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State Initiatives Funded by the Medicare Rural Hospital Flexibility Grant Program

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Introduction

The Medicare Rural Hospital Flexibility Program (Flex Program) consists of two complementary components: cost-based Medicare reimbursement for designated Critical Access Hospitals (CAHs) and a state Flex Grant Program administered by the federal Office of Rural Health Policy to strengthen the rural healthcare infrastructure. Under the Flex Grant Program, each of the 45 participating states may apply for up to $650,000 annually to support the following activities:

- Developing and implementing state rural health plans;
- Developing rural health networks;
- Supporting the conversion and designation of CAHs;
- Providing support and technical assistance to enhance the financial and service viability of these hospitals;
- Developing quality improvement initiatives; and
- Establishing or expanding programs to support rural emergency medical services (EMS).[1]

During the 2004-2005 grant cycle, awards to states averaged approximately $498,000.[2]

States are using Flex Grant Program funds to support initiatives aimed at improving health care systems in rural communities and ensuring access to high-quality health care for Medicare beneficiaries among the nation's 59 million[3] rural residents. With the slowing of CAH conversion activity in recent years, state Flex Grant Programs directed additional funding to hospital quality improvement, provider recruitment and retention, emergency medical services, hospital business operations, and facility renovations and upgrades in the 1,283 existing CAHs and their communities.

To document effective state initiatives using Flex Grant Program funds, Flex Coordinators in all 45 participating states were asked to identify and discuss their states' three most successful initiatives in the past two years. This policy brief summarizes key findings from these interviews. More detailed discussion of our interviews with Flex Coordinators and information on specific state initiatives can be found in *Briefing Paper No. 15: State Initiatives Funded by the Medicare Rural Hospital Flexibility Grant Program*.

Priorities and Accomplishments of State Flex Programs

Interviews with state Flex Coordinators revealed the following priorities and accomplishments:

- A wide range of program initiatives addressing hospital quality and performance improvement, rural hospital financial and service viability, community health systems initiatives, EMS, health information technology (HIT) implementation, and workforce development, among others;
- The use of Flex Grant funds to support CAHs and rural health systems development projects for which there may be no other source of funding; and
- The development of many key initiatives where Flex Grant funding is augmented by other federal, state, and local dollars.

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State Flex Coordinators report successful initiatives in the following areas:

Quality and Performance Improvement. Initiatives identified as successful most often fell into this category. States focused on building CAH quality improvement capacity through benchmarking and patient safety programs, peer review systems, hospital staff training in quality improvement techniques, and participation in national or state public reporting programs, such as CMS' Hospital Compare. In Florida, for instance, the Flex Program has collaborated with the Quality Improvement Organization and the University of Florida College of Pharmacy to ensure medication safety at CAHs.

Rural Hospital Financial and Service Viability. These initiatives are crucial for vulnerable CAHs and a key area of Flex activity. States supported networks between CAHs and referral hospitals, other CAHs, and community providers; provided technical assistance and training to CAH staff on operational, business office, capital, and coding issues; supported hospital reengineering and construction; and provided targeted support to individual facilities. Illinois's statewide CAH network, in partnership with the state hospital association and three universities, offers support to CAHs through an external peer review program, financial indicators for chief financial officers, a group-purchasing arrangement, video conferencing to link members, HIT support, physician recruitment, and insurance and health benefits programs.

Community Health Systems Development Initiatives. Flex funds supported collaborations between CAHs and safety net providers to reduce duplication of services, achieve economies of scale, and improve access to care; funded CAHs' involvement in health promotion, education, and screening activities; and developed community-based decision-making tools to engage stakeholders in the improvement of local health care systems. Oregon's Community Health Improvement Partnerships have addressed issues such as Medicaid access and lowering emergency room usage through collaboration among health system providers.

EMS. Flex initiatives expanded EMS personnel training and leadership development; improved rural trauma and critical care capacity; conducted EMS needs assessments; developed transfer and triage protocols; improved the management and billing capacity of EMS providers, and developed an affordable self-funded liability product for EMS providers. Arizona worked with EMS units and CAHs to develop an on-line EMS/ambulance database, which serves as a billing system and documents transport patterns.

HIT. State Flex Programs funded telemedicine initiatives that expanded access to services; assessed HIT readiness; developed collaborative HIT capacity; and implemented HIT applications including electronic medical records and computerized pharmacy dispensing programs. Louisiana developed and installed an emergency department electronic medical record in several CAHs and small rural hospitals which feeds into the state's quality improvement network to establish benchmarks.

Workforce Development. Initiatives included recruitment and retention programs for physicians, nurses, allied health personnel, laboratory and radiology technicians, and business office staff; leadership development programs; rural placement opportunities for medical students and residents; pipeline programs to encourage students to consider health care careers; and expanded access to continuing education and certification programs. Oklahoma funded a recruitment program that places medical students from Oklahoma State University College of Osteopathic Medicine in rural practice settings, with seven rural training sites established and more in development.

Beyond self-reported measures, it is still too early to measure the success of these initiatives. However, it is clear that states are using Flex Grant funds—and leveraging state and local funds—to strengthen rural health care systems. As the Flex Grant Program moves forward and these initiatives continue, it is expected that specific outcome measures will become available.

This policy brief is based on Flex Monitoring Team Briefing Paper No. 15, available at www.flexmonitoring.org. For more information, please contact John Gale at jgale@usm.maine.edu

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[1]The legislative authority for the Flex Program is described in the Social Security Act, Title XVIII, Sections 1814 and 1820, available at *http://www.ssa.gov/OP_Home/ssact/title18/1800.htm,* Accessed December 12, 2007.
[2]Loux S, Gale J, Yousefian A, Coburn A, Gregg W. *A Review of State Flex Program Plans 2004-2005.* (Briefing Paper No. 10). Portland, ME: Flex Monitoring Team; 2006. *http://flexmonitoring.org/documents/BriefingPaper10_StateFlexGrantReview.pdf*
[3]United States Census Bureau. *Census 2000. http://factfinder.census.gov/servlet/DTTable?_bm=y&-geo_id=01000US&-ds_name=DEC_2000_SF1_U&-_lang=en&-mt_name=DEC_2000_SF1_U_P002&-format=&-CONTEXT=dt,* Accessed December 12, 2007.