over the 25-bed count.

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, lounger, etc.), it is the status of the patient in the bed.

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., during COVID-19, but must document the circumstances to the satisfaction of federal and state officials.

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

Yes, a CAH may build a new hospital and retain its CAH designation, provided it continues to meet all Medicare Conditions of Participation for CAHs, section §485.610(c) standard: Location Relative to Other Facilities and distance requirements.

Are CAH issues the same across all states?

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

Rural Emergency Hospitals (REH)

What is a REH?

REHs are designed to maintain access to critical outpatient hospital services in communities that may not be able to sustain a CAH or small rural hospital. REHs are required to provide 24-hour emergency and observation services and can elect to furnish other outpatient services. Facilities designated as an REH will receive enhanced Medicare payments for certain outpatient services and additional monthly payments. REHs cannot have inpatient beds, must have fewer than 50 beds in the facility, and patient stays cannot exceed 24 hours.

Can a CAH convert to a Rural Emergency Hospital (REH)?

Yes, CAHs can convert to REHs. Eligible hospitals for REH conversion include CAHs and small and/or tribal hospitals with 50 beds or less that are located in a county (or equivalent unit of local government) that is in a rural area defined using the Office of Management and Budget (OMB) designation of non-metropolitan statistical area (MSA), or a hospital with 50 beds or less that is re-classified by CMS as rural.

Where can I go for more information about REHs?

For more information about REHs, visit RHIHub or the Rural Health Redesign Center.

Overview and Funding

The Federal Office of Rural Health Policy (FORHP) was created in 1987 to advise the Secretary of the U.S. Department of Health and Human Services on health care issues impacting rural communities, including:

- Access to quality health care and health professionals
- Viability of rural hospitals
- Effect of the Department's proposed rules and regulations, including Medicare and Medicaid, on access to and financing of health care in rural areas

In line with the mission of HRSA, FORHP helps increase access to care for underserved populations and builds health care capacity through several programs:

Community Based Division (CBD)
Provides support to community organizations to improve health care service delivery and strengthen health networks and encourages collaboration among rural health care providers.

Hospital State Division (HSD)
Supports on-going improvements in care to 50 SORHs and to rural hospitals through the Flex Program. HSD also supports technical assistance for small rural hospitals, including CAHs.

Policy Research Division (PRD)
Coordinates the review of proposed regulations to assess the potential impact on rural health care delivery and financing. The division supports ten Rural Health Research Centers, information dissemination and policy programs, Rural Residency Planning and Development, and RHC technical assistance.

Rural Strategic Initiatives Division (RSID)
Coordinates the Rural Communities Opioid Response Program (RCORP) and other new initiatives that emerge from Agency, Department, or Administration priorities.

Additional Resources

FORHP staffs the National Advisory Committee on Rural Health & Human Services.

For information on locations eligible to receive Rural Health Grants, please refer to the HRSA Eligibility Analyzer.

For more information on rural health grant opportunities, please refer to the Rural Health Find Grant Funding webpage.

Introduction to the Technical Assistance and Services Center

- TASC Communication Tools and Technical Assistance
- TASC Website
- FORHP Flex Program In-Person Events

TASC Communication Tools and Technical Assistance

The goal of TASC is to provide direct and timely information, education, tools, and resources that are easy for Flex Programs to use. TASC offers a variety of communication tools and technical assistance services. The TASC staff are happy to answer any questions you may have about the Flex program or to connect you with the person and/or resource which would be most beneficial. TASC can be reached at:

- E-mail: tasc@ruralcenter.org
- Telephone: (218) 727-9390 or (877) 321-9393

Communication Tools

- TASC website
- TASC e-mail listservs
- TASC 90, Virtual Knowledge Groups (VKGs), and other educational webinars
- Flex Program Forum (a virtual discussion panel for all Flex program staff to discuss challenges, issues, best practices, and lessons learned).
- Monthly electronic newsletter, Rural Route
- Social media
    - LinkedIn
    - Facebook

For assistance getting signed up for the email listservs, webinars, Flex Program Forum, and Rural Route, please reach out to tasc@ruralcenter.org.

Technical Assistance

- Ad hoc TA via email and phone
    - E-mail: tasc@ruralcenter.org
    - Telephone: (218) 727-9390 or (877) 321-9393
- Educational presentations (onsite or virtual)
- Online resource library
- Consultant and subject matter expert speaker referrals
- Educational guides, manuals, and toolkits
- Learning collaboratives on specific topics to improve state Flex Program performance
- Semi-annual Flex Program Workshop for new state Flex Program personnel
- Annual Flex Program Reverse Site Visit (conference) for all state Flex Program personnel

TASC Website

The TASC website contains a wide variety of useful information, tools, and resources to support all program areas of the Flex cooperative agreement, including:

- Electronic version of the Flex Program Fundamentals Guide
- Flex cooperative agreement and Flex Emergency Medical Services (EMS) supplement funding guidance and supporting documents
- Core Competencies for State Flex Program Excellence Guide and self-assessment
- Flex Program Forum (login access required)
- Flex Program Reverse Site Visit information and materials
- Resources to support the Medicare Beneficiary Quality Improvement Project (MBQIP), including the MBQIP Monthly e-newsletter and reporting reminders
- Population Health Toolkit, data scenarios, resources, and population health readiness assessment
- Rural Community Ambulance Agency Transformation Toolkit, including self-assessment and resource collections
- State Flex profiles include current descriptions of Flex Program activities under a selected core competency, and a description of SHIP funded activities, along with state Flex Program staff contact information
- Upcoming and archived educational events, including TASC 90 webinars, Virtual Knowledge Group webinars, SHIP webinars, and Learning Collaborative recordings and supporting materials
- Leadership video series to educate CAH mid-level and board leaders in the transition to value-based care and payment
- Flex Program Learning Modules (launching soon)

FORHP Flex Program In-Person Events

The FORHP Flex Program has two major in-person events which are stipulated in the Notice of Award (NOA); these are the Flex Program Workshop and the Flex Program Reverse Site Visit (RSV).

