

TESTIMONY OF THE MAINE HOSPITAL ASSOCIATION

In Opposition To

Proposed FY 2018-2019 Biennial Budget

February 21, 2017

Senators Hamper and Brakey, Representatives Gattine and Hymanson, and members of the Appropriations and Health & Human Services Committees, my name is Jeffrey Austin and I am here on behalf of the Maine Hospital Association. I am here today to express our opposition to a portion of the proposed biennial budget.

The Maine Hospital Association represents all 36 community-governed hospitals including 33 non-profit general acute care hospitals, 2 private psychiatric hospitals, and 1 acute rehabilitation hospital. In addition to acute care hospital facilities, we also represent 14 home health agencies, 19 skilled nursing facilities, 21 nursing facilities, 13 residential care facilities, and more than 300 physician practices. Our acute care hospitals are nonprofit, community-governed organizations with more than 800 volunteer community leaders serving on the boards of Maine's hospitals. Maine is one of only a handful of states in which all of its acute care hospitals are nonprofit.

There are multiple hits to hospitals in the budget. The net total of the cuts to hospitals, including lost federal match, is at least \$66 million per year in SFY 2019 and going forward. This is a staggering amount of cuts to force hospitals to absorb and does not include the \$10-20 million in rumored nonprofit property taxes. We ask that you reject these cuts.

Budget Context - Part I

Much of this testimony is nearly identical to the MHA testimony from two years ago. The cuts proposed and the condition of the Medicaid budget today is nearly identical to the situation two years ago. We hope you reject these proposals, again, as you did two years ago.

Please keep in mind the correct magnitude of pain you inflict when Medicaid is cut. Because Medicaid is 2/3 funded by the federal government, when you cut General Fund payments to save the state \$1, hospitals lose \$3. The savings to the state is a fraction of the negative impact to Maine hospitals and the Maine economy.

Budget Context - Part II

As you've heard from the administration, the current Medicaid budget is balanced and has been balanced for several years now. This is good news for you and the taxpayers. It should also be good news for those with Medicaid coverage and Medicaid providers like hospitals.

However, this budget doesn't keep Medicaid in balance. It forces Medicaid out of balance by pulling tens of millions of dollars out of Medicaid. Why?

State revenues are stable. Revenues are projected to increase in both SFY 2018 and SFY 2019 as compared to SFY 2017. You don't need to cut hospitals to cover the baseline, and, you have additional revenues to pursue policy changes as well.

Hospitals are being cut, not to balance Medicaid, but to cut taxes and increase spending elsewhere. If the state wants to increase spending on other programs, it needs to identify new revenues to fund that increased spending and not significantly hurt hospitals.

Budget Context - Part III

There is no single explanation for why the Medicaid program has stabilized. Good management? An improved economy? No doubt these play a role.

But if we're being honest, we would have to look at the tens of thousands of Mainers who had their Medicaid coverage removed due to eligibility cuts enacted into law in the 125th Legislature.

This action did indeed help fiscally stabilize the state budget and the Medicaid program. It helped improve the Department's balance sheet. But it significantly hurt hospitals and their balance sheets. The people who lost coverage didn't all leave Maine. Many remain here and are uninsured and now rely on hospital charity care.

In addition to the eligibility cuts, hospitals have also recently absorbed a series of financial cuts imposed by the Legislature over the past four years that were intended to help balance the Medicaid budget.

- A hospital tax increase;
- 10% cut to outpatient reimbursement rates;
- Crossover cuts for Medicaid-covered individuals' o-pays/deductibles;
- Cuts to Emergency Department reimbursements.

These are annual cuts of \$55 million that were imposed when the Medicaid program had a deficit. Hospitals have lost over \$200 million since 2013 because of these initiatives. None of these cuts have been restored. None of these cuts have been offset by other state initiatives for hospitals. Hospital base rates don't have cost-of-living adjustments.

Enough is enough.

