$10 Billion Allocation to Rural Hospitals and Providers - Methodology

Overview

This funding recognizes that rural hospitals, health clinics, and health centers function with lower operating margins than urban and suburban providers and thus are at greater risk of closure as a result of reduced volumes attributable to the coronavirus. Targeted distributions to rural hospitals, health clinics, and health centers were made according to the following methodology.

Recipients fall into three categories:

- Rural acute care general hospitals and Critical Access Hospitals (CAHs)
- Rural Health Clinics (RHCs)
- Community Health Center sites located in rural areas

Distribution Methodology

Rural acute care hospitals and Critical Access Hospitals (CAHs):

The methodology provides hospitals with supplemental funds based on a graduated base amount plus an additional amount to account for a portion of their usual operating costs and the volume of care they regularly provide, according to the following formula. The most recent, publicly available Medicare hospital cost reports were used to identify operating costs:

- Per Hospital $ Allocation = Graduated Base payment + 1.97%* of the hospital's operating expenses

The graduated base payment is calculated as:

- 50% of the first $2 million of expenses (payment of up to $1,000,000)
- 40% of the next $2 million of expenses (payment of up to $800,000)
- 30% of the next $2 million of expenses (payment of up to $600,000)
- 20% of the next $2 million of expenses (payment of up to $400,000)
- 10% of the next $2 million of expenses (payment of up to $200,000)

Rural hospitals with annual operating expenses greater than $10,000,000 receive a base payment of $3,000,000.

Rural hospitals with no operating expense data receive a base payment of $1,000,000.

The total calculated amount was then multiplied by 1.03253231** to determine the actual payment per rural provider.

*The actual value used in the formula was 1.967728428%.

Rural Health Clinics (RHCs):

Provider-Based RHCs: RHCs connected with rural hospitals have their allocations included with their hospital's allocation, and the hospital is responsible for allocating dollars to support its RHC services.

Independent RHCs: A base amount plus a percentage of total operating costs were calculated for independent RHCs not associated with a hospital using RHC Cost Report data according to the following formula:

- Per Independent RHC $ Allocation = $100,000 per clinic site + 3.6% of the RHC's operating expenses

Community Health Centers:

Health Centers in rural areas: The allocation for health centers in rural areas was a flat payment amount per health center site of $100,000. Funds are distributed to each FQHC organization based on the number of individual rural clinic sites it operates.

- Per FQHC $ Allocation = $100,000 per rural clinic site

The total calculated amount for RHCs and health centers was then multiplied by 1.03253231** to determine the actual payment per rural provider.

**This adjustment was applied to ensure that the total value of distributions equaled $10 billion.

Eligibility

Providers eligible for the targeted Rural Health Relief Fund distribution must be located in a geography that meets the following rural definition:

1. All non-Metro counties.
2. All Census Tracts1 within a Metropolitan county that have a Rural-Urban Commuting Area (RUCA) code of 4-10. The RUCA codes allow the identification of rural Census Tracts in Metropolitan counties.
3. 132 large area census tracts with RUCA codes 2 or 3. These tracts are at least 400 square miles in area with a population density of no more than 35 people per square mile.
4. For independent Rural Health Clinics: the authorizing statute applies the Census Bureau definition, which defines a Rural Health Clinic as being located outside of an Urbanized Area as defined by the U.S. Census Bureau.

5. For Critical Access Hospitals: CAHs have a unique safety net role and statutory charge per Section 1820 of the Social Security Act. That statute initially gave state governors the authority to designate necessary provider CAHs, a number of which did not make a distinction between rural and urban designations.

RUCA Codes

(Code Definitions: Version 2.0)

1. Metropolitan area core: primary flow within an Urbanized Area (UA)
2. Metropolitan area high commuting: primary flow 30% or more to a UA
3. Metropolitan area low commuting: primary flow 10% to 30% to a UA
4. Micropolitan* area core: primary flow within an Urban Cluster (UC) of 10,000 through 49,999 (large UC)
5. Micropolitan* high commuting: primary flow 30% or more to a large