Rural Essential Access Community Hospitals (REACH) For Rural America

Adopted, 3/29/01

This proposal was developed by individuals convened by the National Rural Health Association. This proposal is intended to be advisory to the diverse organizations named below but not to speak for those organizations.

Task Force Members

Steve Brenton, President
Iowa Hospital Association

Harold Brown, CEO
Prairie du Chien Memorial Hospital (WI)

Brandon Durbin, CPA, Partner
Durbin & Company, L.L.P. (TX)

George Miller, CEO/Administrator
Jasper Memorial Hospital (TX)

Robert W. Olsen, Vice President
MHA... Association of Montana Health Care Providers

John J. Sheehan, CPA, Partner
Baird, Kurtz & Dobson (MO)

(Chair) Tim Size, Executive Director
Rural Wisconsin Health Cooperative

Karl Richard Stinson, CHE, CEO
Medical Arts Hospital (TX)

John Supplitt, Director
Section For Small and Rural Hospitals
American Hospital Association

Anthony Wellever
Delta Rural Health Consulting & Research (MN)

Gerald Worrick, CEO
Door County Memorial Hospital,
Sturgeon Bay, WI

Consultants

Kathleen Dalton, Research Assistant Professor, Sheps Center for Health Services Research and UNC School of Public Health, Dept of Health Policy

Jane Gibson, Assistant Director
Section for Small or Rural Hospitals American Hospital Association

Staff

Alan Morgan, Vice President of Government Relations & Policy
National Rural Health Association

Robyn Henderson,
Vice President, Program Services
National Rural Health Association

Background

On November 9, 2000, the **Hospital Constituency Group of the National Rural Health Association** submitted a policy proposal to the NRHA Policy Board, which was unanimously adopted as follows: "Rural hospitals should have the option of electing to be cost-based for Medicare reimbursement."

On November 16th, the **Texas Organization of Rural and Community Hospitals**, hosted a cross-section of rural advocates from around the country to explore a similar initiative and advocated a collaborative effort be undertaken. For some time, members and staff of **the American Hospital Association's Small and Rural Governing Council** had been discussing these same concerns.

With these common concerns and upon passage of the NRHA Policy Board's Policy Statement, David Sniff, Chairman of the NRHA Hospital Constituency appointed Tim Size, Past President of the NRHA and Executive Director of the Rural Wisconsin Health Cooperative, to be Chairman of the Task Force with the following charge: "To develop a specific proposal which will offer rural hospitals the option of being paid by Medicare their reasonable costs plus a reasonable operating margin."

Why Rural Essential Access Community Hospitals (REACH)?

National policy leaders recognize that the Prospective Payment System (PPS) does not work in rural areas. After twenty years attempting to adjust PPS to the reality of rural community hospitals, it has become clear that it is time to stop trying to fit a round peg into a square hole.

There are hundreds of small and rural hospitals across the country that are "too busy" to be eligible for the Critical Access Hospital (CAH) program but not "busy enough" to have a PPS margin. Few of them have Medicare-dependent Hospital or Sole Community Hospital status and most that do, don't receive significant advantage from those programs. As a group they are heavily Medicare dependent with negative Medicare margins and meager or nonexistent operating margins. They are important cogs in this state's rural health infrastructure and enjoy significant community and political support.

This proposal is not intended as a request for a subsidy for rural hospitals. Rather, it is a practical and reasonable approach for Medicare to meet its obligation to rural Medicare beneficiaries. In fact, a request for fair payment is just the opposite of a request for a subsidy; it is a claim to not receive special treatment; it is a claim for equitable, consistent treatment. For rural providers, this means they expect to receive, at a minimum, the same pay for the same service elsewhere provided to Medicare beneficiaries. It means that, as a class of providers, they should receive payment for their reasonable costs and a contribution to their margin.

The basis for rural hospitals' claim for a new approach lies in the government data showing that they are paid less than urban hospitals for the same service (see the appended statistics).

1) Rural hospitals, on average are paid 9.6% less than their reasonable costs (as defined by Medicare) for providing services to Medicare beneficiaries, 14.2% less for ""other' rural hospitals under 50 beds." (In this context, Medicare defines beds as "allocated beds" and "'other' rural hospitals under 50 beds" as hospitals not having special designations such as Sole Community or Medicare Dependent.)

