Chapter 14 Section 1

Sole Community Hospitals (SCHs)

Issue Date: November 6, 2007
Authority: 32 CFR 199.14(a)(1)(ii)(D)*(6)*

1.0 APPLICABILITY

This policy is mandatory for the reimbursement of services provided either by network or non-network providers. However, alternative network reimbursement methodologies are permitted when approved by the Defense Health Agency (DHA) and specifically included in the network provider agreement.

2.0 DESCRIPTION

A Sole Community Hospital is a hospital that is designated by the Centers for Medicare and Medicaid Services (CMS) as an SCH and meets the applicable requirements established by 32 CFR 199.6(b)(4)(xvii).

3.0 ISSUE

How are SCHs to be reimbursed?

4.0 POLICY

4.1 Background

Under Title 10, United States Code (USC), Section 1079(j)(2), the amount to be paid to hospitals, Skilled Nursing Facilities (SNFs), and other institutional providers under TRICARE, "shall be determined to the extent practicable in accordance with the same reimbursement rules as apply to payments to providers of services of the same type under Medicare."

4.2 Payment Method For Inpatient Services

4.2.1 For admissions prior to January 1, 2014, institutional inpatient services (other than professional) provided by SCHs shall be reimbursed based on billed charges or negotiated rates.

4.2.2 Primary and Secondary Reimbursement Methodologies

4.2.2.1 For admissions on or after January 1, 2014, inpatient services that are provided by SCHs shall be reimbursed using a primary methodology referred to as a Cost-To-Charge Ratio (CCR) methodology. That is, claims shall be reimbursed by multiplying the SCH's specific Medicare overall inpatient CCR obtained from the CMS Inpatient Provider Specific File (PSF) by the hospital's billed

charges. However, during the transition period discussed in paragraph 4.2.4, a modified CCR is used.

4.2.2.2 Claims shall also be priced using the secondary methodology, i.e., the Diagnosis Related Group (DRG)-based payment methodology, for accumulation and subsequent comparison to the primary methodology amount at year-end.

4.2.3 Year-End Comparison

4.2.3.1 Prior to January 1, 2017, at year-end, the contractor shall compare the aggregate allowed amount under the primary methodology, i.e., the CCR methodology (described in paragraph 4.2.2.1 or 4.2.4 during the transition period) to the aggregate allowed amount for the same care under the secondary methodology, i.e., the DRG-based payment methodology. The year-end comparison is not applicable to the TRICARE Dual Eligible Fiscal Intermediary Contract (TDEFIC) contractor or the TRICARE Overseas Program (TOP) contract.

4.2.3.2 In the event that the DRG allowed amount is the greater of the two calculations, the contractor shall reimburse the hospital the difference between the aggregate allowed amount under the primary cost-based methodology and what would have been allowed under the secondary DRG-based methodology.

4.2.3.3 The comparison shall be applied at the end of the DHA SCH year, based on a 12 month period after the effective date of implementation which is January 1, 2014. The first SCH year is January 1, 2014 to December 31, 2014.

4.2.3.4 DHA shall provide the contractor a hospital-specific capital adjustment factor in the file with the hospital specific CCR. The contractor shall adjust the DRG amount to include capital by multiplying the DRG amount by the DRG capital adjustment factor. The DRG capital adjustment factor will be equal to one plus a value equal to the capital CCR for a specific hospital divided by its operating CCR. For example, if a SCH's operating CCR is 0.35 and its capital CCR is 0.028, then the DRG capital adjustment factor would be equal to 1+ (0.028/0.35) which is equal to 1.08.

4.2.3.5 Beginning January 1, 2017, six months after the end of the TRICARE SCH year (i.e. July of each respective year), DHA's Decision Support (DS) Office shall run query reports of SCH TRICARE Encounter Data (TED) records for the prior SCH year (January 1 through December 31) and compare the aggregate allowed amount under the primary methodology, i.e., the CCR methodology (described in paragraph 4.2.2.1 or 4.2.4 during the transition period) to the aggregate allowed amount for the same care under the secondary methodology, i.e., the DRG-based payment methodology.

