

Maine's Healthcare Trustee

Dirigo Health: compromise struck addressing key hospital issues

Intense negotiations follows groundswell of support for hospitals.

In late May, after several days of intense negotiations, a compromise was announced that addressed many of the significant concerns Maine hospitals have had with LD 1611, the Dirigo Health bill. The compromise was achieved in large part because of the extraordinary work of Maine hospitals in contacting their elected officials.

Some of the most egregious provisions relating to hospitals in LD 1611 have been removed and replaced with a more rational approach to health care reform as a result of negotiations between its sponsors, the MHA, and other parties.

As legislators and administration officials reacted to expressions of concern from hospitals, a negotiated-compromise approach took shape from a collection of proposed amendments.

The amended bill will contain several changes of particular concern to hospitals:

- One amendment eliminates the “global budget” for hospital spending, removes the Hospitals for Maine’s Future plan for hospital/physician allocation of health resources, and eliminates the bill’s threat of state rate-setting measures if voluntary cooperation failed. In place of the global budget and redesign of the hospital delivery system, there would be a study of the hospital system.
- Another change would ask hospitals to hold their consolidated operating margins to 3 percent for a year; to report on charge increases and expense/efficiency measures; and to observe a voluntary cap of 3.5 percent on expense increases in their Case Mix Adjusted Discharge, or CMAD.
- The Certificate of Need expenditure cap is retained subject to negotiated statutory language with MHA. We anticipate intense negotiations on this point in the days ahead.

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MHA raised concerns about key aspects of LD 1611

MHA contended Governor’s Health Plan would harm access to care and hospitals’ ability to meet their communities’ individual health needs.

As MHA expressed strong opposition to three key aspects of LD 1611, the Governor’s proposed Health Care Reform plan during legislative hearings: the global budget for hospitals, 3 percent rate cap on hospital charges and a certificate of need expenditure cap.

MHA worked to educate legislators about the implications of these provisions to providing health care in Maine in terms of access, quality and cost containment.

The Joint Select Committee on Health Care Reform held three days of work sessions in mid May. The committee’s first work session focused on the questions members had after hearing testimony at the May 8th public hearing. Several members of the committee wanted to incorporate other legislation, such as commercial health insurance market reform, that has taken a back seat to the Administration’s plan. Committee co-chair Sen. **Michael Brennan** (D-Portland) cautioned against bringing new issues into the already full agenda facing them. “I don’t want to stray too far outside what’s already in this bill,” said Brennan.

At the committee’s request, MHA presented additional data to the committee on hospital costs, services and capacity.

Leading Democrats continue to
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urge hospitals and other interest groups to support passage of the Governor's plan and work out the details afterward in negotiations. MHA president **Steven Michaud** called that approach "totally unrealistic."

The second and third days of the work sessions largely focused on getting more detailed information about the universal insurance portion of LD 1611. **Trish Riley**, head of Governor Baldacci's Office of Health Care Policy and Finance presented some of the numbers and assumptions that went into development of the plan. Her presentation included a range of financial breakdowns based on how many people would choose to enroll in the plan and how the financial contributions of employers, employees, federal Medicaid funds and Maine's insurers would provide the revenues to make the plan work.

Committee members asked her for additional information, including reimbursement levels received by hospitals and other health care providers from Medicare, Medicaid, Worker's Compensation and insurance companies. A breakdown of the benefit package in the Dirigo Plan as compared to the state employees' plan and the impact of a proposed 4.1 percent surcharge on the premium revenues of insurance companies were also requested.

Several committee members wondered if the reliance on the federal government's Medicaid program to fund a key portion of this plan was wise and whether pre-approval by the federal government wouldn't be helpful. "The worst thing we could do is build an expectation around a funding source that is uncertain," said Sen. **Karl Tumer** (R-Cumberland).

The committee has directed Riley to hold separate meetings with MHA, insurers and others to try to reach agreement on key points of contention. **MHA contacts: Steven Michaud, Mary Mayhew**

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- The CON process will apply to all new services and equipment regardless of the location (subject to threshold dollar amounts), significantly leveling the playing field among all health care providers.

Hospitals would have a voluntary consolidated operating margin target of 3 percent for one year.

The core provision of Dirigo Health — subsidized insurance coverage for qualifying Maine residents — would remain, as would statewide health planning, insurance assessments to fund some of Dirigo Health's subsidies, and provider price disclosures.