Flex Program Workshop

The Flex Program workshop is currently hosted twice a year, usually in the fall and spring. These workshops generally occur in Rockville, Maryland at the HRSA office. Sessions are presented by TASC, FORHP, FMT, RQITA, and additional subject matter experts. Upon workshop completion, participants will better understand the Flex Program's goals and assistance available to support Flex Program excellence.

There are currently two types of Flex Workshops offered:

- Introductory Flex Workshop - designed for new staff to attend as an orientation to the Flex Program . Per the NOA, staff who are new to Flex should attend the Introductory workshop within their first year of hire.
- Advanced Flex Workshop - designed for individuals who have been in a Flex program for multiple years and are interested in expanding their program knowledge, sharing best practices with fellow Flex staff,

and strengthening the Flex Program within their state. This workshop is typically by invitation only but if you would like to attend, reach out to tasc@ruralcenter.org for more information.

The introductory Flex Workshop and Advanced Flex Workshops are held during the same week with a half-day overlap of time to allow newer Flex program staff to engage with experienced Flex program staff.

Attendance and Participation Requirements

As a condition of the state Flex Program cooperative agreement, state programs with new Flex Coordinators or others that are meaningfully involved in the administration of the program are expected to attend the Introductory Flex Workshop within one year of their hire date. There are a few expectations for attendees participating:

- Complete the Core Competencies for State Flex Program Excellence self-assessment prior to the workshop beginning.
- Upon completing the workshop, participants will choose an activity to implement based on knowledge gained from the workshop related to the Core Competency self-assessment results. Participants receive individualized coaching and resources from TASC to support the implementation of their chosen activity.

Workshop topics commonly include:

- History and direction of the Flex Program
- Program Areas of Flex
- Understanding the value-based health care system and resources to support rural health systems' transformation to value-based payment models
- CAH finance and the top 10 financial indicators for CAHs
- National quality initiatives and MBQIP
- Core Competencies for State Flex Program Excellence
- Rural emergency medical services (EMS) challenges and opportunities
- Community and population health
- Flex Program evaluation
- Best practices and tips for Flex Coordinators

While there is no charge to attend the introductory or advanced workshop, state Flex Programs are required to pay for their travel to and from the event location. Travel and lodging expenses are allowable as part of the Flex cooperative agreement. For more information about the FORHP Flex Program Workshop, please contact TASC at tasc@ruralcenter.org or (877) 321-9393.

Flex Program Reverse Site Visit (RSV)

The Flex Program RSV is held annually in the summer. This event is specifically designed for state Flex Program staff and those who support the Flex Program. It provides state Flex Programs with topical learning environments that emphasize collaboration, best practices, and shared experiences. Participants are encouraged to engage with the content and each other to broaden their impact on both critical access hospitals (CAH) and the Flex Programs.

While there are some subject matter experts and technical assistance providers who present content, the bulk of the RSV is led by presentations from other state Flex Program staffers, so it is an excellent learning opportunity for all Flex staff. Per the NOA, at least one person from each state is required to attend, but more staff members may attend. Information regarding the RSV and attendance is usually sent out a couple months before the start of the RSV.

While there is no charge to attend the RSV, state Flex Programs are required to pay for their travel to and from the event location. Travel and lodging expenses are allowable as part of the Flex cooperative agreement. For more information about the FORHP Flex Program RSV, please contact TASC at tasc@ruralcenter.org or (877) 321-9393

Introduction to The Flex Monitoring Team

About the Flex Monitoring Team

The Flex Monitoring Team (FMT) is a consortium of researchers from the Universities of Minnesota, North Carolina at Chapel Hill, and Southern Maine. With a five-year (2023-2028) cooperative agreement award (PHS Grant No. U27RH01080) from the Federal Office of Rural Health Policy (FORHP), the FMT monitors and evaluates the Flex Program by developing relevant quality, financial, and community-benefit performance measures and reporting systems. FMT research assesses the impact of the Flex Program on Critical Access Hospitals (CAHs) and rural communities. The team also examines the ability of the State Offices of Rural Health to achieve overall Flex Program objectives: improving access to quality health care services, improving the financial and operational performance of CAHs, and engaging rural communities in healthcare system development.

How the Flex Monitoring Team Can Help You

The FMT's researchers have years of experience examining topics that are directly relevant to CAHs and the Flex Program. Ongoing and annual research projects typically result in publications that state Flex Coordinators can use to gain a better understanding of CAH financial and operational performance, quality performance, and community impact to support your work (presentations and meetings, grant applications, publications, etc.) with CAH-relevant evidence. The FMT website provides access to current and historic lists of CAHs, all FMT publications, presentation slides, data reports, project descriptions, and more.

FMT also maintains the Critical Access Hospital Measurement and Performance Assessment System (CAHMPAS), an online data query system that allows state Flex Coordinators to explore the financial, quality, and community-benefit performance of CAHs. The financial data portal requires an authorized login and password made available to state Flex Coordinators, State Office of Rural Health directors, and CAH CEOs and CFOs. Financial data for CAHs in your state are identified by name; however, data for CAHs in other states are shown but not identified. New developments to the financial portal include data visualizations showing predicted risk of CAH financial distress and showing state-level CAH reporting and performance on select financial indicators as compared to national benchmarks. Quality and community data are aggregated to the state level and publicly available without a login on the CAHMPAS site. For quality performance, users can create customized tables and graphs with Medicare Beneficiary Quality Improvement Project (MBQIP) data, make comparisons between states, and create tables and graphs for individual or pre-defined sets of measures. Community data also allow users to create customized reports with measures related to community socioeconomic characteristics, health outcomes, health risks and behaviors, and more. Visit the CAHMPAS website for more information and, for financial CAHMPAS login credentials, contact the FMT at monitoring@flexmonitoring.org.

