CAH Coalition
CRITICAL ACCESS HOSPITAL COALITION

October 15, 2019

Dear Senator:

The CAH Coalition, a consortium of innovative health care leaders representing critical access hospitals across the country, is concerned that S. 1895, the Lower Health Care Costs Act, will jeopardize the ability of critical access hospitals to continue to provide care for patients.

We strongly support the stated goal of the legislation – to protect patients from surprise medical bills from out-of-network providers the patient did not or could not choose. But the legislation goes far beyond this goal and imposes administrative requirements that will increase our costs by requiring additional staff; limit our ability to collect fees owed for services provided; and subject us to civil monetary penalties for items out of our control.

This bill could force more critical access hospital closures, further limiting health care choices for patients in rural areas. Additionally, a recent National Bureau of Economic Research study showed that rural hospital closings in California resulted in an almost 6% increase in mortality among the population, while there was no increase in mortality when urban hospitals closed.

- Section 304 places CAHs – not the insurer - at financial risk if the insurer's provider directory is not accurate. The CAH must reimburse an enrollee for the full amount paid in excess of the in-network cost sharing amount, plus interest, if the enrollee can prove he relied on an inaccurate directory maintained by the insurer. CAHs are responsible for informing the insurer about whether we are in or out of network and are subject to civil monetary penalties for failure to do so. Yet CAHs are at risk of refunding the patient for the cost of care provided if the insurer doesn't properly maintain the website under the insurer's sole control.

- Section 305 requires CAHs to provide each patient with an itemized list of services, by provider, no later than 5 calendar days after discharge or date of visit. Civil monetary penalties apply for failure to comply. There are times when this deadline will be difficult, if not impossible to meet. Typically, CAHs provide this information to the patient with the bill for any outstanding balance following receipt of any insurance reimbursement. Shortening the timeframe increases the workload of staffers who are already stretched and this is of nominal benefit to the patient.

- Section 305 also requires CAHs to furnish all adjudicated bills to the patient as soon as practicable but not later than 45 calendar days after discharge or date of visit. Any payment the patient makes for a bill sent after 45 days must be refunded with interest and reported to HHS. Again, civil monetary penalties apply. We are at the mercy of the insurance company to adjudicate the claim in time for us to meet the deadline and we incur financial losses if they do not.

- Section 102 contains detailed notice and consent requirements that must be met before admitting a patient who received emergency services at an out-of-network facility. The process of confirming insurance status is not always quick or easy, especially in rural areas with limited broadband access, even when the patient provides an insurance card and identification. If the patient is out of network – even if an in-network facility is too far away to be a likely option for the patient - we must provide an estimate of the cost of any additional care the patient may require should they chose to remain at our facility. This will require 24/7 access to billing and coding staff.

- We share the concerns raised by other health care providers that setting rates out-of-network providers must accept will lead to a downward spiral in reimbursement for all providers. This will be particularly challenging for many CAHs that already subsidize physicians to maintain access to care.

This legislation threatens the ability of critical access hospitals to keep the doors open to provide necessary care for patients. Eliminating surprise medical bills can be accomplished without exacerbating the financial challenges critical access hospitals are already facing. We encourage the Senate to seek solutions that do not further limit access to care.

Sincerely,

Arizona
White Mountain Regional Medical Center

Arkansas
Howard Memorial Hospital
St. Bernards Medical Center

California
Healdsburg District Hospital
Modoc Medical Center
Seneca Healthcare District
Tehachapi Valley Healthcare District

Colorado
Pagosa Springs Medical Center
Gunnison Valley Hospital
Memorial Regional Health
Aspen Valley Hospital
Estes Park Medical Center
Grand River Hospital District
Lincoln Community Hospital
St. Thomas More
Colorado Canyons Hospital & Medical Center
Memorial Regional Health
Sedgwick County Health Center
Kremmling Memorial & Middle Park

Florida
Hendry Regional Medical Center
Boca Raton Regional Hospital

Idaho
Syringa Hospital
Bingham Memorial
Shoshone Medical Center

Illinois
OSF Saint Luke Medical Center
OSF Saint Paul Medical Center
OSF Holy Family Medical Center
Massac Memorial Hospital

Iowa
Van Diest Medical Center

CAH Coalition
CRITICAL ACCESS HOSPITAL COALITION

Kansas
Newman Regional Health
Sabetha Community Hospital
Mitchell County Hospital Health Systems
Stanton County Hospital
Hanover Hospital
Edwards County Medical Center

Kentucky
Livingston Hospital
Mercy Health-Marcum Wallace Hospital

Louisiana
Union General Hospital
North Caddo Medical Center
Bienville Medical Center
St. Helena Parish Hospital

Maine
Calais Regional Hospital
LincolnHealth

Michigan
OSF St Francis Hospital
ProMedica Herrick Hospital
Perry County General Hospital
Harbor Beach Community Hospital, Inc.
Hills & Dales General Hospital

Minnesota
North Shore Health
Stevens Community Medical Center
CentraCare Health - Monticello
CentraCare Health - Paynesville
CentraCare Health Center - Sauk Centre
CentraCare Health System - Long Prairie
Centracare Health System - Melrose Hospital
Prairie Ridge Hospital and Health Services
Carris Health - Redwood

Mississippi
Perry County General Hospital
North Sunflower Medical Center
Pioneer Community Hospital of Aberdeen

Missouri
Ray County Memorial Hospital
Salem Memorial District Hospital
Carroll County Memorial Hospital

Montana
Big Sandy Medical Center
St. Joseph Medical Center

Nebraska
Pender Community Hospital
Osmond General Hospital
Brodstone Memorial Hospital
Niobrara Valley Hospital
Howard County Medical Center

New Mexico
Dr Dan C Trigg Memorial Hospital
Lincoln County Medical Center
Socorro General Hospital

New York
Schuyler Hospital
Lewis County General Hospital

North Carolina
Blue Ridge Regional Hospital
Ashley Medical Center
Appalachian Regional Healthcare System

North Dakota
Pembina County Memorial Hospital
Wishek Hospital Clinic Association

Ohio
Wyandot Memorial Hospital
ProMedica Defiance Regional Hospital
ProMedica Fostoria Community Hospital
Aultman Orrville Hospital
Hocking Valley Community Hospital
Hardin Memorial Hospital
Morrow County Hospital
Shelby Memorial Hospital

Oregon
Pioneer Memorial Hospital
Morrow County Health District

South Dakota
Hans P Peterson Memorial Hospital

Texas
Cogdell Memorial Hospital
Medina Regional Hospital
Ward Memorial Hospital
W.J. Mangold Memorial Hospital
McCamey County Hospital District
Stonewall Memorial Hospital

Utah
Gunnison Valley Hospital
Intermountain Sanpete Valley Hospital
Central Valley Medical Center
Moab Regional Hospital

West Virginia
Roane General Hospital

Wisconsin
St. Croix Regional Medical Center
Burnett Medical Center
Memorial Medical Center

Wyoming
Sheridan Memorial Hospital