APPENDIX

A. SPECIAL MEDICARE PAYMENTS FOR RURAL HOSPITALS

The scope and history of the Medicare special payment policies for inpatient services by rural hospitals reflect the diversity of issues faced by rural hospitals serving Medicare beneficiaries. By 1990, the full set of these special payment policies had been established for the following designated hospitals, although modifications continued throughout the 1990s:

- Sole Community Hospitals (SCH)
- Rural Referral Centers (RRC)
- SCH/Rural Referral Centers
- Medicare-Dependent Hospitals (MDH)
- Essential Access Community Hospital (EACH)
- EACH/Rural Referral Center

Because each special payment designation responded to a unique set of issues for rural hospitals, both the eligibility criteria and payment methodologies differ substantially. We summarize these provisions below. In addition, we describe two other provisions that increase payments for rural hospitals: reclassifying hospitals so an urban standardized amount or wage index is used to establish PPS payments, and higher DSH payments for certain rural hospitals. The provisions described here were applicable during the 1990–1998 time period covered by this research. The BBA and follow-up legislation subsequently modified many of these provisions.

SPECIAL PAYMENT DESIGNATIONS

Sole Community Hospitals

This designation provides payment protection for hospitals in isolated locations that are the sole source of inpatient services reasonably available to Medicare beneficiaries. Effective April 1, 1990, hospitals that qualified as sole community hospitals were paid the highest of three rates: (1) the updated hospital-specific rate based on the hospital’s 1982 costs per discharge, (2) the updated hospital-specific rate based on its 1987 costs per discharge, or (3) the federal PPS rate, including any applicable outlier amount. A provision of the BBRA allows a sole community hospital to elect to rebase its special payments on the basis of the hospital’s costs per discharge for its fiscal year 1996 reporting period, if the hospital was paid during 1999 on the basis of either its 1982 or 1987 costs per discharge. Sole community hospitals also receive special treatment under criteria for geographic reclassification and DSH payment adjustment (discussed below).

Designation as a sole community hospital remains in effect without need for reapproval unless there is a change in the circumstances under which the designation was approved. Hospitals that were granted exemptions from the hospital cost limits before October 1, 1983, were automatically classified as sole community hospitals. Any other rural hospital seeking designation must meet one of the following criteria:24

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24 A hospital not in a rural area may be designated as a sole community provider if it is more than 35 miles from other similar hospitals.
• More than 35 miles from other similar hospitals; or
• Between 25 and 35 miles from other similar hospitals, and
  ➢ No more than (1) 25 percent of total inpatients or (2) 25 percent of Medicare
    inpatients admitted to hospitals from the hospital’s service area are admitted to
    similar hospitals located within a 35-mile radius of the hospital or to larger hospitals
    within the hospital’s service area, or
  ➢ Has fewer than 50 beds and would admit at least 75 percent of the inpatients from its
    service area except that some patients seek specialized care it does not provide, or
  ➢ Other similar hospitals are inaccessible for at least 30 days in each two out of three
    years because of local topography or prolonged or severe weather conditions;
• Between 15 and 35 miles from other similar hospitals, but because of local topography or
  prolonged severe weather conditions, the other similar hospitals are inaccessible for at least
  30 days in each two out of three years; or
• Travel time between the hospital and the nearest similar hospital is at least 45 minutes
  because of distance, posted speed limits, or predictable weather conditions.

Rural Referral Centers

For discharges occurring before October 1, 1994, hospitals that qualified as rural referral
centers were paid on the basis of the “other urban” prospective payment standardized amount,
rather than the rural amount, adjusted by the DRG weight and the hospital’s area wage index.
Following that date, the same amounts were paid for “other urban” and rural standardized
amounts. However, as discussed below, rural referral centers continue to receive special
treatment under the payment adjustment and criteria for geographic reclassification, which
qualifies them for the urban disproportionate share payments. To qualify as an RRC, a hospital
must be located in a rural area and meet all of the following criteria:

• Have a case-mix index of at least 1.276 for fiscal year 1991, or one that equals the
  median case-mix index for urban hospitals (excluding hospitals with approved teaching
  programs) calculated by CMS for the census region in which the hospital is located;
• For the cost reporting period that began during fiscal year 1991, have at least 5,000
  discharges, or discharges equal to the median number of discharges for urban hospitals in
  its census region, or have at least 3,000 discharges if an osteopathic hospital; and
• Have at least 275 beds or meet one of the following criteria:
  ➢ More than 50 percent of the hospital’s active medical staff are specialists,
  ➢ At least 60 percent of its discharges are for inpatients who reside more than 25 miles
    from the hospital, or
  ➢ At least 40 percent of all inpatients treated are referred from other hospitals or from
    physicians not on the hospital’s medical staff.

CMS reviews referral center status every three years. Beginning on October 1, 1992, to
retain referral center status, a hospital must meet the applicable criteria in the current year or for
at least two of the last three years.
SCH/Rural Referral Centers

Some rural hospitals qualify for designation as both sole community hospitals and rural referral centers. Payments for these hospitals are the greatest allowed under either designation. In addition, special DSH payment adjustments are defined for hospitals with both designations.

Medicare-Dependent Hospitals

The designation of Medicare-dependent hospitals was first available to rural hospitals for cost reporting periods beginning on or after April 1, 1990, and ending on or before October 1, 1994. The BBA reinstated and extended this designation from October 1, 1997, through October 2001, and the BBRA further extended it another five years through October 2006.

