Rural Community Hospital Demonstration Program: Solicitation for 10 Additional Participants

Overview

As part of the Agency's broader rural strategy initiative, CMS is conducting a new solicitation to select additional hospitals to participate in the Rural Community Hospital Demonstration Program ("RCH Demonstration" or "the demonstration").

Hospitals that are currently participating in the demonstration shall continue their participation in accordance with their currently scheduled periods of performance; they do not need to complete a new application.

The RCH Demonstration Program was initially authorized by section 410A of the Medicare Modernization Act (MMA) of 2003. The demonstration was extended three times—by sections 3123 and 10313 of the Affordable Care Act, by section 15003 of the 21st Century Cures Act, and by section 128 of the Consolidated Appropriations Act of 2021, which extended the authorization period for participating hospitals. The final period ends June 30, 2028.

The statute states that no more than 30 rural community hospitals can participate in the demonstration. Twenty hospitals are currently participating in the demonstration as of December 18, 2024; therefore, up to 10 additional qualifying hospitals may be selected to be able to begin participation in the demonstration in 2025.

The RCH Demonstration provides and tests payment under a reasonable cost-based methodology for inpatient services furnished by participant 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 services areas, and to promote high quality and efficient health care delivery. Information on the RCH Demonstration and evaluation reports can be found at: https://www.cms.gov/priorities/innovation/innovation-models/rural-community-hospital.

The MMA requires that the demonstration be budget-neutral. CMS has met this requirement by offsetting the amount of payment enhancement attributable to the demonstration from the national payment rates to hospitals. Each of the past 21 years, the proposed and final rules for the Medicare Inpatient Prospective Payment System (IPPS) have updated the status of the

CMS will select up to 10 additional qualifying hospitals to participate in the Rural Community Hospital Demonstration Program.

Due Date

Applications must be received by **11:59pm Eastern Standard Time March 1, 2025.**

Application Submission

Submit the application by email to: RCHDemo@cms.hhs.gov.

Applications should be no more than 20 double-spaced pages—exclusive of cost report pages, responses to specific items under "Descriptive Information," and maps.

Applicants must complete, sign, date, and return the Medicare Waiver Demonstration Applicant Data Sheet.

Selected hospitals enter the demonstration on a rolling basis May 1, 2025 - June 30, 2028

demonstration and explained the methodology for estimating additional costs for the demonstration. For the RCH Demonstration segment in the fiscal year 2025 IPPS final rule, please see this link: https://www.cms.gov/newsroom/fact-sheets/fy-2025-hospital-inpatient-prospective-payment-system-ipps-and-long-term-care-hospital-prospective-0.

We anticipate that we may receive more applications than open slots. Applicants not selected will be placed on a wait list and may be approved on a rolling basis to join the demonstration should a participant leave the demonstration.

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 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.

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 (the Act), or is treated as being rural pursuant to section 1886(d)(8)(E) of the Act;
- 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 Act.

The original authorizing legislation, section 410A of the MMA, requires that CMS conduct this demonstration in States with low population densities, as determined by the Secretary. Therefore, CMS will only accept applications to this solicitation from hospitals

in the 20 least densely populated States, according to data for 2020 from the U.S. Census Bureau.[1]

These States are: Alaska, Arizona, Arkansas, Colorado, Idaho, Iowa, Kansas, Maine, Mississippi, Montana, Nebraska, Nevada, New Mexico, North Dakota, Oklahoma, Oregon, South Dakota, Utah, Vermont, and Wyoming. **CMS will not accept applications from hospitals located in other states or in the US territories.**

Application Process

Each hospital seeking to participate in the demonstration must submit an application.

Required Descriptive Information

Applicants **must** submit the following descriptive information:

A. Provide the following to verify that the hospital meets the eligibility requirements for participation:
   1. Evidence that the hospital is located in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (the Act) or treated as being rural pursuant to section 1886(d)(8)(E) of the Act and is located in one the 20 least densely populated states.
   2. 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).
   3. Evidence that the hospital makes available 24-hour emergency care services.

B. The following is additional information that CMS may use in ranking hospitals in the case we receive more applications than open slots:
   1. Road miles to the nearest hospital or CAH, and a list of all hospitals or CAHs within 35 road miles of the hospital.
   2. Indicate if the hospital is designated as a sole community hospital, Medicare-dependent hospital, rural referral center, or other hospital designation.
   3. Medicare swing bed approval, if applicable.
   4. Most recent 3 years of data on occupancy rate, average daily census (including in the emergency department), number of discharges, average inpatient length of stay, payer mix. Specify the numbers for each year.
   5. Total Medicare payment for inpatient services from the latest cost report (if applicable, this should include Medicare payment for swing bed services).
   6. Toal costs for Medicare inpatient services from the latest cost report (if applicable, this should include costs for Medicare swing bed services).
   7. The hospital's Medicare inpatient 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.

[1] See the United States Census Bureau: Historical Population Density Data (1910-2020) available at: https://www.census.gov/data/tables/time-series/dec/density-data-text.html

C. The applicant should submit the relevant pages from the most recently submitted cost report to address:
   1. 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); (Worksheet S-3 Part I);
   2. Total Medicare payment for inpatient services from the latest cost report (if applicable, this should include Medicare payment for swing bed services); (Worksheet E, Part A (for swing beds, Worksheet E-2));
   3. Total costs for Medicare inpatient services from the latest cost report (if applicable, this should include costs for Medicare swing bed services); (Worksheet D-1 (for swing beds, also Worksheet D-3));
   4. Medicare Inpatient Operating Margin - the applicant should calculate this amount from Total Medicare Payment for Inpatient Services and Total Medicare Inpatient Costs).
   5. The hospital's total 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.