4.2.3.6 DS shall adjust the DRG amount to include capital by multiplying the DRG amount by the DRG capital adjustment factor. The DRG capital adjustment factor will be equal to one plus a value equal to the capital CCR for a specific hospital divided by its operating CCR. For example, if a SCH's operating CCR is 0.35 and its capital CCR is 0.028, then the DRG capital adjustment factor would be equal to 1+(0.028/0/35) which is equal to 1.08.

4.2.3.7 DS shall provide DHA Medical Benefits & Reimbursement Section (MB&RS) the summary year-end adjustment reports by region for those hospitals where the DRG allowed amount is greater than the CCR allowed amount. MB&RS shall provide the approved year-end adjustment

reports to each TRICARE Regional Office (TRO) Contracting Officer Representative (COR) and to DHA Aurora Contract Resource Management (CRM).

4.2.3.8 The TRO COR shall provide the contractor with the approved year-end adjustment reports to be processed according to instructions in Section G of their contract under Invoice and Payment Non-Underwritten - Non-TEDs, Demonstrations. No payments shall be sent out without approval from DHA Aurora CRM.

4.2.4 Transition Period

4.2.4.1 In the Final Rule published in the **Federal Register** on August 8, 2013, DHA created a multi-year transition period to buffer the impact from any potential decrease in revenue that hospitals may experience during the implementation of a revised SCH inpatient payment system. This transition period provides SCHs with sufficient time to adjust and budget for potential revenue reductions. The transition is as follows:

DHA will measure the ratio of allowed charges to billed charges during Fiscal Year 2012 (FY12) (the base year) for inpatient hospitalizations where DHA is the primary payer and a ratio of allowed to billed charges will be established for each SCH during FY12. This ratio will be used in calculating the modified CCR during the transition period. In the first year of the transition, the allowed amount for each claim under the modified CCR methodology shall be equal to the billed charge multiplied by the modified CCR. The modified CCR is determined separately for each SCH. For network hospitals, the modified CCR is equal to the base year ratio of the allowed to billed minus 0.10. Each year thereafter the modified CCR will decline by 0.10 until it reaches the SCH's Medicare CCR. The SCH's specific Medicare CCR is equal to the sum of the SCH's operating and capital CCR taken from the most recently available CMS Inpatient PSF. For non-network SCHs, the base year rate will decline by 0.15 each year until the SCH reaches it's specific Medicare CCR as taken from the most recently available CMs Inpatient PSF.

Example: In the case of a non-network hospital with Medicare CCR of 0.40 and a base year allowed-to-billed ratio of 1.0, payment in the first year for an inpatient hospitalization claim would be equal to the billed charges on that claim multiplied by a factor of 0.85. The factor in the second year would be 0.70, in the third year it would be 0.55, in the fourth year it would be 0.40, in the fifth year it would be 0.25, and in the sixth year it would be 0.10. In no case can the ratio in a year be less than the hospital's CCR in that year. In the case of a network hospital with a Medicare CCR of 0.40 and an allowed-to-billed base year ratio of 0.90, payment in the first year for an inpatient hospitalization claim would be equal to the billed charges on that claim multiplied by 0.80. The factors in subsequent years would be 0.70, 0.60, 0.50, 0.40, etc. until the CCR is reached.

4.2.4.2 In no year shall the modified CCR fall below the hospital's overall Medicare CCR, as measured by the most recently available inpatient Medicare CCR from the CMS inpatient PSF.

4.2.4.3 Once the hospital reaches its Medicare CCR, the transition is complete for that hospital.

4.2.5 Nursery and Labor/Delivery Adjustment (NLDA)

At the end of a SCH's transition period, i.e., when the SCH reaches its Medicare CCR, a

special allowable cost shall be applied to charges for inpatient nursery and labor/delivery DRGs (610-613, 631-636, 646-651, 676-681, 762-764, 768-773, 776, 779, 783-785, 787-795, 805-807, 817-819, and 831-833). Instead of applying the Medicare CCR for these DRGs, DHA shall apply 130% of the Medicare CCR.

4.2.6 New SCHs and SCHs Without Inpatient Claims

DHA shall pay a new SCH using the average Medicare CCR for all SCHs calculated in the most recent year until its Medicare CCR is available in the CMS inpatient PSF. This applies to any SCH without a Medicare CCR in the inpatient PSF. DHA shall pay hospitals that have a CCR in the inpatient PSF and that change their status to an SCH using that Medicare CCR. For SCHs that had no inpatient claims from DHA immediately prior to implementation of the SCH payment reform but do have a claim after implementation of SCH payment reform, DHA shall pay them based directly on their Medicare CCR.

