APPENDIX B

Summary of Medicare's special payment provisions for rural providers and criteria for qualification

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This appendix summarizes Medicare's special payment provisions and the criteria for qualification for the following groups of rural hospitals:

- Geographically reclassified hospitals
- Sole community hospitals
- Small rural Medicare-dependent hospitals
- Critical access hospitals
- Rural referral centers
- Hospital swing beds

Geographically reclassified hospitals

Hospitals that believe their area wage index or base payment rate does not adequately address the costs they face may apply separately to be reclassified for payment purposes. Both rural and urban hospitals have applied for reclassification into rural, other urban, and large urban areas.[1]

Criteria to qualify

Hospitals may qualify for reclassification in one of three ways:

1. They must prove proximity and similarity to the area of reclassification. Proximity may be based on distance (no more than 15 miles away for an urban hospital and 35 miles for a rural hospital) or employment patterns (at least 50 percent of the hospital's employees reside in the area). Separate similarity tests apply to reclassification for wage index and base payment amount, and a hospital seeking reclassification for both must choose the same area.
   - For wage index reclassification, a hospital's wages must be more than 106 percent (108 percent for urban facilities) of the local area wage index, as well as at least 82 percent (84 percent for urban facilities) of the wage index in the area of reclassification.
   - For base payment reclassification, a hospital must demonstrate that its average case-mix-adjusted cost per discharge is more than its current rate plus 75 percent of the difference between that rate and the rate it would receive if it were reclassified.
2. Different rules apply to rural referral centers (RRCs) and sole community hospitals (SCHs).
   - RRCs and SCHs do not have to demonstrate proximity to the area to which they seek redesignation.
   - RRCs also do not have to meet the 106 percent criterion for average hourly wage.
   - An RRC or SCH that qualifies for reclassification to an urban area is assigned to the area closest to the hospital.
3. All hospitals in a county can apply for group reclassification. For hospitals in a rural county seeking urban redesignation, the county must be adjacent to the metropolitan area to which the hospitals seek to be assigned. The hospitals must demonstrate that the rural county in which they are located currently meets the similarity criteria.

1 A large urban area is defined as an urban area with a population of at least one million.

Payment provisions

A reclassified hospital receives the wage index, base payment rate, or both of the area to which it has been assigned.

Sole community hospitals

The intent of the SCH program, started in 1983, is to maintain access to needed health services for Medicare beneficiaries by providing financial assistance to hospitals that are geographically isolated.

Criteria to qualify

A hospital seeking SCH status must meet one of the following criteria:

1. It must be 35 miles from a like hospital.
2. It must be between 25 and 35 miles from a like hospital and meet one of the following criteria:
   - No more than 25 percent of all inpatients or 25 percent of inpatient Medicare beneficiaries in its service area may be admitted to other like hospitals within 35 miles.
   - It must have fewer than 50 beds and would have met the above criteria, except that some patients or residents had to seek care outside the service area because necessary specialty services were unavailable.
   - Nearby like hospitals must be inaccessible for at least 30 days in 2 out of 3 years because of local topography or periods of prolonged severe weather conditions.
3. It must be between 15 and 25 miles from a like hospital but because of local topography or periods of prolonged severe weather conditions, nearby like hospitals are inaccessible for at least 30 days in 2 out of 3 years.
4. Because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital must be at least 45 minutes.

Payment provisions

Sole community hospitals benefit from four provisions. First, they are paid the highest of four amounts for Medicare inpatient services: the current prospective payment system (PPS) rate, or base year costs per discharge from 1982, 1987, or 1996 updated to the current year. The 1996 base went into effect in fiscal year 2001, and will be phased in between 2001 and 2004 in four 25 percentage-point increments.

Second, an SCH that receives the PPS rate and qualifies for a disproportionate share hospital (DSH) payment receives up to a 10 percent adjustment, rather than the maximum of 5.25 percent received by other rural hospitals.[2]

Third, SCHs need not meet the proximity requirement of geographic reclassification, which could facilitate approval for reclassification to a region with a higher wage index, base payment rate, or both.

Finally, if an SCH experiences a decrease of more than 5 percent in total number of inpatient cases due to circumstances beyond its control, it is eligible to receive payments necessary to fully compensate it for fixed costs.

Small rural Medicare-dependent hospitals

The Medicare-dependent hospital (MDH) program, established in 1987, is intended to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges. This greater dependence on Medicare may make these hospitals more financially vulnerable to prospective payment, and the MDH designation is designed to reduce this risk.

Criteria to qualify

A hospital qualifies for the MDH program by meeting all of the following criteria:

1. It is located in a rural area.
2. It has no more than 100 beds.
3. It is not classified as an SCH.
4. It has at least 60 percent of inpatient days or discharges covered by Medicare.

Payment provisions

Medicare-dependent hospitals benefit from two provisions. First, they are paid for inpatient services the sum of the PPS payment rate plus half of the amount by which the highest of hospital-specific base year costs per discharge for Medicare patients from 1982 or 1987 (updated to the current year) exceeds the PPS rate.

Second, an MDH with a caseload that falls by more than 5 percent (due to circumstances beyond its control) may receive payments necessary to fully compensate it for fixed costs.

