The Medicare Rural Hospital Flexibility Program:

Rapid Progress Toward Full Implementation

A report on the first two years of implementation of the Medicare Rural Hospital Flexibility Program

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by the

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Background

The Medicare Rural Hospital Flexibility Program (MRHF) was enacted as part of the Balanced Budget Act of 1997, and is a nationwide program that creates a new category of rural hospitals called "Critical Access Hospitals" (CAH) as well as authorizes a program of grants to develop rural health care systems. To qualify as a CAH, a hospital must be a rural public or non-profit hospital, operate a limited number of inpatient beds, keep inpatients a maximum of 4 days, and be remote from other hospitals or designated as a necessary provider by the state. Rural hospitals designated as a CAH receive reasonable, cost based reimbursement for care rendered to Medicare participants. Before a hospital can be designated as a CAH, the state must submit and have approved a rural health plan specifically delineating their approach to developing the MRHF program. This brief reports the results of a survey of 48 states conducted June through August, 1999 by the North Carolina Rural Health Research and Policy Analysis Program at the University of North Carolina at Chapel Hill.

Program Diffusion

As of September 1, 1999,

- ✓ 35 states have HCFA-approved state plans. Of the states with approved plans:
  - ✓ 13 have certified CAHs, 7 of these were part of the Rural Primary Care Hospital Demonstration (EACH/RPCH).
  - ✓ 11 states are in the process of drafting rural health plans or have set plans to complete plans by fall, 1999.
  - ✓ 2 states are ineligible for program participation, New Jersey and Rhode Island, because they have no areas designated nonmetropolitan.
- ✓ 58 CAHs are designated; 40 of these were EACH/RPCH facilities, and 18 are newly designated. 20 states have hospitals in the application stage for designation as Critical Access Hospitals.
  - ✓ There are currently 85 hospitals in some stage of application for a Critical Access Hospital designation.
  - ✓ 12 hospitals serving as Medical Assistance Facilities in Montana will convert to Critical Access Hospitals on October 1, 1999.
  - ✓ 48 states have applied for and received the first round of Rural Hospital Flexibility Program grant funding.

The Rural Hospital Flexibility Program is Creating State Rural Health Consortia

All eligible states reported the involvement of multiple agencies and organizations in the development of state rural health plans. The number of participants involved varied from state to state, and included: state hospital associations, the bureaus or departments of health and the agencies responsible for rural health, primary care and/or emergency medical services, fiscal intermediaries, Medicaid agencies, rural hospitals, hospital networks, peer review organizations, state licensing and certification agencies, private insurance groups, offices of the secretary or commissioner of health, medical associations, the primary care associations, state rural health associations, rural community leaders, economic development offices, universities including medical schools and schools of public health, policy centers, Area Health Education Centers (AHECs), and consultants. The majority of states report an intention to develop network arrangements beyond the minimal requirements of the Medicare Rural Hospital

Flexibility Program. Many states stressed the importance of developing vertical network arrangements for optimum health care delivery.

States Are Including Medicaid in the CAH/Rural Hospital Program

39 states report considering or currently reimbursing Medicaid patients at CAHs on a cost based system. Three of these states employ quasi-cost based reimbursement systems. Two of the seven states that report not moving to a cost based Medicaid reimbursement currently employ charge based reimbursement systems.

Strengthening Rural Systems—Rural Flex Funds are Being Used to:

- ✓ States have used or plan to use grant funding to assess the potential of CAHs to benefit rural communities through financial feasibility and community needs assessments.
- ✓ Community education about the Medicare Rural Hospital Flexibility Program.
- ✓ Provide support to rural network development.
- ✓ For technical assistance to CAH candidates, EMS system enhancement, conference funding, recruitment and retention of personnel at CAHs, development of telemedicine, and conversion-generated legal expenses.

State Concerns and Recommendations from Respondents

- ✓ Hospitals do not have sufficient clinical flexibility over length of stay.
  Recommendation: Change the limit to an annual average of 96 hours. Informants have said that an annual average of seventy-two hours would provide them with greater flexibility than the fixed 96 hours.
- ✓ Some hospitals in rural communities are in metropolitan counties and ineligible for the program.
  Recommendation: Modify the definition of "rural" to accommodate these.
- ✓ Some community clinics essentially meet the definition of CAHs.
  Recommendation: Explore a fast track mechanism to allow a community clinic to achieve hospital status.
- ✓ There is confusion over the degree of necessary involvement of EMS.
  Recommendation: Clarify intentions for EMS system relationships especially where there was a dependence on volunteers due to diminishing resources in communities.
- ✓ Other program support recommendations:
  Assess potential conflict of interest created by having a referral facility for a CAH responsible for CAH credentialling and quality assurance. Create a central clearinghouse for information, which could include examples of state plans and grants.

