FLEX PROGRAM FREQUENTLY ASKED QUESTIONS

Flex Program Operations

1. What is the Medicare Rural Hospital Flexibility Program (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 SHIP 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) (those who are assisting states with implementing the program), Rural Health Research Centers, and the Flex Monitoring Team (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 (ORHP), for federal Flex Program funding.

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

   - Core Area 1: Support for Quality Improvement
   - Core Area 2: Support for Operational and Financial Improvement
   - Core Area 3: Support for Health System Development and Community Engagement
   - Core Area 4: Facilitate Conversion of Small Rural Hospitals to CAH Status
   - 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. Either through an internal or external evaluation, and possibly a mixture of the two, States will need to have a way to gather data about the successes of their program and any improvements that could be made.

**Note – States may choose the Flex Program areas they wish to address on an annual basis; however, all states are required to address the Emergency Medical Services (EMS) Integration, Evaluation, and revise their State Rural Health Plan.

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

   TASC e-mails Flex Program changes (including CAH changes) to Flex Program Coordinators as information is made available. Information also comes directly from ORHP, 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 teleconference calls and webinars such as TASC 90, the TASC and Flex Monitoring Teams' 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 ORHP. The approximate timeline* for applications and awards is listed below.

   - March: ORHP sends application guidelines to states
   - May: Grant submission deadline
   - August: Grant award announcements
   - September: The federal grant program year begins

   *Note – Schedule may change; contact ORHP for current year grant schedule.

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

   The TASC staff is available to answer your questions. See Section Two for TASC staff 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 ORHP
- Changes in federal laws and rules governing the Flex Program – contact your state hospital association, CMS, or visit the Federal Register website at http://www.gpo.gov/fdsys/, and the Rural Policy Research Institute (RUPRI) website at http://www.public-health.uiowa.edu/rupri/
- National Conference of State Flex Programs – contact TASC

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

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

   - Contact state Flex Program Coordinators directly via the TASC website
   - *Rural Route* is a bi-weekly 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
   - Links to State Profiles and State Rural Health Plans available on the TASC website and highlighted in the TASC newsletter, *Rural Route*
   - TASC hosts regularly scheduled TASC 90 webinars. These webinars address issues and topics of interest to Flex Program Coordinators. Time is made available on each webinar for states that have issues or concerns. If possible, contact TASC ahead of time to assure that your issue is addressed during the allotted call time Flex Program Forum, a secure web-based message forum for use by the State Flex Programs. The Flex Program Forum is for content related to the Medicare Rural Hospital Flexibility (Flex) Program and rural health care. On the Flex Program Forum, State Flex personnel are able to share messages, pose questions, post documents and web links and comment on each other's posts. This forum is just one other 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.

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:

   - TASC staff, TASC 90 Webinars, other topical webinars, National Conference of State Flex Programs, TASC website, and *Rural Route* e-newsletter (all hosted by TASC)
   - Other state Flex Programs and their websites
   - Publications and the website of the Flex Monitoring Team at http://www.flexmonitoring.org/
   - Health Resources and Services Administration, Federal Office of Rural Health Policy (ORHP) http://www.hrsa.gov/ruralhealth/
   - National Rural Health Association (NRHA) Annual Conference and Annual CAH Conference http://www.ruralhealthweb.org/
   - TASC developed "Best Practices and Success Stories: A Guidebook for Medicare Rural Hospital Flexibility Program Coordinators," which defines the major Flex Program components and offers lists of program activities, best practices, and success stories

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 less. 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 (see Section Five of this manual). Changes in eligibility have occurred as the Flex Program has evolved. Future changes will be e-mailed to Flex Coordinators 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.

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 a list of states that have experience converting a hospital back to a full service 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 distinct part unit [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 (i.e. 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.

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. For hospitals that require a state necessary provider waiver to be a CAH, refer to CMS final rule regarding these types of relocations. (See page 147 at http://www.cms.hhs.gov/QuarterlyProviderUpdates/downloads/cms1500p.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.