The FMT uses an email listserv to disseminate reports and publications. As a state Flex Coordinator, you are automatically subscribed to this list as a requirement of your grant award. Other Flex Program/CAH staff in your state can easily subscribe by contacting the FMT or submitting information via the FMT's homepage.

Ongoing Projects

Analyzing Financial, Quality, and Community Impact Performance of CAHs
Purpose: to improve financial, quality, and community impact performance of CAHs through data analysis and dissemination in the three domains. For this project, the FMT will produce data products on financial, quality, and community impact, using a variety of data sources, including the American Hospital Association Annual Survey, the Hospital Compare database, and the Medicare Beneficiary Quality Improvement Project (MBQIP). The FMT also creates quarterly MBQIP data reports for all CAHs and State Flex Programs. These are distributed to CAHs by State Flex Programs each quarter.

CAHMPAS Query System Maintenance, Enhancement, and Development
Purpose: to prepare and upload updated data for CAHMPAS, develop new and maintain existing features on the website, and provide technical assistance to registered users. In the coming year, this project will continue to update data and enhance user functions for the financial, quality, and community data to provide information in the most usable format for CAHs and state Flex Coordinators.

Maintaining and Updating the National CAH Database
Purpose: to continue tracking CAH conversions and closures. A CAH dataset housed at the University of North Carolina will be updated with information on conversions supplied by the Centers for Medicare and Medicaid Services (CMS). These data are also used to update products on the FMT website, including a spreadsheet that lists all certified CAHs and a map of current CAHs. The site also includes a table that contains state-level totals of the number of CAHs, the number of CAHs with rehabilitation distinct part units (DPU), and the number of CAHs with psychiatric DPUs.

New Projects, 2026-2027

Data Collection Platform (DCP) Analysis
The objective of this project is to analyze, summarize, and report on trends in performance among State Flex Programs (SFPs) and Critical Access Hospitals (CAHs) using new DCP data collected via the Salesforce platform. This analysis will support FORHP and Flex Partners in understanding Flex Program impact and identifying priority areas for technical assistance. The FMT will organize data from the DCP by program area and report summary data for key elements.

Financial and Operational Improvement: Evaluation of the Impact of Flex Activities on CAH Financial Performance and Identifying CAHS in Greatest Need of Capital Investment
Financial and Operational Improvement is a core focus of the Medicare Rural Hospital Flexibility (Flex) Program. This project will evaluate whether participation in Flex financial improvement activities is associated with stronger financial performance among CAHs and identify hospitals with the greatest need for capital investment. The findings will help SFPs target technical assistance and resources to support the long-term financial sustainability of rural hospitals.

Community Engagement in CAHs: Social Return on Investment System Development, Examination of Charity Care and Bad Debt, and how State Flex Programs are Adapting their Activities in the Current Healthcare Environment

Community engagement and program evaluation are essential to demonstrating the value of the Medicare Rural Hospital Flexibility (Flex) Program and supporting CAHs. This project will develop a framework to measure the social return on investment of Flex Program funding, examine current trends in charity care and bad debt among CAHs, and explore how SFPs are adapting their activities to meet emerging healthcare challenges. The project will provide practical tools and evidence to help strengthen Flex Program planning, evaluation, and support for rural hospitals.

Health Information Technology Maturity and Virtual Care in CAHs

Health information technology and virtual care are increasingly important for improving access to high-quality care in rural communities. This project will examine how CAHs participate in health information exchange networks and prepare for emerging national interoperability standards, while also assessing telehealth adoption across service lines. Through data analyses and interviews with CAHs demonstrating strong telehealth adoption, the project will identify best practices and strategies that can help SFPs and CAHs strengthen their technological capabilities and improve access to care for rural patients.

MBQIP Quality Work

This project will advance the next phases of current activities related to the Medicare Beneficiary Quality Improvement Project (MBQIP) and quality improvement within the Flex Program. It will involve several activities including year four of the National CAH Quality Inventory & Assessment and updates to several other resources for State Flex Programs and CAHs.

Research Publications

The Flex Monitoring Team publishes research findings in the form of policy briefs (study overviews paired with key findings), topic-specific toolkits, and state-specific data reports.

All publications are searchable on the website by topic, date, or keyword and are freely available for download. The Flex Monitoring Team's most recent publications include:

- MBQIP Quality Measures National Annual Report - 2024
- 2024 CAH Financial Indicators Report: Summary of Indicator Medians by State
- 2025 National CAH Quality Inventory & Assessment Report
- Strategies for Critical Access Hospital Financial and Operational Performance Improvement: A Systematic Review
- Trends in Inpatient Revenue and Volume Among Critical Access Hospitals
- A Chartbook on the Characteristics and Needs of Frontier Critical Access Hospitals
- Reporting and Performance of Maternity-related Quality Measures in Critical Access Hospitals
- Delivering Quality: Maternity Care Innovation in Critical Access Hospitals

Contact The Flex Monitoring Team

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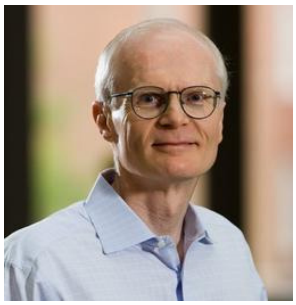

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RQITA
RESOURCE CENTER

RURAL QUALITY IMPROVEMENT TECHNICAL ASSISTANCE (RQITA)

ABOUT RQITA

Demonstrating value through reporting and improving quality measures has become increasingly important for small rural hospitals and clinics. But understanding quality reporting systems and using data for improvement can be particularly challenging for rural health care organizations with limited resources.

