THE FIRST YEAR OF THE MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

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North Carolina Rural Health Research Program

Cecil G. Sheps Center for Health Services Research
The University of North Carolina at Chapel Hill

725 Airport Road, CB #7590, Chapel Hill, N.C. 27599-7590
phone: 919/966-5541 fax: 919/966-5764

Sheps Center World Wide Web Address: www.shepscenter.unc.edu
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Susan Reif, MSW
Thomas C. Ricketts, PhD

North Carolina Rural Health Research Program

Cecil G. Sheps Center for Health Services Research
The University of North Carolina at Chapel Hill

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EXECUTIVE SUMMARY

The Medicare Critical Access Hospital Program (CAH) is a component of the Rural Hospital Flexibility Act passed as part of the part of the Balanced Budget Act of 1997 (BBA). Critical Access Hospitals are part of a nationwide limited service hospital program that was built on the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) and Medical Assistance Facility (MAF) demonstration programs. Critical Access Hospitals (CAHs) can provide outpatient, emergency and limited inpatient services and receive reasonable cost-based reimbursement for their services. The Congress authorized $25 million annually for 5 years to support the Rural Hospital Flexibility program. The first $25 million were appropriated in October 1998; the majority of these funds are scheduled to be awarded in 1999 through the federal Office of Rural Health Policy in HRSA.

This report describes the implementation of the Medicare Critical Access Hospital component of the Rural Hospital Flexibility Act during its first year. This is prior to the availability of any federal grant funds. The North Carolina Rural health Research Program conducted structured interviews with key persons in state offices of rural health, state hospital associations, departments of health, or department of facility licensing in all fifty states between August 3,1998 and September 10, 1998. A brief update of state CAH development status was done in November, 1998 and updates compiled in January, 1999.

Forty-three states have expressed interest in the CAH program. Among these states, eighteen had HCFA approved state plans, three had submitted plans and were waiting for approval, fifteen states were in the process of drafting their state plans, and seven states were attempting to generate interest in the program. Six states did not plan to participate in the program at this time because of a lack of appropriate or interested hospitals and one state had not decided whether they would participate in the program.

Thirty-seven hospitals in five states have been designated CAHs; thirty-six were formerly RPCHs, and one is a new limited service hospital. Fifteen MAFs/RPCHs will convert to CAHs when their state plans are approved or at their new fiscal year. In addition, respondents from states that have developed or are developing their state plans estimated that between 183-227 hospitals would become CAHs. In states that are in the early stages of the development process, respondents anticipated that 17-24 hospitals may convert to CAHs.

In order to receive CAH designation, a hospital must either be 35 miles or greater from the nearest hospital (15 in mountainous terrain or in areas where only secondary roads are available) or be deemed by the state as a "necessary provider." In states where state plans have been approved, respondents expressed satisfaction with HCFA's flexibility in allowing states to determine the criteria for designating hospitals as a "necessary provider." Most state respondents consider this crucial to the success of the program in their state. Designation criteria for necessary provider vary widely among states, and include mileage between hospitals, demographic indicators, being the sole hospital in a community, and location in a Health Professional Shortage Area (HPSA) or Medically Underserved Area (MUA).

States that have been successful with plan development appear to be those that participated in the demonstration projects, those that already had an ongoing dialogue about the possibility of a limited services hospital program, and those with widespread state support. States were also more successful when stakeholders, most importantly hospitals, expressed a need for transition to a limited service hospital model, as were states where the office of rural health or lead state agency appeared to have adequate development funds and political power.

The majority of state respondents expressed concern about the lack of appropriations to support the transition process. Most would use funds for technical assistance to provide financial analysis for hospitals that are considering conversion. Some states would use funds for development of the state plan, network development, community assessment and EMS enhancement. Respondents expressed the need for funds to assist in the comprehensive planning that is needed if the program

is to assist with the maintenance or improvement of rural health care rather than act as a temporary solution to hospitals in crisis. Other concerns expressed by states included adequacy of reimbursement for CAHs, definition of rural which excludes some hospitals that states consider to be rural, potential gaps in services created by loss of full service emergency rooms, and problems with reimbursement from managed care because of the change in status.

