

Rural Community Hospital Demonstration Program New Solicitation of Participants

Overview

Section 10313 of the Patient Protection and Affordable Care Act of 2010 mandates an extension of the Rural Community Hospital Demonstration Program for an additional 5 years. The law allows additional hospitals to participate in the demonstration program. Since 10 hospitals are currently participating in the program, the Centers for Medicare & Medicaid Services (CMS) is conducting a new solicitation that will allow up to 20 new hospitals to participate in the demonstration for a period of 5 years.

Congress included this provision in the law in response to the financial concerns of small, rural hospitals that are too large to qualify as Critical Access Hospitals (CAH). The demonstration is designed to test feasibility and advisability of reasonable cost reimbursement for inpatient services to small rural hospitals. The demonstration is aimed at increasing the capability of the selected rural hospitals to meet the needs of their service areas. Additional reimbursements under the original 5-year demonstration period provided participating hospitals with resources to continue as full service providers and to meet the needs of their service areas.

Background

Since 2004, CMS has been conducting a “Rural Community Hospital Demonstration Program” as mandated under Section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. The original 5-year period of performance mandated by the MMA will end in 2010. For information on this initial period of performance, including the list of participating hospitals, please see the document titled, “Summary,” on this web page.

Based on hospital financial data from the first 2 years of the demonstration (FYB 2005 and FYB 2006), the evaluation found that:

- All hospitals participating during these 2 years did benefit from the demonstration financially although there was wide variation. Reimbursements above the inpatient prospective payment system (IPPS) ranged from less than 10 percent above IPPS to over 75 percent above IPPS for both years.
- The average Medicare inpatient margin for the nine hospitals participating during this time rose from negative 22.8 percent before the demonstration to break even in the first year (.2%) when hospitals were paid based on costs. The average inpatient margin declined the next year (-4.1%) when hospitals were paid the lesser of costs or a target amount.
- Participating hospitals were paid \$37.5 million more than they would have been paid under IPPS during the first 2 years. Annual offsets to the national IPPS

payment rate, published in the *Federal Register*, ensure that the demonstration remains budget neutral.

Case study analyses of hospitals participating as of December 2009 found that:

- Although the hospitals that have participated in the demonstration shared certain characteristics by virtue of their eligibility, they also differed in important respects—including their ownership and governance, their market environments, the size and scope of their operations, and their patterns of inpatient utilization.
- All of the hospitals in the demonstration have relied on a relatively small number of physicians for both inpatient and outpatient care. Although some sites were more attractive to physicians than others, problems with physician recruitment and retention were ubiquitous. On-call rotations for hospital inpatient coverage imposed an added hardship when there were few colleagues available to share the burden.
- Expenses related to capital improvements and major equipment purchases pose a continuing challenge for all demonstration hospitals. They have deemed it essential to maintain state-of-the-art equipment and facilities comparable to those of larger hospitals.
- Most hospitals used initial additional reimbursements for a range of expenses, including losses they would have had under IPPS, improvement projects, medical equipment, expanded or additional services, and community outreach programs.

Eligibility Requirements for Participation

The following eligibility requirements must be met for a hospital to be considered for participation in the demonstration. These requirements are specified in the authorizing legislation. An applicant must be a hospital that:

- Is located in a rural area [as defined in Section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)) or treated as being so located pursuant to section 1886(d)(8)(E) of the Act (42 U.S.C. 1395 ww(d)(8)(E))];
- Has fewer than 51 acute care inpatient beds, as reported in its most recent cost report;
- Makes available 24-hour emergency care services; and
- Is not designated or eligible for designation as a Critical Access Hospital (CAH) under Section 1820 of the Social Security Act.

The authorizing legislation requires that the demonstration be conducted in States with low population densities, as determined by the Secretary. For this demonstration, hospitals must be located in one of the 20 least densely populated States: Alaska, Arizona, Arkansas, Colorado, Idaho, Iowa, Kansas, Maine, Minnesota, Mississippi,

Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, or Wyoming. (U.S. Census Bureau: *Statistical Abstract of the United States*, 2003)

Demonstration Payment Methodology

Hospitals selected for participation in the demonstration will receive payment for inpatient services, with the exclusion of services furnished in a psychiatric or rehabilitation unit that is a distinct part of the hospital, using the following rules:

- 1) For discharges occurring in the first cost reporting period on or after the implementation of the program, their reasonable costs for covered inpatient services;
- 2) For discharges occurring during the second or subsequent cost reporting period, the lesser of their reasonable costs or a target amount. The target amount in the second cost reporting period is defined as the reasonable costs of providing covered inpatient hospital services in the first cost reporting period, increased by the IPPS update factor (as defined in Section 1886(b)(3)(B)) for that particular cost reporting period. The target amount in subsequent cost reporting periods is defined as the preceding cost reporting period's target amount increased by the IPPS update factor for that particular cost reporting period.

Evaluation

The mandate for the demonstration also requires a Report to Congress evaluating the project. Participating hospitals must participate in the evaluation and provide any information requested. The Evaluation of the Rural Community Hospital Demonstration will assess the impact of the demonstration on the financial viability of participating hospitals as well as the ability of hospitals to meet their strategic and operational goals. It consists of case study and financial impact analyses. Data collected directly from the hospitals will document changes in hospital operations and progress on programs and activities implemented during the demonstration. Hospital cost reports will provide financial data to assess differences in reimbursements under the demonstration compared to what they would have been under current law. The Report to Congress will be submitted 6 months after the end of the demonstration.

Research questions include:

- What are hospitals' goals for participating and how are demonstration payments used to achieve these goals?
- What external factors affect participating hospitals' operations?
- What challenges do hospitals face during the demonstration and how are they addressed?
- Does the financial viability of hospitals improve?
- What was the difference in reimbursements under the demonstration compared to what they would have been under current law?