4.2.7 DHA Data

4.2.7.1 During the transition period, on an annual basis, DHA shall provide the contractors with modified CCRs. The overall Medicare CCR is the sum of Medicare's operating and capital inpatient CCRs for each SCH. The operating and capital CCR shall be from the most recently available CMS inpatient PSF.

4.2.7.2 Following the transition, DHA will continue to provide the contractors with the DHA SCH CCR listing by January 1 of each year.

4.2.7.3 The DHA SCH CCR listing during the transition period and thereafter shall be effective for admissions on and after January 1 of each respective year. The contractors shall use the CCRs on the DHA SCH CCR listing for the entire DHA SCH year, i.e., January 1 through December 31.

4.2.7.4 DHA shall also provide the contractors the average Medicare CCR to use for SCHs, without a CCR in the inpatient PSF.

4.2.7.5 DHA shall also provide the contractors with a hospital-specific capital adjustment factor in the file with the hospital-specific CCR.

4.2.8 General Temporary Military Contingency Payment Adjustment (GTMCPA) Payments

4.2.8.1 The Director, DHA, or designee, may approve a GTMCPA payment based on all of the following:

- The hospital serves a disproportionate share of Active Duty Service Members (ADSMs) and Active Duty Dependents (ADDs), i.e., 10% or more of an SCH's total admissions are for ADSMs and ADDs;
- The hospital is a DHA network hospital;
- The hospital's actual costs for inpatient services exceed DHA payments or other extraordinary economic circumstance exists; and

- Without the GTMCPA payment, Department of Defense's (DoD's) ability to meet military contingency mission requirements will be significantly compromised.

4.2.8.2 Following is the GTMCPA Payment Process for the first DHA SCH year (January 1, 2014 through December 31, 2014) and subsequent years.

4.2.8.2.1 The hospital may submit a request for a discretionary GTMCPA payment to their MCSC. The request must be made to the contractor within 12 months of the end of the SCH year (January 1 through December 31) for which the hospital is requesting a GTMCPA payment. For example, a hospital must submit a request for a GTMCPA payment for the SCH year ending December 31, 2016, by December 31, 2017. Late submissions or requests for extensions will not be considered. Hospitals will be given a grace period of six months from January 1, 2017, ending June 30, 2017, to submit GTMCPA payment requests for SCH years ending on or before December 31, 2015.

4.2.8.2.2 The hospital shall submit the following information to the contractor for review and consideration for a GTMCPA payment:

- The total number of inpatient admissions during the previous DHA SCH year and the number of ADSM and ADD admissions for this same period. Hospitals shall not include admissions by non-ADSM or non-ADFM beneficiaries (i.e., retiree or retiree dependents), TRICARE for Life (TFL) beneficiaries, overseas beneficiaries, or beneficiaries with Other Health Insurance (OHI). Only inpatient admissions should be reported. Uniformed Services Family Health Plan (USFHP) ADSM and ADD inpatient admissions visits may be included in the hospital's submission if the visits were paid utilizing the SCH Reimbursement System, but shall be separately identified by the hospital.

- A full 12 months of claims payment data for the previous TRICARE SCH year.

4.2.8.2.3 The contractor shall perform a thorough evaluation of the hospital's request in paragraph 4.2.8.2.2. The evaluation shall consist of the following:

4.2.8.2.3.1 The contractor shall evaluate the hospital's package for completeness. The contractor shall verify the hospital has provided all components in paragraph 4.2.8.2.2.

4.2.8.2.3.2 The contractor shall perform a validation that the hospital meets the disproportionate share criteria. The contractor shall independently calculate the number of ADD/ADSM inpatient admissions, utilizing the contractor's claims data systems, and divide it by the total SCH inpatient admissions reported by the hospital in paragraph 4.2.8.2.2. The contractor shall compare this result to the hospital's submission in paragraph 4.2.8.2.2 to ensure the hospital met the disproportionate share criteria in paragraph 4.2.8.1. The contractor shall work with the hospital to resolve discrepancies in the reported data prior to submission of the request to DHA if the hospital's data show that they qualify, but the contractor's claims data show that they do not.