State respondents supported the role of the ORHP as the logical locus for a grant support program and felt that the ORHP had worked effectively with HCFA. They also expressed interest in a mechanism for states to share information and a need for dissemination or creation of materials that could provide guidance for the technical assistance needed to assist potential CAHs with their financial assessments and for strategic planning.

In its first year, the CAH program has been effectively implemented in up to 15 states. These states had sufficient infrastructure to provide the planning for new conversions and there were communities and hospitals that wanted to participate. Other states found it difficult to move ahead effectively to support conversions without additional resources. The most pressing need for the majority of states, including those implementing and those only planning for the program, is for reliable financial consulting or analysis that could be applied to individual hospitals. Finally, the program should be carefully evaluated to determine its effects on the financial status of hospitals, professional recruitment and retention, and quality of care.

INTRODUCTION

The Medicare Rural Hospital Flexibility Program (MRHFP) was created by the Balanced Budget Act of 1997 (BBA). This program has two components: the creation of a new limited service hospital payment classification, the Critical Access Hospital (CAH) and the authorization for a grant program to assist state in the implementation of the CAH program. The CAH program builds on the Essential Access Community Hospital/Rural Primary Care Hospital (EACH/RPCH) and Medical Assistance Facility (MAF) demonstration programs. The CAH is an acute care facility that provides outpatient, emergency and limited inpatient services in communities where local use no longer supports a full service hospital. CAHs receive reasonable cost-based reimbursement for their services.

The grant program was authorized for $25

CAH update 1/99

States with Approved State Plans (18 states) Updated 1/99	Alaska Arkansas Georgia Idaho Illinois Indiana	Kansas Maine Minnesota Montana Nebraska New York	North Carolina North Dakota Oklahoma South Dakota West Virginia Wisconsin
States that have submitted their state plans Updated 1/99	Iowa Washington Wyoming		
States where RPCHs have converted to CAHs (Nov, 1998)	Kansas (16) New York (3) South Dakota (8) West Virginia (6) North Carolina (3) Colorado will have 3 RPCHs to convert when their state plan is approved		
States with New CAHs (updated 11/98)	South Dakota (1)		
States where hospitals (not RPCHs or MAFs) are in the process of converting to CAHs (updated all states 11/98, spoke with Georgia, Maine, Oklahoma, South Dakota again 1/99)	Georgia Maine New York Oklahoma South Dakota West Virginia		

million annually for five years, but those funds were not appropriated when the BBA passed late in the second session of the 105th Congress. The first $25 million were appropriated in October, 1998. These funds are scheduled to be awarded in September, 1999 through the Office of Rural Health Policy. These grant funds will be used for implementation of the CAH program, improvement of rural emergency medical services, and support of community development activities and other activities to strengthen rural health systems. Starting February 1, 1999, states will be eligible for grants up to $200,000, for the first phase of planning or implementation and they will be eligible for further grants up to $500,000..

The purpose of this study is to describe the early stage of implementation of the CAH program in all fifty states, which occurred prior to availability of federal funds to assist with the process. The study addresses two major questions: whether states participating in the EACH/RPCH and MAF programs have been able to successfully transition to the CAH program and whether additional states have been able to develop state plans and begin implementing the program. In addition, the study identifies barriers to successful program participation.

Background:

The EACH/RPCH and MAF demonstration programs were created as part of an effort to reduce the financial repercussions of the Prospective Payment System (PPS) on rural hospitals and preserve access to critical medical services in rural communities. Rural hospitals that participated in the programs as limited service hospitals were largely exempted from PPS rate structures and instead received cost based reimbursement. These limited service hospitals provided an alternative health care facility to rural communities that could no longer support a traditional hospital and were in danger of losing access to basic health care services [Campion, 1995].