2) In 1999, 54.5% of hospitals designated as "'other' rural hospitals under 50 beds" had a negative inpatient Medicare margin.

3) All rural hospitals under fifty beds only account for 2% of inpatient PPS payments.

Underpayments by Medicare affect small, rural hospitals in multiple ways. To compensate for payments that are less than cost, small, rural hospitals "shift" costs to private payers. According to MedPAC (2001), rural hospitals have the highest payment-to-cost ratios for private payers of any class of hospitals. Because charges are high and rates of health insurance in rural areas are lower, the uncompensated care burden of small, rural hospitals is greater than that of most other hospitals. "Other" rural hospitals under 50 beds have the highest ratio of uncompensated care to cost for all hospitals except teaching hospitals (MedPAC, 2001).

REACH is a measured approach to protecting the core infrastructure of rural health in American that does not undermine or contradict the public policy inherent in the Medicare's Prospective Payment System. Medicare beneficiaries gain only through use of their benefits. To be useful, benefits must be accessible and to be accessible they must be available timely and conveniently to the beneficiary and their care givers (family). Rural hospitals offer the essential services that Medicare beneficiaries need and how they need them, that is timely and conveniently. For benefits to be accessible, rural hospitals must be viable. About 50% of rural hospital admissions are Medicare beneficiaries. Medicare is the primary payer for rural hospital services. For rural hospitals to maintain inpatient and outpatient services and the infrastructure for future services, they need to be reimbursed their reasonable costs.

The Task Force is in the process of modeling the cost of REACH as described below and arranging for the drafting of REACH enabling legislation.

Rural Essential Access Community Hospitals (REACH) Specifics

1. REACH eligibility criteria

    a. REACH would constitute a new designation of hospital for purposes of Medicare payments.

    b. The criteria for becoming a REACH would be:

        i. The hospital must be a rural hospital as defined for inpatient PPS payment purposes. This would include urban hospitals that elect to be treated as rural under section 401 of BBRA.
        ii. The hospital must have 50 or fewer acute beds. Beds are counted as defined in existing regulations, meaning available beds, not licensed beds. (This is consistent with the definition of beds for purposes of the BBRA outpatient PPS hold harmless provisions.)
        iii. The hospital must elect REACH status.
        iv. Governmental, Nonprofit and Proprietary hospitals are all eligible for REACH status.

    c. Obtaining REACH status

        i. Any hospital, (including a qualifying Critical Access Hospital) that meets all of the criteria for REACH status, and applies for such status to its fiscal intermediary, shall be granted REACH status effective as of the start of the next calendar month after the request is made. Applications made prior to the start of a month, and approved after the start of the month, are effective at the beginning of that month.

2. REACH Medicare reimbursement

    a. REACHs would receive cost reimbursement for all hospital inpatient and outpatient services.

    b. In addition, the following would be specified:

        i. REACHs could have distinct part rehabilitation, psychiatric and/or long-term care units
        ii. REACHs would be paid cost reimbursement for other hospital based services including ambulance , home health, skilled nursing units, swing beds, hospice, etc..
        iii. All REACHs would be paid a reasonable return on equity for all reimbursable services, as specified for cost reporting periods beginning before July 6, 1987. (At that time, the rate of return was 150% of a specified index. See CFR 413.157(b)(1))
        iv. Medicare reimbursable bad debts would be reimbursed at 100% (BBA reductions would be eliminated).
        v. REACHs would be paid disproportionate share hospital (DSH) payments. Eligibility to receive DSH payments would be determined under the same eligibility criteria applied to all hospitals. The DSH add-on percentage would be computed under existing rules for rural PPS hospitals. The DSH add-on would be computed by increasing the reimbursement for all services that are reimbursed through the cost report, by the applicable DSH percentage.

3. Defining Reasonable Costs

    a. The basis for reimbursement will be reasonable costs. This includes inpatients, outpatients, emergency, home health, skilled nursing, ambulance, hospice and other community services.