Through the RQITA cooperative agreement with the Federal Office of Rural Health Policy (FORHP), Telligen aims to fill these gaps, focusing on improving quality and health outcomes in rural communities across the country by providing technical assistance to beneficiaries of quality initiatives, including:

- Small Health Care Provider Quality Improvement Grantees (Rural Quality Program)
- Medicare Rural Hospital Flexibility (Flex) Program, including the Medicare Beneficiary Quality Improvement Project (MBQIP)

For more information about the RQITA project, visit the RQITA Resource Center website.

Learn more about the team by reviewing the RQITA Team Biographies.

ABOUT TELLIGEN

Telligen helps millions of people live their healthiest lives by improving health outcomes nationwide through proven health solutions and healthcare expertise.

For more than 50 years, Telligen solutions have been delivering true results for health plan sponsors and federal and state programs.

Nationally recognized experts in rural health quality; longstanding trusted relationships with rural providers, critical access hospitals (CAHs), state offices of rural health, and FORHP.

Other federal roles include serving as a Medicare Quality Innovation Network Quality Improvement Organization (QINQIO) and a Hospital Quality Improvement Contractor (HQIC).

Through RQITA, Telligen works to implement technical assistance to support quality reporting and improvement, collaborating with FORHP and other partners, including:

- Technical Assistance and Services Center (TASC)
- Flex Monitoring Team (FMT)
- State Flex Programs

For more information about Telligen, visit our website.

RQITA
RESOURCE CENTER

MBQIP RESOURCES & TOOLS

- **MBQIP Measures:** This chart outlines the MBQIP Core Measure Set. Measures are divided into two categories: core and additional. Measures are further divided into five domains: global measures, patient safety, patient engagement, care coordination, and emergency department.
- **MBQIP Measure Core Set Information Guide:** This guide provides an overview of measures included in the MBQIP Measure Core Set. This includes information about data collection, reporting processes, and descriptions for each of the measures.
- **MBQIP Fundamentals Guide for State Flex Programs:** Intended to help state Flex Program personnel and relevant subcontractors understand the basics of MBQIP, including current state and history of the program, as well as key resources available to support them in their work.
- **MBQIP Navigator:** Helps Flex coordinators, CAH staff, and others involved with MBQIP understand the measure reporting process. For each reporting channel, information is included on how to register for the submission site, which measures are reported to the site, and how to submit those measures to the site.
- **Quality Improvement Workbook:** This workbook provides valuable resources to support quality improvement efforts. Resources include a timeline to follow and ways to track progress during organizational quality improvement efforts.
- **MBQIP Data Reporting Reminders:** Reminders of upcoming data submission deadlines for MBQIP measures.

Additional Support

- **MBQIP Individualized Technical Assistance and Consultations:** RQITA team members are available for one on one discussions with Flex staff and/or MBQIP subcontractors to help support state level implementation (email RQITA staff at rqita@telligen.com or reach out to tasc@ ruralcenter.org to get connected).
- **MBQIP Orientation Sessions:** RQITA offers orientation sessions for new state Flex staff, typically facilitated in followup to orientation with the TASC team. These orientation sessions are also available for state Flex staff and MBQIP subcontractors upon request. Email tasc@ ruralcenter.org to get connected.
- **Quality Training and Presentations:** RQITA team members are available to present at webinars and/or in person training events and workshops.

RURAL QUALITY ADVISORY COMMITTEE

The Telligen RQITA Resource Center team facilitates a quarterly Rural Quality Advisory Council on behalf of FORHP.

The Council is comprised of leaders in rural health quality, representing diverse perspectives from across the country.

The purpose of the Council is to:

- Provide feedback, guidance, and insight on the development, implementation, and evaluation of the RQITA technical assistance strategies for the MBQIP and SCHPQI programs.
- Offer advice and counsel on development of rural relevant quality improvement goals and metrics, and their integration more broadly into new and existing FORHP funded programs.

MBQIP TECHNICAL ASSISTANCE REQUESTS

Process for MBQIP technical assistance requests/questions:

- CAHs are encouraged to contact their state Flex Program as the first line of MBQIP support.
- Flex Coordinators should direct MBQIP questions to the RQITA Resource Center, rqita@ telligen.com.

FOR MORE INFORMATION

Contact Telligen at: rqita@telligen.com

This publication is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) as part of an award totaling $640,000 with 0% financed with nongovernmental sources. The contents are those of the author(s) and do not necessarily represent the official view of, nor an endorsement by HRSA, HHS or the U.S. Government. For more information, please visit HRSA.gov. *As a technical assistance provider to rural healthcare organizations, Telligen provides access to a wide range of resources on relevant topics. Inclusion on the Telligen webpage or presentations does not imply endorsement of, or agreement with, the contents by Telligen or the Health Resources and Services Administration.*

RQITA
RESOURCE CENTER

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Flex Coordinator Reference

- Useful Organizations
- Acronyms 101
- U.S. Time Zone Map

Useful Organizations for Rural Health Programs

Flex Program-Specific Resources

Federal Office of Rural Health Policy (FORHP)

FORHP is the federal office within HRSA that leads rural health initiatives, administers the Flex Program, and supports policies and programs that improve access, quality, and sustainability of rural health care. FORHP offers state and local grants to enhance rural healthcare and offer community-based programs promoting networks through:

- Rural Community Programs - Provides support to community organizations to improve health care service delivery and strengthen health networks and encourages collaboration among rural health care providers.
- Rural Hospital Programs - Supports on-going improvements in care to 50 SORHs and to rural hospitals through the Flex Program. State and Rural Hospital Programs also support technical assistance for small rural hospitals, including CAHs
- Rural Health Research and Policy Programs - Coordinates the review of proposed regulations to assess the potential impact on rural health care delivery and financing, the division also supports eight Rural Health Research Centers across the country and staffs the National Advisory Committee on Rural Health & Human Services.
- Rural Communities Opioid Response Program (RCORP) - Supports various programs and grant making activities on substance use disorder (SUD) and opioid use disorder (OUD) such as behavioral health access, medication assisted therapy (MAT), centers of excellence, and overdose response.