Conclusions

In its second year, the Medicare Rural Hospital Flexibility Program has made substantial progress toward full implementation. States report that consistent, widespread dissemination of program information is essential to program success. The Medicare Rural Hospital Flexibility Program is an ongoing initiative. It is, therefore, extremely important to the sustainability of the program to monitor and evaluate the program implementation and advancement. Understanding the program's unique characteristics and changes enables appropriate program adjustments and, consequently, may aid in securing access to health care in rural areas.

September 10, 1999 TR/ae/tr

Medicare Rural Hospital Flexibility Program Status, Information Gathered through August, 1999

State	Will Begin Drafting State Plan by Fall 1999	Drafting State Plan	Submitted State Plan	State Plan Approved by HCFA	Number of Eligible CAHs	Number of Current CAHs	Number of Hospitals in Application	Number of Interested Hospitals
Alabama		X			50	0	0	20-25
Alaska				X	9	0	0	5
Arizona		X			15	0	0	12
Arkansas				X	38	0	0	20
California				X		0	7	7
Colorado				X	15 - 20	3	0	5 - 6
Connecticut		X			1	0	0	1
Delaware	X				3	0	0	0 - 3
Florida				X	16	0	0	10-12
Georgia				X	47	1	2	15 - 20
Hawaii		X			5	0	0	5
Idaho				X	20	3	4	4
Illinois				X	11	0	2	8
Indiana				X	35	0	1	7 - 8
Iowa				X	25 - 35	0	9	25 - 30
Kansas				X	40	19	6	
Kentucky				X	29	0	0	0 - 29
Louisiana				X	27	0	0	10
Maine				X	14	3	10	10
Maryland		X			1	0	0	1
Massachusetts	Declined interview							
Michigan				X	15	0	8	16
Minnesota				X	68	2	0	25-30
Mississippi				X	28	0	0	8 - 10
Missouri				X	43	0	0	10
Montana				X	33 - 35	0	3	23
Nebraska				X	38	1	6	15 - 20
Nevada				X	8	0	0	3 - 5
New Hampshire		X			9	0	0	1 - 3
New Jersey	Not eligible for program participation due to the absence of rural areas in the state							
New Mexico				X	12	0	0	6
New York				X	24	4	1	12-15
North Carolina				X	16 - 18	4	1	6
North Dakota				X	33	0	2	11
Ohio		X			16-20	0	0	15
Oklahoma				X	37	1	7	15 - 16
Oregon				X	20	0	0	6 - 8
Pennsylvania		X			2-4	0	0	2
Rhode Island	Not eligible for program participation due to the absence of rural areas in the state							
South Carolina				X	11	0	0	4
South Dakota				X	37	10	0	20
Tennessee				X	44	0	0	8
Texas				X	22	0	0	45
Utah	X				10	0	0	3 - 5
Vermont		X			8	0	0	3 - 5
Virginia	Declined interview							
Washington				X	41	0	1	9
West Virginia				X	10	7	1	1 - 2
Wisconsin				X	33	0	9	13
Wyoming				X	15	0	1	4 - 5
TOTAL	2	9	0	35	1024 - 1059	58	81	449 - 528

ummary of Medicare Rural Hospital Flexibility Program Progression of as July, 1999

