March 2018

CAH Coalition
CRITICAL ACCESS HOSPITAL COALITION

The Pulse

Government Funding, Fighting the Opioid Epidemic, and ER Availability Costs

President Trump signed the $1.3 trillion government spending bill into law on Friday, averting government shutdown and funding the government through September 30, 2018. The bill included $177.1 billion for the Department of Health and Human Services (HHS) including $15 million for a new Rural Residency Program. The bill also includes a number of provisions boosting funding for programs aimed at addressing the opioid epidemic and expanding the use of telehealth.

The funding bill includes $68.8 billion for VA medical care, with $270 million in rural health initiatives. The bill also allows for transferring of funds to the Veterans Choice Program to allow for continuation of the program. The agreement provides $100 million for a Rural Communities Opioids Response to support treatment for and prevention of substance use disorder. This initiative would include improving access to and recruitment of new substance use disorder providers; building sustainable treatment resources, increasing use of telehealth; establishing cross-sector community partnerships, and implementing new models of care, including integrated behavioral health; and technical assistance. HRSA may also use funds for loan repayment through the National Health Service Corps.

Recently, a number of MACs have disallowed CAH ER physician availability costs stating that they were not providing "evidence that the provider explored alternative methods for obtaining emergency physician coverage before agreeing to physician compensation for availability services." The CAH Coalition in Washington worked with stakeholders and found guidance from Noridian Health Care Solutions in California that said "CMS has indicated that if this criterion was the only requirement not met, the contractor should not disallow the availability cost." CMS agreed with Noridian's assessment and will be releasing guidance to all MACs by the end of April 2018.

Clarifying Allowable Costs for CAHs

The Critical Access and Rural Equity (CARE) Act of 2017 seeks to clarify allowable costs for Critical Access Hospitals. The CAH Coalition is active on Capitol Hill asking Members of Congress to cosponsor the CARE Act. The CARE Act addresses some of the most common discrepancies which CAHs encounter including emergency room physician availability cost time study methodology, Certified Registered Nurse Anesthesiologist standby time, and provider fees/ taxes on a state-by-state basis.

There is extreme variation between regions and auditors regarding what are considered allowable costs for CAHs. Creating a more uniform definition of allowable costs enables CAHs to continue their focus on care delivery in rural America—providing stability to these important community lifelines.

Inside this issue

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Strategies for Effective Managed Care Contracting

Many hospitals believe that when a payor issues a contract for signature, it is a take it or leave it proposition. However, when engaging with the payors, hospitals need to understand the need for negotiation. Payors issue contracts hoping that the hospital will simply agree and sign. It is imperative for the hospital to understand its costs and its strengths to build an effective argument for increased rates and better contract language.

For a critical access hospital, 100% of Medicare would equate to 101% of each hospital's cost. So, if a payor offers a contract at 100% of Medicare, since Medicare reimburses the CAH at 101% of cost, this would mean that the payor is also going to pay 101% of cost. However, it is imperative to have them define this and put it in writing in the contract. In addition, have them confirm that their systems have the capability to pay based on cost.

If a payor tries to include language that applies the sequestration, also push back on this. Payors will try to say that Medicare reduces their reimbursement, and Medicare requires that this be passed on to the provider. This is not accurate. The sequestration is not applied to specific services, it is applied to the overall dollars a Medicare plan receives. Medicare does not mandate that a payor pass this on. With this said, attempt to negotiate language that does not allow for this additional reduction for sequestration. When we have had payors push back, an alternative has been to increase reimbursement for the other products, so the overall contract will balance out. However, if there is no commercial business, or very little, this offset will not work. So, we would encourage you to arm yourself with information about Medicare not requiring the payors to reduce payments, and make the argument that you cannot offset on different products like other short term acute care hospitals with a much broader payor mix.

Carolyn Roten

Partner, Strategic Healthcare

Carolyn Roten has thirty years of experience in the health care industry and has experience with managed care contracting services with a wide array of health care providers. Her experience and expertise in network development and contracting is coupled with her knowledge of the health insurance industry.

Now, for those hospitals that have current contracts with payors that have no language in the document stating that they will take the additional 2%, it cannot legally be withheld. So, if a payor is reducing your payments, but there is no language allowing for the additional discount, hospitals should go back to the payor for these additional amounts. There have been a number of lawsuits filed in the past few years for just this reason. *For more click here*.

Bonus Beats:

- **Medicaid is Vital for Rural America's Financial Health: Report**

The University of Minnesota Rural Health Research Center found that families living in rural counties faced increased risk of out-of-hospital birth, birth in a hospital that does not provide obstetric care, and preterm birth, after losing hospital-based obstetric services. Medicaid covers nearly 24 percent of rural, nonelderly residents and offers financial stability to rural facilities. In some cases, it allows them to provide costly, but vital services such as high-risk maternity care.

- **MedPAC Tells Congress to Repeal MIPS**

MedPAC's annual report to Congress on payment policies released last week, the Medicare Payment Advisory Committee advised Congress to eliminate the Merit-based Incentive Payment System (MIPS) created in MACRA and establish a new voluntary value program in fee-for-service Medicare. Stating that MIPS will fail to deliver the desired improvements in quality of care because of flaws in its design, such as a lack of comprehensive measures to assess low-value care.

Coalition Updates

Contact your Member of Congress and urge them to cosponsor the Critical Access and Rural Equity (CARE) Act (HR 3224). The CARE Act protects rural providers by clarifying the definition of CAH allowable costs. It identifies frequently cited auditor discrepancies and removes barriers to care by ensuring coverage of the most common medical services and tests. For more, visit CAHCoalition.com

Legislation sponsored by Congressman David B. McKinley (R-WV) to protect 340B now has 194 House cosponsors. Ask your Member of Congress to cosponsor this important piece of legislation to block implementation of CMS' regulation to cut 340B drug payments. Click here to see whether your Representative has signed on.

The Coalition is advocating for the Veterans Choice Program to be made permanent. Share your stories or comments on the Veterans Choice Program with the CAH Coalition. Reach out to the CAH Coalition online here or over email at contact@cahcoalition.com.

Mark Your Calendars

April 19, 2018

Overcoming Physician Recruitment and Retention Obstacles in CAHs

Take away best practice methodologies for attracting, interviewing, and overcoming the competition to sign physicians and keep them in your organization. Learn key strategies for aligning strategic goals with physician stakeholders, engaging your medical staff, and retaining the high performing physicians in your organization.

To learn more or participate in any upcoming webinars, you can register online at CAHCoalition.com, you can also email us at contact@cahcoalition.com or call us at 202-266-2660.

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About the Coalition

The Critical Access Hospital Coalition is a consortium of innovative health care executives leading Critical Access Hospitals (CAHs) across the country. We exclusively focus on issues impacting CAHs. Our sole purpose is to assist policy makers in understanding the unique needs of CAHs and the vital role they play in the health of rural communities.

The CAH Coalition works to educate members of Congress, HHS, CMS, other federal agencies and organizations about the importance of our member hospitals. We work together as a bipartisan Coalition to develop new federal policies impacting CAHs, including reimbursement, regulations, and other actions.

The Coalition delivers a positive message about CAHs and works collaboratively with other organizations with common interests.