4. REACH outpatient coinsurance

    a. Patient liabilities for outpatient hospital services will be determined under the outpatient PPS (APC) methodology.

    b. There will be no patient liability (deductible and coinsurance) for outpatient diagnostic laboratory services.

5. Limitation on new facilities electing REACH status

    a. Any hospital, (including Critical Access Hospitals that meet the Hospital Conditions of Participation) licensed, certified and operating as of the date of enactment, or obligated as defined by the secretary as of the date of enactment may elect REACH status.

    b. This provision will not prevent the following hospitals from electing REACH status:
        i. This will not prohibit a replacement facility [as defined in 42 CFR Section 412.300 (b)(1)] with the same service area [as defined in 42 CFR 412.92 (b)(1)(ii)] from qualifying.
        ii. This will not prohibit a facility that was operating as of the effective dates, if due to a change in ownership, has obtained a new distinct provider number.

6. Quality improvement

    a. A REACH must meet Medicare hospital Conditions of Participation (CoPs).

    b. The REACH facilities, in complying with hospital CoPs, will develop strategies for improving the processes of care, quality outcomes and organizational performance as the focus of management and leadership at all levels within the organization.

7. Effective dates

    a. These provisions are effective upon enactment.

    b. Applications for REACH status made within 180 days of enactment are to be deemed received by the fiscal intermediary as of the date of enactment and thus effective with the start of the first calendar month beginning after enactment.

    c. REACH status is granted for payment purposes only so no survey and certification process is to be required if the hospital is already a Medicare certified hospital.

8. Source of Funding

    a. New money

Summary Rural Hospital Medicare Payment Statistics

Sources:
[1] *Federal Register*, 88/1/00, pp 47191-47204
[2] *ProPAC Report To The Congress*, June, 1997
[3] *MedPAC Report To The Congress*, June, 2000
[4] *MedPAC Report To The Congress*, March, 2001

Rural Hospitals constitute 2,136 (44%) of all 4,888 PPS hospitals[1].

Distribution of Rural Hospitals & Inpatient PPS Payments By Bed Size

Size	Number[1]	% Rural Hospitals[1]		Percent Inpatient PPS Payments[2]	
		category	cumulative	category	cumulative
0-49 beds	**1,233**	**58%**	**58%**	**2%**	**2%**
50-99 beds	535	25%	83%	4%	6%
100-149	219	10%	93%	3%	9%
150-199	81	4%	97%	2%	11%
200 or more	68	3%	100%	2%	13%

Rural Hospital Types, Receiving DSH or Reclassified[1]

	Number	% Rural Hospitals
Non Special	835	39%
RRC	150	7%
SCH	661	31%
MDH	352	16%
SCH AND RRC	57	3%
DSH (SCH)	149	7%
DSH (<100)	103	5%
DSH (>100)	48	2%
Reclassified (for FFY 2001)	114	5%

Hospital Medicare Margins (Excluding GME)

	Average Inpatient Margin In 1999[4]	Average Outpatient Margin In 1999[4]	% With Negative Inpatient Margin In 1998[3]	1999[4]
All hospitals	12.0%	-15.4%	28.9%	34.1%
Rural	3.4%	-16.0%	39.4%	43.9%
Sole Community	4.5%	-15.0%	36.6%	42.2%
Small rural Medicare Dependent	7.8%	-19.4%	35.2%	36.1%
Other Rural < 50	**1.3%**	**-19.3%**	**46.3%**	**54.5%**
Other Rural ≥ 50	1.3%	-17.7%	43.2%	45.1%
Rural DSH	5.5%	-16.1%	30.2%	32.3%
Rural Government	.2%	-16.2%	45.7%	50.4%

Hospital Medicare Payment-To-Cost Ratio, By Hospital Group, In 1998[3] & 1999[4]

	1998	1999	Change '98 to '99
All hospitals	102.6%	101.1%	1.5%
Rural	93.6%	90.4%	3.2%
Sole Community	93.6%	90.6%	3.0%
Small rural Medicare Dependent	91.4%	88.7%	2.7%
Other Rural < 50	**88.9%**	**85.8%**	**3.1%**
Other Rural ≥ 50	94.0%	92.0%	2.0%
Rural DSH	95.7%	93.3%	2.4%
Rural Government	92.3%	89.1%	3.2%