D. **Narrative Responses:** The applicant should address the following questions in narrative format. This narrative should be no more than 20 pages, double spaced. Cost report pages, and specific responses to the items requested above, including any maps, do not count toward this page limit. To be considered complete, an application must address each category among those listed below.

Applicants should specify proposed interventions that increase access to and improve quality of care, while enhancing patient care options and the ability for beneficiaries to remain in their communities. Applicants should also describe how additional funding under the demonstration will sustain operation as a full-service hospital, and how essential the hospital's health care services are to meeting the health care needs of the community.

1. Problem Statement (40 out of 100 points): Explain why the applicant hospital desires to receive payment under a reasonable cost-based methodology instead of payment under the current IPPS.

- List current challenges and how payment under a reasonable cost-based methodology will improve the situation. For example, would participation in this demonstration allow the hospital to stay open, not reduce needed services, or improve care quality?
- Identify any specific services that are currently or likely to be threatened due to funding shortfalls. Explain the hospital's role in providing health care services to the surrounding population and indicate whether there are issues of remoteness, isolation, and/or absence of other hospital or shortage of health care providers in the area.

- Identify the needs of the surrounding population and the potential benefits of addressing the critical gaps. Is the hospital or area experiencing any demographic shifts or changes in service mix that are important to address? Please identify any critical areas or populations of unmet need, such as maternal health, behavioral health, older adults, or minorities.
- Describe any barriers to converting to other hospital types (i.e., CAH or Rural Emergency Hospital), and how remaining as a full-service hospital addresses community need.
- 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 any resulting impact on this hospital. Is the applicant hospital filling gaps left by the closure of other hospitals?

2. **Strategy for Financial Viability (20 out of 100 points):** 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 in responding to financial, demographic, and health care delivery factors that pose risk to sustaining operation. Will participation in the demonstration fill a gap in funding that currently threatens operations and essential health care services?

   The applicant should describe how its strategy will both enhance revenue and reduce costs. Do revenue enhancement proposals apply to needed acute care and swing-bed services that will generate funding? Please include realistic and substantiated utilization and revenue projections.

   Please also identify financial and utilization trends for other service lines (e.g., outpatient, skilled nursing facility, Rural Health Clinic) and for other payers (e.g., commercial insurance, Medicare Advantage).

   Is the hospital owned or managed by an outside organization or entity? If it is part of a health system, please describe the system's network. If so, the application should describe how participation in the demonstration will complement this relationship.

   The applicant should also detail efforts to control costs so as to be viable. Cost control strategies should include documented activities within the hospital; and, if applicable, on the part of a larger ownership or management entity.

3. **Goals for Demonstration (20 out of 100 points):** 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, and they may also include participation in value-based payment and quality of care programs, such as accountable care organizations, bundled payment initiatives, or regional collaboratives. Please provide a realistic and feasible plan for implementing these projects. This description should also include plans for improving the overall quality of care, and, if applicable, decreasing the number of potentially avoidable admissions, readmissions, transfers, and skilled nursing facility (SNF) admissions.

4. **Collaboration with Other Providers (20 out of 100 points):** The applicant should describe how it works with other health care providers and facilities to serve the Medicare population overall 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?

   The applicant should describe integration of goals for meeting patients' needs with other service lines within the geographic area – e.g., primary care, SNF, home health, and hospice. It is encouraged but not required for applicants to propose collaborations with a larger and more dispersed network, such as for ED coverage, specific services and specialties, telemedicine, administrative functions, and education and training.

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://www.cms.gov/priorities/innovation/innovation-models/rural-community-hospital). 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 see the attached application checklist (Appendix) to help you make sure you have all required documents included in your application.

Please submit the application by email to the following mailbox: RCHDemo@cms.hhs.gov.

Application Review Process

The selection process will be competitive. If an applicant meets the eligibility requirements, the application will be referred to an independent technical review panel for evaluation and scoring. The panelists' evaluations will rate responses to the questions asked above: problem statement, strategy for financial viability, goals for the demonstration, and collaboration with other providers, in conjunction with the other

required descriptive information requested above, which will help to provide additional data to support the problem statement.

The CMS Administrator will make the final selection from among the applications with the highest scores. Scores will be based on the quality and clarity of the information and responses provided in a hospital's application, and on the feasibility of proposals. Hospitals not selected will be placed on a wait list, ordered from highest to lowest score with the highest score being at the top of the list. If any participants drop out, CMS may draw new demonstration participants from the top of the wait list until that slot is filled. Decisions will be final, and no appeals will be granted, however, CMS will release the score to each applicant, and discuss with an applicant their score, upon request.

Selected hospitals may begin participation in the RCH Demo on a rolling basis beginning May 1, 2025 through June 30, 2028.

Due Date

Applications will be considered timely if we receive them on or before **11:59pm Eastern Standard Time (E.S.T.) March 1, 2025.**

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

For further information, please send an email to RCHDemo@cms.hhs.gov.

Appendix: RCH Document Checklist

Does your application include:

Document	Y/N
All the following pages from the most recent cost report	
(Worksheet S-3 Part I); This should show the 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);	
(Worksheet E, Part A (for swing beds, Worksheet E-2)); This should show the number of Total Medicare payment for inpatient services from the latest cost report (if applicable, this should include Medicare payment for swing bed services);	
(Worksheet D-1 (for swing beds, also Worksheet D-3)); This should show the total costs for Medicare inpatient services from the latest cost report (if applicable, this should include costs for Medicare swing bed services);	
Medicare Inpatient Operating Margin the applicant should calculate this amount from Total Medicare Payment for Inpatient Services and Total Medicare Inpatient Costs).	
The hospital's total 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.	