Critical Access Hospital and Medicare Rural Hospital Flexibility Program

North Dakota Health Information Management Association
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Focused on Access, Financing and Quality Through:
- Health services research
- Health policy
- Education
- State and community health services development
- Information Resource

How: Through partnerships

Where: Grand Forks, ND
When: Established over 20 years ago
Today’s Focus

• Rural Health Issues

• What is a CAH?

• National Data

• North Dakota FLEX

Demographic Issues

• Revised population – 633,176
  (2002 Revised 2000 Census)

• 1990-2000  47 of 53 counties lost population

• 1990-2000  48 of 53 counties saw a decline in number of youth

• Median age  1960 was 26.2 and in 2000 it was 36.2
Demographic Issues

- People 65 and older accounted for 12.3% of ND population in 1980 but 14.7% in 2000

- Elderly growth is not ubiquitous
  - 1990-2000, 39 counties saw a decline in the number of county residents 65 and older
  - Counties that equal or exceed state average (14.7%), 35 experienced a decline in the number of people 65 and older

- The state’s birth rate has declined every year since 1982
2000 Census Percent Change - Children
1990-2000

Legend
- Up to 10% loss
- 20 - 30% loss
- Gain
- 10.01-20.0% loss
- Over 30% loss

North Dakota Frontier Counties

36 of 53 North Dakota Counties designated as Frontier
(less than 6 persons per square mile) Based on 2000 Census
Health Professions

- 89% of ND counties are entirely or partially a HPSA/MUA for physicians
- NDHA (2000) projected 3 year need of 120 full-time and 34 part-time registered nurses and 44 full-time and 17 part-time LPN
- Average age of RN – 43 years
- Only 15% of ND’s RNs are 30 or younger
- 93% of EMTs are volunteers
- 63% of statewide EMS survey (2000) said recruitment and retention of EMTs was a serious problem
North Dakota Rural Hospitals
Organizational Structure - 1998

Source: 1999 Rural Hospital Survey, UND Center for Rural Health

North Dakota Rural Hospitals
Payer Mix - 1998

Source: 1999 Rural Hospital Survey, UND Center for Rural Health
North Dakota Rural Hospitals
Source of Revenue - 1998

Source: 1999 Rural Hospital Survey, UND Center for Rural Health

North Dakota Rural Hospital
North Dakota Rural Hospitals
If We Do Not Link With Another Health Care System, It Will Jeopardize Our Survival

What is a CAH?

- History of Alternative Hospital Arrangements
  - Experimental Projects 1947-1980:
    - California
    - Kentucky
    - Colorado
    - North Carolina
    - Florida
    - Washington
    - Wyoming
  - Special Medicare Waivers
  - MAF (1987)
  - EACH/PCH (1989)
  - BBA 1997 (CAH)

Source: 1999 Rural Hospital Survey, UND Center for Rural Health
Critical Access Hospital Criteria

- Rural Location
- 25 beds (15 acute)
- 35 miles from another hospital
  - 15 by secondary roads
  - Necessary provider
- 24-hour emergency services
- 96-hour average LOS

- Network member
  - Referral and transfer
  - Communication and telemedicine
  - Transportation
  - Credentialing and quality assurance
- MDs, PAs, NPs, etc., subject to state and federal laws re: duties
- Medicare participation

The Purpose

- Local access through administrative flexibility
  - Staffing
  - Services

- Cost-based Medicare payments
Why Become a Critical Access Hospital?

- Local economic stability
- Local access through networks
- 100 percent access; zero health disparities
- Foundation for related personnel and services

National CAH/FLEX

- Growth in Number of CAHs
  - 1998 - 38
  - 1999 - 66
  - 2000 - 232
  - 2001 - 458
  - 2002 - 661
  - 2003 - 722 (Jan.)
### National CAH/FLEX Data
#### Hospital Characteristics

<table>
<thead>
<tr>
<th></th>
<th>CAHS (N = 721)</th>
<th>Small Rural Hospitals (ADC ≤ 15) (N = 439)</th>
<th>Other Rural Hospitals (ADC ≤ 15) (N = 939)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Number of Beds</td>
<td>30.2</td>
<td>34.5</td>
<td>95.9</td>
</tr>
<tr>
<td>Median Daily Census</td>
<td>3.7</td>
<td>7.3</td>
<td>30.1</td>
</tr>
<tr>
<td>Average Length of Stay</td>
<td>3.3</td>
<td>3.7</td>
<td>3.9</td>
</tr>
<tr>
<td>Average Proportion of Discharges Paid for by Medicare</td>
<td>59.3%</td>
<td>54.3%</td>
<td>47.8%</td>
</tr>
<tr>
<td>Average Operating Margin</td>
<td>-16.2%</td>
<td>-19.2%</td>
<td>-1.1%</td>
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### National CAH/FLEX Data
#### County Characteristics and Health Care Resources

