MHA

Maine Hospital Association

Representing community hospitals and the patients they serve.

TESTIMONY OF THE MAINE HOSPITAL ASSOCIATION

In Opposition To

Proposed FY 2016-2017 Biennial Budget

March 4, 2015

Senators Hamper and Brakey, Representatives Rotundo and Gattine, 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 37 community-governed hospitals including 34 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 cuts to hospitals in the budget. The net total of the cuts to hospitals, including lost federal match, is at least $55 million per year. This is a staggering amount of cuts to force hospitals to absorb and does not include the $10-20 million in proposed property taxes. We would ask that you reject these cuts.

Budget Context - Part I

As you've heard from the administration, the current Medicaid budget is balanced. That is a remarkable sentence. I don't know that there has ever been a time, when, at the beginning of a biennial budget the Medicaid program's funding would be balanced. **Hospitals are being cut, not to balance Medicaid, but to increase spending elsewhere. If the state wants to increase spending on other programs, it needs to identify new revenues to fund that spending and not cannibalize the rest of Medicaid.**

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If the administration would merely flat-fund the General Fund contribution to the "Payment to Providers" account (Page A-335) at the current amount of $425 million, instead of reducing the General Fund contribution by $35M in FY 2016 and $45M in FY 2017, you could fund many of the increased spending initiatives sought by the administration without cutting providers such as hospitals. Flat-funding doesn't seem like too much to request when spending is flat, revenues are above budgeted projections and the FMAP is in the state's favor.

Budget Context - Part II

There is no definitive explanation for why the Medicaid program has stabilized. Good management? Surely, it plays a part. An improved economy? No doubt.

But if we're being honest, we would have to look at the 40,000 Mainers who lost Medicaid coverage in the past few years, primarily due to eligibility cuts enacted into law in the 125th Legislature.

This action did indeed help fiscally stabilize the program and helped improve the Department's balance sheet. But it significantly hurt hospitals. These 40,000 people didn't leave Maine. Many remain here and are uninsured and moved to hospital charity care.

As a result, hospitals feel as if they have absorbed the negative fallout from these eligibility cuts that were necessary to stabilize the state's budget. Cutting hospitals even further as is proposed here is wrong.

Critical Access Hospital Rate Cut (Page A-337)

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 $6.8 million per year ($2.5 million in General Funds.)**

There are 16 Critical Access Hospitals. The CAH program is a federal program for mostly small, rural, safety net providers. CAH hospitals agree to focus their work on safety net services, and in exchange, they receive cost-based reimbursement.

In 2013, the 16 CAH hospitals had a collective operating loss of $8 million. In 2014, these hospitals earned a collective $600,000 in operating revenue. There is simply no way these hospitals can absorb anything like the proposed $7 million per year cut.

You've repeatedly been told that the initiative is designed to "align" Medicaid reimbursement with Medicare reimbursement of 101%. We don't object to alignment, as long as Medicaid further aligns with Medicare and drops its tax on hospitals.

The Medicaid reimbursement for CAH hospitals above 101% is tied to Maine's hospital tax. Repeal the tax and you can reduce the reimbursement rate. Cut the reimbursement without eliminating the tax effectively breaks the deal the was made by the Legislature years ago.

The DHHS fact sheet misleadingly argues that other states don't reimburse hospitals at the 109% rate. That is true, but deceptive. Other states use other mechanisms related to their provider tax programs. For example, almost every other state in the country has a Medicaid Disproportionate Share Hospital (DSH) program to aid their private hospitals. Maine does not. Maine is not an outlier as DHHS argues. **This initiative is a broken promise and a reimbursement cut that can't be sustained.**

Hospital Based Physician Changes (Page A- 336)

This initiative would take place in the four distinct steps described below. 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; the sum of these initiatives is to strip the leading provider of primary care to Medicaid patients of almost $30 million per year.

Note: The Department has informed us that none of these changes would apply to Critical Access Hospitals

1. Eliminate all facility fee payments for most office visits to all hospital employed physicians – primary care and specialists alike. [E&M procedure codes (99201-992150).] *This includes E&M procedure codes billed by all physicians, including specialists.*

   This would be a reduction in MaineCare hospital funding to hospitals of approximately **$21 million per year.** This will not align hospitals with Medicare. Medicare provides this funding. Either aligning with Medicare is a public policy goal, or it's not.

2. Eliminate partial cost-based reimbursement for all hospital based physician services. Hospitals are reimbursed 83% of the cost of providing outpatient physician services to Medicaid patients. According to the Department's analysis of the most recently filed cost reports, **this would be a reduction in MaineCare funding to hospitals of approximately $25 million per year**. We believe it is much higher.

3. Increase the current fee schedule for *all hospital based physicians* to the fee schedule paid under Section 90 (non-hospital based physicians). This would be an increase in funding to hospitals of approximately **$11 million per year ($4 million in General Funds).**

4. Further increase the physician fee schedule payments for *hospital based primary care physicians* to the Medicare fee schedule rates. This would be an increase in funding to hospitals of approximately **$12 million per year ($4.5 million in General Funds).**

Parity is a noble policy goal. But, these cuts bring us further out of parity with FQHCs which have higher reimbursement than hospital providers today. So, this initiative undermines parity as much as it advances it.

Also, hospital-based doctors and private doctors are not the same. They don't have the same regulatory requirements. A study released last week 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.

On the flip side, private doctors pay taxes. We're not the same. But our primary objection is not that we oppose parity.

