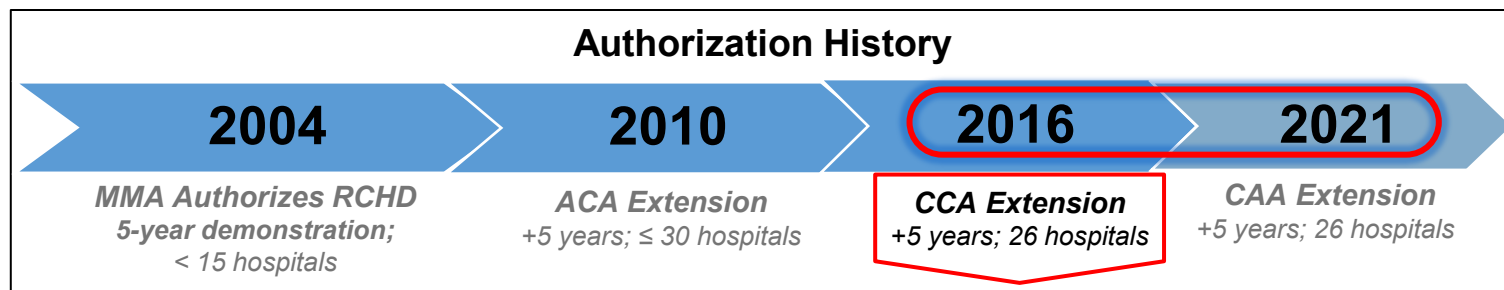






DEMONSTRATION OVERVIEW

The RCHD, a budget-neutral demonstration, tests whether cost-based reimbursement for Medicare inpatient services can increase the financial viability of small rural hospitals.



This Final Report covers the CCA extension from 2016 to 2021 and provides results for the 26 hospitals participating as of FY 2021.

Notes. MMA refers to the Medicare Modernization Act, ACA to the Affordable Care Act, CCA to the 21st Century Cures Act, and CAA to the Consolidated Appropriations Act.

Hospital Eligibility Criteria	How RCHD Payments for Inpatient Care Are Structured	
 Rural  <51 Acute Care Beds  24-Hour Emergency Care  Ineligible to Be Critical Access Hospital	With Each New Authorization	In the first year (or base year), payments are equal to “reasonable and allowable costs” for acute and skilled nursing facility levels of care. These base year payments are also used to compute payment target amounts for future years.
	Subsequent Years	Lesser of: Current year reasonable and allowable costs; or Current year target amount based on projections from the base year amount.

CCA Extension Participants

New RCHD Hospitals	12 hospitals that first joined the RCHD under the CCA extension.
Continuing RCHD Hospitals	14 hospitals that first joined the RCHD under prior MMA authorization or ACA extension.

Characteristics of the CCA Participating Hospitals Before the RCHD

- RCHD hospitals started the demonstration with much lower Medicare inpatient margins than similar rural hospitals.
- Despite Medicare losses, these hospitals had evidence of stronger overall finances (e.g., higher total profit margins, more liquidity, higher patient volumes).
- Bottom line:** RCHD mainly attracted hospitals seeking to offset Medicare losses but were not those in the weakest financial shape overall.

KEY EVALUATION FINDING

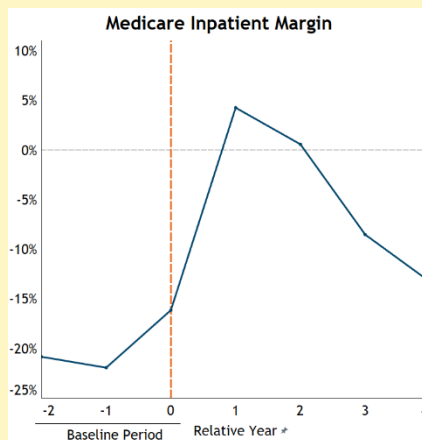
Annual payments for inpatient services under RCHD were, on average, \$1.6 million more for *New Hospitals* and \$2.68 million more for *Continuing Hospitals* than what would have been paid for under IPPS. These payments varied significantly across participating hospitals.



New Hospitals

On average, RCHD payments allowed hospitals to slightly exceed the breakeven point for providing Medicare inpatient services in their first participation years.

Pre-pandemic improvements (seen in Years 1 and 2) were practically erased after the pandemic started in Year 3.



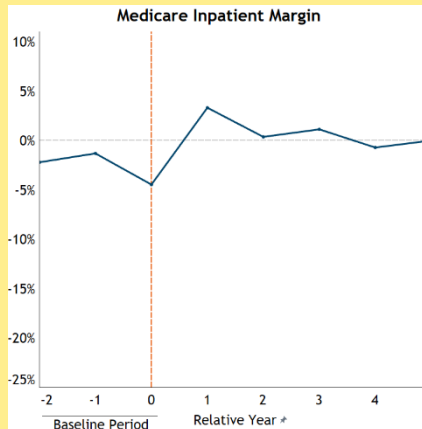
In interviews, some hospitals, operating with negative margins, reported that the demonstration helped prevent even worse financial losses.



Continuing Hospitals

On average, RCHD payments allowed hospitals to maintain a breakeven point for providing Medicare inpatient services, as intended.

Continued participation maintained prior improvements to margins achieved in the prior authorization period and did not cause any additional effects.



Hospital leaders emphasized the importance of the demonstration in supporting their financial viability and service lines.

The COVID-19 emergency began during the reporting period. Because hospitals joined the CCA extension in different years, the pandemic's impact appears in different post-demonstration (Relative) years for Continuing vs. New Hospitals.

KEY TAKEAWAYS

- As designed, the RCHD did impact and improve Medicare inpatient margins. Combined Medicare inpatient *and* outpatient margins (not shown) still did not reach a breakeven point for all participants, especially for new hospitals during the COVID-19 period.
- Hospital leaders consistently reported that RCHD participation was crucial for maintaining financial viability, especially in hospitals operating with negative margins.