Evaluation of the Rural Community Hospital Demonstration

CCA Extension Final Report (Covering 2016–2021)

Executive Summary

Centers for Medicare & Medicaid Services

Center for Medicare & Medicaid Innovation

SEPTEMBER 2025

American Institutes for Research® | AIR.ORG

AIR®

Advancing Evidence.
Improving Lives.

Presented to

Center for Medicare & Medicaid Innovation (CMMI)
Centers for Medicare & Medicaid Services (CMS)
7500 Security Boulevard, Baltimore, MD 21244
Contracting Officer's Representative: Thomas Shaffer

Task & Deliverable

HHSM-500-2014-00032I 75FCMC19F0002, Deliverable #5

Submitted By

American Institutes for Research® (AIR®) Headquarters
1400 Crystal Drive, 10th Floor
Arlington, VA 22202-3289
202.403.5000
www.air.org

Project

Evaluation of the Rural Community Hospital Demonstration

Authors

Daniela Zapata, Ph.D., American Institutes for Research
Tanvi Rao, Ph.D., American Institutes for Research
Angshuman Gooptu, Ph.D., American Institutes for Research
Ze Song, Ph.D., American Institutes for Research
Drew Wood-Palmer, M.P.H., American Institutes for Research
Shantoy Hansel-Kidney, M.P.H., American Institutes for Research
Margaret (Peggy) O'Brien, Ph.D., Mission Analytics
Ellie Coombs, M.P.P., Mission Analytics
Nick Theobald, Ph.D., Mission Analytics
Elizabeth Crane, M.P.H., Mission Analytics

DISCLAIMER: *This project was funded by the Centers for Medicare & Medicaid Services under contract no.* HHSM-500-2014-00032I*, Task Order* 75FCMC19F0002*. The statements contained in this report are solely those of the authors and do not necessarily reflect the views or policies of the Centers for Medicare & Medicaid Services.* AIR® *assumes responsibility for the accuracy and completeness of the information contained in this report*

Executive Summary

The Rural Community Hospital Demonstration (RCHD)

The Rural Community Hospital Demonstration (RCHD) was authorized under the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003. The goal of this demonstration is to improve the financial health of small rural hospitals by offering the potential for higher Medicare payments for covered inpatient hospital services.

Eligibility Criteria

To participate, hospitals must:

- Be in a rural area
- Have fewer than 51 beds
- Operate a 24-hour emergency department
- Not qualify as a Critical Access Hospital

Demonstration Extensions

Under the initial, five-year MMA authorization, the demonstration was implemented in the 10 least populated states, and within those states, only up to 15 hospitals could participate. After it, the RCHD has been extended three times:

- By the Patient Protection and Affordable Care Act ACA (2010) – Expanded to 20 least densely populated states, up to 30 hospitals.
- By the 21st Century Cures Act CCA (2016) – Opened to all states, with priority to the 20 least densely populated.
- By the Consolidated Appropriations Act CAA (2021) – Extended for another five years.

This Report

This report focuses on the CCA extension period, covering 26 hospitals active as of FY 2021. In this report, as in *Interim Report Two,* RCHD hospitals are divided into two groups: *new* hospitals and *continuing* hospitals.

The distribution of these 2 types of hospitals is:

- 12 *new* hospitals (i.e., joined under CCA and their first exposure to RCHD)

- 14 *continuing* hospitals (i.e., joined under prior MMA or ACA RCHD extensions)

Evaluation Goals

This final report uses Medicare cost reports (available through FY 2021), interviews with hospital representatives, and other data sources to:

- Describe the characteristics of active RCHD hospitals as of FY 2021,[1] *before* they joined the demonstration.
- Describe the RCHD payments hospitals received between FYs 2005 and 2021.
- Assess financial impacts on:
  - **Medicare margins** (i.e., inpatient alone and combined [inpatient and outpatient] margins)
  - **Operating and total profit margins**, which include non-Medicare revenue and costs
  - **Other Medicare revenue indicators** (e.g., Medicare share of inpatient discharges)
  - **Other financial health indicators** (e.g., days cash on hand, debt ratios)
- This evaluation report covers the same topic areas covered by previous interim reports, but differs from previous interim reports in the following ways:
  - It uses a different sample of hospitals.
  - It uses a different baseline period than the one used in *Interim Report One.*
  - It includes public health emergency (PHE) years due to the Covid-19 pandemic.

RCHD Payment Methodology

RCHD hospitals are paid based on **costs**, not standard Medicare rates and are implemented as a 5-year cycle of Base Year + 4 subsequent years. *Continuing* hospitals are then 're-based' and the cycle repeats:

- **Year 1 (Base Year)**: Paid for reasonable costs of care for Medicare beneficiaries treated for inpatient acute care and swing-bed stays.
- **Subsequent 4 Years**: Paid the lesser of actual costs or a **target amount** (adjusted for inflation, case-mix, and discharges).
- **Rebase Year**: Applies to hospitals continuing into a new extension period. Paid for reasonable costs of care for Medicare beneficiaries treated for inpatient acute care and swing-bed stays.

[1] At the time the quantitative analyses were conducted, verified cost report data was only available up to FY 2021.