Medicaid Payment to Hospitals

Over the past four years, Medicaid payments to hospitals¹ have dropped by approximately \$60 million per year. This is not adjusted, or estimated, or relative to some moving target. Actual Medicaid spending on hospitals is down 11% over the past 4 years. This trend must reverse.

	SFY 2012	SFY 2016	Change
PPS Hospitals - Inpatient	\$157 Million	\$138 Million	- 12%
PPS Hospital – Outpatient*	\$158 Million	\$123 Million	- 22%
Non-PPS – Total*	\$157 Million	\$162 Million	+3%
Crossovers	\$51 Million	\$47 Million	- 9%
Hospital Tax (Net)*	(\$16 Million)	(\$21 Million)	+ 30%
Total	\$507 Million	\$449 Million	- 11%

This pattern of dramatic spending cuts is not true for other major provider groups in Medicaid; many others have seen net increases since SFY 2012.

Finally, you have received information from others regarding the change in Medicaid spending at hospitals. Those other presentations are misleading. They don't look at the actual liabilities in an apples-to-apples way. The above presentation is the accurate presentation of Medicaid spending on hospital facilities.

Hospital Tax Increase (Part III / pages 156 and A-339): \$7.5 Million Cost to Hospitals

The budget proposes to **increase the hospital tax by \$7.5M** with no corresponding increase in match. The purpose of the hospital tax is to support Medicaid and hospital services. The budget clearly increases the tax to serve non-Medicaid purposes.

The state imposes a tax on hospital net patient service revenues. The state collects approximately \$95 million from hospitals each year pursuant to this tax.

The revenues are used to help fund the Medicaid program...including hospitals. After you exclude the reimbursements that hospitals receive, the net loss to hospitals as a result of the hospital tax is \$21 million per year.

Other Medicaid providers also pay taxes to the state. However, the state has largely held these other providers harmless...they don't experience an aggregate loss as hospitals do. When this law was enacted, the state promised Hospitals that they would not sustain a loss due to the hospital tax. That promise has been repeatedly broken.

We don't support the hospital tax and we oppose tax increases. That said, the Legislature has only increased the tax when circumstances required it. There is no such circumstance now.

¹ This table reflects payments to hospitals and does not include the separate payments to hospital employed physicians in the outpatient setting. That data is not separately reported by the state (to our knowledge).

Hospital taxes have been re-based twice in the past six years; hospital reimbursement rates haven't been re-based in over a decade. Reimbursement rates have only been cut while taxes have only been increased.

There should be absolutely no more rebasing hospital taxes until you rebase hospital rates.

Critical Access Hospital “CAH” Rate Cut (Page A-339): \$6.3 Million Hospital Loss

This initiative proposes to reduce all inpatient and outpatient CAH reimbursement from 109% of allowable costs to 101% of allowable costs. **CAH hospitals would lose \$6.3 million per year (\$2.25 million in General Funds.)** If the DHHS budget estimate of the impact of the cut is accurate, it appears that **the CAH costs to Medicaid have gone down 7% during the past two years!**

There are 16 Critical Access Hospitals. The CAH program is a federal program for small safety net providers. Most CAH hospitals in Maine are in small, rural and economically disadvantaged communities (see attachment). CAH hospitals agree to focus their work on safety net services, and in exchange, they receive “allowable” cost-based reimbursement.

Half of the individual CAH hospitals had negative margins in calendar year 2015. To reduce the CAH rate as proposed would nearly wipe-out the margins of hospitals that have positive margins and would devastate those hospitals already in the red. There is simply no way these hospitals can absorb this cut. By comparison, **uncompensated care costs at CAH hospitals were over \$30 million in 2015.**

The reason the Medicaid reimbursement for CAH hospitals is more than 101% is directly tied to Maine's tax on hospitals. If you were to *repeal* the hospital tax you could reduce the reimbursement rate. If you cut the reimbursement without eliminating the tax you are effectively further breaking the deal that was made by the Legislature with hospitals years ago.

This initiative is a broken promise and a reimbursement cut that can't be sustained.