The EACH/RPCH program was created as part of the Budget Reconciliation Act of 1989. Under this program seven states received grants to develop networks that consisted of the limited service hospital (RPCH) and the acute care referral hospital (EACH). RPCHs provided outpatient and short term inpatient care that was limited to an average length of stay of 72 hours. The first RPCH was certified in South Dakota in September of 1993. By August 1997, an additional 37 hospitals in 6 states converted to RPCHs [GAO, 1998].

In 1987, Montana became the first state to legislate the creation of a limited service hospital program [Campion, 1995]. Montana's MAF program received Medicare waivers that allowed for cost based reimbursement of basic emergency care, outpatient services, and inpatient care (limited to 96 hours) provided at these limited service hospitals. The first MAFs were licensed in December of 1990 and by 1995 there were nine MAFs [Campion, 1995]. A total of twelve hospitals converted to MAFs.

Results from a GAO study of the experience of the EACH/RPCH program indicate that RPCHs "provided additional and, likely, more proximate access to health care for Medicare beneficiaries in areas where the facilities were located." RPCHS also "served as the source of outpatient care ranging from emergency to primary care "[GAO, 1998]. These facilities primarily served patients who had respiratory ailments, circulatory system problems such as congestive heart failure, and digestive system illnesses. A review of MAFs, also performed by the GAO, identified MAFs to be important sources of emergency and primary care in the communities where they were located. These facilities primarily treated patients with urgent but uncomplicated conditions and stabilized patients with more complex needs prior to transferring them to full service hospitals [GAO, 1995]. The GAO report found that Medicare costs for inpatient care at MAFs were lower than they would have been if the care had been provided in full service rural hospitals.

Participants in the EACH/RPCH demonstration program and other rural health experts identified shortcomings of the program and recommended programmatic changes such as increasing the length of stay limit, increasing the number of beds allowed in the limited service hospital and adapting the networking provisions [Campion, 1995]. The Critical Access Hospital

program utilizes features from both demonstration projects and addresses some of the identified shortcomings of the EACH/RPCH program by increasing lengths of stay from an average of 72 hours to 96 hours, increasing the number of acute care beds allowed from 6 to 15, and replacing EACH payments and requirements with a provision that the CAH form a network with one or more hospitals for referral, transfer, use of communication systems and provision of emergency and non emergency transportation.

Program Requirements:

States that are interested in participating in the CAH program must submit a state plan that outlines their process for program implementation and this plan must be approved by their regional HCFA office. In order to be eligible as a critical access hospital, a facility must be a rural public or nonprofit hospital located in a state that has obtained approval for their state plan. In order to qualify as CAHs, hospitals must also be more than a 35 mile drive from any other hospital or CAH (15 miles in mountainous terrain or in areas with only secondary roads available) or must be certified by the state as being a necessary provider of health care services to residents in the area. In addition, the facility must have 24 hour emergency services available, have a length of stay limit of 96 hours, be part of a network with at least one acute care hospital, and have no more than 15 acute beds. An exception to the 15 bed limit is made for swing-bed facilities. These facilities are allowed to have up to 25 inpatient beds that can be used for either acute or skilled nursing facility level of care; however, no more than 15 beds can be used for acute care at any one time. Existing RPCHs and MAFs can be grandfathered as CAHs if they are eligible to be designated as a CAH by the state.

METHODS

In order to examine the early implementation of the CAH program, interviews with key persons at the state office of rural health, state hospital association, department of health or department of licensure in all fifty states were completed between August 3, 1998 and September 10, 1998. The director of the state office of rural health in each state was contacted to answer a structured questionnaire regarding their progress in implementation of the CAH program. In a few states another agency, such as the state hospital association, the department of health or the state licensing department, was the lead agency for the CAH program; therefore, interviews were performed with representatives of that agency rather than the office of rural health. However, in the majority of states the office of rural health was identified as taking the lead role in the program development process.

