Updating the Hospital Specific Payment Base Year for Medicare-Dependent and Sole Community Hospitals

Summary
When Congress established the Medicare-dependent Small Rural Hospital and Sole Community Hospital programs, it did so to ensure that these critical safety net providers would remain viable under the Inpatient Prospective Payment System (IPPS). Congress understood that the IPPS pays hospitals a fixed amount for inpatient services, and that while that fixed payment scheme properly incentivizes most hospitals to control costs, some rural providers have less ability to control costs, and could be susceptible to inadequate Medicare payment. For this reason, Congress provided a safety valve for these hospitals. Under current Medicare statute, MDHs and SCHs may benefit from special payments known as hospital specific payments (HSPs). MDHs and SCHs receive these special payments only if they are greater than what the hospital would receive as PPS payments. Some MDHs and SCHs receive these supplemental payments, while others do not.

Background
Medicare Dependent Hospitals: The MDH program was established by Congress to support small rural hospitals for which Medicare patients make up a significant percentage of inpatient days or discharges, and which therefore are vital to providing hospital services to program beneficiaries, and also particularly susceptible to changes in Medicare program policy. To qualify as a MDH, a hospital must be: (1) located in a rural area, (2) have no more than 100 beds, and (3) demonstrate that Medicare patients constitute at least 60 percent of its inpatient days or discharges. Because they primarily serve Medicare beneficiaries, MDHs rely heavily on Medicare payment to sustain hospital operations. As such, Congress acknowledged the importance of Medicare reimbursement to MDHs and established special payment provisions to buttress these hospitals. Congress recognized that if these hospitals were not financially viable and failed, Medicare beneficiaries would lose an important point of access to hospital services.

Sole Community Hospitals: The SCH program was created to maintain access to needed health services for Medicare beneficiaries in isolated communities. The SCH program ensures the viability of hospitals that are geographically isolated and thus play a critical role in maintaining access to care in remote communities. Hospitals qualify for SCH status by demonstrating that because of distance or geographic boundaries between hospitals they are the sole source of hospital services available in a wide geographic area. There are a variety of ways in which hospitals can qualify for SCH status, but the majority qualify by being more than 35 miles from another provider.

Hospital Specific Payments: MDHs and SCHs are reimbursed by Medicare for operating costs associated with inpatient services provided to program beneficiaries on the greater of the federal payment rate applicable to the hospital (*i.e.,* the payment that the hospital would otherwise receive under the inpatient PPS) or a cost-based payment, which is determined by adding together the federal payment rate applicable to the hospital and the amount that the federal payment rate is exceeded by a hospital-specific rate. These are based on the hospital's costs in fiscal year 1982, 1987, 1996 or 2006 trended forward, whichever is higher. MDHs can use 1982, 1987 or 2002 as a base year. A hospital that qualifies for MDH or SCH status will continue to be reimbursed under the PPS for as long as reimbursement under the PPS is more than reimbursement on a cost-basis; the hospital will be paid on a cost-basis if cost-based reimbursement is greater than reimbursement under the PPS.

There are 451 SCHs; about 276 are paid based on the HSP. There are 169 MDHs; about 74 are paid based on the HSP.

Policy Proposal

The current base years were established by Congress in statute. CMS does not have the authority to add a new base year. As such, Congress has added new base years from time-to-time. Congress last required an update more than decade ago (see, section 122 of Public Law 110-275, the Medicare Improvement for Patients and Providers Act of 2008). It is time for this program to reflect more current cost experience. H.R.1887 addresses this issue by adding a more current base year (2016). This update will benefit some hospitals that do not currently receive hospital specific payments and boost payments for certain other hospitals that currently use one of the older base years. We estimate that 244 hospitals in 45 states will benefit in one of these ways.