RCHD payments are composed of a payment for acute inpatient stays and a payment for swing-bed stays, which are calculated separately. A swing bed is an acute care bed used to furnish either acute or skilled nursing facility (SNF)-level care.[2]

Data and Methods

- **Quantitative**: Medicare cost reports were analyzed using descriptive statistics and multivariate difference-in-differences (DID) regressions with a comparison group comprised of similar non-participant hospitals. Regressions included control variables for the incidence of Covid-19, including deaths per 1,000 population, cases per 1,000 population, and percentage of inpatient beds occupied by suspected or confirmed Covid-19 patients. Additionally, we calculated the effects of the RCHD prior to the PHE and during the pandemic years.
- **Qualitative**: Interviews with hospital executives conducted in FY 2021.

Key Findings

- **Before joining the RCHD**: Participant hospitals had lower Medicare margins than non-participants indicating that Medicare payments did not cover the costs of providing care.
- **After joining the RCHD:** Participant hospitals received higher payments for acute care and swing-bed inpatient services than they would have received under either IPPS or SNF PPS. Additional payments hospitals received under the RCHD varied substantially. The impact of these additional payments on hospital finances is as follows:
  - **RCHD impacts for *New* Hospitals**: *New* hospitals experienced large but not statistically significant *Medicare margin increases* overall; gains were significant pre-COVID, but not during the pandemic. These margin increases indicate that Medicare payments were closer to covering the costs of providing care.
  - **RCHD impacts for *Continuing* Hospitals**: Prior improvements in Medicare margins were maintained but there were no new gains beyond the ones experienced during ACA period. Gains were significant pre-COVID, but not during the pandemic. There were no changes to total profit margins for these hospitals.

Hospitals Characteristics Prior to Joining the Demonstration

- **RCHD hospitals compared to non-participants:**

[2] Centers for Medicare & Medicaid Services. (2018, October). *Report to Congress: Rural Community Hospital Demonstration,* p. 8. https://innovation.cms.gov/files/reports/rch-rtc.pdf

  - Prior to joining the RCHD, all participant hospitals had negative or substantially lower Medicare inpatient margins compared to non-participating hospitals. This suggests that hospitals joined the demonstration to improve their Medicare financial performance.
  - Had older capital infrastructure.
  - Were more likely to be non-profits, have higher inpatient discharges, and treat more clinically complex patients.
  - Were more likely to be in less densely populated, wealthier, and more educated counties.
  - Were less likely to be in Competitive markets (defined as having three or more hospitals within 35 miles).
- ***Continuing* versus *new* RCHD hospitals:**
  - Had higher total profit and operating margins indicating a relatively stronger financial position. However, they still faced challenges with negative Medicare inpatient and combined margins.
  - Were more likely to operate in Competitive markets.
  - Were more likely to be in counties that were slightly younger, less educated, and less affluent (based on lower unemployment rates and higher median home values).

Payments RCHD Hospitals Received

- ***New* Hospitals:** Received approximately $1.62M higher payments than what they would have received under IPPS (33% higher than IPPS). These additional payments helped improve hospitals' Medicare inpatient margins bringing them closer to break-even, although they remained negative . Medicare combined margins also improved slightly but stayed negative.
- ***Continuing* Hospitals**: Received approximately $2.68M higher payments than what they would have received under IPPS (48% higher than IPPS). These payments helped hospitals move closer to breaking even on their Medicare inpatient margins.
- **Variation:** Payment increases varied widely across hospitals.

Impact of the RCHD on Key Hospital Financial Measures

- ***New* RCHD Hospitals**: Participation led to large but not statistically significant increases in Medicare inpatient and combined margins during the CCA period. These gains were statistically significant before COVID, but not during the pandemic, resulting in no significant overall effect for the full period.

- ***Continuing* RCHD Hospitals**: No additional margin improvements were observed beyond those seen during the ACA period which were maintained. However, pre-COVID data showed statistically significant gains, likely due to rebasing. These gains were not sustained during the pandemic.
- **Pandemic Impact:** Hospital leaders cited rising costs and reduced service utilization during COVID as key factors that weakened overall financial performance.
- **Demonstration Value**: Despite financial challenges, many hospitals credited the RCHD with helping to stabilize operations and prevent deeper losses, especially those operating with negative margins.
- **Swing-Bed Revenue:** New hospitals saw an increase in Medicare swing-bed revenue share. Interviews with hospital administrators confirmed that swing beds were viewed as financially beneficial and often central to the decision to remain in the demonstration.

Overall Assessment: Findings for this report mostly align with earlier reports, suggesting the RCHD has reached a steady state in its financial impact and has achieved its goal of offering a mechanism for improved financial viability for RCH hospitals. *Continuing* hospitals maintained Medicare inpatient margins near break-even during the CCA extension, while new hospitals saw an improvement in their margins due to first time participation in the Demonstration. The COVID-19 pandemic dampened these effects, particularly for new participants.

About the American Institutes for Research®

Established in 1946, the American Institutes for Research® (AIR®) is a nonpartisan, not-for-profit institution that conducts behavioral and social science research and delivers technical assistance both domestically and internationally in the areas of education, health, and the workforce. AIR's work is driven by its mission to generate and use rigorous evidence that contributes to a better, more equitable world. With headquarters in Arlington, Virginia, AIR has offices across the U.S. and abroad. For more information, visit AIR.ORG.

AIR® Headquarters
1400 Crystal Drive, 10th Floor
Arlington, VA 22202-3289
+1.202.403.5000 | **AIR.ORG**

28247_08/25