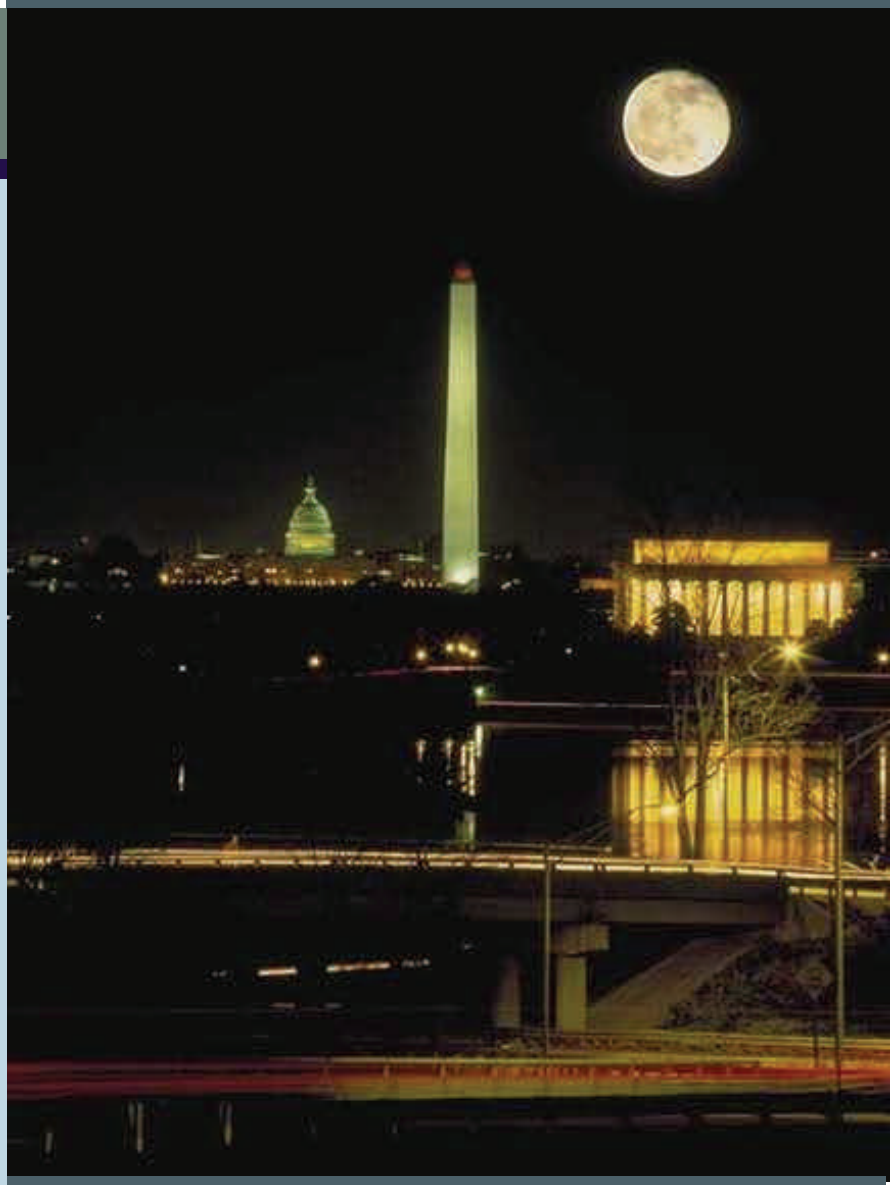