The structured questionnaire contained questions regarding the following topics: progress in development of the state plan and barriers encountered in this process; status of network development; development of designation criteria; number of current and projected CAHs; licensure for CAHs; other changes in rural services expected because of the CAH program; and overall concerns regarding the program. In mid-November state respondents were faxed a tabular copy of the interview results and asked for updates and corrections. The federal HCFA office was contacted in mid-January to update and verify the number of states with approved state plans.

RESULTS

Participation in the program:

Forty-three states expressed interest in the CAH program. These states were at various stages of the program development process (see Table 1 for a summary of results). As of mid-January, eighteen states had state plans that had been approved by HCFA regional offices. These eighteen states were not concentrated in one area, although the Midwest had the highest number of approved plans. Respondents in states where plans have been approved described few problems in obtaining plan approval. Three states had submitted their state plans and were waiting for a decision from their HCFA regional office. Fifteen states were in the process of drafting their state plans. Some states were initiating this process while others were nearing completion and

planned to submit the state plan in the next month or two.

The majority of states that were working on development of their plan indicated no significant internal problems with this process. However, several states mentioned lack of funding for the development process as a factor that has delayed the expedient completion of a state plan. Most states have found state agencies and other stakeholders to be supportive and interested in the program. State agencies and stakeholders included state hospital associations; departments of licensure, Medicaid, and emergency medical services; offices of primary care; and rural hospitals. In a number of states, the office of rural health and other interested agencies had discussed the possibility of a limited service hospital program and were in agreement of the need for such a program prior to the passage of the BBA. In some of these states, interested agencies had already begun work on development of a limited service hospital program.

Seven states were attempting to generate interest in the program and four of these were experiencing difficulty stimulating this interest. Lack of interest by hospitals or stakeholders, lack of leadership for development, lack of political will to explore the option, and lack of funding for development were listed as reasons for difficulty in creating interest in the program. Respondents from all seven of these states mentioned insufficient funding as an issue. Some were concerned with lack of funds to develop the state plan while others indicated that there were no funds available for technical assistance to aid hospitals in exploring the feasibility of the CAH option.

One state experienced an administrative change in their state office of rural health and had not had a chance to explore the feasibility of the program for their state. Six states were not interested in CAH program participation at the time of the interview because they had no hospitals that were interested or appropriate. Five are small states in the northeast or eastern seaboard. The remaining state, Hawaii, sent a survey to rural hospitals to assess interest in the program. No hospitals expressed interest, as their evaluations did not show financial improvement through conversion to CAHs.

Participation of EACH/RPCH and MAF states in the program:

Five of the seven EACH/RPCH states, (Kansas, New York, North Carolina, West Virginia, South Dakota), and Montana (the MAF state) had HCFA approved state plans. In Colorado and California, respondents stated that they were in the process of developing their state plans. Several EACH/RPCH states experienced a lack of interest by hospitals because of changes in Medicare Part B reimbursement from the EACH/RPCH program. Under the EACH/RPCH program, RPCHs could elect to receive an all-inclusive payment, which combined the professional and facility services components into a single payment [Campion, 1995]. Hospitals were concerned that change from the all-inclusive rate of the EACH/RPCH program to the cost based outpatient reimbursement of the CAH program would result in a less secure financial situation.

Number of hospitals converted and projected to convert:

As of January 1999, thirty-seven hospitals in five states were CAHs. Thirty-six of these hospitals were former RPCHs and one is a new CAH. Fifteen MAFs and RPCHS will convert when their state plans are approved or at the start of their new fiscal year. Respondents in states that had developed state plans or were in the process of developing their state plans were asked to project how many hospitals would convert to CAHs in the next one to two years. Based on estimates of the interest that they had identified at the time of the interview, respondents in 34 states projected that 183-227 hospitals will convert to CAHs. However, they cautioned that many factors, such as changes in Medicare reimbursement, local economies, or local political will, could easily alter these estimates. Respondents in states that were attempting to generate interest in the program were also asked to estimate how many potential CAHs they might have. The number of potential CAHs in five states that were early in the development process was 17-24. Many of

these estimates were basically the best guess of the person interviewed, as most respondents had performed no formal evaluations.