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"While some difficult negotiations still remain before this proposal is acceptable, the plan has moved much closer to addressing hospital concerns," said MHA president **Steven Michaud** "and is a more rational and balanced approach to health care reform now."

"We could not have achieved this agreement without the extraordinary support of our member hospitals in expressing their concerns to their elected officials," said Michaud.

MHA contacts: Steven Michaud, Mary Mayhew

Hospital representatives testified about concerns with Baldacci health plan

Lawmakers conducting public hearings on the administration's Dirigo Health plan were cautioned that its provisions could cause severe financial pressure for the care Maine hospitals offer.

Witnesses representing Maine hospitals offered selective support and "qualified opposition" as legislators held the first public hearing on the Baldacci Administration's Dirigo Health plan.

The plan, unveiled with a 72-page summary on May 5, is before the Legislature in statutory format as LD 1611, "An Act To Provide Affordable Health Insurance to Small Businesses and Individuals and To Control Health Care Costs." The public hearing was conducted by the Joint Select Committee on Health Care Reform.

Rep. **Christopher O'Neil** (D-Saco) presented LD 1611 for the Administration. Noting the cost, complexity and access problems of the current system, which he called "a mess," O'Neil said, "Help is on the way."

Another sponsor, Sen. **Sharon Treat** (D-Gardiner), said LD 1611 "goes way beyond past efforts," adding "This time, we've got it right."

MHA President **Steven Michaud** spoke in "qualified opposition" to LD 1611, but said, "We believe that the bill can very quickly and easily be amended to achieve significant health care reform for the state of Maine in terms of access, quality and cost containment."

Michaud praised Gov. Baldacci for moving quickly to carry out a campaign promise to propose health-care reforms, and expressed support for "the vast majority of the Governor's plan." For example, Michaud said, health care could be improved by strengthening Certificate of Need (CON) procedures, conducting state-wide health planning, establishing a quality forum, and developing public information on pricing.

The MHA testimony focused on three concerns about LD 1611:

First, Michaud said, "The global budget for hospitals, if administered as foreseen in the bill, would be devastating." By 2005, he said, the difference between Maine hospitals' total costs and the budget permitted by annual price-index changes could range from \$600 million to \$800 million. The \$750 million gap estimated from the language of the May 5 plan summary, he said,

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would be equivalent to the entire budgets of Maine's 24 smallest hospitals.

"Total hospital expenses are a function of not only inflation but of patient volume increases," Michaud noted. That is, total hospital costs would rise even in a zero-inflation environment if they were providing more services, more intensively, to more patients—a scenario that appears inevitable based on the demographics of Maine.

Michaud urged removing the global-budget provision from the bill and developing other cost-containment measures.

The second MHA concern was the "unnecessary and unrealistic" 3 percent guideline for price changes through 2004. Michaud said hospitals' costs for pharmaceuticals, labor, liability insurance, blood and supplies are rising faster than 3 percent, and the Legislature recently cut \$58 million from Medicaid payments to hospitals. He suggested dropping the "voluntary" price guidelines—backed by the threat of State controls—from the plan, and assessing trends as other measures take hold.

The third concern Michaud cited was the proposed one-year moratorium on new Certificates of Need, to be followed by caps on future CONs. "It seems to us," he said, "that a cap on CON expenditures is inconsistent with rational health planning."

Two MHA member hospitals' CEOs lent the weight of their experience to the cautions.

Rumford Hospital CEO and MHA chairman of the board **John Welsh** predicted "a disastrous impact on Rumford Hospital, indeed, on all small, rural hospitals in Maine" if LD 1611 were enacted as drafted. "Many community hospitals may be forced to close," Welsh said, "but even if we do remain open, it will be impossible to serve our patients in the ways they need and deserve."

Laying out the factual basis for his concern, Welsh noted that Rumford Hospital, one of eight critical-access hospitals in Maine, serves 11 towns with 60 percent of the population covered by Medicare or Medicaid. Though critical-access hospitals receive cost-based reimbursement from those programs, Welsh predicted severe impacts on services, facilities maintenance, and staff retention from new budget and pricing caps.

Richard Willett, CEO of Skowhegan's Redington-Fairview General Hospital, said his hospital draws 70 percent of revenues from Medicare and Medicaid, and expects to lose \$1.3 million in its current fiscal year.