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</tr>
</thead>
<tbody>
<tr>
<td>Hospitals in a Health Professional Shortage Area (HPSA)</td>
<td>73.7%</td>
<td>76.1%</td>
<td>64.9%</td>
</tr>
<tr>
<td>Hospitals in Frontier Counties</td>
<td>36.5%</td>
<td>17.5%</td>
<td>2.2%</td>
</tr>
<tr>
<td>Hospitals in County with a “Rural Health Clinic”</td>
<td>66.3%</td>
<td>60.1%</td>
<td>50.8%</td>
</tr>
<tr>
<td>Hospitals in Counties with a Federally-Qualified Health Center</td>
<td>19.1%</td>
<td>29.2%</td>
<td>23.0%</td>
</tr>
</tbody>
</table>
ND CAH/FLEX

- 28 CAHs (37 eligible) – 76%
- Serve 181,000 North Dakotans or 43% of rural population
- 65 and older – state average is 14.7% but CAH county average is 20.7%
- Frontier nationally is 36% but ND it is 50%
- HPSA/MUA – nationally 74% of CAHs in such an area but in ND it is 96%

ND CAH/FLEX
Technical Assistance

- What does the FLEX program offer to North Dakota’s rural hospitals?
  - Community Assessments
  - Strategic Planning
  - Focus Groups
  - Community Forums
  - Internal Personnel Audits
  - Workshop Development
  - Grant Development
  - Community Education
  - CAH Clearinghouse (access to AHA, TASA, FLEX Tracking Program)
### ND CAH/FLEX
#### Technical Assistance

- CAH Financial Clearinghouse (NDHA)
- Claims Data Analysis (NDHD)
- Special Studies
- Rural Hospital List Serv
  - FLEX Update
  - Communication

### ND CAH/FLEX
#### FLEX Grants

**CAH Program Grant**

**Categories**

- Financial Analysis/Assessments
  - Up to 10,000 for any eligible hospital
  - One pre-CAH analysis per hospital

- Other Financial Analysis
  - Analyze post-CAH conversion reimbursement
  - Chargemaster review (one per hospital and capped)
  - Regulatory change (impact of increased reliance on non-physician provider, etc.)
  - Outpatient reimbursement changes
  - Service development/diversification feasibility studies
  - Clinic/outpatient services review and comparisons (e.g., RHC, FQHC, CAH/FQHC integration, etc.)
  - Other ideas
ND CAH/FLEX
FLEX Grants

CAH Program Grant (cont.)
• Network Development
  ➢ No dollar cap
  ➢ Must be a CAH or actively involved in seeking CAH status
  ➢ Service diversification
    - Cardiac Rehab - Pulmonary Rehab - EMS
    - Physical Therapy - Surgery - Tele-radiology
    - Urgent Care - Wellness Program - Training/Education
  ➢ System Stability
    - Consultant Assistance - Legal Assistance - Telemedicine
    - Community Education - Quality Improvement
    - Staff Recruitment and Retention
    - Communication Systems (Polycom system)

ND CAH/FLEX
FLEX Grants

CAH Program Grant (cont.)
• Local Health Task Force Development
  ➢ No dollar cap
  ➢ Must be a CAH or actively involved in seeking CAH status
  ➢ Cannot pay for food/beverages out of the federal funds
  ➢ Avoid travel costs
  ➢ Can pay for presenters/speakers/experts to come to your town
  ➢ Promotional costs
  ➢ Ideas
    - Workforce task force (R/R Committee)
    - Citizens to save/support the XYZ hospital
    - Regional task force for area health services (other towns)
  ➢ Task force can build community involvement, community support, regional awareness and support, and visibility
ND CAH/FLEX  
FLEX Grants

EMS Network Grant  
- Purpose is to establish an EMS network and collaborative relationships between the CAH and EMS

- The network will consist of, at a minimum, one CAH and two certified ambulance units

- The applicant must be the CAH and the CAH assumes fiscal responsibility for the project funds

- Capped at $15,000

EMS Network Grant (cont.)

- Networks have been addressing the following:
  - Regional mass casualty incident protocol and operating plan
  - EMS equipment (AEDs, mannequins, software)
  - EMS training (ACLS, PALS, EMS-C)
  - Marketing
  - Recruitment/retention
ND CAH/FLEX
FLEX Grants

Network Enhancement Grant
- Network Enhancement Grants are the new focus of the program
- Eligible networks: at a minimum, one CAH and one other separate legal entity
- CAH is the applicant but represents the network
- Requires a detailed MOA
- Requires a strong budget narrative (detail)
- Describe how the network facilitates a collaborative relationship between the partners (and also present role/responsibility in the MOA)

ND CAH/FLEX
FLEX Grants

Network Enhancement Grant (cont.)
- Funded networks:
  - Quality Improvement (Mayville)
  - Shared Service Network (planning)
  - Provider Network (planning and assessment)
  - Cardiac Emergency Network