

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. **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.**

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

4.2.7.3 The TRICARE 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 TRICARE SCH CCR listing for the entire TRICARE SCH year, i.e., January 1 through December 31.

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

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

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 (that also includes the hospital-specific capital adjustment), 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 (GTMCPAs)

4.2.9.1 The TMA Director, or designee, may approve a GTMCPA based on 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 TRICARE network hospital;
- The hospital's actual costs for inpatient services exceed TRICARE payments or other extraordinary economic circumstance exists; and
- Without the GTMCPA, Department of Defense's (DoD's) ability to meet military contingency mission requirements will be significantly compromised.

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

4.2.9.2.1 The Director, TRICARE Regional Office (DTRO), shall conduct a thorough analysis and recommend approval to the TMA Director of an appropriate year-end adjustment to total SCH payments for a network hospital qualifying for a GTMCPA.

4.2.9.2.2 In analyzing and recommending the appropriate year-end percentage adjustment, the DTRO shall ensure the SCH meets the four criteria listed in [paragraph 4.2.9.1](#) and the GTMCPA does not exceed a ratio of 1.15 above the hospital's costs during the previous TRICARE SCH year.

4.2.9.3 Following are the annual Data Requirements for GTMCPAs for the first TRICARE SCH year (January 1, 2014 through December 31, 2014) and subsequent years.

4.2.9.3.1 The hospital's request for a GTMCPA for the first TRICARE SCH year shall include the data requirements in [paragraph 4.2.9.4](#), and a full 12 months of claims payment data from the TRICARE SCH year the GTMCPA is requested.

4.2.9.3.2 The hospital shall submit the following information to the contractor for review and consideration:

- The total number of admissions during the previous TRICARE SCH year and the number of ADSM and ADD admissions for this same period.
- The hospital's rationale and the recommended percentage adjustment as supported by the above data requirement submissions.

4.2.9.4 Following are the annual Contractor Data Review Requirements for the first TRICARE SCH year (January 1 through December 31) and subsequent years, to evaluate network adequacy necessary to support military contingency mission requirements:

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

4.2.9.5 If upon initial evaluation, the contractor determines the hospital meets the disproportionate share criteria in [paragraph 4.2.9.1](#) and is deemed essential for continued network adequacy, the request from the hospital along with the supporting documentation in [paragraph 4.2.9.4](#) shall be submitted to the DTRO for review and determination.

4.2.9.6 The DTRO shall request TMA Medical Benefits & Reimbursement Office (MB&RO) run a query of claims history to determine if the network hospital qualifies for a GTMCPA, i.e., the hospital's payment-to-cost ratio is less than 1.15 for care provided to ADSMs and ADDs during the previous TRICARE SCH year (January 1 through December 31).

4.2.9.7 The DTRO shall review the supporting documentation and the report from TMA MB&RO to determine if the network hospital qualifies for a GTMCPA. The recommendation for approval of a GTMCPA shall be submitted to the MB&RO to be forwarded to the Director, TMA, or designee for review and approval. Disapprovals by the DTRO will not be forwarded to MB&RO for TMA Director review and approval.

4.2.9.8 If a hospital meets the disproportionate share criteria in [paragraph 4.2.9.1](#) and is deemed essential for network adequacy to support military contingency mission requirements, the approved hospital's GTMCPA will be set so the hospital's payment-to-cost ratio for TRICARE inpatient services does not exceed a ratio of 1.15. A hospital cannot be approved for a GTMCPA if it results in a hospital earning more than 15% above its costs for TRICARE beneficiaries.

4.2.9.9 Total TRICARE SCH payments for the qualifying hospital will be increased by the Director TMA, or designee, by way of an additional payment after the end of the TRICARE SCH year (January 1 through December 31). Subsequent adjustments will be issued to the qualifying hospitals for the prior TRICARE SCH year to ensure claims that were incurred but not reported the previous year are adjusted. The adjustment payment is separate from the application GTMCPA approved for the current TRICARE SCH year.

4.2.9.10 Upon approval of the GTMCPA request by the TMA Director, MB&RO shall notify the DTRO of the approval. The DTRO shall notify the Contracting Officer (CO) who shall send a letter to the contractor notifying them of the approval.

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

4.2.9.12 TMA-Aurora shall send an approval to the contractors to issue GTMCPA payments out of the non-financially underwritten bank account based on fund availability.

4.2.9.13 GTMCPAs 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.

4.2.9.14 The Director, TMA or designee is the final approval authority. A decision by the Director TMA or designee to adopt, modify, or extend GTMCPAs is not subject to the appeal and hearing procedures in [32 CFR 199.10](#).

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 Prior to July 1, 2014, 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.

4.4.1.1 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 TMA's web site, the contractor shall send the information to TMA, MB&RO to review and to update the listings on the web, if appropriate.

4.4.2 Effective July 1, 2014, TMA will no longer update and maintain the SCH listing on TMA'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/PropMedicareFeeSvcPmtGen/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; 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.

TRICARE Reimbursement Manual 6010.58-M, February 1, 2008

Chapter 14, Section 1

Sole Community Hospitals (SCHs)

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 -