Hospital Based Physician Changes (Page A- 339): \$16 Million Hospital Loss

This initiative is also a repeat which has been rejected in the past.

The initiative reduces Medicaid payments to hospital-based primary care providers. The net impact is a \$16 million cut to essential hospital-employed primary care practices per year. This initiative has multiple, moving parts embedded within it. The net impact of these changes is a significant cut to hospital primary care programs.

The department repeatedly states that its goal is investing in primary care. However, the sum of these initiatives is to strip the leading provider of primary care to Medicaid patients of resources necessary to provide their care.

Note: In past years, these proposed changes did not apply to Critical Access Hospitals

Parity is a noble policy goal, but in this case is phony.

There are two significant providers of primary care services to Medicaid patients: hospital-based and FQHC-based primary care practices. FQHCs receive higher reimbursement for primary care services than do hospitals.

The cuts proposed bring us further out of parity with FQHCs which have higher reimbursement than hospital providers and are receiving a *pay increase* this year. So, this initiative undermines parity as much as it advances it.

Also, hospital-based doctors and private doctors are not the same. Private doctors don't have the same regulatory requirements as do hospital-based practices. A study by the American Hospital Association highlights differences. Using national data, the study found that patients served by hospital based outpatient practices:

- Were 2.5 times more likely to be on Medicaid or eligible for charity care;
- Almost twice as likely to be a dual-eligible patient;
- Almost twice as likely to be from high poverty areas.

Hospital outpatient patients are sicker and have more complex medical needs. Hospital-based doctors have to provide charity care under Maine law, private doctors do not.

Like parity, fairness is also an important policy goal. Medicaid today refuses to cover the cost of services hospital-based physicians provide to Medicaid patients. Under-reimbursement is established in rule.

Currently, hospitals are reimbursed 83% of the cost of providing physician outpatient services to Medicaid patients. **Current law forces a 17% loss on the hospital-employed physicians covered by this initiative.** Unlike most industries, hospitals don't decide on the price they charge Medicaid consumers. When the consumer is a Medicaid patient, the state imposes a price and it does so at **17% below cost**. The cuts proposed in the budget makes the hospital losses in the Medicaid program much worse. This is unfair.

Ultimately, why would a primary care practice retain its "hospital" status instead of flipping to private practice if the reimbursement rate is the private rate? Why deal with the licensing, reporting and state-mandated charity care obligations? It makes no sense.

Eligibility Cuts (Page A-339 and A-340): \$37 Million Hospital Loss

The two Medicaid eligibility cuts primarily impact the individuals who will lose health care coverage.

To be clear, though, the funding does not go to those individuals. The funding goes to the providers who care for these individuals. We don't know how much of the Medicaid budget for these individuals goes to hospitals. The Department of Health and Human Services might.

Generally speaking, hospitals represent approximately 1/3 of the Medicaid budget. Using that ratio, hospitals will lose approximately \$37 million (\$13 million state share) per year when they are fully implemented in SFY 2019.

The state mandates that hospitals provide all individuals below 150% of the federal poverty level with free care. All of the individuals impacted by these cuts are below 150% and thereby eligible for free care. To quote the Governor in his 'state of the state' address: *"Free is very expensive to someone."*

This is not an initiative to manage care or to restructure the program pursuant to a waiver. This is simply DHHS dumping its current responsibility on to hospitals and other providers to pick up the pieces.

This loss of revenue, though, can't be matched with cost reduction strategies. The hospital workload won't go down too much. In fact, it could go up if patients who have conditions managed today by others will have no choice but to go to the hospital where they are entitled to free care as mandated by state policy.

Federal Context

The above objections to these changes apply regardless of the federal situation. However, as the federal government is looking at structural changes to the Medicaid program. Many of those changes, such as "block grants," generally use the most recent level of spending at the state level. Now is not the time to reduce the Medicaid budget; any such reduction could be locked-in by the federal government, to the detriment of Maine. Furthermore, provider taxes have come under increasing scrutiny over the past few years and there is a credible threat to the future viability of these programs. Now is not the time to be increasing the state's reliance on provider taxes.