Designation Criteria:

The majority of states have either developed their own criteria for designation of "necessary provider" or plan to develop criteria that are reflective of rural health care needs in their state. Although respondents in most of the western states said that the majority of their rural hospitals meet the mileage criteria, some plan to ask or have asked for additional flexibility in criteria in order to have the option of including hospitals that do not meet the mileage criteria. States that developed their own criteria used a wide variety of factors to define necessary provider. Some of the most common criteria include hospital located in a Health Professional Shortage Area (HPSA); located in a Medically Underserved Area (MUA); located in a county where the poverty rate, unemployment rate or proportion of the population over 65 exceed state averages; designation as a Medicare dependent hospital, and being the only hospital in a county. Additional criteria that have been used or are being considered by states include: being more than 20 miles from the next nearest hospital; the only hospital in a region that provides certain types of services such as obstetric services; located in an area where the population is at risk for poor outcomes as determined by Claritas Marketing Data Systems; located in a county with high accident rates; located in a low population density area; hospital more than 50 miles from a trauma care center; and population increase of more than 30% at any time in the year.

Respondents in states where plans have been approved were pleased with the flexibility that HCFA has demonstrated in allowing states to determine their own criteria for necessary provider. Most states viewed this flexibility as critical to the success of the program. Some respondents in states that were at earlier stages of plan development expressed concern that flexibility in the designation criteria would not be allowed. These states could benefit from information about the experiences of their fellow states that are farther along in the process.

Network Development:

The status of network development varied greatly between states. The majority of states had some network development that occurred for the purposes of referral, managed care, telemedicine, or purchasing agreements. However, the number of networks, how they were used and the strength of their associations differed by state. Many states may have to formalize current networks or develop additional networks for use in the CAH program. Several state respondents described very little network development, therefore they will have to initiate this process for the program. Two Southeastern states received grants from Robert Wood Johnson Foundation's Southern Rural Access Program that included provisions for network development and six others are in the process of applying for these grants. In addition, several other states had received federal or state funding for network development. Several states respondents mentioned that funding for network development is needed in their state, as they do not currently have funding available for this endeavor.

Licensing of Critical Access Hospitals:

Mechanisms for licensure of CAHs varied widely across states. Some states created new legislation or plan to create new legislation for licensure, while others are able to adapt previous licensure categories. Most respondents from states that were in the early stages of development were not sure how they would approach this issue. Respondents from several states that have developed state plans said that the licensing agency in their state was involved in the plan development process. Respondents reported that the participation of these agencies was beneficial in the process of deciding on the most appropriate way to license the CAH facilities.

Anticipated effects of the program on rural services in general:

Respondents from all states that plan to be involved in the CAH program were asked to

comment on how they thought the program would effect the provision and structure of rural health care services in general. Many respondents from states that were in the early stages of plan development were uncertain as to the influence the program would have, although some speculated that implementation of the program would result in more community involvement and better coordination of care. Respondents from several states in later stages of plan development also stated that they anticipated greater community involvement, as well as strengthening of hospital networks and greater regionalization of care.

Some respondents believe that the extent of the program's influence on rural health care services will depend on the availability of funding for program planning. State respondents described the need for planning for activities, such as community involvement in the program, network development, and strengthening EMS networks, that would assist in improving continuity and quality of patient care. Several respondents expressed the sentiment that without comprehensive planning the program may be implemented as a short-term fix for hospitals that are in crisis but will not result in longer term solutions to problems of rural health.

Six state respondents did not expect that the program would have an influence on rural services in general. These respondents viewed the program as a way to ensure the survival of small rural hospitals and maintain access for persons in those communities, but they did not expect the program would act as a catalyst for additional changes in rural health services. A few respondents were concerned about potential negative ramifications of the program on emergency services, as CAHs are not required to have full service emergency rooms.