4.2.8.2.3.3 The contractor shall perform an evaluation to determine if the hospital is essential for continued network adequacy and is necessary to support military contingency mission requirements. The contractor shall report the following data elements for the prior SCH year, as well as provide a brief narrative with supporting rationale, describing why the hospital is essential for

continued network adequacy and why a GTMCPA payment is necessary to maintain this continued network adequacy.

- Number of acute care hospitals and beds in the network locality;
- Efforts that have been made to create an adequate network;
- Availability and types of services of military acute care services in the locations or nearby; and
- Other cost effective alternatives and other relevant factors.

4.2.8.2.3.4 If the contractor's independent analysis shows that: (1) the hospital met the disproportionate share criteria; and (2) the hospital is essential for continued network adequacy, the contractor shall submit all documentation in paragraphs 4.2.8.2.2 and 4.2.8.2.3 to the DTRO. If the hospital fails to meet the disproportionate share criteria or is not essential for continued network adequacy, the contractor shall notify the DTRO of their findings, but will not submit the full request for a GTMCPA payment to the DTRO unless requested by the DTRO.

4.2.8.2.4 The DTRO shall perform a thorough review and analysis of the hospital's submission and the contractor's review, utilizing any DHA data the DTRO deems necessary, to determine if the hospital meets the four criteria listed in paragraph 4.2.8.1 and qualifies for a GTMCPA payment. If the hospital qualifies, the GTMCPA payment will be set, utilizing DHA data, so the hospital's PCR for TRICARE inpatient hospital services does not exceed a ratio of 1.15. A hospital shall not be approved for a GTMCPA if the payment would result in the hospital's PCR exceeding 1.15. The DTRO shall forward their recommendation for approval of the GTMCPA payment and the recommended percentage adjustment, to the Director, DHA. Disapprovals by the DTRO will not be forwarded to the Director, DHA, for review and approval. The PCR shall be calculated as follows:

4.2.8.2.4.1 Step 1. Determine actual TRICARE SCH Payments, excluding OHI and USFHP claims. The SCH GTMCPA payment is specific to the SCH reimbursement system and there is no authority to include non-SCH paid amounts in the PCR calculation. Claims for beneficiaries with OHI, claims for beneficiaries with USFHP, claims for ineligible beneficiaries, duplicate claims, and denied claims shall not be included in the calculation.

4.2.8.2.4.2 Step 2. Determine the hospital's costs, by identifying the billed charges for all non-OHI, non-USFHP SCH inpatient claims. There is no authority to include non-SCH amounts in the PCR calculation. Claims for beneficiaries with OHI, claims for beneficiaries with USFHP, claims for ineligible beneficiaries, duplicate claims, and denied claims shall not be included in the calculation.

4.2.8.2.4.3 Step 3. Divide Step 1 by Step 2.

4.2.8.2.4.4 Step 4. If the amount in Step 3 is lower than 1.15 the hospital may receive a GTMCPA payment so that total TRICARE SCH payments are equal to or less than 115% of their costs. The percentage used is at the discretion of the Director, DHA.

4.2.8.2.5 TRICARE SCH payments for the qualifying hospital will be increased by the Director, DHA, or designee, at his/her discretion by way of an additional GTMCPA payment after the end of the TRICARE SCH year (January 1 through December 31). Subsequent adjustments to the GTMCPA

payment will be issued to the qualifying hospital for the prior SCH year, when requested by the hospital, to ensure claims that were not paid-to-completion (PTC) the previous year are adjusted. These adjustments are separate from the applicable GTMCPA payment approved for the current SCH year.

4.2.8.2.6 Upon approval of the GTMCPA payment request by the DHA Director, the DTRO shall notify the Contracting Officer (CO) who shall send a letter to the contractor notifying them of the GTMCPA payment approval.

4.2.8.2.7 The contractor shall process the GTMCPA payments per the instructions in Section G of their contracts under Invoice and Payment Non-Underwritten - Non-TEDs, Demonstrations. No GTMCPA payments will be sent out without approval from DHA-Aurora, CRM, Budget.

4.2.8.2.8 DHA shall send an approval to the contractor to issue GTMCPA payments out of the non-financially underwritten bank account based on fund availability.

