



# HOSPITALS ON THE FRONTIER

**M**aintaining access to healthcare in rural areas is a problem that has captured the attention of policymakers in recent years. Because hospitals tend to be the center of healthcare activities in rural communities, a primary focus has been the development of strategies for strengthening rural hospitals and for establishing alternative institutional structures to maintain acute care services in a rural community when a hospital is no longer viable.<sup>1</sup>

The concept of a limited service rural hospital recently gained nationwide attention when Montana introduced the medical assistance facility (MAF) model, which allows a hospital to have a "limited license under less stringent rules (rather than close completely)."<sup>2</sup> Montana developed the MAF concept in response to growing concern about rural hospital closure and the resultant loss of access to inpatient acute care services. In remote rural areas, this loss of access also translates to significant economic deterioration. The availability of healthcare services helps to maintain viable local economies, since the community will be in a better position to attract healthcare providers and other needed professionals such as teachers and employers.<sup>3</sup>

## LEGISLATIVE ACTION

In 1987 the Montana legislature created the MAF as a new category of acute care facility licensure. An MAF is a down-scaled, limited-service

*The Medical Assistance Facility Demonstration Project Maintains Acute Care Access in Rural Montana*

BY KEITH McCARTY

rural hospital that makes extensive use of midlevel practitioners and has flexible staffing requirements. MAFs are not only rural but, more specifically, frontier hospitals—located in counties or

## Summary

The concept of a limited service rural hospital recently gained nationwide attention when Montana introduced the medical assistance facility (MAF) model, which allows a hospital to have a license under less stringent rules (rather than close completely). The MAF is a down-scaled, limited-service rural hospital that makes extensive use of midlevel practitioners and has flexible staffing requirements. MAFs restrict admission to patients with low-intensity, acute illnesses who typically require short-term hospitalization.

Montana currently has four MAFs certified as Medicare and Medicaid providers under the terms of a waiver agreement with the Health Care Financing Administration (HCFA). MAFs are located in four "frontier" communities—counties or regions with fewer than six residents per square mile.

A 96-hour cap on inpatient stay effectively guarantees that the MAF's scope of services will be circumscribed. However, the array of services that meet the definition of low intensity and short term is potentially broad. The flexibility—and thus the real strength—of the MAF model is in the licensure rules, which relax some of the requirements that the small rural hospital has difficulty meeting (such as those regarding staffing).

The demonstration project is now entering its final two years. So far, it has gained widespread interest and support. The central question is whether HCFA will extend the waiver after 1993. Another possibility is the reclassification of MAFs to rural primary care hospitals, which do not require waiver coverage to receive Medicare and Medicaid reimbursement.



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regions with fewer than six residents per square mile.

MAFs restrict admissions to patients with low-intensity, acute illnesses who typically require short-term (four days or less) hospitalization. In addition, the MAF licensure rules make a significant concession to the likelihood of low utilization and personnel shortages in frontier communities because on zero-census days MAFs can

relax the usual standards for staffing inpatient care areas (see **Table**). This limited service or "alternative" model is the prototype for the rural primary care hospital (RPCH) authorized by Congress in Public Laws 101-239 and 101-508.

#### **MEDICARE WAIVER FOR DEMONSTRATION PROJECT**

After the close of the 1987 legislative session, the Montana Hospital Research and Education

## **MAJOR DIFFERENCES BETWEEN HOSPITAL CONDITIONS OF PARTICIPATION AND MEDICAL ASSISTANCE FACILITY LICENSURE RULES**

### **Hospital Conditions of Participation**

### **MAF Licensure Rule**

Every patient is under the care of a doctor of medicine or osteopathy; a doctor of dental surgery or dental medicine . . . ; a doctor of podiatric medicine . . . ; a doctor of optometry . . . ; a chiropractor.

Every patient is either under the care of a physician or under the care of a nurse practitioner (NP) or physician assistant (PA) supervised by a physician.

Patients are admitted to the hospital only on the recommendations of a licensed practitioner permitted by the State to admit patients to a hospital. If a patient is admitted by a practitioner not specified [above], the patient is under the care of a doctor of medicine or osteopathy.

Whenever a patient is admitted to the facility by a PA or a NP, the facility's sponsoring physician is notified of that fact, by phone or otherwise, within 24 hours after the admission. . . .