State	Status of the State Plan	Status of Rural Network Development	Areas of Emphasis for the Medicare Rural Hospital Flexibility Program
Alabama	In the process of drafting the state plan; Estimated submission by September 1999	Loose rural networks exist; Will need to formalize and expand existing networks; Believes it is important to assure the rural hospitals that they will not be subordinates; Plan to have referral facility for each CAH	EMS development; Community education; Requiring financial evaluations for potential CAHs
Alaska	Plan approved	Basic network development will be accommodated by already existing loose networks, but might be a problem depending on the definition of the relationship of referral network facilities; Plan to have referral facility for each CAH	Community needs assessments; Community education; Fiscal analyses; Telemedicine development
Arizona	In the process of drafting the state plan; Estimated submission in 10/99	Loose networks that need to be formalized; Plan to have referral facility for each CAH	Strong community education; Financial feasibility studies
Arkansas	Plan approved	Foresees no problems establishing networks; Many hospitals already function as CAHs with loose networks; Plan to have referral facility for each CAH	Community education and network development; Financial feasibility studies
California (EACH/RPCH State)	Plan approved	Most hospitals have non-formalized networks which can easily be formalized under the CAH program; Plan to have referral facility for each CAH	Community needs assessments; Network development for new and existing networks; Considering retention and recruitment of personnel; Dental care
Colorado (EACH/RPCH State)	Plan approved	Loosely defined networks; Plans to strengthen these associations in the future; Plan to have referral facility for each CAH	Financial feasibility; Community needs; Community education
Connecticut	In process of drafting state plan	Basic rural networks will need to be developed; There are very loose associations currently present; Plan to have referral facility for each CAH	EMS development; Network development; Financial feasibility studies
Delaware	Will begin drafting state plan late in 1999	Minimum network requirements for program exist; Hospitals will determine to what point they would like to expand upon these; Plan to have referral facility for each CAH	Continuing evaluations of community needs assessments, including looking at minority needs; Encouraging financial feasibility studies
Florida	Plan Approved	Very strong rural networks; Nine certified rural health networks exist funded by state and federal monies; Network development for any non-affiliated hospitals should be easy; Plan to have referral facility for each CAH	EMS enhancement; Strong community education and marketing; Encouraging community needs assessments
Georgia	Plan approved	Slow development but will expand as the program progresses; Plan to have referral facility for each CAH	Detailed financial assessments; Community needs
Hawaii	Drafting plan; Anticipate submission by September 1999	Unsure of status at this time	Network facilitation; Community education
Idaho	Plan approved	Had already established informal networks that were and are being formalized; Plan to have referral facility for each CAH	EMS coordination and enhancement; Financial analyses
Illinois	Plan approved	All hospital had referral hospital already per state hospital requirements; These networks affiliations will be expanded upon; Plan to have referral facility for each CAH	EMS coordination and enhancement; Development of health professional training; Community education; Community needs assessments; Financial evaluations
Indiana	Plan approved	Some hospitals had formalized networks and some hospitals had to establish networks; Appears to be an easy process; Plan to have referral facility for each CAH	Financial feasibility; Encourage community needs assessments; Community education and marketing; EMS development

IOWA	Plan approved	There are some loose networks functioning but these associations will need to be developed; Plan to have referral facility for each CAH; Plan to have referral facility for each CAH	Requiring financial feasibility studies; Development of EMS services into the networks; Requiring community health needs assessments
KANSAS (EACH/RPCH STATE)	Plan approved	Network relationships existed prior to the program; Plan to have referral facility for each CAH	Financial feasibility studies; Will do some patient satisfaction/QA assessments; Network development, including a written plan; Community needs
KENTUCKY	Plan approved	No comment	Network development; Community needs assessment; Financial analyses
LOUISIANA	Plan approved	Loose networks exist but will be formalized with the assistance of grant funding; Plan to have referral facility for each CAH	Financial feasibility studies; Community needs assessments; EMS coordination and enhancement
MAINE	Plan approved	Loose networks exist and meet the minimum program requirements; These networks will be expanded upon as the program progresses; Plan to have referral facility for each CAH	EMS coordination and enhancement; Community resources and needs assessments; Required community education
MARYLAND	In process of drafting state plan; Anticipate submission by December 1999	Loose networks exist to meet minimum requirements of program; Plan to expand on existing networks; Plan to have referral facility for each CAH	Required community needs; Required financial evaluations
MASSACHUSETTS	Declined interview		
MICHIGAN	Plan approved	Some notable networks already exist in certain areas; All hospitals have some type of referral agreement, but some potential CAH facilities will need to formalize their associations; Plan to have referral facility for each CAH	Community needs assessments; Financial studies
MINNESOTA	Plan approved	Minimum requirements already in existence; Plan to have referral facility for each CAH	Financial feasibility evaluations; EMS coordination and enhancement; Community needs assessments; Community education
MISSISSIPPI	Plan approved	Rudimentary networks established that will need to be expanded upon for the program; Plan to have referral facility for each CAH	Community education; Community needs assessments; Financial evaluations; EMS coordination and development
MISSOURI	Plan approved	Loose affiliations exist which fulfill the minimum program requirements; Plan to expand and strengthen existing networks; Plan to have referral facility for each CAH	Financial feasibility evaluations; Community needs assessments; Telecommunications and informational network development; Community education; State QA development; Data collection of program benefits and detriments
MONTANA (MAF STATE)	Plan approved	Networks well established at MAF facilities that will grandfather to CAH on 10/01/99; Other potential CAH facilities have informal networks established; Plan to have referral facility for each CAH	Community education; Financial feasibility evaluations; Providing the maximum amount of support possible to hospitals
NEBRASKA	Plan approved	Loosely developed networks existing prior to the program; These networks were formalized for program purposes; Plan to have referral facility for each CAH	Community education and marketing; Supporting financial feasibility evaluations; Overseeing proper policies and procedures are in place; Community planning
NEVADA	Plan approved	Program network requirements exist for interested facilities; Plan to have referral facility for each CAH	Telecommunications development; EMS coordination and development; Community education; Monitoring economic impact of program
NEW HAMPSHIRE	In process of drafting state plan	Informal networks exist; Grant money will be used to expand and formalize these networks; Plan to have referral facility for each CAH	Community needs assessments; Financial evaluations
NEW JERSEY	Not eligible for program due to lack of rural areas		