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. When the department says that hospitals are "cost-settled" they are partially cost settled. **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 below cost. The cuts proposed in the budget makes the hospital losses in the Medicaid program much worse. This is unfair.

We do not oppose an initiative to aid non-hospital physicians. If the state wants to increase pay to non-hospital based physicians, we have no objection. Hospitals would ask to simply be left out of these initiatives in their entirety, the cuts and the increases.

Cut to Hospital Emergency Department Payments (Page A-339)

Note: The Department has informed us that this would not apply to Critical Access Hospitals

This initiative reduces the facility fee payment for certain non-emergent conditions from the current tiered APC rates.. The list of diagnosis codes that the Department considers as non-emergent includes: Strep Throat, General Anxiety Disorder, Conjunctivitis, Ear Infections, Sinusitis, Diaper Rash, Dermatitis and Eczema, Joint Pain, Backache, Limb Pain, Rash, Headache, and Cough. **The result of this initiative is a $3 million cut per year ($1 million in General Funds).**

The DHHS fact sheet alleges that this initiative will reduce incentives for Medicaid recipients to use the Emergency Department unnecessarily. That statement is inaccurate. This is a penalty imposed on hospitals, who, under federal law, must keep their Emergency Department open to all individuals 24 hours per day, 365 days per year. Cutting hospital reimbursement is not a disincentive to Medicaid recipients to use the service.

When the state sought partners for its high-utilizer "ED" project, our members voluntarily engaged with DHHS. Hospitals helped the department save the Medicaid program millions of dollars. Our members were given no share of the savings. Hospital employees worked harder, and lost revenue, to help you save money. Hospitals will do the right thing when presented with such opportunities. They will engage in DHHS-led initiatives to reduce unnecessary utilization, as we have in the past. **Hospitals don't need a thank you for their hard work helping the state save money, but they don't deserve a rate cut.**

Cut to Hospital Based Mental Health Providers (Page A-337)

This initiative would eliminate hospital specific (Section 45) reimbursement for community based behavioral health services delivered in a hospital setting. Hospitals would be required to bill these services at the Section 65 mental health agency rates. This initiative also applies to private psychiatric hospitals**. The result of this initiative is estimated by DHHS to be a $2 million cut per year ($800K in General Funds) We question the state's estimate on this initiative.** (*This amount does not include the further reductions to Section 65 rates that would consequently hurt hospital-based providers. You will review those cuts that we also object to tomorrow.*)

For most budget cuts, hospitals do not make a prediction of closed doors or terminated services. That is not true with this cut. There is no regulatory requirement or necessity for a hospital to operate a community mental health practice. Some hospitals and health systems have attempted to throw a financial lifeline, in the form of hospital-based reimbursement, to the underfunded mental health system. Using federally-allowed methods of reimbursement to help sustain mental health services is the right thing to do. Our members see the consequences every day of a mental health system that isn't meeting the needs of the public. If you cut this reimbursement, **you** are cutting the lifeline and community mental health services will be eliminated.

Continuation of Health Homes (Page A-336)

MaineCare currently provides a payment for MaineCare recipients who are enrolled in "Health Homes". The enhanced federal funding for these payments has expired and this initiative proposes to continue these PMPM payments at the regular match rate. Therefore these are not new payments but rather a continuation of existing payments. Hospital based practices comprise a significant portion of the health homes so these practices should receive a significant percentage of the continued funding. The statewide impact of this initiative *including hospital based and non-hospital based practices* is approximately **$19 million per year ($7 million in General Funds)**. We have not seen any estimate of what portion of the reimbursement would accrue to hospital-based physicians.

Other Issues

Hospitals also have concerns with initiatives related to:

- **Fund for Healthy Maine;**
- **Methadone/Suboxone;**
- **45-Day/90-Day Application Rule;**
- **Cut to Community Based Mental Health Providers, and**
- **Crossover Cuts Related to Limiting Eligibility for the MSP program.**

These cuts, which will be the subject of hearings at other times, will have a dramatic impact on hospitals as well.

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. 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 priorities on the backs of others. 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 pay its fair share. It doesn't today and this budget makes it much worse. I understand that you have received briefings by the Administration. We would ask for the same courtesy to defend our members from $55 million in annual cuts.

Thank you for accepting the testimony of the Maine Hospital Association.

Medicaid Cuts			
Hospital Based Doc Cut I (Cost-Based Reimbursement)		$25 Million	$25 Million
Hospital Based Doc Cut II (Facility Fee)		$21 Million	$21 Million
Mental Health Cut I (Elimination of Section 45/Conversion to Section 65)		$2.0 Million	$2.0 Million
CAH Rate Cut (109% to 101%)		$7 Million	$7 Million
Emergency Department Cut		$3 Million	$4 Million
Crossover Cut (Result of MSP Eligibility Cuts – Assuming Hospitals are half)		$16M*	16M*
Subtotal		**$89 Million**	**$90 Million**
Increases			
Increase in Physician Fee to Medicare Rate		$23 Million	$23 Million
Maintenance of Health Home Payment (Assuming half is Hospitals)		$10 Million	$10 Million
Subtotal		**$33 Million**	**$33 Million**
Medicaid Subtotal		**$56 Million**	**$57 Million**
Other			
Mental Health Cut II		???	???
Fund for Healthy Maine etc.		???	???
Extend Disability Determination Deadline from 45 to 90 Days		???	???
Taxes		**FY 2016**	**FY 2017**
Non-Profit Tax (50% of Value above $500K)		$15 Million	$15 Million