If Redington-Fairview were forced to deal with its indicated \$7 million share of the estimated global-budget shortfall, Willett said "it would be the

equivalent of completely eliminating the Emergency Department, the Special Care Unit, the Birthing Center, the Ambulance service, the Oncology Treatment Service, Cardio-Pulmonary Rehabilitation service and probably about 1/3 of our [65] inpatient beds."

Recent cuts in clinical areas forced by the Medicaid reductions, he said, "pale in the scope of what will happen with a global budget as proposed."

Many other groups and individuals joined hospitals in opposing portions of the legislation. Representatives from the hospital community, including nurses and trustees provided excellent testimony in support of MHA's position, emphasizing the negative impact the proposed cuts would have on their hospital's ability to continue to provide services.

Other opponents included the Maine Medical Association, Organization of Maine Nurse Executives, Anthem, Aetna and Cigna and the Maine Insurance Agents Association.

Gordon Smith, executive vice president of the Maine Medical Association, said doctors "stand with the Maine Hospital Association" in opposing the global budget and spending cap provisions. Smith also said "it is not possible to provide universal health care without mandating that all Mainers buy insurance," and pointed out that recent Medicaid cuts of \$58 million hurt health care providers who are already poorly reimbursed for their services by government insurance programs.

Some physician representatives raised concerns with the broadening of the CON process to include physician offices. They said they simply could not afford the costs of the CON process and questioned why physician offices were included in the legislation.

The Maine Chamber of Commerce and Industry joined Consumers for Affordable Health Care, Maine State Nurses Association and other consumer advocates in support of the legislation.

A number of groups, including the Maine Association of Health Care Purchasing Collaborative, National Federation of Independent Businesses and Home Care Alliance of Maine testified neither for nor against the legislation but cited a number of questions or concerns about the bill.

Concerns are not going entirely unnoted. In her testimony, a key supporter of the Dirigo Health plan suggested two amendments to respond to concerns such as those expressed by the MHA witnesses and others.

Trish Riley, executive director of the Portland-based National Academy for State Health Policy, suggested two amendments to address concerns raised by hospitals and by rural lawmakers. Riley said price-change guidelines for hospitals should be pegged to the federal hospital input-cost index (about 3.5 percent a year, she said), rather than the Consumer Price Index. Another amendment would clarify the intent to preserve health care providers in rural areas.

The Maine Hospital Association can supply further analysis.
MHA contact: Mary Mayhew

Fed tax cut bill to increase Medicaid funds for Maine

Senator Collins played an instrumental role in securing \$65 million for Maine's Medicaid Program by insisting that the tax cut bill include \$20 billion in state aid.

"Fiscal aid to the states is an essential part of an economic growth package," said Senator Collins, who voted for the tax cut legislation that narrowly passed the U.S. Senate 51-50 with Vice President Cheney casting the deciding vote.

Congress is putting the final touches on the bill in conference committee and President Bush is expected to sign it.

Other hospital payment provisions included in the economic stimulus and tax cut legislation would provide some relief to rural hospitals and Medicaid disproportionate share hospitals and improves Medicaid payments to states through the program's federal medical assistance percentage, commonly known as the federal Medicaid matching percentage.

"This is a piece of good news from the federal government for Maine hospitals who are struggling under low Medicaid reimbursement rates," said **Steven Michaud**, MHA president. "We want to thank Senator Collins for her leadership in helping Maine hospitals."

MHA contact: Mary Mayhew

Legislature abandons major tax reform this year

The Taxation Committee is crafting a competing measure to the MMA tax referendum issue on the ballot this November.

Governor Baldacci's long-awaited tax reform proposal will not be taken up by the Legislature's Taxation after all, a victim of a rapidly approaching deadline for Legislative adjournment. The Committee will focus instead on developing an alternative to the Maine Municipal Association referendum question.

Although the Governor's recently introduced tax reform legislation did not include any provisions allowing local municipalities the option of charging nonprofit organizations for the actual cost of providing services to the nonprofit or any provisions altering the definitions of charitable & benevolent entities, the MHA closely monitored developments given the recent deliberations of the Taxation Committee on these issues.

MHA strongly opposes any provision that would charge tax-exempt organizations a fee for municipal services. MHA believes it is inconsistent to seek consolidation of municipal services and then penalize nonprofit hospitals because they serve a broader population than just that of the host municipality.

MHA will continue to defend hospitals' exemption from property taxes and object to the levying of service fees and will monitor tax reform efforts in the second legislative session. **MHA contact: Mary Mayhew**

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