Hospitals that qualify as Medicare-dependent hospitals are paid according to the sum of the federal payment rate applicable to the hospital and the amount by which the federal rate is exceeded by a specified percentage of the higher of (1) the hospital-specific rate based on the hospital’s 1982 costs, or (2) the hospital-specific rate based on its 1987 costs. The applicable percentages for the hospital-specific rates are 100 percent for discharges occurring on or before April 1, 1993, and 50 percent for discharges occurring between April 1993 and October 1994 and occurring from October 1, 1997, through October 2006.

To qualify for this designation, a rural hospital must meet all of the following criteria:

• Have 100 or fewer inpatient beds;
• Not be classified as a sole community hospital; and
• Be dependent on Medicare for at least 60 percent of its inpatient days or discharges for its cost reporting period that began during fiscal year 1987.

Essential Access Community Hospital

Designated by participating states and approved by CMS, hospitals that qualify as EACHs are the referral hospitals for EACH/RPCHs. These hospitals are paid as sole community hospitals. A participating state could designate a hospital as an EACH if the hospital:

• Was in a rural area more than 35 miles from a hospital designated as either an EACH or a rural referral center, or met other geographic criteria set by the state;
• Had at least 75 inpatient beds or was more than 35 miles from any other hospital; and
• Had executed agreements with RPCHs participating in the rural health network to provide emergency and medical backup services, accept patients transferred from RPCHs, exchange data with RPCHs, and grant staff privileges to physicians who provide care at the RPCHs.

With the introduction of the Medicare Rural Hospital Flexibility Program, effective October 1, 1997, no new EACH designations may be made. Existing EACHs continue to be paid as sole community hospitals as long as they comply with the applicable requirements.
EACH/Rural Referral Center

Some EACHs also qualify for designation as rural referral centers. Payments for these hospitals are the greatest allowed under either designation.

HOSPITALS RECLASSIFIED FOR STANDARDIZED AMOUNT OR WAGE INDEX

The Medicare Geographic Classification Review Board has the responsibility for making determinations of hospital reclassification for purposes of payments under the Prospective Payment System. Rural hospitals may be reclassified to permit use of a higher standardized payment amount or wage index from another area in the PPS payment calculation. A hospital in a rural county may be reclassified as follows:

- The hospital must meet proximity criteria by being a sole community hospital or rural referral center, or must demonstrate close proximity to the area to which it seeks reclassification, such that the distance from the hospital to the area is no more than 35 miles, and at least 50 percent of the hospital’s employees reside in the area.

- The hospital must meet financial criteria for reclassification for an area’s standardized amount or wage index:
  - To receive an area’s standardized amount, the hospital must demonstrate that its incurred costs are more comparable to the amount it would be paid if it were reclassified than to its payment under its current classification.
  - To receive an area’s wage index, the hospital must demonstrate that (1) its incurred wage costs are comparable to hospital wage costs in the area, (2) the hospital average hourly wage is at least 108 percent of the average for hospitals where the hospital is located, and (3) the aggregate average hourly wage for all hospitals in the rural county is at least 84 percent of the average wage in the area, or the average wage weighted for occupational categories is at least 90 percent of the urban area’s average wage.

- The hospital must be a participant in a group of all hospitals in a rural county applying for reclassification, the rural county must be adjacent to the metropolitan area to which reclassification is sought, and the group must demonstrate that:
  - The rural county meets Census Bureau standards for redesignation to a metropolitan area as an outlying county, and
  - The aggregate average hourly wage for all hospitals in the rural county is at least 85 percent of the average wage in the adjacent urban area, or the average wage weighted for occupational categories is at least 90 percent of the urban area’s average wage.

SPECIAL PROVISIONS FOR DISPROPORTIONATE SHARE PAYMENTS

Adjustments are made to the federal portion of the operating cost DRG payment to allow additional payments for hospitals serving a disproportionate share of low-income patients. A DSH percentage is calculated for each hospital as the sum of (1) the percentage of Medicare Part A patient days attributable to patients who also are Supplemental Security Income (SSI) recipients, and (2) the percentage of total patient days attributable to patients entitled to Medicaid
but not Medicare. A rural hospital qualifies for an operating cost DSH adjustment if it has a
DSH percentage of:

- At least 15 percent for a rural hospital with 500 or more beds;
- At least 30 percent for a rural hospital that has more than 100 beds but fewer than 500
  beds, or is classified as a sole community hospital; or
- At least 45 percent for a rural hospital with 100 beds or fewer that is not classified as a
  sole community hospital.

For each rural hospital group that qualifies for DSH payments, the adjustments are shown in Table A.1.

<table>
<thead>
<tr>
<th>Type of Rural Hospital</th>
<th>DSH Payment Adjustment Factor</th>
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<tbody>
<tr>
<td>With 500 or more beds, and at least 15% DSH percentage</td>
<td>The same as for urban hospitals with 100 or more beds with a DSH percentage of at least 15%.</td>
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</tbody>
</table>
| With 100–499 beds or a sole community hospital, and 30% DSH percentage | a. If rural referral center—4% plus 60% of difference between DSH percentage and 30%.
  b. If sole community hospital—10%.
  c. If SCH/rural referral center—the greater of (1) 10% and (2) 4% plus 60% of difference between DSH percentage and 30%. |
| With 100 beds or fewer, not a SCH, and at least 45% DSH percentage | 4%.                                                                                           |