Need for appropriations:

At the time of the interviews there was no federal funding available for implementation of this program. When interviewed in August-September, 1998, the majority (32) of state respondents expressed concern about the lack of appropriations for development and implementation of the program. Many of the state offices of rural health have very limited budgets that restrict their ability to respond to new innovations such as the CAH program. State respondents that expressed concerns about funding for the program were asked what they would use the funding for if it were available. Six state respondents said they needed funding to assist with the development of the state plan. These states were interested in the program but were having difficulty securing the resources needed for plan development. Several state respondents mentioned that lack of funding for the program had slowed the progress of plan development because they could not afford additional staff time and existing staff had little extra time to allocate to this activity.

Two-thirds of respondents that expressed funding concerns said they would use appropriations for technical assistance to provide financial assessments for hospitals interested in conversion. Many respondents also said that they would utilize the funding to assist hospitals in doing a community needs assessment. Some states required that participating hospitals complete financial feasibility studies and community assessment prior to conversion. According to state representatives, most hospitals that are considering conversion do not have the resources needed to perform the financial and community assessments that are warranted prior to conversion.

Additional uses for funding stated by respondents included network development, enhancing EMS systems, and implementation and administration of the program including licensing and monitoring of critical access hospitals. A number of respondents discussed the need for funds for comprehensive planning to improve systems of care for rural communities. Planning activities included some of the needs listed above, such as community assessment and involvement, network development, enhancement and better networking of EMS systems, as well as planning for adequate staffing of these hospitals, educating communities, providers, and managed care organizations about the CAH program, and stimulating hospitals and communities to plan for the future rather than waiting for a crisis to make changes.

Additional concerns regarding the CAH program:

Many state respondents expressed concerns regarding the CAH program that were not related to appropriations for the program. In addition, respondents were asked if they had any concerns that they would like the Office of Rural Health Policy (ORHP) to be aware of or any issues they would like ORHP to advocate for. State concerns and suggestions are outlined below:

Several states expressed concerns regarding the adequacy of reimbursement for hospitals. Respondents in four states (HI, NH, IL, MN) reported that some of their hospitals performed preliminary financial analyses that showed program participation to result in a negative financial outcome.

Several EACH/RPCH demonstration states were concerned that their limited service hospitals may begin to lose money because they will no longer receive the inclusive Medicare Part B reimbursement. Several of these states reported that the outpatient reimbursement has been a deterrent to hospitals considering conversion.

Eight states identified the definition of rural as a concern. They have hospitals that could potentially benefit from the program that are in areas that have rural characteristics but are located in metropolitan counties.

Some respondents expressed concern that downsizing hospitals may cause them to be less appealing to managed care and therefore not receive contracts. This already appears to be an issue in one state where a managed care organization is not recognizing the CAH as a hospital and is refusing reimbursement for services.

Several state respondents expressed a desire for federally qualified rural health clinics (FQHCs) to be able to convert to CAHs or at least be allowed to have some inpatient hospital beds.

Many state respondents acknowledged the difficulty of devising a plan that would work for 50 heterogeneous states. Several of these respondents mentioned the desire to have a more flexible program where states could design a program that would best suit their needs and apply for a waiver.

States expressed need for a formalized method for dissemination of any materials that would be of assistance for program development and implementation. The American Hospital Association's Critical Access Hospital Compendium (http://www.aha.org/memberserv/critacceshosp.html) was mentioned as a publication that may be beneficial to states.

CONCLUSIONS

The majority of states expressed interest in the CAH program and have made some progress in the development phase of the program. States that have been the most successful in the development phase appeared to be those who were already involved in the limited service hospital demonstration programs or already had discussed the possibility of a limited hospital service program; those that had widespread state support and a perceived need on the part of stakeholders including hospitals that were interested in conversion; and states where the office of rural health or other involved state agency or hospital association appeared to have adequate funds and political power. States that were not interested in the program, with the exception of Hawaii, were small states located in the northeast or eastern seaboard that generally have few or no rural hospitals.

State respondents expressed several concerns about the CAH program. The most frequently expressed concern was lack of appropriations for planning, development, implementation, and maintenance of the program. This concern has potentially been obviated by the passage of the omnibus appropriations bill. Other frequently listed concerns include the adequacy of reimbursement for hospitals and the exclusion of hospitals that may benefit from the program but are located in a Metropolitan Area.