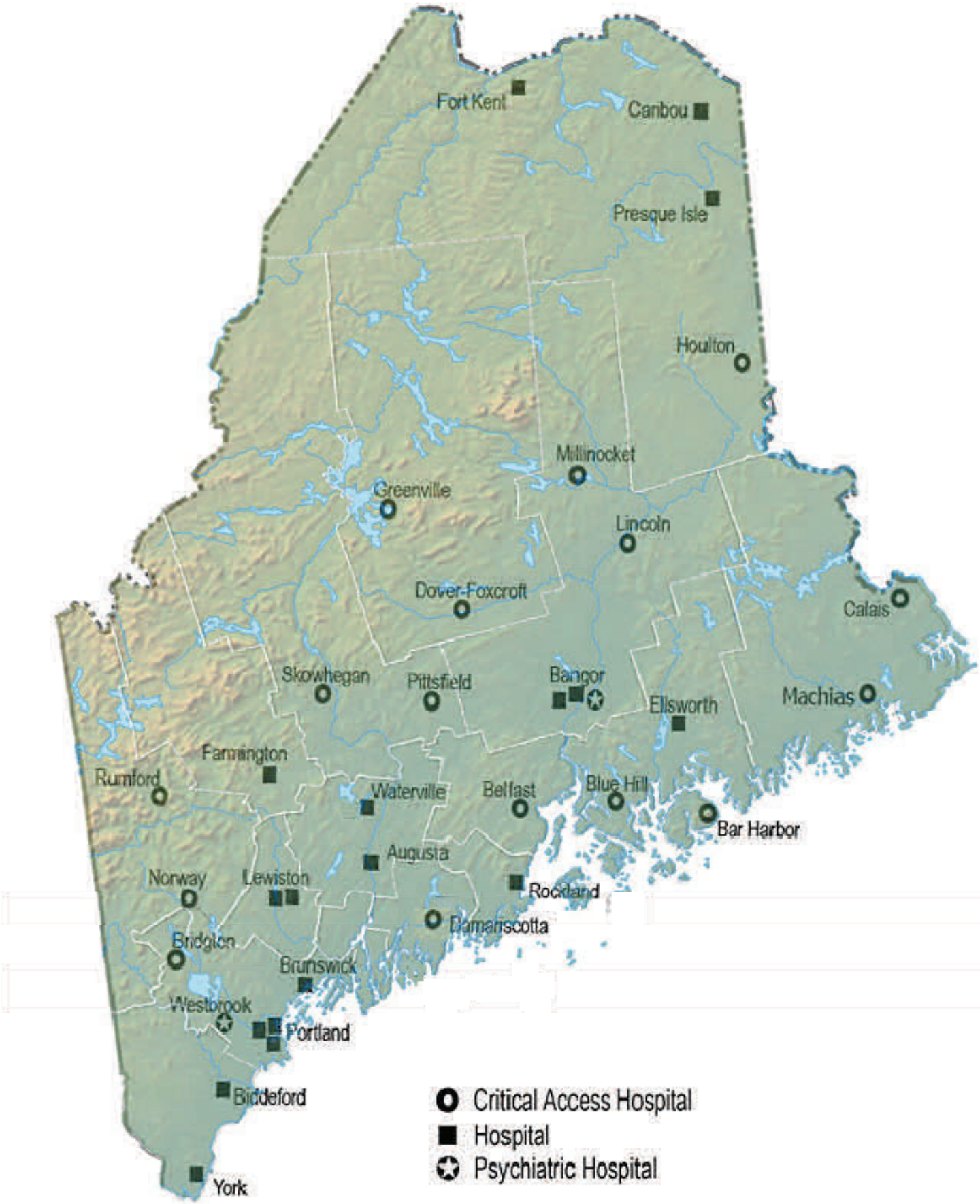
Maine Hospital Association