Critical access hospitals

The critical access hospital (CAH) program, established in 1997, is intended to support limited-service hospitals located in rural areas that cannot support a full-service hospital. The CAH program replaced the essential access community hospital (EACH), rural primary care hospital (RPCH), and Montana medical assistance facilities (MAF) programs, which had similar features. Before the Balanced Budget Refinement Act of 1999 (BBRA), the CAH program was limited to public and non-profit private hospitals.

Criteria to qualify

A hospital may qualify for the CAH program in one of three ways:

1. It meets the following criteria:
   - It is located in a rural area.

2 Hospitals that receive cost-based payment for Medicare inpatient services do not receive payment adjustments available under the PPS (DSH, indirect medical education, outlier payments, etc.). This applies to hospitals certified as sole community, critical access, or Medicare-dependent.

- It is more than 35 road miles (or, in the case of mountainous terrain or in areas with only secondary roads available, 15 miles) from a similar hospital.
- It provides 24-hour emergency care services.
- It has no more than 15 acute care beds (or 25 in limited cases, including up to 10 swing beds).
- It has stays averaging no more than 96 hours per patient. (The Balanced Budget Act of 1997 (BBA) mandated a length-of-stay maximum of 96 hours; the BBRA changed this to a 96-hour average length of stay.)

2. It is certified by the state as being a necessary provider of health care services to residents in the area. Hospitals cannot apply for designation as a CAH unless their state has developed or is in the process of developing a "rural health plan," which is submitted to the Health Care Financing Administration (HCFA) for review and approval.
3. It was previously certified under the RPHC or MAF programs.

Payment provisions

Critical access hospitals are reimbursed by Medicare for both inpatient and outpatient services on the basis of their current Medicare-allowable costs. They are exempt from the inpatient and outpatient PPSs, but are subject to the home health and skilled nursing facility (SNF) systems. CAH swing beds are exempt from the SNF PPS.

Rural referral centers

The RRC program, established in 1983, is intended to support high-volume hospitals that treat a large number of complicated cases and function as regional or national referral centers. RRC designation is intended to support the greater intensity and costs these facilities may have.

Criteria to qualify

A rural hospital must meet one of three criteria to qualify:

1. It has at least 275 beds.
2. It demonstrates that:
   - at least 50 percent of its Medicare patients are referred from other hospitals or from physicians not on the hospital staff,
   - at least 60 percent of its Medicare patients live more than 25 miles away, and
   - at least 60 percent of the Medicare services it furnishes are provided to beneficiaries who live more than 25 miles away.
3. It demonstrates that it:
   - has a case-mix index value greater than or equal to the median for all urban hospitals in the same census region, and
   - has at least 5,000 discharges per year (3,000 for osteopathic hospitals) or at least the median number of discharges for urban hospitals in the same region, and meets at least one of the following three criteria:
     a. more than 50 percent of its medical staff are specialists,
     b. at least 60 percent of its discharges are for inpatients who reside more than 25 miles away, and
     c. at least 40 percent of its inpatients are referred from other hospitals or from physicians not on the hospital's staff.

Payment provisions

Under the original PPS legislation, RRCs received the urban rather than rural base payment rate, adjusted by their area wage index. When the rural and "other urban" payments were combined in 1994, this preferential payment policy was eliminated for most RRCs. A few still qualify for the large urban base payment rate, which is 1.6 percent higher than the combined rural/other urban rate.

The RRC program offers two other special payment provisions. First, qualifying RRCs receive a higher DSH adjustment than do other rural hospitals. Most rural hospitals' DSH add-ons are capped at 5.25 percent, but RRCs receive an additional 0.6 percent adjustment for every percentage point that their disproportionate patient percentage exceeds 30.[3] Second, RRCs are exempt from two of three criteria for geographic reclassification: an RRC need not demonstrate proximity to the area to which it seeks redesignation or that its wages exceed 106 percent of the average for its actual area.

Hospital swing beds

The hospital swing bed program, established in 1980, is intended to enhance access to long-term care in rural communities. The swing-bed provisions allow rural hospitals to provide long-term care services to Medicare and Medicaid patients without establishing a separate unit.

Criteria to qualify

To qualify, a hospital must meet the following criteria:

1. It has fewer than 100 beds and is located in a rural area.
2. It has been granted a certificate of need (if required by the state) for the provision of long-term care services.
3. It has not had a swing-bed approval terminated within the two years before its application.

3 The disproportionate patient percentage (DPP) is defined as the ratio of Medicare Supplemental Security Income days to total Medicare days plus the ratio of Medicaid days to total days. To qualify for DSH payments, a hospital's DPP must be at least 15.

If the hospital has more than 49 beds and was approved as a swing-bed hospital after March 1988, it must have an agreement with each Medicare-participating SNF located in the hospital's geographic region requiring it be notified when beds suitable for post-acute care placement will be open, and generally must transfer patients within five days after determining that a SNF bed is available.

Payment provisions

Hospitals with swing beds are paid the average Medicare rate per patient day for routine services provided in freestanding SNFs in their census region. Ancillary services are reimbursed on a reasonable cost basis, where costs are determined in a manner comparable to that of all other ancillary services provided by the hospital. For swing-bed hospitals with more than 49 beds, the number of SNF patient days in each cost reporting period is required to be less than 15 percent of the hospital's available bed days. The BBA did not include swing-bed hospitals in the SNF PPS, but required HCFA to develop a transition to the SNF PPS for swing-bed hospitals.