Rural Community Hospital Demonstration Program: Solicitation for Additional Participants

Overview

Section 15003 of the 21st Century Cures Act mandates an extension of the Rural Community Hospital Demonstration Program for an additional 5 years. The law allows some previously participating hospitals to continue participation, and allows additional hospitals located in any state to participate in the demonstration program, subject to a maximum of 30 hospitals participating at the same time. The Centers for Medicare & Medicaid Services (CMS) is conducting a new solicitation to select additional hospitals to participate in the demonstration program for a period of 5 years. Hospitals that were participating in the demonstration as of the last day of the initial 5-year period, or as of December 30, 2014, and decide to continue participation do not have to complete this solicitation.

The CMS began the demonstration in 2004 for an initial 5-year period, as mandated under section 410A of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA). Sections 3123 and 10313 of the Affordable Care Act extended the demonstration for an additional 5-year period of performance.

The demonstration provides and tests payment under a reasonable cost-based methodology for inpatient services furnished by participating hospitals. The goal is to increase the financial viability and capability of the selected rural community hospitals to meet the health care needs of Medicare beneficiaries in their service areas, and to promote high quality and efficient health care delivery. In this solicitation, applicants are asked to specify interventions that both increase access to and improve the quality of care, while enhancing patient care options and the ability for beneficiaries to remain in their communities.

Each year since 2004, CMS has included a segment specific to the demonstration program in the proposed and final rules for the Medicare inpatient prospective payment (IPPS) system. On an annual basis, this segment has detailed the status of the demonstration, as well as the methodology for ensuring budget neutrality. We intend to continue this approach of proposing a budget neutrality methodology in future IPPS rulemaking.

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 section 410A of the MMA, the original 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 (beds in a psychiatric or rehabilitation unit which is a distinct part of the hospital shall not be counted) ;
- Makes available 24-hour emergency care services; and
- Is not eligible for Critical Access Hospital (CAH) designation, or has not been designated a CAH under section 1820 of the Social Security Act.

As permitted by the 21st Century Cures Act, additional hospitals selected for the demonstration under this solicitation may be located in any State.

Demonstration Payment Methodology

Hospitals selected for participation in the demonstration will receive payment for Medicare 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 of providing 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 Inpatient Prospective Payment System (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.

Application Process

Each hospital that wants to participate in the demonstration for the first time must submit an application. If an applicant meets the eligibility requirements, the application 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, strategy for improving its financial situation, and approach to efficient health care delivery. In addition, panelists will look for specific justification of how the hospital intends to use the demonstration's payment methodology to improve patient care and community services.

In addition, applicants must submit the following information:

Descriptive Information

1. Evidence that the hospital is in a federally designated rural area, as defined by the statutes referenced above.
2. Road miles to the nearest hospital or CAH, and number of hospitals or CAHs within 35 road miles of the hospital. (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. Medicare swing bed approval.
5. Most recent 3 years of data on occupancy rate, average daily census, number of discharges, average inpatient length of stay, payer mix. Specify the numbers for each year.
6. If the hospital makes available 24-hour emergency care services.
7. Eligibility for CAH designation.
8. Eligibility for sole community hospital designation.
9. Management type of the hospital - private, publicly owned, faith-based, and/or owned by a large multi-hospital system.
10. A plan or statement of how the hospital enhances quality of care.
11. Total Medicare payment for inpatient services from latest cost report (if applicable, this should include Medicare payment for swing bed services).
12. Total costs for Medicare inpatient services from the latest cost report (if applicable, this should include costs for Medicare swing bed services).
13. The hospital's Medicare inpatient operating margin.
14. The hospital's operating margin (including inpatient services, outpatient services, distinct part psychiatric units, and rehabilitation units). The applicant should specify which among these is used in calculating this amount.

For 3, 11, 12, and 13 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 (for swing beds, also Worksheet E-2); Total Medicare Inpatient Costs: Worksheet D-1 (for swing beds, also Worksheet D-3); 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. This narrative should be no more than 20 pages. Cost report pages, and specific responses to the items requested above, including the quality plan and maps, do not count toward this page limit. To be considered complete, an application must address each category among those listed below.