Federal Issues

2017

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Augusta
Norway
Lewiston
Rockland
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Bridgton
Brunswick
Westbrook
Portland
Biddeford
York
Critical Access Hospital
Hospital
Psychiatric Hospital

Hospitals Need Help

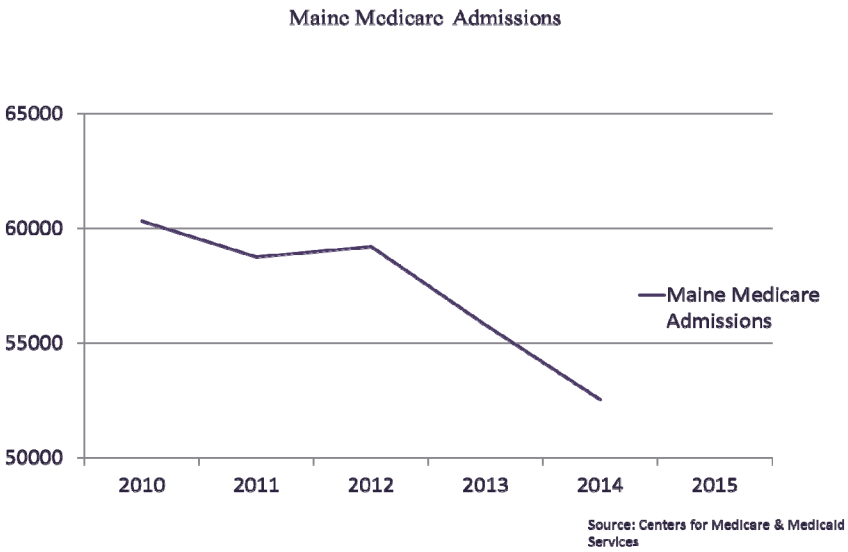
For the past several election cycles the same forces have dominated the healthcare landscape:

- Government payers are broke and are shifting risk to providers;
- Private payers are disappearing and shifting risk to consumers;
- Poor lifestyle choices are costing more; and
- Payers are demanding value and are learning how to do it effectively.

Maine's hospitals have absorbed enormous cuts in the Medicare program over the past six years. Payments for services provided to Medicare patients have been reduced by more than $300 million since 2010. These cutbacks include cuts to hospital spending enacted as part of the Affordable Care Act and the 2013 sequestration efforts that mandated a 2% across-the-board reduction in all Medicare payments. Any further cuts to Medicare reimbursement would be unsustainable and would harm Medicare patients.

Fewer Medicare Patients are Being Admitted to Maine Hospitals

Maine hospitals have participated in various programs, such as those to reduce readmissions, to improve hospital quality and patient experience. Because of these successful efforts, Medicare admissions have dropped by over 5% in the past four years. This is during a period in which the number of Maine people served by the Medicare program has increased by more than 12%.



Source: Centers for Medicare & Medicaid Services

About MHA

The Maine Hospital Association represents all 36 community-governed hospitals in Maine. Formed in 1937, the Augusta-based nonprofit Association is the primary advocate for hospitals in the Maine State Legislature, the U.S. Congress and state and federal regulatory agencies. It also provides educational services and serves as a clearinghouse for comprehensive information for its hospital members, lawmakers and the public. MHA is a leader in developing healthcare policy and works to stimulate public debate on important healthcare issues that affect all Maine citizens.

Mission Statement

To provide leadership through advocacy, information and education; to support its members in fulfilling their mission to improve the health of their patients and the communities they serve.

Since 2011, the number of hospitals in Maine has declined by three. While those facilities are still operating with a more focused purpose, they are not independent hospitals.

The three hospitals were Goodall Hospital (Sanford), Parkview Adventist Medical Center (Brunswick) and St. Andrews Hospital (Boothbay).

In any given year, there will be a few hospitals that are having a financial challenge. That is always the case in healthcare. While things have improved slightly since 2014, significant financial challenges remain.

Operating Margins. Sixteen hospitals had negative margins in 2015. Since 2012, an average of 18 hospitals have had negative operating margins.

During 2015, the aggregate margin for all hospitals in Maine was 1.1 percent. The reason for this difficulty includes both good news and bad news for the broader economy. For example, one of the leading reasons for lower margins is lower utilization of hospital services, particularly inpatient care.