National Rural Health Resource Center (The Center)

The Center is a nonprofit organization dedicated to sustaining and improving health care in rural communities. As the nation's leading technical assistance and knowledge center in rural health, the Center focuses on five core areas:

- Transition to Value and Population Health
- Collaboration and Partnership
- Performance Improvement
- Health Information Technology
- Workforce

Technical Assistance and Services Center (TASC)

TASC is a program of the Center that provides tools, education, and technical assistance to Critical Access Hospitals (CAHs) and to state Flex Programs.

Flex Monitoring Team (FMT)

FMT is a FORHP-funded research consortium from the Universities of Minnesota, North Carolina-Chapel Hill, and Southern Maine. FMT evaluates the Flex Program and operates and maintains the CAHMPAS data system that provides analysis on financial, quality, and community engagement in CAHs. They provide state Flex Programs and CAHs with ways to optimize their performance based on evidence and best practices.

Rural Quality Improvement Technical Assistance (RQITA)

RQITA provides technical assistance, tools, and training to help rural hospitals strengthen quality improvement efforts and meet MBQIP and other quality reporting requirements.

Resources to support MBQIP can be found on the MBQIP webpage.

Federal Agencies

U.S. Department of Health and Human Services (HHS)

HHS is the federal department responsible for improving the health and well-being of Americans through health care, public health, and social service programs.

Health Resources and Services Administration (HRSA)

HRSA is the department within HHS that improves access to care for rural populations through funding, workforce development, and health system support programs. This includes programs that deliver health services to people with HIV, pregnant women, mothers and their families, those with low incomes, residents of rural areas, American Indians and Alaska Natives, and those otherwise unable to access high-quality health care.

Centers for Medicare & Medicaid Services (CMS)

CMS is the department within HHS that administers Medicare, Medicaid, CHIP, and Marketplace programs and oversees policies that significantly affect rural hospitals and providers.

Agency for Healthcare Research and Quality (AHRQ)

AHRQ, a component of HHS, produces research, evidence and tools to improve health care quality, safety, access, and affordability.

Office for the Advancement of Telehealth (OAT)

OAT promotes telehealth adoption through grant programs and initiatives that expand access to care in rural communities and supports the efforts of HHS to expand access and improve health outcomes.

Bureau of Labor Statistics (BLS)

BLS is a federal agency that provides workforce, employment, wage, and economic data useful for rural health workforce planning and analysis.

U.S. Centers for Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS)

CDC's NCHS is the nation's principal source of health statistics and population health data.

MedlinePlus

MedlinePlus is a service of the National Library of Medicine. It provides free, reliable, patient-friendly health information.

Nursing Home Resource Center

The Nursing Home Resource Center is a CMS resource hub offering guidance, policy updates, and data for nursing homes, long-term care providers, residents, and their families.

National Rural Health Organizations

National Association of Rural Health Clinics (NARHC)

National Association of Rural Health Clinics promotes rural health clinics as a means of improving and sustaining the availability of quality, cost-effective health care to patients in rural, medically underserved areas. NARHC works with Congress, federal agencies, and rural health allies to expand and protect the interests of rural health clinics. NARHC members can become actively engaged in the legislative and regulatory process through the Association.

National Rural Health Association (NRHA)

The NRHA is a national, nonprofit membership organization that brings together practitioners, facilities, educators, state and federal agencies, and other professionals dedicated to advancing health care in rural communities. They provide leadership on rural health issues through advocacy, communications, education, and research.

National Organization of State Offices of Rural Health (NOSORH)

NOSORH assists State Offices of Rural Health in their efforts to improve access to, and quality health care for America's rural citizens. NOSORH supports development of state and community rural health leaders, creating partnerships that foster information sharing and spur rural health-related programs and activities enhancing access to quality healthcare services.

National Cooperative of Health Networks Association (NCHN)

NCHN is a professional organization comprised exclusively of health networks, alliances, and consortium dedicated to supporting the success of health networks.

Rural Health Information Hub (RHIhub)

The RHIhub, funded by FORHP, is a national clearinghouse that provides rural health data, funding opportunities, toolkits, topic guides, and evidence-based resources for rural communities and organizations.

Rural Health Redesign Center (RHRC)

The RHRC, is a nonprofit committed to addressing the challenges facing rural hospitals and communities across the nation. RHRC receives FORHP funding to provide technical assistance to rural hospitals exploring the Rural Emergency Hospital (REH) designation in the REH-Technical Assistance Center (REH-TAC).

Quality Improvement and Technical Assistance Organizations

American Hospital Association (AHA)

The AHA is a national organization that represents and serves hospitals, health care networks, their patients, and communities through advocacy, education, and operational resources.

Institute for Healthcare Improvement (IHI)

The IHI develops quality improvement methods, training, and resources to improve health care outcomes and patient safety.

The Joint Commission

The Joint Commission provides accreditation and certification of healthcare organizations and programs and offers products and services designed to streamline operations and promote quality and patient safety.

The American Health Quality Association (AHQA)

The AHQA is an educational, not-for-profit, national association that promotes initiatives to improve health care quality and patient safety. AHQA represents Quality Improvement Organizations (QIOs) and professionals working to improve health care quality and patient safety.