1. **Problem Statement**: Explain why the applicant hospital desires to receive payment under a reasonable cost-based methodology instead of payment under the current IPPS. List current problems and how payment under a

reasonable cost-based methodology will improve the situation. Be as specific as possible. Would participation in this demonstration allow the hospital to stay open, or not reduce needed services? Also, describe if any rural hospitals have closed in the applicant's state or surrounding area during the past 5 years, and, if so, how that has affected the delivery of needed health care services, and how the hospital plans to address any resulting shortfalls. Is the applicant hospital filling gaps left by the closure of other hospitals?

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 under the demonstration. Please explain how participation in the demonstration will assist the hospital respond to financial, demographic, and health care delivery factors that pose risk to sustaining operation. The applicant should also detail efforts to control costs so as to be viable.

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 Medicare beneficiaries in the hospital's service area. Goals of such projects may include increased access to care and provision of additional services, but they may also include transitioning to alternative delivery and payment models, such as accountable care organizations, bundled payment initiatives, or regional collaboratives. This description should also include plans for improving the quality of care, and, if applicable, decreasing the number of avoidable admissions, readmissions, and transfers.

4. **Collaboration with Other Providers to Serve Area:** The applicant should describe its current geographic area and the population it serves. The applicant should describe how it works with other health care providers and facilities to serve the Medicare 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 participation in the demonstration?

Application Review

The application process will be competitive. An independent 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 on the quality and clarity of the information and responses provided in their applications. Decisions will be final, and no appeals will be granted.

Section 15003 of the 21st Century Cures Act, which authorizes the current extension of the demonstration, requires CMS to give priority in selecting new participants to hospitals that are located in one of the 20 states with the lowest population densities. Thus, in making the selection from among the applications with the highest scores, CMS will give priority to applications from the following states: Alaska, Arizona, Arkansas, Colorado, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Vermont and Wyoming (ProQuest Statistical Abstract of the United States: 2015).

The statute also allows CMS to consider the population density of the state in selecting among applicants. In addition, as permitted by the statute, CMS will consider the impact of closures of hospitals located in rural areas in the state in which the applicant hospital is located during the 5-year period immediately preceding the date of the enactment of the 21st Century Cures Act. CMS will consider both of these factors when selecting from among the applications with the highest scores.

Due Date

Applications will be considered timely if we receive them on or before **May 17, 2017**. Applications must be received by 5 PM Pacific Daylight Time on the due date.

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

Application Submission

In addition to responding to the items under "Descriptive Information", applicants must complete, sign, date, and return the Medicare Waiver Demonstration Applicant Data Sheet found on this web page (https://innovation.cms.gov/initiatives/Rural-Community-Hospital/). Fill in the five year Project Duration according to the hospital's upcoming cost report period beginning and end dates. CMS will specify the periods of performance for participating hospitals when the selections are announced. The entire application will consist of the above data sheet, all narrative information requested in the solicitation, responses to specific information items, cost report pages, and maps.

Please submit the application by email to the following mailbox: RCHDemo@cms.hhs.gov. Applicants may, but are not required to, submit up to six hard copies to assure that each review panelist receives the application in the manner intended by the applicant (e.g., collated, tabulated, colorized). These applications should be mailed or sent by an overnight delivery service to the following address:

Centers for Medicare & Medicaid Services
ATTN: Siddhartha Mazumdar, Rural Community Hospital Demonstration
Seamless Care Models Group
Mail Stop WB-10-01
7500 Security Boulevard
Baltimore, MD 21244

Applications must be typed for clarity and should be no more than 20 double-spaced pages, exclusive of cost report pages, responses to specific items under "Descriptive Information", and maps. Because of staffing and resources limitations, we cannot accept applications by facsimile (FAX) transmission.

Hospitals that were participating in the demonstration as of the last day of the initial 5-year period, or as of December 30, 2014, do not have to complete this solicitation in order to continue participation. However, CMS will require a participation agreement for all hospitals that choose to participate in the upcoming 5-year period authorized by the 21st Century Cures Act. This agreement will detail the demonstration payment methodology, requirements for cooperation with Medicare Administrative Contractors, as well as audit and evaluation contractors, and quality reporting and program integrity requirements.

For further information, please send an email to RCHDemo@cms.hhs.gov or call Siddhartha Mazumdar at (410) 786-6673.