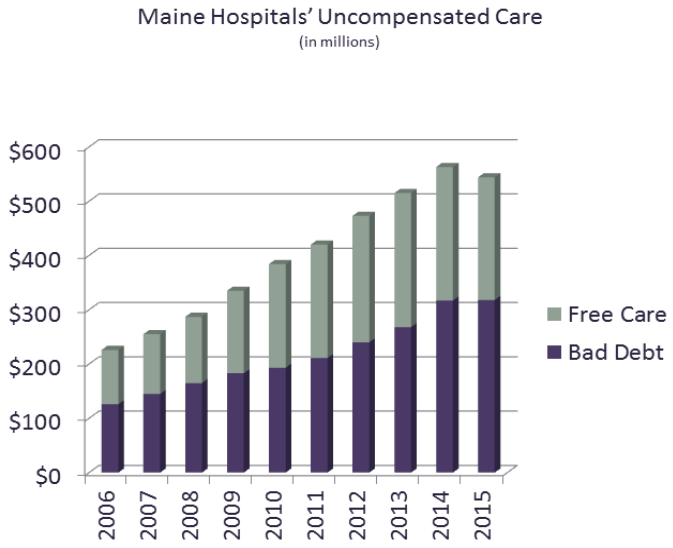
Efforts undertaken by hospitals and others to avoid the most intensive care can both improve quality and save money for employers and insurance plans.

However, other reasons for the lower margins at hospitals include Medicaid and Medicare rate cuts. There have been tax increases at the state level and tens of millions of dollars per year in reduced Medicare reimbursement under the Affordable Care Act. **Those cuts were not restored in the proposed American Health Care Act.**

Another significant contributor is Uncompensated Care, which is a combination of both free care and bad debt.

Free Care—care provided for which no payment is sought, and

Bad Debt—care for which payment is sought but not received.



Source: Hospital Audited Financial Statements, Hospital Only (not consolidated)

Hospitals Are Vital to Maine Communities

Maine's 36 community hospitals not only provide a vital local service, they provide good local jobs. In 15 of 16 counties, a hospital is among the four largest local employers. (Sagadahoc County does not host a community hospital.)

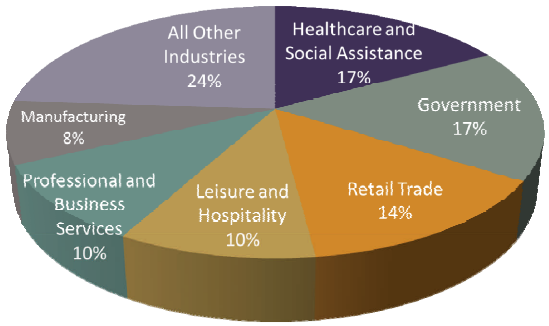
Hospital leaders understand that healthcare costs are a concern for most people. However, healthcare is a necessary service that can't realistically be outsourced overseas. The contributions of hospitals to local economies is important.

According to the American Hospital Association (AHA), Maine hospitals employ more than 35,600 people, most of whom work full time and receive benefits. The total hospital payroll is over $2.5 billion annually. The doctors, nurses, administrators, technicians, and maintenance workers who have these jobs buy homes and cars, eat in local restaurants and shop at local stores. They also pay state and local taxes. According to AHA, each hospital job supports about one more job outside the hospital and every dollar spent by a hospital supports roughly $1 of additional business activity.

Community Benefits. In addition to the economic impact that hospitals can have as large employers, hospitals provide innumerable other community benefits.

For example, hospitals conduct comprehensive community health needs assessments and then develop the programs necessary to meet those needs. Hospitals are also the local source for flu shots, health screenings, professional and community education and charity care. In aggregate, these hospital investments not only improve the health of Maine people, but also provide extensive additional economic benefit to the local community in which these services occur.

Shares of Jobs by Sector



"Hospitals are vital economic engines. Although they represent only 2% of the 2,539 reporting public charities, hospitals are responsible for 54% of the sector's $10 billion impact on the Maine economy," —Maine Association of Non-Profits.

No ACA Repeal Without Fair Replacement

There should be no repeal of the Affordable Care Act (ACA) without an adequate and simultaneous replacement of its provisions.

The ACA contained both positives and negatives for hospitals. Without knowing what the final bill will include, MHA has generated what we call the "nightmare" scenario…the ACA hospital cuts continue, as proposed in the American Health Care Act, and the benefits to hospitals are not replaced.

If Congress repeals the ACA, it must repeal the cuts to hospitals.