NEW MEXICO	Plan approved	All hospitals have mechanisms in place to create formalized networks; Should be an easy process; Plan to have referral facility for each CAH	Encouraging community needs assessments; Encouraging financial feasibility evaluations; Network development and improvement; EMS development and integration, including increasing staff
NEW YORK (EACH/RPCH STATE)	Plan approved	Significant rural networks already existed in the state; Networks supported by state grant funds; Only one potential CAH is not a member of a network; No problems foreseen developing a network at this facility; Plan to have referral facility for each CAH	Community education; Financial evaluations and community needs (part of CON in New York); EMS coordination and enhancement QA piece
NORTH CAROLINA (EACH/RPCH STATE)	Plan approved	Strong rural networks in state; Easily identified for program purposes; Plan to have referral facility for each CAH	Financial evaluations; Community needs assessments; EMS coordination and enhancement, including the examination of transportation issues; Monitor impact of program
NORTH DAKOTA	Plan approved	Loose networks exist that will be expanded and formalized for program involvement; Plan to have referral facility for each CAH	Community education; Telemedicine development; Network development; Financial feasibility studies; EMS coordination and enhancement
OHIO	In the process of drafting the state plan	Very loose network affiliations exist; Intends to put a great deal of effort into network development; Plan to have referral facility for each CAH	EMS integration and coordination; Network development; Require financial feasibility studies; Community needs assessments; Strong community education and marketing
OKLAHOMA	Plan approved	Loose networks/affiliations exist; Local communities will be given flexibility as to what degree these networks will be expanded upon; Plan to have referral facility for each CAH	Encourage community needs; Strong community education; Physical/financial analysis; Examination of quality and health care issues; EMS coordination and development is needed; Emphasize community not state focus
OREGON	Plan approved	Strong and extensive networks exist; It should be an easy process to create networks for any facilities that do not have formalized networks; Plan to have referral facility for each CAH	Financial evaluations; Community education and marketing; Rudimentary needs assessments; Network development; Strengthen EMS relationships with hospitals; Examine recruitment and retention issues
PENNSYLVANIA	In process if drafting state plan; Anticipate completion in the Fall of 1999	Networks will need to be extensively developed; May exist on a very loose basis for some facilities; Plan to have referral facility for each CAH	Network development; Community education and outreach; Financial evaluations; General health planning
RHODE ISLAND	Not eligible for program due to lack of rural areas		
SOUTH CAROLINA	Plan approved	All facilities have the minimum network required for program participation; Will work on establishing vertical health care networks; Plan to have referral facility for each CAH	Examine infrastructure of EMS Financial feasibility assessments; Community needs assessments; Developing vertical networks
SOUTH DAKOTA (EACH/RPCH STATE)	Plan approved	Program required networks already established prior to program involvement; Plan to have referral facility for each CAH	Community resource development; Requiring financial evaluations; Community and hospital staff education; Expanding existing networks
TENNESSEE	Plan approved	Some informal networks exist but state would like to see rural networks significantly expanded and strengthened; Plan to have referral facility for each CAH	Network development; EMS coordination and development; Telehealth development; Requiring financial feasibility evaluations; Community needs assessments; Examine provider recruitment and retention issues; Community education and marketing
TEXAS	Plan approved	Have some formal and informal networks; By and large there are existing networks that will be fairly easy to formalize; Plan to have referral facility for each CAH	Requiring financial needs assessments; Requiring community education; EMS coordination; Monitor impact of program; Network development
UTAH	Will begin drafting plan late in the summer	The status of networks is not consistent--- some facilities have loose networks established and some do not; This area will need to be developed; Plan to have referral facility for each CAH	Examine EMS and hospital relationships; Financial evaluations; Community needs assessments; Provide general coordination and program tracking