Rural Health Innovations (RHI)

RHI is the consulting arm of the National Rural Health Resource Center (the Center), a non-profit organization, offers population health and strategic planning services to rural hospitals and clinics, and rural health networks — with a focus on providing training and hands-on support that's designed to enhance the quality and performance of health care organizations and improve the health of their communities. RHI's team also supports rural organizations across the country in the development of community health needs assessments and community health implementation plans, the formation and maintenance of rural health networks, the design and execution of population health-related projects, and long-term, organizational strategic planning.

Rural Health Value

Rural Health Value is a national initiative funded through a cooperative agreement with FORHP. The current program is titled Rural Health Innovation and Transformation Technical Assistance (RHIT-TA). The team

facilitates the transition of rural healthcare organizations, payers, and communities from volume-based to value-based health care and payment models.

Research, Data, and Policy Resources

Rural Health Research Gateway

The Rural Health Research Gateway provides easy and timely access to research and findings of the Federal Office of Rural Health Policy (FORHP) funded Rural Health Research Centers, 1997-present. Our goal is to help move new research findings of the Rural Health Research Centers to various end users as quickly and efficiently as possible. Learn more about Rural Health Research Gateway and the many rural health research centers.

Georgia Health Policy Center (GHPC)

The GHPC provides evidence-based research, program development and policy guidance to improve health status at the community level. The center conducts, analyzes and disseminates qualitative and quantitative findings to connect decision makers with the objective research and guidance needed to make informed decisions about health policy and programs.

Telehealth Resources

Center for Connected Health Policy (CCHP)

The CCHP, a federally funded program under the Public Health Institute that advances state and national telehealth policies that promote better systems of care and improved health outcomes, as well as provide greater opportunities to quality, affordable health care and services.

National Consortium of Telehealth Resource Centers (NCTRC)

The NCTRC is a collaborative of 12 regional and 2 national Telehealth Resource Centers (TRCs), committed to implementing telehealth programs for rural communities. Funded by HRSA, the TRCs provide timely and accurate information on telehealth, helping organizations and practices overcome barriers, advance telehealth education, and provide resources.

Workforce and Recruitment Resources

National Rural Recruitment & Retention Network (3RNET)

3RNET is a nonprofit, membership organization that connects health care professionals with seeking careers in rural communities in rural communities.

National EMS Quality Alliance (NEMSQA)

NEMSQA develops and endorses evidence-based quality measures for EMS and health care partners that improve the experience and outcomes of patients and care providers. Their vision is to improve patient outcomes through the collaborative development of quality measures for EMS and health systems of care.

Acronyms 101

3RNet	National Rural Recruitment and Retention Network
AAA	American Ambulance Association
AAFP	American Academy of Family Physicians
ACA	Affordable Care Act or Patient Protection and Affordable Care Act
ACHE	American College of Healthcare Executives
ACLS	Advanced Cardiac Life Support
ACO	Accountable Care Organization
ACS	American College of Surgeons
ADC	Average Daily Census
ADE	Adverse Drug Event
AED	Automated External Defibrillator
AFIB	Atrial Fibrillation
AFS	Ambulance Fee Schedule
AHA	American Hospital Association
AHC	Accountable Health Communities Model or Academic Health Center
AHEAD	Achieving Healthcare Efficiency through Accountable Design Model
AHIMA	American Health Information Management Association
AHQA	American Health Quality Association
AHRQ	Agency for Healthcare Research and Quality
AIM	ACO Investment Model
AIMS	Access Increases in Mental Health and Substance Abuse Services
AIR	All Inclusive Rate
ALOS	Average Length of Stay
ALS	Advanced Life Support
AMA	American Medical Association or Against Medical Advice
AMC	Academic Medical Center
AMI	Acute Myocardial Infarction
AMIA	American Medical Informatics Association
ANA	American Nurses Association

APC	Ambulatory Payment Classification
APM	Alternative Payment Model or Advanced Alternative Payment Model
AR	Accounts Receivable
ARP	American Rescue Plan
ARRA	American Recovery and Reinvestment Act of 2009
ASC	Ambulatory Surgical Center
ASP	Antibiotic Stewardship Program
ATLS	Advanced Trauma Life Support
BBA	Balanced Budget Act of 1997
BBRA	Balanced Budget Refinement Act of 1999
BCBS	Blue Cross Blue Shield
BCHS	Bureau of Community Health Services
BCP	Business Continuity Plan
BFCC	Beneficiary and Family Centered Care Quality Improvement Organization (BFCC-QIO)
BHP	Bureau of Health Professions
BHRD	Bureau of Health Resources Development
BHW	Bureau of Health Workforce
BIA	Bureau of Indian Affairs
BIPA	Benefits Improvement and Protection Act of 2000
BLS	Bureau of Labor Statistics or Basic Life Support
BPHC	Bureau of Primary Health Care
BSC	Balanced Scorecard
BTLS	Basic Trauma Life Support
CAC	Children's Asthma Care
CAH	Critical Access Hospital
CAHFIR	Critical Access Hospital Financial Indicator Report (FIR)
CAHMPAS	Critical Access Hospital Measurement and Performance Assessment System
CALS	Comprehensive Advanced Life Support
CAP	Community Access Program