ACA Cuts to Hospitals			
	Market Basket Update	Medicare DSH	**Totals**
1 Year	$63 Million	$26 Million	**$89 Million**
10 Year	$633 Million	$262 Million	**$895 Million**

ACA Cuts to Hospitals

Market Basket Cut. The ACA reduced the rates that Medicare pays to hospitals. The ACA required CMS to change the formulas it uses to provide its annual adjustment in such a way that hospitals were paid less and the federal government saved money. This "market basket" cut was implemented in 2011 but has ramped up over time.

The loss to Maine hospitals from this cut was about $3 million in 2011. Next year, hospitals will lose about $63 million because of this cut.

DSH Cut. The second cut to hospitals was reductions in Disproportionate Share Hospital payments (DSH). DSH payments provide additional financial help to those hospitals that serve a significantly disproportionate number of low-income patients.

There are two DSH programs, one in Medicare and one in Medicaid. The ACA cut both programs.

Medicare DSH. The ACA included provisions to cut Medicare DSH payments by 75% beginning in federal fiscal year 2014. The annual loss to Maine hospitals because of the DSH cut is $16 million.

Medicaid DSH. Because Maine does not provide Medicaid DSH payments to Maine's hospitals, there is no impact to Maine hospitals from the Medicaid DSH cuts.

ACA Benefits to Hospitals

The ACA provides three primary benefits to hospitals: Exchange Subsidies, Medicaid Expansion and the 340B Drug Discount Program. The 340B program is so important, we will discuss it separately.

Exchange Subsidies. The ACA provides subsidies to individuals to buy commercial insurance on the health insurance exchanges.

In Maine, about 75,000 people receive subsidies. Maine hospitals and their practices provide the vast majority of care to these individuals. Maine hospitals receive about $200 million a year in compensation for care provided to those with subsidized coverage. This is a huge amount of money for Maine hospitals.

Maine's individual health insurance market before the ACA was not strong. If these subsidies are repealed without an adequate replacement, many individuals will become uninsured.

Medicaid Expansion. Another benefit for Maine hospitals is the opportunity to expand Medicaid to more people. Maine has not expanded Medicaid.

About 40,000 Maine citizens would receive health coverage if Maine were to expand. By law, Maine hospitals must provide free care to Maine citizens below 150% of the federal poverty level. All of those who would be covered are now eligible for this free care. Accordingly, the decision not to expand Medicaid in Maine disproportionately affects Maine hospitals.

If other states that have expanded Medicaid continue to receive 90% federal funding for their Medicaid expansion populations, then states that have not expanded should continue to be allowed to pursue expansion.

Other Impacts

Other programs influenced by the ACA include Value-Based Purchasing provisions that tie hospital reimbursement to outcomes. Maine hospitals support these programs but they can be improved. Two of the three quality programs only punish hospitals for poor performance; they don't reward hospitals for their high quality. These programs shouldn't be used to cut overall Medicare spending.

If Congress keeps the ACA-related cuts to hospitals, then it must provide comparable benefits to hospitals as provided in the ACA.

	ACA Benefits to Hospitals at Risk		
	Subsidies on Exchanges	340B for CAHs	**Total**
1 Year	$200 Million	$15 Million	**$215 Million**
10 Year	$2 Billion	$150 Million	**$2.15 Billion**

340B Hospitals

The Aroostook Medical Center
Blue Hill Memorial Hospital
Bridgton Hospital
CA Dean Memorial Hospital
Calais Regional Hospital
Down East Community Hospital
Eastern Maine Medical Center
Houlton Regional Hospital
Inland Hospital
LincolnHealth
Maine Medical Center
MaineGeneral Medical Center
Mayo Regional Hospital
Millinocket Regional Hospital
Mount Desert Island Hospital
Northern Maine Medical Center
Pen Bay Medical Center
Penobscot Valley Hospital
Redington-Fairview General Hospital
Rumford Hospital
Sebasticook Valley Health
St. Mary's Regional Medical Center
Stephens Memorial Hospital
Waldo County General Hospital

Protect the 340B Drug Discount Program

The 340B Drug Discount Program was created in 1992 and provides eligible hospitals with access to discounted drug prices for their patients receiving outpatient hospital services. Eligible hospitals include those that provide a disproportionate amount of care to low income patients, Critical Access Hospitals (CAH), Rural Referral Centers, Sole Community Hospitals and children's hospitals.