Application Process

Each rural community hospital that wants to participate in the demonstration must submit an application. If an application meets basic eligibility requirements, it will be referred to a technical panel for evaluation and scoring. A panel of experts will conduct an independent review. The panelists' evaluations will include ratings based upon responses to the questions asked of the applicants. Panelists will examine the hospital's financial need, its strategy for improving its financial situation, and the benefit to its service area. Panelists will look for specific justification of how enhanced funding will improve patient care, community services, and the hospital's financial situation.

Medicare Waiver Demonstration Application Data Sheet:

The applicant must submit the CMS' Medicare Waiver Demonstration Application Data Sheet, available at this link:

http://www.cms.gov/DemoProjectsEvalRpts/downloads/2004_Rural_Community_Hospital_Demonstration_Program.pdf.

In addition, applicants must submit the following information:

Descriptive Information:

1. Evidence that the hospital is in a Federal designated rural area, as defined by the statutes referenced above.
2. Miles to the nearest hospital or CAH (a map with distances between providers would be helpful.)
3. Number of acute care inpatient beds, from the latest cost report (beds in a psychiatric or rehabilitation unit of a hospital shall not be counted toward the total number of beds).
4. Number of swing beds, if applicable.
5. Most recent 3 years of data on occupancy rate, average daily census, number of discharges, payer mix. Give numbers for each year.
6. Does the hospital make available 24-hour emergency care services?
7. Is the hospital eligible for CAH designation?
8. Eligibility for sole community hospital designation.
9. What is the management of the hospital? Is it private, publicly owned, faith-based? Is it owned by a large multi-hospital system?
10. Total Medicare payment for inpatient services from the latest cost report.
11. Total Costs for Medicare inpatient services from the latest cost report.
12. The hospital's Medicare inpatient operating margin.
13. The hospital's operating margin (including inpatient services, outpatient services, distinct part psychiatric units, rehabilitation units, and home health agencies. The applicant should specify which among these is used in calculating this amount).

For numbers 3, 10, 11, and 12, the applicant should also submit the relevant pages from the most recently submitted cost report. (Acute care beds: Worksheet S-3 Part I;

Medicare Payment for Inpatient Services: Worksheet E, Part A; Total Medicare Inpatient Costs: Worksheet D-1; Medicare Inpatient Operating Margin - the applicant should calculate this amount from Medicare Payment for Inpatient Services and Total Medicare Inpatient Costs).

The applicant should address the following questions in narrative format. There is a 15 page limit. Cost report pages and maps do not count toward this page limit.

1. **Justification:** Explain why your hospital desires to receive cost reimbursement rather than the current inpatient prospective payment system. List current problems, and explain why the inpatient prospective payment system has caused the problem, and how cost-based reimbursement will improve the situation. Be as specific as possible.
2. **Strategy for Financial Viability:** The applicant should describe its strategy for improving its financial situation, both in terms of efforts it has undertaken recently and those that it plans for under the demonstration. In particular, the applicant should detail efforts to control costs so as to be viable. How much revenue is expected from a change in Medicare reimbursement? Would this program allow the hospital to otherwise stay open or not reduce services?
3. **Goals for Demonstration:** The applicant should describe any specific projects for which it will use additional Medicare funds obtained through the demonstration and how any such projects will benefit the hospital and the community. Goals of such projects may include but are not limited to increased access to care and provision of additional services.
4. **Collaboration with Other Providers to Serve Area:** The applicant should describe its current service area and the population it serves. The applicant should describe how it works with other health care providers and facilities together to serve the population and how any enhancements supported by additional Medicare funds will contribute to the population's health. Will relationships with other providers change as a result of the demonstration?

Application Review:

The application process will be competitive. A review panel will score all eligible applications. Responses to the four questions requiring narrative responses will be weighted equally in evaluating applications.

The CMS Administrator will make the final selection from among the applications with the highest scores. Sites will be selected based upon need and on the quality and clarity of the descriptions and proposed solutions in their applications. Diversity among types of organizations, service areas, and geographic areas may be taken into account in the final selections.

Due Date:

Applications will be considered timely if we receive them on or before October 14, 2010. Applications must be received by 5 PM Eastern Standard Time on the due date.

Only applications that are considered “timely” will be reviewed and considered by the technical panel.

Application Submission:

Complete, sign, date, and return the Medicare Waiver Demonstration Application Data Sheet found on this webpage. Fill in 5 year Project Duration according to the hospital’s cost report period beginning and end dates. The entire application will consist of the above data sheet, all narrative information requested in the solicitation, cost report pages, and maps.

An unbound original and two copies, plus an electronic copy on CD of the application must be submitted; applicants may, but are not required to submit six additional copies to assure that each review panelist receives the application in the manner intended by the applicant (e.g., collated, tabulated, colorized). The applications should be MAILED or sent by an overnight delivery service to the following address:

**Centers for Medicare & Medicaid Services
ATTN: Sid Mazumdar, Rural Community Hospital Demonstration
Medicare Demonstrations Program Group
Mail Stop C4-15-27
7500 Security Boulevard
Baltimore, MD 21244**

Applications must be typed for clarity and should not exceed 15 double-spaced pages, exclusive of the Medicare Waiver Demonstration Application Data Sheet, cost report pages, and maps. Because of staffing, resource limitations, and because we require an application containing an original signature, we cannot accept applications by facsimile (FAX) transmission.

For further information, contact Sid Mazumdar at (410) 786-6673 or via e-mail siddhartha.mazumdar@cms.hhs.gov.