CART	Centers for Medicare and Medicaid Services Abstraction and Reporting Tool
CAUTI	Catheter-Associated Urinary Tract Infection
CBO	Congressional Budget Office
CBSA	Core Based Statistical Area
CC	Care Coordination
CCHIT	Certification Commission for Healthcare Information Technology
CCM	Coordinated Care Model or Chronic Care Management
CCN	CMS Certification Number
CCO	Coordinated Care Organization or Community Care Organization
CDC	Centers for Disease Control and Prevention
CDE	Clinical Data Exchange
CDI	Clostridioides difficile (C. diff.) Infection
CDS	Clinical Decision Support
CEHRT	Certified Electronic Health Record Technology
CEO	Chief Executive Officer
CEU	Continuing Education Unit
CFO	Chief Financial Officer
CFR	Code of Federal Regulations
CHC	Community Health Center
CHIP	Children's Health Insurance Program
CHNA	Community Health Needs Assessment
CHW	Community Health Worker
CIHQ	Center for Improvement in Healthcare Quality
CIT	Critical Illness and Trauma Foundation
CLABSI	Central Line-Associated Bloodstream Infection
CLIA	Clinical Laboratory Improvement Act of 1967 or Clinical Laboratory Improvement Amendments of 1988
CME	Continuing Medical Education
CMHC	Community Mental Health Center
CMMI	Center for Medicare and Medicaid Innovation
CMO	Chief Medical Officer

CMS	Centers for Medicare and Medicaid Services
CON	Certificate of Need
CoP	Conditions of Participation
COPD	Chronic Obstructive Pulmonary Disease
CP	Community Paramedic or Community Paramedicine
CPC	Comprehensive Primary Care Initiative
CPC+	Comprehensive Primary Care Plus Initiative
CPHQ	Certified Professional in Healthcare Quality
CP-MIH	Community Paramedicine-Mobile Integrated Health
CPOE	Computerized Provider Order Entry
CPT	Current Procedural Terminology
CQI	Continuous Quality Improvement
CQM	Clinical Quality Measure
CRNA	Certified Registered Nurse Anesthetist
CY	Calendar Year
DACA	Data Accuracy and Completeness Acknowledgement
DGME	Direct Graduate Medical Education
DHHS	Department of Health and Human Services (or HHS)
DME	Durable Medical Equipment
DNV	Det Norske Veritas Healthcare (accrediting agency)
DON	Director of Nursing
DOQ-IT	Doctor's Office Quality – Information Technology
DPU	Distinct Part Unit
DRG	Diagnosis Related Group
DRP	Disaster Recovery Plan
DSA	Disproportionate Share Adjustment
DSH	Disproportionate Share Hospital
DUNS	Dun and Bradstreet Universal Numbering System
DVT	Deep Vein Thrombosis
EACH	Essential Access Community Hospital

EAP	Emergency Activation Plan
ECG	Electrocardiogram
eCQM	Electronic Clinical Quality Measure
ED	Emergency Department
EDIE	Emergency Department Information Exchange
EDTC	Emergency Department Transfer Communication
EHB	Electronic Handbook
EHDI	Early Hearing Detection and Intervention
eHI	e-Health Initiative
EHR	Electronic Health Record
EMR	Electronic Medical Record, Emergency Medical Responder
EMS	Emergency Medical Services
EMT	Emergency Medical Technician
EMTALA	Emergency Medical Treatment and Labor Act
EOP	Emergency Operations Plan
ERP	Emergency Response Plan
ESRD	End Stage Renal Disease
FACHE	Fellow of the American College of Healthcare Executives
FCC	Federal Communications Commission
FCHIP	Frontier Community Health Integration Project
FEC	Freestanding Emergency Center
FEMA	Federal Emergency Management Agency
FFR	Federal Financial Report
FFS	Fee-for-Service
FHSR	Foundation for Health Services Research
FI	Fiscal Intermediary
FIR	Financial Indicators Report
Flex	Medicare Rural Hospital Flexibility Program
FMT	Flex Monitoring Team
FOA	Funding Opportunity Announcement

FOIA	Freedom of Information Act
FORHP	Federal Office of Rural Health Policy
FQHC	Federally Qualified Health Center
FTE	Full-Time Equivalent
FY	Fiscal Year
GAO	Government Accountability Office
GEMT	Ground Emergency Medical Transport
GI	Gastrointestinal
GME	Graduate Medical Education
GMS	Grants Management Specialist
GPRA	Government Performance and Results Act
HAC	Hospital Acquired Condition
HACRP	Hospital Acquired Conditions Reduction Program
HAI	Health Care-Associated Infection
HAZMAT	Hazardous Materials Management
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HCP	Health Care Personnel
HCPCS	Healthcare Common Procedure Coding System
HCRIS	Healthcare Cost Report Information System
HEN	Hospital Engagement Network (see HIIN)
HFAP	Healthcare Facilities Accreditation Program
HHA	Home Health Agency
HHS	Department of Health and Human Services (or DHHS)
HIE	Health Information Exchange
HIIN	Hospital Improvement Innovation Network (formerly HEN)
HIMSS	Healthcare Information and Management Systems Society
HIPAA	Health Information Portability and Accountability Act
HIQR	Hospital Inpatient Quality Reporting Program
HISPC	Health Information Security and Privacy Collaboration
HIT	Health Information Technology

HITECH	Health Information Technology for Economic and Clinical Health Act
HITEQ	Health Information Technology Evaluation, and Quality Center
HITSP	Health Information Technology Standards Panel
HMIRS	Hazardous Materials Information Resource System
HOQR	Hospital Outpatient Quality Reporting Program
HPC	Health Policy Commission
HPSA	Health Professional Shortage Area
HRET	Health Research & Education Trust (affiliate of AHA)
HRSA	Health Resources and Services Administration
HSA	Health Savings Account; or Health Systems Agency
HTN	Hypertension
HUD	Housing and Urban Development
IAFC	International Association of Fire Chiefs
IAFF	International Association of Fire Fighters
IBH	Integrated Behavioral Health
ICD-10	International Classification of Diseases – 10th Edition
ICD-11	International Classification of Diseases – 11th Edition
ICS	Incident Command System
ICT	Information and Communication Technology
ICU	Intensive Care Unit
IHI	Institute for Healthcare Improvement
IHS	Indian Health Services
IOM	Institute of Medicine
IP	Inpatient
IPAB	Independent Payment Advisory Board
IPPS	Inpatient Prospective Payment System
IQR	Inpatient Quality Reporting Program
IRF	Inpatient Rehabilitation Facility
IRS	Internal Revenue Service
IT	Information Technology