The 340B Drug Discount Program requires pharmaceutical manufacturers to provide prescription drugs to qualifying hospitals and other covered entities at or below a "340B ceiling price" established by the Health Resources and Services Administration. These drugs are then provided to all hospital patients with the exception of those patients on the Medicaid program. Medicaid patients are covered under a similar drug discount program administered by State Medicaid Agencies.

In 2010, the Affordable Care Act made all CAHs, Sole Community Hospitals and Rural Referral Center Hospitals categorically eligible to participate in the 340B Drug Discount Program. By extending these benefits to small rural hospitals, approximately one-third of all U.S. hospitals now participate in the 340B program, yet pharmaceuticals purchased at 340B pricing account for only 2% of all medicines purchased in the United States each year.

This program produces significant savings for safety-net providers, generally between 20% and 50% of the drug's cost.

Currently, 24 Maine hospitals qualify for the 340B Drug Discount program and receive a collective benefit estimated to be $103 million. The combined operating margins for those 24 hospitals in 2016 was $77 million. Thirteen of those 24 hospitals had negative margins.

Please oppose any changes to the 340B Drug Discount Program that would have a negative impact on hospitals and the low-income patients that benefit from this important program. It is especially important for Congress to retain 340B eligibility for the nation's rural hospitals that benefited from the changes in the Affordable Care Act.

Rural Hospitals Need Help With the VDA

A Volume Decrease Adjustment (VDA) is a payment adjustment granted by Medicare to either Sole Community Providers or Medicare Dependent Hospitals when these providers experience a decline in discharges greater than 5% in any given year due to an externally imposed, unusual circumstance beyond the hospital's control. The hospital must submit its request no later than 180 days after the date on the intermediary's Notice of Amount of Program Reimbursement and it must complete the following:

- Submit to the intermediary documentation demonstrating the size of the decrease in discharges and the resulting effect on per-discharge costs; and
- Show that the decrease is due to circumstances beyond the hospital's control.

The intermediary determines a lump sum adjustment amount not to exceed the difference between the hospital's Medicare inpatient operating costs and its total Diagnosis Related Group (DRG) revenue for inpatient operating costs based on DRG-adjusted prospective payment rates for inpatient operating costs (including outlier payments for inpatient operating costs determined under subpart F of this part, and additional payments made for inpatient operating costs, hospitals that serve a disproportionate share of low-income patients as determined under § 412.106 and for indirect medical education costs as determined under § 412.105). To decide the adjustment amount, the intermediary considers:

- The individual hospital's needs and circumstances, including the reasonable cost of maintaining necessary core staff and services in view of minimum staffing requirements imposed by State agencies;
- The hospital's fixed (and semi-fixed) costs, other than those costs paid on a reasonable cost basis under part 413 of this chapter; and
- The duration of the decrease in utilization.

The intermediary makes its determination within 180 days from the date it receives the hospital's request and documentation. The determination is subject to review under subpart R of part 405 of this chapter. The time required by the intermediary to review the request is considered cause for granting an extension for the hospital to apply for that review.

A hospital can be designated a **Sole Community Hospital (SCH)** if it is:

- At least 35 miles from other like hospitals;
- Rural, located between 25 and 35 miles from other like hospitals, and meets one of these criteria:
  - ◊ No more than 25 percent of residents who become hospital inpatients or no more than 25 percent of the Medicare beneficiaries who become hospital inpatients in the hospital's service area are admitted to other like hospitals located within a 35-mile radius of the hospital or, if larger, within its service area; or
  - ◊ The hospital has fewer than 50 beds and would meet the 25 percent criterion above if not for the fact that some beneficiaries or residents were forced to seek specialized care outside of the service area due to the unavailability of necessary specialty services at the hospital.
- Rural and between 15 and 25 miles from other like hospitals but because of local topography or periods of prolonged severe weather conditions, the other like hospitals are inaccessible for at least 30 days in each of 2 out of 3 years; or
- Rural and because of distance, posted speed limits, and predictable weather conditions, the travel time between the hospital and the nearest like hospital is at least 45 minutes.

