HISTORY OF THE MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

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

The Flex Program also created critical access hospitals (CAHs), which are limited service hospitals designed to provide essential services. CAH designation allows the hospital to be reimbursed on a reasonable cost basis for inpatient and outpatient services provided to Medicare patients (including lab and qualifying ambulance services) and, in some states, Medicaid patients.

The design of the Flex Program was based primarily 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 Montana in 1987 and received Medicare waivers in 1990.

The legislation has undergone many changes and updates such as the Balanced Budget Refinement Act (BBRA) in late 1999, the Benefits Improvement Protection Act (BIPA) in late 2000 and the Medicare Prescription Drug, Improvement and Modernization Act (MMA) of 2003.

Building on the experience of Rural Primary Care Hospitals (RPCHs) developed under the Essential Access Community Hospital (EACH) program (in New York, West Virginia, North Carolina, South Dakota, Kansas, Colorado and California), CAHs were designed to decrease rural hospital closures, strengthen local health care delivery and improve rural health care access.

In 1999, the Technical Assistance and Services Center (TASC) was created by the Federal Office of Rural Health Policy (FORHP) to provide technical assistance and resources to the grantees of the Flex Program. TASC provides a resource network for answers and information regarding the program including best practices, peer learning and tools. TASC has been so successful that many other Health Resources and Services Administration
(HRSA) programs have used this model to develop technical assistance centers for their programs.

TASC recognized a growing need for a critical knowledge base in health information technology (HIT) for rural health grantees and rural health providers. Currently, HIT requirements in quality, safety, HIPAA, telemedicine, reimbursement, pharmacy and meeting meaningful use criteria for incentives are overwhelming many rural health care providers. Therefore, TASC has been providing informational resources, education and technical assistance on HIT since 2006. HIT activities must be related to quality improvement, financial and operational improvement or health system development and community engagement.

TASC, along with the Flex Monitoring Team, conducted a survey in 2006 that revealed the largest barriers for implementing HIT in small rural hospitals. TASC also manages the National Rural HIT Coalition and the National Rural HIT Coalition Workforce and Broadband Sub-groups, which are groups of rural HIT leaders and rural health experts that share best practices, barriers of HIT implementation and achievements in the meaningful use of electronic health records, health information exchanges, telehealth and practical solutions for rural facilities.

Another significant subject, which will alter not only the course of rural health care, but health care for all Americans, is the passage of the Patient Protection and Affordable Care Act (ACA) of 2010, also known as health care reform. ACA includes monumental changes to the way health care is delivered in this country and introduces new programs and projects in the areas of: accountable care organizations (ACOs); bundled payments; health insurance coverage for all Americans; home health and medical homes; Medicare and Medicaid payment changes and demonstration projects; workforce; long-term care; and public health. Changes in the health care market place are expected to accelerate. The intense focus on the Triple Aim (population health, higher quality, lower cost) will provide important challenges to rural hospitals and their communities. CAHs cannot afford to remain on the sidelines. Instead, CAHs should actively position themselves for the transformed payment systems which will include:

- Emphasis on value over volume
- Quality incentives and penalties
- Overall reductions in revenue
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 accountable care organizations and other shared savings models
- Capital will be required to implement physician alignment strategies
- Quality will drive reimbursement levels and will be a market differentiator
- Quality reporting will require a more sophisticated infrastructure
- Collaboration and effective alignment with the physician-provider community will be imperative as health care moves from a volume-based system to a value-based system

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

The challenges rural hospitals face are not insurmountable. To meet them head on will require a strong commitment to the communities served, as well as the desire to problem solve and work collaboratively. This commitment, desire and collaboration are qualities that define rural hospitals and rural leaders. Because they are the lifelines for the residents they call neighbors, rural hospitals can lead the way in transforming the American health care system. They are smaller, less complex and, therefore, able to change quicker than their urban counterparts. Rural hospitals are also more closely connected to their local communities than their urban counterparts. Transformational change will be difficult and will take time and energy to implement. Rural hospitals must begin now to prepare for the future.

Nationally, there is an important movement toward increased quality of care and patient health care experiences. FORHP created the Medicare Beneficiary Quality Improvement Project (MBQIP) as a Flex Program activity within the core area of quality improvement. The primary goal of this project is for CAHs to implement quality improvement initiatives to improve their patient care and operations. MBQIP will provide Flex funding to support CAHs with technical assistance and national benchmarks to improve health care outcomes. CAHs participating are requested to report a specific set of quality measures determined by FORHP and engage in quality improvement projects.
to benefit patient care. The passage of meaningful use and the ACA heightened national attention on quality activities and reporting. In the environment of meaningful use, pay for performance, bundled payments and ACOs, CAHs may soon be compared with their urban counterparts to ensure public confidence in their quality of health services. This initiative takes a proactive and visionary approach to ensure CAHs are well-equipped and prepared to meet future quality legislation. Additionally, MBQIP fulfills the Flex grant quality improvement objectives regarding Hospital Compare reporting and supporting participation in various multi-hospital quality improvement initiatives. The main emphasis of this project is putting patients first by focusing on improving health care services, processes and administration. More information on can be found at: http://www.ruralcenter.org/tasc/resources/mbqip.

As of November 2014, there were 1,325 hospitals in the nation designated as critical access hospitals. The majority of CAH designations in the country are now complete, due to support provided by the state Flex Programs. However, CAH designation is only one part of the Flex Program. States use their grant dollars to: improve networks, health system development and the integration of emergency medical services (EMS); provide benefit to the community, work on performance improvement, financial improvement and operational improvement; and address quality improvement issues, all in an effort to enhance and ensure health care access to rural Americans.