VERMONT	In process of drafting plan	Potential CAHs have loose networks; Networks need to be further developed and formalized for the program; Plan to have referral facility for each CAH	EMS coordination; Community needs assessments and planning; Community education
VIRGINIA	Declined interview		
WASHINGTON	Plan approved	Networks were developed and formalized in the past under other state health reform; Concepts are being developed as to how to reemphasize these networks; Plan to have referral facility for each CAH	Economic modeling; Creation of best practices, policies and procedures; Community needs assessments; Examine EMS integration and coordination
WEST VIRGINIA (EACH/RPCH STATE)	Plan approved	Some formalized networks already existed but some networks needed to be established; Some newly formed CAHs have chosen to join a network already established from another CAH; Plan to have referral facility for each CAH	Requiring financial feasibility evaluation; Requiring community needs assessments; Requiring community education; Encouraging community involvement in decision making; Expanding existing networks
WISCONSIN	Plan approved	Strong formalized networks in existence; Plan to have referral facility for each CAH	Requiring financial feasibility evaluations; Requiring community needs assessments; Development and coordination of EMS; Telehealth development; Systems planning development; Examine staff recruitment and retention issues; Community education; EMS coordination and enhancement
WYOMING	Plan approved	Very few networks exist; It will be challenging to develop and formalize networks for the program due to tremendous referral pattern out of state; Plan to have referral facility for each CAH	Community needs assessments; Financial feasibility evaluations; Community education; Enhancing program involvement/relations with the hospital association; Network development

Alaska

- State plan approved, 15 hospitals in the state, 9 meet current CAH criteria, 2 interested, 1 actively considering application.
- Have had little hospital interest due to low proportion of Medicare in population
- Alaska is requiring fiscal analysis and community needs evaluations prior to conversion.
- Bulk of funding will be used for community needs assessments, developing health networks, and coordinating EMS.
- Could have problems with quality assurance and credentialling mechanisms since potential CAH hospitals work independently and they will need to adjust to network relationships.
- Alaska plans to develop a state wide health network that would include CAHs.
- Coordination of networks and EMS requires large financial and employee time outlays due to the distances between health care facilities and transportation difficulties.
- Length of stay limitations will be especially a problem in Alaska due to the great distances between facilities.
- Native health care systems and the military health care system are a strong presence in Alaska. State would like to include them in networking.
- Extensive EMS system exists with 20 air ambulances and approximately 100 ground ambulances prompted by the need to transfer patients to the limited, often distant hospitals in the state.
- Investigating use of telemedicine for remote areas as part of network activities.
- FLEX has brought increase awareness of access issues. Key players are being brought to the table for needed coordination.
- Medicaid reimbursement structure does not fit well with the FLEX cost-based system.

Mississippi

- Plan approved, 25-30 hospitals eligible, 8-10 considering or moving toward application.
- The Mississippi Office of Rural Health anticipates using 25 –30% of FLEX resources for community purposes, including community needs assessments and community program education.
- EMS operates regionally, each region spanning 10 – 12 counties with state coordination, this will facilitate integration with rural hospital networks.
- Plans to create a mini grant program for EMS system development and coordination.
- EMS and trauma system links in rural areas are especially important due to budget shifts. FLEX resources are critical in helping rural EMS.
- The state coordinating agencies plan to contract with various groups to develop economic profiles on counties where potential CAHs exist.
- Hospitals independently perform financial feasibility studies, but the state is trying to format a standard template.
- Initially, the state is not pushing network development beyond initial program requirements, but intends to encourage further affiliations as program progresses.
- Exploring CAH reimbursement from Medicaid on a cost basis.

