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

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

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

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

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

For more policy/legislative information, please visit the Core Competencies for State Flex Program Excellence Guide at https://www.ruralcenter.org/tasc/core-competencies.

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

- Program Area 1: Quality Improvement (required)
- Program Area 2: Financial and Operational (required)
- Program Area 3: Population Health Management and Emergency Medical Services Integration (optional)
- Program Area 4: Designation of CAHs in the State (required if requested)
- Program Area 5: Integration of Innovation Health Care Models (optional – pending FORHP approval)
- Other key areas of the Flex Program include the following
  - Network Development
  - State Rural Health Plan*
  - State Flex Program Evaluation

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

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

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

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

   Yes. TASC and its partners stay abreast of rural health policy and program changes. Updates are provided via the Flex Program email lists, Rural Route newsletter, regularly scheduled conference calls and webinars such as TASC 90 and Virtual Knowledge Group webinars. Information is also shared via the Flex Program Forum, the TASC and FMT websites, other stakeholder websites and at conferences and workshops throughout the year.
5. How do I apply for federal Flex Program funding?

Each state interested in acquiring federal Flex Program funding must submit an annual grant application to FORHP. The approximate timeline* for applications and awards is below:

- January/February: FORHP sends application guidelines to states
- March - May: Grant submission
- August: Grant award announcements
- September 1: The federal grant program year begins

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

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

TASC is available to answer your questions. See Section 3 for contact information.

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

- CAH Licensing and Certifications (including Joint Commission and other accrediting bodies) – contact your state hospital licensing bureau, your CMS regional office or TASC.
- Federal Flex Program Grant – contact the Flex Project Officer at FORHP (FORHP Flex Program Project Officers in Section 2).
- Rural Health Value, formerly known as Rural Health System Analysis and Technical Assistance (RHSATA), is a 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. Visit their website at http://cph.uiowa.edu/ruralhealthvalue/index.php.

- The American Hospital Association (AHA) Section for Small or Rural Hospitals — The AHA ensures the unique needs of this segment of its membership are a national priority. Working side by side with state and regional associations and with counsel from its governing council, the AHA Section for Small or Rural Hospitals monitors the issues and concerns facing its constituents, develops policy and identifies solutions to their most pressing problems. Visit their website at http://www.aha.org/about/membership/constituency/smallrural/index.shtml.

- Annual Flex Program Reverse Site Visit – contact TASC

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

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

- **Rural Route** is a monthly electronic newsletter sent out by TASC. If you would like your question to go out to a broad group, you can email it to tasc@ruralcenter.org and we will include it in our “Requests for Information” section of the e-newsletter. You could also post your question in the Flex Program Forum for your peers to respond to directly (see below for more information).

- Contact information, including email addresses, phone number and websites, are available through the State Flex Profiles on the TASC website at https://www.ruralcenter.org/tasc/flexprofile.

- TASC hosts regularly scheduled TASC 90 webinars. These webinars address issues and topics of interest to state Flex Program Coordinators. Time is made available on each webinar for states to voice issues or concerns. If possible, contact TASC ahead of time to ensure that your issue is addressed during the allotted call time.
• The Flex Program Forum is a secure web-based message forum for use by the state Flex Programs. Forum content focuses on the Flex Program and rural health care. State Flex personnel are able to share messages, pose questions, post documents and web links, as well as comment on each other’s posts. This Forum is a method for state Flex Programs to continue to connect and share information, ideas, lessons learned and best practices. The Forum can be found on the TASC website at https://www.ruralcenter.org/tasc/forum/home.

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

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

• Staff at the National Rural Health Resource Center working on the TASC program, TASC 90 Webinars, other topical webinars, Virtual Knowledge Group calls, Flex Program Reverse Site Visit, TASC website, Flex Program Forum and Rural Route e-newsletter (all coordinated by TASC)

• Other state Flex Programs and their websites

• Publications and the website of FMT: http://http://www.flexmonitoring.org/

• HRSA FORHP: https://www.hrsa.gov/ruralhealth/

• National Rural Health Association (NRHA) Annual Conference and Annual CAH Conference: https://www.ruralhealthweb.org/

• The TASC Core Competencies for State Flex Program Excellence, which defines nine Flex Program competencies and provides a guide to state Flex Programs for improving capacity in each of the nine areas: https://www.ruralcenter.org/tasc/core-competencies

Critical Access Hospitals (CAHs)

1. What is a CAH?

A critical access hospital (CAH) is a small rural hospital that has 25 beds (inpatient and/or swing beds) or fewer. There is also a 96-hour average annual length of stay limit for CAH patients. CAHs have unique operating requirements and receive cost-based plus one
percent reimbursement (101% total) for providing inpatient and outpatient services and certain other services to Medicare* beneficiaries.

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

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

There are several federal eligibility criteria for CAH designation and changes in eligibility have occurred as the Flex Program has evolved. More information about the current requirements can be found in the resources to support understanding of policies and regulations within the Core Competencies for State Flex Program Excellence Guide at https://www.ruralcenter.org/tasc/core-competencies. Future changes will be sent to Flex Coordinators via email and posted on the TASC website.

**Note – As of January 1, 2006, hospitals must be 35 miles or greater from the next nearest hospital to convert to CAH status, with the exception of those accessible by secondary roads or in mountainous terrain.

3. Can a CAH convert back to a full service hospital?

Yes, a CAH can convert back to a full service hospital. Contact TASC for examples of hospitals that have converted back to a prospective payment system hospital.

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

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

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

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

6. Are CAH licensure surveys announced or unannounced?

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

Examples of mock surveys from state offices can be found in the resources on the TASC website at https://www.ruralcenter.org/tasc.

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

Yes, a new provider number will be assigned.

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

A CAH can have up to 25 Medicare Certified beds, including any swing beds. Some states allow CAHs to have a larger number (above 25) of state licensed beds; however, they cannot be used by the hospital.

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

Yes, observation beds are included in the bed count. 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 what kind of bed it is (gurney, lounger, etc.), it is the status of the patient in the bed.

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

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

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

Yes, but certain requirements must be maintained or met anew. For hospitals that require a state necessary provider waiver to be a CAH, refer to the Medicare Conditions of Participation for CAHs, section §485.610(d) Standard: Relocation of CAHs With a Necessary Provider Designation Interpretive Guidelines §485.610(d)
For CAHs that are not designated as Necessary Providers, please see the Medicare Conditions of Participation for CAHs, section §485.610(c) Standard: Location Relative to Other Facilities or Necessary Provider Certification Interpretive Guidelines at [https://cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf](https://cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_w_cah.pdf).

12. Are CAHs issues the same across all states?

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