

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 TRICARE Management Activity (TMA) 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 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.

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 TRICARE 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 TMA 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.

4.2.4 Transition Period

4.2.4.1 In the Final Rule published in the **Federal Register** on August 8, 2013, TRICARE 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:

TMA will measure the ratio of allowed charges to billed charges during Fiscal Year 2012 (FY12) (the base year) for inpatient hospitalizations where TRICARE 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 its 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, 765-768, 774, 775, 787-792, and 795). Instead of applying the Medicare CCR for these DRGs, TRICARE shall apply 130% of the Medicare CCR.

4.2.6 New SCHs and SCHs Without Inpatient Claims

TRICARE 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. TRICARE 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 TRICARE immediately prior to implementation of the SCH payment reform but do have a claim after implementation of SCH payment reform, TRICARE shall pay them based directly on their Medicare CCR.

4.2.7 TMA Data

4.2.7.1 During the transition period, on an annual basis, TMA 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 The updated CCRs shall be effective for admissions on and after January 1 of each respective year.

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

4.2.8 Process for SCHs Year One (Effective January 1, 2014 through December 31, 2014) and Subsequent Years

4.2.8.1 Approximately three months after the end of the TRICARE SCH year, the contractors shall run query reports of claims history and compare the aggregate allowed amount per SCH under the cost-based methodology during the previous TRICARE SCH year to the aggregate allowed amount per SCH for the same care under the DRG-based payment system methodology, for each SCH.

4.2.8.2 In the event that the DRG allowed amount is the greater of the two calculations, the contractor shall process adjustment payments per the instructions in Section G of their contract under invoice and Payment Non-Underwritten - Non-TEDs, Demonstrations. No payments will be sent out without approval from TMA-Aurora (TMA-A), Contract Resource Management (CRM), Budget.

4.2.8.3 The year-end adjustments will be paid approximately six months following the end of the TRICARE SCH year.

4.2.9 General Temporary Military Contingency Payment Adjustments (TMCPAs)

The TMA Director, or designee, may approve a General TMCPA based on the following criteria:

- The hospital serves a disproportionate share of Active Duty Service Members (ADSMs) and Active Duty Dependents (ADDs);
- The hospital is a TRICARE network hospital;
- The hospital's actual costs for inpatient services exceed TRICARE payments or other extraordinary economic circumstance exists; and
- Without the General TMCPA, Department of Defense's (DoD's) ability to meet military contingency mission requirements will be significantly compromised.

4.2.10 Essential Access Community Hospitals (EACHs)

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

4.2.11 Direct Medical Education

TRICARE 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 TRICARE's Outpatient Prospective Payment System (OPPS). Reference [Chapter 13](#).

4.4 SCH Listing

4.4.1 TMA will maintain the SCH listing on TMA's web site: <http://www.tricare.mil/hospitalclassification/>, and will update the list on a quarterly basis and notify the contractors by e-mail when the list is updated.

4.4.2 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.

4.4.3 If the contractor receives documentation from an SCH indicating their status is different than what is on the SCH listing on TMA's web site, the contractor shall send the information to TMA, Medical Benefits & Reimbursement Branch (MB&RB) to review and to update the listings on the web, if appropriate.

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; i.e., 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 TRICARE under a cost containment waiver; i.e., 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.

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