Montana

- 12 Medical Assistance Facilities (MAF) will grandfather into the Flex program in the Fall.
- There are approximately 35 non-MAF hospitals eligible for the program, 3 are in current application, 23 have expressed interest.
- Informants expect 15 operating CAHs by the Fall.
- The state is not requiring specific evaluations by hospitals prior to conversion, but is providing funding for financial analyses, community assessments, community education, and technical assistance if desired.
- The state rural Flex program will support:
  1) network development,
  2) EMS improvement and integration,
  3) the development of a mini grant program for facilities and communities to assess the benefits and burdens of program involvement, and
  4) centralized technical assistance.
- Rural FLEX resources will be used to integrate the unstructured and self-contained county-level systems into a cohesive state-wide system.
- Plans to create "scholarships" to finance EMS training, and to expend grant funds to enhance EMS personnel recruitment and retention.
- Rural plan anticipates development of state-wide EMS protocols for patient handling and system management. Currently has a program called "EMS of Excellence" under which management courses are provided.
- Encouraging as many network affiliations between facilities as possible.
- Plans a state-wide initiative to develop telehealth capacity.
- Medicaid reimbursed on a cost basis.

South Carolina

- State plan approved, 11 hospitals eligible for the program, 4 interested.
- Four hospitals that fall outside of the current definition of rural are interested in conversion
- The state is requiring and funding financial feasibility and community needs assessments prior to conversion.
- CON program active in SC, but will not affect CAHs.
- The plan anticipated licensing CAHs as special category hospitals, but still under determination.
- Program activities include:
  1) infrastructure development,
  2) network formation and expansion, and
  3) EMS improvement.
- State maintains an effective EMS system run through the Health Department; the rural plan anticipates support to volunteer rescue squads coordinated with network activity.
- SC intends to develop a "healthier" EMS infrastructure by tightening the tie between state and county EMS coordination and planning.
- Plans to develop a small grant program for EMS development and improvement.
- The rural plan stresses vertical network development among facilities offering different services.
- In the process of moving Medicaid to cost based reimbursement in CAHs.

Texas

- Plan approved, 25 eligible hospitals, 45 interested.
- The rural plan emphasizes feasibility studies for potential CAHs and requires substantial community involvement in planning.
- Majority of related funding will be used for community education and consultation.
- EMS regions span several counties and may include between 15 – 20 hospitals. CAHs will be linked into this expansive system.
- The EMS system received state Tobacco settlement monies for enhancement purposes and this will be coordinated with rural network activities.
- Eligible CAHs have long-standing formalized network relationships and the program will build on these.
- West Virginia hospitals with busy ER service but low inpatient volume due to remoteness—attempting to adapt FLEX program to this need.
- 10-12 hospitals that fall outside of the current rural definition are interested in conversion.
- Program has strengthened agency/hospital relations; common goals and common objectives make relationships solid.
- Participants envision the program having long range effects on access, including:
  1) revitalizing and sustaining hospitals, thereby providing health care otherwise unavailable rural areas,
  2) facilitating local cooperative ventures within networks, and
  3) aiding in the development of telemedicine.
- The program will work with Medicaid to establish reasonable Medicaid cost reimbursement at CAHs.

West Virginia

- 7 operating CAHs, 10 are eligible under current criteria, 1 in application process, and 2 that have expressed interest.
- Several CAHs, including past EACH/RPCH participants, report the Flex program tremendously aiding financial stability.
- Prior to conversion require: an in depth financial feasibility evaluation using state model; a community needs assessment that includes setting up a community advisory council with town and hospital community members, and local public meetings discussing the Flex program.
- WV adjusted disproportionate share distribution in favor of CAHs so that CAHs receive 100% reimbursement of charity care rendered with the remaining disproportionate share monies divided by non-CAH facilities.
- The focus is on community-based systems including network development and the enhancement of Emergency Medical Services (EMS). Approximately 85% of program-related efforts work will be concentrated in these areas.
- Smaller proportion of effort will used for designation evaluations in West Virginia compared to other states due to experience gained through EACH/RPCH participation and the small number of new facilities that may convert.
- Rural plan envisions focus on continuing medical education programs, and shared administrative and billing methods.
- Goal is to improve health care access state-wide on two levels by keeping hospitals open that would have otherwise ceased to operate, and increasing health care networking within rural communities.
- Target hospitals and health systems have been able to expand their breadth of health services due to the augmentation of health care associations and resources.
- Medicaid reimbursed on a cost-basis with an all-inclusive payment.
- Some stresses with managed care contract negotiation at some CAH facilities is reported. Some managed care companies are requiring JACHO accreditation for contracting while others are not.