A doctor of medicine or osteopathy is on duty or on call at all times.

A physician, NP, or PA is on duty or on call and physically available at the facility within one hour at all times. . . .

The hospital must have an organized nursing service that provides 24-hour nursing service.

A medical assistance facility must have a nursing service that provides 24-hour nursing services whenever a patient is in the facility. . . .

The hospital must provide 24-hour nursing services furnished or supervised by a registered nurse and have a licensed practical nurse or registered nurse on duty at all times. . . .

A registered nurse must be on duty at least 8 hours per day, and the Director of Nursing or another registered nurse designated as the Director's alternate must be on call and available within 20 minutes at all times.

The hospital must maintain, or have available, diagnostic radiologic services.

If a medical assistance facility maintains, or has available, diagnostic radiologic services, they must meet the following standards. . . .

[The conditions of participation have no comparable standard.]

No patient is cared for in the facility for more than 96 hours.

[The conditions of participation have no comparable standard.]

The medical assistance facility must enter into agreements with one or more providers participating in Medicare or Medicaid to provide services meeting the needs of its patients which the facility itself is unable to meet.

From Abt Associates, Inc., *The Montana Medical Assistance Facility Demonstration Evaluation: Implementation Case Study* (draft), November 8, 1991, p. 6.



## DEMONSTRATION PROJECT OBJECTIVES

- To demonstrate that, as a result of the MAF option, frontier communities in Montana can prevent the permanent loss of institutional healthcare services that would ordinarily result from hospital closure
- To demonstrate that Medicare/Medicaid program patients in Montana's frontier areas will accept the MAF as a satisfactory alternative to the traditional full-service hospital
- To demonstrate that the MAF will provide low-acuity healthcare services equal in quality to the services provided by full-service hospitals located in other frontier areas
- To demonstrate that the MAF model has the potential for implementation in frontier areas elsewhere in the United States

Foundation (MHREF) proposed a demonstration of the efficacy of the MAF model to the Health Care Financing Administration (HCFA). Finding the MAF model promising, HCFA funded a multiyear demonstration project, which is now entering its final two years. The project's goals are shown in the **Box** above.

The foundation for the demonstration rested on HCFA's issuance of a Medicare waiver, which ultimately required congressional authorization [Section 4008(i)(1) of Public Law 101-508]. MHREF asked HCFA to:

- Accept Montana's MAF licensure rules in lieu of the Medicare Hospital Conditions of Participation, waiving those conditions not applicable to MAF operation
- Reimburse Medicare services on the basis of reasonable cost
- Allow the state's peer review organization (PRO) to provide utilization review services for all patients, not just Medicare beneficiaries

MHREF argued that the MAF model could not be demonstrated as designed unless HCFA granted these requests. The waiver was issued in December 1990, and only days later the first facility, McCone County MAF in Circle, was licensed and certified by the Montana Department of Health and Environmental Sciences.

For the small rural hospital plagued by high fixed costs of operation, the MAF creates a downsizing option that has not previously existed. In circumstances where hospital closure has already occurred or appears to be inevitable, the MAF enables a frontier community to maintain an institutional healthcare presence. Montana currently has four MAFs certified as Medicare and Medicaid providers under terms of the waiver agreement with HCFA. MAFs are located in Circle, Ekalaka, Jordan, and Terry, all in the eastern portion of the state. These are small facilities, ranging in size from 2 to 10 acute care beds.

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Each site was once a full-service hospital with 5 to 20 beds.

### A SPARSE AND AGING POPULATION

Montana is the fourth largest state but among the least populated. Of its 56 counties, 44 are characterized as frontier. In recent years, five of Montana's frontier counties (including the four MAF sites) have experienced hospital closures because of financial problems, loss of physicians, or both. These counties are large and remote. Hospital closure exacerbates the already difficult problem of acute care access. Garfield County, for example, is the size of Connecticut, but *Jordan is its only incorporated town. Closure of the hospital in 1986, following the loss of the facility's sole physician, left residents with no recourse but to travel long distances—70 to 135 miles—for hospital care. Finally, in 1991, after five years without inpatient acute care services, Garfield County residents welcomed the certification of two MAF beds in Jordan.*