JCAHO	Joint Commission on Accreditation of Healthcare Organizations (the Joint Commission)
JCREC	Joint Committee on Rural Emergency Care
LAN	Learning Action Network
LOS	Length of Stay
LPN	Licensed Practical Nurse
LTC	Long Term Care
LTCF	Long Term Care Facility
MAC	Medicare Administration Contractor
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MAF	Medical Assistance Facility
MAT	Medication-Assisted Therapy
MBQIP	Medicare Beneficiary Quality Improvement Project
MCO	Managed Care Organization
MDH	Medicare Dependent Hospital
MedPAC	Medicare Payment and Advisory Commission
MIH	Mobile Integrated Health
MIPPA	Medicare Improvements for Patients and Providers Act of 2008
MIPS	Merit-based Incentive Payment System
MMA	Medicare Prescription Drug, Improvement and Modernization Act of 2003
MOA	Memorandum of Agreement
MOU	Memorandum of Understanding
MPI	Master Patient Index
MRSA	Methicillin-Resistant Staphylococcus Aureus
MSA	Metropolitan Statistical Area
MSDS	Material Safety Data Sheets
MSSP	Medicare Shared Savings Program
MU	Meaningful Use (now known as Promoting Interoperability)
MUA	Medically Underserved Area
MUP	Medically Underserved Population
NACHC	National Association of Community Health Centers

NACRHHS	National Advisory Committee on Rural Health and Human Services
NAEMT	National Association of Emergency Medical Technicians
NARHC	National Association of Rural Health Clinics
NASEMSO	National Association of State Emergency Medical Services Officials
NCC	Non-Competing Continuation
NCHN	National Cooperative of Health Networks
NCQA	National Committee for Quality Assurance
NGA	Notice of Grant Award
NHIN	National Health Information Network
NHSN	National Healthcare Safety Network
NHTSA	National Highway Traffic Safety Administration
NIH	National Institute for Health
NIMS	National Incident Management System
NLM	National Library of Medicine
NOA	Notice of Award
NOFO	Notice of Funding Opportunity
NoP	Notice of Participation
NOSORH	National Organization of State Offices of Rural Health
NP	Nurse Practitioner
NPI	National Provider Identifier
NPRM	Notice of Proposed Rulemaking
NQF	National Quality Forum
NRHA	National Rural Health Association
NTIA	National Telecommunications and Information Administration
OAT	Office for the Advancement of Telehealth
OHITQ	Office of Health Information Technology and Quality
OIG	Office of Inspector General
OMB	Office of Management and Budget
OMH	Office of Minority Health
ONC	Office of the National Coordinator for Health Information Technology

OP	Outpatient
OPPS	Outpatient Prospective Payment System
OQR	Outpatient Quality Reporting Program
OTP	Opioid Treatment Program
P4P/PfP	Pay for Performance or Partnership for Patients
PAC	Post-Acute Care
PACS	Picture Archiving and Communications System
PALS	Pediatric Advanced Life Support
PB	Provider-Based
PBPM	Per Beneficiary Per Month
PCA	Primary Care Association
PCC	Primary Care Clinicians
PCMH	Patient-Centered Medical Home
PCO	Primary Care Office
PCP	Primary Care Provider
PE	Pulmonary Embolism
PFS	Physician Fee Schedule
PHE	Public Health Emergency
PHR	Personal Health Record
PI	Performance Improvement or Promoting Interoperability
PIMS	Performance Improvement & Measurement System
PIN	Policy Information Notice from HRSA
PMPM	Per Member Per Month
PO	Project Officer
POND	Practice Operations National Database
POS	Point of Service
PPACA	Patient Protection and Affordable Care Act of 2010
PPO	Preferred Provider Organization
PPS	Prospective Payment System
PQRS	Physician Quality Reporting System

PRO	Peer Review Organization
PSA	Physician Scarcity Area
PSI	Patient Safety Indicators
PTN	Practice Transformation Network
QHI	Quality Health Indicators
QHIN	Qualified Health Information Network
QHP	Qualified Health Plan
QI	Quality Improvement
QIN	Quality Innovation Network
QIO	Quality Improvement Organization
QNet	QualityNet
QPP	Quality Payment Program
RAC	Recovery Audit Contractor
REH	Rural Emergency Hospital
RFI	Request for Information
RFP	Request for Proposals
RHC	Rural Health Clinic
RHIhub	Rural Health Information Hub
RHIO	Regional Health Information Organization
RHPI	Rural Hospital Performance Improvement Project
RHRC	Rural Health Research Center
RHSATA	Rural Health System Analysis and Technical Assistance Program
RHV	Rural Health Value
ROCI	Return on Community Investment
ROI	Return on Investment
RPCH	Rural Primary Care Hospital
RQITA	Rural Quality Improvement Technical Assistance
RRC	Rural Referral Center
RSV	Reverse Site Visit
RTTD	Rural Trauma Team Development

RUPRI	Rural Policy Research Institute
RUS	Rural Utilities Service
RVU	Relative Value Unit
SAM	System for Award Management
SAMHSA	Substance Abuse and Mental Health Services Administration
SAN	Support and Alignment Network
SCH	Sole Community Hospital
SCHIP	State Children's Health Insurance Program
SDOH	Social Determinants of Health/Social Drivers of Health
SHIP	Small Rural Hospital Improvement Program
SME	Subject Matter Expert
SNF	Skilled Nursing Facility
SRHA	State Rural Health Association
SSIs	Surgical Site Infections
VKG	Virtual Knowledge Group

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Where We Are

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