4.2.8.2.9 GTMCPA payments shall be reviewed and approved on an annual basis; i.e., they will have to be evaluated on a yearly basis by the DTRO in order to determine if the hospital continues to serve a disproportionate share of ADSMs and ADDs and whether there are any other special circumstances significantly affecting military contingency capabilities.

4.2.8.2.10 The Director, DHA, or designee is the final approval authority for GTMCPA payments. A decision by the Director, DHA, or designee to approve, reject, adopt, modify, or extend GTMCPA payments is not subject to the appeal and hearing procedures in 32 CFR 199.10.

4.2.8.2.11 DHA, upon request, will provide the detailed claims data used to calculate the hospital's PCR and maximum GTMCPA payment, if any, to the requesting hospital through the contractor.

4.2.8.2.12 GTMCPAs may be extended to SCH facilities that have changed their status during the SCH GTMCPA year. If an SCH network facility changes their status during the SCH year, and the facility was and remained a network facility that is essential for military readiness, contingency operations, and network adequacy and the facility served a disproportionate share of ADSMs and ADDs during the period of the year it was subject to SCH reimbursement, then a pro-rated SCH GTMCPA may be authorized. Any SCH adjustment will only apply to SCH payments.

4.2.9 Essential Access Community Hospitals (EACHs)

The SCH reimbursement method applies to hospitals classified by CMS as EACHs.

4.2.10 Direct Medical Education

DHA will reimburse SCHs who timely file a request for their direct medical education costs as outlined in Chapter 6, Section 8.

4.3 Payment Method For Outpatient Services

Outpatient services provided by a SCH are subject to DHA's Outpatient Prospective Payment System (OPPS). Reference Chapter 13.

4.4 SCH Listing

4.4.1 Prior to July 1, 2014, DHA will maintain the SCH listing on DHA's web site: http://health.mil/HospitalClassifications, and will update the list on a quarterly basis and notify the contractors by e-mail when the list is updated.

4.4.1.1 After June 1, 2006, and prior to January 1, 2014, if an SCH is added or dropped off of the list from the previous update, the quarterly revision date of the current listing shall be listed as the facility's effective or termination date, respectively.

4.4.1.2 Prior to July 1, 2014, if the contractor receives documentation from an SCH indicating their status is different than what is on the SCH listing on DHA's web site, the contractor shall send the information to DHA, MB&RS to review and to update the listings on the web, if appropriate.

4.4.2 Effective July 1, 2014, DHA will no longer update and maintain the SCH listing on DHA's web site. It is the contractor's responsibility to determine whether a hospital has been designated as an SCH under CMS and to reimburse them in accordance with the provisions of this policy. The contractors shall maintain accurate network status of their regional SCHs.

4.4.3 Effective July 1, 2014, the contractors shall take the steps necessary to ensure they are identifying and reimbursing SCHs appropriately. This may include referencing CMS' Inpatient Provider Specific File (IPSF) at http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ProspMedicareFeeSvcPmtGen/psf_text.html, contacting hospitals in their region to verify hospital status, or some other action to meet this requirement. SCHs are identified in CMS' IPSF by provider type 16 or 17 for SCHs and 21 or 22 for EACHs. CMS' IPSF is an historical file with effective dates for any change made to it, e.g., change in hospital status.

4.5 Billing And Coding Requirements

4.5.1 The contractors shall use type of institution 91 for SCHs.

4.5.2 The contractors shall use pricing rate code CR for inpatient SCH claims priced using the methodology described in paragraphs 4.2.2.1 and 4.2.4.

5.0 EXCLUSIONS

5.1 Psychiatric and rehabilitation distinct part units are exempt from the inpatient SCH CCR methodology.

5.2 State Waivers. The DRG-based payment system provides for state waivers for states utilizing state developed rates applicable to all payers; e.g., Maryland. Psychiatric hospitals and units in these states, may also qualify for the waiver; however, the per diem may not exceed the cap amount applicable to other higher volume hospitals.

5.3 The SCH reimbursement method does not apply to any costs of physician services or other professional services provided to SCH inpatients.

5.4 The SCH reimbursement method does not apply to hospitals in states that are paid by Medicare and DHA under a cost containment waiver; e.g., Maryland.

6.0 EFFECTIVE DATE

Implementation of the SCH CCR reimbursement method for inpatient services is effective for admissions on or after January 1, 2014.

- END -