Medicare reimbursement to MAFs is crucial because of the demographics in Montana's frontier counties. Population loss during the past decade has accelerated the aging of the population, for whom travel is always inconvenient and sometimes impossible. Harsh winter and late spring snowstorms are common in Montana. Road conditions can be hazardous six months of the year. Without local services, the elderly are at great risk regarding both health and safety. As younger residents move elsewhere and few replacements move in, the average age in many frontier areas moves steadily upward. Over the 1980s, McCone County registered a population loss of 15.8 percent, Carter County 16.5 percent, Prairie County 24.7 percent, and Garfield County 4 percent. At the same time, the median age of the population increased 22 percent, 9 percent, 25 percent, and 17.5 percent, respectively.<sup>4</sup> MHREF projects Medicare utilization in the MAFs serving these areas at 65 percent to 80 percent, based on either patient days or revenue.

Clearly, MAF viability is contingent on Medicare reimbursement. The waiver issued by HCFA allows MAFs to receive program payments for services delivered to Medicare beneficiaries. The state Medicaid program also participates in the MAF demonstration. Medicare utilization in MAFs is not expected to exceed 2 percent, however.

### KEY FEATURES OF THE MAF MODEL

The key feature of the statutory definition of MAF, which characterizes the model as providing a limited institutional healthcare service, is the 96-hour cap on inpatient stay (see **Box**, p. 45).



The length-of-stay limitation effectively guarantees that the MAF's scope of services will be circumscribed. The restriction on scope does not necessarily mean, however, that every MAF's array of medical services will be narrow.

Although MAFs were designed to treat low-intensity, short-term, acute illnesses on an inpatient basis, the array of services that meet the definition of low intensity and short term is potentially broad and will surely be influenced as much or more by the composition of the medical staff as by the 96-hour length-of-stay limitation. The flexibility—and thus the real strength—of the MAF model is in the licensure rules, which relax some of the requirements that the small rural hospital has difficulty meeting. The rules are designed to be accommodating without sacrificing quality of care.<sup>5</sup>

The licensure rules anticipate that MAFs may not be able to treat all patients who come to the facility. Accordingly, the MAF is required to have transfer agreements with full-service hospitals and service agreements with other Medicare and Medicaid providers (e.g., a skilled nursing facility or home health agency) to meet "the needs of its patients which the facility itself is unable to meet." In addition to the staffing and service provisions listed in the **Table**, the MAF must have pharmaceutical and clinical laboratory services "adequate to fulfill the needs of its patients." MAFs must also provide 24-hour-a-day emergency services that are "equipped and staffed at levels equal to, or greater than, those provided for ambulance services."<sup>6</sup> The licensure rules establish the floor level (i.e., minimum set of services) at which MAFs must operate but do not prohibit or discourage other service offerings. The medical and nursing staff composition will vary from site to site. For example, at three of the MAFs, physician assistants are located on-site and physicians (facility medical directors) commute from other locations. In Circle, however, the medical director and physician assistant are both on-site.

Because each MAF is at the same location as a nursing home, an outpatient clinic, and other health services, a complement of these services (not just acute care) is available at a single site. Typical of all MAFs, the Dahl Memorial MAF and Nursing Home in Ekalaka provides space for dental services, mental health and substance abuse counseling, and WIC and family planning programs. The county's volunteer ambulance service is also dispatched from this facility.

Much of the local interest in the MAF model centers on the provision of full-time emergency services. Abt Associates, Inc., the firm contracted by HCFA to evaluate the project, interviewed a representative sample of residents in Carter,

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Garfield, and McCone counties in August 1991. Among the findings, Abt reports: "Those interviewed in all three sites felt that the overwhelming need in the community was for emergency care. Long distances to hospitals outside of the county and their dependence on agriculture, makes emergency care services very important to these communities."<sup>7</sup>

#### QUALITY ISSUES: UTILIZATION REVIEW

Utilization review for all MAFs is conducted by the Montana-Wyoming Foundation for Medical Care, the state's Medicare PRO. The PRO provides three levels of MAF utilization review:

1. Preadmission review to determine the "medical necessity" of inpatient care
2. Preadmission review between the 48th and 72d hour of patient stay to determine appropriateness of discharge and/or transfer plans, to determine whether the quality of care meets professionally recognized standards, and to determine whether the length of stay is appropriate
3. Retrospective review to determine whether patients received a covered level of care for each day's stay and to monitor quality of care

Some mixing of these functions occurs when preadmission reviews are not possible (since the PRO is not available 24 hours a day). For example, medical necessity may be determined as a result of the preadmission review, and the retrospective review may be a validation of the information obtained. Private insurers can elect to perform these reviews independently if the Department of Health and Environmental Sciences determines that their procedures meet PRO standards.