Furthermore, as you know, the future of the Affordable Care Act is uncertain. Changes to that law could result in substantial losses to hospitals; we don't need an artificial state crisis now.

Budget Summary

	SFY 2018			SFY 2019		
	State	Federal	Total	State	Federal	Totals
Hospital Tax	\$7,541,145	-	\$7,541,145	\$7,541,145	-	\$7,541,145
CAH Cut	\$2,256,022	\$4,072,231	\$6,328,253	\$2,256,655	\$4,071,598	\$6,328,253
HOPD Cut	\$5,714,512	\$10,314,974	\$16,029,486	\$5,716,115	\$10,313,371	\$16,029,486
Eligibility I*	\$1,088,039	\$1,963,964	\$3,052,003	\$2,176,689	\$3,927,317	\$6,104,006
Eligibility II*	-	-	-	\$10,924,872	\$19,711,336	\$30,636,207
Total	\$16,599,718	\$16,351,169	\$32,950,887	\$28,615,476	\$38,023,622	\$66,639,907

Hospital Request – Restore the 10% Outpatient Cut

Hospital finances have been thin for several years. And as we noted to you, hospitals are the lone Medicaid provider to have experienced budgetary cuts that have not been restored or fully offset. Those cuts were not rooted in rate studies or program reform. They were imposed in the Appropriations process simply to balance the Medicaid budget.

The Medicaid budget is balanced to the point that the state has surplus revenue.

We are asking you to restore one of the five budget cuts hospitals have absorbed in the past 6 years. Please help us when we need it, as we helped the State when Medicaid needed it. Now is the time to restore the 10% hospital outpatient rate cut that was imposed by this Committee in 2013.

Annual State General Fund Cost: \$4,860,000.

Conclusion

If the State were interested in reforming Medicaid payments to hospitals we would be eager to engage. Please understand, hospitals are underpaid for serving Medicaid patients by approximately \$150 million per year. The hospital “costs” to the state have been declining for years. Power point presentations from DHHS inaccurately and misleadingly represent Medicaid’s spending on hospitals as increasing. It isn’t.

Hospitals need Medicaid to increase its reimbursement. Hospitals have only had rate cuts over the past 6 years. The only answer we ever get when we ask for assistance, is “not now.” If not now, when?

Medicaid can’t simply turn its back on hospital reimbursement rates forever.

None of the initiatives in the budget was discussed with hospitals prior to submission. This budget does not reform, improve, or modernize how hospitals are paid. It’s an attempt to fund some non-Medicaid priorities on the backs of hospitals. If the Appropriations Committee is interested in modernization, we are happy to work with you. But, a bedrock principle of reform is that the state pays its fair share. It doesn’t today and this budget makes it much worse.

To quote the Governor’s ‘state of the state’ address: “*Do no Harm.*” Please apply the Governor’s maxim to hospitals and the Medicaid program by opposing the hospital-related cuts in the budget and please provide the first positive pay adjustment for hospitals in more than a decade. Thank you for accepting the testimony of the Maine Hospital Association.

Maine Critical Access Hospitals

Blue Hill Memorial Hospital—**Blue Hill**

Bridgton Hospital—**Bridgton**

Calais Regional Hospital—**Calais**

Charles A. Dean Memorial Hospital—**Greenville**

Down East Community Hospital—**Machias**

Houlton Regional Hospital—**Houlton**

LincolnHealth—**Damariscotta and Boothbay Harbor**

Mayo Regional Hospital—**Dover-Foxcroft**

Millinocket Regional Hospital—**Millinocket**

Mount Desert Island Hospital—**Bar Harbor**

Penobscot Valley Hospital—**Lincoln**

Redington-Fairview General Hospital—**Skowhegan**

Rumford Hospital—**Rumford**

Sebasticook Valley Health—**Pittsfield**

Stephens Memorial Hospital—**Norway**

Waldo County General Hospital—**Belfast**