Updating the Hospital-Specific Payment Base Year for MDHs and SCHs

Overview

When Congress established the Medicare-Dependent Hospital (MDH) and Sole Community Hospital (SCH) 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 are susceptible to inadequate Medicare payments.

For this reason, Congress provided a safety valve for these hospitals. Under current Medicare statute, MDHs and SCHs can benefit from hospital-specific payments (HSPs). MDHs and SCHs receive these special payments only if they are greater than what the hospital would otherwise receive under the federal IPPS rate. Some MDHs and SCHs receive HSPs, 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. These hospitals are therefore vital to providing hospital services to Medicare beneficiaries, and are also particularly susceptible to changes in Medicare program policy. To qualify as an 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 rural 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 a hospital 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 IPPS) or a cost-based HSP, 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. For MDHs, these are based on the hospital's costs in 1982, 1987 or 2002, whichever is higher. SCHs can use 1982, 1987, 1996 or 2006 as a base year. A hospital that qualifies for MDH or SCH status will continue to be reimbursed under the IPPS for as long as reimbursement under the

federal rate is more than reimbursement on a cost-based HSP; the hospital will be paid on a cost-based HSP if the cost-based reimbursement is greater than reimbursement under the federal rate.

Currently there are 463 SCHs; 267 are paid based on the HSP. There are 171 MDHs; 78 are paid based on the HSP.

Legislative Proposal

The current base years were established by Congress in statute and, as such, Congress has periodically added new base years for MDHs and SCHs. Congress last enacted an update for MDHs 18 years ago[1] and for SCHs more than 15 years ago.[2] It is well past time for these programs to reflect a more current cost experience.

S. 1110, introduced by Senators Bob Casey (D-PA) and Chuck Grassley (R-IA), would make these long-overdue updates by adding a more current base year from which MDHs and SCHs could derive their hospital-specific rate. The legislation would also permanently extend the MDH program and the Low-Volume Hospital Payment Adjustment, both of which will expire on December 31, 2024 without congressional action.

The Alliance for Rural Hospital Access strongly supports S. 1110 and urges Congress to advance this legislation so that MDHs and SCHs can continue to meet the needs of their rural communities. 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.

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[1] See Section 5003 of Public Law 109-171, the Deficit Reduction Act of 2005, enacted on February 8, 2006.
[2] See Section 122 of Public Law 110-275, the Medicare Improvement for Patients and Providers Act of 2008, enacted on July 15, 2008.