#### SUCCESS OF THE DEMONSTRATION

The MAF demonstration project and the Medicare waiver are currently scheduled to continue through 1993. Abt Associates has designed an evaluation study to examine quality issues, uti-

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### STATUTORY DEFINITION OF MAF

In Montana, a medical assistance facility is defined as a healthcare facility that:

- a. Provides inpatient care to ill or injured persons prior to their transportation to a hospital, or provides inpatient medical care to persons needing that care for a period of no longer than 96 hours.
- b. Either is located in a county with fewer than six residents per square mile, or is located more than 35 road miles from the nearest hospital.

From Montana Legislative Council, *Montana Code Annotated*, 50-5-101-29.

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Within Montana, several small hospitals have indicated interest in converting to MAF licensure.

lization, and costs. Although the demonstration's ultimate success is clearly tied to evaluation results, just the initial achievement of establishing the four MAFs in remote areas of Montana has engendered considerable interest and support.

The interest is nationwide. MHREF has received requests for information from more than 40 states regarding the project, the licensure rules, the waiver, and evaluation issues. Within Montana, several small hospitals have recently indicated interest in converting to MAF licensure. MHREF anticipates at least one more such conversion within the next few months and perhaps others by year's end.

Support is coming from many fronts. HCFA has continued to fund the demonstration project and has worked cooperatively with MHREF to resolve barriers as they arise. Last September, Gail Wilensky, PhD, HCFA's administrator at the time, traveled to Jordan and toured Garfield County Health Center. At a social gathering afterward, she praised the community's effort to solve local healthcare problems at a local level.

Support for the MAF project by other agencies is also notable. The state Medicaid program has enthusiastically participated in the waiver; the Medicare fiscal intermediary has accommodated this new type of provider by processing claims without difficulty; private insurers have done likewise; and the Department of Health and Environmental Sciences has assigned the same surveyors to all the MAFs, so that facility-specific licensure and certification issues are always handled by persons with MAF expertise.

The central questions that remain concern what happens after 1993. Will

HCFA extend the waiver? Will the MAFs be granted covered-service status under Medicare? Are these facilities again at risk for closure if evaluation results are negative? MHREF is working with HCFA to continue operation of the MAFs after the formal demonstration has ended. One possibility is the reclassification of MAFs to RPCH status. RPCHs do not require waiver coverage to receive Medicare and Medicaid reimbursement. Furthermore, the RPCH has a conceptual tie to the MAF model, since the former is

derivative of the latter.

In the meantime, the demonstration of the MAF model continues. As a result, residents of four frontier counties have local access to acute care services, helping to maintain the rural quality of life. □

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## LEASING MADE SIMPLE

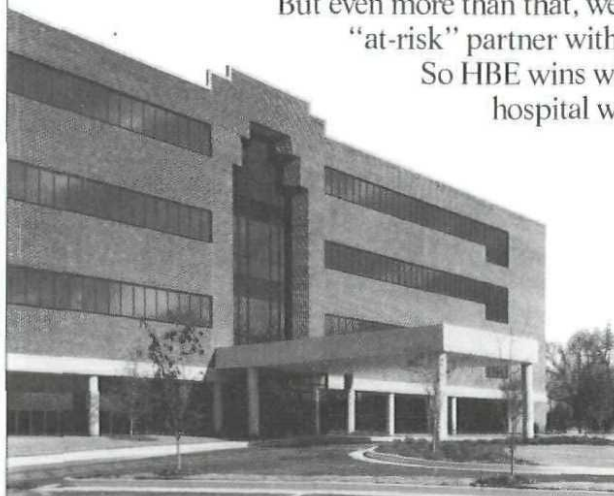
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