In states with approved state plans, respondents praised HCFA for their flexibility in allowing states to determine appropriate critical access hospital designation criteria. Respondents were also complimentary of the efforts that the Office of Rural Health Policy has made in trying to secure the critical CAH program appropriations, as well as their continued support of and advocacy for the state offices of rural health. State

respondents had recommendations for activities that could influence the success of the program implementation and assist in meeting desired goals. These included the desire for ORHP to continue an ongoing dialogue with HCFA to address program issues as they arise and interest in a mechanism for states to share information as well as a need for dissemination or creation of materials that could provide guidance for the technical assistance needed to assist potential CAHs with their financial assessments. Respondents in states where initial financial evaluations show poor outcomes of conversion would like to see further exploration of this issue, which could have substantial repercussions for the success of the program. Respondent strongly emphasized the necessity for as much flexibility as possible for program implementation in order to accommodate the very diverse needs of states. Finally, respondents expressed the need for continued strategic planning to address the needs of rural hospitals and improve the health of residents in rural communities.

The CAH program should be carefully evaluated to determine its effects on the financial status of hospitals as well professional recruitment and retention, and quality of care. Careful program monitoring could assist in identifying barriers that interfere with successful program implementation and provide solutions for alleviating these barriers.

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TABLE 1: Summary of Individual State Results

State	Expressed interest in program	Struggling to generate interest in the program	Discussing initiation of planning process with stakeholders	Working on the state plan	State plan approved by HCFA	How many are CAHs or were former RPCH/MAF and will convert to CAH	Predicted CAHs next 1-2 years, states developing state plans or approved plans	Potential CAHs in states that are an early stage of MRHFP development
AL	X		X					5-10
AK	X				Approved		1-3	
AR	X				Approved		3-5	
AZ	X	X						5
CA	X			X			6-7	
CO	X			X		3RPCHs will convert	2-3	
CT	No hospitals interested/ Appropriate							
DE	No hospitals can benefit at this time							
FL	X			X			4	
GA	X				Approved		4-8	
HI	No hospital interested at this time							
ID	X				Approved		9	
IA	X				Submitted		12	
IL	X				Approved		3-5	
IN	X				Approved		6-7	
KS	X				Approved	16 RPCH are now CAHs	10-12	
KY	X			X			3-5	
LA	X			X			5-6	
ME	X				Approved		4-7	
MD	No interested hospitals at this time							
MA	Will explore option, not sure if any hospitals will be appropriate							
MI	X			X			5-7	
MN	X				Approved		2 on working on CAH designation, uncertain how many more will convert	
MS	X			X			4-5	
MO	X	X						
MT	X				Approved	12 MAFs will convert	5	
NE	X				Approved		8-10	
NV	X			X			5	
NH	X			X			Uncertain	
NJ	No rural hospitals							

NM	X			X – early stage			4-6	
NY	X				Approved	3 RPCHs are now CAHs	4-5	
NC	X				Approved	5 RPCHs are now CAHs	5	
ND	X				Approved		3-5	
OH	X		X – lack of funding an issue					1-2
OK	X				Approved		8-10	
OR	X			X			4-5	
PA	X		X					
RI	Not needed at this time							
SC	X			X			3	
SD	X				Approved	8 RPCHs are now CAHs and 1 new CAH as of 1/1/99	6-7	
TN	X			X			6	
TX	X			X			15-20	
UT	X	X						1-2
VT	X	X						5
VA	X			X			2-3	
WA	X				Submitted		10	
WV	X				Approved	6RPCHs converted to CAHs	3 (1 waiting for HCFA approval)	
WI	X				Approved		8-10	
WY	X				Submitted		3-5	
TOTAL	43, 1 not sure	4	3	15	18 approved 3 submitted	36 former RPCHS are CAHs; 15 MAF/RPCH will convert and 1 new CAH	183-227	17-24