A hospital is classified as a **Medicare-Dependent Hospital** if it is in a rural area and:

- Has 100 or fewer beds;
- Is not also classified as a SCH; and
- At least 60 percent of its inpatient days or discharges were attributable to individuals entitled to Medicare Part A benefits.

Hospitals Appealing CMS' VDA Decision

(as of April 25, 2017)

The Aroostook Medical Center

MaineCoast Memorial Hospital

Stephens Memorial Hospital

Cary Medical Center

Inland Hospital

LincolnHealth

Pen Bay Medical Center

The Current Issue

Last August and September, several Maine hospitals received revised volume decrease adjustment calculations from the Medicare Audit Contractor (MAC) National Government Services (NGS). The adjustments were labeled as Notice of Program Reimbursement and demanded that the hospitals remit a cash refund within 15 days. The primary differences between the original and revised calculations were adjustments for variable cost. The operating costs identified in the original submissions were reduced by approximately 15% based on variable costs identified by NGS on the respective trial balances (mostly supplies). This adjustment was made so as to compensate the hospital only for the fixed costs that were incurred during the period. Although the MAC adjusted the cost for fixed only, there was no adjustment made for the corresponding payments sent to hospitals. This results in an unfavorable mismatch where costs are reduced but payments still reflect compensation for both fixed and variable costs. As a result, hospitals had to send back a significant amount of reimbursement (almost all) to Medicare.

The calculations were completed at the direction of the Centers for Medicare & Medicaid Services (CMS), which has overturned a Provider Reimbursement Review Board (PRRB) decision that supported the more logical calculation that would reduce both costs and payments for the variable component. There are 35-40 hospitals affected by this decision in jurisdictions J and K and primarily affects Maine, New Hampshire, Vermont and upstate New York.

NGS indicates that CMS instructed them to revise all final determinations within the allowable look-back period and going forward. In Maine, this results in take-backs for fiscal years going back to 2007.

The negative financial impact of this decision in Maine is approximately $10 million dollars and affects 7-10 small Medicare Dependent and Sole Community Hospitals—hospitals that can ill afford to send money back to Medicare.

These hospitals need the Maine delegation to ask CMS not to claw back 10 years worth of reimbursements and to adjust the formula to reflect the PRRB decision.

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2017

MHA Member Hospitals

Acadia Hospital, Bangor
The Aroostook Medical Center, Presque Isle
Blue Hill Memorial Hospital, Blue Hill
Bridgton Hospital, Bridgton
Calais Regional Hospital, Calais
Cary Medical Center, Caribou
Central Maine Medical Center, Lewiston
CA Dean Memorial Hospital, Greenville
Down East Community Hospital, Machias
Eastern Maine Medical Center, Bangor
Franklin Memorial Hospital, Farmington
Houlton Regional Hospital, Houlton
Inland Hospital, Waterville
LincolnHealth, Damariscotta & Boothbay Harbor
Maine Coast Memorial Hospital, Ellsworth
MaineGeneral Medical Center, Augusta & Waterville
Maine Medical Center, Portland
Mayo Regional Hospital, Dover-Foxcroft
Mercy Hospital, Portland
Mid Coast Hospital, Brunswick
Millinocket Regional Hospital, Millinocket
Mount Desert Island Hospital, Bar Harbor
New England Rehabilitation Hospital of Portland
Northern Maine Medical Center, Fort Kent
Pen Bay Medical Center, Rockport
Penobscot Valley Hospital, Lincoln
Redington-Fairview General Hospital, Skowhegan
Rumford Hospital, Rumford
St. Joseph Hospital, Bangor
St. Mary's Regional Medical Center, Lewiston
Sebasticook Valley Health, Pittsfield
Southern Maine Health Care, Biddeford & Sanford
Spring Harbor Hospital, Westbrook
Stephens Memorial Hospital, Norway
Waldo County General Hospital, Belfast
York Hospital, York

MHA

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